

Agenda

West Dunbartonshire
Health & Social Care Partnership

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

Date: Tuesday, 22 September 2026

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

Michelle McGinty (Chair)
Michelle Wailes (Vice Chair)
Libby Cairns
Lesley McDonald
Martin Rooney
Sophie Traynor

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

Date of Issue: 15 September 2026.

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, 22 SEPTEMBER 2026

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 carried out by roll call vote to ensure an accurate record.

5 (a) MINUTES OF PREVIOUS MEETING 7 - 13

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 23 June 2026.

(b) ROLLING ACTION LIST 15

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

6 EXTERNAL AUDIT FINAL REPORT 17 - 112

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

7/

- 7 2025/26 AUDITED ANNUAL ACCOUNTS AND REPORT 113 - 223**
- Submit report by Julie Slavin, Chief Financial Officer, providing an update to Members on completion of the audit of the HSCP Board's (IJB) Annual Accounts for the year ended 31 March 2026.
- 8 ANNUAL HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 225 - 242**
2019 IMPLEMENTATION STATUS AND ASSURANCE REPORT –
HEALTH (2025)
- Submit report by Val Tierney, Chief Nurse, outlining the reporting requirements for health services and confirms current HSCP assurance levels with respect to overall compliance with the duties within the Act.
- 9 AUDIT PLAN PROGRESS REPORT AND AUDIT PLAN 2026-27 243 - 265**
- Submit report by Gillian McConnachie, Chief Internal Auditor, enabling members to monitor the performance of Internal Audit and gain an overview of the HSCP Board's overall control environment.
- 10 QUARTERLY PERFORMANCE REPORT – QUARTER 1 267 - 289**
- Submit report by Beth Culshaw, Chief Officer, presenting the Members with information reported against the strategic priorities for the period April to June 2026 for consideration.
- 11 QUARTERLY REGULATED SERVICES UPDATE – 291 - 333**
QUARTER 1
- Submit report by Julie Slavin, Chief Financial Officer, providing an update on Care Inspectorate inspection activity.
- 12 HSCP QUARTER 1 CLINICAL & CARE GOVERNANCE 335 - 346**
COMMITTEE REPORT
- Submit report by Val Tierney, Chief Nurse, providing an update on key areas of progress, or any issues or challenges, in meeting this aim. The Quarterly Clinical and Care Governance Report (Appendix 1) supplements annual reporting, offering the committee regular updates. It covers services hosted, jointly provided, or commissioned externally, and highlights key achievements, risks, and challenges affecting care quality.

13 STRATEGIC RISK REGISTER

347 - 359

Submit report by Beth Culshaw, Chief Officer, presenting the Strategic Risk Register.

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

At a Hybrid Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee held in the Civic Space, 16 Church Street, Dumbarton on Tuesday, 23 June 2026 at 2.01 p.m.

- Present:** Libby Cairns, Lesley McDonald and Michelle Wailes, NHS Greater Glasgow and Clyde, Councillors Michelle McGinty, Martin Rooney and Sophie Traynor; West Dunbartonshire Council.
- Attending:** Beth Culshaw, Chief Officer; Julie Slavin, Chief Financial Officer; Gillian McConnachie, Chief Internal Auditor; Tom Reid and Mark Ramsay, External Auditors – Forvis Mazars;
- Also Attending:** Sylvia Chatfield, Head of Mental Health, Addictions and Learning Disabilities; Fiona Wilson, Clinical Director; Helen Little, Musculoskeletal Physiotherapy Manager; Val Tierney, Chief Nurse; Sharon Laing, Acting Chief Social Work Officer; Neil McKechnie, Contracts, Commissioning and Quality Manager; Alastair Handley, Systems, Digital & Information Governance Manager and Natalie Roger and Lynn Straker, Committee Officers.
- Apology:** Apologies for absence were intimated on behalf of Karyn Wood, Head of Human Resources; Fiona Taylor, Head of Health and Community Care and Anne MacDougall, Stakeholder Member.

Councillor Michelle McGinty in the Chair

STATEMENT BY CHAIR

Councillor Michelle McGinty, Chair advised that the meeting was being audio streamed and broadcast live to the internet and would be available for playback. Chair also welcomed Councillor Sophie Traynor, West Dunbartonshire Council as a new Voting Member to the HSCP Board.

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 meeting held on 3 March 2026 were submitted and approved as a correct record.

ROLLING ACTION LIST

The Rolling Action List was submitted for information and relevant updates were noted and agreed.

REGULATED COMMISSIONED SERVICES REPORT

A report was submitted by Julie Slavin, Chief Financial Officer, providing an update on Care Inspectorate inspection activity.

After discussion and having heard the Chief Financial Officer and from Neil McKechnie, Contracts, Commissioning and Quality Manager, in further explanation of the report and in answer to Members' questions, the Committee agreed to note the content of this report.

QUARTER 4 2025/26 CLINICAL AND CARE GOVERNANCE REPORT

A report was submitted by Val Tierney, Chief Nurse, providing an update on key areas of progress and any issues or challenges.

After discussion and having heard the Chief Nurse and from Alastair Handley, Systems, Digital & Information Governance Manager, in further explanation of the report and in answer to Members' questions, the Committee agreed:-

- (1) to note the progress related to strengthening oversight, assurance of care quality, and related improvement efforts; and
- (2) to consider the update on risks previously escalated to the NHSGGC Primary Care Clinical Governance relating to Speech and Language Therapy and the Interpreting Service.

STRATEGIC RISK REGISTER SIX MONTH REVIEW

A report was submitted by Beth Culshaw, Chief Officer, presenting the Strategic Risk Register.

After discussion and having heard the Chief Officer in further explanation of the report and in answer to Members' questions, the Committee agreed for the report to be updated and brought back to the next meeting of the HSCP Audit and Performance Committee on 22 September 2026 for comment prior to its submission to the HSCP Board for approval on 29 September 2026.

AUDIT PLAN PROGRESS REPORT

A report was submitted by Gillian McConnachie, Chief Internal Auditor, providing information to enable members to monitor the performance of Internal Audit and gain an overview of the HSCP Board's overall control environment.

After discussion and having heard the Chief Internal Auditor and the Chief Financial Officer in further explanation of the report and in answer to Members' questions, the Committee agreed to note the progress made in relation to the Internal Audit Annual Plan for 2025/26.

ANNUAL REPORT ON THE AUDIT AND PERFORMANCE COMMITTEE FOR THE YEAR ENDED 31 MARCH 2026 INCLUDING SELF-EVALUATION OF AUDIT AND PERFORMANCE COMMITTEE

A report was submitted by Julie Slavin, Chief Financial Officer, providing the 2025/26 Annual Report on the Audit and Performance Committee, incorporating the outcome and improvement actions for the recent self-assessment on the impact and effectiveness of the Committee.

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

- (1) to approve the HSCP Board's Audit and Performance Committee Annual Report 2025/26;
- (2) to approve the self-evaluation of the Committee's impact and effectiveness, and areas of improvement, based on the outcomes of its self-assessment using the CIPFA Audit Committees Guidance; and
- (3) to agree that the HSCP Board's Audit and Performance Committee Annual Report 2025/26, which is designed to both provide assurance to the HSCP Board and to identify actions to improve the Audit and Performance

Committee's impact and effectiveness, should be presented to the September HSCP Board meeting.

REVIEW OF TERMS OF REFERENCE OF THE AUDIT AND PERFORMANCE COMMITTEE

A report was submitted by Julie Slavin, Chief Financial Officer, providing the Audit and Performance Committee with a revised Terms of Reference (ToR) of the Audit and Performance Committee following a recent scheduled review.

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

- (1) to approve the recommended changes to the current Terms of Reference of the Audit and Performance Committee to reduce voting membership from six to four retaining equal representation from West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board; and
- (2) to remit to the HSCP Board for final approval, recognising that the Audit and Performance Committee is a formal committee of the Board.

INTERNAL AUDIT ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2026

A report was submitted by Gillian McConnachie, Chief Internal Auditor, based on the internal audit work carried out for the year ended 31 March 2026, which contains an independent opinion on the adequacy and effectiveness of West Dunbartonshire's Health & Social Care Partnership (HSCP) 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 of the report, the Committee agreed to note the contents of this report.

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

A report was submitted by Julie Slavin, Chief Financial Officer, providing an update on the progress of the 2025/26 external audit, and seeking the Committee's consideration and approval of the response to the external auditor's request for assurances on governance, risk management and compliance with International Auditing Standards.

After discussion and having heard the External Auditors - Forvis Mazars and the Chief Financial Officer in further explanation of the report and in answer to Members' questions, the Committee agreed to approve the response to our external auditors on compliance with International Standards for Auditing (ISAs) in relation to fraud, laws and regulations, litigation and claims and going concern.

BEST VALUE STATEMENT

A report was submitted by Beth Culshaw, Chief Officer, providing a statement in relation to how the HSCP Board has delivered Best Value during the financial year 2025/26.

After discussion and having heard the Chief Officer in further explanation of the report, the Committee agreed to approve the Best Value Statement within the report.

2025/26 CODE OF GOOD GOVERNANCE & ANNUAL GOVERNANCE STATEMENT

A report was submitted by Julie Slavin, Chief Financial Officer, advising of the outcomes of the annual self-assessment of compliance with the Local Code of Good Governance and associated improvement actions and seeking approval of the refreshed Local Code of Good Governance and Sources of Assurance and the draft Annual Governance Statement for inclusion in the HSCP Board's 2025/26 Unaudited Annual Accounts.

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

- (1) to review and approve the Local Code of Good Governance and Sources of Assurance as detailed within the report;
- (2) to note the outcome of the annual self-evaluation and the update of the improvement actions detailed within the report; and
- (3) to consider the detail of the Annual Governance Statement within the report and approve its inclusion in the 2025/26 Unaudited Annual Accounts.

UNAUDITED ANNUAL REPORT AND ACCOUNTS 2025/26

A report was submitted by Julie Slavin, Chief Financial Officer, requesting consideration of the unaudited Annual Report and Accounts for the HSCP Board covering the period 1 April 2025 to 31 March 2026 and seeking approval of the unaudited accounts and associated working papers to be passed to our external auditors for their review.

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

- (1) to consider and approve the 2025/26 unaudited Annual Report and Accounts, including movements in reserves;
- (2) to approve their submission to the HSCP Board's external auditors for review by 30 June; and

- (3) to note that the audited Annual Report and 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.

ADJOURNMENT

Councillor Michelle McGinty, Chair, adjourned the meeting for a short recess. The meeting reconvened at 3.25 p.m. with all Members listed in the sederunt present.

ANNUAL PERFORMANCE REPORT 2025/26

A report was submitted by Beth Culshaw, Chief Officer, providing an overview of the HSCPs performance in planning and carrying out integrated functions.

After discussion and having heard the Chief Officer in further explanation of the report and in answer to Members' questions, the Committee agreed to grant the Chief Officer delegated authority to publish the West Dunbartonshire HSCP Annual Performance Report 2025/26 in line with the legislative timescales of 31 July 2026.

ANNUAL REPORT FOR MUSCULOSKELETAL PHYSIOTHERAPY SERVICE 2025/26

A report was submitted by Helen Little, Musculoskeletal Physiotherapy Manager, presenting present the Annual Report for Musculoskeletal (MSK) Physiotherapy service (Greater Glasgow and Clyde) 2025/26.

After discussion and having heard the Musculoskeletal Physiotherapy Manager in further explanation of the report and in answer to Members' questions, the Committee agreed to note the contents of the report.

ANNUAL CLINICAL & CARE GOVERNANCE REPORT 2025

A report was submitted by Val Tierney, Chief Nurse, providing assurance that the HSCP's health and care governance systems effectively monitor and support improvement in the quality of services it commissions and delivers. This includes services that are hosted, delivered jointly with partner organisations, or commissioned from external providers.

After discussion and having heard the Chief Nurse in further explanation of the report, the Committee agreed this report will be submitted 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 review and evaluation of care quality.

WEST DUNBARTONSHIRE COLLABORATIVE CARE HOME SUPPORT TEAM ANNUAL REPORT 2025

A report was submitted by Val Tierney, Chief Nurse, outlining the continued development and delivery of the Care Home Support model in West Dunbartonshire and highlighting the efforts of West Dunbartonshire HSCP Collaborative Care Home Support Team (CCHST), in partnership with the NHS Greater Glasgow & Clyde Care Home Collaborative (CHC), in promoting high standards of care and resident wellbeing.

After discussion and having heard the Chief Nurse and the Head of Mental Health, Addictions and Learning Disabilities in further explanation of the report and in answer to Members' questions, the Committee agreed:-

- (1) to note the governance arrangements that support Care Homes and align with the strategic direction of the My Health, My Care, My Home Healthcare Framework for adults living in care homes; and
- (2) to note the achievements of the CCHST and CHC including the positive impact of care home assurance visits, the culture of shared learning and continuous improvement and the positive impact of the care home support model in delivering better health, care, and resident and workplace outcomes.

HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 SOCIAL CARE ANNUAL REPORT 2025/26

A report was submitted by Val Tierney, Chief Nurse, introducing the HCSP Social Care Annual Report for 2025-26 to the HSCP Board Audit and Performance Committee for their consideration and approval.

After discussion and having heard the Chief Nurse in further explanation of the report and in answer to Members' questions, the Committee agreed to approve the content of the HCSA Social Care Annual Report 2025-26.

IMPLEMENTATION OF DIRECTIONS POLICY

A report was submitted by Beth Culshaw, Chief Officer, providing the Audit and Performance Committee with an update on the implementation of the Directions Policy, which was approved by the HSCP Board on the 23 September 2020 and implemented on the 30 September 2020

After discussion and having heard the Chief Officer in further explanation of the report, the Committee agreed to note the progress made in respect of the implementation of the Directions Policy.

The meeting closed at 3.55 p.m.

**WEST DUNBARTONSHIRE HSCP AUDIT AND PERFORMANCE COMMITTEE
ROLLING ACTION LIST**

Agenda Item	Decision / Minuted Action	Responsible Officer	Timescale	Progress/ Update/ Outcome	Status
Item 6 - Quarterly Performance Report 2025/26 Quarter Three	Briefing note to be distributed to Members regarding what is offered to those complex needs cases where no service has been deemed suitable.	Sylvia Chatfield	23 June 2026	Sylvia Chatfield advised the Briefing note will be sent to Members in next few days detailing next steps for those deemed unsuitable for therapies.	Open
Item 7 - Quarter 4 Clinical and Care Governance Committee Report	Briefing note to be distributed to Members detailing assurance of improvement and data to support improvement.	Val Tierney	22 September 2026	Briefing note issued to all members on 24 June 2026 providing assurance on improvement and data to support this.	Closed

Updated: LS 23 June 2026

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD**AUDIT AND PERFORMANCE COMMITTEE****Report by Julie Slavin, Chief Financial Officer****22 September 2026**

Subject: Proposed Annual Audit Report 2025/26 – 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 2026, 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 July 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 2026;
 - 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 2025/26 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 in a number of key areas and themes including 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 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 July 2026.
- 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 2025/26 Accounts.

4. Main Issues

- 4.1 At the time of writing, the audit of the 2025/26 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, as set out in Appendix C.”

- 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 on the 23 June 2026. 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(s) that could impact on the 2025/26 final accounts.

- 4.3** The senior management team have reviewed their own response, submitted in July, 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 2025/26 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 are two recommendations arising from the wider scope audit set out within Section 7 of Appendix 3 as detailed below, both of which have been accepted by management.

Financial Sustainability – Level 1

- The IJB should continue to strengthen medium-term financial sustainability by developing and delivering recurring savings and transformation initiatives that reduce reliance on reserves to support financial balance.
- Progress against planned savings, reserve utilisation and future budget gap mitigation should continue to be regularly reported to the IJB Board and Audit & Performance Committee.
- Enhanced scenario modelling and quantified sensitivity analysis would support greater transparency over financial risks and strengthen long-term financial resilience.

Management Response

- The IJB recognises financial sustainability as a key strategic risk and will continue to support long-term financial resilience through established governance arrangements, delivery of savings and transformation programmes, annual review of the Medium-Term Financial Outlook, and ongoing development of financial planning, scenario modelling and risk analysis.

Vision, leadership and governance - Workforce Planning and Strategic Plan Alignment – Level 2

- The IJB should complete development of the longer-term Workforce Plan and Leadership and Talent Framework.
- Formal milestones should be established and monitored with oversight of those charged with governance. Future workforce planning should demonstrate a clear link between workforce priorities, succession planning arrangements, Strategic Needs Assessment findings and strategic service delivery objectives

Management Response

- Interim workforce planning arrangements are in place, with a comprehensive Workforce and Organisational Development Plan 2027-2032 being developed alongside the Strategic Plan 2027-2032. This will strengthen workforce and succession planning, supported by clear milestones, governance oversight, and alignment with strategic, service and financial planning priorities.

4.7 The report also provides members with an update of two recommendations from last year's audit (2024/25) which have been assessed as being complete.

- **Financial Management (Training for budget holders) – Level 3**

The IJB should ensure refresher training is provided to budget holders to ensure procedures are understood and consistently applied.

Implementation timescale: Training materials finalised by November 2025 and phased roll-out, incorporating feedback throughout 2026.

Update: Complete

- **Financial Sustainability – Level 2**

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.

Implementation timescale: 1 April 2026.

Update: Complete

However, the risks that gave rise to the original recommendation remain relevant and have been incorporated into the Financial Sustainability Level 1 risk reported above.

- 4.8** 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.
- 4.9** The Chief Financial Officer and IJB Standards Officer will remind members of the importance of reviewing and updating their register of interests in advance of the preparation of the unaudited annual accounts. However, responsibility for the registration and declaration of interests remains with individual IJB members, in accordance with guidance issued by the Standards Commission for Scotland.
- 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: 14 September 2026

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: Draft Auditor Report

Background Papers: HSCP Audit and Performance Committee June 2026 –
Unaudited Annual Report and Accounts 2025/26

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 Committee exercises active oversight of management's arrangements for preventing, detecting and responding to fraud and error through a combination of:

- Scrutiny of the control environment that underpins the annual accounts and
- Structured assurance reporting from internal audit, governance processes and the partner bodies upon which the IJB relies for transaction processing.

The IJB's financial statements are prepared by professionally qualified finance staff and are based on transactions processed through the core financial systems of West Dunbartonshire Council and NHS Greater Glasgow & Clyde, with the Committee taking assurance from the operation and review of those systems' internal controls and from internal and external audit activity. This reflects the approach set out in last year's response, updated for 2025/26.

The Committee's oversight is supported by annual and in-year governance assurance processes, including the annual governance statement and the annual review of the Local Code of Good Governance, which draw together assurance from senior officers' self-assessment and certificates of assurance within partner arrangements.

In addition, the Committee expects management to maintain clear standards of ethical behaviour and compliance. The IJB is not an employing organisation; accordingly, staff delivering HSCP services comply with the employing partners' codes of conduct and associated policies (including whistleblowing and counter-fraud arrangements). This is consistent with the assurance position set out in the prior year response and remains applicable for 2025/26.

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 2025/26? Please provide details.**HSCP Board Audit and Performance Committee Response**

The Committee oversees management's identification and response to fraud risk and internal control breaches through routine assurance reporting, including internal audit progress reporting and oversight of action plans arising from audit work. Each Committee receives an audit plan progress report which summarises internal audit activity against the annual plan, includes progress in addressing agreed actions, and provides a summary of

internal audit work undertaken within both partner bodies which may impact the HSCP control environment.

The Committee also takes assurance from the structured annual governance processes that assess the effectiveness of the internal control framework, including annual governance statement reporting and the annual Local Code review arrangements.

The regular update reports to Committee have not referenced any breaches in-year, and no material breaches have been raised through other escalation routes, including regular Chair and Vice Chair meetings with the Chief Officer and Chief Financial Officer.

The Committee receive a range of assurances/reports during the year which align to aspects of internal control. Reports in 2025/26 have included:

- Annual Audit Plans from internal and external audit
- Annual Internal Audit Report and Assurance Statement
- Internal Audit progress reports
- Annual Governance Statement
- Strategic Risk Register Six Month Review
- Annual Clinical and Care Governance Report
- Regulated Services Report

All HSCP Heads of Service, Chief Officer and Chief Financial Officer attend meetings 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 2025 – 31 March 2026? Where appropriate please provide details.

HSCP Board Audit and Performance Committee Response

The IJB does not employ staff or operate transactional banking arrangements. In practice, suspected or alleged fraud relating to delegated services is managed through the employing partner organisations' established counter-fraud frameworks and is escalated through the relevant governance and audit routes. This position is consistent with the basis of assurance described in the prior year response and continues to apply for 2025/26.

Based on the Chief Internal Auditor's review of internal audit reports for both partner organisations, 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

The Committee recognises that fraud risk exists in any large and complex system and therefore places emphasis on ongoing vigilance, effective internal controls, and strong audit and governance arrangements.

The Committee's assurance is drawn from:

- i. Internal audit reporting and monitoring of agreed actions (including work relevant to the HSCP control environment within partner bodies), and
- ii. Structured governance assurance processes which consolidate senior officers' assurance and internal control self-assessment.

In addition, the Committee's wider scrutiny of strategic risks supports its understanding of areas where fraud risk could be elevated, including risks associated with commissioned services and contract monitoring, as captured within 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

The Committee is satisfied that key internal controls exist and are designed to operate effectively across the arrangements that support delivery of HSCP services and preparation of the IJB's annual accounts. In particular, financial transactions are processed through partner organisations' core systems, where segregation of duties, authorisation limits, management review and established financial procedures are integral to the control environment. This remains consistent with the assurance position described in the prior year response.

The Committee also takes assurance from internal audit reporting against the annual audit plan and from the monitoring of internal and external audit actions, which provide independent challenge and follow-up on the effectiveness of controls.

Where control improvement is required, this is identified through governance self-assessment and improvement actions (for example, actions that strengthen consistency of induction oversight, management information quality, structured self-evaluation and procurement/commissioning maturity). These improvement themes are explicitly captured in the Local Code of Governance self-assessment material and associated improvement actions.

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 2025/26. 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

The Committee is satisfied that staff are encouraged to raise concerns, including concerns about suspected fraud or inappropriate conduct, through established partner arrangements. As the IJB is not the employing body, staff delivering HSCP services operate under the employing partners' policies and reporting routes (including whistleblowing and counter-fraud arrangements). This continues to reflect the assurance position set out in the prior year response.

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

The Committee recognises that fraud and corruption risk is associated with roles that exercise financial authority, approve expenditure, manage procurement and contracting, or have control over valuable assets or sensitive information. Rather than relying solely on role-based categorisation, the Committee expects risk to be managed through system-based controls: segregation of duties, authorisation limits, transparent reporting, internal audit review, and escalation mechanisms where concerns arise. This approach is consistent with the prior year response and continues to apply for 2025/26.

The Committee's understanding of higher-risk activity is also informed by strategic risk reporting (including risks associated with contract monitoring and management of commissioned services).

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 Committee is not aware of related party relationships or transactions that could reasonably be expected to give rise to fraud in the IJB's accounts. The Committee expects compliance with established declarations of interest requirements, which are embedded within governance arrangements (including standing agenda arrangements for declarations).

Register of Interest returns are completed by every member of the IJB and the Chief Financial Officer will review if any interests declared impact on related party disclosures.

Both WDC and NHSGGC will provide letters of assurance for 2025/26 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

The Committee is not aware of any entries in the accounting records that it believes to be false or intentionally misleading, nor is it aware of any assets, liabilities or transactions that have been improperly included or omitted from the IJB's financial statements.

The Committee's assurance is based on the combination of:

- i. Partner system controls for transaction processing,
- ii. Professional preparation and review of the financial statements, and
- iii. Independent internal and external audit scrutiny and follow-up of actions.

This is consistent with the assurance basis described in the prior year response and remains applicable for 2025/26.

The Committee also recognises the broader external environment in which fraud risk can evolve, and therefore expects management to remain alert to emerging risks through partner counter-fraud arrangements and to escalate material concerns through the established governance routes.

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 Committee is well sighted on the financial challenges and performance pressures facing the HSCP and the wider public sector. The Committee receives structured reporting that supports scrutiny of performance and improvement actions, including quarterly performance reporting designed to enable exception-based narrative and scrutiny.

The Committee expects financial decisions and performance improvement activity to be supported by transparent reporting, appropriate governance, and best value considerations. The Best Value Statement prepared for governance reporting articulates the IJB's arrangements for transparency and scrutiny, including publication of papers and accessible reporting.

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

The Committee gains assurance regarding compliance with relevant laws and regulations through governance and assurance structures that draw together:

- i. Statutory officer advice and review routes,
- ii. Partner organisational compliance frameworks, and
- iii. Annual governance assurance processes which consolidate senior officers' assurance and internal control self-assessment.

The annual governance statement describes how assurance is obtained from partner processes (including annual self-assessment and certificates of assurance) and how governance arrangements manage matters such as declarations of interest.

Where new or revised statutory duties apply to areas of HSCP delivery, assurance reporting is provided through established governance reporting routes, with reports prepared to evidence compliance and assurance (for example, compliance assurance reporting related to statutory frameworks).

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 Committee expects the financial statements to disclose contingent liabilities and provisions as appropriate and takes assurance that management's annual accounts preparation processes engage with relevant senior officers and partner routes to identify matters requiring disclosure. This remains consistent with the assurance approach described in the prior year response.

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 IJB) will continue in operational existence for the foreseeable future. In accordance with the CIPFA Code of Local Government Accounting, the IJB 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 IJB will continue in operational existence for the foreseeable future.

The Committee is satisfied that it is appropriate to adopt the going concern basis in preparing the financial statements. The IJB is a statutory body and prepares its accounts on the assumption that it will continue to operate for the foreseeable future unless national decisions are taken to dissolve the IJB without transfer of functions.

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 Committee's assurance is informed by the robustness of the HSCP's financial planning and governance arrangements, including the Committee's scrutiny of strategic risks and the operation of governance processes that provide assurance on internal control and organisational sustainability.

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.

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 Committee recognises that the HSCP operates in a challenging environment with significant and continuing demand, workforce and financial pressures across community health and social care. The Committee therefore places emphasis on strong financial governance, transparent risk reporting and clear improvement planning.

However, the Committee has not identified events or conditions that cast significant doubt on the appropriateness of adopting the going concern basis in preparing the IJB's financial statements for 2025/26.

The IJB agreed a balanced 2026/27 budget on 24 March 2026 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. The Medium Term Financial Outlook sets out the broad themes of how the IJB will transform services, make better use of technology and support the robust application of eligibility criteria to support financial sustainability.

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 includes the annual review of the adequacy and effectiveness of the governance framework, including the system of internal control. For 2025/26, the review concluded that governance arrangements were operating effectively and were fit for purpose. The Chief Internal Auditor concluded that reasonable assurance can be placed upon the adequacy and effectiveness of governance, risk management and internal control arrangements within the HSCP Board and within the partner control environments upon which the Board relies.

All financial transactions relating to delegated HSCP services are processed through the financial systems of West Dunbartonshire Council (WDC) and NHS Greater Glasgow and Clyde (NHSGGC). The HSCP therefore relies on partner controls, including approval and authorisation processes, segregation of duties, authorised signatory limits, WDC Financial Regulations and NHSGGC Standing Financial Instructions. The financial statements reflect transactions processed through those partner systems.

The HSCP Board receives regular financial performance reports throughout the year. These are supported by monthly budget monitoring, review of significant variances with budget holders, Heads of Service and senior managers, and appropriate mitigating actions where required. The annual accounts are prepared by professionally qualified finance staff and are subject to senior management review, internal audit consideration and external audit scrutiny.

The scale and complexity of the HSCP budget is recognised, with a 2025/26 integrated budget of approximately £276m and total expenditure in the unaudited accounts of £271m including set aside. While material misstatement can never be fully ruled out, management considers the likelihood to be low due to the control framework, regular reporting, partner assurance arrangements and audit review.

- ***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

The scale and complexity of HSCP activity means that the risk of error or fraud can never be fully eliminated. During 2025/26, the HSCP managed significant levels of expenditure and commissioned substantial health and social care services through partner organisations and external providers. Management therefore applies a risk-based approach to the identification and management of fraud risk, supported by regular budget monitoring, scrutiny of material variances, service performance review, robust care assessment and review processes, commissioning and procurement

controls, and oversight through the Senior Management Team, partner governance arrangements and the Audit and Performance Committee.

Fraud risk is considered as part of the wider governance, risk management and internal control framework. Senior managers participate in annual governance assurance processes, including review of the Local Code of Good Governance and the completion of assurance returns for partner organisations. These arrangements provide assurance regarding counter-fraud measures, stewardship of public funds and compliance with relevant financial, governance and regulatory requirements.

Management recognises that there are inherent fraud risks within any large and complex public sector organisation. Within the HSCP, the principal areas of exposure relate to high-value and high-volume activities, including commissioned social care services, care package assessment and review, financial assessment and charging arrangements, agency staffing and overtime expenditure, payroll and establishment controls, prescribing, Family Health Services and procurement activity.

These risks are mitigated through a range of established controls, including eligibility criteria, assessment and review processes, commissioning and contract monitoring arrangements, procurement support, authorised signatory limits, electronic approval workflows, budget monitoring, management supervision and internal audit review. In addition, the strengthened commissioning and contract management function, reporting on regulated commissioned services and oversight provided through the Service Sustainability Oversight Group offer further assurance in relation to areas of significant expenditure and service risk.

Where a suspected fraud or financial irregularity is identified, it would be escalated through the appropriate governance and reporting arrangements, including, as necessary, the Chief Financial Officer, Internal Audit, Counter Fraud Services, Human Resources, Legal Services and relevant partner governance structures, depending on the nature and significance of the issue.

- ***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

The HSCP Board does not directly employ staff. HSCP staff are employed by either WDC or NHSGGC and are therefore subject to the codes of conduct, whistleblowing arrangements, counter-fraud policies, financial regulations, standing financial instructions and governance frameworks of their employing organisation. These policies are communicated through partner intranets, management briefings, mandatory training, staff communications and professional development arrangements.

The HSCP Board Local Code of Good Governance reinforces expectations relating to integrity, accountability, openness, stewardship, respect for the rule of law and ethical behaviour. Board members and relevant senior officers are required to maintain declarations of interest and to comply with relevant codes of conduct. Standing agenda items at Board and Committee meetings include declarations of interest. The HSCP also promotes positive organisational culture through leadership communication, staff engagement, iMatter, Extended Management Team arrangements, Joint Staff Forum engagement and initiatives such as Civility Saves

Lives. These arrangements support a culture where staff are expected to act professionally, raise concerns and safeguard public resources.

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

Management Response

The Audit and Performance Committee receives regular assurance on internal audit activity, audit progress, strategic risk, governance arrangements, financial reporting, external audit activity, the Annual Governance Statement and the annual review of the Local Code of Good Governance. The Committee also receives progress updates on governance improvement actions.

The Chief Internal Auditor reports directly to the Audit and Performance Committee and has direct access to the Chief Officer, Chief Financial Officer and Committee Chair. The Committee is therefore sighted on the processes for identifying and responding to fraud, error, internal control weaknesses and governance improvement actions.

Those charged with governance have also provided a separate response to external audit for 2025/26, confirming their oversight of management arrangements and noting no significant internal control breaches or significant fraud incidents relating to HSCP service activity.

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 2025/26? Please provide details.

Management Response

It is the responsibility of management within the HSCP and partner organisations, to develop and maintain sound systems of risk management, governance and internal control. This includes identifying, responding to, and escalating any potential breaches of internal control in accordance with partner processes and HSCP governance arrangements.

The Annual Governance Statement and annual Local Code review set out the assurance taken from partner internal control systems, senior officer assurance, internal audit and external audit arrangements. Internal control systems, however well designed and operated, have inherent limitations. Management therefore places emphasis on layered controls, regular review, transparent reporting and timely escalation.

The HSCP Board, WDC and NHSGGC maintain risk-based internal audit arrangements. The HSCP internal audit plan is developed through engagement with senior managers and the Chief Internal Auditor, taking account of recognised strategic and operational risks. Audit findings and agreed actions are reported to, and monitored by, the Audit and Performance Committee.

During 2025/26, the Audit and Performance Committee received a range of internal control assurance reports, including annual internal and external audit plans, internal audit progress reports, the Annual Internal Audit Report and Assurance Statement, the

Annual Governance Statement, the Strategic Risk Register six-month review, the Annual Clinical and Care Governance Report and Regulated Services Reports.

Management is not aware of any significant breaches of internal control during 2025/26 in respect of HSCP service activity. This is consistent with the Annual Governance Statement and the Audit and Performance Committee response, which report no significant internal control breaches or fraud incidents identified within HSCP activities during 2025/26.

Improvement actions have nevertheless been identified and agreed to strengthen the control environment, including a full review of Strategic and Operational Risk Registers, further embedding structured self-evaluation, finalising the business case for replacement of the CareFirst Social Work Case Management System and reviewing Audit and Performance Committee Terms of Reference and voting membership.

3) Do you have knowledge of any actual, suspected or alleged fraud during the period 1 April 2025 – 31 March 2026? Where appropriate please provide details.

Management Response

Management is not aware of any actual, suspected or alleged fraud during the period 1 April 2025 to 31 March 2026 that relates to HSCP service activity and would have a material impact on the 2025/26 financial statements.

The IJB does not directly employ staff, operate transactional banking arrangements or process transactions through its own financial ledger. Any suspected or alleged fraud relating to delegated services would be managed through the established counter-fraud, internal audit, legal, HR, information governance and escalation arrangements of WDC or NHSGGC as appropriate, with HSCP senior managers supporting investigations where required.

HSCP staff continue to support National Fraud Initiative-related activity led through partner arrangements where relevant. A risk-based approach is taken to the review of individual care packages, charging and assessment processes, commissioned care provision and other areas of significant public expenditure e.g. Standard Operating Procedures for approval of overtime.

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 and complex organisations and management recognises that fraud risk exists in any system of this scale. The HSCP directs and oversees significant public expenditure, including internal service delivery and commissioned services from external providers. No system of internal control can provide absolute assurance and management remains alert to the possibility of fraud or irregularity.

Management is not aware of any specific suspicion that fraud was occurring within HSCP activity during 2025/26.

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

Management Response

Management has no specific suspicion that fraud is occurring within HSCP activity. However, management recognises that the HSCP, WDC and NHSGGC operate within large, complex public-sector systems and that fraud risk is inherent wherever significant public funds are spent. These include commissioned social care services, agency staffing and overtime, care package assessment and review, direct payments and self-directed support, client contributions and financial assessment, prescribing, Family Health Services, procurement, invoice processing and payroll-related controls.

These risks are mitigated through assessment and review processes aligned to Eligibility Criteria, management supervision, procurement and commissioning controls, contract monitoring, electronic authorisation, financial regulations, Standing Financial Instructions, internal audit review and financial performance reporting.

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 recognises that areas involving significant expenditure and reliance on third-party information carry increased inherent risk. This includes external care providers, care package expenditure, prescribing, Family Health Services and charging or income assessment processes. The accounts also identify pressures from agency staff, premium-rate overtime and complex care packages, which require active management and oversight.

Controls to mitigate these risks include commissioning and contract management, use of procurement frameworks, approval limits, budget monitoring, provider oversight, Care Inspectorate reporting, regulated commissioned services reporting, eligibility criteria, My Life Assessment and review arrangements.

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

Management Response

Management would not identify a particular location as more likely to give rise to fraud. The higher risks relate to service activities and transaction types. These include services involving high-value care packages, external commissioning, financial assessment, payments to providers, prescribing and independent contractor payments.

For services supporting older people, people with disabilities or individuals who may not be able to provide full financial information, there remains a risk that capital or non-capital assets may not be fully declared during financial assessment. Controls include financial assessment procedures, checks where available (DWP and Land Registry),

re-assessments and management review. The risk cannot be eliminated entirely but is managed through established processes.

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

Yes. Management is satisfied that key internal controls, including segregation of duties, exist and are designed to operate effectively across the arrangements that support delivery of HSCP services and preparation of the IJB's annual accounts. This assurance is based on partner financial systems, internal audit activity, annual governance processes, professional preparation and review of the accounts, and regular reporting to SMT, the HSCP Board and the Audit and Performance Committee.

HSCP staff are employed by either WDC or NHSGGC and therefore operate within the policies and systems of the employing organisation. Financial transactions are processed through partner systems, where controls such as segregation of duties, authorisation hierarchies, approval limits, management review and audit trails are embedded within core processes.

Other controls include regular budget monitoring and variance analysis, review of savings delivery, vacancy control procedures, authorisation of agency and overtime expenditure, procurement controls, contract monitoring, care package reviews, charging and payments processes, declarations of interest, gifts and hospitality arrangements, whistleblowing and counter-fraud policies, internal audit reviews and external audit scrutiny.

Management recognises that maintaining an effective control environment is more challenging in a period of financial constraint, rising demand, workforce pressure and service redesign. Continued internal audit support, transparent financial performance reporting, the Local Code improvement plan and the 2026 improvement actions will therefore remain important in strengthening assurance.

In overall terms, the Chief Internal Auditor's annual opinion supports reasonable assurance over the adequacy and effectiveness of governance, risk management and internal control for the year to 31 March 2026.

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 adhering to the core policies and processes of their employing organisation. Relevant policies, including fraud, whistleblowing, grievance, disciplinary, conduct and

information governance policies, are available through partner intranets and communication channels.

Both WDC and NHSGGC promote a zero-tolerance approach to fraud and support cultures that enable individuals to identify potential fraud and report concerns safely and appropriately. Staff are expected to report concerns relating to misuse of public funds, financial irregularity, conflicts of interest, improper procurement, inappropriate payments, safeguarding concerns, data breaches, theft, bribery, corruption or unethical behaviour.

Within the HSCP, managers are expected to support staff to raise concerns through line management, HR, Internal Audit, counter-fraud, whistleblowing or clinical and care governance routes as appropriate. Concerns about services to vulnerable people and the safeguarding of individuals and assets remain particularly important.

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 risks are more appropriately considered by reference to activities and controls rather than by identifying individual posts. However, management recognises that roles with authority to approve expenditure, commission services, procure goods and services, approve care packages, authorise agency or overtime, process payments, access sensitive data or manage income assessment may carry higher inherent risk.

Higher-risk activity includes commissioning and contract management, procurement, financial management, authorisation of staffing expenditure, care package assessment and approval, income assessment and charging, prescribing and Family Health Services expenditure.

The risks are managed through segregation of duties, authorisation limits, management oversight, procurement controls, contract monitoring, financial performance reporting, declarations of interest, internal audit review, supervision and partner counter-fraud arrangements. The strengthened Commissioning and Contracts function, reporting on regulated commissioned services and audit scrutiny provide further assurance.

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

Management is not aware of any related party relationships or transactions that could reasonably give rise to instances of fraud in the 2025/26 financial statements.

The HSCP Board has related party relationships with WDC and NHSGGC by nature of the statutory integration arrangements, funding mechanism and commissioning of delegated services. These relationships are disclosed within the annual accounts and

are subject to partner ledger controls, annual accounts preparation processes and letters of assurance from the partner bodies.

Risks are mitigated through established declarations of interest requirements. Register of Interest returns are completed by HSCP Board members and relevant senior officers, declarations of interest are sought at Board and Committee meetings, and the Chief Financial Officer reviews declared interests to assess any impact on related party disclosures.

Both partner bodies also maintain arrangements for gifts and hospitality, conflicts of interest, procurement governance and authorisation of expenditure.

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

Management is not aware of any accounting entries that are false or intentionally misleading. The financial statements reflect transactions processed through WDC and NHSGGC financial systems, which are subject to partner controls, management review, budget monitoring and audit scrutiny.

Areas with higher inherent risk are those involving high-value or high-volume expenditure, reliance on third-party information or significant management judgement. This includes commissioned services, care package expenditure, prescribing, Family Health Services, agency staffing, overtime, client contributions and accruals. These areas are subject to financial monitoring, management review and relevant partner controls.

- ***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. Management is not aware of any assets, liabilities or transactions that have been improperly included in, or omitted from, the HSCP Board annual accounts. The accounts preparation process includes engagement with senior managers and partner finance teams to confirm expenditure, income, reserves, debtors, creditors, provisions and contingent liabilities where relevant.

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

Management Response

No system of internal control can provide absolute assurance and it is theoretically possible for a false accounting entry to evade detection if controls were deliberately overridden or if supporting information provided to finance teams was intentionally misleading. However, management considers this risk to be mitigated by segregation

of duties, electronic approvals, budget monitoring, variance analysis, management review, internal audit and external audit scrutiny.

Should management become aware of any suspected false or misleading accounting entry, it would be investigated immediately through the relevant finance, internal audit, management and partner governance routes.

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

Management Response

External fraud risk factors include payments to external providers, independent contractors, Family Health Services, prescribing activity, cyber-enabled fraud, mandate fraud, invoice fraud and fraud involving service user financial information.

The HSCP relies on partner controls, procurement and commissioning processes, counter-fraud arrangements, internal audit activity and management review to mitigate these risks.

- 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

Management is not aware of any inappropriate organisational or management pressure being applied, nor any incentives being offered, to manipulate financial reporting, accounting entries, operational performance or governance reporting.

The financial challenges and risks facing the HSCP Board and partner organisations are well documented through regular financial performance reports, budget reports, the Medium Term Financial Outlook, Strategic Risk Register and Board development sessions. The HSCP operates in a challenging financial environment characterised by annual funding settlements, increasing demographic demand, inflationary pressures, workforce challenges and rising cost and complexity of care.

It is the responsibility of every budget holder and member of staff committing public funds to ensure Best Value, stewardship of resources and delivery of approved savings and service redesign plans. The HSCP Finance Team supports regular budget monitoring, and significant variances are investigated with Heads of Service and budget holders. Senior Management receives regular financial information and updates on savings delivery, reserves, risks and mitigation.

There is robust challenge and support from the Chief Officer, Chief Financial Officer, Senior Management Team, Audit and Performance Committee and HSCP Board. This includes transparent reporting of service pressures, use of reserves, agency staff, overtime, commissioned services, prescribing and future budget gaps.

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 the IJB is a legal body in its own right, it does not employ staff, hold cash or operate its own transactional systems. The majority of operational legal and regulatory obligations apply through the partner organisations that deliver services under direction from the HSCP Board. Changes in laws and regulations are identified through partner governance arrangements, statutory officer roles, legal advice, professional networks, Scottish Government guidance, national policy updates and internal governance routes.

Senior managers are members of partner corporate management and professional networks and are supported by statutory and professional advisors including the Chief Officer, Chief Financial Officer, Chief Social Work Officer, Clinical Director, Chief Nurse, legal advisors, procurement, HR, information governance and finance professionals.

Examples of relevant 2025/26 areas include the ongoing Integration Scheme review, implementation and monitoring of Health and Care Staffing duties, climate change reporting duties, public sector finance and accounting requirements, procurement requirements, and preparation for the implications of the Care Reform (Scotland) Act 2025.

- ***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 supported by a range of statutory officers and professional advisors. Board and Committee reports include sections on legal, financial, HR, equality, risk and strategic implications. Legal and professional advice is obtained where required.

The Audit and Performance Committee scrutinises the Annual Governance Statement, Local Code of Good Governance review, internal audit reports, external audit reports, strategic risks, performance reports, clinical and care governance reports, regulated commissioned services reports and improvement action plans. These arrangements provide assurance that relevant legal and regulatory matters are identified, monitored and escalated appropriately.

During 2025/26, Committee members also undertook self-assessment work against CIPFA Audit Committee guidance, and an improvement action has been agreed to review the Committee Terms of Reference and voting membership.

- ***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

Employees receive communications and training through their employing partner organisation. This includes mandatory and role-specific training on matters such as data protection, equality, information governance, health and safety, professional standards, financial regulations, clinical and care governance and statutory duties.

Board members and non-executive members receive induction, development sessions, Board papers, professional advice and briefings. Partners and stakeholders are engaged through the Strategic Planning Group, Locality and Engagement Networks, provider engagement, consultation activity, Partnership Board reporting, published policies and the HSCP website.

HSCP policies and Board reports are updated where required to reflect legal and regulatory requirements. The annual governance review and Local Code sources of assurance also evidence the frameworks used to support compliance.

- ***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

Management accepts that minor operational issues can arise in a complex service environment and these are addressed through normal management, HR, clinical governance, social work governance, complaints, incident, legal or audit routes as appropriate. Management is not aware of any significant non-compliance with laws or regulations during 2025/26 that would require disclosure in the annual accounts or would materially affect the financial statements.

Where exceptions to procurement processes are required for social care or health care services, these are documented through appropriate waiver or direct award processes and approved through the relevant governance routes. Workforce risks, including working time and use of overtime, are actively monitored by management and mitigated through staffing controls, supervision and operational oversight.

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. As part of the annual accounts preparation process, the Chief Financial Officer engages with members of the HSCP Senior Management Team and partner finance and governance colleagues to identify any actual or potential litigation, claims, provisions or contingent liabilities that may require disclosure in the financial statements.

The 2025/26 unaudited accounts state that there are no contingent liabilities or contingent assets to disclose. Management is not aware of any actual or potential litigation or claims that would materially affect the HSCP Board financial statements.

The HSCP Board holds indemnity insurance for costs relating primarily to potential claim liabilities regarding HSCP Board member and officer responsibilities. WDC and NHSGGC retain responsibility for claims in respect of services for which they are statutorily responsible and which they provide.

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 through the annual budget setting process, regular financial performance reporting, review of reserves, the Medium Term Financial Outlook, Strategic Risk Register, partner funding arrangements and the provisions of the Integration Scheme.

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 Board is required to prepare its financial statements on this basis unless informed by the relevant national body of an intention for dissolution without transfer of services or functions to another entity.

The HSCP Board agreed a balanced 2026/27 budget on 24 March 2026. The budget report and financial monitoring arrangements recognise future budget gaps, demographic growth, inflationary pressures, workforce pressures and the need for continuing service redesign. The Chief Financial Officer also reviewed the robustness of estimates and adequacy of reserves as part of budget setting.

The final 2025/26 unaudited accounts show unearmarked reserves of £4.773m, representing approximately 2.02% of net expenditure excluding Family Health Services, slightly above the 2% target set out in the Reserves Policy. Earmarked reserves are held for specific commitments and transformation priorities. Management is therefore satisfied that the going concern basis remains appropriate.

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

No. Management recognises the significant and continuing financial, workforce, demand and service sustainability pressures facing the HSCP and the wider health and social care sector. These risks are transparently reported through financial performance reports, the Medium Term Financial Outlook, the Strategic Risk Register, the Annual Governance Statement and Board budget setting reports.

The HSCP continues to face future budget gaps and will require further transformation, service redesign, robust application of eligibility criteria, effective commissioning, management of agency and overtime, review of care packages, digital improvement

and continued partnership working with WDC and NHSGGC. These are significant risks to financial sustainability but are recognised, actively managed and subject to established governance arrangements.

The Integration Scheme sets out the process for addressing budget variances, including recovery planning and the role of partner organisations where overspends cannot be fully mitigated. Management has not identified any event or condition that would cast significant doubt on the appropriateness of preparing the 2025/26 financial statements on a going concern basis.



Annual Audit Report

West Dunbartonshire Integration Joint Board – year ended 31 March 2026

September 2026

Audit and Performance Committee
West Dunbartonshire Integration Joint Board
16 Church Street
Dumbarton
G82 1QL

XX September 2026

I am pleased to present our Annual Audit Report (“AAR”) for West Dunbartonshire Integration Joint Board for the year ended 31 March 2026. 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”) and for the sole benefit of the Audit and Performance Committee. 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,

[signature using the firm’s authorised electronic signature]

Tom Reid (Director)

Forvis Mazars LLP

100 Queen Street
Glasgow
G1 3DN

Forvis Mazars LLP

Forvis Mazars LLP is the UK firm of Forvis Mazars Group, a leading global professional services network. Forvis Mazars LLP is a limited liability partnership registered in England and Wales with registered number OC308299 and with its registered office at 30 Old Bailey, London, EC4M 7AU. Registered to carry on audit work in the UK by the Institute of Chartered Accountants in England and Wales. Details of our audit registration can be viewed at www.auditregister.org.uk under reference number C001139861. VAT number: GB 839 8356 73

Contents

- 01 Executive summary
- 02 Status of our audit
- 03 Audit approach and risk summary
- 04 Significant findings
- 05 Summary of misstatements
- 06 Fraud considerations
- 07 Wider scope
- 08 Best Value

- Appendix A: Internal control conclusions
- Appendix B: Draft management representation letter
- Appendix C: Draft audit report
- Appendix D: Confirmation of our independence
- Appendix E: Other communications
- Appendix F: Wider scope and Best Value ratings

This document is to be regarded as confidential to West Dunbartonshire Integration Joint Board. It has been prepared for the sole use of the Audit and Performance Committee as the appropriate committee charged with governance. No responsibility is accepted to any other person in respect of the whole or part of its contents. Our written consent must first be obtained before this document, or any part of it, is disclosed to a third party.

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 2026 which are prepared in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom 2025-26 (“the Code”).

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. Please refer to the ‘*Status of our audit*’ section 2 for a list of significant audit matters outstanding at the date of this report. We will provide an update to you on completion of those outstanding matters by way of a follow up letter.

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 3, with a summary of our audit approach over those areas. Significant findings from our audit are set out in the ‘*Significant findings*’ section 4.

Audit misstatements

We have identified no adjusted or unadjusted misstatements above our reporting threshold to date. This may be subject to change following completion of the outstanding audit matters in section 2 of the report.

Significant control deficiencies

We did not identify any significant deficiencies in internal control. The non-significant control observations that we have identified to date are set out in ‘*Appendix A: Internal control conclusions*’.

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 have reported one significant risk in relation to financial sustainability. We have also raised a recommendation regarding vision, leadership and governance. We have no significant wider scope risks to report in relation to arrangement in financial management and use of resources to improve outcomes arrangements. Further details have been provided in the ‘*Wider scope*’ section 7 of this report.

Best Value

We have no risks to report regarding the Best Value arrangements that the IJB has in place in relation to the vision and leadership; governance and accountability; effective use of resources; partnerships and collaborative working; working with communities; sustainability; and fairness and equality arrangements that the IJB has in place. Further details have been provided in the ‘*Best Value*’ section 8 of this report.

Management Commentary and Annual Governance Statement opinion

We 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 otherwise appears to be 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 such objections to the accounts.

Executive summary (continued)

Qualitative aspects of IJB's accounting practices

We have reviewed IJB's accounting policies and disclosures and conclude that they comply with the Code of Practice on Local Authority Accounting in the United Kingdom 2025-26, appropriately tailored to the IJB's circumstances.

Unaudited accounts were received from the IJB on 26 June 2026 and were of a good quality.

Significant matters discussed with management

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

Other matters of significance

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.

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. We have concluded our work on Wider Scope and Best Value. The areas where work remains outstanding are detailed below.

Audit quality control and completion procedures

Our audit work will undergo final stages of review. 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.

Medium

Annual Report and Accounts and letter of representation

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.

Low

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.

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 3 March 2026.

Materiality

Our provisional materiality at the planning stage of our audit was set at £5,558k using a benchmark of 2% of gross revenue expenditure at surplus/deficit level as per the Annual Audit Plan. Our performance materiality was provisionally set to £4,168k.

The following significant judgements have been made in determining the financial statement materiality amounts:

- that the main users of the financial statements are the Scottish Government, other IJBs, local authorities, regulators, elected members, the 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.

In determining the performance materiality levels, we made the following significant judgements:

- that we are now in the fourth year of our audit appointment and therefore have a more mature and detailed understanding of the IJB's operations, risks, and financial environment;
- that the financial reporting process does not involve significant journal adjustments, which decreases the risk of misstatement;
- that the IJB has a strong control environment, which reduces the likelihood of pervasive misstatements;
- that the IJB's transactions are neither few nor straightforward;
- that we have not identified significant errors in prior periods; and
- management has demonstrated a willingness to promptly identify, disclose, and correct matters where they arise.

Based on the final financial statement figures and other qualitative factors mentioned above, the final overall materiality we applied was £5,853k (final performance materiality: £4,390k; final clearly trivial threshold: £176k).

Internal audit

As per our Annual Audit Plan, we did not use the work of internal audit during the course of our audit. We did obtain a copy of the reports issued by internal audit relating to the financial period under audit and contacted the Chief Internal Auditor. There are no adverse findings to 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	Yes	No	Yes	No	No	No	Risk is satisfactorily addressed.	14

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 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. You should assess this risk as part of your oversight of the financial reporting process.
How we addressed this risk We addressed this risk through performing audit work over: • accounting estimates: by evaluating the methods and assumptions used by management to develop the estimate; • journal entries: testing any journals that meet our fraud risk criteria and other adjustments made in preparing the financial statements; and • significant transactions: considering and testing any significant transactions outside the normal course of business or otherwise unusual.
Audit conclusion We have reviewed the bad debt provision and confirmed that the judgements and estimates made by management in determining the provision are reasonable. We did not identify any journal entries posted in preparation of the accounts that met our risk criteria. We have tested and confirmed significant adjustments, including resource transfers between partner bodies, which were included in the preparation of the financial statements. Our work has provided the assurance we sought 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 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. We confirm no such reports have been prepared.
- Section 102(3) of the 1973 Act allows us to make a special report to the Commission if an item of account is contrary to law; there has been a failure on someone's part to bring into account a sum which ought to have been brought into account; a loss has been incurred or deficiency caused by the negligence or misconduct of a person, or by the failure of a body to carry out a duty imposed on them by any enactment; or a sum which ought to have been credited or debited to one account of a body has been credited or debited to another account and the body has not taken, or is not taking, steps to remedy the matter. We confirm no such reports have been prepared.
- Section 97A of the 1973 Act allows us to undertake or promote comparative and other studies to make and publish recommendations for the securing by local government bodies of Best Value, improving economy, efficiency and effectiveness in the provision of services by local government bodies and improving the financial or other management of local government bodies. We confirm no such studies or recommendations have been prepared.

05

Summary of misstatements

Summary of misstatements

Adjusted and Unadjusted misstatements

Our overall materiality, performance materiality, and clearly trivial (reporting) threshold were reported in our Annual Audit Plan, issued on 3rd March 2026. Any subsequent changes to those figures are set out in the *'Executive summary'* section of this report.

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

Disclosure misstatements

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

- **Note 11 - Related party Transactions**

- The Code requires bodies to disclose related parties that exert significant influence through legislation and grant funding. The IJB has added an additional disclosure in the 2025/26 accounts to include the Scottish Government as one such related party. This is because the Scottish Government can exert significant influence through legislation and funding of the IJB's partner bodies, therefore indirectly influencing the financial and operating policy decisions of the IJB.

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

We identified the following disclosure misstatements during our audit that have not been corrected by management:

- **Provisions**

- The unaudited accounts included a provision of £546k (24/25: £487k) in the balance sheet for unrecovered charges for specific social care delegated services. We have recommended in prior year audits (2022/23, 2023/24 and 2024/25) 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.

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

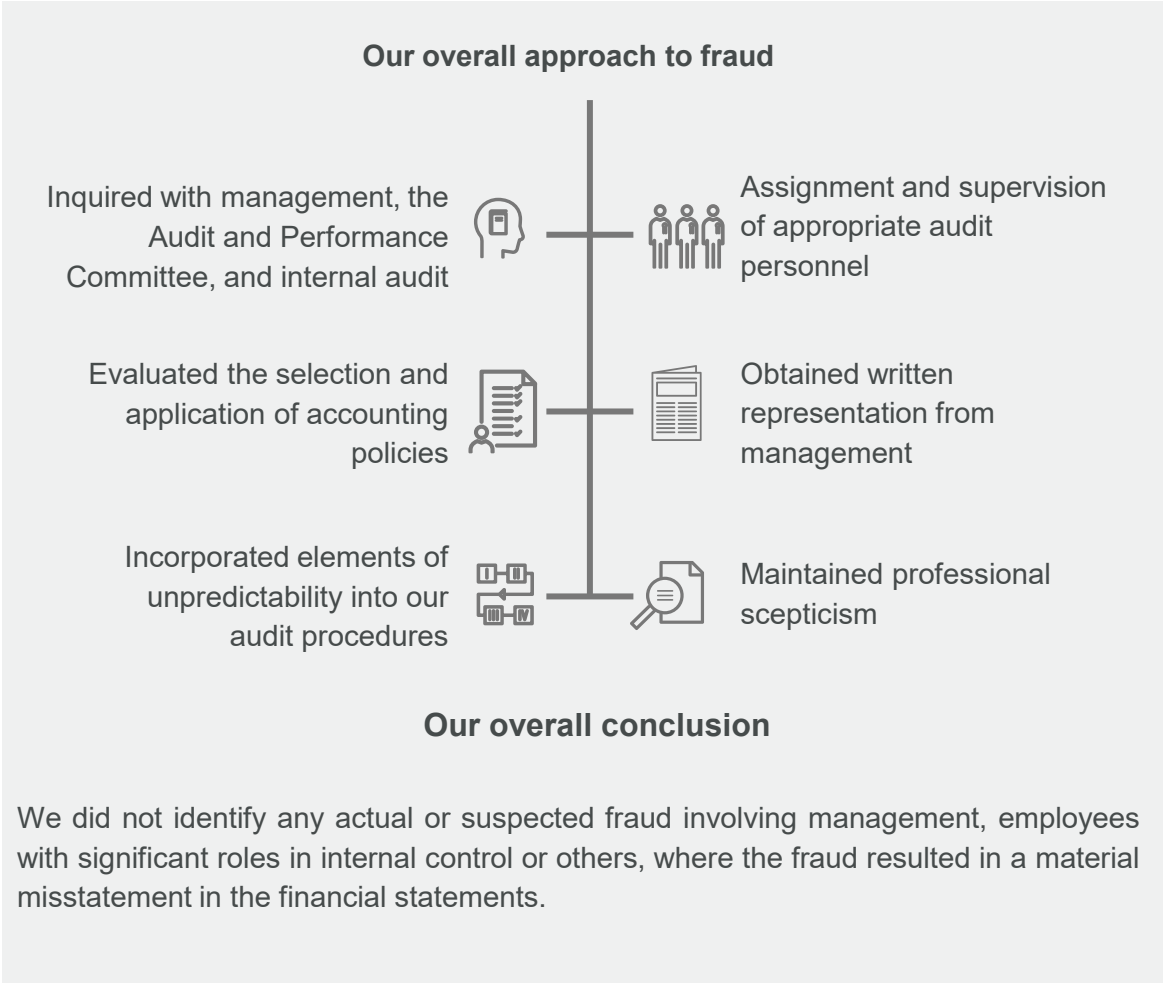
Management has primary responsibility for the prevention and detection of fraud. It is important that management, with your oversight, place a strong emphasis on fraud prevention, which may reduce opportunities for fraud to take place, and fraud deterrence, which could persuade individuals not to commit 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.



07

Wider scope

Commentary on Wider Scope

Overall Summary



Commentary on Wider Scope

Wider Scope summary

As auditors appointed by the Auditor General of Scotland, our Wider Scope responsibilities are set out in the Code of Audit Practice 2021. The Code requirements broaden the scope of the 2025/26 audit and allow us to use a risk-based approach to report on our consideration of the IJB’s performance 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	23	No	No	No
Financial sustainability	28	Yes – see risk 1 on page 29	Yes – see recommendation 1 on page 31	No
Vision, leadership and governance	33	No	No	Yes – See recommendation 2 on page 38
Use of resources to improve outcomes	39	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 (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Financial management culture	The IJB have established a strong financial management culture supported by a comprehensive framework of procedures, regular financial reporting, and effective governance arrangements. During 2025/26, the control environment was further strengthened through the development of a 'Financial Management Processes and Procedures' Manual in June 2026 along with the introduction of structured budget holder training, responding positively to recommendations arising from the previous year's audit. The implementation of refreshed budget holder training and the new Financial Management Processes and Procedures Manual occurred after the end of the 2025/26 financial year. As a result, the full benefits of these strengthened arrangements were not realised during most of the period under review. The benefits from these will be seen from 2026/27 onwards. Financial planning, monitoring, forecasting and reporting are embedded throughout the organisation, with clearly defined roles and responsibilities for budget holders, finance staff and senior management. Financial management arrangements are supported by an experienced and suitably qualified finance function, led by a Chief Financial Officer operating in accordance with statutory responsibilities. Longer-term financial planning arrangements are well developed, including the 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, incorporating scenario planning of future cost pressures, funding assumptions, savings requirements and reserve utilisation. Strategic planning arrangements demonstrate clear alignment between financial resources, service priorities and anticipated future demand.	The IJB has effective financial arrangements in place. Financial monitoring, forecasting and longer-term planning arrangements are operating effectively and have contributed to a strong financial performance during 2025/26. While significant future financial sustainability challenges remain, these risks are recognised, transparently reported and actively managed through established financial planning processes.	No significant risks identified

Financial management (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Accountability	Financial Regulations provide a clear framework of responsibilities for the Board, Chief Officer, Chief Financial Officer and budget holders, while documented procedures reinforce expectations regarding budget setting, monitoring and financial reporting. Financial and performance information is reported regularly through established governance structures, including the Board and Audit and Performance Committee. Reporting arrangements provide comprehensive information on budget performance, forecast outturn positions, savings delivery, reserve movements, performance against strategic objectives and key financial risks. Performance reporting is aligned with the Strategic Plan and National Health and Wellbeing Outcomes. Board members receive regular updates on service performance and improvement activity, supported by reporting against a broad range of performance indicators and associated improvement actions. The IJB demonstrated effective budgetary control during the year. Approved savings and service redesign efficiencies of £5.484 million were largely delivered, with 98% achieved or on track for delivery. The IJB reported a surplus on service provision of £4.908 million prior to reserve movements, while unearmarked reserves increased from £3.576 million to £4.773 million, exceeding the target reserve level of 2% by 0.07% of net expenditure.	The IJB's budget monitoring arrangements support financial accountability. Roles, responsibilities and reporting requirements are clearly presented, and members are provided with sufficient information to scrutinise performance, monitor financial risks and oversee delivery of strategic objectives. The IJB has delivered a surplus position and increased reserves in a difficult economic environment.	No significant risks identified

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). Consistent with prior years , 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. Independent assurance is provided through Internal Audit activity. The Chief Internal Auditor concluded that reasonable assurance could be placed upon the adequacy and effectiveness of governance, risk management and internal control arrangements during 2025/26 and reported no significant control weaknesses.	The IJB has effective arrangements in place to prevent and detect fraud, error and financial irregularity. Financial regulations, internal controls, internal audit assurance and governance oversight collectively provide a strong control environment. No significant weaknesses in internal control arrangements were identified during 2025/26, and ongoing improvements to procedures and training further strengthen the organisation's control framework.	No significant risks identified

Financial management (continued)

Follow up of previously-reported recommendations

In September 2025 we reported one recommendations to the IJB to address risks identified from our Wider Scope audit for financial management. As part of our work in 2025/26, we followed up the progress made by the IJB against the recommendations made, and determined whether the risk remained during the year.

	Financial management finding as previously reported	Management response and implementation timeframe	Work undertaken and judgements made in 2025/26	Conclusions reached
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. Recommendation The IJB should ensure refresher training is provided to budget holders to ensure procedures are understood and consistently applied.	Management 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. Implementation timescale Training materials finalised by November 2025 and phased roll-out, incorporating feedback throughout 2026.	Progress against the recommendation The IJB has implemented the recommendation. During 2026, management developed and delivered a structured budget holder training programme covering budget holder responsibilities, financial regulations, variance reporting, budget monitoring, savings monitoring and financial governance arrangements. Attendance records and participant feedback confirmed that training was delivered and positively received by participants. Management also introduced a Financial Management Processes and Procedures Manual in June 2026, providing a documented framework covering budget setting, financial monitoring, financial reporting and governance responsibilities. These actions strengthen the financial control environment and promote a more consistent approach to budget management across the organisation. Both the refresher training and the new procedures manual were implemented in June 2026, after the 2025/26 financial year-end and following approval of the 2026/27 budget. Consequently, the benefits of the enhanced arrangements were not available throughout most of the audit period or during the 2026/27 budget-setting process.	Conclusions Complete. The recommendation has been implemented through the introduction of budget holder refresher training and the development of a Financial Management Processes and Procedures Manual. These arrangements address the underlying concern identified in the prior year and strengthen support available to budget holders. No evidence was identified that weaknesses in budget monitoring or financial reporting arose from the prior issue. However, implementation took later than anticipated and therefore the improved arrangements were not in operation for most of 2025/26.

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 risk in arrangements that we presented in our Annual Audit Plan, issued on 3 March 2026 and the work undertaken to respond to this.

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. Initial budget outlooks project significant funding gap for 2026/27 of ~£12.8million, reduced by using a superannuation reserve allocation to bring budget gap to approximately £9.7million. The IJB is considering budget options for 2026/27 and its partner organisations are still to agree their funding contributions. As in previous years, the IJB expects to use reserves to balance the budget. The IJB's un earmarked reserves were 1.62% of net expenditure at 31 March 2025, which is below the contingency level of 2% in its reserves policy. The scale of the savings the IJB needs to make, in the context of the national pressures facing community health and social care service, put its financial sustainability at risk.	Work undertaken The IJB has established comprehensive financial planning arrangements through its MTFO, annual budget setting process, strategic risk management framework and regular financial performance reporting. The IJB achieved a favourable draft outturn position in 2025/26, reporting an adjusted underspend of £0.400 million in the June 2026 report and delivering approximately 98% (£5.394 million) of planned savings. A reserves strategy remains in place and continues to be applied through the annual budget-setting and financial planning process. As at 31 March 2026, the IJB held unearmarked reserves of £4.773 million, representing approximately 2.07% of net expenditure and therefore marginally exceeding the policy target of 2%. Earmarked reserves totalled £18.542 million, bringing total reserves to £23.315 million. Approximately 62% of earmarked reserves are expected to be utilised during 2026/27. Whilst savings delivery and financial monitoring arrangements are well developed, some of the favourable financial performance achieved during 2025/26 reflects non-recurring factors, including workforce vacancies, recruitment delays and staff turnover. The Annual Report also highlights continuing uncertainty arising from annual funding settlements and the impact this may have on workforce planning, service transformation and delivery of recurring savings. The Strategic Needs Assessment identifies a declining population, projected to fall from approximately 89,120 in 2025 to 77,308 by 2047, alongside an increasingly ageing population and growing prevalence of long-term health conditions. The IJB demonstrates a strong understanding of long-term pressures facing health and social care services. The MTFO includes multi-year financial forecasting and has quantified scenario planning through Best Case, Mid-Range and Worst-Case projections covering the period to 2027/28. These scenarios model variations in key assumptions including pay inflation, demographic pressures, prescribing costs, partner funding, Scottish Living Wage uplifts and wider service demand pressures.	
		Results of our work We have determined that governance arrangements are generally effective. The IJB demonstrates a good understanding of its medium and longer-term financial challenges and has established appropriate governance, monitoring and reporting arrangements to mitigate emerging risks. However, future financial balance is dependent upon successful delivery of recurring savings, workforce plans and transformation programmes and there remains challenges around the planned use of reserves. As such, we have raised a recommendation on page 31.	

Financial sustainability (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Financial planning	The Board approved the IJB’s MTFO in November 2024, which provided a three-year financial forecast and high level ten-year projection of financial gaps. In addition to this, management update the budget gap figures on an annual basis. Financial sustainability is recognised as the most significant strategic financial risk facing the organisation and is appropriately reflected as the highest-rated risk within the Strategic Risk Register. During the 2025/26 period the reserves position strengthened significantly with total reserves increasing to £23.315 million, including £18.542 million of earmarked reserves held for clearly defined purposes. Reserve utilisation is subject to governance oversight and is incorporated into medium-term financial planning arrangements. Despite the positive outturn position for 2025/26, significant medium and longer-term financial sustainability challenges remain, which are prevalent across the public sector. The approved 2026/27 budget required £5.136 million of reserve utilisation to achieve financial balance. While this approach is consistent with the Reserves Policy, current plans indicate that approximately 62% of earmarked reserves will be utilised during 2026/27. The IJB is actively monitoring the demographic, operational and service pressures projected to affect future financial sustainability through its Strategic Needs Assessments (SNA). These pressures are reflected within strategic planning and financial assumptions. This ties in with the MTFO which identifies substantial future funding gaps of £8.567 million in 2027/28 and £12.373 million in 2028/29 after planned savings and management actions have been applied.	The IJB are aware of the financial risks in the coming years and are actively monitoring and preparing savings plans to attempt to mitigate the financial impact. The MTFO demonstrates many of the characteristics expected of effective medium-term financial planning and provides a sound basis for strategic decision-making. However, opportunities remain to strengthen quantified sensitivity analysis and scenario planning to improve understanding of the potential impact of changes in key assumptions such as inflation, demand growth, workforce costs, prescribing pressures and future funding settlements.	Financial sustainability – Level 1 There is a risk to the longer-term financial sustainability of the IJB. See page 31 for information on the significant risks identified.

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	IJB’s response and implementation timescale
1	Financial sustainability – Level 1 Despite achieving a favourable financial outturn in 2025/26, there remains a financial sustainability risk as the organisation continues to rely on reserve drawdowns to achieve financial balance and faces significant projected budget gaps in future years. The approved 2025/26 budget included a planned drawdown of £3.049 million from earmarked reserves, with total earmarked reserves being drawn down by £3.760 million during the year. This was offset with £7.471 million being added bringing the closing earmarked reserve to £18.542 million as at 31 March 2026. The Medium-Term Financial Outlook identifies remaining budget gaps of £8.567 million in 2027/28 and £12.373 million in 2028/29 after planned mitigation measures. Continued reliance on reserves and non-recurring funding to support financial balance may reduce financial resilience and limit the IJB's ability to respond to future financial pressures.	The IJB should continue to strengthen medium-term financial sustainability by developing and delivering recurring savings and transformation initiatives that reduce reliance on reserves to support financial balance. Progress against planned savings, reserve utilisation and future budget gap mitigation should continue to be regularly reported to the IJB Board and Audit & Performance Committee. Enhanced scenario modelling and quantified sensitivity analysis would support greater transparency over financial risks and strengthen long-term financial sustainability.	Management’s response The IJB recognises financial sustainability as its highest-rated strategic risk and continues to monitor this through established governance, risk management and financial reporting arrangements. Future-year financial gaps, reserve utilisation, savings delivery and emerging financial risks are routinely reported to the IJB and Audit & Performance Committee. Delivery of medium and longer-term financial sustainability will continue to be supported through a range of workstreams including service redesign and transformation programmes, improved use of digital technologies, workforce planning initiatives and the planned and appropriate use of reserves in line with the approved Reserves Policy. These arrangements are intended to support recurring savings, improve efficiency and ensure resources remain aligned to strategic priorities and assessed need. The current Medium-Term Financial Outlook (MTFO) covers the period 2024/25 to 2027/28 and is updated annually through the budget-setting process to reflect revised assumptions, funding positions, demographic pressures and emerging risks. Following approval of the Strategic Plan 2027-2032, scheduled for May 2027, the MTFO will undergo a full refresh to ensure continued alignment between strategic priorities, financial planning, service transformation activity. As part of this refresh, opportunities to further strengthen scenario planning and sensitivity analysis will be considered. Responsible officer Chief Financial Officer Implementation date May 2027

Financial sustainability (continued)

Follow up of previously-reported recommendations

In September 2025 we reported one recommendations to the IJB to address risks identified from our Wider Scope audit for financial sustainability. As part of our work in 2025/26, we followed up 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 2025/26	Conclusions reached
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. Recommendation 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 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. Implementation timescale: 1 April 2026	Progress against the recommendation The IJB has made progress in responding to the recommendation. Financial planning arrangements continue to be supported by a regularly updated MTFO, annual budget setting process, strategic risk management framework and ongoing Board scrutiny. Financial sustainability remains the highest-rated strategic risk and is subject to regular monitoring and reporting.	Conclusions Complete. The recommendation has been implemented. The IJB has refreshed and maintained its Medium-Term Financial Outlook, updated financial assumptions and continued to monitor financial sustainability through established governance arrangements. However, the risks that gave rise to the original recommendation remain relevant and have been incorporated into the Financial Sustainability Level 1 risk reported on the previous page.

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 (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Clarity of plans to implement the vision	The IJB continues to demonstrate a clear and well-articulated vision of “Improving Lives with the People of West Dunbartonshire”, which is supported by a strategic outlook that aligns with national health and wellbeing outcomes and local priorities. A Strategic Needs Assessment (SNA) was completed in 2025 to provide a comprehensive assessment of service demand, workforce pressures and future care requirements. The assessment identifies key long-term challenges, including an ageing population, rising demand for community-based services, child poverty and mental health needs. These assessments provide an insight to support future planning and reinforce the continued relevance of the existing strategic priorities. The Board approved an extension to the current 2023-2026 strategic plan by one-year up to 2027 to allow additional engagement activity and incorporation of the findings from the SNA as part of the consideration of the next Strategic Plan covering 2027-2032. This demonstrates responsiveness and a commitment to ensuring that future strategic priorities are informed by updated evidence, stakeholder engagement and co-production activity with local communities, service users and other stakeholders being involved in the process. Community participation and engagement arrangements are well established and supported through the Participation and Engagement Strategy and Strategic Planning Group. These arrangements provide mechanisms for incorporating stakeholder and service user perspectives into strategic planning. While evidence demonstrates a clear commitment to engagement, there remains an opportunity to strengthen the demonstration of how feedback and engagement outcomes directly influence operational decision-making and measurable service improvements.	The IJB has established clear arrangements for implementing its vision and strategic objectives. The decision to extend the Strategic Plan reflects a measured and appropriate response to changing circumstances and supports the development of a more informed and sustainable future strategy. However, effective delivery of the vision will depend on the successful completion of the new Strategic Plan and ensuring that supporting workforce and service planning arrangements are fully aligned with future priorities.	Strategic Alignment – Level 2 The IJB is finalising its Strategic Plan and ensuring supporting plans are fully aligned and implemented. There is a risk that delays in finalising and embedding the new strategy could reduce clarity over its longer-term priorities, implementation arrangements and alignment between strategic, workforce and financial planning. See page 38 for further information and our recommendations made to the IJB.

Vision, leadership and governance (continued)

Our overall assessment (continued)

Area assessed	Our findings	Our judgements	Significant risks identified
Strategy and priorities	The IJB'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 the SNA, a Strategic Delivery Plan and the MTFO, ensuring priorities are evidence-based and linked to financial decision-making. Good progress has been made in strengthening the alignment between strategic planning. The former Integrated Workforce Plan has been reframed as the Workforce and Organisational Development Interim Plan 2025-2027, which was extended to align with the development of the next Strategic Plan 2027-2032. The interim plan reflects key findings from the SNA and focuses on workforce sustainability, recruitment and retention, succession planning, leadership development, workforce wellbeing and integrated working. Management has also progressed succession planning activity. It has identified key workforce risks associated with the potential loss of critical skills and leadership capacity. It now maintains a matrix detailing the talent pipeline and readiness to fill roles if they are made vacant. The development of the Strategic Plan 2027-2032 remains on track, supported by stakeholder engagement and ongoing workforce planning activity. However, the longer-term Workforce Plan, Leadership and Talent Framework and supporting succession planning arrangements remain under development and are dependent on completion of the new Strategic Plan. Given the significant workforce and demographic challenges identified in the SNA, successful delivery of these arrangements will be vital to ensure workforce capacity and delivery of the IJB's strategic vision.	The IJB has a coherent strategic framework. Strategic priorities remain relevant and appropriately targeted towards key population and service pressures. Good progress has been made in strengthening succession planning arrangements However, the full benefits of these arrangements will only be realised once the longer-term Workforce Plan and associated succession planning framework are finalised and implemented alongside the Strategic Plan 2027-2032. Continued focus will therefore be required to ensure workforce planning is fully integrated with strategic, financial and service planning arrangements.	Please refer to the risk identified on page 34 regarding Strategic Alignment. See page 38 for our recommendations made to the IJB.

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 provide effective oversight, accountability and assurance in support of strategic objectives and Best Value responsibilities. Governance arrangements are supported by clear decision-making structures, regular Board and Audit & Performance Committee scrutiny, strategic risk management, performance reporting and internal audit assurance. The Annual Governance Statement and Chief Internal Auditor's opinion both conclude that governance, risk management and internal control arrangements remain effective. Governance improvement actions are routinely monitored and reported, and evidence demonstrates that audit findings and self-assessment activity are used to strengthen governance and organisational performance. The Board has maintained oversight of key strategic developments, including extension of the current Strategic Plan, development of the Strategic Plan 2027-2032 and ongoing financial sustainability challenges. Governance arrangements supporting development of the new Strategic Plan have been strengthened through the establishment of a Strategic Planning Project Group which provides challenge, assurance and stakeholder oversight. Progress has also been made in reviewing partnership governance arrangements relating to hosted services. Legal advice has been obtained, a Lead Partnership Governance Group has been established, and a financial due diligence exercise has been completed across the six IJBs. Revised draft Integration Schemes have been prepared and will be refined following the 2026/27 shadow year before progressing through formal approval processes.	The IJB has effective governance arrangements that support transparency, accountability, partnership working and informed decision-making. Strong assurance and scrutiny mechanisms are in place, and good progress has been made in reviewing partnership governance arrangements.	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	During 2025/26, the Board and Audit & Performance Committee received regular reports covering financial performance, budget monitoring, savings delivery, strategic risks and service performance. This enabled members to monitor delivery of strategic priorities, assess emerging risks and consider the sustainability of services. Performance reporting is structured around the Strategic Plan's four strategic outcomes and the National Health and Wellbeing Outcomes. The Board receives quarterly performance reports and an Annual Performance Report, which for 2025/26 included reporting against 49 performance indicators supported by local and national benchmarking information, trend analysis and narrative commentary. The Audit & Performance Committee receives regular performance, risk and assurance reports throughout the year, including updates on strategic risks, internal and external audit recommendations, governance improvement actions and service performance. Financial reporting includes regular revenue budget monitoring reports, updates on delivery of savings programmes, reserve levels and Medium-Term Financial Outlook assumptions. Financial information is routinely linked to strategic priorities, transformation programmes and strategic risks, supporting informed decision-making regarding service sustainability and resource allocation. The Annual Performance Report, Annual Governance Statement, Annual Accounts and Best Value reporting collectively provide a comprehensive overview of organisational performance, financial stewardship and progress towards strategic objectives. The integration of financial, workforce, performance and risk information provides members with a strong evidence base for scrutiny, challenge and decision-making.	The IJB has effective arrangements for reporting and scrutiny of financial and performance information. Reporting frameworks provide members with sufficient information to support challenge, accountability and decision-making, and there is clear evidence that performance information informs strategic planning and service improvement activity.	No significant risks identified.

Vision, leadership and governance (continued)

Identified risks in vision, leadership and governance arrangements and recommendations for improvement

As a result of our work we have identified risks in the IJB's vision, leadership and governance 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.

	vision, leadership and governance significant risks identified	Recommendation for improvement	IJB's response and implementation timescale
2	Workforce Planning and Strategic Plan Alignment – Level 2 The IJB has established interim workforce and succession planning arrangements and has made progress in aligning workforce priorities with strategic and financial planning. However, the longer-term Workforce Plan, Leadership and Talent Framework and associated succession planning arrangements are still being developed alongside the Strategic Plan 2027-2032. Whilst the IJB is finalising its Strategic Plan and ensuring supporting plans are fully aligned and implemented. There is a risk that delays in finalising and embedding the new strategy could reduce clarity over its longer-term priorities, implementation arrangements and alignment between strategic, workforce and financial planning.	The IJB should complete development of its longer-term Workforce Plan and Leadership and Talent Framework. Formal milestones should be established and monitored with oversight of those charged with governance. Future workforce planning should demonstrate a clear link between workforce priorities, succession planning arrangements, Strategic Needs Assessment findings and strategic service delivery objectives.	Management's response Interim workforce and succession planning arrangements are already in place through the Workforce and Organisational Development Interim Plan 2025–2027, providing a framework for progressing key workforce priorities while the longer-term Strategic Plan is developed. Work is underway to develop the Workforce and Organisational Development Plan 2027–2032 alongside the Strategic Plan 2027–2032, ensuring that future workforce priorities are directly informed by the Strategic Needs Assessment, anticipated service demand, demographic pressures, financial planning and emerging service delivery priorities. This will include the development of the Leadership and Talent Framework and strengthened succession planning arrangements, with a particular focus on leadership resilience, critical roles, workforce capacity, recruitment and retention, and future skills requirements. Formal milestones will be established to support delivery and provide appropriate governance oversight. Progress will be monitored through the relevant IJB governance arrangements, with alignment between workforce, financial and strategic planning clearly demonstrated within the final plan. The Workforce and Organisational Development Plan 2027–2032 is scheduled to be presented to the IJB for approval in March 2027, aligned with the development and approval of the Strategic Plan 2027–2032. Responsible officer Head of People and Change Implementation date March 2027 with ongoing implementation and monitoring thereafter

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 (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Resources deployed to improve strategic outcomes	The IJB has established comprehensive arrangements to assess and respond to service user needs through strategic planning, performance management and stakeholder engagement. 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. An example of this good practice is the Learning Disability Service Review which has been informed by analysis of demographic pressures, future demand projections and care package costs. This has helped in supporting consideration of alternative models of support designed to promote independence whilst ensuring resources remain aligned to assessed need and statutory responsibilities. The Children and Families Transformation Programme ("What Would It Take?") represents a further example of resources being redirected towards preventative and early intervention care, with management reporting encouraging feedback at the early stage with both improved outcomes and improved financial performance.	The IJB demonstrates a strong understanding of service user needs and has appropriate mechanisms for incorporating population intelligence, performance evidence and stakeholder views into decision-making. Despite pressure on finances and service demand, the IJB are taking action and are deploying resources within their control.	Please refer to the risk identified on page 34 regarding Strategic Alignment. See page 38 for our recommendations made to the IJB.

Use of resources to improve outcomes (continued)

Our overall assessment (continued)

Area assessed	Our findings	Our judgements	Significant risks identified
Needs of service users being met	There are several arrangements in place to understand and respond to the needs of service users through strategic planning, engagement and performance monitoring. The Participation and Engagement Strategy 2024-2027 promotes co-production having been developed through consultation with service users, carers, community groups, third-sector organisations and partner agencies. The Board's decision to extend the current Strategic Plan to 2027 demonstrates a commitment to ensuring that future priorities are informed by engagement activity and findings from the Strategic Needs Assessment 2025. The strategy also includes actions to strengthen representation from seldom-heard groups, improve feedback mechanisms and increase community involvement in service planning and decision-making. The IJB continues to assess whether service user needs are being met through a performance management framework comprising 49 local and national indicators aligned to strategic priorities and National Health and Wellbeing Outcomes. Of the 49 performance indicators monitored by the IJB, performance in 2025/26 was mixed. While several measures show stable or improving trends, a number of strategically important indicators continue to perform below target, particularly in relation to delayed discharge, waiting times and unscheduled care. The IJB has strengthened performance scrutiny arrangements and introduced targeted recovery actions, with progress monitored through exception reporting and regular Board oversight. This provides assurance that underperformance is being actively managed	The IJB has a clear and effective approach to understanding and involving service users in service planning and evaluation, supported by comprehensive engagement arrangements and transparent performance reporting. Service user needs are considered in decision-making and resource allocation. Steps are being taken to actively address areas of underperformance in relation to the local and national indicators.	No significant risks identified.

Use of resources to improve outcomes (continued)

Our overall assessment (continued)

Area assessed	Our findings	Our judgements	Significant risks identified
Arrangements to deliver continuous improvements in priority services	The IJB has a strong focus on continuous improvement and has implemented a range of structured improvement and transformation programmes designed to address service pressures, improve outcomes and support long-term sustainability. Events in the year highlight that resources have been targeted towards priority areas where demand, performance pressures and sustainability risks are greatest. Significant examples during 2025/26 include the Care at Home Redesign Programme, which was informed by increasing demand from an ageing population, rising complexity of need, workforce pressures and service capacity challenges. The redesign has influenced investment decisions and associated savings proposals intended to support future sustainability whilst maintaining independence and community-based care. 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 8).	The IJB has effective arrangements for driving continuous improvement, with evidence of service redesign, targeted recovery plans and transformation activity focused on priority service areas. Improvement activity is supported by robust governance oversight, and there are emerging positive outcomes from major transformation programmes.	No significant risks identified.

08

Best Value

Commentary on Best Value

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 assess the seven Best Value themes at the IJB over the period of the audit appointment. 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 any previously reported Best Value findings, and have assessed the pace and depth of improvement implemented by the IJB.

At the planning stage of the audit, we undertook work to understand the arrangements that the IJB has in place under each of the reporting criteria and we considered whether there were any risks to our audit in those arrangements. We have kept our understanding of arrangements under review and updated our risk assessment throughout the audit to reflect emerging issues that may suggest significant risks in arrangements exist. The following slides outline the work that we have undertaken for each of the seven Best Value themes and any improvements or risks in arrangements that have been identified as part of our assessment.

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	46	No	No	No	Satisfactory

Best Value (continued)

Significant risks

We have not identified any significant risks in arrangements as part of our continuous planning procedures.

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 Board of the IJB is the key decision-making body accountable for securing Best Value. Its membership includes six voting members from both partner bodies, being West Dunbartonshire Council and NHS Greater Glasgow and Clyde.

The Board is supported by the Audit and Performance Committee, Project Management Office and Senior Management Team. These arrangements are designed to ensure effective reporting on the outcomes of Best Value arrangements and that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively.

The Board meets six times per year, with regular financial and performance reporting. The IJB publishes all papers and minutes on its website. Complaints from the public are also regularly reported to the Board and investigated. These arrangements demonstrate the IJB's openness and transparency.

The IJB has effective arrangements in place to support delivery of Best Value. Governance, performance, financial and risk management arrangements are well established and integrated, providing clear accountability and oversight. The IJB demonstrates an ability to work alongside its partner bodies, with reserve levels being closely monitored to ensure appropriate levels are maintained, while considering the financial risk across the partnership.

In terms of collaboration with other IJB's, a lead partnership governance group was established in early 2025 and a financial due diligence exercise was undertaken jointly by all six CFOs, with a report presented in June 2026. Roles and responsibilities are clearly defined and there is evidence of constructive challenge, transparency and scrutiny.

The IJB prepares a Best Value Statement which is reviewed and updated on an annual basis. Officers presented the latest report to the June 2026 Audit and Performance Committee. 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 (e.g. finances and workforce) is effective and sustainable.

Best Value (continued)

Overall commentary on the Best Value reporting criteria (continued)

The IJB, through its Best Value Statement, can evidence that resources are being directed towards priority service areas and service redesign activity. The IJB continues to demonstrate a commitment to improvement through a range of transformation and redesign programmes, including:

- Care at Home and Learning Disability service redesign;
- Children's Services Improvement Programme;
- digital transformation including transition to Digital Telecare alarms;
- prescribing efficiency initiatives; and
- wider sustainability reviews.

The IJB's Strategic Needs Assessment 2025 is a strategic assessment of current and future population needs within West Dunbartonshire that has strengthened the IJBs forward planning. This assessment has allowed the IJB to assess the demographic, health and social challenges and feed this into planning future priorities.

The extension of the 2023-2026 Strategic Plan by an additional year to 2027. This provides a further opportunity to enhance stakeholder engagement and co-production with stakeholders including service users, communities, staff, providers and partner organisations. The extension was approved by the Board to allow additional engagement activity and incorporation of the findings from the Strategic Needs Assessment as part of the consideration of the next Strategic Plan covering 2027-2032.

The IJB's pace of improvement is generally good; however, progress is constrained by financial pressures, workforce challenges and increasing service demand. Continued delivery of transformation activity, such as those mentioned above, will be necessary to achieve intended long-term benefits and support sustainability.

The IJB demonstrates evidence of continues improvement in several areas. Its strategic

planning has been strengthened through the Strategic Needs Assessment and greater integration between performance, risk and financial reporting. Its financial performance improved during 2025/26, with a favourable outturn, strong savings delivery and an improved reserves position. The organisation has progressed several significant transformation and service redesign programmes.

- The IJB continued implementation of its Care at Home redesign programme during 2025/26, including the introduction of a redesigned staffing model and standardised rota arrangements. The programme is intended to improve service responsiveness, workforce utilisation and long-term sustainability.
- The IJB continued to deliver improvement activity across Children's Services, including initiatives to strengthen mental health and wellbeing support and expand early intervention services. The programme aims to improve outcomes for children, young people and families through preventative approaches, earlier support and improved access to community-based services.
- The IJB completed the transition from analogue to digital telecare during 2025/26, ahead of the national implementation deadline. The programme supported more than 1,600 residents and improved the resilience, reliability and long-term sustainability of telecare services, helping people to live independently within their communities.

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. For example, it has identified an opportunity to further strengthen the integration of performance and financial reporting. Greater alignment between key performance indicators and financial information would provide the Board with a clearer understanding of how resource allocation contributes to service outcomes. This would support more informed decision-making, enhanced transparency and stronger evidence of value for money.



Appendices

- 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

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 the 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 the 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.

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.

Appendix A: Internal control conclusions (continued)

Other deficiencies in internal control

Review of related party transactions

Description of deficiency

Three Board members' annual declarations of interest were submitted after the unaudited annual report and accounts were approved for issue. This included one which was omitted because the individual left during the year. 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 also identified this deficiency during our 2024/25 audit and included a control recommendation in our 2024/25 Annual Audit Report.

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, for all members who have served in year, are received in suitable time for a full review to be carried out prior to issuing the unaudited accounts.

Management response

The Standards Commission for Scotland is very clear that responsibility for registering and declaring interests rests with the individual IJB member. The CFO and Standards Officer will issue a reminder to members to update register entries in sufficient time for entries to be considered in advance of the preparation of unaudited accounts.

Responsible Officer Standards officer

Implementation date April 2027

Appendix B: Draft management representation letter

Forvis Mazars
100 Queen Street
Glasgow
G1 3DN

XX September 2025

Tom Reid,

West Dunbartonshire Integration Joint Board - Audit for Year Ended 31 March 2026

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 2026 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 2025/26 (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 the 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

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.

Appendix B: Draft management representation letter

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.

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 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.

Appendix B: Draft management representation letter

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 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.

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 management commentary and the Events after the Reporting period 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 management commentary and the Events after the Reporting period 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.

Appendix B: Draft management representation letter

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.

Management Commentary

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

Remuneration Report

The disclosures within the Remuneration Report fairly reflect my understanding of the IJB's remuneration of officers over the period covered by the financial statements.

Unadjusted misstatements

I confirm that the effects of the uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to this letter as an Appendix.

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: XXXX

Date: XXXX

Appendix B: Draft management representation letter

Appendix

Schedule of unadjusted misstatements

We identified the following disclosure misstatements during our audit that have not been corrected by management:

- **Provisions**

- The unaudited accounts included a provision of £546k (24/25: £487k) in the balance sheet for unrecovered charges for specific social care delegated services. We have recommended in prior year audits (2022/23, 2023/24 and 2024/25) 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.

Appendix C: Draft audit report

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

Reporting 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 2026 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 2025/26 (the 2025/26 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 2026 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 2025/26 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

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.

Appendix C: Draft audit report

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 the 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 the 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.

Appendix C: Draft audit 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, Annual Governance Statement, Statement of Responsibilities 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).

Appendix C: Draft audit report

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, Director
For and on behalf of Forvis Mazars LLP

100 Queen Street
Glasgow – G1 3DN
XX September 2026

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 remain available to the Audit and Performance Committee to discuss any matters relating to our independence, should such a discussion be required.

Confirmation of independence

We confirm that the firm, Forvis Mazars LLP, and all covered persons remain independent of West Dunbartonshire Integration Joint Board in accordance with the requirements of the FRC Ethical Standard.

Relationships disclosure

A review of relationships between the firm, covered persons, and West Dunbartonshire Integration Joint Board, including its directors, senior management, affiliates, and connected parties, has identified no matters that bear on our integrity, objectivity, or independence during the engagement period.

Appendix D: Confirmation of our independence

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 in March 2026. Having completed our work for the 2025/26 financial year, we can confirm that our fees are as follows:

Area of work	2025/26 fees	2024/25 fees
Auditor remuneration	£38,560	£37,150
Pooled costs	£1,330	£930
Contribution to PABV costs	£7,180	£7,130
Sectoral cap adjustment	(£11,590)	(£11,200)
Total fees	£35,480	£34,000

Non-audit and additional services

The firm has not provided any non-audit or additional services to West Dunbartonshire Integration Joint Board or its affiliates during the relevant period, and no fees have been charged in respect of such services.

Use of component auditors

We have not made arrangements for any of our activities as auditor to be conducted by another firm that is not a Forvis Mazars’ member firm.

Use of experts

We have not used the work of external experts.

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.

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 '<i>Fraud considerations</i>' for our fraud considerations and conclusion. We will obtain written representations from management and, where appropriate, the Audit and Performance Committee, confirming that - they acknowledge their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud; - 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; - they have disclosed to the auditor their knowledge of fraud or suspected fraud affecting the entity involving: - management; - employees who have significant roles in internal control; or - others where the fraud could have a material effect on the financial statements; and - 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 2025. Details of that assessment and our conclusion are set out in our 2024/2025 Transparency Report, which is available on our website here.

Appendix F: Wider scope ratings

We need to gather sufficient evidence to support our commentary on the 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.

Contact

Forvis Mazars

Tom Reid

Director

Tel: +44 781 635 4994

tom.reid@mazars.co.uk

The contents of this document are confidential and not for distribution to anyone other than the recipients.
Disclosure to third parties cannot be made without the prior written consent of Forvis Mazars LLP.

Forvis Mazars LLP is the UK firm of Forvis Mazars Global, a leading global professional services network. Forvis Mazars LLP is a limited liability partnership registered in England and Wales with registered number OC308299 and with its registered office at 30 Old Bailey, London, EC4M 7AU. Registered to carry on audit work in the UK by the Institute of Chartered Accountants in England and Wales. Details about our audit registration can be viewed at www.auditregister.org.uk under reference number C001139861. VAT number: GB 839 8356 73

© Forvis Mazars 2024. All rights reserved.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD**AUDIT AND PERFORMANCE COMMITTEE****Report by Julie Slavin, Chief Financial Officer****22 September 2026**

Subject: Audited Annual Accounts 2025/26**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 2026.

2. Recommendations

- 2.1** The HSCP Board's Audit and Performance Committee is asked to:
- a) Consider the audited Annual Accounts for 2025/26; 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 2025/25 at its meeting of 23 June 2026. 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 2025/26 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 2026 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 and disclosure 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 2025/26	Unearmarked Reserves £000	Earmarked Reserves £000	Total General Fund Reserves £000
Opening Balance as at 31 st March 2025	(3,576)	(14,831)	(18,407)
Total Comprehensive Income and Expenditure (Increase)/Decrease 2025/26	(1,197)	(3,711)	(4,908)
(Increase)/Decrease in 2025/26	(1,197)	(3,711)	(4,908)
Closing Balance as at 31 st March 2026	(4,773)	(18,542)	(23,315)

- 4.3** The Audit and Performance Committee are requested to consider the audited Annual Accounts for 2025/26 and remit them to the 29 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 2025/26 financial year with an adjusted surplus (after all planned application of earmarked reserves) of £0.400m. This surplus was transferred to un-earmarked reserves along with the release of £0.797m from 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: 14 September 2026

Person to Contact: Julie Slavin – Chief Financial Officer
E-mail: Julie.Slavin@nhs.scot

Appendices: Appendix 1: HSCP Board's (IJB) Annual Accounts for the year ended 31 March 2026

Background Papers: HSCP Audit and Performance Committee June 2026 – Unaudited Annual Report and Accounts 2025/26

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 2026

www.wdhscp.org.uk



Contents

Introduction	3
Management Commentary	5
Introduction	6
West Dunbartonshire HSCP Board Remit and Vision	7
West Dunbartonshire HSCP Board's Strategy and Business Model	8
Strategic Planning for our Population	12
Climate Change	25
Performance Reporting 2025/26	28
Financial Performance 2025/26	42
Medium Term Financial Outlook	54
Conclusion	59
Statement of Responsibilities	60
Remuneration Report	63
Annual Governance Statement	68
Executive Summary	69
Scope of Responsibility	70
Our Governance Framework	70
Our Assessment of Effectiveness	71
Compliance with Best Practice	73
Where our Governance Needs to Improve	73
How we Have Improved our Governance Arrangements in 2025/26	75
Forward Look on Governance	77
Conclusion and Opinion on Assurance	78
Assurance and Certification	78
Comprehensive Income and Expenditure	79
Movement in Reserves	81
Balance Sheet	83
Notes to the Financial Statements	85
Independent Auditors Opinion	100
Appendix 1: List of Website Links	106

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 2026.

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**



**2025/26 Integrated Budget
of £227m**

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 2025/26 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 89,120 (1.6% of Scotland's population)



2,095 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 (1,691 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 2025/26;
- Financial Performance for 2025/26; 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

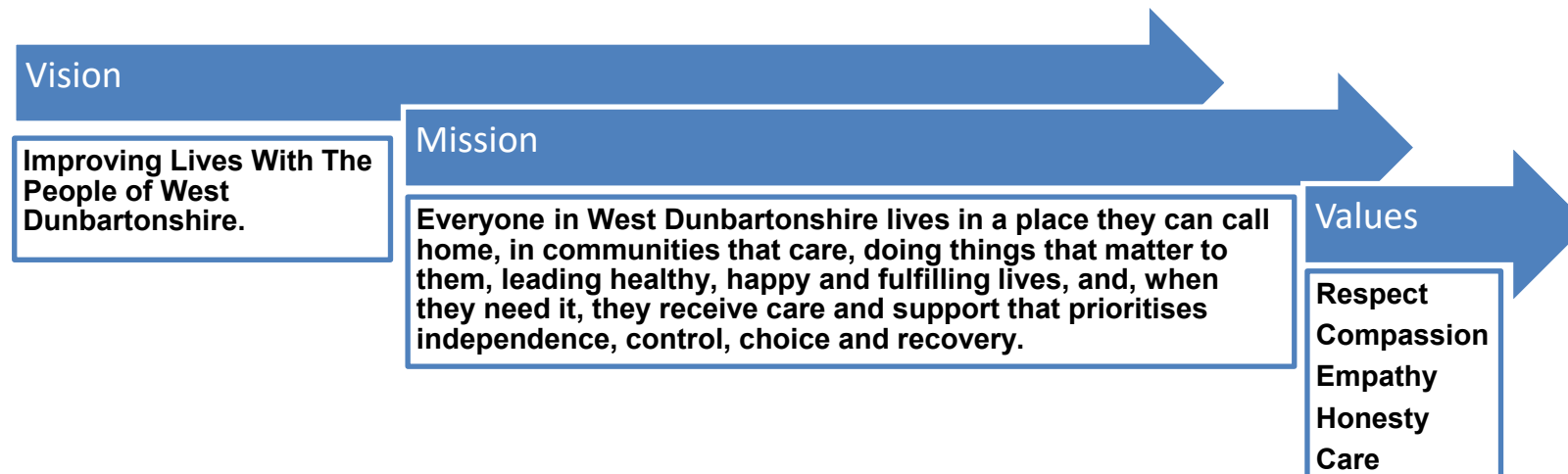


The 2014 Act requires that Integration Schemes undergo review within five years of establishment, unless by earlier request of the Council or the Health Board. This review was undertaken jointly by all 6 HSCPs in the Greater Glasgow and Clyde area. The group co-developed updated versions of the Schemes for their respective HSCPs 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. The review is still ongoing and has been delayed due to receipt of legal advice relating to the treatment of Board-wide hosted services. The review is expected to be completed during 2026/27. 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.

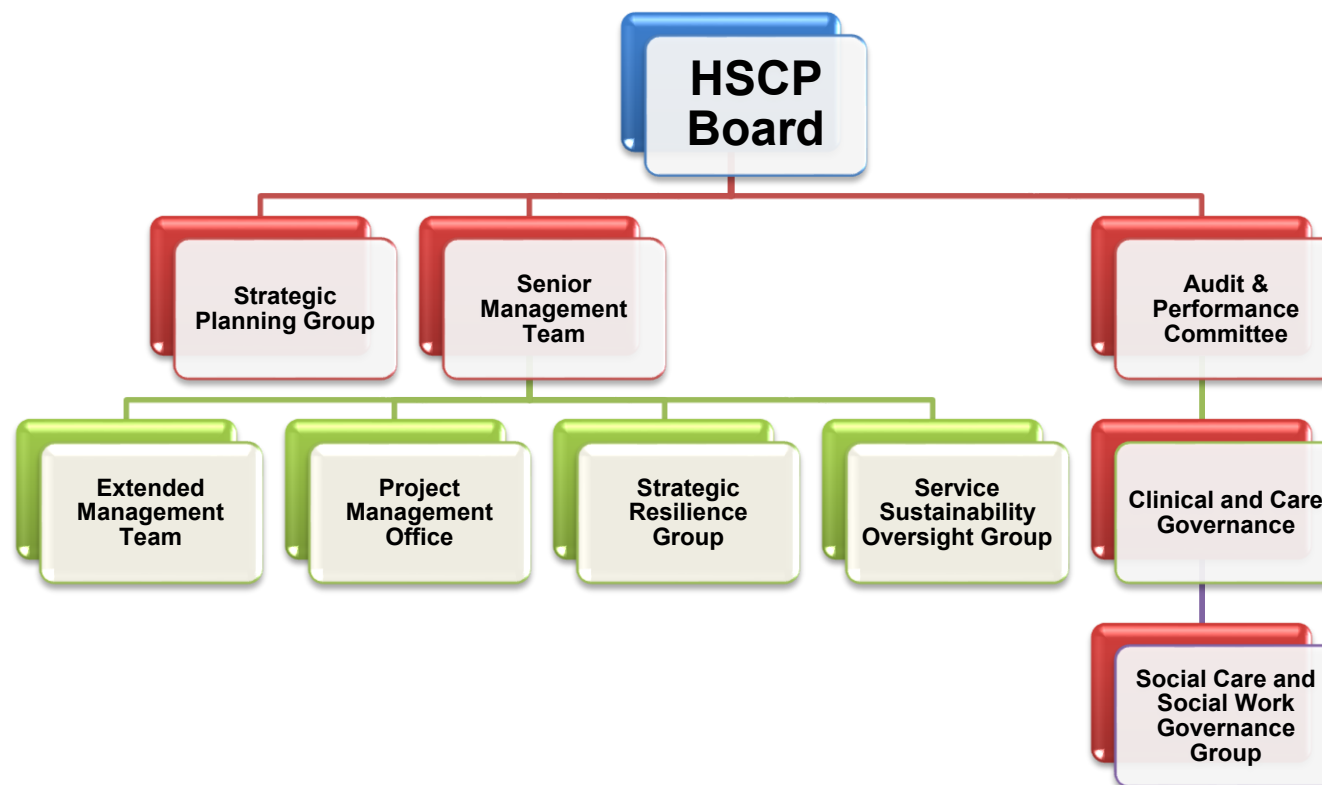
Exhibit 3: Strategic Outcomes



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.

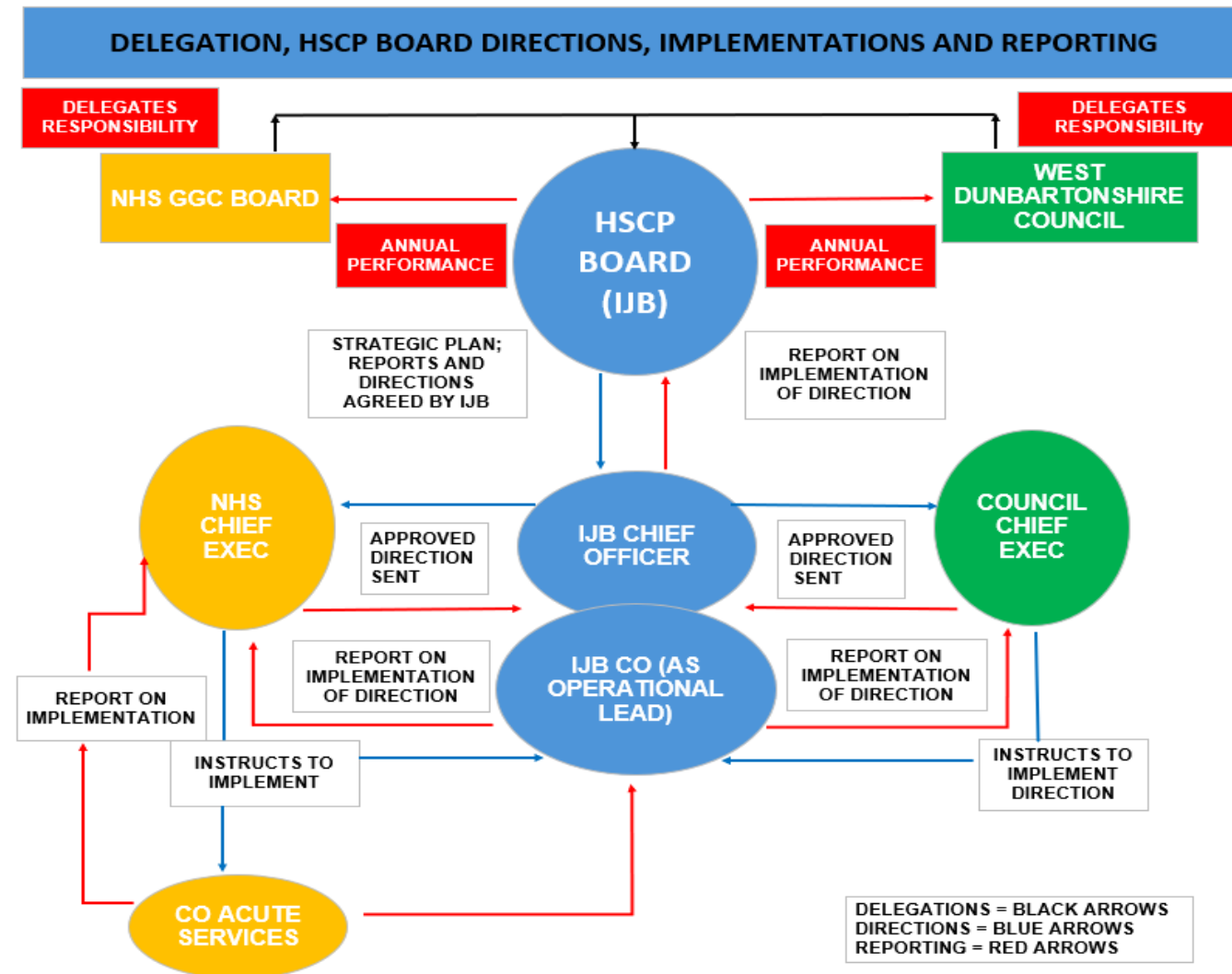
The HSCP Board also includes several non-voting professional and stakeholder members.

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 89,120 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 to 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.
- 9. Resources are used effectively and efficiently in the provision of health and social care services.

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.

An updated West Dunbartonshire HSCP [Strategic Needs Assessment 2025](#) (see Appendix 1, 3) was developed during 2025/26 and considered by the West Dunbartonshire Strategic Planning Group, HSCP Senior Management and the Carers Development Group in October and November 2025 respectively.

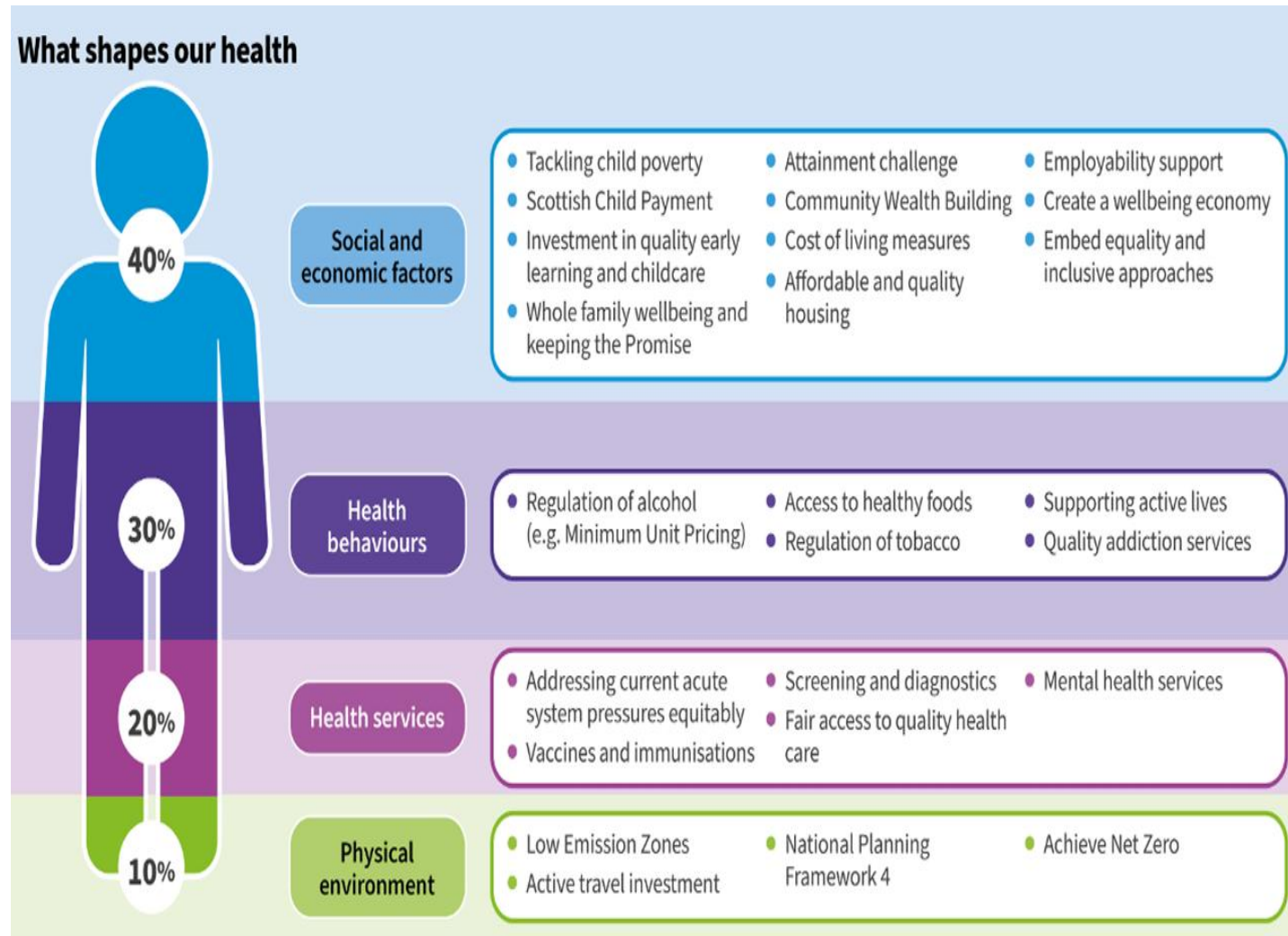
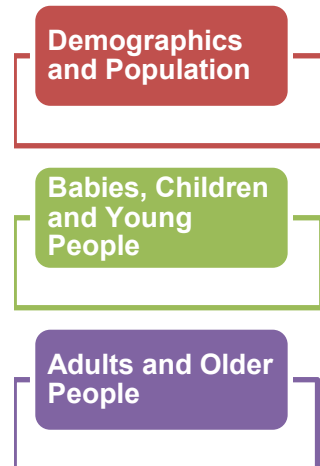
Key points highlighted during these considerations was the importance of community conversations, a focus on co-production and the impact of the SNA on not only strategic planning but also on service planning going forward.

The Strategic Plan was scheduled to be refreshed in 2026, however following consideration by the above groups the HSCP Board agreed on 27 January 2026 to extend the lifespan of the current strategic plan for one additional financial year until 2027 to allow time for a focused period of stakeholder engagement and consultation with the aim of co-producing a strategic plan for 2027 to 2032 along with focus on renewed one year delivery plans for 2026/27, capturing data from, among other sources, the updated SNA.

Strategic Needs Assessment 2025

The 2025 SNA examines the factors that shape an individual's health.

The main sections are structured around:

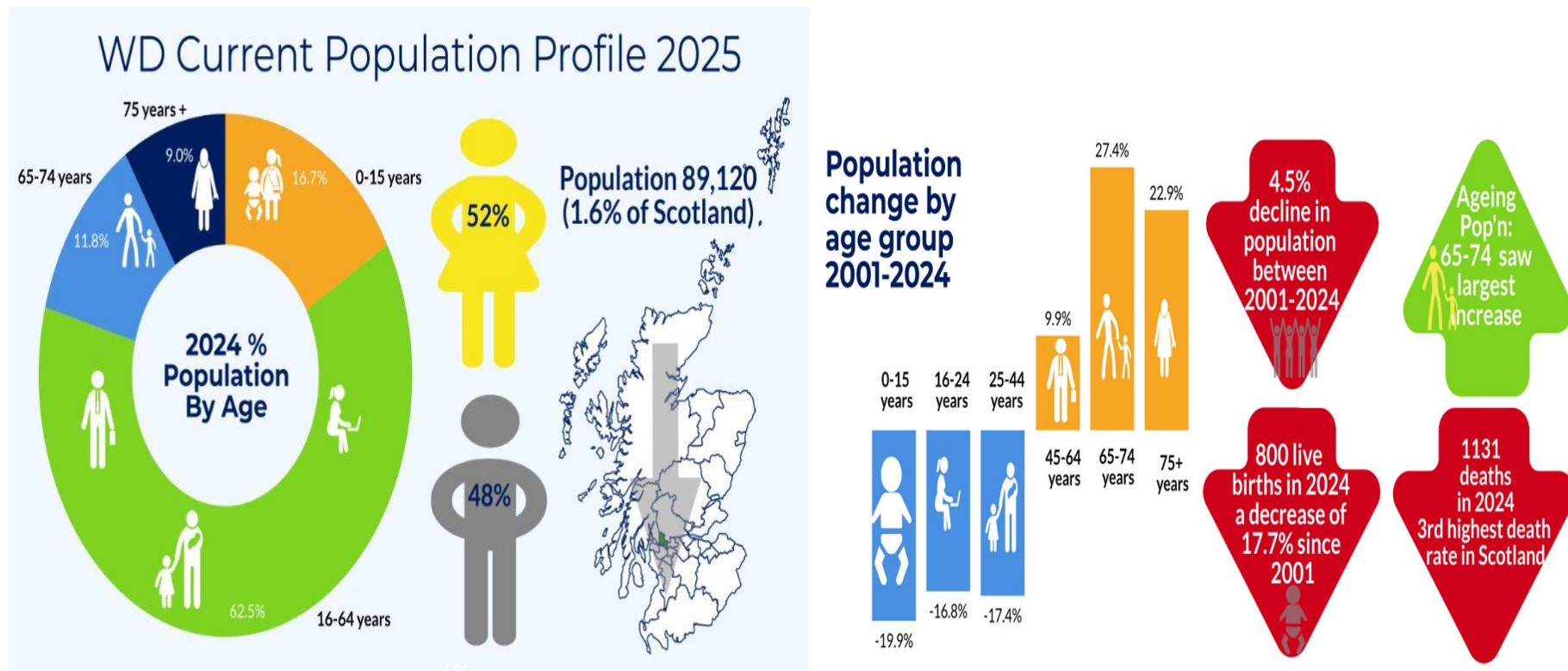


Source: Strategic Needs Assessment 2025

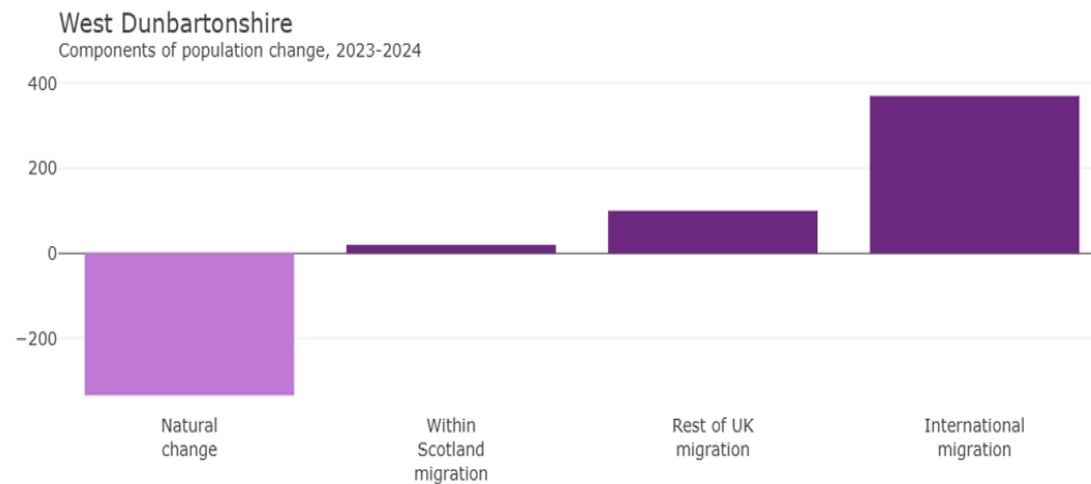
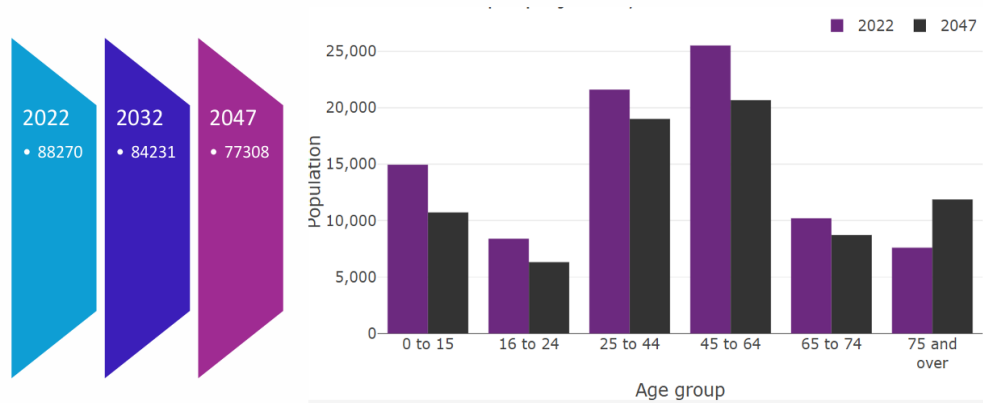
An extract of some of the key statistics is provided below within Exhibit 9.

Exhibit 9: Extract from [Strategic Needs Assessment 2025](#) (see Appendix 1, 3)

Demographics

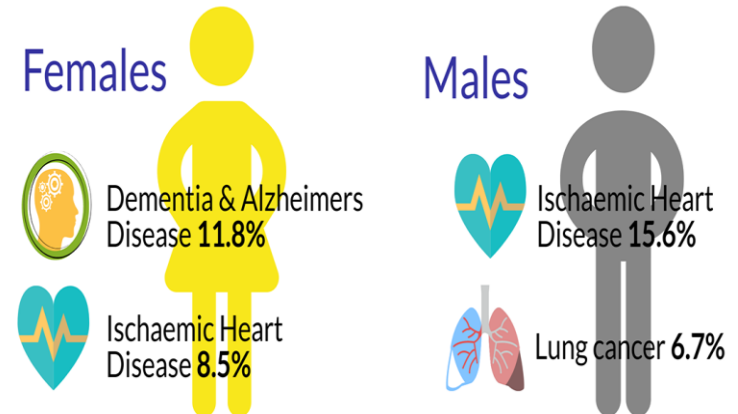


West Dunbartonshire Population projections to 2047



Leading causes of death 2023

Note: cancer would be the leading cause of death if all cancers were grouped together

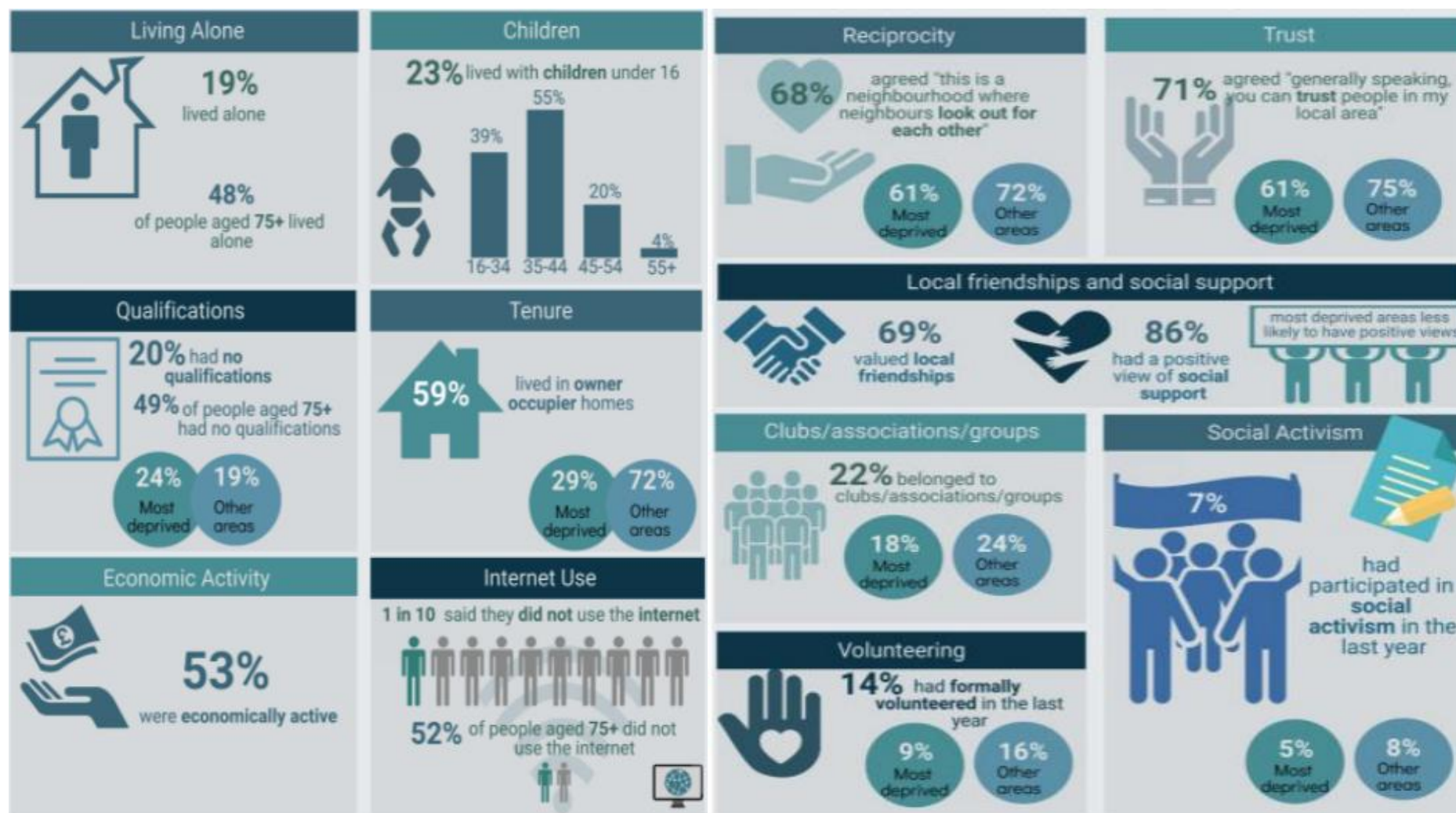


The population of West Dunbartonshire is projected to reduce to 77,308 by 2047;

It is an ageing population which is becoming more ethnically, religiously and culturally diverse; and

The percentage of the population with long term conditions has increased.

Population Characteristics

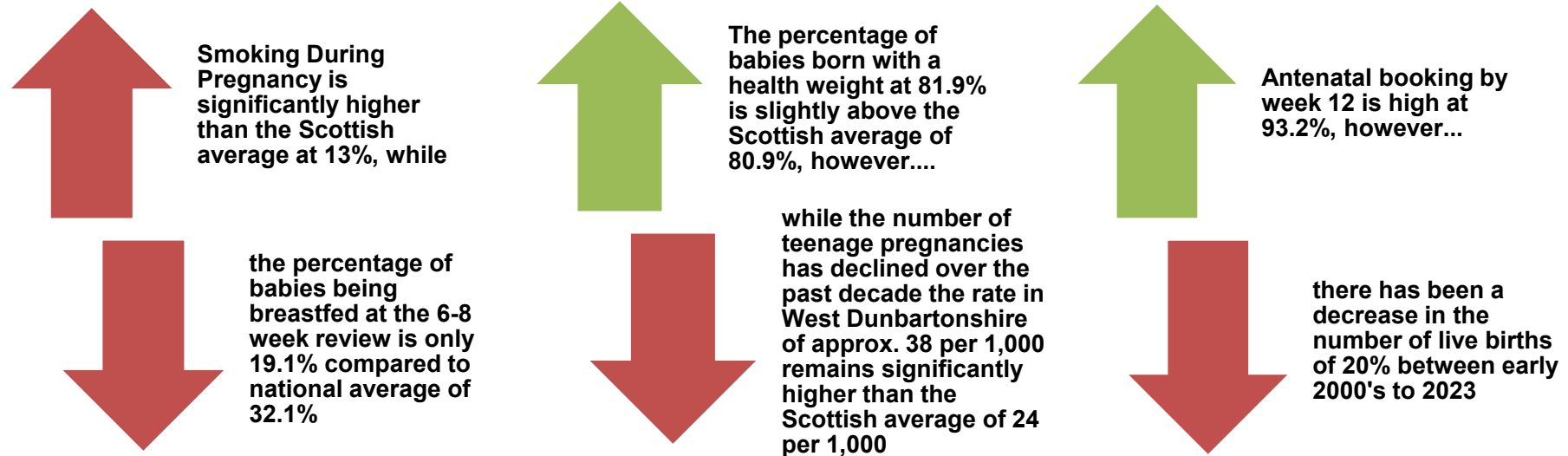


Babies, Children and Young People



Maternity and Early Years

The data shows several key challenges where outcomes are poorer than the national average requiring targeted action to support mothers, babies and families

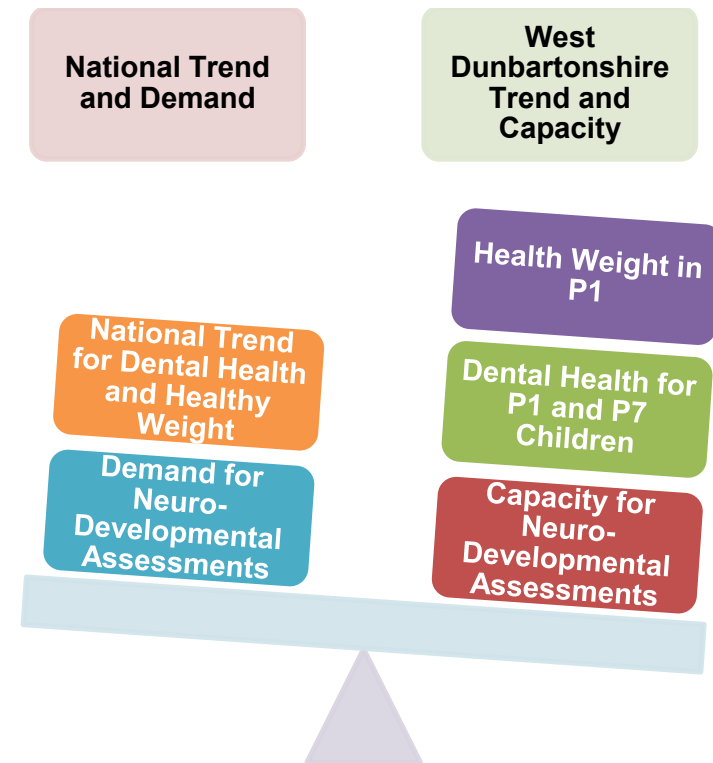
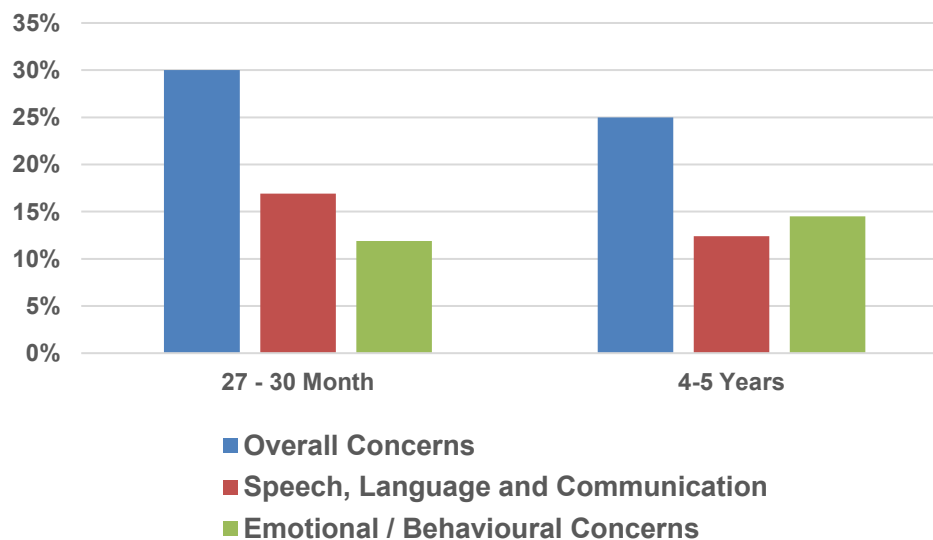


Developmental Concerns and School Age Health

The data shows that at the 27-30-month review children from the most deprived areas are significantly more likely to have a developmental concern recorded compared to those in the least deprived areas.



Developmental Concerns



The imbalance of the above indicates the extent of the ongoing public health challenges with demand for neuro developmental assessments far outstripping capacity.

Youth Behaviours

There are notable gender differences in Wellbeing with young females less likely than males to:

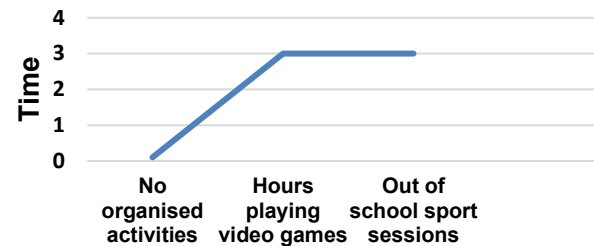
- Report “Very Good” mental health;
- Feel happy with their lives; or
- Get 8+ hours of sleep on average



Self-Harm Statistics



Leisure and Activities



A = Overall number of young people who have reported harmed themselves on purpose at some point, of which

B = Females who have attempted suicide

C = Males who have attempted suicide

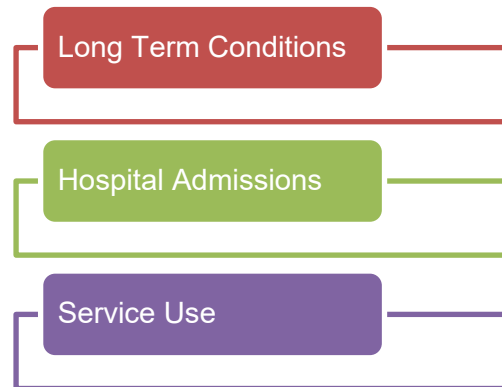
High percentage feel safe at home

Strong parental disapproval of drunkenness. **HOWEVER** young people report feeling peer pressure to drink, smoke, etc.

Most find it easy to get warmth/caring from parents



Adults and Older People

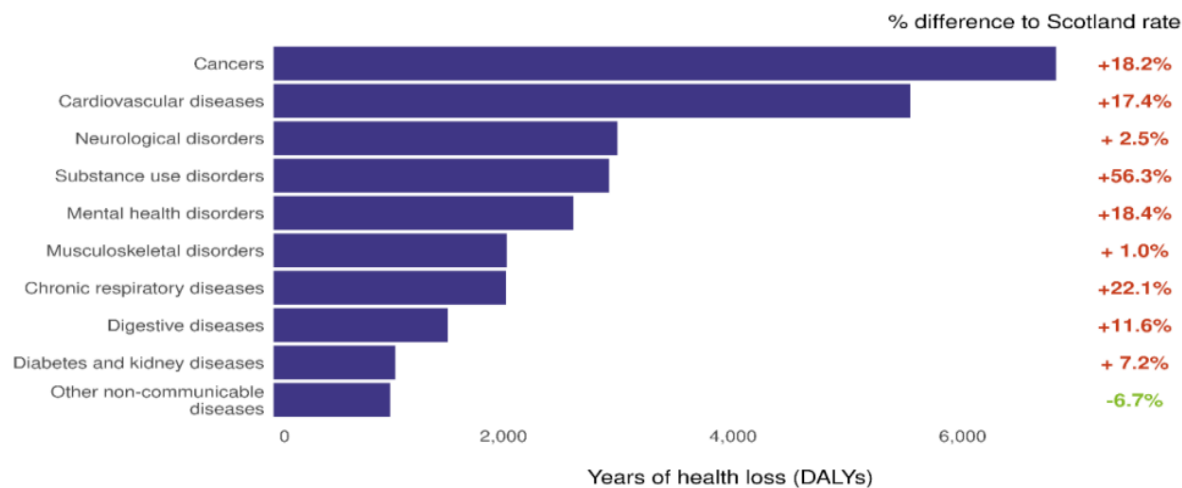


The top three grouped causes of ill-health and early death in West Dunbartonshire account for 47% of the total burden of health loss.

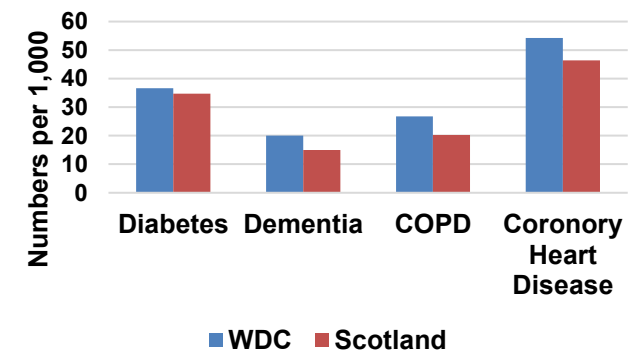
Largest differences in burden – compared to Scotland – occur due to:

- Substance use disorders;
- Chronic respiratory diseases; and
- Mental health disorders

Burden of Disease



Long Term Condition Comparisons



Climate Change

Scotland details climate change as a top government priority through its [Scotland's Climate Change Plan: 2026–2040](#). Published in March 2026 this plan outlines policies, targets and actions to achieve net zero emissions while supporting economic growth and local communities.

While the Climate Change Plan addresses mitigation over the long term the third Scottish National Adaption Plan (SNAP3) published in September 2024 covers the period 2024 to 2029 and focuses on adaptation and building resilience to the ongoing and future impacts of climate change.

This represents Scotland's most ambitious climate adaption programme to date. It responds to the latest UK Climate Change Risk Assessment and the Climate Change Committee's guidance, aiming to foster resilience across society, economy, ecosystems and public services and is structured around five long term outcomes

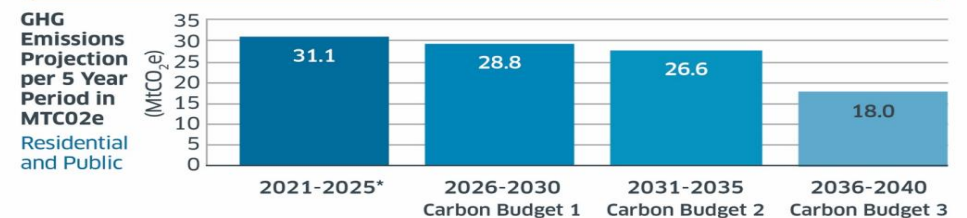
Among these outcomes, "Public services are collaborating in effective and inclusive adaptation action" is particularly relevant to the Integration Joint Boards as it oversees the delivery of health and social care services.

The Climate Change Plan identifies a number of key policies across a range of sectors to meet carbon budgets. The relevance of some of these key sectors to Integration Joint Boards is detailed in Exhibit 10.

SNAP3 requires public service bodies, including IJB's, to integrate climate resilience into their planning and operations ensuring healthcare delivery, social care and community wellbeing are safeguarded against extreme weather and climate-related disruptions.

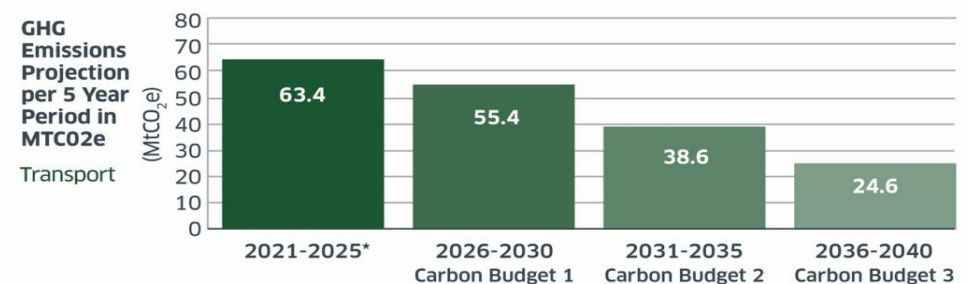
Exhibit 10: Extracts from [Scotland's Climate Change Plan: 2026-2040](#) (see Appendix 1, 4)

Buildings (Residential and Public)



Improved public health and wellbeing from moving to clean heating systems, including improved air quality. Warmer, less damp homes can lead to improved health outcomes and quality of life. Targeted energy efficiency improvements will lower energy demand and bills, helping to lift households out of fuel poverty.

Transport (including Aviation and Shipping)



In relation to climate change Integration Joint Boards 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

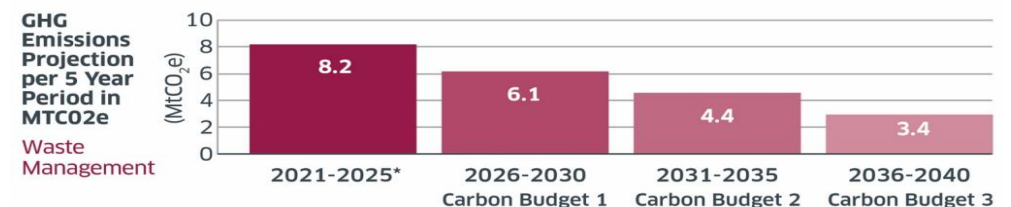
These duties are reinforced by guidance from the Scottish Government and Audit Scotland, which emphasise the need for IJBs to embed climate considerations into strategic planning and operational delivery.

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.

Over £6.6 billion worth of co-benefits between 2026-2040, including improved health outcomes through increased levels of exercise and reductions in noise pollution, as well as reduced road congestion and improved road safety.

Lower emissions contribute to better air quality, which can lead to improved public health outcomes, particularly in communities near industrial sites.

Waste Management



The shift to sustainable resource use will also see **less litter** on our streets and in our local environment, which will help to **improve and strengthen communities**, and could lead to **long-term public health benefits**.

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.

Given the scale of GP Prescribing in cost and volume we have a focus on reducing medicines waste as one strand of our efficiency programmes.

Medicines waste costs more than **£100,000 every day** which is enough to pay the daily wages of more than **700 nurses** – As part of Glasgow Climate Week in May 2026 NHSGGC held a public interactive event as part of a campaign to reduce medicines waste – for the good of people’s health, to support NHS services and to help the environment.

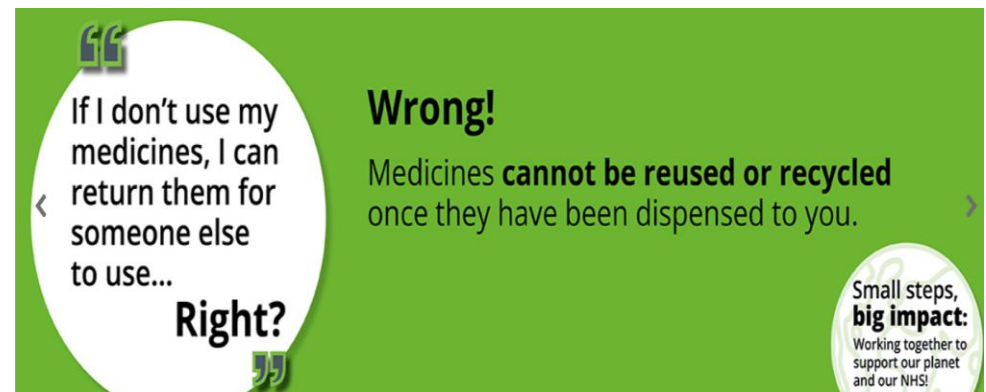
The HSCP is reviewing its property strategy in partnership with the Council and Health Board which will reflect the embedded flexible working policy that will rationalise the use of buildings and reduce staff travel, i.e. positive impact on reducing carbon emissions.

Did you know:

Medicines account for **25%** of the carbon footprint of NHSGGC.

While the volume of medicines burned daily in Scotland is equivalent to the **weight of a small car**.

The event aimed to dispel some common misconceptions around medicines.



Performance Reporting 2025/26

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

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

The 2025/26 APR was presented to the Audit and Performance Committee on 23 June 2026 to grant the Chief Officer delegated authority to publish in line with the legislative timescale of 31 July 2026 and subsequently presented to the HSCP Board for approval on 18 August 2026. The report can be viewed [here](#) (see Appendix 1, 6).

The performance report includes 49 indicators with ambitious targets and progress measured against:

- 19 local benchmarks;
- 14 national benchmarks; and
- 16 monitoring indicators 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.

Performance continued to be influenced by complex factors, with changing activity and demand remaining key drivers in 2025/26. 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 11 below with the detail contained within the June 2026 APR. Analysis on key performance indicators reported for monitoring purposes only have been excluded due to the subjective interpretation of RAG status.

Exhibit 11: Overall Strategic Plan Performance Analysis

Overall Strategic Plan Performance Analysis	19 Local Targets				14 National Targets			
	R	A	G	B	R	A	G	B

Key Performance Indicators

Caring Communities	0	1	1	0	1	0	3	1
Safe and Thriving Communities	2	4	2	0	2	1	0	0
Equal Communities	0	2	0	0	2	1	0	0
Healthy Communities	3	4	0	0	1	1	1	0

	Target missed by 15% or more
	Target narrowly missed
	Target achieved
	Data not yet available

Targets missed by 15% or more relate to:

- Psychological Therapies
- MSK waiting times
- Delayed discharges and unscheduled care
- Adult support and protection risk assessments
- Criminal Justice reporting and unpaid work timescales
- Hospital emergency admissions

New reserves to support West Dunbartonshire HSCP to improve waiting times and other performance targets in the delivery of its Musculoskeletal service and unscheduled care service will be utilised over the next two financial years.

The Annual Performance Report provides significant detail on improvement actions

Overall Strategic Plan Performance Analysis	60 Actions		
	R	A	G

Strategic Action Plan Progress

Caring Communities	0	8	17
Safe and Thriving Communities	0	6	11
Equal Communities	0	4	10
Healthy Communities	0	0	4

	Overdue
	Not yet due
	Due date achieved

Overall Strategic Plan Performance Analysis	27 Actions		
	R	A	G

Strategic Enablers

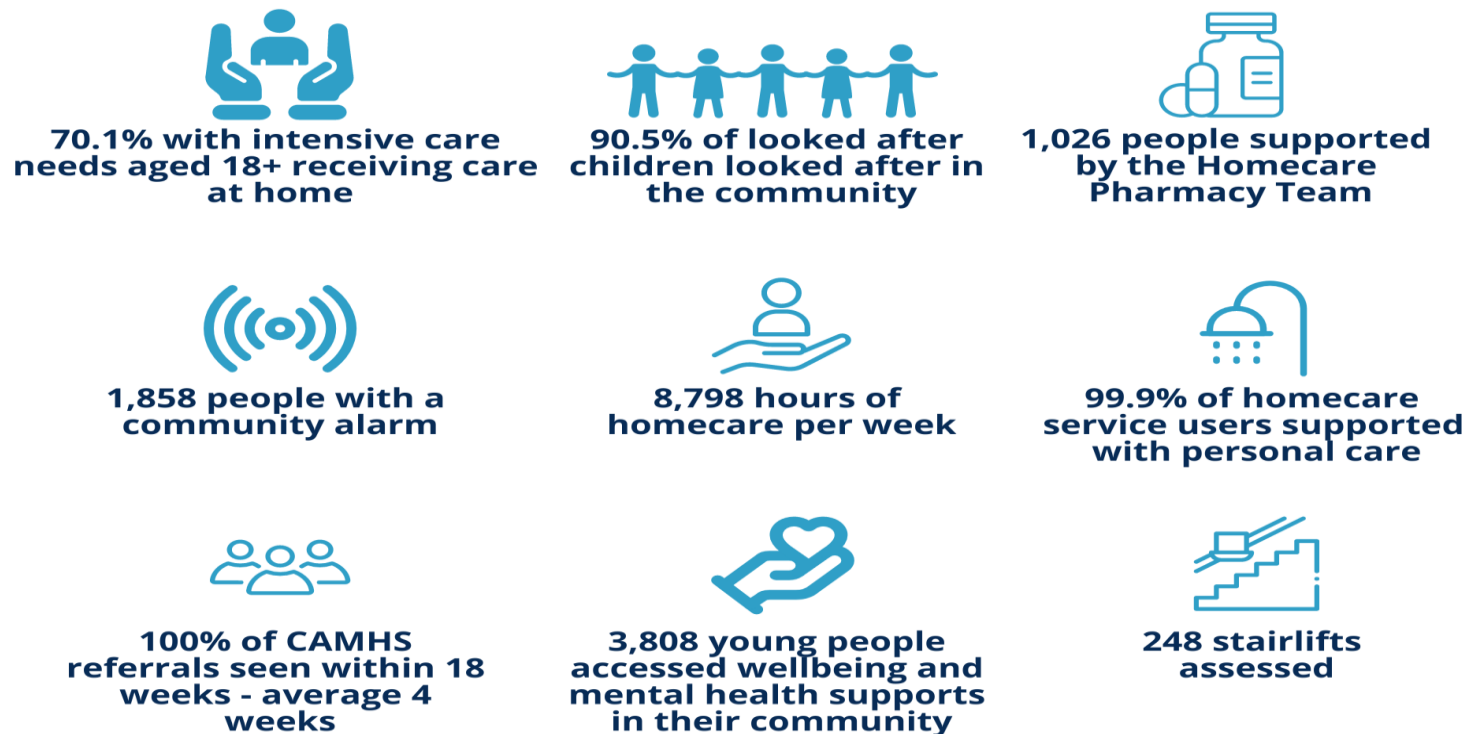
Workforce	0	5	3
Finance	0	1	2
Technology	0	5	1
Partnerships	0	2	4
Infrastructure	0	2	2

	Overdue
	Not yet due
	Due date achieved

Performance Highlights 2025/26

The following graphic presents a pictorial view of some high level performance highlights with more extensive detailed service narrative following thereafter.

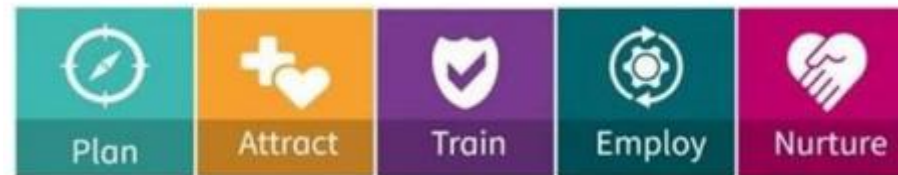
Exhibit 12: Pictorial View of Performance Highlights



Service Updates 2025/26

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. A one-year Workforce Plan for 2025/26 was presented to the HSCP Board on 25 November 2025, and serves as an interim measure and is designed to align with the development of the HSCP Boards next strategic plan. The intention is to return to a longer-term planning horizon from 2026 onwards, ensuring continuity and strategic alignment across service delivery and workforce priorities.



During 2025/26, West Dunbartonshire HSCP continued to place a strong emphasis on recognising staff contribution, supporting wellbeing and sustaining a positive organisational culture.

Our people are at the heart of everything we do. The Staff Excellence Awards remained an important mechanism for celebrating the commitment and impact of the workforce, with nominations increasing by 56% compared to the previous year, reflecting growing staff engagement and a strong culture of appreciation across the partnership. The introduction of the Chief Officer's Award further reinforced the HSCP's commitment to kindness and compassionate leadership by recognising individuals who consistently demonstrate positive and respectful behaviours in the workplace.

- Leader of the Year: Derek Dolan, Senior Charge Nurse, Glenarn Ward, Dumbarton Joint Hospital
- Employee of the Year: Mikey Quinn, MSK Physiotherapist
- Team of the Year: West Dunbartonshire HSCP Justice Services Team
- Innovation of the Year: Crosslet & Queens Quay Catering Teams
- Volunteer of the Year – Jamie MacLeod, Mentor Scotland
- Chief Officer's Award: Karen Glass, Practice Development Physiotherapist

Wider wellbeing and culture activity also continued throughout the year, supported by access to initiatives such as the NHSGGC Active Staff programme and participation in national and local campaigns including Civility Saves Lives and World Kindness Day. A growing network of Civility Champions has helped to promote positive behaviours across services, complemented by professional recognition days that celebrate kindness, professionalism and the contribution of staff. The HSCP also continued to support staff experience and professional development through structured engagement and targeted workforce initiatives.

The annual iMatter Staff Experience Survey remained a key mechanism for capturing staff feedback and supporting team-based improvement, with participation increasing slightly to 55%. Overall staff experience and employee engagement scores remained stable, suggesting a broadly sustained staff experience during a particularly challenging period, with more areas showing improvement than decline. Alongside this, support for Newly Qualified Social Workers continued to be strengthened through the SSSC Supported Year, which has been in place since October 2024. The programme provides a structured and supportive transition into professional practice through peer support, mentoring, shadowing and mandatory learning aligned to SSSC Continuous Professional Learning requirements and local workforce priorities.

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.

HSCP Digital Strategy

The HSCP Digital Strategy is an ambitious approach to developing digital services and structures, with the aim of delivery successful change for employees, service users and other stakeholders. As we move towards the final year of our HSCP Digital Strategy 2024 to 2027, the HSCP is able to reflect on areas where progress has been made, areas which still need some focus, and will soon start the process of developing a new Digital Strategy which will be linked to the development of a new HSCP Strategic Plan, ensuring Digital is considered as one of the main strategic priorities

- ❖ West Dunbartonshire Health and Social Care Partnership (WDHSCP) achieved a major milestone by completing the transition from analogue to digital Telecare alarms well ahead of the national deadline. More than 1,600 vulnerable residents now benefit from a safer, more resilient digital service powered by Chiptech “SEVEN” alarms and supported through the National Shared Alarm Receiving Centre provided by East Dunbartonshire Council. This success reflects exceptional teamwork, a strong and long-standing partnership with East Dunbartonshire Council, and invaluable guidance from the Scottish Digital Office. Delivered within budget and using WDHSCP’s own

Telecare team, the project showcases what can be achieved through collaboration, commitment, and a clear focus on protecting residents.

- ❖ The HSCP supports the implementation of new digital applications which will further support our teams. Along with West Dunbartonshire Council colleagues, work is underway on the implementation of OneDrive and SharePoint which will support greater collaboration utilising digital technologies and with specific apps having been rolled out to support change. The introduction of modern applications will drive organic improvements in digital capabilities as employees gain practical experience with modern tools.
- ❖ Care Opinion for the HSCP has also been launched, enabling service users and carers to provide feedback on their care experiences. Care Opinion is used well across health and social care and should enable an additional communications route for service users to comment, positively or negatively, on HSCP services. Submissions are reviewed by relevant managers, with responses provided and learning adopted to support improvement.

Our Services

Care Homes

The Crosslet & Queens Quay Catering Teams have transformed mealtimes through creativity, passion and a real drive to make life better for the Care Home residents. Their innovative approach to nutritious, enjoyable food has earned them national recognition, including becoming the first Care Homes in Scotland to achieve the Food for Life Bronze Award. Always thinking differently, they have introduced new ways to support health and wellbeing — from tailored menus to projects that reduce reliance on costly supplements, whilst improving residents' outcomes.

Their themed events, celebrations and genuine care bring joy, comfort and connection to daily life. Through their imagination and commitment, the teams have made a lasting difference to quality of care, resident wellbeing and the way resources are used across both homes.

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. Phase 3 of the re-design has now been implemented, with approximately 92% of the workforce transitioned to a new standard rota, 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 continues to work through an agreed improvement plan, with ongoing support from the Care Inspectorate to drive further enhancements. To

strengthen oversight, reporting tools continue to be used to track 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 continue to be a key area for improvement despite updated operational guidance being rolled out to ensure staff are well supported on return to work and that attendance management processes are consistently applied.

Unscheduled Care

West Dunbartonshire HSCP continues to face **sustained and complex pressures** in relation to delayed discharge, with performance remaining out with national and regional indicators despite ongoing improvement activity. Delays are driven by a combination of rising acuity and complexity of need, workforce capacity constraints, legal processes associated with Adults with Incapacity and Guardianship, and limitations in Care at Home and care home market capacity, many of which are outside the direct control of the HSCP. Prolonged hospital stays adversely affect individual outcomes, particularly for older people, increasing the risk of deconditioning and often resulting in higher levels and cost of care being required on discharge, while also leading to significant acute bed days lost and reduced hospital flow. These challenges have material financial implications, placing pressure on Care at Home budgets and external commissioning due to increasing complexity and reliance on higher-cost care.

In response, the HSCP has progressed a programme of whole-system improvement actions, including earlier and more proactive discharge planning, strengthened joint working through the Community Hospital Discharge Team, enhanced performance intelligence and oversight via system dashboards, stabilisation and recruitment within key workforces, expansion of intermediate care capacity, targeted action to reduce avoidable legal delays, and strengthened partnership working with acute and community partners.

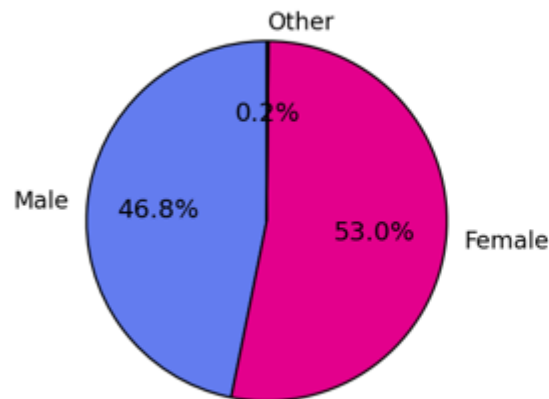
While these actions have improved planning, coordination and governance, the scale and persistence of delayed discharge underline the need for continued, coordinated system-wide action to achieve sustained improvement.

Children's Services

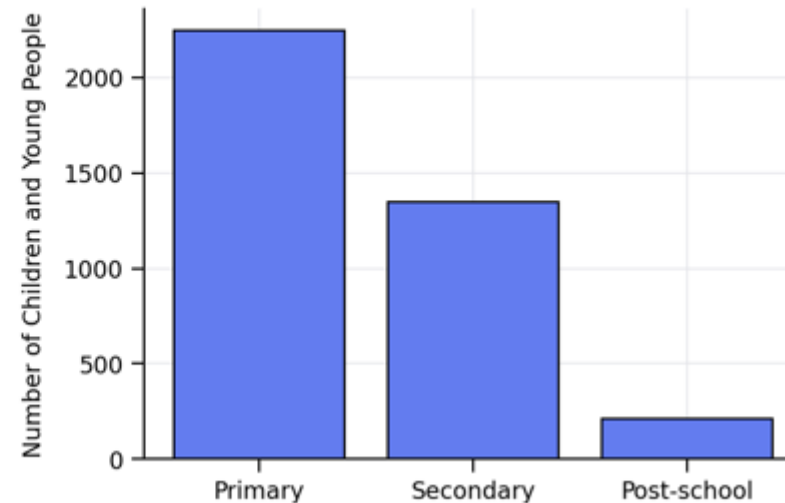
- ❖ **Community Mental Health and Wellbeing Activity.** The Children and Young Peoples Community Mental Health and Wellbeing activity has supported 3808 young people in 2025/26 to access wellbeing and mental health supports in their community. The services have also provided support via resources and training to 54 parents and carers with an overview of community mental health supports provided in Exhibit 13 below.

Exhibit 13: Overview of Community Mental Health Supports provided in 2025/26

Children and Young People by Gender



Children and Young People by Age Group



- ❖ **Distress Brief Intervention Service.** The young person distress service continues to expand its patient pathways, with more third sector organisations becoming referrers for 14- and 15-year-olds. The service was extended to include all adults in January 2026, which also saw an increase in referrals for young adults (up to 25 years). Support has been offered by our service provider, Scottish Action for Mental Health (SAMH) to frontline staff groups particularly in Primary Care.

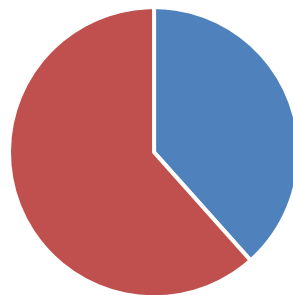
By the end of the year, Primary Care referral numbers exceeded those accessing via the education pathway. Access via the Primary Care pathway has been strengthened by an electronic referral via SCI Gateway. A total of 486 onward referrals or signposting took place, showing that many young people needed help with more than one issue.

The outcome measures of closed cases for 2025/26 indicate an improvement of 5 rating points for median distress rating between level 1 (at referral) and level 2 (at service provider).

Service demographics provided by SAMH for West Dunbartonshire are provided in Exhibit 14 below.

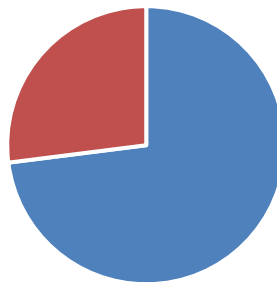
Exhibit 14: Distress Brief Service Demographics

Service Demographics



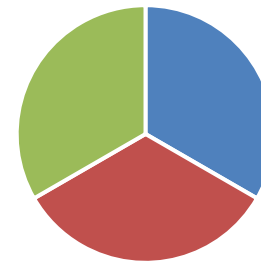
■ Age 14-15 ■ Age 16-24

Gender Split



■ Female ■ Male

Top 3 Reasons



■ Stress/Anxiety ■ Self-Harm ■ Suicidal Thoughts

Note: The upper age limit was extended to 26 for young people with experience of care

- ❖ **Suicide Prevention.** During 2025/26, a comprehensive programme of mental health and suicide prevention training was delivered across West Dunbartonshire in partnership with statutory and third sector organisations. A total of 196 training places were booked, with 130 participants attending, reflecting good overall engagement despite some non-attendance. Participation spanned a wide range of professional groups, including health and social care, education, policing, housing, third sector and community-based services. The programme combined awareness-raising and skills-based provision, with What's the Harm? the most frequently accessed course, followed by Scottish Mental Health First Aid and ASIST, which support the identification of mental distress and suicide risk. Shorter courses, including Ask, Tell, Save a Life and Introduction to Self-Harm, complemented this offer by supporting early intervention and extending reach across frontline and non-clinical staff groups.
- ❖ **Early Intervention.** Y Sort It (the Planet Youth Community Delivery partner) continues to implement the learning from the Planet Youth Approach in West Dunbartonshire that recognises the need for early intervention for a young person's wellbeing. A key time in a young person's life is the transition from Primary to High school.

Y Sort it increased capacity to support young people during their transition to secondary school by creating play, learning and wellbeing activities for those aged 8-12 years. These activities were delivered throughout 2025/2026 including supporting our current youth club and holiday provision.

- ❖ **Planet Youth Prevention Approach.** The Planet Youth approach in West Dunbartonshire continues to provide a strong evidence base for upstream prevention work addressing the wellbeing of young people. Based on the Icelandic Prevention Model, Planet Youth focus on strengthening protective factors within families, schools and communities while using regular, high-quality local data to inform action. West Dunbartonshire has been involved in Planet Youth since 2019 as one of six Scottish pilot areas.

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 2025/26, the prescribing budget absorbed a £3.602m (16.6%) increase over the previous year, reflecting rising costs and demand. To mitigate this, a challenging efficiency programme of £1.130m was implemented across multiple initiatives.

In 2025/26 the HSCP achieved 119% of its prescribing efficiency targets with overall savings of £1.350m, compared to 101% and £14m for NHS GGC. Notable achievements include:

- ❖ Polypharmacy reviews: 97% of target achieved (highest HSCP) with > 2,300 review delivered and 100% increase on 2024/25; and
- ❖ Care Home savings: 209% of target achieved
- ❖ PIIGlets: 664% of target achieved¹
- ❖ Various switches: overall 134% of target achieved

¹ PIIGlets are Prescribing Initiative Implementation Guides which support the prescribing team in actioning centrally co-ordinated switches and changes to prescriptions that focus on selecting the most cost-effective options available e.g. brand-generic switch, switch to formulary choice preparation, switch to cost-effective formulation, dose optimisation, deprescribing of non-evidenced based medicines.

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

Learning Disability

- ❖ **Individuals with a Learning Disability are recognised as being less physically active than the general population.** Updated WHO guidance (2022) recommends 30 minutes of physical activity per day for people with a Learning Disability; however, existing programmes such as Live Active were not designed to meet their needs and did not offer the reasonable adjustments required for full participation. To address this gap, Healthcare Support Workers (HCSWs), supported by Physiotherapy, developed and implemented a weekly exercise class specifically designed for people with a Learning Disability, the aim of which was to provide an inclusive, accessible, and person-centred weekly exercise class tailored specifically for individuals with a Learning Disability, promoting improved physical health, mobility, and sustained engagement in physical activity.

The introduction of the adapted exercise class has achieved several positive outcomes: The class provides a supportive, inclusive environment designed around individual mobility and health needs; individuals who previously faced barriers to attending mainstream programmes can now engage in regular physical activity; and the class promotes healthier lifestyles, improved fitness, and greater confidence, encouraging long-term participation.

- ❖ **Community connections aim to deliver person-centred care,** they treat everyone with respect and compassion, acknowledging unique life experiences. Involving people in care decisions fosters independence and wellbeing, while strengthening therapeutic relationships and enhancing quality of care. Providing person-centred care leads to positive emotional, physical, and social outcomes, aligns with best practices, and reflects our commitment to compassionate, holistic support.

This approach has benefited service users and their families, a success reflected in a recent inspection where the Care Inspectorate awarded Community Connections a grade 6 for supporting wellbeing. Grade 6 is generally awarded in circumstances where services are sector leading.

NHSGGC Musculoskeletal (MSK) Physiotherapy

Musculoskeletal (MSK) conditions continue to have a major impact on people's lives. It is one of the leading causes of absence from work and more years are lived with an MSK disability than any other condition.

The MSK Physiotherapy Service continues to provide a person-centred approach, where each person is individually assessed and their bespoke care is focused on symptom management, movement, exercise and supported self- management.

NHS Greater Glasgow and Clyde's MSK Physiotherapy Service is hosted within West Dunbartonshire HSCP who manage activity across the health board area. There have been five projects within the MSK service this year as illustrated within Exhibit 15.

Exhibit 15: Priority Objectives 2025/26

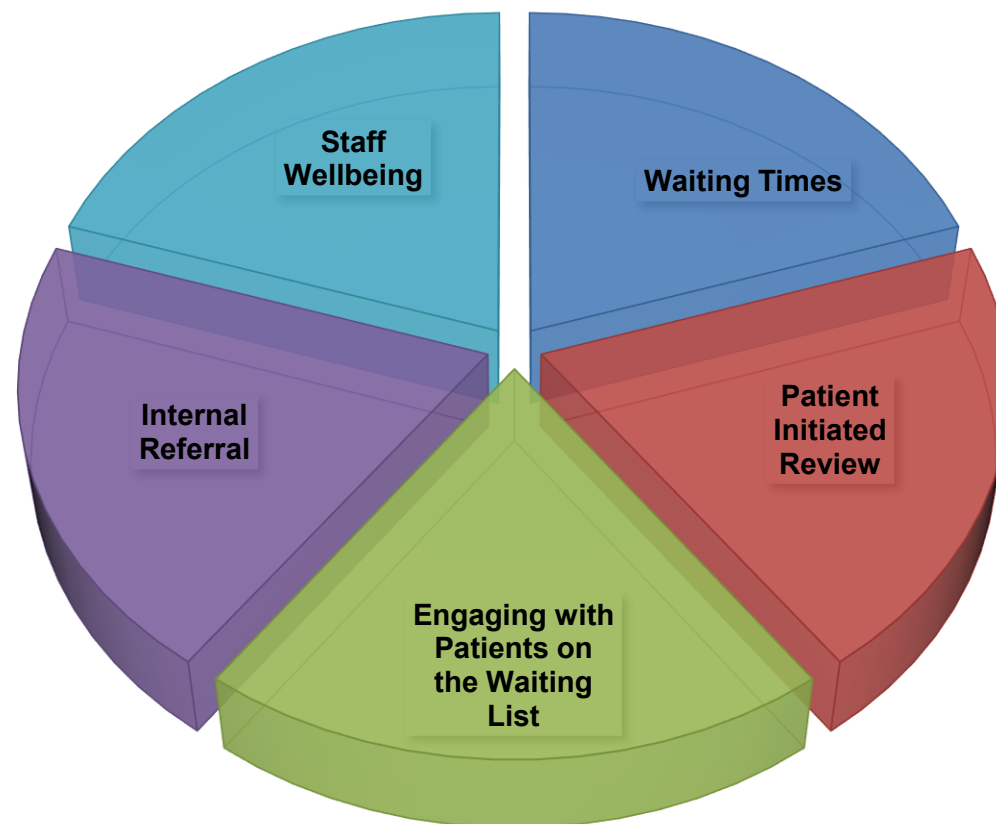
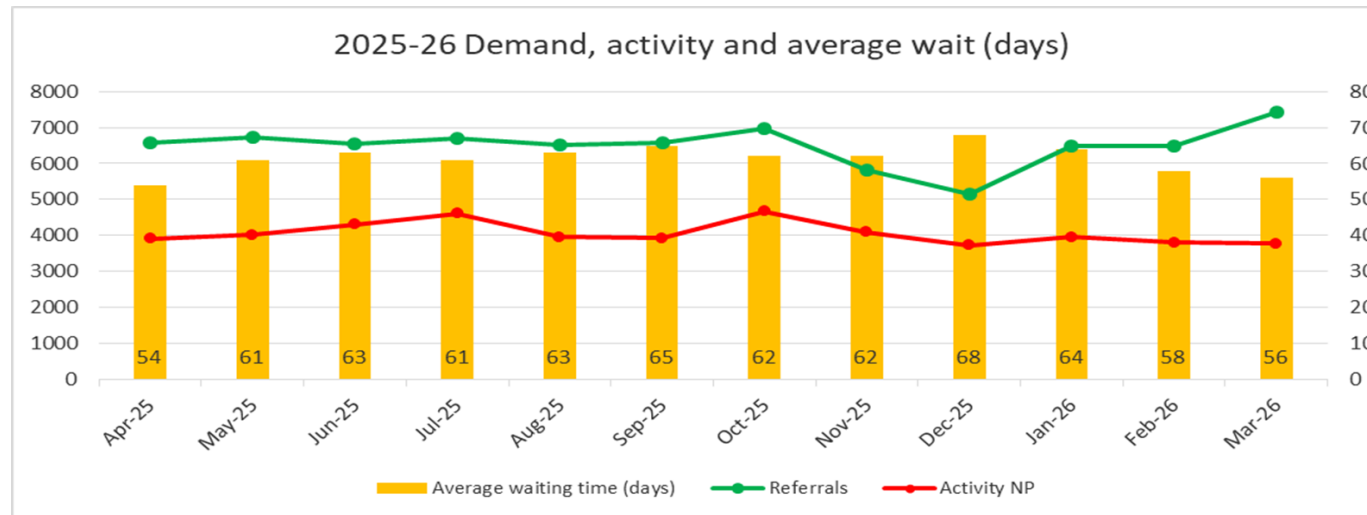


Exhibit 16: Demand, Activity and Waiting Time



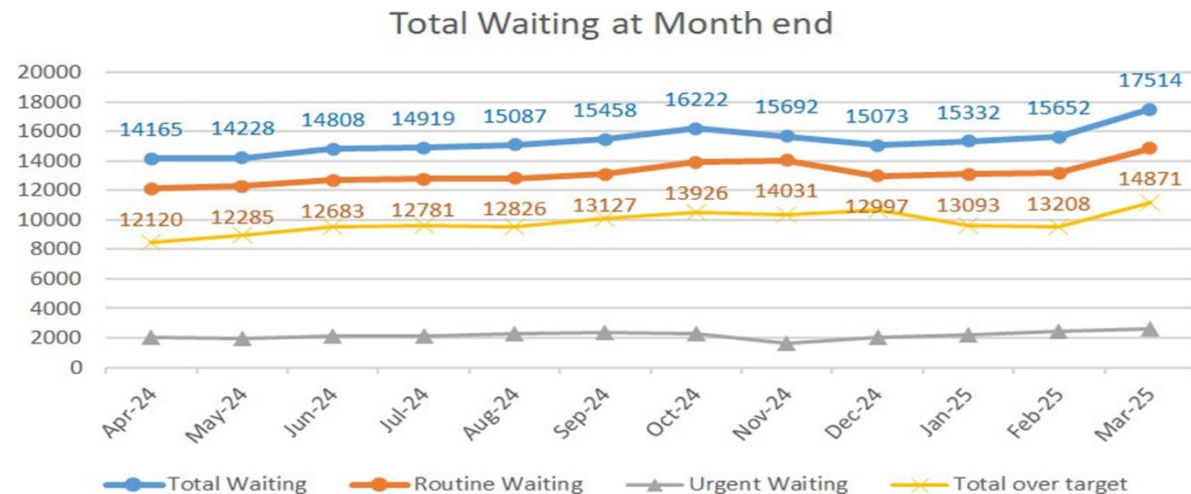
Demand for the MSK Physiotherapy Service has remained static in 2025/26 compared to the two previous years (with demand rising 6.8% on top of a 13.3% rise the previous year).

The service received a total of 78,498 referrals, averaging between 6,000 and 7,000 per month with referrals peaking at over 7,000 in October 2025 and March 2026 as illustrated in Exhibit 16.

While recruitment for MSK vacancies has improved, with more applicants than in previous years. Staff turnover remains high due to the service size, as many employees move to promoted roles. This leads to ongoing challenges with service capacity and activity when posts are vacant, both during the vacancy and when others absorb the caseload. In addition, sickness absence averaged 7.3%, consistently above the 4% target.

As a result, the number of patients waiting for appointments across NHS Greater Glasgow and Clyde increased throughout the year, as shown in Exhibit 17.

Exhibit 17: Total Waiting at Month End



Primary Care

- ❖ **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 2025/26 initiatives including:
 - Clydebank Cluster carried out a Quality Improvement Project looking at uptake and referrals into the local **smoking cessation service Quit Your Way**. This was based on evidence which shows a reduction in rates of lung cancer with smoking cessations v's smoking reduction. While annual figures for 2025/26 are not yet available, the number of referrals by the end of Quarter 3 were comparable to the full year 2024/25.
 - The **Topiramate Pregnancy Prevention Programme** began in 2024. Topiramate is used for epilepsy and migraine prevention. The mandatory programme targets women of childbearing age taking topiramate to reduce risks of birth defects and developmental issues from exposure during pregnancy, requiring annual risk assessments, contraceptive education, and ongoing monitoring. West Dunbartonshire HSCP practices completed patient reviews, provided counselling, and set up annual recalls.
 - All practices across the HSCP have participated in the **Cardiovascular Direct Enhanced Service (DES)** which looks to manage and treat any risk factors for development of cardiovascular disease in a subgroup of patients aged 35-60. To support this work around cardiovascular disease prevention the HSCP organised Community days held in the Vale Centre for Health and Care and Clydebank Health Centre to share the local services which can support patients in health and wellbeing including Live Active, Quit Your Way, Alcohol services, Health Improvement, Dieticians, CVS walking groups. The Cardiovascular DES will continue to run in 2026/27 and the HSCP will look to support uptake of health and wellbeing services with the aim of improving cardiovascular health in the population.

Financial Performance 2025/26

The Statement of Accounts contains the financial statements of the HSCP Board for the year ended 31 March 2026 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 2025/26

1 April 2025 to 31 March 2026	West Dunbartonshire Council	Greater Glasgow & Clyde Heath Board	Total
	£000	£000	£000
Funds Received from Partners	(94,182)	(181,807)	(275,989)
Funds Spent with Partners	96,277	174,804	271,081
Deficit/(Surplus) in Year 2025/26	2,095	(7,003)	(4,908)

Note: Totals may not add due to rounding

The Comprehensive Income and Expenditure Statement (CIES) on page 80 details the cost of providing services for the year to 31 March 2026 for all health and care services delegated or hosted by the HSCP Board.

The total cost of delivering services amounted to £271.081m against funding contributions of £275.989m, both amounts including notional spend and funding agreed for Set Aside of £49.337m, (see Note 7 "Taxation and Non-Specific Grant Income" page 92). This therefore leaves the HSCP Board with an overall surplus on the provision of services of £4.908m prior to planned transfers to and from reserves, the composition of which is detailed within Note 12 "Usable Reserve: General Fund" pages 97 to 98.

The HSCP Board's 2025/26 Financial Year

The HSCP Board approved the 2025/26 revenue budget on 24 March 2025. 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 £3.898m for support related to increases to Employers National Insurance Contributions, Scottish Living Wage for adults and children, Free Personal Care uplifts, Children and Young Person's Community Mental Health funding and Scottish Disability funding.

The Board approved a total indicative net revenue budget of £210.334m (excluding Set Aside estimated budget of £46.348m).

This was supplemented with an allocation from earmarked reserves of £3.049m to close the gap between funding and estimated cost of services, resulting in a total opening budget of £213.383m.

Throughout 2025/26 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 2025/26

2025/26 Budget Reconciliation	Health Care £000	Social Care £000	Total £000
Budget Approved on 24 March 2025	117,937	95,446	213,383
Rollover Budget Adjustments	2,011	0	2,011
Primary Care	(5)	0	(5)
Adult and Older People Services	1,410	112	1,522
Children's Services	5	(24)	(19)
Prescribing	(265)	0	(265)
Family Health Services	1,261	0	1,261
Other	11,388	346	11,734
Reported Budget 2025/26	133,742	95,880	229,622
Funded from Earmarked Reserves	(1,272)	(1,777)	(3,049)
Funded from Partner Organisations	132,470	94,103	226,573

Note: Totals may not add due to rounding

Final Outturn Position 2025/26

The latest Financial Performance Report, which can be found [here](#) (see Appendix 1, 7), was issued to the HSCP Board on 26 May 2026 and projected a gross underspend of £4.729m (0.02%) for the financial year ended 31 March 2026 prior to planned transfers to/from earmarked reserves (including the drawdown of reserves approved to balance the budget) to leave a net underspend of £0.092m to be added to un-earmarked reserves.

The 2025/26 Financial Performance Reports included appendices detailing budget transfers, key variances, savings progress, and earmarked reserves. Approved savings and service redesign efficiencies totalled £5.484m, with 98% (£5.394m) achieved or on track to be delivered as planned and the remainder at risk but covered by service underspends.

These financial statements finalise the outturn position for 2025/26 as at 31 March 2026.

Prior to planned transfers to/from earmarked reserves and after accounting for all known adjustments, the position is a gross underspend of £4.908m and a net underspend of £0.400m which are movements of £0.179m and £0.308m 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 2026 Projected Outturn

Reconciliation of Movements in Reported Position between Final Outturn and May 2026 HSCP Board Report	Final / Forecast Full Year £000	(Drawdown) / Transfer to Earmarked Reserves £000	(Drawdown) / Transfer to Unearmarked Reserves £000
Final Favourable Variance Reported - Impact on Reserves	4,908	4,508	400
May 2026 Favourable Variance Reported - Impact on Reserves	4,729	4,637	92
Movement since May 2026 Draft Outturn Report	179	(129)	308
Represented By:			
Additional Altzeimers Accrual	(29)	0	(29)
Earmarking temp admin post for ASP	0	40	(40)
Revision of decision to accrue costs for OOA Client Transfer	209	0	209
Drawdown of TEC reserves	0	(30)	30
Underspend re Contingency Budget	0	(135)	135
Drawdown of Health Improvement spend from planning reserve	0	(3)	3
Roundings	(1)	(1)	0
Movement since May 2026 Draft Outturn Report	179	(129)	308
Proposed Reallocation of Earmarked Reserves	0	(797)	797
Movement since May 2026 Draft Outturn Report to Final Reserves	179	(926)	1,105

Note: Totals may not add due to rounding

Table 4: Final Outturn against Budget 2025/26 by Service Area

West Dunbartonshire Integration Joint Board	2025/26 Annual Budget	2025/26 Net Underspend/ Expenditure (Overspend)	2025/26 Reserves Underspend/ Adjustment (Overspend)	2025/26 Underspend/ (Overspend)
Consolidated Health & Social Care	£000	£000	£000	£000
Older People, Health and Community Care	59,776	59,787	(11)	(286)
Physical Disability	3,789	3,832	(43)	41
Children and Families	33,073	34,261	(1,188)	(148)
Mental Health Services	14,708	15,104	(396)	(564)
Addictions	4,207	4,133	74	(60)
Learning Disabilities	22,225	21,882	343	(180)
Strategy, Planning and Health Improvement	2,223	1,955	268	127
Family Health Services (FHS)	40,098	40,241	(143)	0
GP Prescribing	22,857	21,388	1,469	744
Hosted Services - MSK Physio	8,847	8,806	41	0
Hosted Services - Retinal Screening	937	911	26	0
Justice	154	(11)	165	80
HSCP Corporate and Other Services	13,296	8,993	4,303	4,754
IJB Operational Costs	383	383	0	0
Cost of Services Directly Managed by West Dunbartonshire HSCP	226,573	221,665	4,908	4,508
Set aside for delegated services provided in large hospitals	49,337	49,337	0	0
Assisted garden maintenance and Aids and Adaptions	79	79	0	0
Total Cost of Services to West Dunbartonshire HSCP	275,989	271,081	4,908	4,508

Note: Totals may not add due to rounding

Table 5: Final Outturn against Budget 2025/26 by Subjective Analysis

West Dunbartonshire Integration Joint Board	2025/26 Annual Budget	2025/26 Net Expenditure	2025/26 Underspend/ (Overspend)	2025/26 Reserves Adjustment	2025/26 Underspend/ (Overspend)
Consolidated Health & Social Care	£000	£000	£000	£000	£000
Employee	97,869	96,088	1,781	1,121	660
Property	1,243	1,254	(11)	0	(11)
Transport and Plant	1,384	1,334	50	0	50
Supplies, Services and Admin	9,808	4,188	5,620	5,077	543
Payment to Other Bodies	70,603	74,713	(4,110)	(1,259)	(2,851)
Family Health Services	41,627	41,818	(191)	0	(191)
GP Prescribing	22,858	21,388	1,470	744	726
Other	2,934	2,450	484	0	484
Gross Expenditure	248,326	243,233	5,093	5,683	(590)
Income	(21,753)	(21,568)	(185)	(1,175)	990
Net Expenditure	226,573	221,665	4,908	4,508	400

Note: Totals may not add due to rounding

The Comprehensive Income and Expenditure Statement (CIES) on page 80 is required to show the surplus or deficit on services and the impact on both general and earmarked reserves. The final position for 2025/26 was an overall surplus of £4.908m with £4.508m and £0.400m added to earmarked and un-earmarked reserves respectively. Earmarked reserves are detailed in Note 12 of these accounts on pages 97 to 98 coupled with some additional information detailed below in the “key messages”.

While the CIES provides actual expenditure and income values for services in 2025/26 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 £0.648m mainly due to a reduction in residential placements due to deaths and discharges and an increase in property income due a revision in the calculation methodology partially offset by the cost of agency spend arising from recruitment challenges;
 - Older People Non-Residential Care realised a net overspend of £0.668m due to an overspend in the cost of non-residential external care packages previously budgeted and charged to Care at Home;
 - The Care at Home Service realised an overspend of £0.439m 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;
 - Adult Community Services and Community Health Operations realised a net underspend of £0.594m due to staffing vacancies; and
 - Sheltered Housing and Other Older People services realised a net underspend of £0.140m due to staff turnover.
- **Physical Disabilities** – net overspend of £0.084m mainly due to a significant fee uplift for one provider.
- **Children and Families** – net overspend of £1.040m mainly due to an increase in the number of young people being supported within children with disabilities and external accommodation on a care only basis.
- **Mental Health** – net underspend of £0.168m mainly due to high levels of staff turnover and unplanned recruitment delays partially offset by increased and extended contract cover for medical vacancies.
- **Addictions** – net underspend of £0.134m mainly due to budgeted rehabilitation not required.
- **Learning Disabilities** – net underspend of £0.523m mainly due to staffing vacancies and client service reviews.
- **Strategy Planning and Health Improvement** – net underspend of £0.141m mainly due to staff vacancies.
- **GP Prescribing** – Net underspend of £0.725m primarily driven by reductions in the cost of Dapagliflozin and lower prescribing volumes.
- **Family Health Services (FHS)** – Net overspend of £0.143m within General Medical Services primarily driven by the cost of Superannuation contributions, Locum cover, and premises cost.
- **HSCP Corporate and Other Services** – net overspend of £0.299m mainly due to staffing restructure costs and unallocated administrative and turnover 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 2025/26 was calculated as £49.337m. 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, 8)

The HSCP Board's Risk Management Strategy and Policy is supplemented with a Risk Appetite Statement. The most recent risk appetite statement was approved in August 2025, at which time the then Head of Strategy and Transformation reviewed the risk management policy and concluded that no material changes were required. The current risk strategy and policy documents can be viewed [here](#) on pages 33 to 57 (see Appendix 1, 9).

The risk appetite statement is based on the matrix within the guidance document [Risk Appetite Matrix for Health and Social Care Partnership | Good Governance \(good-governance.org.uk\)](#) and the latest review can be viewed [here](#) on pages 353 to 369 (See Appendix 1, 10) 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 18.

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.

There are twenty-two key strategic risks as summarised in Table 6 below.

Exhibit 18 – Risk Matrix

		Likelihood				
Impact	5	10	15	20	25	
	4	8	12	16	20	
	3	6	9	12	15	
	2	4	6	8	10	
	1	2	3	4	5	

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		8	8
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 unplanned absence from existing workforce and wider HSCP services		12	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 through Clinical 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		12	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
A significant incident renders Dumbarton Health Centre partially or fully unusable.		16	4

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 23 June 2026 HSCP Audit and Performance Committee for comment which can be viewed [here](#) (see Appendix 1, 11). Following consideration of the updated Strategic Risk Register by the Audit and Performance Committee, it was agreed that Senior Management would undertake a review to refresh and re-baseline the Partnership's approach to strategic risk management. The review will assess the balance between strategic and operational

risks, consider risks recorded within Heads of Service operational risk registers for potential escalation to the Strategic Risk Register, identify and reduce duplication and overlap, and review the structure, format and numbering of risks to improve clarity and governance oversight. The review will be informed by input from Internal Audit and the NHS Greater Glasgow and Clyde Risk Lead to ensure alignment with good practice and provide independent challenge. A revised Strategic Risk Register will be presented to the Audit and Performance Committee on 22 September 2026.

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, 12) 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 £4.615m, and for 2025/26 the final position is £4.773m (see Note 12: Usable Reserve: General Fund) which equates to a reserves level of 2.07%.

Our overall movement in reserves is covered above in the "2025/26 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 2025/26 in relation to local and national priorities will not complete until future years (£8.599m) 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, investment in MSK, development and implementation of a Property Strategy, Carers funding, costs to implement the final phase of the agenda for change pay reform and underwriting the Cost of Complex Care Packages.

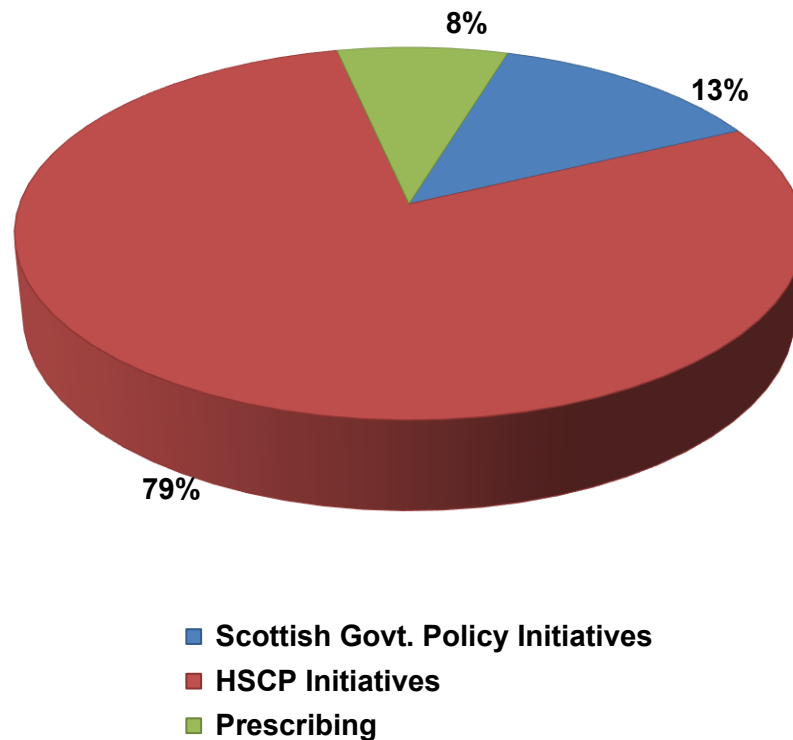
We started the year with £14.831m earmarked reserves and during the year a total of £3.760m was drawn down as detailed below:

- £1.216m (Social Care only) approved in March 2025 to balance the 2025/26 budget;
- £1.747m 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
- £0.797m 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 £7.471m to earmarked reserves throughout the year with £3.350m being an increase to existing reserves (mainly for alcohol and drugs partnerships, planning and health improvement projects, underwriting of prescribing pressures and Local Authority employers’ superannuation future commitments) and £4.121m for the creation of new reserves (mainly due a transfer of significant non-recurring health funding to support West Dunbartonshire HSCP in the delivery of its Musculoskeletal service, support unscheduled care pressures and advance funding provided in relation to the anticipated costs of implementing the final phase of the reduced working week and ongoing agenda for change reform).

The final balance on earmarked reserves is £18.542m and a profile of the 2025/26 earmarked closing balance is detailed in Figure 1.

Figure 1: Profile of Earmarked Reserves

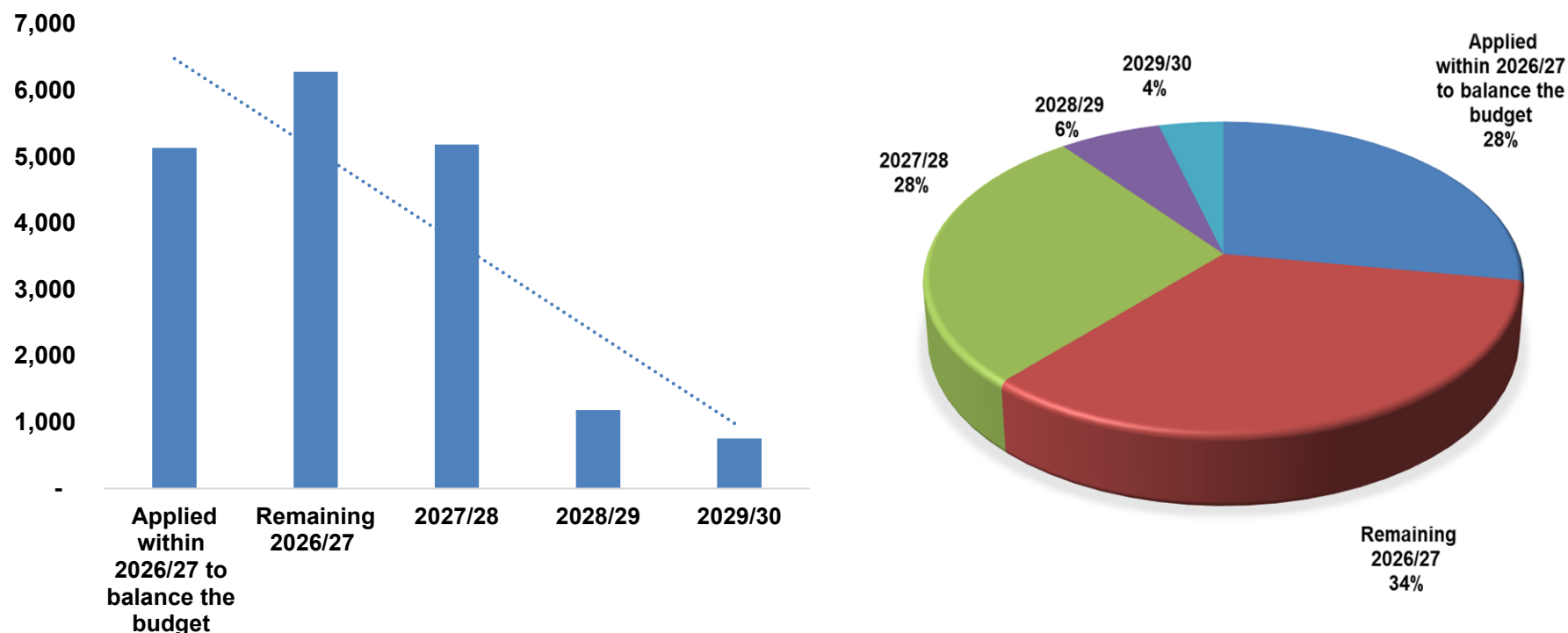


The analysis shows that:

- 13% 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;
- 79% relate to HSCP initiatives to support service redesign and transformation, service improvements (such as property investment, investment in the Musculoskeletal service and support for unscheduled care pressures) and future employer liabilities; and
- 8% 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 62% of all earmarked reserves are anticipated to be drawn down in 2026/27 with 28% 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 £4.773m which equates to approximately 2.07% of net expenditure (excluding Family Health Services). This is slightly above the 2% target detailed within the HSCP Board's Reserves Policy and is a result of ongoing work to replenish un-earmarked reserves which has been an ongoing priority during 2025/26.

Medium Term Financial Outlook

The HSCP Board approved the indicative 2026/27 Revenue Budget on the 24 March 2026. 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, 13).

For 2026/27 the Council maintained at least a flat cash position from 2025/26, 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 2% uplift, with a commitment to pass on any further funding linked to the anticipated costs of implementing the final phase of the reduced working week (move from 37 hour to 36 hours per week) and ongoing Agenda for Change reform. This was transferred from the Health Board as part of a late non-recurring package of financial support as detailed within the “Reserves” section above.

The [Scotland's fiscal outlook: medium-term financial strategy](#) (MTFS) 2025 (Appendix 1, 14) committed to multi-year funding settlements, particularly through the introduction of the 2026/27 to 2028/29 multi-year [Scottish Spending Review 2026](#) (Appendix 1, 15) published alongside the Budget in January 2026. 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, however despite this commitment multi-year funding settlements are not guaranteed, and funding projections continue to be subject to updates, assumptions, and approval processes.

The Accounts Commission's Integration Joint Boards Finance Bulletins and wider Finance and Performance reports highlight a continued deterioration in financial sustainability across Scotland, with rising demand, significant savings requirements and reducing reserves. This remains relevant to West Dunbartonshire, although the HSCP currently retains a comparatively stronger reserve position than that seen nationally. The [Integration Joint Boards: Finance and performance 2024 | Audit Scotland](#) report (Appendix 1,16) was presented to the West Dunbartonshire HSCP Board in September 2024 and discussed at HSCP Board members sessions on budget setting and performance reporting measures.

As highlighted under “Reserves” un-earmarked reserves increased by £1.197m during the year to 2.07% of net expenditure, slightly above the HSCP's 2% policy target, providing limited short-term resilience. Earmarked reserves also increased by £3.711m, with 62% planned for use in 2026/27 to support specific cost pressures and maintain financial balance. The increase in reserves largely reflects non-recurring health funding and is aligned to specific, time-limited priorities, including MSK investment, unscheduled care, and the implementation of reduced working week and Agenda for Change reform. This funding was both welcome and important, supporting delivery of key services, however it does not support recurring cost pressures.

The HSCP Board supported by the Medium-Term Financial Outlook has utilised reserves support in a planned and managed way to both mitigate residual budget gaps and address in-year budget gaps. However, in line with the Accounts Commission's [Local government budgets 2026/27 | Audit Scotland](#) report (Appendix 1, 17), it highlights that funding is not keeping pace with demand and identifies a significant national budget gap. There remains a material risk that underlying financial pressures in health and social care will continue. This will require ongoing service redesign and sustained partnership working with West Dunbartonshire Council and NHS Greater Glasgow and Clyde to ensure longer-term financial sustainability.

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, 18). The MTFO sets out the broad key themes on how we will work towards minimising future pressures and support financial 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.

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 was retitled the Care Reform (Scotland) Bill.

The **Care Reform (Scotland) Act 2025**, which was passed by the Scottish Parliament on 10 June 2025 and received Royal Assent on 22 July 2025, is now fully enacted introducing significant reforms to social care.

The Act focusses on the rights and support of care recipients, unpaid carers and social care workers.

The overall objectives of the Act detailed below with the key provisions listed in Exhibit 19:

- Strengthen the rights to people in care homes;
- Support unpaid carers and social care workers;
- Improve the **consistency and quality** of care across Scotland; and
- Promote **fair work, ethical commissioning, and sectoral bargaining** to enhance workforce conditions

Exhibit 19: Key Provisions of the Care Reform (Scotland) Act 2025

Key Provisions

- Digital Care Records
- Support for Unpaid Carers
- Care Homes
- Integration and Commissioning
- Regulation of Social Services
- Protection of Adults at Risk
- Advocacy, Information and Advice
- Monitoring and Oversight
- National Social Work Agency
- Delivery of Care

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.

While the overall context of the November 2024 MTFO remains unchanged the indicative budget gaps are revised annually to reflect most recent approved funding offers from each funding partner and updated future years funding and cost projections.

Projections include the future year impact of 2026/27 partner funding offers, demographic growth and pay / non-pay inflationary assumptions as well as roll forward of approved savings, management adjustments (e.g. turnover targets, service reviews).

Updated budget gaps for the period 2026/27 to 2028/29 are detailed in Table 7 and illustrate the scale of the risk.

Through 2026/27 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 including any financial implications arising from the enactment of The Care Reform (Scotland) Act 2025.

Table 7: Indicative Budget Gaps

Budget Gap Analysis	2026/27 £000	2027/28 £000	2028/29 £000
Social Care	108,161	112,619	119,003
Health Care	122,100	125,009	128,042
Set Aside	48,139	48,139	48,139
Total Indicative Spend	278,400	285,767	295,184
West Dunbartonshire Council	98,404	101,807	105,209
NHSGCC	121,730	123,025	125,230
Set Aside	48,139	48,139	48,139
Total Resources	268,273	272,970	278,578
Indicative Budget Gap	10,127	12,796	16,607
Management Adjustments	4,049	3,288	3,288
Savings Options	941	941	941
Application of Reserves	5,136	0	0
Measures to Balance the Budget	10,127	4,229	4,229
Indicative Budget Gap	0	8,567	12,377

Note: Totals may not add due to rounding

One material risk that has increased for since the 2026/27 budget was approved in March relates to General Medical Service (GMS) costs within Family Health Services. The GMS contract has consistently overspent in previous years with each deficit increasing year on year. Early forecasting for 2026-27 indicates a potential overspend of £3.1m, which would be shared with each HSCP based on their percentage of actual expenditure. A high-level estimate of our share is approximately £0.250 million. The main cost drivers for this are; the cost of Superannuation contributions, Locum cover, and premises cost. Superannuation is an emerging risk due to the introduction of workforce capacity funding from 2026/27. Without an appropriate uplift in GMS Board Admin allocations for this financial year, the above-mentioned overspend is a real possibility. This position is being monitored closely.

Conclusion

Throughout 2025/26, 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 2026/27, 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: 29 September 2026

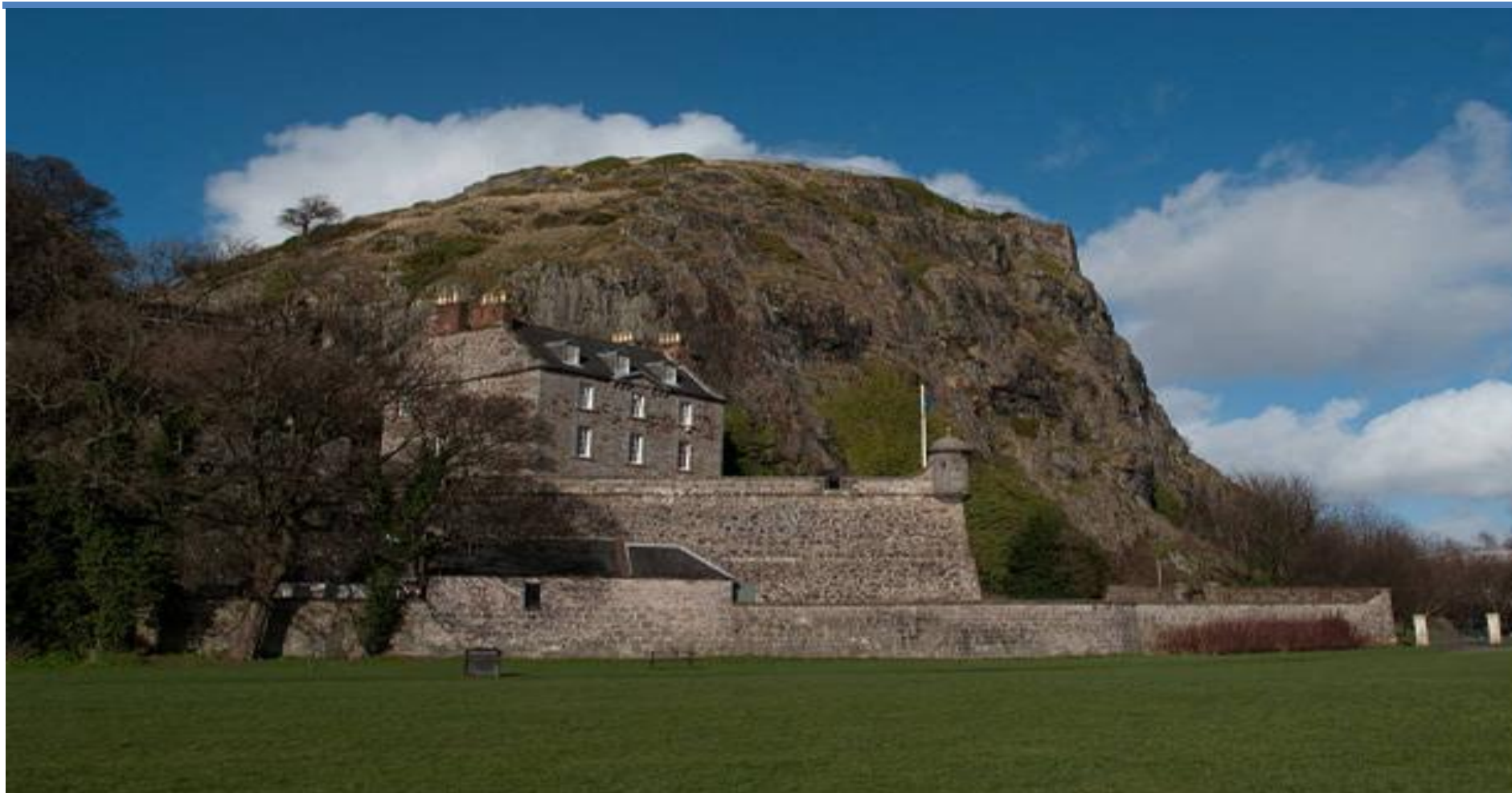
Beth Culshaw
Chief Officer

Date: 29 September 2026

Julie Slavin
Chief Financial Officer

Date: 29 September 2026

Statement of Responsibilities



Responsibilities of the Health and Social Care Partnership Board

The Health and Social Care Partnership Board is required to:

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

I confirm that these Unaudited Annual Accounts were approved at a meeting of the Audit and Performance Committee on 23 June 2026.

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

Michelle Wailes
HSCP Board Chair

Date: 29 September 2026

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 2026 and the transactions for the year then ended.

Julie Slavin CPFA
Chief Financial Officer

Date: 29 September 2026

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 2025 to 31 March 2026

Voting Board Members 2025/26	Position	Dates	Organisation
Michelle Wailes	Chair	1 April 2025 to 31 March 2026	NHS Greater Glasgow & Clyde Health Board
Fiona Hennebry	Vice Chair	1 April 2025 to 19 January 2026	West Dunbartonshire Council
Fiona Hennebry	Voting Member	20 January 2026 to 18 March 2026	West Dunbartonshire Council
Michelle McGinty	Voting Member	1 April 2025 to 19 January 2026	West Dunbartonshire Council
Michelle McGinty	Vice Chair	20 January 2026 to 31 March 2026	West Dunbartonshire Council
Lesley MacDonald	Voting Member	1 April 2025 to 31 March 2026	NHS Greater Glasgow & Clyde Health Board
Libby Cairns	Voting Member	1 April 2025 to 31 March 2026	NHS Greater Glasgow & Clyde Health Board
Martin Rooney	Voting Member	1 April 2024 to 31 March 2025	West Dunbartonshire Council

Fiona Hennebry resigned from the HSCP Board on 18 March 2026 and as at 31 March 2026 the position remained unfilled resulting in West Dunbartonshire Council having only two voting members.

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 2025/26 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 Senior Officers 2024/25		Salary, Fees & Allowance	Compensation for Loss of Office	Total Earnings 2025/26
£		£	£	£
135,734	B Culshaw (Chief Officer)	141,103	0	141,103
103,795	J Slavin (Chief Financial Officer)	108,367	0	108,367

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

		In Year Pension Contributions		Accrued Pension Benefits	
Senior Officers	Position at 31/03/26	For Year to 31/03/2025	For Year to 31/03/2026	For Year to 31/03/2026	Difference from 31/03/2025
		£	£	£000	£000
B Culshaw	Chief Officer	8,823	9,171	25	3
J Slavin	Chief Financial Officer	23,354	24,383	21	3

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 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 31/03/2025	Number of Employees 31/03/2026
£100,000 - £104,999	1	
£105,000 - £109,999		1
£135,000 - £139,999	1	
£140,000 - £144,999		1

Michelle Wailes
HSCP Board Chair

Date: 29 September 2026

Beth Culshaw
Chief Officer

Date: 29 September 2026

Annual Governance Statement



Executive Summary

This Annual Governance Statement describes how the HSCP Board has ensured effective governance, risk management and internal control during the 2025/26 financial year and presents the results of the annual review of their effectiveness and whether our governance arrangements were fit for purpose.

Our annual review was conducted in accordance with the CIPFA/Solace Delivering Good Governance in Local Government: Framework (2016) and the accompanying CIPFA Addendum (May 2025).

Based on the review undertaken and subject to the detail provided below, we are satisfied that our governance arrangements were operating effectively during 2025/26 and were fit for purpose, supporting the delivery of our strategic objectives and duty to deliver on Best Value. This overall opinion is supported by multiple assurances, notably the Chief Internal Auditor's annual opinion, which provides reasonable assurance on the adequacy and effectiveness of the HSCP's governance, risk management and internal control systems.

Key improvements delivered in 2025/26 include the embedding of business continuity planning and external inspection reporting into Board assurance processes. The review has also identified targeted areas for further improvement in the coming year, notably: strengthening risk management arrangements; continuing to embed a more structured self-evaluation framework; aligning workforce planning with the Board's strategic planning cycle; and reviewing the Audit & Performance Committee's terms of reference and membership. An Improvement Action Plan for 2026 has been prepared to address these areas, and the Board is committed to implementing these actions and monitoring progress through its governance structures.

Looking ahead, the HSCP Board recognises the significant system pressures and future risks facing health and social care. These include continuing financial sustainability challenges, pressures on workforce capacity, rising service demand, and the need for transformational change to meet future needs within constrained resources. The Board's governance arrangements will be further strengthened and adapted to ensure continued resilience and effective oversight amid these challenges, with a focus on robust financial planning, risk management, partner collaboration, and transparent performance monitoring.

Michelle Wailes
Chair of the HSCP Board

Beth Culshaw
Chief Officer

Scope of Responsibility

The HSCP Board operates under a formal Integration Scheme and is accountable for ensuring that its governance arrangements are fit for purpose, supporting the achievement of its strategic objectives and the delivery of Best Value. In doing so, the Board is committed to conducting its business in accordance with relevant laws, regulations and appropriate standards, and to ensuring that public funds are safeguarded, properly accounted for and used economically, efficiently and effectively.

The Board has established robust governance arrangements, including effective systems of internal control and risk management, to support the delivery of outcomes and to provide assurance that its responsibilities are being discharged appropriately. These arrangements seek to promote a culture of continuous improvement and support effective decision-making based on sound information, risk awareness and transparency. In line with the requirements of the Local Authority Accounts (Scotland) Regulations 2014, this Statement sets out the HSCP Board's governance arrangements for 2025/26 and presents the outcome of the annual review of their effectiveness. It identifies areas where governance arrangements require improvement, outlines the actions to address these, and provides a forward-looking outlook on governance.

Our Governance Framework

The HSCP Board's governance framework comprises the core structures, processes and values by which it is directed and controlled and how it engages with, and accounts to, its stakeholders and the public. At the heart of this framework is the Local Code of Good Governance which can be found [here](#) (see Appendix 1, 19), which was updated and reviewed during 2025/26. The Local Code is explicitly aligned to the seven principles of good governance defined in the CIPFA/SOLACE Framework namely:

- A. Behaving with integrity, demonstrating strong commitment to ethical values and representing the rule of law.
- B. Ensuring openness and comprehensive stakeholder engagement,
- C. Defining outcomes in terms of sustainable economic, social and environmental benefits.
- D. Determining the interventions necessary to optimise the achievement of intended outcomes.
- E. Developing the entity's capacity, including the capability of its leadership and the individuals within it.
- F. Managing risk and performance through robust internal control and strong public financial management.
- G. Implementing good practices in transparency, reporting, and audit to deliver effective accountability.

Key components of the governance framework are set out in detail within the Sources of Assurance document which can be found [here](#) (see Appendix 1, 20) and include:

- **Formal governance documents** – e.g. the Integration Scheme, Standing Orders, Financial Regulations, and the Performance & Audit Committee's Terms of Reference. These define the HSCP Board's governance structure, decision-making processes, and financial management arrangements.
- **Policy and control environment** – including the Members' Code of Conduct, risk management strategy and Strategic Risk Register, complaints handling processes, information governance and data protection arrangements, and compliance with partner policies for whistleblowing, anti-fraud and staff conduct (as the HSCP Board itself does not directly employ staff).
- **Clear roles and responsibilities** – including statutory roles such as the Chief Officer, the Chief Financial Officer (as section 95 Officer) responsible for financial stewardship, and key professional advisors (e.g. Chief Social Work Officer, Chief Internal Auditor, Clinical Director and Chief Nurse) who support the Board and its committees.
- **Decision-making, scrutiny and transparency** – Regular meetings of the HSCP Board and its Audit and Performance Committee are held in public, with papers and minutes published on the HSCP website. Board and Committee meetings include standing items for declarations of interest and are subject to clear Standing Orders and procedures to ensure transparency and accountability.
- **Internal and external audit arrangements** – The HSCP Board's internal audit function is delivered by the Council's Internal Audit service under a formal agreement, with input from the Health Board's internal auditors as appropriate. Both internal audit services operate in conformance with professional standards (Public Sector Internal Audit Standards, transitioning to the new Global Internal Audit Standards as of April 2025). The HSCP Board also receives assurance from the **external auditors** appointed to audit its accounts, as well as from external inspection agencies (e.g. the Care Inspectorate and Audit Scotland) in relation to services delivered by the HSCP or its partners.

The governance framework enables the HSCP Board to monitor the achievement of its strategic objectives, ensure the quality and value for money of services, and fulfill its statutory accountability obligations. The HSCP Board's framework is designed to manage risk to a reasonable level – it cannot eliminate all risk of failure to achieve policies, aims and objectives, but it seeks to provide a reasonable degree of assurance that significant risks are mitigated.

Our Assessment of Effectiveness

This statement has been prepared in accordance with the CIPFA/SOLACE Delivering Good Governance in Local Government Framework (2016) and the May 2025 [Addendum](#). The Addendum requires the Annual Governance Statement to provide an honest assessment of effectiveness, identify improvement areas and explain how the overall opinion has been determined.

The review concluded that governance arrangements continue to provide a sound framework of governance, risk management and internal control, supported by assurance from internal audit, senior officers and partner organisations. Key elements of the review included:

- **Self-assessment against the Local Code (Principles A–G)** by senior officers, evaluating how well current governance arrangements operate in practice, and identifying any improvement areas. The self-assessment confirmed that the HSCP Board's core governance arrangements are in place and operating largely as intended (with no areas assessed as fundamentally non-compliant), while highlighting some opportunities for further enhancement (detailed later in this Statement).
- **Assurances from management and statutory officers** – including annual governance certificates of assurance and checklists from HSCP Heads of Service (covering internal controls and compliance in their areas of responsibility) and input from the HSCP Board's standards officer and legal advisors. This helps ensure all relevant laws, regulations and policies are being complied with and that any emerging issues are identified.
- **Internal audit** – The Chief Internal Auditor's Annual Report and Opinion was considered as a key part of the review. The internal audit work for 2025/26 included delivery of the approved Internal Audit Plan and regular progress reports to the Audit and Performance Committee.
 - The Chief Internal Auditor's Annual Assurance Statement has concluded that **“reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control” within the HSCP Board (and the partner Council and Health Board) for the year to 31 March 2026**
- **External audit and inspection** – The HSCP Board also took into account external sources of assurance. External audit reports for West Dunbartonshire Council and NHS Greater Glasgow & Clyde were reviewed by the Chief Internal Auditor and provided additional evidence on the wider control environment in which the HSCP operates.
- **External Inspection** - Inspection findings (e.g. from the Care Inspectorate) were regularly reported to and scrutinised by the Audit and Performance Committee, ensuring that any issues identified through external regulatory oversight are addressed and monitored.
- **Oversight by those charged with governance** – The HSCP Board's Audit and Performance Committee has actively overseen and contributed to the governance review. In June 2026, the Committee considered reports on the annual Local Code review and this draft Annual Governance Statement, and Committee members (those charged with governance) provided formal written assurances to the Board and external auditors on key governance and audit matters. These assurances confirmed, for example, the Committee's satisfaction with management's processes to manage fraud risk and internal control, and no significant internal control breaches or fraud incidents have been identified within HSCP activities during 2025/26.



Chair
Michelle Wailes
Non-Exec Member



Vice Chair (to Jan. 2026)
Fiona Hennebry
Councillor



Voting Member
Lesley MacDonald
Non-Exec Member



Vice Chair (from Jan. 2026)
Michelle McGinty
Councillor



Voting Member
Libby Cairns
Non-Exe Member



Voting Member
Martin Rooney
Councillor

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.

Where our Governance Needs to Improve

The 2025/26 self-assessment against the Local Code as referenced above was considered by the Audit and Performance Committee on 23 June 2026. A copy of the report is available [here](#) (See Appendix 1, 21).

Whilst areas for improvement have been identified, these are not material and do not undermine the overall effectiveness of the governance framework; four new improvement actions have therefore been agreed, alongside updated reporting on previously agreed actions, including the closure of completed actions and the progression of ongoing and new actions to further strengthen the control environment.

Table 12: New Improvement Actions

Improvement Action	Lead Officer(s)	Target Date
Principle C: Defining outcomes – Identifying and managing risks to the achievement of outcomes Principle F: Managing risks and performance through robust internal control and strong public financial management – Ensuring responsibilities for managing individual risks are clearly allocated <u>Action</u> Full review of Strategic and Operational Risk Registers to strengthen definition of strategic and operational risks, consistency of scoring and tracking delivery of mitigating actions	Chief Officer supported NHSGGC Chief Risk Officer	September 2026
Principle C: Defining outcomes – Sustainable economic, social and environmental benefits Principle F: Managing risks and performance through robust internal control and strong public financial management – Regular reporting on Strategic Plan and progress towards outcome achievement <u>Action</u> Development of the new strategic plan will be led by a refreshed Strategic Planning Group and shaped by extensive stakeholder engagement and participation to determine priorities and making the best use of the resources available. Membership of the Strategic Planning Group will be reviewed to strengthen effectiveness on driving forward agreed strategic priorities.	Chief Officer supported by Heads of Service	March 2027

Improvement Action	Lead Officer(s)	Target Date
Principle D: Determining interventions – Ensuring the capacity exists to generate the information required to review service quality regularly Action Finalise business case for replacement to Carefirst Social Work Case Management System and review capacity of the Systems, Digital and Information Team	Chief Officer and Head of Human Resources	March 2027
Principle F: Managing risks and performance through robust internal control and strong public financial management - Ensuring an audit committee or equivalent group or function which is independent of the executive and accountable to the IJB Action Aligned to improvement actions agreed following 2 members self-assessment sessions against CIPFA: Audit Committees – Practical Guidance. Audit and Performance Committee review of Terms of Reference and recommendation to review voting membership	Chief Financial Officer and Chief Internal Auditor	September 2026

How We Have Improved Our Governance Arrangements in 2025/26

The table below provides an update on the progress of previously agreed improvement actions and their progress in 2025/26. In addition to these actions there has been self-assessment work undertaken with members of the Audit and Performance Committee to strengthen the HSCP Board's governance framework.

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)*". Following a self-assessment of compliance in January 2025, a further self-assessment session was held with members of the Audit and Performance Committee on 12 May 2026 on Evaluating the impact and effectiveness of the Audit and Performance Committee. The session focused on assessing the Committee's effectiveness against the CIPFA self-assessment framework. The self-assessment was balanced but positive, identifying strengths and areas for improvement across HSCP members, senior management and audit partners. The full report can be viewed [here](#). (See Appendix 1, 21)

Table 13: Update on Previously Agreed Actions

Improvement Action	June 2026 Review
Principle E: Developing the entity's capacity, including the capability of its leadership and the individuals within it Action Align more clearly the Strategic Plan to the Integrated Workforce Plan (IWP) to support the delivery of the approved strategic outcomes. The current IWP covers a 3 year period and this work will be undertaken in Year 2.	ONGOING On 25 November the HSCP Board a one year Workforce Plan as an interim measure to allow development of a longer term plan alongside the next strategic plan which will cover 2027 – 2032. The intention is to return to a longer-term planning horizon, ensuring continuity and strategic alignment across service delivery and workforce priorities.
Principle D: Determining the interventions necessary to optimise the achievement of the intended Action Development of Business Impact Analysis documentation across the HSCP to support key Business Continuity Plans	COMPLETE Business Impact Analysis has been embedded into Business Continuity Plans.
Principle E: Developing the entity's capacity, including the capability of its leadership and the individuals within it Action 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	COMPLETE The Audit and Performance Committee receive detailed updates on all external inspection activity, including services commissioned that support service users outwith West Dunbartonshire boundaries.
Principle C: Defining outcomes – Identifying and managing risks to the achievement of outcomes Principle G: Implementing good practices in transparency, reporting, and audit to deliver effective accountability Action Develop a more structured approach to self-evaluation	ONGOING Whilst progress has been made to scope and develop the improvements needed for self-evaluation, over the coming year efforts will be made to embed this in practice.

Forward Look on Governance

The HSCP Board recognises that it operates in a dynamic environment and that its governance arrangements must remain resilient and adaptable to future challenges. Key system pressures and strategic risks on the horizon include:

- **Financial sustainability** – Ongoing funding constraints, inflationary pressures and rising costs of care will require continued strong financial governance, medium- to long-term planning, and prioritisation of resources. The Medium Term Financial Outlook is regularly refreshed, and a balanced 2026/27 budget has been agreed. However, future years will require further transformation, underpinned by disciplined Best Value review, robust option appraisal and oversight of change programmes.
- **Workforce capacity and sustainability** – Like many health and care systems, the Partnership faces challenges in recruitment, retention and workforce planning. The Board will maintain a focus on strategic workforce planning (Integrated Workforce Plan), staff wellbeing and development, absence management and organisation design to ensure the capacity and capabilities needed for high-quality service delivery into the future.
- **Service demand and demographic pressures** – Demand continues to grow due to an ageing population and increasingly complex needs. The Board will strengthen commissioning and performance management arrangements to target resources effectively and engage with stakeholders on priorities and service models.
- **Legislative and policy changes** – The Board will monitor and prepare for relevant national policy developments (for example, any reforms to health and social care governance frameworks) to ensure that its own governance structures remain compliant with any new statutory requirements and best practice guidance.
- **Technology and data** – The growing role of digital innovation (such as new case management systems or data analytics) will require governance considerations around information governance, cyber security, and effective use of data to inform decision-making. The Board will work with partners to ensure appropriate internal controls and skills are in place for these advancements.
- **Climate and sustainability** – The Board will consider governance implications of climate commitments and net-zero targets, aligning with Council and Health Board strategies.

In facing these challenges, the HSCP Board is committed to maintaining high standards of governance to support innovation and service transformation while safeguarding public funds and ensuring accountability. The annual governance review process will increasingly focus on future resilience (e.g. scenario planning for emerging risks, stress-testing governance against new challenges) as encouraged by CIPFA. The HSCP Board will continue to adapt its governance arrangements to ensure it remains responsive, effective and trusted by the public.

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 2026 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: 29 September 2026

Beth Culshaw
Chief Officer

Date: 29 September 2026

Comprehensive Income and Expenditure



Comprehensive Income and Expenditure Statement for the year ended 31 March 2026

This statement shows the cost of providing services for the year according to accepted accounting practices.

2024/25 Gross Expenditure £000	2024/25 Gross Income £000	2024/25 Net Expenditure £000	West Dunbartonshire Integrated Joint Board - Health & Social Care Partnership	Notes	2025/26 Gross Expenditure £000	2025/26 Gross Income £000	2025/26 Net Expenditure £000
67,397	(9,153)	58,244	Older People Services		69,351	(9,564)	59,787
3,794	(237)	3,557	Physical Disability		4,108	(276)	3,832
33,797	(2,181)	31,616	Children and Families		35,586	(1,325)	34,261
16,809	(3,182)	13,627	Mental Health Services		18,493	(3,389)	15,104
4,291	(190)	4,101	Addictions		4,398	(265)	4,133
21,733	(664)	21,069	Learning Disabilities Services		22,424	(542)	21,882
36,670	(1,496)	35,174	Family Health Services (FHS)		42,031	(1,790)	40,241
22,626	0	22,626	GP Prescribing		21,388	0	21,388
8,375	(267)	8,108	Hosted Services - MSK Physio		9,024	(218)	8,806
865	0	865	Hosted Services - Retinal Screening		911	0	911
3,129	(3,032)	97	Criminal Justice		3,172	(3,183)	(11)
11,942	(1,207)	10,735	Other Services		11,964	(1,016)	10,948
363	0	363	IJB Operational Costs		383	0	383
231,791	(21,609)	210,182	Cost of Services Directly Managed by West Dunbartonshire HSCP		243,233	(21,568)	221,665
45,781	0	45,781	Set aside for delegated services provided in large hospitals		49,337	0	49,337
303	0	303	Assisted garden maintenance and Aids and Adaptions		79	0	79
277,875	(21,609)	256,266	Total Cost of Services to West Dunbartonshire HSCP		292,649	(21,568)	271,081
0	(256,019)	(256,019)	Taxation & Non-Specific Grant Income (contribution from partners)	7	0	(275,989)	(275,989)
277,875	(277,628)	247	(Surplus) or Deficit on Provisions of Services and Total Comprehensive (Income) and Expenditure		292,649	(297,557)	(4,908)

Note: Totals may not add due to rounding

Movement in Reserves Statement



Movement in Reserves Statement as at 31 March 2026

This statement shows the movement in the year on the HSCP Board's reserves with 2024/25 provided 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. A detailed breakdown of the movement in reserves can be found in note 12 on pages 97 to 98.

2025/26 Movement in Reserves

Movement in Reserves During 2025/26	Unearmarked Reserves	Earmarked Reserves	Total General Fund Reserves
	£000	£000	£000
Opening Balance as at 31st March 2025	(3,576)	(14,831)	(18,407)
Total Comprehensive Income and Expenditure (Increase)/Decrease 2025/26	(1,197)	(3,711)	(4,908)
(Increase)/Decrease in 2025/26	(1,197)	(3,711)	(4,908)
Closing Balance as at 31st March 2026	(4,773)	(18,542)	(23,315)

Note: Totals may not add due to rounding

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

Balance Sheet



Balance Sheet as at 31 March 2026

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.

HSCP Board Balance Sheet

2024/25 £000	BALANCE SHEET	Notes	2025/26 £000
18,894	Short Term Debtors	9	23,861
18,894	Current Assets		23,861
0	Short Term Creditors		0
(487)	Provisions	10	(546)
(487)	Current Liabilities		(546)
18,407	Net Assets		23,315
(3,576)	Usable Reserves: General Fund	12	(4,773)
(14,831)	Usable Reserves: Earmarked	12	(18,542)
(18,407)	Total Reserves		(23,315)

Note: Totals may not add due to rounding

The audited accounts were issued on 29 September 2026.

Julie Slavin CPFA
Chief Financial Officer

Date: 29 September 2026

Notes to the Financial Statements



1. Material Accounting Policies

1.1 General Principles

The Financial Statements summarises the HSCP Board's transactions for the 2025/26 financial year and its position at the year-end of 31 March 2026.

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 2025/26, 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 2024/25 demographic pressures in 2025/26 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 2026/27. The medium-term financial outlook for the period to March 2028 was approved in November 2024 and initially identified mid-range budget gaps of £9.6m and £11.2m for 2026/27 and 2027/28 respectively, not allowing for any additional funding that may offset this. The March 2026 budget report presented a balanced budget for 2026/27, updated the mid-range budget estimates for 2027/28 to £8.6m, and identified a mid-range budget gap for 2028/29 of 12.4m. The HSCP Board continues to work within significant financial pressures, and 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 June 2026.

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 2026, 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 2026 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 2026 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 2026, 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 2026, 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 2026 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 HMRC and all VAT is recoverable from it. The Council is not entitled to fully recover VAT paid on a very limited number of items of expenditure and for these items the cost of VAT paid is included within service expenditure to the extent that it is irrecoverable from HMRC.

Where the NHS is the provider, expenditure incurred will include irrecoverable VAT as generally the NHS cannot recover VAT paid and will seek to recover its full cost as income from the Commissioning HSCP.

2. Prior Year Re-Statement

There are no prior year re-statements.

3. Accounting Standards Issued Not Yet Effective

The Code requires the disclosure of information relating to the expected impact of an accounting change that will be required by a new standard that has been issued but not yet adopted.

The HSCP Board considers that there are no such standards which would have significant impact on its Annual Accounts.

4. Critical Judgements and Estimation Uncertainty

Within Greater Glasgow and Clyde, each IJB has responsibility for services which it hosts on behalf of the other IJB's. In delivering these services the IJB has primary responsibility for the provision of the services and bears the risks and reward associated with this service delivery in terms of demand and the financial resources required. As such the IJB is considered to be acting as 'principal', and the full costs should be reflected within the financial statements for the services which it hosts. This is the basis on which West Dunbartonshire's IJB accounts have been prepared and is based on the Code of Practice.

The Annual Accounts contain estimated figures that are based on assumptions made by the HSCP Board about the future or that which are otherwise uncertain. Estimates are made using historical expenditure, current trends, and other relevant factors. However, because balances cannot be determined with certainty, actual results could be materially different from the assumptions and estimates made. In applying these estimations, the HSCP Board has no areas where actual results are expected to be materially different from the estimated used.

5. Events After the Reporting Period

Events after the balance sheet date are those events, both favourable and unfavourable, that occur between the end of the reporting period and the date when the statement of accounts is authorised for issue. Two types of events may be identified:

- those that provide evidence of conditions that existed at the end of the reporting period – the Financial Statements are adjusted to reflect such events; and

- those that are indicative of conditions that arose after the reporting period - the Financial Statements are not adjusted to reflect such events, but where this would have a material effect, the nature and estimated financial impact of such events is disclosed in the notes

The unaudited accounts were authorised for issue by the Chief Financial Officer on 23 June 2026. 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 2026, 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

Table 14: Expenditure and Income Analysed by Nature

There are no statutory or presentational adjustments which reflect the WDHSCP Board's application of the funding received from partners.

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

Table 14 provides a summary of Expenditure and Income Analysed by Nature.

2024/25	West Dunbartonshire Integration Joint Board Health & Social Care Partnership Consolidated Health & Social Care Services	2025/26
£000		£000
92,390	Employee Costs	96,088
1,502	Property Costs	1,254
1,538	Transport	1,334
4,848	Supplies and Services	4,188
69,730	Payment to Other Bodies	74,713
22,626	Prescribing	21,388
36,467	Family Health Services	41,818
2,656	Other	2,415
34	Audit Fee	35
303	Assisted Garden Maintenance and Aids and Adaptations	79
45,781	Set Aside for Delegated Services Provided in Large Hospitals	49,337
(21,609)	Income	(21,568)
(256,019)	Taxation and non specific grant income	(275,989)
247	(Surplus)/Deficit on the Provision of Services	(4,908)

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 15 includes £49.337m 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 15: Taxation and Non-Specific Grant Income

2024/25 £000	Taxation and Non-Specific Grant Income	2025/26 £000
(120,102)	NHS Greater Glasgow and Clyde Health Board	(132,470)
(89,833)	West Dunbartonshire Council	(94,103)
(45,781)	NHS GGCHB Set Aside	(49,337)
(303)	Assisted garden maintenance and Aids and Adaptions	(79)
(256,019)	Total	(275,989)

Note: Totals may not add due to rounding

8. Hosted Services

Consideration has been made on the basis of the preparation of the 2025/26 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 2025/26 financial statements.

The cost of the hosted services provided by WDHSCP to other IJBs for 2025/26 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 16: Services Hosted by West Dunbartonshire HSCP

2024/25 £000 Net Expenditure by WD HSCP	Host Integrated Joint Board	Service Description	2025/26 £000 Net Expenditure by WD HSCP
7,522	West Dunbartonshire	MSK Physiotherapy	8,176
792	West Dunbartonshire	Retinal Screening	814
32	West Dunbartonshire	Old Age Psychiatry	410
8,346		Cost to GGC IJBs for Services Hosted by WD	9,400

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 17 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 17: Services Hosted by Other IJB's

2024/25 £000 Net Expenditure by WD HSCP	Host Integrated Joint Board	Service Description	2025/26 £000 Net Expenditure by WD HSCP
897	East Dunbartonshire	Oral Health	980
4,278	East Dunbartonshire	Specialist Children's Service	4,255
427	East Renfrewshire	Learning Disability	356
16	East Renfrewshire	Augmentative and Alternative Communication	28
462	Glasgow	Continence	527
671	Glasgow	Sexual Health	710
2,195	Glasgow	Mental Health Central Services	2,197
677	Glasgow	Addictions - Alcohol and Drugs	670
970	Glasgow	Prison Healthcare	1,024
221	Glasgow	Health Care Police Custody	312
4,806	Glasgow	General/Old Age Psychiatry	4,462
31	Renfrewshire	General/Old Age Psychiatry	0
4	Inverclyde	General/Old Age Psychiatry	26
547	Renfrewshire	Podiatry	610
322	Renfrewshire	Primary Care Support	332
16,524		Cost to WD for Services Hosted by Other IJBs	16,488

Note: Totals may not add due to rounding

9. Debtors

Table 18: Debtors

2024/25 £000	Short Term Debtors	2025/26 £000
	0 NHS Greater Glasgow and Clyde Health Board	0
	18,894 West Dunbartonshire Council	23,861
	18,894 Total	23,861

Note: Totals may not add due to rounding

10. Provisions

Table 19: Provisions

Bad Debt Provision	£000
Opening Provision as at 1 April 2025	487
Contributions in year	72
Amounts utilised in year	(13)
Unutilised amounts reversed in year	0
Closing Provision as at 31 March 2026	546

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 Greater Glasgow and Clyde Health Board and West Dunbartonshire Council. The nature of the partnership means that both organisations exert significant influence through legislation, delegated functions and Integration Authorities funding mechanism. The HSCP Board may in turn exert influence on each partner through its governance and funding arrangements.

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, including legal advice, human resources

support, certain financial services and technical support. Neither organisation levied an additional charge for these services for the year ended 31 March 2026.

Table 20: Transactions with NHSGGC and Balances Due at 31 March 2026

Key management personnel comprise those persons with authority and responsibility for planning, directing and controlling the activities of the HSCP Board.

2024/25 £000	Transactions with NHS Greater Glasgow and Clyde	2025/26 £000
(165,883)	Funding Contributions Received from the NHS Board	(181,807)
163,908	Expenditure on Services Provided by the NHS Board	174,804
(1,975)	Net Transactions with NHS Board	(7,003)

The non-voting Board members employed by WDC and NHSGGC are recharged to the HSCP Board and include the Chief Officer, Chief Financial Officer and Chief Social Work Officer.

2024/25 £000	Balance with NHS Greater Glasgow and Clyde	2025/26 £000
0	Debtor Balances: Amounts due from the NHS Board	0
0	Net Balance with NHS Greater Glasgow and Clyde	0

Note: Totals may not add due to rounding

Table 21: Transactions with West Dunbartonshire Council and Balances Due at 31 March 2026

Other key management personnel include the Head of Planning and Health Improvement and two staff representatives

2024/25 £000	Transactions with West Dunbartonshire Council	2025/26 £000
(90,136)	Funding Contributions Received from the Council	(94,182)
91,995	Expenditure on Services Provided by the Council	95,894
363	Key Management Personnel: Non Voting Members	383
2,222	Net Transactions with West Dunbartonshire Council	2,095

Details of the remuneration for some specific post-holders are provided in the Remuneration Report.

2024/25 £000	Balance with West Dunbartonshire Council	2025/26 £000
18,407	Debtor Balances: Amounts due from West Dunbartonshire Council	23,315
18,407	Net Balance with West Dunbartonshire Council	23,315

Note: Totals may not add due to rounding

Other related party interests

Board members and relevant senior officers are required to complete a Register of Interests in accordance with the HSCP Board's governance arrangements. For 2025/26, these declarations were reviewed against material transactions, including relevant commissioning, grant and funding arrangements, to identify related party transactions requiring disclosure. No material related party transactions requiring separate disclosure were identified other than those set out in this note.

Related parties also include organisations which we may not transact with but can still exert significant influence over our financial and operating policy decisions. The Scottish Government is such a related party of the HSCP Board as it can exert significant influence through legislation and funding of the HSCP Board's Partner Bodies and therefore can indirectly influence the financial and operating policy decisions of the HSCP Board. The value of transactions directly with the Scottish Government in 2025/26 and 2024/25 was nil.

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 22 summarises the main movements in earmarked reserves across high-level categories of:

- 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 and alcohol and drugs addictions.
- 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, to underwrite ongoing work in relation to service improvements across several HSCP services and to mitigate future increases in employer liabilities.
- Prescribing – This reserve is held to underwrite the prescribing pressure arising from volatility in demand and price.

Table 22: Summary of Reserves Movements

Balance as at 31 March 2025 £000	Total Reserves	Transfers Out 2025/26 £000	Transfers In 2025/26 £000	Balance as at 31 March 2026 £000
	Scottish Govt. Policy Initiatives			
(2,863)	Adult and Older People Services	1,366	(558)	(2,055)
(69)	Childrens Services	43	(136)	(162)
(189)	Carers Funding	0	0	(189)
0	Other	0	(42)	(42)
	HSCP Initiatives			
(1,614)	Service Redesign / Transformation	0	(85)	(1,700)
(1,323)	Complex Care	742	0	(581)
(4,732)	Service Performance Improvements	966	(3,323)	(7,089)
(1,522)	Employer Liability	0	(2,333)	(3,855)
(1,149)	Other	43	(250)	(1,356)
	Prescribing			
(1,369)	Prescribing	600	(744)	(1,513)
(14,831)	Total Earmarked Reserves	3,760	(7,471)	(18,542)
(3,576)	Total Unearmarked Reserves	0	(1,197)	(4,773)
(18,407)	Total General Fund Reserves	3,760	(8,668)	(23,315)
	Overall Movement			(4,908)

Notes:

1. Recovery / Renewal of Services has been renamed Service Performance Improvements
2. Superannuation has been renamed Employer Liability
3. Totals may not add due to rounding

13. External Audit Costs

In 2025/26 the HSCP Board incurred external audit fees in respect of external audit services undertaken in accordance with the Code of Audit Practice. See Table 23 below:

Table 23: External Audit Fees

2024/25 £000	2025/26 £000
34 Fees Payable	35

Independent Auditor's Report



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

Reporting 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 2026 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 2025/26 (the 2025/26 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 2026 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 2025/26 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 the 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 the 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, Annual Governance Statement, Statement of Responsibilities 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, Director
For and on behalf of Forvis Mazars LLP

100 Queen Street Glasgow – G1 3DN
29 September 2026

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. [strategic-needs-assessment-2025.pdf](#)
4. [Scotland's Climate Change Plan: 2026–2040](#)
5. [Annual and Quarterly Performance - West Dunbartonshire HSCP](#)
6. [WD HSCP August 2026 Board](#)
7. [WD HSCP Financial Performance Report May-2026](#)
8. [wd-hscp-board-financial-regulations-revised-february-2024.pdf](#)
9. [WD HSCP June 2021 Risk Strategy and Policy Report](#)
10. [WD HSCP August 2025 Board](#)
11. [WD Audit and Performance Committee June 2026](#)
12. [WD HSCP Board's Reserves Policy](#)
13. [WD HSCP March 2026 Board](#)
14. [Scotland's fiscal outlook: medium-term financial strategy](#)
15. [Scottish Spending Review 2026](#)
16. [Integration Joint Boards: Finance and performance 2024 | Audit Scotland](#)
17. [Local government budgets 2026/27 | Audit Scotland](#)
18. [medium-term-financial-outlook-2024.pdf](#)
19. [WD HSCP Board's Local Code of Good Governance](#)
20. [Local Code Annual Review: Sources of Assurance](#)
21. [WD Audit and Performance Committee June 2026](#)

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD**Audit and Performance Committee****Report by Val Tierney Chief Nurse****22 September 2026**

**Subject: Annual Health and Care (Staffing) (Scotland) Act 2019 (HCSSA)
Implementation Status and Assurance Report – Health (2025)**

1. Purpose

- 1.1** The Health and Care (Staffing) (Scotland) Act 2019 (The Act) took effect on April 1, 2024. The aim of the Act is to provide 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.
- 1.2** The Act sets out responsibilities for both integration authorities and health boards.
- 1.3** This report outlines the reporting requirements for health services and confirms current HSCP assurance levels with respect to overall compliance with the duties within the Act (Appendix1).

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. Quarterly Assurance reporting is not required from Care services.
- 2.3** Note the overall level of compliance for delegated health services in West Dunbartonshire HSCP Quarter 1 (2026) Internal Assurance Report is assessed as reasonable (Appendix 1).

3. Background

- 3.1** The Act was passed by the Scottish Parliament in May 2019 and came into force on 1 April 2024. Implementation of the Act supports high-quality care by ensuring access to a competent and effective workforce. It promotes openness and transparency by ensuring staff are informed about staffing decisions and can raise concerns. The Act builds on existing policies and

procedures across both health and care services. The Act places a duty to ensure there are both sufficient staff numbers and an appropriate mix of professional roles.

3.2 Where healthcare is delegated to an integration authority, the duties and requirements of the Act continue to apply. The key requirements are summarised below:

- I. Report to Scottish Ministers on the use of high-cost agency staff.
- II. Identify staffing risks in real time, with procedures to escalate and address risks, including those that are severe or recurring.
- III. Seek and take account of clinical advice on staffing.
- IV. Ensure clinicians who lead teams have sufficient time to fulfil their leadership responsibilities.
- V. Ensure staff receive training appropriate to their role.
- VI. Use the common staffing method where required.

3.2 The Act's Statutory Guidance requires NHSGGC Board Level Clinical Leaders to provide quarterly reports, as a minimum, to Health Board members. These reports should set out their views on compliance with all relevant requirements of the Act for the roles within scope of their leadership, to support appropriate staffing.

3.3 The HSCP Chief Officer is asked to provide a single consolidated submission on assurance levels for their area of responsibility. This should include all health professionals identified within the Act. The HSCP return will be reviewed alongside other submissions and incorporated into a single NHSGGC Board Level report for submission through Board standing committees.

4. Main Issues

4.1 The West Dunbartonshire HSCP Consolidated Health Report Quarter 1 (2026) is included at Appendix 1 and provide and provides evidence to support the assessment of reasonable assurance regarding compliance with the principles and duties enshrined in the Act. It confirms that sound systems of governance, risk management and control are in place.

Table 1: West Dunbartonshire HSCP Assurance Levels – Q1 2026-2027

Duties	Assurance Levels
12IA Duty to ensure Appropriate Staffing	Reasonable Assurance
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
12IF Provision of Clinical Advice	Reasonable Assurance
12IH Duty to ensure adequate time given to clinical leaders	Reasonable Assurance
12II Duty to ensure appropriate staffing: training of staff	Reasonable Assurance
12IF Provision of Clinical Advice	Reasonable Assurance
12IH Duty to ensure adequate time given to clinical leaders	Reasonable Assurance
12II Duty to ensure appropriate staffing: training of staff	Reasonable Assurance
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

- 4.2** The HSCP has established a baseline understanding of current compliance and assurance levels. The gap analysis has informed the 2026/2027 action plan, which will support progress towards substantial assurance by embedding these duties within routine reporting and strengthening care quality, workforce planning, financial management and risk assessment business-as-usual processes. Achieving substantial assurance is contingent on the implementation of Safe Care and e rostering across NHSGGC. West Dunbartonshire is scheduled for implementation in March 2028.

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** 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.

Table 2:
Common Staffing Method Triangulation Recommended WTE & Associated Costs

Service	Additional r(wte)	Cost
District Nursing [Day]	1.69 Band 5 wte	£98 745.
District Nursing [OOH]	0	0
Health Visiting	0	0
School Nursing	4.08 various	£ 158 230
Learning Disability Nursing	0.5 wte Band 4 HCSW	£21 300
Mental Health Inpatient Wards	0	0
Diabetes CNS	0.33 wte Band 6	£18 390
Total		£ 296 674

8. Risk Analysis

- 8.1** Recruitment in health and social care render this a difficult environment for the implementation of the Act.
- 8.2** Strategic and Service Risk registers have been reviewed and updated related to the implementation of the Act.
- 8.3** 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.

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 2025/26.

- 11.2** Quarterly Assurance report submitted to NHSGGC Health Care Staffing Oversight Board.
- 11.3** 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.

Name Val Tierney

Designation Chief Nurse West Dunbartonshire HSCP
Date 22.08.2026

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

Appendices:

Appendix 1: West Dunbartonshire HSCP Quarter 1 2026 HCSA Assurance Report to NHSGGC

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 , where possible we have removed duplication so evidence only needs identified once.
- > Also identify significant risks or challenges that you may need some support to mitigate or are already in the process of review, we are required to dientify examples of each in the anuual report.
- > Identify areas of success that may benefit from learning or approach being shared.
- > Enactment began on 01 April 2024. Q2 (25-26) 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

Substantial assurance

Reasonable assurance

Limited assurance

No assurance

Supporting Resources

System adequacy

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.

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.

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.

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.

Controls

Controls are applied continuously or with only minor lapses.

Controls are applied frequently but with evidence of non- compliance.

Controls are applied but with some significant lapses.

Significant breakdown in the application of controls.

<https://www.nhsggc.scot/health-care-staffing-scotland-act-2019/>

On this webpage you will find lots of resources to support understanding and application under Resources and Guidance Section

Assurance Statement Summary

Requires Director or Chief Officer to complete (or authorised depute)

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

the required assurances (including associated checklists) from Deputy Directors (or equivalents) within my command responsibility

workbook to be accurate.

considered in the preparation of the quarterly assurance statement:

an area of particular risk. This has been escalated to the Professional Lead and also to NHSGGC Primary Care Clinical and Care Governance Group for *exacerbating challenges - all available mitigations are in place. West Dunbartonshire Community Mental Health Teams are no longer in risk* evidenced via PROMS and PREMS. The service has had challenges around ongoing increased demand for service and staffing challenges which are impacting on performance metrics regarding waiting times - all mitigations and remedial actions are in place to address this within the context of available resources. More recently the service successfully secured funding via NHS GGC operational Improvement planning to recruit additional staffing Main *Common Staffing framework triangulation exercise last year determined a need for significant additional resources , not withstanding the caveat that there were challenges especially around the triangulation and availability of meaningful data the waiting list and risk assessment currently in place indicate that demand exceeds capacity within the service. Investment in the School Nurses [to undertake SCPHN qualification] and Student District Nurses (SPQ) in order to maintain workforce pipeline is an ongoing challenge.*

significant matters arising which would require to be raised specifically .

Name Beth Culshaw

Job Title Chief Officer

Date 06.07.2026

Duties	Assurance Levels (Select from Drop Down)
121A Duty to ensure Appropriate Staffing	Reasonable Assurance

Evidence needs to be able to be obtained should it be requested for Due Diligence or a HIS Info request.

Evidence Source	Summary	Location
	This one-year Workforce Plan has been developed as a holding plan to ensure compliance with the Health and Care (Staffing) (Scotland) Act 2019, which requires workforce plans to be in place. It is intentionally time-limited to allow future workforce planning to align with the HSCP's strategic planning cycle. The plan continues to link to the HSCP's key strategic priorities and will be interwoven with the development of the next HSCP Strategic Plan, ensuring a coherent and forward-looking approach to workforce development.	
Paper to IJB -Draft Or		West Dunbartonshire HSCP Webs
Care Opinion Reports	Care Opinion commenced September 20025, plans to increase use and promotion of use across HSCP. The Annual Clinical and Care Governance report 2025 reveals the range of services that proactively seek service user feedback and how they use this to drive improvement in services. Public Involvement Lead has returned for absence and priority will be to work with	WDC HSCP Clinical Care Governan
I matter	This was discussed at last HSCP Workforce HCSA group - Organisational development Manager to remind leaders to need consider and reflect on elements that pertain to HCSA in improvement plans	Shared Drive WDHSCP
MHS NHSGGC	Consultation Helensburgh Ongoing - Board wide mental Health Strategy	Sylvia Chatfield HOS
SMT Minutes . WDHSCP CCG minutes . Quarterly CCG reports to WD IJB Audit and Performance Committee		

Evidence Section does not need to match checklist line for line, if included in a single process/document

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 &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. To Evidence :- > 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 have included clinical advice, are being considered and used > Local Workforce Plans in place determines what constitutes appropriate numbers for (a) the nature of the particular kind of health care provision, (b) the local context in which it is being provided, (c) the number of patients being provided it, (d) the needs of patients being provided it, and (e) appropriate clinical advice. > 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. > Process for revising W/F plan with output from annual Common Staffing Method for appropriate services / staffing (Dynamic Service review).	Yes	
Systems and Processes are in place and proactively promoted, to gain feedback from patients / services Users to inform and aid Service improvements To Evidence: - > Care Opinion in place and Promoted (or any / and similar patient feedback systems or processes) > where this feedback has informed service improvements or changes > where this feedback has been used to inform staffing decisions	Yes	
Systems and Processes are in place and proactively promoted, to gain feedback from staff to aid and inform Service improvements To Evidence: - > I Matter in place with good level of engagement and active action plans in place and Promoted (or / and any similar staff feedback systems or processes) > where this feedback has informed service improvements or changes > where this feedback has been used to inform staffing decisionsE9E9:G10B8E8:G9E9:H10E9:G10E9:E8:G9	Yes	
Any new or revised agreements (SLA's, Contracts or any other agreement for services delivered by others) 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. To Evidence :- > List any Board to Board SLA's that are new or being revised, that they include the relevant sections drafted for HCSSA > List an New or Revised Contracts that procure or commission service delivery by any professionals as named by the Act, and that the specification was developed outlining appropriate systems & processes that are in in with the Act. > List any other form of agreement that is new or being revised, ensuring they meet the acts intent.		Partial
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met). To Evidence :- > It is envisaged that this is through regular Senior Management Team Meetings or similar and includes triangulation of all relevant material data, from compliance with other duties listed in other tabs of this assessment. > These meeting would be noted including decision making and action planning.	Yes	

Required * Complete the table to the Left

Required ** Complete the table below

Areas of Shared Learning or Success to Spotlight
RWW Ongoing success of approach adopted by District Nursing Team
Service areas - professionals encouraged to ensure local BCP reflected requirement for RTS and RE
Areas of Challenge or Concern & Mitigations Required
Sufficient Funding to support robust pipeline of post graduate student SPQ/ SCPHN Sn and HV
implementation of Safe Care
Lack of funding in HSCP to support outcome of CSM triangulation efforts

Action	Time scale #	Lead	Governance	Risks
Promote more Systematic Use of Care Opinion	Mar-27	HST	SMT CCG	
1 Development of three year workforce plan 2026-2029 ensure use 6 step methodology and all service areas reflect implication of HCSA on their workforce planning . Ensure elements of the act with respect to protected learning time and leadership are strengthened.	2027	HOHR	SMT /IJB	
Ensure outputs from Common Staffing Method Triangulation method are discussed at SMT July 2026 and reflected in workforce plan - ongoing (reports prepared for July SMT and will be submitted to NHSGGC as requested by August 2026) Consider in discussion requirement to add to HSCP risk register	Aug-26	VT	SMT / WD HCSA END	Financial
4 Promote Use of Care Opinion (increase number of stories) and enhance reporting v	Mar-27	Alistair Hanley / C	CCG/SMT	Only one Public Involvement Officer - risk of single point of failure
5 For Quarter 2 Report - we will have identified Champions from each services who w	Septemebr 2026	VT	HCSA/Workfo	Non engagment
6				
7				
8				
9				
10				
Please provide estimated date for action to be completed with Evidence available for due diligence				

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

Evidence needs to be able to be obtained should it be requested for Due Diligence or a HIS Info request.

Evidence Source	Summary	Location
RTS and risk escalation	All Nursing service areas have a RTS and risk escalation SOP in place	General Channel
Record of Team Huddles	Use of Datix incident reporting remains variable across teams	Service Level records - shared drive /Datix reports
RTS & RE	Lead decision makers are clearly developed across nursing structures and MSK Physiotherapy services . Service business continuity plans reflect role of RTS and RE	Shared Drive
RTS	Service level SOPS identify section pathways from practitioner	General Channel

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, 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. To Evidence > Local level RTS & RE SOPs in place for all services / teams (completing all aspects of Org level SOP Checklist) >Staff are appropriately informed and understand the SOP >Staff are aware of the Time To Lead local SOP and its interrelatedness to Clinical Advice and Risk Escalation?		Partial
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. To Evidence >Are your team huddles / meetings in place and recorded? >Are the factors for assessing actual and potential staffing concerns in your SOP do you use this in huddles/meetings? > Is Datix incident reporting process within your SOP (or other system if Datix not system in place, i.e. HSCPs)? > 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?		Partial
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. If a decision which conflicts with clinical advice received, any risks caused by that decision are identified and mitigated so far as possible and 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. To Evidence > 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 appropriate mitigations included within the SOP? > Does your Business Continuity Plan consider RTS & RE and can processes still apply, when B/C enacted?		Partial
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. To Evidence >Do you have a flow process map in place so this is clearly identified and understood within your SOP?		Partial

RTS		http://www.wdhscp.org.uk/media/2991/document-pack-hscp-audit-and-performance-committee-23-september-2025.pdf	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. To Evidence > Are local records held and include minimum requirements as outlined in the Organisational level RTS & RE SOP?		Partial
	real time staffing records for each service area capture the		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. To Evidence > 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
Evidence Section does not need to match checklist line for line, if included in a single process/document			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? (Evidence SOP in Ttl Tab)		Partial
Use of Datix reporting /Use of HR reports t SMT/Brave report	The use of Datix reporting for HCSA incidents is not consistently embedded across all services		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 To Evidence > Are you using Datix reports or similar, SSTS reports and local records to systematically identify, analyse, evaluate, mitigate and manage RTS severe and recurrent risks consistently and at an appropriate level? State what these are and where they are for evidence.		Partial
RTS and RE TOC	As of 29th July - the District Nursing Team , treatment Rooms and Diabetes Nurse Specialist and A Local Authority Care Home will complete weekly report that will be pulled through to an SMT report - the plan is to quickly expand this to all Health and care services covered by the act by the ned of 20206		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? Evidence Required > Is this captured in your RTS & RE process or within other processes? If other process state and link in evidence		Partial
SMT Agenda /HSCP	Datix reports are scrutinised at quarterly clinical and care governance meetings and emerging themes identified - exception reports from all HOS and CN/CD/CSWO review and identify any staffing risks with an implications for safe person centred care. This information is triangulated at SMT meetings where risks are reviewed decision making and action planning is captured.		There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met) To Evidence :- > It is envisaged that this is through regular Senior Management Team Meetings or similar and review of all relevant data on recurring incidents, mitigations and requirement for escalation to Risk Register > These meeting would be noted including decision making and action planning.		Partial
			Do You Have Safe care in use for Real Time Staffing? If so has your local SOP been updated to Reflect this, including escalation, mitigation, disagreement in decision making and resolution? To Evidence > Local SOP which includes Safe Care		No

Required * Complete the table to the Left

Required ** Complete the table below

Areas of Shared Learning or Success to Spotlight
Strengthened Quarterly CCG report to IJB Audit and Performance - addresses HCSA - links care quality explicitly to staffing challenges where warranted http://www.wdhscp.org.uk/media/2991/document-pack-hscp-audit-and-performance-committee-23-september-2025.pdf
http://www.wdhscp.org.uk/media/2991/document-pack-hscp-audit-and-performance-committee-23-september-2025.pdf

Action	Time scale #	Lead	Governance	Risks
1. Require to complete e mapping exercise to ensure all localised RTS &RE service SOP are sensitive enough to capture implications for professions within scope where these relate to integrated teams.	End Aug 2026	VT	HCS And Workforce Group	Workforce Capacity
2 Require to update all RTS &RE Local SOP to reflect updated SOP including clearer definitions of severe and recurrent risk, review escalation pathways	End 2026	VT	HCS And Workforce Group	Workforce Capacity

Areas of Challenge or Concern & Mitigations Required
Substantial Assurance will only be achieved with the introduction and use of safe care

3 Strengthen SMT oversight of recurrent risk -as an interim measure introduce East Dunbartonshire RTS recording methodology across WD HSCP SMT services - commence with District Nursing and Local Authority Care Homes test concept commences 29th June 2026	End August 2026	VT/PT	WF &HCSA Group	Non compliance / Decision not to invest resource in this SMT
4 Ensure all Teams have Time to Lead SOP that reflects RTS& RE - review	End August 2026	VT	HCSA Group	Capacity
6. There are aspects of risk escalation and its reporting which also requires consistent re	TBC	HOS	SMT	
7				
8				
9				
10				
Please provide estimated date for action to be completed with Evidence available for due diligence				

Duties	Assurance Levels
12IF Provision of Clinical Advice	Reasonable Assurance
12IH Duty to ensure adequate time given to clinical leaders	Reasonable Assurance

Evidence needs to be able to be obtained should it be requested for Due Diligence or a HIS Info request.

Evidence Source	Summary	Location
Fully implemented	Fully implemented across nursing teams with local SOPs in	Fully implemented across nursing teams with local SOPs in
Quarterly Assurance	Clinical Leaders contribute via HCSA and Workforce Group	HSCP Shared Drive
NHSGGC Time to Lead SOP - adapted by local Teams	Well developed local SOP in Nursing families - less evidence for all functions and professional groups	Shared drive
Datix Reports / daily Huddle Reports	Clinical Leaders clearly identified in Nursing Teams. Oversight of CCAT and care quality metrics takes place at regular intervals. Quality Improvement Action Plans are in place. Clinical Supervision implemented and evidence this takes place regularly with robust records kept. Where Clinical Leaders require to step down and provide caseload direct care to patients this is being recorded on SSTs/ Datix for District Nursing Services and Children and Family Team Leaders. observation of clinical practice being introduced as part of Health Visiting CCAT process	
SMT/Service Level triangulation Meetings	Chief Nurse, Head of Service Senior Nurse / Service e manager meet undertake common staffing method triangulation meetings following completion of all service level tool runs . RTS and RE supports and all staff cognisant of rostering policy . Team Leads encouraged to attend rostering master classes.	CSM Reports Shared drive

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**
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. Evidence Required > Organisational Level SOP	yes	
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. . Evidence Required > Submission of this assessment from the relevant HSCP/Directorate/Sector on a quarterly basis to enable a consolidated report from the Legislated Board Lead clinicians. > Designated clinical leaders within the relevant HSCP/Directorate/Sector are contributing to the submission on a quarterly basis to enable a consolidated report from the Legislated Board Lead clinicians.	yes	
Systems and processes are in place, that include the means to raise awareness, in all functions and professional groups, to ensure that all individuals with lead clinical professional responsibility for a team of staff receive adequate 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 & replicate as required within local teams / services		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: - Evidence Required > Clear Definition of Clinical Leader locally (Part of Time to Lead SOP) > 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 > Does your Business Continuity Plan consider Clinical Advice and Time to Lead and can processes still apply, when B/C enacted?	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. To Evidence > Reviews of related Job Descriptions have clarity of Leadership aspects aligned to the role > Job Planning clearly outlines time to be aligned to leadership activities > Workplans for individuals have clear leadership activity identified as outlined by this duty		Partial

SMT Agenda and Meetings / WD Clinical and Care Governance Meetings Minutes . Via Supervision		Shared Drive
SSTS rosters are in Place . NHSGGC Rostering Policy	The nursing rosters were recently reviewed and confirmed . All teams follow PAA as recommended in NHSGGC	SSTS
SSTS rosters are in Place . NHSGGC Rostering Policy	The nursing rosters were recently reviewed and confirmed . All teams follow PAA as recommended in NHSGGC	SSTS

Evidence Section does not need to match checklist line for line, if included in a single process/document

Areas of Shared Learning or Success to Spotlight

Areas of Challenge or Concern & Mitigations Required
variation in definitions and protected time, this is expected, but hopefully the work discussed in last week's

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) To Evidence :- > It is envisaged that this is through regular Senior Management Team Meetings or similar and review of all relevant data on recurring incidents and mitigations which may show a recurring theme of the lack of adequate leadership time being protected and being assigned to other case holding duties due to staffing issues. > These meeting would be noted including, identifying clinical leaders participating, decision making and action planning.		Partial
Roster Planning is in place, with relevant professional or business rules established across Job Families To Evidence > SSTS Rosters are in place > Roster Policies are identified for Job Families	Yes	
Do You Have Safe Care in use for Real Time Staffing (In process of being rolled out organisationally)? If so are you utilising this for recording mitigations in respect to Time to Lead and producing reports? If so, has your local SOP been updated to reflect this? To Evidence > Local TtL SOP which includes recording and reporting from Safe Care		No

Required * Complete the table to the Left

Required ** Complete the table below

Action	Time scale #	Lead	Governance	Risks
1Map existence of Local Time to Lead SOPs across all Professionals and Teams	End Auge 2026	VT	via HSCP wforce& HCSA group	Lack of cap
2Ensure all areas / professions have articulated who is a clinical leader and what is sufficient time to Lead - Integrated Teams and Professional Groups	End Auge 2026	VT	via HSCP wforce& HCSA group	Lack of cap
3Develop means of aggregating and surfacing intelligence coming from Supervision meetings / 1-1's / PDP-Rs in respect to decision making and disagreements in the interim or people being able to maintain their clinical leadership time?	End Aug 20206v	Senior Nurses	HCSA Group /Chief nurse Meeting	
4				
5				
6				
7				
8				
9				
10				

Please provide estimated date for action to be completed with Evidence available for due diligence

Duties	Assurance Levels
12II Duty to ensure appropriate staffing: training of staff	Substantial Assurance

Evidence needs to be able to be obtained should it be requested for Due Diligence or a HIS Info request.

Evidence Source	Summary	Location
Statutory and Mandat	HCSA training is available and promoted but reports on completion not available. Statutory and mandatory training is routinely reported on to SMT and local teams and managers. Evidence of role specific education and training is in place for some services e.g. health visiting , District Nursing but not visible for all . All nurses must revalidate and have 35 hours minimum learning and development to evidence meeting revalidation standards	HR reports storyboard
Personal Development Planning and Review /Stat Man training Records /local Service Level Records for Profession Specific Training /SMT reports /Board wide induction programme		TURAS / HR Sory board /Board wide Induction Programme /Local Induction Preceptorship programmes
Review of PAA - allocated and taken - for learning and development	PAA - Reviewed at completion of CSM . Discussed at supervision and PDP planning and review . Cancellation of training recorded on RTS proforma (nursing) . Themes or recurrence escalated to Service Manager and beyond if risk becomes enduring	HR Story board /RTS proformas / Escalations via team Leads /Service managers via risk assessment

Evidence Section does not need to match checklist line for line, if included in a single process/document

Areas of Shared Learning or Success to Spotlight

Areas of Challenge or Concern & Mitigations Required
TURAS module Completion challenging due to lack of reporting - this is being escalated nationally

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**
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) To Evidence: > 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 for all Statutory Mandatory Training across Job Families? (LearnPro & SHaW) > Is Role specific education and training in place as required?	yes	
Systems and processes include means to determine the level of training required, and time and resource to support this, for all relevant employees. To Evidence > Promotion of Turas Modules based on staff roles and responsibilities for HCSSA locally? > How is awareness, and any training required to comply with RTS & RE or TtL SOPs promoted and recorded? > 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?	yes	
Systems and processes include the means to ensure all relevant employees receive both time and resources to undertake the training. > Identify how this is recorded, monitored and reviewed, where system / automated reporting is not available?	yes	

Required * Complete the table to the Left

Required ** Complete the table below

Action	Time scale #	Lead	Governance	Risks
1Continue to promote awareness and completion of HCSA TURAS modules Promote the HCSSA Webpage in Professional and Operational structures & encourage staff to look at the resources especially the FAQs, SOP's and Case Studies from varied services	Ongoing	VT/HHHR	WF HCSA Group	Unable to report on TURAS module completion
2				
3				
4				
5				
6				
7				
8				
9				
10				

Please provide estimated date for action to be completed with Evidence available for due diligence

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 needs to be able to be obtained should it be requested for Due Diligence or a HIS Info request.

Evidence Source	Summary	Location
CSM Reports to SMT and to END	Common staffing method triangulation meetings take place following the use of the mandated service level tools in all areas in scope .	HSCP Shared Drive
Service level Staff Training Records	All training opportunities advertised widely , staff encouraged to attend and provided with time to do so. NHSGGC predicted absence allowance adhered to as per rostering policy. This is regularly reviewed with service managers and team leaders .	Service Level
Completed Common Staffing Method Reporting Templates -	Reported via SMT with local reports prior to submission to SMT. Common staffing method successfully implemented and informs discussion around workforce requirements and proposed efficiencies / clinical advice being sought systematically in this process and this supported robust transparent decision making	Shared Drive
Service level Feedback /Care Opinion /Complaints /	Quality metrics . Complains and service user and care feedback are used to inform CSM triangulation discussions . Care Opinion introduced in September 2026 . Agreed via CCG that all upheld level 2 complaints will require reflective account and action plan from	Various
Triangulation Meetings	Meetings take place - 3 levels following completion of workload tools and triangulation meetings - fed back via HOS ?Senior Nurse / Manager t team Leads and to Practitioners . I matters completion	Captured and recorded on CSM documentation
Use of Datix risk Module Certain Services	Datix reports / risk assessments and escalation re staffing mitigations - Baseline Cover guidance Health visiting / service business continuity plans / risk	Service Files SMT reports

Evidence Section does not need to match checklist line for line, if included in a single process/document

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. To Evidence >CSM Reporting Template is utilised	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 and include the means to deliver the agreed level of training to all relevant employees. To Evidence > Training sessions are planned and promoted as required >All relevant staff which this duty applies to are encouraged to attend relevant training sessions and receive time to attend >Predicted absence allowance is applied to relevant job families	Yes	
The Common Staffing Method has been applied on an annual basis over a two week period in the legislated areas of practice and all elements of the Common Staffing Method have been included To Evidence > Awareness of the SLT Timetable and planning for its application > CSM SOP awareness and application > Toolkits utilised > CSM Reporting Template utilised > CSM Local Report produced	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). To Evidence >CSM Local Report produced	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. To Evidence >CSM Reporting Template utilised	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. To Evidence >Datix Risk Module or Converted Risk Report from non Datix Risk System		Partial
"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. To Evidence > CSM SOP awareness and application > CSM Reporting Template utilised > CSM Local Report produced	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. 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 To Evidence > CSM SOP awareness and application > CSM Reporting Template utilised	yes	

Areas of Shared Learning or Success to Spotlight

Areas of Challenge or Concern & Mitigations Required
Funding challenge - HSCP financial constraints - responding to need identified via CSM
Managing expectations of staff - in response to staffing level tool completion
Managing anxieties of those with no staffing level tool that their needs will be assessed and given due

"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, 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 and are given adequate time to use it. To Evidence >CSM SOP awareness and application >CSM Reporting Template utilised > Toolkits utilised >HCSSA Informed / Skilled level Learning promoted and taken >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). To Evidence >CSM SOP awareness and application >CSM Reporting Template utilised	Yes	
Required * Complete the table to the Left	Required ** Complete the table below	

Action	Time scale #	Lead	Governance	Risks
1Continue to implement CSM - optimise communication around this duty and the impact of completion of CSM	Ongoing	VT	SMT/CCG	Failure to demon
2. Ensure where Datix module (or agreed alternative) is being used systematically or consistently record staffing incidents that require escalation. Strengthen assurance from integrated teams - particularly where there are small numbers of Allied Health Professionals within these teams.	End Aug 2026	VT	SMT	There is a small risk that oversight of staffing risks may not be reported and escalated effectively
3				
4				
5				
6				
7				
8				
9				
10				
Please provide estimated date for action to be completed with Evidence available for due diligence				

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT & PERFORMANCE COMMITTEE

Report by Gillian McConnachie, Chief Internal Auditor

22 September 2026

Subject: Audit Plan Progress Report and Audit Plan 2026-27**1. Purpose**

- 1.1** The purpose of this report is to enable WD HSCP Board Audit and Performance Committee members to monitor the performance of Internal Audit and gain an overview of the WD HSCP Board's overall control environment.
- 1.2** The report also presents an update on the Internal Audit work undertaken at West Dunbartonshire Council and NHS Greater Glasgow and Clyde (NHSGGC) since the Audit Committee meeting in March 2026 that may have an impact upon the WD HSCP Board's control environment.

2. Recommendations

- 2.1** It is recommended that the Audit and Performance Committee approve the indicative Internal Audit Plan for 2026-2027 and note the progress made in relation to the Internal Audit Annual Plan for 2026-27.

3. Background

- 3.1** In June 2026, the Audit and Performance Committee was provided with an initial indication of activity to be undertaken during 2026-27 and was informed that further work on the potential audit coverage and detailed implementation of a risk-based audit plan would be carried out, including discussions with senior management, a review of the Corporate Risk Register and of prior audit coverage.
- 3.2** This work has now concluded and the Internal Audit Plan for 2026-27 is now provided at **Appendix 1**. This includes both activity specifically on the HSCP Board activity and on HSCP operational activity.

4. Main IssuesHSCP Board Audit Plan Update 2026-27

- 4.1** The annual audit plan sets out the audit coverage for the year utilising available staff resources to enable the Chief Internal Auditor to provide the annual internal audit opinion regarding the adequacy and effectiveness of internal control within West Dunbartonshire HSCP.

- 4.2** Work on delivering the audit plan for 2026-27 is at an early stage, with a key dependency being successful recruitment into the vacant Auditor post.

Follow-Up Work

- 4.3** When audit reports are issued by Internal Audit, an action plan is agreed with management in relation to issues highlighted by the audit report. Progress on implementing the actions is monitored by Internal Audit on a monthly basis and reported to the Audit Committee.

Internal Audit Action Plans

- 4.4** The current status of internal audit action plans is included at Appendix 1.

External Audit Action Plans

- 4.5** An update on external audit action plans is included at Appendix 2.

West Dunbartonshire Council Internal Audit Update

- 4.6** There were no Internal Audit reports issued to the Council in the period since the last committee which are relevant to the WD HSCP Board.

NHSGCC Internal Audit Update

- 4.1** The NHSGCC Internal Audit Plan for 2026/27 includes the following areas of focus, to be delivered by Azets:

Review	Planned Days
Performance Monitoring	44
Estates – Repairs and Maintenance	45
Payroll	45
Non-Pay expenditure	35
Waiting Times Management	45
Duty of Candour	40
Staff Absence Management	40
Resident Doctor Compliance: Working Time and Reward	40
Cyber incident readiness	35
Digital Strategy	35
Property Transaction Monitoring	8
Follow Up	30

- 4.2** Since the last update to this committee, there were two Internal Audit reports issued to the NHSGGC Board which may be considered relevant to the WD HSCP Board as follows:

Audit Title	Rating	Number and Priority of Recommendations			
		4	3	2	1
Duty of Candour (1)	Minor improvement required	0	2	8	1
Property Transaction Monitoring	Effective	0	0	1	0
Total		0	2	9	1

(1) Duty of Candour - the grade 3 recommendations relate to developing formal arrangements for monitoring compliance with Duty of Candour training requirements and to develop a centralised electronic repository for adverse event review documentation and Duty of Candour evidence.

- 4.3** Action plans have been agreed with NHSGGC management to address the above issues. Internal Audit at NHSGGC undertakes follow up work to confirm the implementation of agreed actions and report on progress to their Audit Committee.

5. Options Appraisal

- 5.1** Not required for this report.

6. People Implications

- 6.1** There are no personnel issues with this report.

7. Financial Implications

- 7.1** There are no financial implications with this report.

8. Risk Analysis

- 8.1** The annual audit plan for 2026-27 was prepared taking cognisance of the risks included in the WD HSCP Board risk register. Consultation with the Chief Officer and the Chief Financial Officer is being carried out to ensure that risks associated with delivering the strategic plan are considered.

9. Equalities Impact Assessment (EIA)

9.1 Not required for this report.

10. Environmental Sustainability.

10.1 There are no issues.

11. Consultation

11.1 The Chief Financial Officer has been consulted on the content of this report.

12. Strategic Assessment

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

13. Directions

13.1 This report does not require a Direction.

Gillian McConnachie
Chief Internal Auditor

22 September 2026

Person to Contact: Gillian McConnachie, Chief Internal Auditor
E-mail – gillian.mcconnachie@eastdunbarton.gov.uk

Appendices: Appendix 1 – Internal Audit Plan 2026-27
Appendix 2 – Status of Internal Audit Actions at 31 August 2026
Appendix 3 – Status of External Audit Actions at 31 August 2026

Background Papers: None

Appendix 1

**Internal Audit
Plan
West Dunbartonshire Health & Social
Care Partnership Board
2026-27**

Internal Audit Plan 2026-27

Background

The Annual Internal Audit Plan is prepared on an annual basis, detailing the work that the Internal Audit team plan to carry out in the year ahead. Planning the work is important to demonstrate that Internal Audit is proactive and that the activities are targeted to areas of risk and need. The Plan also must be flexible so that Internal Audit can react to events that might happen during the year.

The Annual Internal Audit Plan is prepared by the West Dunbartonshire Health and Social Care Partnership (WDHSCP) Board's Chief Internal Auditor and presented to the Audit & Performance Committee.

Plan

The plan for 2026-27 is specified to provide adequate evidence relating to the WDHSCP Board's systems to enable the Chief Internal Auditor to provide a year-end opinion. This will be closely monitored and the Audit & Performance Committee will be kept informed of any change in the situation, with resources and expected outturn monitored as the year progresses.

The plan includes the work directly related to the WDHSCP Board such as consultancy advice on development of the new Strategic Plan and also operational areas for which HSCP management have responsibility.

Planning Process

The planning process begins with Internal Audit's perspective included in an annual assessment of risks which is compared to Senior Management's expectations. This includes not only our understanding of systems and controls but also the WDHSCP Board's goals, external risks and current economic climate. The following alternative sources of assurance are also considered at the planning stage: external reports on the WDHSCP Board, the WDHSCP performance reports, the risk registers, how the WDHSCP Board manages its risks and where improvements are required.

All auditors in the team have an accounting or internal audit qualification. When one of our stakeholders reads an Internal Audit Report they can be assured that it has been prepared with due recognition of all the best practices, ethics and professional responsibilities, as is required.

Having worked through all of the above, Internal Audit have a considerable amount of information and potential areas for review. Internal Audit cannot cover all areas of risk and we need to make sure what we plan to do is manageable and balanced against the abilities of the team.

The Plan for 2026-27 includes a number of key areas of need to be reported on. However, and consistent with prior years audit days will be assigned in the Plan to each assignment, based on an assessment of the relative risks of the audits planned and the expected complexities involved in undertaking the audit work. The work has been planned to enable Internal Audit to draw conclusions on the WDHSCP Board as a whole.

Future Reporting will determine the focus of the Internal Audit Team with the following principles applying:

- The internal audit team will remain flexible and responsive to emerging risks and requests for assurance over new processes. This may lead to changes to the plan in the course of the year and ensures that the work remains risk focussed.
- The higher priority audits remain top priority for completion; and,
- Service demands, audit resource availability, key officer availability and the skills mix of the individual members of the internal audit team will also be considered when scheduling audits.

Key areas of Audit Focus

Our ambitious plan of work has identified the following as key areas for review. These will be reviewed across the period to March 2027:

- *WDHSCP Board - Strategic Planning and Performance Management Arrangements*
- *WDHSCP Board - Annual reporting*
- *Follow up work*
- *Absence Management*
- *Delayed Discharge Arrangements*
- *Regularity - Section Payments*

Consideration has also been given as to how the Internal Audit plan aligns to the WDHSCP Board's Strategic Plan. Audits will consider whether the controls in place are adequate to support the achievement of the system's objectives.

Internal Audit Plan – Working to a Standard

The Internal Audit Plan

Planning for 2026-27 is based on a documented risk assessment process. The process uses the WDHSCP Board's existing Risk Registers, the expectations of stakeholders, whilst considering the WDHSCP Board's Strategic Priorities.

Planning takes into account the requirement to produce an annual audit opinion. This opinion is delivered through the statement on the adequacy and effectiveness of the WDHSCP Board's framework of governance, risk management and internal controls. The statement is included within the 'Internal Audit Annual Report' presented each year to the meeting of the Audit & Performance Committee following the end of the financial year and is used to inform the governance statement included in the annual accounts.

Planning is linked to the Internal Audit Charter, ensuring that activities are consistent with existing direction, organisational objectives and priorities.

Audit Resources

The Chief Internal Auditor plans to confirm that, in her opinion, their planned resources are appropriate and sufficient and will be effectively deployed to provide the required assurances to stakeholders. The provision of the internal audit service is through a directly employed in-house team. The Chief Internal Auditor is provided through a shared arrangement with East Dunbartonshire and Inverclyde Councils.

Planning is developed to ensure that staff availability, qualifications, experiences and skills are sufficient and appropriate. The process is supported by the Council's Be the Best Conversations Framework providing an ongoing mechanism to assess the effectiveness of staff in their roles and supporting future developments through training.

In relation to the total staff days allocated to the 2026-2027 plan, a resource allocation spreadsheet is completed for each member of staff which is split between annual leave, public holidays, training days, general administration and operational plan days. The operational plan includes 26 days in relation to the WDHSCP Board Internal Audit activity and 65 days in relation to HSCP services and processes. The detail of the planned audits is shown in Table 1.

The Chief Internal Auditor continually reviews the available resources to ensure that the Plan continues to be achievable. The impact of uncertain or unanticipated resource changes may need to be reported to Members where this affects the ability of the team to deliver the plan.

Staff training and coaching are being used to good effect to aid in delivery of the Plan. In addition, the budgeted allocation for administrative time has been reviewed to ensure that the application of resources continues to be reasonable. The Chief Internal Auditor does not ordinarily carry out the assignments included in the annual audit plan but provides the technical quality review and oversight of the delivery of the overall plan. Time is also set aside for overall audit planning, reporting on Internal Audit performance and attending the Audit & Performance Committee. Where there are any resource issues which may impact on delivery of the plan, this will be reported to Audit & Performance Committee at the earliest opportunity.

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 in the UK Public Sector require that the Chief Internal Auditor must hold a professional qualification such as CMIIA (Chartered Internal Auditor), a professional accountancy qualification or equivalent and be suitably experienced.

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 a personal training record for Continuing Professional Development purposes.

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. An annual declaration is undertaken by staff in relation to specific aspects of the Code.

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 relevant senior manager responsible for implementing the agreed action plan.

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

Policies and Procedures

The Internal Audit Manual serves as the Internal Audit Team's policies and procedures. The Internal Audit Manual is aligned to the provisions of the Public Sector Internal Audit Standards and, in complying with the manual, the team is demonstrating compliance with the standards. The Public Sector Internal Audit Standards (PSIAS) were the previous applicable standards that the Internal Audit team conformed with. From 1 April 2025 GIAS-UKPS became the applicable standards.

The Manual is reviewed on an ongoing basis with significant reviews taking place following changes in guidance, good practice or prevailing standards. A full review will be undertaken in 2026-27, to ensure full compliance with Global Internal Audit Standards in the UK Public Sector (GIAS-UKPS).

Coordination with External Scrutiny Bodies

The Chief internal Auditor is required to share information with other providers of assurance and consulting services to ensure proper coverage and minimise duplication of efforts.

The External auditors, Forvis Mazars, audit plan for the 2025-26 accounts includes the intention to where possible use the work performed by internal audit when designing the nature, extent and timing of audit procedures. Forvis Mazars will discuss with internal audit our work and findings prior to commencing controls evaluation procedures.

Where Forvis Mazars intend to rely on the work of internal audit they will evaluate the work performed by internal audit and then perform their own procedures to determine the adequacy of that work for the audit.

Reporting to Senior Management and the Board

As part of this plan, the Chief Internal Auditor will prepare and present regular performance reports to the Audit & Performance Committee over the course of the financial year. The internal audit monitoring reports will review progress against the original plan in the interests of consistency and accountability. Performance reports will capture the activities of the Internal Audit Team relative to the original plan.

Ongoing reporting will also highlight specific issues as they relate to risk exposures, control issues, fraud, governance or any other matters that the Chief Internal Auditor deems appropriate for consideration by the Committee. Significant issues will also be captured within the annual internal audit report.

On an annual basis, the Chief Internal Auditor will provide a report that will include the purpose, authority and responsibilities relative to the plan but also any significant issues noted in the above.

2026-27 Audit Work

The indicative planned number of days allocated to audit area is *Table 1*. Internal Audit activity evaluates and contributes to the improvement of governance, risk management and control processes using a systematic and disciplined approach as outlined in the Internal Audit Charter.

Planned audit work includes consideration of assurance audits and regularity work. This varied application of audit resources ensures that different aspects of WDHSCP Board business have been subjected to testing, with assurances being sought over a range of activities.

Overall Opinions

Following the completion of the audit plan an overall opinion will be issued, taking into account the strategies, objectives and risks of the WDHSCP Board and the expectations of senior management, the Audit & Performance Committee and other stakeholders. The overall opinion must be supported by sufficient, reliable, relevant and useful information.

Internal Audit Plan – Allocations and Activities

TABLE 1 – Audit Planned Activities 2026-27

1 a. WDHSCP Board Internal Audit Plan – provided by West Dunbartonshire Council’s Internal Audit Service

Outputs	Area	Review	Planned Days	Rationale	Priority
1	2 - Regularity	Annual Audit Report	2	Annual report	1
2	2 - Regularity	Follow Up	2	Follow up on previously issued recommendations	1
3	2 - Regularity	Internal Audit Plan 2027-28	2	Planning for forthcoming year.	1
4	3 - Consultancy	WDHSCP Board - Strategic Planning and Performance Management Arrangements	20	Provision of consultancy advice as new Strategic Plan is developed	2
Total Days Allocated			26		

1 b. HSCP Internal Audit Plan– provided by West Dunbartonshire Council’s Internal Audit Service

Outputs	Area	Review	Planned Days	Rationale	Priority
1	1 - Audit	Absence Management	15	To provide assurance that absence procedures are being adhered to with a focus on Homecare.	2
2	1 - Audit	Delayed Discharge Arrangements	25	To review processes in place to ensure delayed discharges are minimised.	2
3	2 - Regularity	HSCP Section Payments	25	Reviewing the application of controls around cash payments.	3
Total Days Allocated			65		

**WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF INTERNAL AUDIT ACTIONS
AT 31 AUGUST 2026**

**Summary: Section 1 Summary of Management Actions due for completion by
31/08/2026**

There were no actions due for completion between 1 May
and 31 August 2026.

Section 2 Summary of Current Management Actions at 31/08/2026

At 31 August 2026 there were no audit reports delayed due
to management not finalising the action plan within agreed
timescales.

Section 3 Current Management Actions at 31/08/2026

At 31 August 2026 there were 2 current audit actions.

Section 4 Analysis of Missed Deadlines

At 31 August 2026 there were 2 audit actions where the
agreed deadline had been missed.

**WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF INTERNAL AUDIT ACTIONS**

SUMMARY OF MANAGEMENT ACTIONS DUE FOR COMPLETION BY 31.08.2026

SECTION 1

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

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

**WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF INTERNAL AUDIT ACTIONS**

SUMMARY OF CURRENT MANAGEMENT ACTIONS AS AT 31.08.2026

SECTION 2

CURRENT ACTIONS

Month	No of actions
Due for completion September 2026	1
Completion date to be advised	1
Total Actions	2

**WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF INTERNAL AUDIT ACTIONS
ANALYSIS OF MISSED DEADLINES**

SECTION 4

Action	Owner	Expected Date	Status
IJB Workforce Planning Arrangements (August 2023)			
Adequacy of Succession Planning Arrangements (Amber) All Heads of Service will work with the Head of HR to embed succession planning through service planning structures and through annual performance reviews. Additionally, the Head of HR will consider any additional leadership resource requirements to enable visibility across services and create the conditions for engagement. IAAP/181	Head of HR	31.03.27	
Adequacy of Training (Green) The HSCP Finance Manual and supporting appendices were issued to all Heads of Service on 23 June 2026, and cascaded to budget holders. An in-person training session was delivered on 25 June 2026, attended by 13 budget holders representing a cross-section of health and social care services, including Children's, Adult and Older People's Services. Feedback from the post-training survey was positive and has been used to further refine the training materials. The manual, appendices and survey results have been retained as supporting evidence. Training will be rolled out in 2 more sessions across remaining budget holders by the end of September and mid-October, supported by our Senior OD advisor. The Finance Team maintains regular contact with budget holders through routine budget monitoring arrangements and will continue to identify, address and support as required. IAAP/254	Chief Financial Officer and Head of HR	30.09.26*	

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

SECTION 4

Report	Action	Original Date	Revised Date	Management Comments
IJB Workforce Planning Arrangements (August 2023)	Adequacy of Succession Planning Arrangements (Amber) All Heads of Service will work with the Head of HR to embed succession planning through service planning structures and through annual performance reviews. Additionally, the Head of HR will consider any additional leadership resource requirements to enable visibility across services and create the conditions for engagement.	31.03.24 31.10.25	31.03.27	The Interim Workforce and OD Plan (2025–2027) was approved by the IJB in August 2026. The 2027–2032 plan, which will continue to include succession planning as a key priority, is scheduled to go to the IJB for approval in March 2027. Earlier this year, succession planning discussions were undertaken with all Heads of Service, and a succession planning matrix was completed for senior and critical roles across the HSCP. This provided a clearer understanding of areas of strength, potential workforce risks, and the development required to support future leadership capacity. The review identified a mixed picture. A number of services have strong potential successors and established talent pipelines, with some individuals already undertaking duties at a higher level. However, succession risks were identified in a small number of critical senior leadership roles, particularly where there are limited 'ready now' successors, specialist professional requirements, or potential retirement risks over the next few years. Common development themes included leadership and management capability, quality improvement, use of data for performance management, and strategic leadership skills. These priorities have now been incorporated into the Workforce Plan and will inform future organisational development and leadership interventions.

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

SECTION 4

Report	Action	Original Date	Revised Date	Management Comments
IJB Budgetary Control Arrangements (April 2025)	Adequacy of Training (Green) Training materials already developed and HSCP Finance Manager working with Senior OD Manager on full roll out.	31.03.26	30.09.26	The HSCP Finance Manual and supporting appendices were issued to all Heads of Service on 23 June 2026. An in-person training session was delivered on 25 June 2026. Feedback from the post-training survey was positive and has been used to further refine the training materials. Training will be rolled out in 2 more sessions across remaining budget holders by the end of September and mid-October.

WEST DUNBARTONSHIRE PARTNERSHIP BOARD INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF EXTERNAL AUDIT ACTION PLAN POINTS AT 31 AUGUST 2026

Summary: Section 1 Summary of Management Actions due for completion by 31/08/2026

There were no actions due for completion by 31 August 2026.

Section 2 Summary of Current Management Actions Plans at 31/08/2026

At 31 August 2026 there were no audit reports delayed due to management not finalising the action plan within agreed timescales.

Section 3 Current Management Actions at 31/08/2026

At 31 August 2026 there was one current audit action.

Section 4 Analysis of Missed Deadlines

At 31 August 2026 there were no audit actions where the agreed deadline had been missed.

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

SUMMARY OF MANAGEMENT ACTIONS DUE FOR COMPLETION BY 31.08.2026

SECTION 1

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

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

**WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF EXTERNAL AUDIT ACTIONS**

SUMMARY OF CURRENT MANAGEMENT ACTIONS AS AT 31.08.2026

SECTION 2

CURRENT ACTIONS

Month	No of actions
Due for completion September 2026	1
Total Actions	1

**WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF EXTERNAL AUDIT ACTIONS**

CURRENT MANAGEMENT ACTIONS AS AT 31.08.2026

SECTION 3

Action	Owner	Expected Date	Status
Annual Audit Report (September 2025)			
Financial Management (Training for budget holders) – Level 3 Recommendation The IJB should ensure refresher training is provided to budget holders to ensure procedures are understood and consistently applied. Management Response Training pack has been finalised after a well-received pilot session on 25 June with a cross section of budget holders. On track to be fully rolled out by end of September through to mid-October.	HSCP Board Chief Financial Officer/Head of Human Resources	30.09.26	

Status Key

	On track		Complete
	Overdue – update required		Missed original due date

* See analysis of missed deadlines – Section 4

**WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF EXTERNAL AUDIT ACTIONS
ANALYSIS OF MISSED DEADLINES**

SECTION 4

Report	Action	Original Date	Revised Date	Management Comments
There were no actions where the original due date was missed.				

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP**AUDIT AND PERFORMANCE COMMITTEE****Report by Beth Culshaw, Chief Officer****22 September 2026**

**Subject: West Dunbartonshire Health and Social Care Partnership (HSCP)
Quarterly Performance Report 2026/27 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 West Dunbartonshire HSCP Strategic Plan 2023-2027: Improving Lives Together.
- 1.2** This report presents the HSCP performance information reported against the strategic priorities for the period April to June 2026 (Appendix I) for the Committee's 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 2026/27 Quarter One and performance against the Strategic Plan 2023 - 2027 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 Local targets have been reviewed for 2026/27 and used in this report. 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 – 2027: 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 It should be noted that due to timing issues this report presents partial Quarter One data.

4.4 The HSCP have 45 performance indicators. Of the 37 reported on in Quarter One, 10 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:
- Failure to have in place strong social work and social care governance in relation to quality of services and care provided, reliable and accessible data to provide assurance, ability to ensure through measures that statutory requirements are met and reported on, and adequate quality assurance and monitoring methods are in place.
- 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: Beth Culshaw
Designation: Chief Officer

Date: 22 September 2026

Person to Contact: Alastair Handley
Systems, Digital & Information Governance Manager
West Dunbartonshire Health and Social Care Partnership
16 Church Street
Dumbarton
G82 1QL

Email: alastair.handley@west-dunbarton.gov.uk

Appendices: West Dunbartonshire HSCP Performance Report
2026/27: Quarter One April to June 2026

West Dunbartonshire Health & Social Care Partnership

West Dunbartonshire Health and Social Care Partnership Performance Report 2026/27: Quarter 1 April to June 2026

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, which has been extended to March 2027.

Unscheduled Care targets for emergency hospital admissions, unplanned bed days and A&E attendances are currently being considered as part of the Transforming Together Agenda. Due to the validation and timing of Public Health Scotland data, no Quarter 1 figures are yet available for these measures.

All other local targets have been reviewed for 2026/27.

Key Highlights/Challenges

- A projected year-end overspend of £0.664m, or 0.30%, against the revised annual revenue budget of £224.817m.
- 91.1% of looked after children being looked after in the community.
- All children and young people continue receiving Child and Adolescent Mental Health Services treatment within 18 weeks of referral and an average wait of 3 weeks.
- All children on the Child Protection Register have a completed and current risk assessment.
- Psychological Therapies successfully recruited to a 1.0 WTE Band 7 12- month fixed term post, starting at the end of August 2026.
- Significant challenges in relation to delayed discharge. Additional senior management resource has been deployed for a three-month period to review pathways, processes and workload management.
- An intermediate discharge team model implemented at the Vale of Leven Hospital, involving Social Work and Allied Health Professional participation in ward rounds.
- Criminal Justice Social Work recruited two fixed term qualified social worker posts until March 2027.
- Improvement in MSK Physiotherapy maximum wait for the service has decreased by two weeks within Quarter 1.
- £1.2 million in funding to address waiting times across Greater Glasgow and Clyde for MSK Physiotherapy over the next 2 years. As a result, 8 additional posts are currently out to advertisement to increase service capacity.
- A sustained reduction in NHS absence over the previous three quarters and an improvement in Council absence this quarter.

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 2026/27					Q4 2025/26	Q1 2025/26	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	92.7%	95%	L			96.6%	97.4%	
2	Percentage of carers who feel willing to continue in their caring role when asked through their Adult Carer Support Plan	96.4%	95%	L			100%	98.7%	
3	Number of Adult Carer Support Plans completed	55	N/A	M			58	77	
4	Balance of Care for looked after children: % of children being looked after in the Community	91.1%	90%	N			90.5%	89.3%	
5	Number of Looked After Children	448	N/A	M			432	484	
6	Number of Looked After children looked after in a residential setting	40	N/A	M			41	52	
7	Number of Looked After children looked after at home with parents	91	N/A	M			76	86	
8	Number of Looked After children looked after by foster carers	107	N/A	M			105	120	
9	Number of Looked After children looked after in other community settings (includes kinship, friends/relatives, placed for adoption, supported accommodation and other community settings)	210	N/A	M			210	226	

Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
10	Child and Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	100%	90%	N			100%	100%	
11	Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services	5	18	L			5	4	
12	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	58.5%	90%	N			51.9%	48.5%	
13	Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	Published September	90%	N	Not yet available	Not yet available	90.6%	98.4%	

Safe and Thriving Communities

Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	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 from IRD meeting	11%	95%	N		N/A	Was paused – Now being reported from IRD meeting date		
16	Number of Child Protection investigations	102	N/A	M			84	86	
17	Number of children on the Child Protection Register at end of reporting period	50	N/A	M			45	69	
18	Number of children referred in total to the Scottish Children's Reporter Administration (SCRA) on non-offence (care and protection) ground	106	N/A	M			153	180	
19	Number of children referred in total to the Scottish Children's Reporter Administration (SCRA) on offence grounds	23	N/A	M			21	32	
20	Percentage of Adult Support and Protection clients who have current risk assessments and care plan/protection plan	54%	100%	N			88.5%	64.3%	
21	Number of delayed discharges over 3 days (72 hours) non-complex cases	50	0	N			30	22	
22	Number of acute bed days lost to delayed discharge 18+ All reasons	4,702	3,420	L			4,746	3,512	

Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
23	Number of acute bed days lost to delayed discharge 18+ Complex Codes	1,223	1,422	L	✓	↑	1,509	1,303	
24	Number of acute bed days lost to delayed discharges 65+ All reasons	3,524	2,694	L	✗	↓	3,439	2,927	
25	Number of acute bed days lost to delayed discharge 65+ Complex Codes	679	1,049	L	✓	↑	1,030	929	
26	Number of people receiving Telecare/Community Alarm service - All ages	1,845	N/A	M		↓	1,858	1,818	
27	Number of people receiving homecare - All ages	1,159	N/A	M		↓	1,189	1,116	
28	Number of weekly hours of homecare - All ages	9,847	N/A	M		↑	8,798	7,242	

Equal Communities									
Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
29	Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	68.9%	98%	N	✗	↑	65%	69.6%	
30	Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.	67%	80%	N	✗	↓	68.4%	67.7%	
31	Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	11.8%	80%	N	✗	↓	33.3%	32.9%	
32	Percentage of children from BME communities who are looked after that are being looked after in the community	87%	90%	L	⚠	↓	88.9%	81.3%	
33	Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	100%	80%	L	✓	↑	66.7%	50%	
34	Percentage of people under 65 consenting to a referral for benefits maximisation at point of assessment/review	14%	N/A	M		↓	15.7%	25.8%	
35	Percentage of people aged 65 and over consenting to a referral for benefits maximisation at point of assessment/review	21.1%	N/A	M		↑	9.6%	9.1%	

Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
36	Percentage of females consenting to a referral for benefits maximisation at point of assessment/review	13%	N/A	M			11.6%	8.5%	
37	Percentage of males consenting to a referral for benefits maximisation at point of assessment/review	27.7%	N/A	M			11.4%	17.1%	

Healthy Communities									
Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
38	Number of emergency admissions 18+	Not yet available	1,989	L	Not yet available	Not yet available	Not yet available	2,260	
39	Number of emergency admissions aged 65+	Not yet available	1,066	L	Not yet available	Not yet available	Not yet available	1,149	
40	Number of unscheduled bed days 18+	Not yet available	20,094	L	Not yet available	Not yet available	Not yet available	23,180	
41	Unscheduled acute bed days (aged 65+)	Not yet available	14,565	L	Not yet available	Not yet available	Not yet available	16,134	
42	Number of Attendances at Accident and Emergency 18+	Not yet available	5,005	L	Not yet available	Not yet available	5,685	6,295	
43	Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	38%	90%	N			37%	31%	
44	Prescribing cost per weighted patient (Annualised)	Not yet available	£199.38	N	Not yet available	Not yet available	£180.33	£179.35	
45	Compliance with Formulary Preferred List	Not yet available	78%	N	Not yet available	Not yet available	74.58%	74.28%	

Financial Update

The HSCP Board considered the 2026/27 Financial Performance Period 3 Report at its meeting on 18 August 2026. The report provided an update on the financial position to 30 June 2026 and an early projection to 31 March 2027, based on activity and financial performance during the first quarter of the year.

At Period 3, the year-to-date position is a small underspend of £0.118m, representing 0.23% of the budget for the first three months. However, the latest forecast projects a year-end overspend of £0.664m, or 0.30%, against the revised annual revenue budget of £224.817m. This is an early forecast and will continue to be refined as further activity and expenditure data becomes available.

Key Financial Risks

- Care at Home demand, capacity and commissioned care costs.
- Emerging General Medical Services cost pressures.
- Delivery of the 2026/27 savings programme.
- Potential reliance on unearmarked reserves to support the year-end position.
- Medium-term financial sustainability and projected funding gaps.

The main pressures continue to be in Adult and Older People services, particularly Care at Home and externally commissioned non-residential care packages. These pressures are linked and reflect demand across the wider older people care pathway, where capacity within HSCP delivered services, complexity of need and reliance on external provision all influence both performance and cost. Recent recruitment and full implementation of Care at Home work patterns are expected to improve internal capacity and reduce reliance on agency staffing, overtime and external commissioning as the year progresses, although this remains a key assumption within the forecast position.

There is also an emerging financial risk within General Medical Services. Early forecasts indicate a potential overspend across NHS Greater Glasgow and Clyde, with West Dunbartonshire HSCP's share currently estimated at around £0.250m. This is mainly linked to superannuation, locum and premises-related costs, and remains subject to ongoing discussion with the Health Board and Scottish Government.

Delivery of the 2026/27 savings programme remains critical. Savings totaling £5.080m are being monitored, with around 41% assessed as achieved or on track at this stage. The remaining savings require further action and will continue to be monitored by the Senior Management Team.

The forecast overspend remains subject to ongoing management action across all service areas. Maintaining financial balance through expenditure control, delivery of planned savings and active management of demand pressures remains a collective responsibility across the HSCP. Should the forecast overspend materialise, a drawdown from unearmarked reserves would be required.

The continued use of reserves to support recurring expenditure reduces financial resilience and reinforces the need to deliver sustainable recurring savings and address the underlying drivers of demand and cost growth.

Looking ahead, the 2027/28 budget setting process will commence shortly. Current modelling indicates medium-range budget gaps of £10.4m in 2027/28 and £14.3m in 2028/29 if current demand and cost pressures continue. A refreshed budget gap analysis and updated medium-term financial outlook will be reported to the HSCP Board as the budget development process progresses.

Absence

NHS Absence – Quarterly Cumulative Position

- Quarter 3 (Oct-Dec): 8.03%
- Quarter 4 (Jan-Mar): 6.82%
- Quarter 1 (Apr-Jun): 6.18%

Trend Analysis – NHS

NHS absence has shown a sustained improvement over the last three quarters. Following a peak of 8.03% in Quarter 3, absence reduced to 6.82% in Quarter 4 and further improved to 6.18% in Quarter 1. This represents an overall reduction of 1.85 percentage points across the period.

The downward trend suggests that the significant winter pressures experienced during Quarter 3 have eased, with absence levels continuing to stabilise into the new financial year. If Quarter 1 levels were sustained across a full year, the annualised absence rate would be 6.18%.

Council Absence – Quarterly Cumulative Position

- Quarter 3 (Oct-Dec): 10.64%
- Quarter 4 (Jan-Mar): 11.84%
- Quarter 1 (Apr-Jun): 9.77%

Trend Analysis – Council

Council absence remained at a high level throughout the period, increasing from 10.64% in Quarter 3 to 11.84% in Quarter 4 before reducing significantly to 9.77% in Quarter 1. The Quarter 1 figure represents an improvement of 2.07 percentage points compared with Quarter 4 and an overall reduction of 0.87 percentage points compared with Quarter 3.

While the recent decrease is encouraging, absence levels remain elevated and continue to present workforce capacity challenges. If Quarter 1 levels were sustained across a full year, the annualised absence rate would be 9.77%.

Overall Position

The most recent quarter demonstrates improving absence trends across both NHS and Council workforces. NHS absence has reduced steadily over the three-quarter period, falling from 8.03% in Quarter 3 to 6.18% in Quarter 1. Council absence increased during Quarter 4 before reducing to 9.77% in Quarter 1, representing its lowest position across the reporting period.

While absence levels and patterns differ across the two workforces, both services have shown improvement in the most recent quarter. Attendance performance remains a key priority, with continued focus on supporting employee wellbeing, attendance management and workforce resilience.

Conclusion

The cumulative quarterly analysis demonstrates:

- A sustained reduction in NHS absence over the three-quarter period.
- An improvement in Council absence in Quarter 1 following an increase in Quarter 4.
- Positive attendance trends across both workforces in the most recent quarter.
- The continuing importance of targeted attendance support and wellbeing interventions to maintain workforce resilience and service continuity.

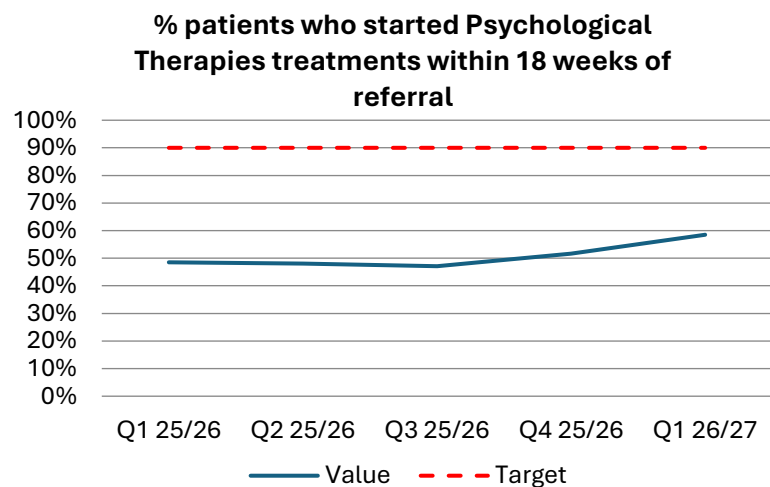
Absence performance will continue to be monitored, with further analysis undertaken to understand contributory factors and support ongoing improvement activity.

West Dunbartonshire Health and Social Care Partnership Exceptions Reporting: Quarter 1 April to June 2026

Performance Area: Psychological Therapies

Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	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	58.5%	90%	N			51.9%	48.5%	

Quarter	Value	Target
Q1 25/26	48.5%	90%
Q2 25/26	48.1%	90%
Q3 25/26	47.1%	90%
Q4 25/26	51.9%	90%
Q1 26/27	58.5%	90%



Key Points:

83 of the 142 people who started psychological therapies between April to June 2026 did so within 18 weeks of referral.

Clients on the waiting list may be awaiting specific treatments such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), Eye Movement Desensitisation and Reprocessing Therapy (EMDR) and Interpersonal Psychotherapy (IPT). These require specialist-trained clinicians, which contributes to longer wait times.

Some client preferences are also accommodated, e.g. gender of clinician and in some cases where appropriate, mode of delivery: face-to-face or remote sessions.

No assessment input from Wellbeing Nurses at present.

Improvement Actions:

Successfully recruited to the 1.0 WTE Band 7 12- month fixed term post (starting at the end of August 2026).

Unable to recruit to the 0.5 WTE Band 7 12- month fixed term post. Options being discussed with Integrated Operations Manager around how to use these funds most appropriately.

Performance Area: Child Protection

Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
15	Percentage of child protection investigations to case conference within 28 days from IRD meeting	11%	95%	N		N/A	Was paused – Now being reported from IRD meeting date		

Key Points:

This indicator has been paused since April 2024 due to the implementation of new paperwork which complicated the process of identifying where an investigation should be proceeding to case conference and the associated timescales.

As of April 2026, we will measure the 28 days from the point of the Inter-Agency Referral Discussion (IRD) meeting pending improved recording processes.

3 of the 28 children proceeding to case conference were conferenced within 28 days of the IRD meeting. Annual leave of key people, including parents and social workers, have impacted on availability and conference timescales.

Improvement Actions:

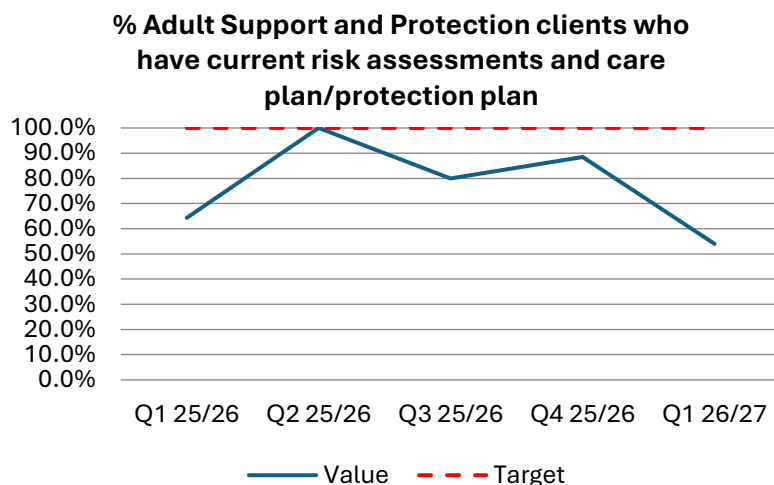
A project has been initiated to improve Child Protection processes and timescales, beginning with process mapping to identify pinch points.

Team Leaders will now no longer chair their own team's Child Protection Planning Meetings, so increasing the pool of chairs and to reduce the likelihood on no chair availability.

Performance Area: Adult Support and Protection

Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	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	54%	100%	N			88.5%	64.3%	

Quarter	Value	Target
Q1 25/26	64.3%	100%
Q2 25/26	100.0%	100%
Q3 25/26	80.0%	100%
Q4 25/26	88.5%	100%
Q1 26/27	54.0%	100%



Key Points:

All relevant paperwork was in place for 7 of the 13 Adult Support and Protection clients with a case conference in Quarter 1.

Annual leave during the summer period and staff absence may have impacted on meeting timescales for paperwork completion.

Improvement Actions:

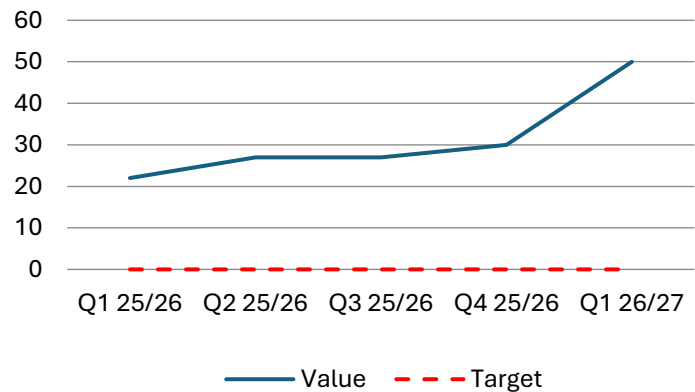
We continue to identify gaps in recording with prompts sent out to service areas.

Performance Area: Delayed Discharge

Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	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	50	0	N	🛑	⬇️	30	22	
22	Number of acute bed days lost to delayed discharge 18+ All reasons	4,702	3,420	L	🛑	⬆️	4,746	3,512	
24	Number of acute bed days lost to delayed discharges 65+ All reasons	3,524	2,694	L	🛑	⬇️	3,439	2,927	

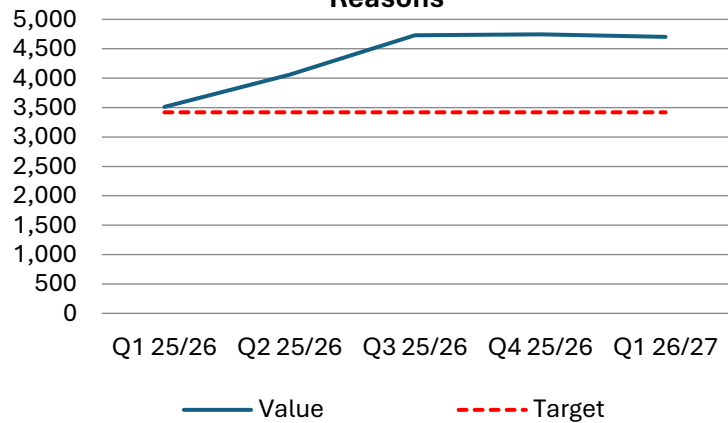
Quarter	Value	Target
Q1 25/26	22	0
Q2 25/26	27	0
Q3 25/26	27	0
Q4 25/26	30	0
Q1 26/27	50	0

**Number of delayed discharges over 3 days
(72 hours) non-complex cases**



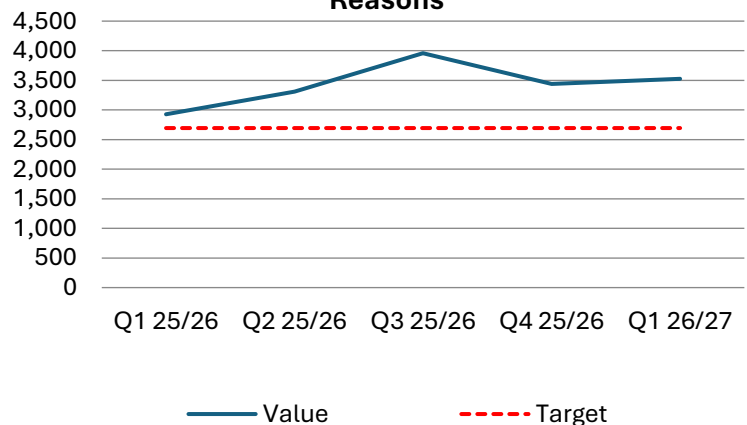
Quarter	Value	Target
Q1 25/26	3512	3420
Q2 25/26	4061	3420
Q3 25/26	4730	3420
Q4 25/26	4746	3420
Q1 26/27	4702	3420

**Bed Days Lost to Delayed Discharge 18+ All
Reasons**



Quarter	Value	Target
Q1 25/26	2927	2694
Q2 25/26	3307	2694
Q3 25/26	3958	2694
Q4 25/26	3439	2694
Q1 26/27	3524	2694

**Bed Days Lost to Delayed Discharge 65+ All
Reasons**



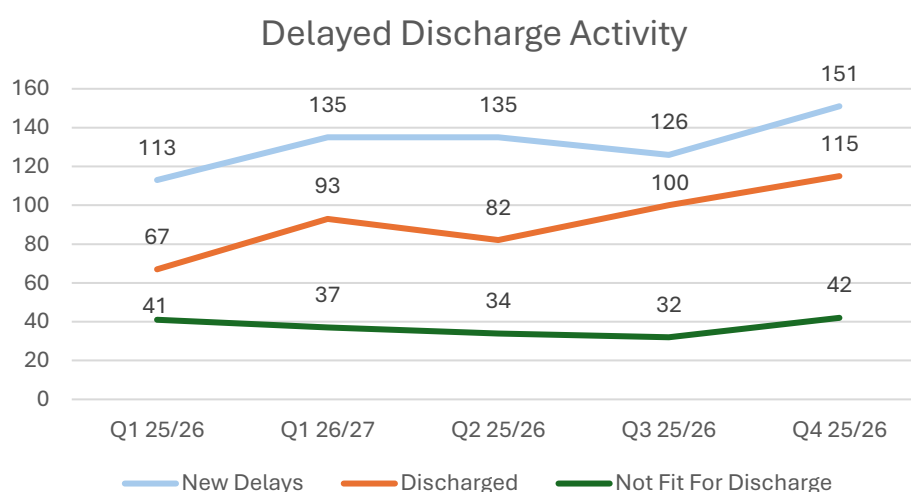
Key Points:

The Scottish Government's aspirational target is that no one should experience a delay in discharge from hospital of more than 3 days where the reason for the delay is standard and not complex e.g. relating to Adults with Incapacity legislation. At 30th June 2026, the number of people with a standard delay of more than 3 days was 50, the highest recorded at a quarter end. This census point figure is an accurate reflection of delay levels during the quarter as the average number of daily delays was 52, compared with 39 in Quarter 1 2025/26.

While bed days for delays due to any reason have continued to exceed our local targets, by 37% for all adults 18 and over, bed days for complex cases have seen a reduction and are below target for the first time since Quarter 1 2025/26.

	Q1 26/27	Target	% Below Target
Bed days lost to complex delays 18+	1223	1422	14.0%
Bed days lost to complex delays 65+	679	1049	35.3%

The majority of the increase in delays therefore are standard delays, which are shorter in duration, but are exceeding the 3 day timescale in many cases. As at 30th June 2026, the average length of standard delay was 18 days. The chart below demonstrates levels of activity and the throughput of delays.

**Improvement Actions:**

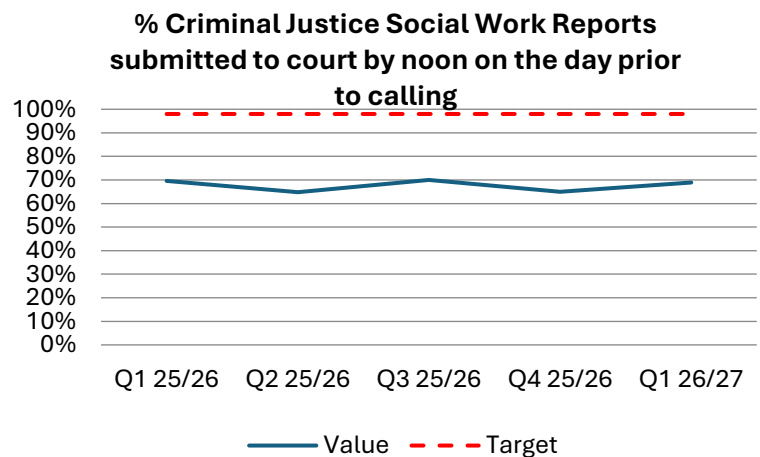
Additional senior management resource has been deployed for a three-month period to review pathways, processes and workload management. Identified improvement actions will be supported by implementation plans, impact measures and regular performance reporting to the Head of Service.

An intermediate discharge team model has also been implemented at the Vale of Leven Hospital, involving Social Work and Allied Health Professional participation in ward rounds. The impact of this model is being monitored through the Whole System Division.

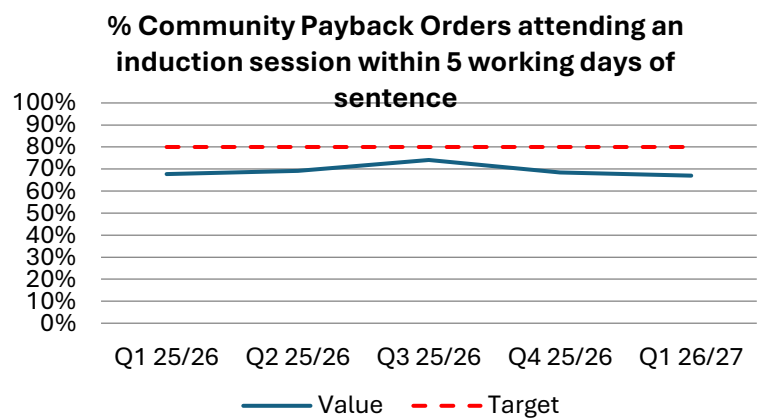
Performance Area: Criminal Justice Social Work

Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
31	Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	68.9%	98%	N			65%	69.6%	
32	Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.	67%	80%	N			68.4%	67.7%	
33	Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	11.8%	80%	N			33.3%	32.9%	

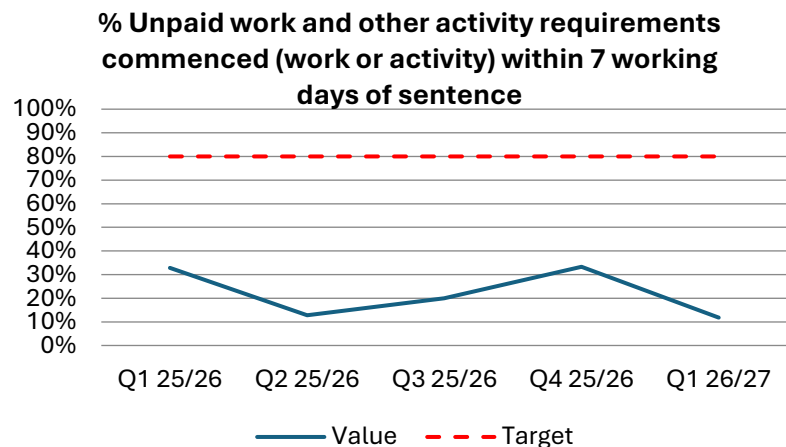
Quarter	Value	Target
Q1 25/26	69.6%	98%
Q2 25/26	64.8%	98%
Q3 25/26	70.0%	98%
Q4 25/26	65.0%	98%
Q1 26/27	68.9%	98%



Quarter	Value	Target
Q1 25/26	67.7%	80%
Q2 25/26	69.2%	80%
Q3 25/26	74.1%	80%
Q4 25/26	68.4%	80%
Q1 26/27	67.0%	80%



Quarter	Value	Target
Q1 25/26	32.9%	80%
Q2 25/26	12.8%	80%
Q3 25/26	20.0%	80%
Q4 25/26	33.3%	80%
Q4 26/27	11.8%	80%



Key Points:

In Quarter 1 there were 235 requests for Justice Social Work Reports to Courts between April and June 2026. There has been an 8.6% decrease of requests compared to the previous Quarter 4 2025/26 with 257 Requests. 68.9% 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.

Service users attending an induction session within 5 working days of sentence has decreased slightly from 68.4% in Quarter 4 to 67% during April to June 2026.

Service users attending work placements within 7 days has decreased from 33.3% in Quarter 4 2025/26 to 11.8% in Quarter 1 2026/27. Two full time vacancies which are in the process of being recruited to have been a contributing factor. It is hoped these vacancies will be filled and that a marked improvement will be seen once the successful applicants are in post.

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:

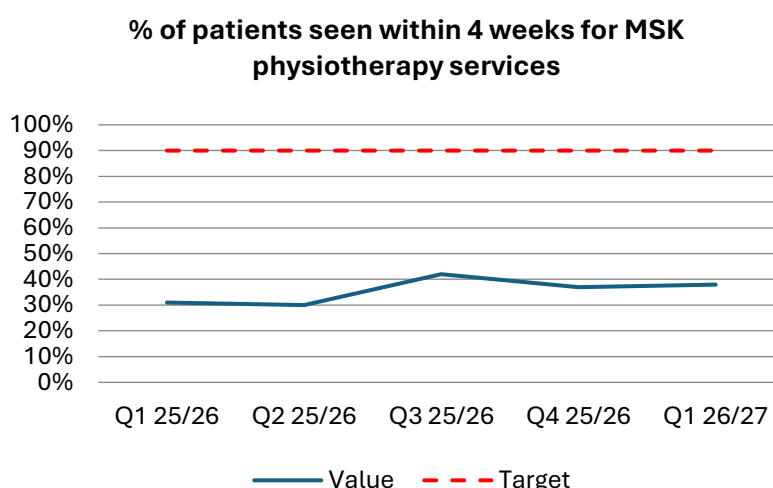
We have recruited two fixed term qualified social worker posts to March 2027, however investment is needed on a permanent basis to sustain improvements within the service.

We require to provide additional capacity within the unpaid work service to support meeting national standards within this area. Budgetary constraints remain a pivotal consideration in our inability to recruit to additional posts.

Performance Area: MSK Physiotherapy

Ref	Performance Indicator	Q1 2026/27					Q4 2025/26	Q1 2025/26	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
47	Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	38%	90%	N			37%	31%	

Quarter	Value	Target
Q1 25/26	31%	90%
Q2 25/26	30%	90%
Q3 25/26	42%	90%
Q4 25/26	37%	90%
Q1 26/27	38%	90%



Key Points

Demand for MSK service provision has risen 20% over the last 3 years, but was relatively static in 2025/26. Demand has risen across Quarter 1 2026/27 and continues to be significantly above service capacity.

All referrals categorised as urgent are seen within the 4 week target. The number of patients waiting on a routine appointment has increased slightly within Quarter 1. This is due to higher than normal turnover and vacancy levels during April to June and, despite promptly getting posts to advert, the recruitment process is taking some time.

There was also increased sickness absence within May which resulted in caseloads having to be absorbed and impacted on June waiting times.

Improvement Actions

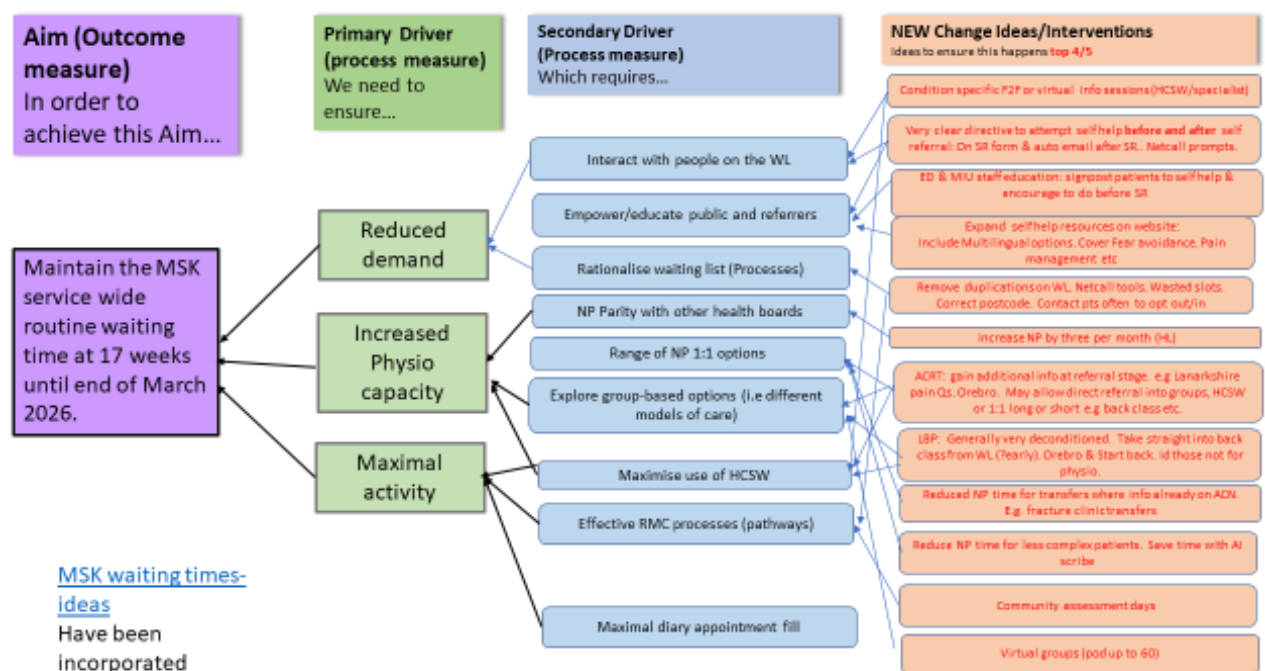
The service recently received £1.2 million in funding to address waiting times across Greater Glasgow and Clyde over the next 2 years. As a result there are 8 additional posts currently out to advertisement to increase service capacity. The service will also plan for any required service change to support waiting times work.

Waiting times remain a priority project within the service and the 20% increase in demand over the last 3 years has meant that some of the impact of the waiting times improvement work to increase capacity has only served to stabilise the increasing trend in routine waiting times.

The maximum wait for the service has decreased by two weeks within Quarter 1, which is positive given the level of demand and staff turnover.

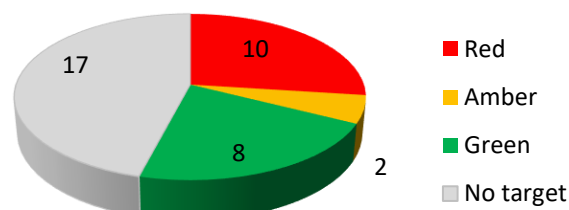
The driver diagram below illustrates the ongoing tests of change within the service and will be updated for 2026/27. The focus is on routine waiting times, as until the routine waits come closer to the 4-week target, the percentage seen within the 4-week target will be relatively unchanged.

The updated aim statement is being worked on by the service to reflect current levels of demand and future staffing.



Summary of Strategic Plan Key Performance Indicators

Quarter 1: April to June 2026 (Partial Data)



West Dunbartonshire Health and Social Care Partnership

Complaints Reporting: Quarter 1 April to June 2026

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 2026 the following learning points or actions were identified through the investigation of complaints received by the HSCP.

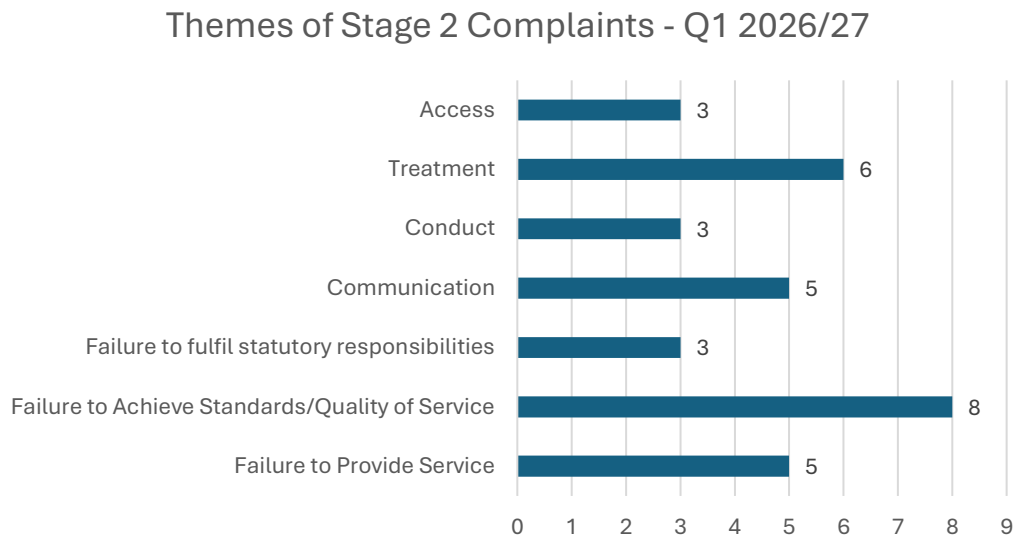
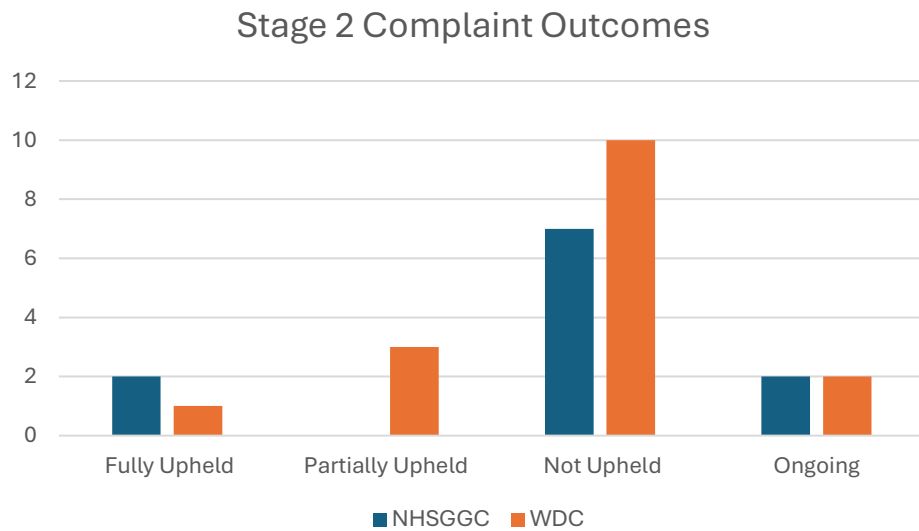
Service Area	Lessons Learned/Actions Taken
Residential Care	All staff have been reminded of the importance of checking emails daily and ensuring that any respite admissions are promptly and accurately recorded in the service diary. A monthly respite plan will now be provided to the service by the Respite Co-ordinator. This will introduce a more robust and reliable system for managing respite admissions. Staff have been reminded of the importance of ensuring foot plates remain on the correct wheelchair and this will be part of quality assurance audit processes.
District Nursing	Recommendations were made to enhance safe practice when reviewing vaccination records. To strengthen our local processes, contact arrangements for patients who require vaccination in their own homes are being reviewed.

SPSO Indicator	Measure	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27
2	Number of Stage 1 complaints (whether escalated to Stage 2 or not)	56	82	66	100	78
	Number of complaints direct to Stage 2	30	20	22	26	27
	Total number of complaints	86	101	88	126	105
3	% closed within timescale - Stage 1	Not Available*				
	% closed within timescale - direct to Stage 2	80%	74%	50%	31%	56%
	% closed within timescale - escalated to Stage 2	N/A	100%	N/A	N/A	N/A
4	Average response time - Stage 1	Not Available*				
	Average response time - direct to Stage 2	17	17	19	23	19
	Average response time - escalated to Stage 2	N/A	20	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 still in development stages.

Indicator 5: Outcomes of Complaints – Stage 2

Outcome	Model Complaints Handling Procedure		% of total
	NHSGGC	WDC	
Fully Upheld	2	1	11%
Partially Upheld	0	3	11%
Not Upheld	7	10	63%
Ongoing	2	2	15%
Total	11	16	27



Complaints may cover more than one theme.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Julie Slavin, Chief Financial Officer

22 September 2026

Subject: Regulated Commissioned Services Report**1. Purpose**

- 1.1** To provide the West Dunbartonshire HSCP (WD HSCP) Board Audit and Performance Committee with an update on Care Inspectorate inspection activity.
- 1.2** This report covers the following service types:
- Externally commissioned regulated services located within West Dunbartonshire;
 - Internal regulated services delivered by West Dunbartonshire Council (the Council) whose service delivery is carried out by the HSCP; and
 - Out of area regulated commissioned services.

The reporting period covered in this report is from 1 April 2026 – 30 June 2026 (Quarter 1) for services which had inspection reports published during this period.

- 1.3** Given the public nature of Care Inspectorate inspection reports, this report includes details of all commissioned services, including internal services which are registered with the Care Inspectorate. This is to ensure members of the Audit and Performance Committee are kept updated and informed in relation to all regulated commissioned services.
- 1.4** Where any regulated commissioned service receives a score of 2 – Weak, or less, or is rated RED within Appendix 1 – Regulated Commissioned Services Table, an exceptions report will be provided as an appendix to this report.
- 1.5** For the purposes of transparency, a table of all commissioned regulated services is detailed in Appendix 1 – Regulated Commissioned Services Table, which is RAG rated and highlights the percentage of services risk rated as Red, Amber or Green.

2. Recommendations

- 2.1** The HSCP Board Audit and Performance Committee is asked to note the content of this report and its appendices.

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 when inspecting both adult and children's services:

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 The Care Inspectorate have resumed looking at Key Questions which now include elements from the Covid Key Question in their inspections. The table below details the thematic areas of inspection for adult registered services and children's registered services:

Adult Services:

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
---	----------------------------	----------------------------	-------------------------	--

Children's Services:

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
--	----------------------------	----------------------------	-------------------------	------------------------------	---

- 3.3 The Care Inspectorate also undertake Core Assurance Inspections. Core assurance inspections are more light touch and provide assurance that better performing services (low risk) continue to deliver care and support that meets people's needs. It is not a validation of previous evaluations, and no new evaluations (grades) are awarded. Findings are reported under the headings; legal assurances, wellbeing, leadership, staffing, and planned care.

- 3.4** The commissioned service providers which were inspected during the period 1 April 2026 to 30 June 2026 and had reports published within this period are:

Externally Regulated Commissioned Services:

- Advinia Care Home Group, Hill View Care Home – Older Adults Residential Service;
- Carman Care Adults Support Service;
- Dalmuir Park Housing Association Limited – Dalmuir Park Housing Association – Adult Support Service;
- Edinbarnet Estates Ltd – Edinbarnet – Older Adult Residential Service;
- Hearts at Home Social Care Limited - Adults and Children Support Service;
- Maven Healthcare (Clyde Court) LLP, Clyde Court Care Home – Older Adult Residential Service;
- Pelan Ltd, Strathleven Care Home – Older Adults Residential Service;

Internally Provided Regulated Services:

- Home Care Service - Adult Community Support Service;
- Learning Disability Community Connections – Adults Support Service;
- Queens Quay Care Home – Older Adult Residential Service;
- Craigellachie – Children & Young People's Residential Service;

Out of Authority Regulated Commissioned Services:

- Antonine Court Limited, Antonine Court – Adults Day Support Service;
- Antonine Court Limited, Antonine Allstars – Children's Day Support
- Consensus Support Services Ltd, Clare House – Adult Residential Service;
- Hansel Alliance, Crail / Wilson Houses Small Group Living Services – Adults Support Services;
- The National Autistic Society, Central Scotland Services – Adult Support Service;
- The National Autistic Society, Catrine Bank – Adult Support Service;
- Quarriers, Glasgow Connect – Adult Support Service;

- 3.5** A copy of each inspection report has been published and can be accessed on the Care Inspectorate website: www.careinspectorate.com
- 3.6** The structure of the Care Inspectorate website means that we cannot include direct links to each report.
- 3.7** The following appendices accompany this report:
- Appendix 1 – Regulated Commissioned Services Table
 - Appendix 2 – Comp Care Update Report
 - Appendix 3 – Antonine Court Ltd Update Report

4. Main Issues

Externally Regulated Commissioned Services:

Advinia – Hillview Care Home

4.1 Advinia – Hillview Care Home is registered to provide to support to 150 older people. In May 2026 the Provider took the decision to close one unit within the Hillview Care Home complex reducing their capacity to 120.

4.2 The service was inspected on 14 – 22 April 2026, the report was published until May 2026. The table below highlights the grades achieved by the provider from the previous 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
22.04.26	3 Adequate	3 Adequate	3 Adequate	3 Adequate	3 Adequate
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
20.11.25	Follow-up inspection no change to grades from previous inspection				
Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
04.09.25	3 Adequate	3 Adequate	3 Adequate	4 Good	4 Good

4.3 The service received the following requirements in relation to their most recent inspection.

No.	Requirement	Timeline For Completion
1	The provider must ensure that people living in the service are safeguarded and that their health, welfare and safety needs are effectively managed and met. To do this, the provider must ensure at a minimum that they: a) follow current best practice and local area guidance regarding escalation and	3 August 2026

	reporting of Adult Support and Protection issues. b) support staff with training regarding Adult Support and Protection legislation, the current reporting processes and their role and responsibilities to safeguard people.	
2	The provider must ensure that quality assurance processes are used effectively to improve outcomes for people experiencing care. To do this, the provider must ensure at a minimum that they : a) use feedback from people living in the service, their families, and staff to inform the Service Improvement Plan; b) ensure quality assurance tools are used effectively and lead to meaningful action; c) use the outcomes of adverse events to inform learning and improve outcomes for people; d) use the clinical governance systems to ensure accurate recording of details of clinical risk and the measures in place to minimise risk; e) ensure that plans of care to minimise clinical risk are communicated effectively with relevant staff teams.	3 August 2026
3	The provider must take action to ensure that the right staff are in the right place, with the right skills, at the right time to fully support people's needs. This must include, but not be restricted to ensuring that : a) effective staffing methods are in place to provide sufficient numbers of staff to meet people's health, welfare, and safety needs; b) staffing levels are flexible and can respond to changes in people's needs; c) staff skill mix and knowledge consistently support people's assessed needs.	3 August 2026

4	The provider must ensure that people experience a high-quality care home environment. To do this, the provider must carry out a full assessment of the environment of the home internally and externally and use the outcome to inform an environmental improvement plan that is specific, measurable, achievable, relevant, and time bound. The environmental improvement plan must be shared with the Care Inspectorate	3 August 2026
---	---	---------------

4.4 Key messages highlighted by inspectors were:

- People living in Hillview Care Home and their families consistently expressed satisfaction with staff. Describing them as kind and compassionate;
- Access to meaningful activities should be improved to support people's wellbeing;
- The provider's quality assurance system needs to be used effectively and consistently to drive improvement of outcomes for people who live in the home;
- The provider needs to ensure that the home is staffed with sufficient staff to fully meet the health, welfare and safety needs of people;
- The quality of the environment of the home needs to be improved to ensure that people experience living in a comfortable and well-maintained home.

Carman Care

4.5 Carman Care are registered to provide housing support and care at home services in a sheltered housing complex to older people and people with medical conditions and more complex needs. The provider also extends their support to older people who live in the wider community. At the time of inspection there were 89 people being supported by the service.

4.6 The service was inspected on 29 & 30 April 2026, this was a Core Assurance Inspection, and the report issued in May 2026. The table below highlights the grades achieved by the provider from the previous 3 inspections:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
30.04.26	Core Assurance Inspection – no grades awarded				
Inspection date	How well do we support people's	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support

	wellbeing				planned
04.08.25	5 Very Good	N/A	5 Very Good	N/A	5 Very Good
Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
06.03.23	5 Very Good	4 Good	N/A	N/A	N/A

4.7 During the inspection it was confirmed that people continued to receive care that met their needs and protected their safety, wellbeing, and rights. This was evidenced as Inspectors:

- Spent time with eight people using the service and spoke with three people by phone.
- Received feedback from two relatives and six staff and management.
- Observed practice and daily life.
- Sampled relevant documents.

4.8 Key messages highlighted by inspectors were:

- People's wellbeing was supported by safe and effective practice, with evidence of positive outcomes for individuals and reassurance for families.
- Leadership was effective, with opportunities to strengthen how improvement activity is recorded and evidenced;
- People were supported by a consistent and capable staff team;
- The setting supported people's wellbeing and independence;
- Care and support was delivered in a caring and person-centered way

Dalmuir Park Housing Association Sheltered Housing Service

4.9 Dalmuir Park is registered as a Housing Support Service that provides a service to adults and older people with physical or sensory needs and/or learning difficulties living in their own homes. Support is provided to people living in Dalmuir Park Housing's 70 self-contained sheltered properties split between two nearby sites within the Dalmuir area of Clydebank, West Dunbartonshire. At the time of inspection there were 70 tenancy agreements in place.

4.10 The service was inspected 29 April & 6 May 2026 with the report issued in May 2026. The table below highlights the grades achieved by the provider from the previous 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
06.05.26	5 Very Good	N/A	N/A	N/A	N/A
Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
03.12.24	Core Assurance Inspection – no grades awarded				
Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
27.07.23	5 Very Good	5 Very Good	N/A	N/A	N/A

4.11 Key messages highlighted by inspectors were:

- Feedback from people using the service and their families consistently highlights the professionalism, commitment, and positive impact of the staff.
- People are meaningfully involved in decision-making, with their needs and wishes, which is central to shaping the support they receive.
- People are supported and encouraged to build, maintain, and re-establish social connections, enabling them to live fulfilling and engaged lives.
- People are supported to make informed health and lifestyle choices that promoted both their physical wellbeing and mental health.

Edinbarnet Estates Ltd – Edinbarnet Care Home

4.12 Edinbarnet Estates Ltd – Edinbarnet Care registered to provide to support to 48 older people.

4.13 The service was inspected on 18 May 2026, this was a Core Assurance Inspection, and the report issued in June 2026. The table below highlights the grades achieved by the provider from the previous 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
18.05.26	Core Assurance Inspection – no grades awarded				
Inspection date	How well do we support people's	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support

	wellbeing				planned
15.09.25	5 Very Good	n/a	n/a	5 Very Good	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
17.10.24	4 Good	4 Good	5 Very Good	4 Good	4 Good

4.14 During the inspection it was confirmed that people continued to receive care that met their needs and protected their safety, wellbeing, and rights. This was evidenced as Inspectors:

- Spent time with eight people using the service.
- Received feedback from the relatives, the manager and ten.
- Observed practice and daily life.
- Sampled relevant documents.

4.15 Key messages highlighted by inspectors were:

- People were supported to maintain contact with their family and the people important to them. Visitors were welcomed into the home.
- The manager had a clear vision about plans for improvement and development of the service. This resulted in a good quality service which promoted positive outcomes for people.
- Recruitment processes followed current best practice guidance. This ensured staff were recruited safely and people were safeguarded.
- The maintenance records were up to date to show that checks of the equipment and safety of the home were completed. This ensured that the home was safe, and people were protected from harm.
- Plans were person centered and reflected people's personal choices and preferences. This guided staff to ensure that people's choices and wishes were respected and supported good outcomes for people. Care reviews were being carried out six monthly, which ensured that people and their representatives had the opportunity to formally discuss current care and plan for future care.

Hearts at Home Social Care Limited

4.16 Hearts at Home Social Care Limited is registered to deliver a support service to children and adults with physical disabilities, learning disabilities and older people living in their own homes and in the community. At the time of inspection, the service was providing care and support to seven people.

4.17 The service was inspected on 10 – 12 June 2026 and the report issued in

June 2026. This service has only been inspection twice since registering in November 2020. The table below highlights the grades achieved by the provider from the previous 2 inspections:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
12.06.26	4 Good	3 Adequate	3 Adequate	n/a	n/a
Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
12.03.25	5 Very Good	4 Good	4 Good	n/a	4 Good

4.18 The service received the following requirements in relation to their most recent inspection in

No.	Requirement	Timeline For Completion
1	The provider must ensure that quality assurance processes are carried out effectively and in a manner which achieves improvements in the service. To do this the provider must ensure, at a minimum: a) routine and regular management audits are being completed across all key areas of the service being provided not limited to staff training, medication, care plans, and adult protection; b) internal quality assurance systems identify any issue which may have a negative impact on the health and welfare of people supported and obtain regular feedback from people, relatives, and staff to inform service improvements; c) clear action plans with timescales are devised where deficits and/or areas for improvement have been identified; d) action plans are regularly reviewed and signed off by an appropriate person in the organisation when improvements are achieved.	5 October 2026

2	The provider must implement safer recruitment processes. To do this, the provider must ensure, at a minimum: a) recruitment processes follow good practice guidance from the Scottish Social Services Council (SSSC) and the Care Inspectorate: 'Safer Recruitment Through Better Recruitment' (September 2023); b) ensure staff have access to a robust induction and complete all mandatory training which is recorded and reviewed.	5 September 2026
----------	---	------------------

4.19 Key messages highlighted by inspectors were:

- Staff were good at developing meaningful relationships with people.
- Leadership oversight and quality assurance required improvement.
- People benefitted from a consistent and stable staff team and experienced caring, compassionate care.
- Recruitment did not follow best practice, and a requirement was made to support improvement.

Maven Healthcare (Clyde Court) LLP

4.20 Maven Healthcare (Clyde Court) LLP – Clyde Court Care Home is registered to provide a care service to 70 older people.

4.21 The service was inspected on 14 – 16 April 2026 and the report issued in May 2026. The table below highlights the grades achieved by the provider from the previous 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
17.04.26	4 Good	3 Adequate	n/a	n/a	n/a
Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
23.10.25	n/a	3 Adequate	n/a	3 Adequate	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
17.09.25	3 Adequate	n/a	n/a	n/a	n/a

4.22 Key messages highlighted by inspectors were:

- The home was providing care and support of a good standard. Improvements had been made and health and wellbeing outcomes for people had been positively impacted.
- Quality assurance was taking place regularly but could have been more thorough and effective. The new manager was keen to sustain improvements at the home.

Pelan Ltd – Strathleven Care Home

4.23 Pelan Ltd – Strathleven Care Home is registered to provide to support to 21 older people. At the time of inspection 17 people were living at Strathleven.

4.24 The service was inspected on 8 – 9 April 2026 and the report issued in April 2026. The table below highlights the grades achieved by the provider from the previous 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
14.04.26	5 Very Good	5 Very Good	n/a	n/a	n/a
Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
15.07.25	5 Very Good	5 Very Good	5 Very Good	4 Good	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 Very Good	5 Very Good	5 Very Good	4 Good	4 Good

4.25 Key messages highlighted by inspectors were:

- People experienced warm, respectful care and were treated with dignity.

- People's health and wellbeing were very well supported, with staff responding quickly to their needs.
- People were able to make choices about their day and lived in a calm, homely environment.
- People had access to meaningful activities and opportunities to stay connected to their community.
- The service was well led, with strong systems in place to monitor quality and drive improvement.

Internal Regulated Services

Home Care

- 4.26** The Home Care Service provides care at home support to people living in their own homes. The service operates throughout the West Dunbartonshire local authority area from two office bases, in Clydebank and Dumbarton.
- 4.27** A separate report was taken to WD HSCP Board concerning the services' most recent inspection.

Learning Disability Community Connections

- 4.28** The Community Connection service works with people with learning disabilities and aims to provide support for community activities, creating and maintaining relationships, promotion of independence and managing a safe and comfortable home. At the time of inspection, the service was supporting 31 people living in West Dunbartonshire.
- 4.29** The service was inspected on 26 May 2026, this was a Core Assurance Inspection, with the report published in June 2026. The table below highlights the grades achieved by the service in 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
27.05.26	Core Assurance Inspection – no grades awarded				
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
31.10.25	6 Excellent	n/a	5 Very Good	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
16.05.23	5 Very Good	5 Very Good	n/a	n/a	n/a

4.30 During the inspection it was confirmed that people continued to receive care that met their needs and protected their safety, wellbeing, and rights. This was evidenced as Inspectors:

- Spent time with twelve people and five staff.
- Received feedback from three people and three staff.
- Observed practice and daily life.
- Sampled relevant documents.

4.31 Key messages highlighted by inspectors were:

- Regular group support spot checks evidenced that supervisors were actively seeking and responding to feedback on what was working well and where improvements were needed. This demonstrated a reflective culture and a clear commitment to continuous improvement.
- Staff all felt supported and told us that they worked well together as a team. Staff were confident in building positive interactions and relationships with people. People appeared comfortable and relaxed in the presence of their staff and told us; 'the staff are nice and help each other', 'the support workers are lovely' and 'the staff are supportive'. This positively supported people's independence, choice and sense of wellbeing.
- We identified areas where care plan records could be further strengthened. The service should ensure that review dates for health information and risk assessments aligned with care plan dates. Even where no changes were required, consistent review dates across the care plan would provide stronger assurance that the care plan was current and had been reviewed.

Queens Quay House

4.32 Queens Quay House is a care home for older people. The service provides residential care for up to 84 people. At the time of inspection there were 73 people living at Queens Quay House.

4.33 The service was inspected on 25 March 2026, this was an unannounced follow-up inspection, with the report published in April 2026. There were no changes to grades from the previous inspection in January 2026. The table below highlights the grades achieved by the service in 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
25.03.26	Follow-up inspection – no change to grades from previous inspection				
Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned

14.01.26	3 Adequate	3 Adequate	3 Adequate	5 Very Good	3 Adequate
Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
30.04.25	n/a	n/a	n/a	n/a	4 Good

4.34 Key messages highlighted by inspectors were:

- Improvements had been made and people could now be assured that they were being supported by staff to receive their medication as prescribed.
- Systems were in place for medication management to be monitored daily and for management to have an overview.
- Medication training reviews had been undertaken with staff by management to ensure that staff had the correct skills and knowledge.

Craigellachie Children's House

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

4.36 The service was inspected on 9 – 10 June 2026, and the report issued in July 2026. The table below summarises the grades awarded to Craigellachie Children's Home over their last three inspections:

Date of Inspection	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
12.06.26	n/a	n/a	n/a	n/a	n/a	4 Good
Date of Inspection	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
04.07.25	n/a	n/a	n/a	n/a	n/a	4 Good
Date of Inspection	How well do we support	How good is our	How good is our staff	How good is our	How well is our care	How well do we support children

	children and young people's wellbeing	leadership	team	setting	planned	and young people's rights and wellbeing
23.09.24	n/a	n/a	n/a	n/a	n/a	3 Adequate

4.37 Key messages highlighted by inspectors were:

- Young people felt safe, valued and supported.
- Strong, trusting relationships promoted confidence, wellbeing and progress.
- Staff effectively supported independence and future aspirations.
- Leaders needed to strengthen supervision arrangements to support staff development and oversight of practice.
- The service had strengthened safeguarding practice, resulting in improved arrangements to protect and promote the wellbeing of children and young people.

Out of Area Regulated Commissioned Services

4.38 The table below details the regulated services that we commission from external local authorities that were inspected or had reports published during the period. 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. WD HSCP does not attend the inspection feedback session with the Care Inspectorate. The Host authority will notify the WD HSCP by exception in connection with quality issues and/or challenges with Care Inspectorate inspections following the feedback session.

Adult Services:

Service Name	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
ANTONINE COURT LIMITED Antonine Court	23.06.26	2	1	2	2	2
CAREVIEW HOMES LTD – Millbank Care Home	21.05.26	Core Assurance Inspection				
CONSENSUS SUPPORT SERVICES LTD Clare House	23.03.26	5	n/a	n/a	4	n/a

HANSEL ALLIANCE - Crail / Wilson Houses Small Group Living Services	25.06.26	4	4	n/a	3	n/a
NATIONAL AUTISTIC SOCIETY SCOTLAND - Central Scotland Services	14.05.26	Core Assurance Inspection				
NATIONAL AUTISTIC SOCIETY SCOTLAND – Catrine Bank	12.03.26	3	3	3	n/a	3
QUARRIERS - Glasgow Connect	05.06.26	5	n/a	n/a	n/a	n/a
SILVERLINE CARE - CLYDE CARE LTD – Bailleston Care Home	04.06.26	4	4	n/a	n/a	n/a
APPLECROSS NURSING HOME LTD – Applecross Nursing Home	15.04.26	5	5	n/a	n/a	5
BELLEAIRE CARE LIMITED – Belleaire House	27.04.26	4	n/a	4	n/a	n/a

BUCHANAN LODGE CARE LIMITED - Holmes Group – Buchan Lodge Care Home	28.05.26	Core Assurance Inspection				
CALEDONIAN CARE CONSULTANTS LTD - Bluebird Care (Dunbartonshire)	28.05.26	Core Assurance Inspection				
CRC CARE LTD - CRC Care	06.03.26	3	3	3	n/a	3
GANARN LIMITED – Ivybank House Nursing Home	07.05.26	Core Assurance Inspection				
HOLMES CARE GROUP SCOTLAND LTD – Bankview Care Home	22.05.26	Core Assurance Inspection				
LEUCHIE – Leuchie House	29.05.26	Core Assurance Inspection				
MANSFIELD CARE LIMITED – Argyll House Nursing Home	05.05.26	3	3	3	4	3
MORAR LODGE NURSING HOME LIMITED – Morar Lodge Nursing Home	25.06.26	4	4	4	4	4
MORRISONS COMMUNITY CARE LIMITED – Abbotsford House	02.06.26	5	n/a	n/a	5	5
NEWARK CARE – Burnfield	21.05.26	Core Assurance Inspection				
OAKBRIDGE CARE LIMITED	11.06.26	4	4	n/a	n/a	n/a
RENAISSANCE CARE (NO1) LIMITED – Whitecraigs Care Home	05.06.26	Core Assurance Inspection				

Children's Services:

Service Name	Date of Inspection	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
Curo Salus - Moniabrock	16.01.26	n/a	n/a	n/a	n/a	n/a	6 Excellent
Spark of Genius – Foxhill Cottage	19.01.26	n/a	n/a	n/a	n/a	n/a	4 Good
Scotnursing & Medical Services Ltd – Support Service	05.02.26	5 Very Good	4 Good	n/a	n/a	4 Good	n/a
Alltogether Care Services Ltd	10.02.26	6 Excellent	n/a	6 Excellent	n/a	n/a	n/a

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 older people care home 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 a 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, under the National Care Home Contract fail to retain the grades detailed at 7.1, WD 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 3 (Adequate) and WD 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 WD 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 WD HSCP's commitment to work with providers within an agreed assurance framework.

13. Directions

13.1 Not required for this report.

Name: Julie Slavin
Designation: Chief Financial Officer
Date:

Person to Contact: Neil McKechnie
Contracts, Commissioning & Quality Manager
West Dunbartonshire HSCP
Hartfield Clinic
Latta Street, Dumbarton, G82 2DS
Email: Neil.McKechnie@west-dunbarton.gov.uk

Appendices: Appendix 1 – Regulated Commissioned Services Table
Appendix 2 – Comp Care Update Report
Appendix 3 – Antonine Court Ltd 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 Julie Slavin, Chief Financial Officer

Date: 22 September 2026

Subject: Appendix 1 – Regulated Commissioned Services Table

1. Purpose

- 1.1** To provide the HSCP Board Audit and Performance Committee with a snapshot risk profile of all Regulated Commissioned Services funded by West Dunbartonshire HSCP (WD HSCP), during the period 1 April 2026 – 30 June 2026.

2. Background

- 2.1** To ensure WD HSCP Board Audit and Performance Committee have visibility of the risk profile of regulated services commissioned by the HSCP, the information contained in paragraph 3 has been provided for noting.
- 2.2** The criteria for Red, Amber and Green services is as follows:

Risk Rating	Criteria
Red	Any service that is graded 2 (Weak) or less by the Care Inspectorate and/or subject to a Large Scale Investigation.
Amber	Any service that is graded 3 (Adequate) by the Care Inspectorate.
Green	Any service that is graded 4 (Good) or higher by the Care Inspectorate.

- 2.3** As the Care Inspectorate may inspect a service across multiple thematic areas the risk rating shall be based on the weakest grade obtained.

3. Main Issues

- 3.1** In the period 1 April 2026 – 30 June 2026 the following Mental Health, Learning Disability & Addiction regulated commissioned services were risk rated accordingly:

Risk Rating	Percentage of Services This Period	Percentage of Services Last Period	Comments
Red	2%	9%	
Amber	15%	4%	-
Green	83%	87%	-

- 3.2** In the period 1 April – 30 June 2026 the following Health and Community Care regulated commissioned services were risk rated accordingly:

Risk Rating	Percentage of Services This Period	Percentage of Services Last Period	Comments
Red	1%	2%	-
Amber	11%	9%	-
Green	88%	89%	-

- 3.3** In the period 1 April – 30 June 2026 the following Children's Health Care and Justice regulated commissioned services were risk rated accordingly:

Risk Rating	Percentage of Services This Period	Percentage of Services Last Period	Comments
Red	2%	0%	
Amber	7%	7%	-
Green	91%	93%	-

3.4 The table below shows the risk rating applied to all commissioned regulated services during the period April – June 2026:

Service Area: Learning Disability, Mental Health & Addictions and Health and Community Care

Provider	Service	CI Registration Number	Date of Last Inspection	Grades						Risk Rating
				KQ1	KQ2	KQ3	KQ4	KQ5	KQ6	
ACADABILITY LIMITED	Acadability - Academy House	CS2017357054	03.12.25	n/a	3	n/a	n/a	n/a		
ACTIVE ADULT LTD (HUNTERCOME)	Moorpark Place	CS2021382527	16.01.26	5	n/a	n/a	4	n/a		
ALTERNATIVES WEST DUNBARTONSHIRE CDS	Community Drug Services Housing Support Unit - Safe as Houses	CS2003054982	31.08.17*	5	n/a	4				
ALTERNATIVES WEST DUNBARTONSHIRE CDS	Alternatives WD CDS - Support Service	CS2013322988	19.07.19	6	n/a	n/a	n/a	5		
ANTONINE COURT LIMITED	Antonine Court - Day Support	CS2005102929	23.06.26	2	1	2	2	2		
CAPABILITY SCOTLAND	Upper Springland -	CS2003017755	08.11.23	5	5	n/a	n/a	n/a		
CAPABILITY SCOTLAND	Junction 52 - Day Support	CS2003001071	16.05.24	5	5	5	n/a	5		
CAPABILITY SCOTLAND	Support Service	CS2003055087	27.02.26	5	3	4	n/a	4		
CAREVIEW HOMES LTD	Millbank - Care Home	CS2009233155	21.05.26	6	n/a	6	4	n/a		
CARE HOMES (SCOTLAND) LTD	Spingboig Care Home	CS2007142131	08.01.26	4	n/a	n/a	4	n/a		
CONSENSUS SUPPORT SERVICES LTD	Clare House	CS2008184125	23.03.26	5	n/a	n/a	4	n/a		
CORNERSTONE COMMUNITY CARE	Baxter View	CS2014325265	31.07.26	n/a	3	n/a	n/a	n/a		
CORNERSTONE COMMUNITY CARE	West Dunbartonshire Services 1	CS2004073011	14.11.25	5	4	4	n/a	4		
ENABLE SCOTLAND	ENABLE Scotland: West	CS2004079638	07.08.25	5	n/a	5	n/a	5		
ENABLE SCOTLAND	Esmond Street Advanced Support Service	CS2003000839	31.07.26	4	3	n/a	n/a	n/a		
ENHANCE SCOTLAND	Arran View Care Home	CS2019378502	13.06.25	5	n/a	n/a	4	n/a		
GARVALD WEST LINTON LTD	Garvald West Linton	CS2003009177	19.02.26	4	n/a	n/a	5	n/a		
HANSEL ALLIANCE	Crail / Wilson Houses Small Group Living Services	CS2003001303	25.06.26	4	4	n/a	3	n/a		
JERICO SOCIETY	Jericho Benedictines Housing Support Unit (Bank Street)	CS2009198981	12.01.24	5	5	n/a	n/a	n/a		
KEY HOUSING ASSOCIATION	Key - Dunbartonshire	CS2004073239	06.03.25	5	5	5	n/a	5		
LIVING AMBITIONS LIMITED	Living Ambitions Limited Glasgow (Clyde)	CS2023000239	09.01.26	5	n/a	n/a	n/a	4		
MEALLMORE LTD	Alderwood House	CS2020379050	06.03.26	5	n/a	n/a	5	n/a		
MEALLMORE LTD	The Oaks	CS2014323954	18.03.26	5	n/a	n/a	5	n/a		

NATIONAL AUTISTIC SOCIETY SCOTLAND	Central Scotland Services	CS2008168914	14.05.26	5	n/a	4	n/a	5		
NATIONAL AUTISTIC SOCIETY SCOTLAND	Catrine Bank	CS2006141046	12.03.26	3	3	3	n/a	3		
NATIONAL AUTISTIC SOCIETY SCOTLAND	Daldorch - Adult Service	CS2020380626	09.05.25	5	4	4	n/a	4		
NEIGHBOURHOOD NETWORKS	Neighbourhood Network	CS2003053949	20.04.23	6	5	n/a	n/a	n/a		
QUARRIERS	Dunn St, Duntocher - Respite Service	CS2010238999	27.02.026	5	n/a	n/a	5	n/a		
QUARRIERS	Glasgow Connect	CS2004070598	05.06.26	5	n/a	n/a	n/a	n/a		
QUARRIERS	Quarriers Shared Lives Family Placement Service	CS2007142998	09.01.19 *	4	4	4				
REAL LIFE OPTIONS	Real Life Options East Dunbartonshire Service	CS2004071266	06.03.26	5	n/a	5	n/a	n/a		
SACRO	Sacro National Intensive Support Package	CS2005087474	15.03.24	6	5	n/a	n/a	n/a		
SANCTUARY CARE LTD	Millport Housing Support Service	CS2019378611	02.07.26	5	n/a	n/a	n/a	n/a		
SANCTUARY CARE LTD	Millport Care Centre	CS2019378610	06.08.25	5	n/a	n	4	n/a		
SCOTNURSING LTD	ScotNursing & Medical Services Limited - Support Service	CS2011303124	05.02.26	5	4	n/a	n/a	4		
SENSE SCOTLAND	Touchbase Adult Support Services	CS2003000894	05.03.18 *	5	5	4	4			
SENSE SCOTLAND	Sense Scotland Supported Living West Dunbartonshire and Surrounding Areas	CS2022000013	20.03.26	6	n/a	5	n/a	n/a		
SHARE SCOTLAND	Share Scotland - Glasgow	CS2003053756	21.06.24	6	n/a	5	n/a	n/a		
SILVERLINE CARE - CLYDE CARE LTD	Baillieston Care Home	CS2022000213	04.06.26	4	4	n/a	n/a	n/a		
SOUTH PEAK SERVICES.	South Peak	CS2004076276	26.05.22	5	4	n/a	n/a	n/a		
STEPPING STONES ORGANISATION (Mental Health)	Stepping Stones - Support Service	CS2016353166	12.05.23	5	5	n/a	n/a	n/a		
THE RICHMOND FELLOWSHIP SCOTLAND	East & West Dunbartonshire Supported Living Services	CS2004061347	03.07.26	5	n/a	5	n/a	n/a		
THISTLE HEALTHCARE LIMITED	Ardenraig Care Home	CS2003015202	19.01.26	n/a	3	n/a	n/a	n/a		
TUS NUA CARE SERVICES LTD	Tus Nua Care Service - Support Service	CS2013316012	23.10.23	5	5	n/a	n/a	n/a		
UNITY ENTERPRISE	Empower - Day Service	CS2018367446	22.10.21	5	n/a	n/a	n/a	n/a	4	
WILLIAM SIMPSON'S	William Simpson Care Home	CS2010279960	06.03.26	4	n/a	n/a	4	n/a		

Service Area: Health and Community Care

Provider	Service	CI Registration Number	Date of Last Inspection	Grades							Risk Rating
				KQ1	KQ2	KQ3	KQ4	KQ5	KQ6		
ADVINIA CARE HOMES LTD	Hill View Care Home	CS2017361014	22.04.26	3	3	3	3	3			
ADVINIA CARE HOMES LTD	Elderslie Care Home	CS2017361010	08.05.25	4	5	4	4	4			
ADVINIA CARE HOMES LTD	Rutherglen Care Home	CS2017361020	14.01.26	3	3	3	3	4			
ALLTOGETHER CARE SERVICES LTD	Alltogether Care Services Ltd	CS2013317305	10.02.26	6	n/a	6	n/a	n/a			
ANTONINE CARE LTD	Antonine House	CS2012310887	11.07.25	5	n/a	n/a	5	n/a			
APPLECROSS NURSING HOME LTD	Applecross Nursing Home	CS2003010474	15.04.26	5	5	n/a	n/a	5			
BALMORAL HOMECARE LTD	Balmoral Homecare	CS2025000065	24.09.25	4	n/a	n/a	n/a	n/a			
BALQUHIDER CARE LIMITED	Balquhider House	CS2014332915	10.07.26	4	4	4	n/a	3			
BELLEAIRE CARE LIMITED	Belleaire House	CS2021000263	27.04.26	4	n/a	4	n/a	n/a			
BEN VIEW RESOURCE CENTRE	Ben View Community Bathing Service	CS2008179974	22.11.24	5	5	n/a	n/a	n/a			
BOCLAIR CARE LIMITED	Boclair Care Home	CS2022000224	02.07.25	5	n/a	n/a	5	n/a			
BRITISH RED CROSS SOCIETY	Glasgow Support at Home	CS2025000437	09.07.26	5	4	5	n/a	4			
BUCHANAN HOUSE CARE LIMITED - Holmes Group	Buchanan House Care Home	CS2020378653	22.10.25	5	n/a	5	5	n/a			
BUCHANAN LODGE CARE LIMITED - Holmes Group	Buchanan Lodge Care Home	CS2020378654	28.05.26	5	n/a	n/a	4	n/a			
CALEDONIAN CARE CONSULTANTS LTD	Bluebird Care (Dunbartonshire)	CS2008183616	28.05.26	5	n/a	5	n/a	n/a			
CALL-IN HOMECARE LTD	Call-In Homecare West of Scotland	CS2023000324	07.08.25	5	n/a	5	n/a	n/a			
CALEDONIA SOCIAL CARE LIMITED	Caledonia Social Care (West)	CS2016353182	20.01.26	5	5	n/a	n/a	5			
CARE CONCERN GROUP - PRIORY CC136 LIMITED	Ashlea Court Care Home	CS2025000103	Service registered in March 2025 - no inspection to date								
CARE CONCERN GROUP - KINGSACRE	Kingsacre Care Home	CS2019373856	18.09.25	4	4	4	5	4			
CARELINE HOME SUPPORT	Careline Home Support	CS2004076261	27.11.25	4	n/a	4	n/a	n/a			
CARE1 PROFESSIONAL SERVICES LTD	Care1 Professional Services Ltd	CS2018370582	01.08.25	4	4	4	n/a	4			
CARING GRACE LTD	Caring Grace Limited	CS2023000204	28.02.25	4	4	4	n/a	4			
CARMAN CARE	Carman Care	CS2013322906	30.04.26	5	n/a	5	n/a	5			
CERA CARE OPERATIONS (SCOTLAND)	CERA	CS2009234919	02.03.26	5	n/a	5	n/a	n/a			

LIMITED										
CLEARVUE INVESTMENTS LIMITED	The Argyle Care Centre	CS2005111774	25.04.25	5	4	5	4	5		
CRC CARE LTD	CRC Care	CS2013319689	06.03.26	3	3	3	n/a	3		
C&S RECRUITMENT	Support Care24	CS2024000285	13.02.26	4	4	4	n/a	4		
DALMUIR PARK HOUSING ASSOCIATION LIMITED	Dalmuir Park Housing Association Sheltered Housing Service	CS2004063084	06.05.26	5	n/a	n/a	n/a	n/a		
DOONFOOR CARE LIMITED	Greenan Manor Care Home	CS2019378127	05.08.26	5	n/a	n/a	n/a	n/a		
EDINBARNET ESTATES LTD	Edinbarnet	CS2003010454	18.05.26	5	n/a	n/a	5	n/a		
ERSKINE VETERANS CHARITY	Erskin Home	CS2003010196	09.12.25	5	n/a	n/a	5	n/a		
FOX CARE LTD	Jordanhill Care Home	CS2008192624	28.08.25	5	n/a	5	5	n/a		
GANARN LIMITED	Ivybank House Nursing Home	CS2003011596	07.05.26	5	n/a	n/a	4	n/a		
GLENFAIRN LIMITED	Glenfairn House Nursing Home	CS2003001322	05.03.26	5	n/a	n/a	5	n/a		
GLENGALL CARE GROUP CARRICKSTONE LIMITED	Carrickstone Care Home	CS2024000161	20.03.26	4	n/a	n/a	5	n/a		
HAMBERLEY PROPERTIES FV(MILNGAVIE) LIMITED	Milngavie Manor	CS2017356770	03.10.25	5	5	5	5	5		
HARVEYS HEALTHCARE (SCOTLAND) LTD	Bute House Care Home	CS2019372681	30.07.25	4	4	4	4	4		
HAYLIE HOUSE TRUST LTD	Haylie House Care Home	CS2003001143	29.01.26	5	n/a	N	5	n/a		
HC-ONE LIMITED	Castle View Nursing Home	CS2011300851	16.01.26	5	n/a	n/a	5	n/a		
HC-ONE LIMITED	Hillside View	CS2011300713	04.06.26	5	4	n/a	n/a	4		
HC-ONE LIMITED	Mugdock House Care Home	CS2016349833	07.02.26	6	n/a	n/a	5	n/a		
HC-ONE LIMITED	Quayside	CS2016349826	07.07.26	4	4	n/a	n/a	n/a		
HC-ONE LIMITED	Wynford Locks Nursing Home	CS2016349825	11.03.26	5	n/a	n/a	4	n/a		
HEARTS AT HOME SOCIAL CARE LIMITED	Hearts at Home Social Care Limited	CS2020379829	12.06.26	4	3	3	n/a	n/a		
HERMITAGE CARE HOME LIMITED - Morar Care	Hermitage House	CS2022000018	29.01.26	5	n/a	n/a	5	n/a		
HOLMES CARE GROUP SCOTLAND LTD	Almond Court Care Home	CS2020379123	07.07.26	2	2	2	2	2		
HOLMES CARE GROUP SCOTLAND LTD	Almond View Care Home	CS2020379131	18.07.25	4	4	4	4	4		
HOLMES CARE GROUP SCOTLAND LTD	Bankview Care Home	CS2020379133	22.05.26	4	4	4	4	4		
JOAN CARERS LTD	Joans Carers	CS2004077225	09.03.26	5	n/a	5	n/a	n/a		
KEANE PREMIER HEALTHCARE GLASGOW LTD	Greyfriars Care Centre	CS2018371797	29.01.26	5	n/a	n/a	5	n/a		

LEUCHIE	Leuchie House	CS2011289688	29.05.26	6	n/a	5	n/a	n/a		
MANOR GRANGE CARE HOME LLP	Manor Grange Care Home	CS2016349056	29.01.26	5	n/a	n/a	5	n/a		
MANSFIELD CARE LIMITED	Argyll House Nursing Home	CS2007164138	05.05.26	3	3	3	4	3		
MAVEN HEALTHCARE CLYDE COURT LLP	Clyde Court Care	CS2022000324	17.04.26	4	3	n/a	n/a	n/a		
MEALLMORE LTD	Kincaid House	CS2021000264	02.12.25	4	n/a	n/a	5	n/a		
MORAR LODGE NURSING HOME LIMITED	Morar Lodge Nursing Home	CS2003010220	25.06.26	4	4	4	4	4		
MORRISONS COMMUNITY CARE LIMITED	Abbotsford House	CS2003000786	02.06.26	5	n/a	n/a	5	5		
MCKENZIE CARE LTD	Ailsa Lodge Care Home	CS2012313838	11.11.25	4	5	5	4	4		
M-VERTH LIMITED	M-Verth Limited	CS2020380002	19.01.26	3	4	4	n/a	4		
NEWARK CARE	Burnfield	CS2003010477	21.05.26	5	n/a	n/a	5	n/a		
NURSING 24/7 LTD	Nursing 24/7 Ltd	CS2024000222	03.12.25	4	4	4	n/a	4		
OAKBRIDGE CARE LIMITED	Oakbridge Care Home	CS2003010470	11.06.26	4	4	n/a	n/a	n/a		
OAKMINSTER HEALTHCARE LTD	Florence House	CS2003010458	04.12.25	5	n/a	n/a	4	n/a		
PACIFIC CARE LIMITED	Mosswood Care Home	CS2012312934	12.03.26	5	n/a	n/a	5	n/a		
PELAN LTD	Strathleven Care Home	CS2003001442	14.04.26	5	5	n/a	n/a	n/a		
RENAISSANCE CARE (NO1) LIMITED	Whitcraigs Care Home	CS2016346354	05.06.26	5	n/a	5	4	n/a		
ROBERTS CARE AND TRAINING LIMITED	Roberts Care & Training Ltd	CS20099193466	16.01.26	5	n/a	5	n/a	n/a		
SHONA CARE LTD	Shona Care Ltd	CS2020379168	21.07.26	n/a	4	n/a	n/a	n/a		
SOLRIPE ALLSTARTS LIMITED	Home Instead West Dunbartonshire, Argyll & Bute and Arran	CS2022000053	09.07.26	5	n/a	n/a	n/a	n/a		
STERLING CARE HOMES LIMITED	Nightingale House	CS2003010219	12.02.25	4	n/a	n/a	4	n/a		
SUMMERLEE HOUSE LIMITED	Summerlee House	CS2008172820	09.07.25	6	n/a	n/a	6	n/a		
THE MUNGO FOUNDATION	West End Project - Dumbarton	CS2003001418	14.01.20	5	n/a	n/a	n/a	5		

Service Area: Children's Health Care and Justice

Provider	CI Registration Number	Date of Last Inspection	Grades						Risk Rating
Fosterplus (fostercare) ltd	CS2004080743	12/09/2024	4	5	5	n/a	5	n/a	GREEN
Curo Salus - Moniabrock	CS2019376757	16/01/2026	n/a	n/a	n/a	n/a	n/a	6	GREEN
Curo Salus -garden lodge	CS2006128113	08/09/2022	n/a	n/a	n/a	n/a	n/a	6	GREEN

Curo Salus - Bridgend	CS2008190390	29/09/2025	n/a	n/a	n/a	n/a	n/a	5	GREEN
Curo Salus - Laurel House	CS2013319767	11/10/2025	n/a	n/a	n/a	n/a	n/a	3	AMBER
ARISAIG SERVICES (within St Philip's School)	CS2018364373	14/10/2024	n/a	n/a	n/a	n/a	n/a	5	GREEN
East Park community residences group 1	CS2016346438	25/03/2024	n/a	n/a	n/a	n/a	n/a	6	GREEN
East Park community residences group 2	CS2023000257	02/07/2024	n/a	n/a	n/a	n/a	n/a	5	GREEN
Good shepherd close support	CS2013321127	21/02/2025	n/a	n/a	n/a	n/a	n/a	5	GREEN
Catch Scotland ltd - housing support	CS2010274138	09/05/2025	5	5	5	n/a	n/a		GREEN
Carevisions Foster care	CS2004080447	01/11/2023	3	n/a	n/a	n/a	3		AMBER
Carevisions - ibert farmhouse	CS2005109836	11/05/2022	n/a	n/a	n/a	n/a	n/a	5	GREEN
Spark of genius - easter haystons	CS2017354835	30/05/2023	n/a	n/a	n/a	n/a	n/a	4	GREEN
Spark of genius - west cottage	CS2016349363	30/06/2023	n/a	n/a	n/a	n/a	n/a	6	GREEN
Spark of genius- Sunderland	CS2025000310	not yet inspected							GREEN
Spark of genius - north lodge	CS2023000256	20/01/2025	n/a	n/a	n/a	n/a	n/a	6	GREEN
Spark of genius - Foxhill cottage	CS2025000373	19/01/2026	n/a	n/a	n/a	n/a	n/a	4	GREEN
Kibble fostering	CS2004082220	13/12/2023	5	n/a	n/a	n/a	6	n/a	GREEN
Applied care and development ltd - Wallace hall	CS2003015103	21/03/2024	n/a	n/a	n/a	n/a	n/a	5	GREEN
Applied care and development ltd - close support - torrs complex	CS2003015103	21/03/2024	n/a	n/a	n/a	n/a	n/a	5	GREEN
Alltogether Care Services Ltd	CS2013317305	10/02/2026	6	n/a	6	n/a	n/a	n/a	GREEN
Foster care associates scot limited	CS2004083526	05/05/2023	5	n/a	n/a	n/a	5		GREEN
Quarriers fostering	CS2004085352	23/11/2023	4	n/a	n/a	n/a	4		GREEN
Quarriers - Rivendell	CS2003001119	30/10/2024	n/a	n/a	n/a	n/a	n/a	4	GREEN

Crossreach - Carraig view	CS2020381520	09/05/2025	n/a	n/a	n/a	n/a	n/a	3	AMBER
Crossreach children services - finniescroft farm	CS2016345742	04/03/2024	n/a	n/a	n/a	n/a	n/a	4	GREEN
Starley hall school ltd	CS2003007103	04/09/2025	n/a	n/a	n/a	n/a	n/a	4	GREEN
Barnardo's fostering	CS2004082106	22/03/2023	3	3	4	n/a	5	n/a	AMBER
Harmony education trust ltd	CS2003011066	20/06/2025	n/a	n/a	n/a	n/a	n/a	5	GREEN
Swiis foster care Scotland ltd	CS2004080882	06/11/2024	5	n/a	n/a	n/a	5	n/a	GREEN
Scotnursing & medical services ltd - nurse agency	CS2011300901	05/02/2026	5	4	n/a	n/a	4	n/a	GREEN
Scotnursing & medical services ltd - support service	CS2011303124	16/04/2024	5	n/a	5	n/a	n/a	n/a	GREEN
Fostering relations ltd	CS2007145923	14/08/2024	5	n/a	n/a	n/a	5	n/a	GREEN
Vsa - linn moor school	CS2003000163	13/03/2025	n/a	n/a	n/a	n/a	n/a	5	GREEN
The national fostering agency (scotland) ltd	CS2005098696	28/11/2024	5	n/a	n/a	n/a	n/a	5	GREEN
The national fostering agency	CS2018363688	28/11/2024	5	n/a	n/a	n/a	4	n/a	GREEN
Fostering people limited	CS2012311047	27/02/2025	5	n/a	n/a	n/a	5	n/a	GREEN
Jmt care services ltd	CS2009196557	31/07/2025	6	n/a	n/a	n/a	6	n/a	GREEN
Foster care connect ltd	CS2005086428	21/05/2025	4	4	4	-	5	n/a	GREEN
East Dunbartonshire council fostering	CS2005087079	15/11/2023	5	n/a	n/a	n/a	4	n/a	GREEN
Scottish nursing guild - nurse agency	CS2007155863	18/05/2022	6	6	n/a	n/a	n/a	n/a	GREEN
The adolescent and children's trust - fostering	CS2007162713	20/09/2024	5	n/a	n/a	n/a	5	n/a	GREEN
Key housing association	CS2004073239	06/03/2025	5	5	5	n/a	5	n/a	GREEN
St Andrews children society limited	CS2004080812	30/01/2025	4	n/a	n/a	n/a	4	n/a	GREEN
Moore house care and education - holly bank (Granby avenue)	CS2005087031	23/08/2024	n/a	n/a	n/a	n/a	n/a	5	GREEN

Antonine Court Limited - Antonine All Stars	CS2023000362	19/06/2026	1	1	1	n/a	2	n/a	RED
Kirkton Holme at Airdrie childcare	CS2017358765	09/11/2023	5	5	5	5	n/a	n/a	GREEN
Rock trust - bedrock and housing first for youth	CS2004056512	13/06/2025	5	n/a	5	n/a	n/a	n/a	GREEN
Birthlink	CS2004085774	20/05/2024	5	4	5	n/a	5		GREEN
Alltogether care services ltd	CS2004085774	18/04/2023	6	6	n/a	n/a	n/a	n/a	GREEN
National autistic society Scotland	CS2008168914	25/09/2025	5	n/a	4	n/a	5	n/a	GREEN
Cornerstone community care	CS2024000121	27/03/2025	n/a	n/a	4	n/a	4	n/a	GREEN
Hyndland after school club	CS2003005764	12/02/2025	3	3	3	4	n/a	n/a	GREEN
Chatterbox childcare ltd	CS2005098748	17/10/2024	4	4	3	4	n/a	n/a	GREEN
Pride and joy nursery	CS2014325911	28/10/2021	4	5	4	4	n/a	n/a	GREEN
Rossie secure accommodation	CS2003001447	22/01/2025	n/a	n/a	n/a	n/a	n/a	5	GREEN

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 Where a regulated service receives a grade 2 (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 WD HSCP is satisfied that the provider has demonstrated sustained levels of improvement.

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 WD HSCP's commitment to work with providers within an agreed assurance framework.

12. Directions

12.1 Not required for this report.

Name: Julie Slavin
Designation: Chief Financial Officer
Date: 22 September 2026

Person to Contact: Neil McKechnie
Contracts, Commissioning & Quality Manager
West Dunbartonshire HSCP
Hartfield Clinic,
Latta Street, Dumbarton G82 2DS
E-mail: Neil.McKechnie@west-dunbarton.gov.uk

Appendices: None

Background Papers: None

**WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP
BOARD**

AUDIT AND PERFORMANCE COMMITTEE

Report by Julie Slavin Chief Financial Officer

22 September 2026

Subject: Appendix 2 – Comp Care Update Report

1. Purpose

- 1.1** To provide the HSCP Board Audit and Performance Committee with an update on Care Inspectorate activity relating to Independent Lifestyles T/A Compcare Comprehensive Care Services (Comp Care), which is a home care provider within West Dunbartonshire.

2. Background

- 2.1** In line with the updated reporting scope, the Contracts, Commissioning & Quality Assurance Team provide the HSCP Board Audit and Performance Committee with a report for noting, for any service (including those services commissioned by West Dunbartonshire HSCP but delivered in a different Local Authority) rated as being Red in the Regulated Commissioned Services Report. The risk ratings are defined as being:

Risk Rating	Criteria
RED	Any service that is graded 2 (Weak) or less by the Care Inspectorate and/or subject to a Large-Scale Investigation.
AMBER	Any service that is graded 3 (Adequate) by the Care Inspectorate.
GREEN	Any service that is graded 4 (Good) or higher by the Care Inspectorate.

- 2.2** Comp Care is rated as RED, because they have been assessed as a 2 – Weak in one or more areas by the Care Inspectorate.
- 2.3** Comp Care are a home care provider who operate in West Dunbartonshire, Renfrewshire, South Ayrshire Falkirk and East Dunbartonshire.
- 2.4** During the period of moratorium, Comp Care notified all placing authorities concerning a significant issue regarding visa's which may compromise their ability to sufficiently resource the services they deliver and meet their obligations under the Health and Care (Staffing) (Scotland) Act 2019.

- 2.5** WD HSCP sought advice and guidance from West Dunbartonshire Council's Legal team and Corporate Procurement Unit to understand its contractual position should the provider be unable to meet its obligations under our Terms and Conditions.

3. Main Issues

- 3.1** There are significant risks to vulnerable service users associated with continuing to engage Comp Care should they be unable to meet their contractual obligations.
- 3.2** Following advice from West Dunbartonshire Council's Legal Team, WD HSCP's Senior Management Team agreed that notice should be served on Comp Care.
- 3.3** WD HSCP have reviewed all care and support packages delivered by Comp Care and new providers have been identified through our Supporting Community Independence – Care at Home Framework.
- 3.4** WD HSCP have been advised that Comp Care have since gone into liquidation and are no longer trading. All care and support packages were transferred to alternate providers prior to Comp Care withdrawing services.

4. Options Appraisal

- 4.1** Not required for this report.

5. People Implications

- 5.1** There are no personnel issues associated with this report for West Dunbartonshire Council staff.
- 5.2** There are personnel implications for Comp Care's employed staff who are working under Sponsorship Visas.

6. Financial and Procurement Implications

- 6.1** There are no financial and procurement implications associated with this report. The Supporting Community Independence – Care at Home Framework has a fixed hourly rate, meaning that the transfer to alternative providers was done so without incurring higher hourly rate costs.

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 2 (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 WD HSCP is satisfied that the provider has demonstrated sustained levels of improvement.

7.3 Comp Care's risk profile remains Red.

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.

Name: Julie Slavin
Designation: Chief Financial Officer
Date: 22 September 2026

Person to Contact: Neil McKechnie
Contracts, Commissioning & Quality Manager
West Dunbartonshire HSCP
Hartfield Clinic,
Latta Street, Dumbarton G82 2DS
E-mail: Neil.McKechnie@west-dunbarton.gov.uk

Appendices: None

Background Papers: Comp Care's Care Inspectorate inspection report is available online at <https://ci-web-media-production-bucket.s3.eu-west-2.amazonaws.com/inspection-reports/CS2025000205/326697.pdf>

**WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP
BOARD**

AUDIT AND PERFORMANCE COMMITTEE

Report by Julie Slavin Chief Financial Officer

Date: 22 September 2026

Subject: Appendix 3 – Antonine Court Update Report

1. Purpose

- 1.1** To provide WD HSCP Board Audit and Performance Committee with an update on Care Inspectorate activity relating to Antonine Court Limited, which incorporates the services known as Antonine Court and Antonine Allstars.

2. Background

- 2.1** In line with the updated reporting scope, the Contracts, Commissioning & Quality Assurance Team provide WD HSCP Board Audit and Performance Committee with a report for noting, for any service (including those services commissioned by West Dunbartonshire HSCP but delivered in a different Local Authority) rated as being Red in the Regulated Commissioned Services Report. The risk ratings are defined as being:

Risk Rating	Criteria
RED	Any service that is graded 2 (Weak) or less by the Care Inspectorate and/or subject to a Large-Scale Investigation.
AMBER	Any service that is graded 3 (Adequate) by the Care Inspectorate.
GREEN	Any service that is graded 4 (Good) or higher by the Care Inspectorate.

- 2.2** Antonine Court is a day centre registered with the Care Inspectorate to provide a care service to a maximum of 32 adults with physical disability and/or complex needs.
- 2.3** Antonine Allstars offers evening and weekend support to up to 30 children and young people who have physical disability, learning disability and/or complex needs.
- 2.4** The service is located in Drumchapel and shares premises with the organisation's children and young people's care service. Although the premises are shared the services operate at different times of the day and week.

- 2.5** This is an out of area service where Glasgow City Council are the contracting entity for both services and with Glasgow City Health and Social Care Partnership undertaking annual contract monitoring. In 2025-26 Antonine Court and Antonine Allstars gained a place on Glasgow City HSCP's Framework for Day Services including Day Centres.
- 2.6** West Dunbartonshire HSCP (WD HSCP) spot purchases 1 place at Antonine Court and 12 places in Antonine Allstars (with a further 4 on the waiting list). Antonine Court has been placed under Large Scale Investigation by Glasgow City HSCP and Antonine Allstars took the decision to cancel their Care Inspectorate registration, meaning the service is no longer operational.
- 2.7** Antonine Court and Antonine Allstars are rated as RED, because they have been assessed as a 2 (weak) and 1 (unsatisfactory) in one or more areas by the Care Inspectorate.
- 2.8** Antonine Court Ltd receive referrals from Glasgow City HSCP, WD HSCP and East Dunbartonshire HSCP.
- 2.9** WD HSCP spot purchases 1 place at Antonine Court and 12 places in Antonine Allstars.
- 2.10** On 19 June 2026 WD HSCP withdrew all children and young people from Antonine Allstars and a risk assessment was completed with respect the placement at Antonine Court.

3 Main Issues

- 3.1** WD HSCP had raised concerns regarding the services delivered by Antonine Court Ltd since April 2026, directly with the provider and Glasgow City HSCP. This culminated in the Care Inspectorate carrying out an unannounced inspection on the 16, 17 and 18 June 2026 of both services.
- 3.2** WD HSCP attended the Care Inspectorate feedback on the 19 June 2026. Key themes were noted as:
- Non-conformance with Safer Recruitment and Protection of Vulnerable Groups (PVG) protocols.
 - Notifications and incidents not been reported or recorded.
 - No internal investigations pertaining to incidents.
 - Key organisational policies and practice based policies are missing, insufficient or non-specific to the service.
 - Evidence of children, young people and vulnerable adults not being appropriately supervised.
 - Inappropriate restrictions implemented which increased fire safety risks.
 - Lack of clarity regarding staff disciplinary processes and procedures.

- 3.3** Following inspection of both services, the Care Inspectorate provided the following grades:

Antonine Court

Key Quality Question	Grade
How well do we support people's wellbeing?	2 (weak)
How good is our leadership?	1 (unsatisfactory)
How good is our staff team?	2 (weak)
How good is our setting?	2 (weak)
How well is our care and support planned?	2 (weak)

Antonine Allstars

Key Quality Question	Grade
How well do we support people's wellbeing?	1 (unsatisfactory)
How good is our leadership?	1 (unsatisfactory)
How good is our staff team?	1 (unsatisfactory)
How well is our care and support planned?	2 (weak)

- 3.4** On 19 June, Antonine Court Ltd advised that Antonine Allstars were pausing their service, however, Antonine Court would remain operational.
- 3.5** The Care Inspectorate carried out a follow-up inspection of the services given the level of risk and aligned to the short notice requirements, and as a result of this inspection, on 25 June 2026 the Care Inspectorate served an Emergency Condition Notice and Improvement Notice on Antonine Court Ltd by way of Enforcement Action.
- 3.6** The Emergency Condition Notice limited to the numbers of adults that could attend the service to 10 and was served as a direct alternative to seeking a court order to cancel the services registration.
- 3.7** The Enforcement Action notices placed a number of requirements on the service which are required to be met within a range of timescales the first one being 7 July 2026 and the furthest away being 4 August 2026. WD HSCP will work in partnership with Glasgow City HSCP who are the lead commissioner for this service to track progress with the improvements
- 3.8** Antonine Court Ltd, advised the host authority and Care Inspectorate Antonine Allstars were voluntarily cancelling their Care Inspectorate registration, meaning the children's and young people's service would cease.

3.9 WD HSCP had made an earlier decision to withdraw all children and young people from Antonine Allstars and allocate individual budgets to families as there is no alternative service provision available within West Dunbartonshire.

3.10 WD HSCP Senior Management Team prepared an Elected Members briefing note on 29 June 2026.

3.11 Glasgow City HSCP has placed Antonine Court under Large Scale investigation. WD HSCP will be part of this process with the first meeting scheduled for 3 July 2026.

4. Options Appraisal

4.1 Not required for this report.

5. People Implications

5.1 There are no personnel issues associated with this report for West Dunbartonshire Council staff.

5.2 There are personnel implications for Comp Care's employed staff who are working under Sponsorship Visas.

6. Financial and Procurement Implications

6.1 There are no financial and procurement implications associated 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 2 (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 WD HSCP is satisfied that the provider has demonstrated sustained levels of improvement.

7.3 Antonine Court's risk profile status has changed to Red and WD HSCP will support the Large Scale Investigation process.

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.

Name: Julie Slavin
Designation: Chief Financial Officer
Date: 22 September 2026

Person to Contact: Neil McKechnie
Contracts, Commissioning & Quality Manager
West Dunbartonshire HSCP
Hartfield Clinic,
Latta Street, Dumbarton G82 2DS
E-mail: Neil.McKechnie@west-dunbarton.gov.uk

Appendices: None

Background Papers: The Care Inspectorate reports can be accessed by following the links below:

Antonine Court [328308.pdf](#)
Antonine Allstars [328543.pdf](#)

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP**AUDIT AND PERFORMANCE COMMITTEE****Report by Val Tierney Chief Nurse****22 September 2026**

Subject: HSCP Quarter 1 Clinical & Care Governance Committee Report**1. Purpose**

West Dunbartonshire HSCP aims to provide high quality care, which is person-centred, effective, and safe. The purpose of this report is to provide an update on key areas of progress, or any issues or challenges, in meeting this aim. The Quarterly Clinical and Care Governance Report (Appendix 1) supplements annual reporting, offering the committee regular updates. It covers services hosted, jointly provided, or commissioned externally, and highlights key achievements, risks, and challenges affecting care quality.

2. Recommendations

- 2.1** Note the progress related to strengthening oversight, assurance of care quality, and related improvement efforts.
- 2.2** Note the update on the risk previously escalated to the NHSGGC Primary Care Clinical Governance relating to Speech and Language Therapy

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** Efforts continue to strengthen oversight and reporting on social care and social work governance and care quality. With agreement to develop core metrics to support oversight of care quality.

- 4.2 Concerted efforts continue regarding the management of significant adverse event reviews (SAER) to support timely completion and ensure alignment with NHSGGC key performance indicators. Improvement is achieved but sustaining remains challenging and that efforts to increase capacity in the system are ongoing.
- 4.3 The increase in the number of complaints in comparison to the last quarter was noted and the impact of care at home service redesign noted. The addition of a systematic method for capturing lessons learned from upheld complaints that reached stage 2 was recognised as a positive step toward providing stronger evidence of how services act on complaints and improve. Insights from these reports will be included in the HSCP's annual complaints report. It was also agreed that promoting the use of Care Opinion across all service areas will be a key focus of activity for the public engagement Officer.
- 4.4 The Community Optometry service now offers several new activities, which led to concerns about community optometrists' access to Occupational Health support for needlestick injuries and access to Hepatitis B immunisation. It has been agreed that needlestick injuries of Optometrists will be managed by NHSGGC Occupational Health (OH) Services. Work is ongoing to clarify expectations regarding oversight arrangements for the Optometry service to ensure professional regulation and oversight and to monitor the quality of new service provision.
- 4.5 The strong performance of the District Nursing, Focussed Intervention and Community Care and treatment Team across all key quality metrics was commended.
- 4.6 Speech and Language Therapy (SLT) Risk Update on issues escalated in previous report. This remains on HSCP Strategic Risk Register. Controls are in place locally while awaiting outcome of board wide review. Successful recruitment of 1.0 wte SLT due to commence September 2026. However, meantime risk remains and this was again escalated via appropriate NHSGGC channels.

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** Issues surrounding staff absence, recruitment, and retention continue to present a credible risk to the quality of care provided. Staffing shortages continue to impact on several adult social work services, leading to challenges in meeting statutory deadlines for assessments, care planning, and reviews. Efforts are underway to better identify and measure risks, as well as to track the effectiveness of strategies aimed at reducing these pressures and improving performance. Strengthened assurance and oversight processes related to quality assurance and improvement across social work and social care, support effective response to emerging risks minimising their potential impact. There remains a risk that staffing challenges may lead to non-compliance with statutory requirements set out in the Health and Care (Scotland) Staffing Act (2019).
- 8.4** Appendix 1 details improvements in NHSGGC key performance indicators for significant adverse event reviews and challenges sustaining compliance noting that delays in improvement may 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 06.07.2026

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

Appendix 1

West Dunbartonshire Quarter 1 Clinical and Care Governance Committee Exception
Report (2026-2027)

GOVERNANCE LEAD UPDATE FOR Primary Care and Community Clinical Governance Forum



Report To:	1. WDHSCP CCG (02.06.2026) 2. West Dunbartonshire SMT (15.07.2026) 3. Primary Care and Community Clinical Governance Forum Meeting (23.07.2026) 4. West Dunbartonshire Integration Joint Board Audit and Performance Committee (22.09.2026)									
Report Author:	Val Tierney Chief Nurse									
Date:	Exception report from WDHSCP Clinical and Care Governance Meeting 02.06.2026 Quarter 1 Report -									
Sector/ Directorate	East Dunbartonshire	☐	East Renfrewshire	☐	Glasgow City	☐	Inverclyde	☐	Renfrewshire	☐
	West Dunbartonshire	☒	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

Clydebank Coil Training hub is due to start providing appointments to Clydebank patients from beginning of July. This is a 1-year joint project with Sandyford Services with the aim of increasing numbers of trained coil fitters within Clydebank and increasing access to coil fitting for patients in Clydebank. This builds on the successful introduction of the service in Vale of Leven/ Dumbarton.

SECTION 2: KEY SUCCESSES

Please outline any key areas you would like to highlight

Adult Nursing – Community treatment and Care Services (CTAC), District Nurses & Focussed Intervention team (FIT)

- District Nursing CCAAT in March Clydebank Green overall and Dumbarton/Vale were Gold. Both areas showed record keeping for MUST could be improved upon an Action Plan is in place to address.
- Treatment Room Clydebank first CCAAT with new board wide tool was Amber, however it should be noted a significant reason for this that the completion of the Direction to Administer that is completed by GPs impacted as they do not write milligrams in full as per recommended practice. In addition, there were other aspects within the tool that could not be applied correctly due to EMIS Web system utilised within Treatment Room Services. Quality Assurance lead is feeding back to board group regards this.

- District Nursing Key Performance Indicators (KPI):
 - Preferred Place of Death (PPD) has now been at 100% for 12 months (85% is board target 60% is national target)
 - PPD Achieved A 91.9% average over last 12 months (85% is board target 60% is national target)
 - SSKINS 99% (90% is board target)
 - MUST 99% (90% is board target)
 - CAUTI 99% (90% is board target)
 - Appraisal across services 87%
 - MUST for Focussed Intervention team (FIT) 95%
- Ongoing monitoring of Quality Assurance CCAAT and KPIs to evidence care/treatment being delivered is of high standard and to identify any gaps in services, training etc.

SECTION 3: KEY RISKS

Please outline any key areas you would like to highlight

Update on issues escalated in previous report.

1. Speech and Language Therapy (SLT) Risk Update on issues escalated in previous report. – remains on HSCP Strategic Risk Register

Controls In Place locally while awaiting outcome of board wide review: - and successfully recruitment of 1.0 wte due to commence September 2026. Meantime risk remains

1.1 Risk raised AHP Director, who has raised with Board Nurse Director. Position Paper being drafted.

1.2. Weekly: Additional hours (4 hr) by the SLT lead, and 4hrs by SLT as overtime.

Prioritisation of high-risk referrals and ongoing treatment continues. Gap in provision 19/6 -29/6 due to planned leave with advice to admit to hospital if urgent assessment required. FW will follow up with AHP Director as this was not considered to be a reasonable mitigation. SLT – recruited 1.0 wte due to commence Sept 2026.

2. Compacare

Comp Care are a home care provider who operate in West Dunbartonshire, Renfrewshire, South Ayrshire Falkirk and East Dunbartonshire. Currently Comp Care deliver 670 hours per week within West Dunbartonshire to 35 service users. Following an increase in ASP activity in Quarter 3 and Quarter 4 of 2025-26 a decision was taken by WD HSCP to place a moratorium on placing new packages of care with the provider in January 2026.

On 16 March 2026 Comp Care advised all purchasing Health and Social Care Partnerships that their organisations Sponsor Licence has been revoked by the UK Home Office (Visa's and Immigration Department). Meaning that a curtailment notice will be served on the visas of most of their staff who are overseas workers. This is not a decision that can be appealed by Comp Care. WD HSCP is working with colleagues from other placing authorities and West Dunbartonshire Council's Legal and Procurement team to ensure we are able to manage the risk and take appropriate actions as are necessary in this emerging situation WD HSCP have increased the risk rating attributed to Comp Care from Green to Red and appropriate contingency planning has commenced as would be standard when faced with this type of issue. Comp Care is rated as RED, because they have been assessed as a 2 – Weak in one or more areas by the Care Inspectorate.

3. School Nursing

WDHSCP service has a risk assessment in place, staffing capacity limits delivery of all care pathways and the waiting list numbers are increasing. The risk assessment is reviewed monthly. NHSGGC wide work is underway to complete a service specification and determine the most effective use of the school nurse resource in offering targeted support to the most vulnerable children and young people.

4. Older Peoples Care Homes (External)) - noted

1. Enhanced surveillance continues re Clyde Court which continues to make good progress, and we continue to support them on their improvement journey – they have had support from NHSGGC CHC with learning and education across a range of areas and have engaged well with this
2. Annual Collaborative Care Home Support Team annual Report 2025 submitted to WDHSCP CCG. Noted highlighted concern regarding resident reviews completion both by care homes and HSCP and requirement for improvement. This is a risk and is challenging given the pressure on HSCP review team.
3. Note that the number of intermediate care beds in Hillview has been reduced from 7 to 5 following service evaluation- Occupancy was steady at 60% and this money can be reinvested in another area for greater effect.
4. Work is ongoing with Queens Quay and NHSGGC Flow navigation Centre using Consultant Connect to develop pathways to further enhance call before you convey activity

Noted Queens Quay inspection and two requirements outstanding progress update provided regards

1. Staff have knowledge and skills to use electronic eMarr system. Systems are put in place to ensure that medications have been administered and where not given, a reason noted. There are robust audit trails to ensure that these systems are being adhered to.
2. Staffing: Use a suitable dependency tool to review the needs of people regularly and adjust staffing levels appropriately. Ensure staff are deployed effectively. Work is planned to enhance communication and oversight of staffing from point of care to Senior Management Team (SMT)

4. Adult Social Work Staffing shortages continue to impact on several adult social work services, leading to challenges in meeting statutory deadlines for assessments, care planning, and reviews. Efforts are underway to better identify and measure risks, as well as to track the effectiveness of strategies aimed at reducing these pressures and improving performance. Staff absences and unfilled positions pose a significant risk to both service delivery and quality across various teams. The growing demand for certain services puts extra pressure on employees, with Social Work Services especially impacted by these challenges.

7. District Nurse risk to service due to current electronic recording system becoming obsolete, recommended temporary move to EMIS web by ehealth which does not have the required recording system, whilst new platform built. This is noted as a NHSGGC wide risk.

8. District Nurse Referral risk – Current referrals are received through GP system EMIS Primary Care system which is being replaced in July 2026. The new system called Vision does not have the same visibility within the task function which is currently the main route of communication with DN teams for a number of practices. eHealth recommend West Duns move to SCI gateway referral which eHealth advised is the system used in all other HSCPs within GGC. Moving to sci referral would also help to align to front door project and SPOA. A plan is being agreed with GP colleagues to support safe transition to SCI gateway referrals into the District Nursing service

SECTION 4: HOSTED SERVICES

Please provide information to date and highlight key areas.

HSCP	Hosted Service	Comments
West Dunbartonshire HSCP	MSK Physiotherapy	Main issues still MSK waiting times (max wait decreased one week to 17 weeks). The Board has provided the service with £1.2 million to address waiting times over next 2-3 years (money transferred and added to MSK reserves budget). The service is starting by over recruiting 8 wte to see immediate improvement and allow some time for further waiting list initiative planning Of note this month is that the MSK service has been audited over an 8-week period and the report has been finalised and will be presented to Board Audit and Risk Committee. Audit is extremely positive. Generally, the positives are around the service culture; clear suite of operational procedures; consistent clinical vetting; all urgent patients seen within the 4-week target; structured urgent care pathways and robust reporting process to West Dunbartonshire and Board. There were positives around the use of Quality improvement methodology; work plans; SOPs; trackcare error reporting and consistent single service approach to patient care across all geographical areas and a “collaborative; patient centred and highly responsive culture” across the MSK service and staff displayed a clear commitment to patient experience and fair access. For minor improvement there were recommendations for the MSK service in regards to version control (one SOP was out of date for review); the reporting process should be documented to formalise it; there was suggestions for Quality assurance check to be done in regards to an incomplete self-referral that admin staff held on to for 2 weeks trying to contact patient rather than follow SOP and return referral. There was a query to the Board around whether quality assurance checks should be in place within Referral Management Centre (RMC) around incorrect reinstatement of referrals and the use of medical unavailability. There was also a query around clinical revalidation of waiting lists for the Board (the Auditors were provided with proof that the

		service had tried to get this done but Board were not doing this for waiting times under 32 weeks at present).
	Retinal Screening	An error has occurred with one set of results letters sent out for the DES programme, such that two letters have been included in each envelope, one for the addressee and a letter for another patient. Each letter has name, address and CHI details for each patient. This affects 266 patients. These letters will all be sent again. Advice is being sought from Information Governance for this data breach. The PAG agreed the following actions. • Detailed check of all print runs using the same profile by the same user between March 6th and now, to ensure these print runs have not been similarly affected. • To immediately resend all results letters from the print run on 6/3/26, ensuring single letter to each patient. • To follow advice from Information Governance about the data breach including any apologies that need to be made. • Ensure refresher training for all relevant staff in the Call/Recall Team for the Royal Mail 'Hybrid print/post' app, including detailed check of all pages in the example print output (that must be checked and agreed before agreeing to the print run in the app). • Advise DPH of this data breach and prepare communications statement.
	Optometry	Confirmed It has now been agreed that needlestick injuries of Optometrists will be managed by NHSGGC Occupational Health (OH) Services. Proposal is that they would contact Flow Navigation Centre for support . The group recognised the need to ensure safe pathways of care and polices ad procedures with respect to developments in service Work ongoing to confirm oversight arrangements to increase professional regulation / oversight. Also to monitor quality of new service provision – anterior eye issues, community glaucoma service – and to

		ascertain NHSGGC role / West Dunbartonshire CCG expectations and Lead Optometrist role
--	--	--

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

Please outline any key areas you would like to highlight

Successful Recruitment of 1.0 wte due to commence September 2026. Meantime risk remains (see above)

SECTION 6: PCCCGF WORKPLAN

Please outline any progress /ideas for shared learning across NHSGGC

Discussion took place on updating 2026 work plan to reflect achievements in strengthening governance reporting and oversight of care quality across the HSCP. This will be a key focus of clinical and care governance development session scheduled for 22nd July, alongside the following priorities

NHSGGC Clinical Governance Related Guidance Policy

[Clinical governance standards – Healthcare Improvement Scotland](#)

1. Social Work Social Care Proforma for reporting to CCG Subgroup
2. Quality Framework HSCP – finalise sign off
3. CCG Action plan
4. Review of TOR CCG Group

SECTION 7: ADULT SUPPORT PROTECTION

Please provide update as discussed at Local HSCP Governance Groups

Staffing shortages continue to impact on several adult social work services, leading to challenges in meeting statutory deadlines for assessments, care planning, and reviews. Efforts are underway to better identify and measure risks, as well as to track the effectiveness of strategies aimed at reducing these pressures and improving performance. Staff absences and unfilled positions pose a significant risk to both service delivery and quality across various teams. The growing demand for certain services puts extra pressure on employees, with Social Work Services especially impacted by these challenges.

SECTION 8: COMPLIMENTS, COMPLAINTS AND FEEDBACK

With the return of the Public Engagement Officer a key focus for development agreed was need to increasing the number of Care Opinion stories submitted by supporting services to effectively promote this opportunity.

The quarter 4 (205-2026) Complaints data was reviewed at the meeting noting an increase in Stage 1 complaints received this Quarter compared to last Quarter (3) where there were 66 Stage 1 complaints received, an increase of 34 complaints. A peak in complaints within Care at Home was noted attributed to service redesign and inspection/press activity

There had also been an increase in Stage 2 complaints received this Quarter compared to last Quarter (3) where there were 22 Stage 2 complaints received, an increase of 4 complaints. The need for improvement on complaints response time was noted. Actions to align stage one reporting more closely with NHSGCC reporting requirements to be progressed by Complaints Officer. Also noted was the work underway to capture and focus on learning and service improvement activity because of stage 2 complaints that are upheld. Report due September CCG meeting.

Two SPSO Complaints :

SPSO ID	Service Area	SPSO Outcome	Action/Lessons for HSCP
202503691	Children's Health, Care & Criminal Justice	Not one the SPSO will investigate further because the HSCP's response to the complaint is mostly reasonable.	The SPSO asked the HSCP to provide a letter of apology for the delay and take action to support learning and improvement from this issue.
202512548	Occupational Therapy	The SPSO are satisfied that the HSCP have investigated the complaint in a reasonable and proportionate way.	No action/lessons

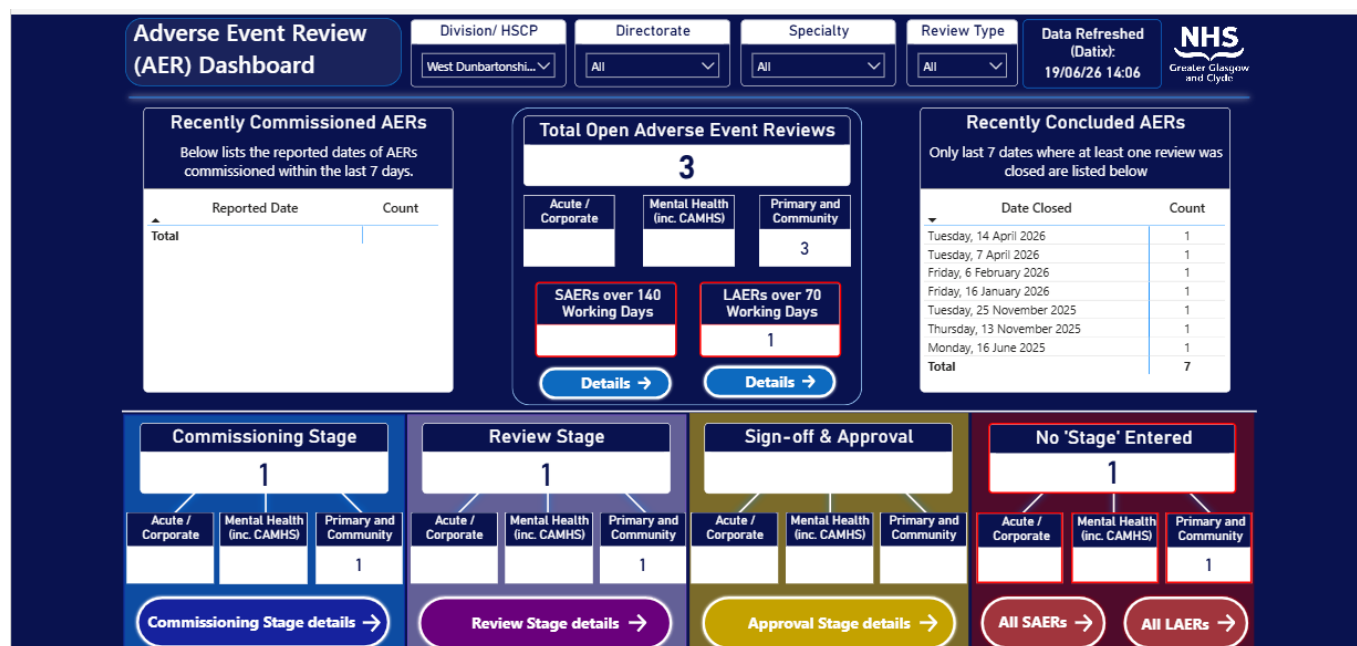
Section 9: Updated 19.06.2026 – Key Performance Indicators Datix / SAER

9.1 Overdue Datix Incidents – Awaiting review by Local Managers

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
West Dunbartonshire HSCP	78	80	82	61	88	53	57	55	31	33	63	49

9.2 Overdue /Open Local Adverse Event Reviews(LAER) / Significant Adverse Event Reviews (SAER)

Report from NHSGGC Dashboard 02.07.2026



Open SAER - Commissioning Stage - SAER commissioned and underway due for completion 07.08.2026

Datix ID & Link	Division	Directorate	Specialty	Incident Category	Reported Date	Breach Date	Days Active (w/days)	Commissioner	AE Type
937911	West Dunbartonshire HSCP	Health and Community Care	District Nursing	Pressure Ulcer Care	09/04/26	22/10/26	51	Fiona Taylor	SAER

Review Stage: LAER concluded and submitted to WDHSCP AEOG 16.06.2026 for review > 70 days. Submitted to NHSGGC Clinical Risk 18.06.2026

AERs at review stage (based on filters selected)									
(i) Reviews >70 working days marked red. (ii) Reviews which pass >70 working days in next 2 weeks marked amber.									
Datix ID & Link	Division	Directorate	Specialty	Incident Category	Reported Date	Breach Date	Days Active (w/days)	Commissioner	AE Type
900165	West Dunbartonshire HSCP	Health and Community Care	Rehabilitation Service	Other Incidents	28/08/25	04/12/25	211	Fiona Taylor	LAER

SAER concluded and submitted to WDHSCP QA on 16.06.2026. Submitted to NHSGGC Clinical Risk 18.06.2026

AERs at review stage (based on filters selected)									
(i) Reviews >70 working days marked red. (ii) Reviews which pass >70 working days in next 2 weeks marked amber.									
Datix ID & Link	Division	Directorate	Specialty	Reported Date	Breach Date	Days Active (w/days)	Commissioner	AER Progress Stage	AE Type
920194	West Dunbartonshire HSCP	Children and Family Services	Health Visiting	24/12/25	08/07/26	127	Lesley James	No data - service to update	SAER

There are now no overdue SAERS or LAERS in West Dunbartonshire

Potential SAERS Outstanding n=1 (action requested)

There are no overdue SAER actions

One new SAER was commissioned General Practice and Specialist Children's Services - 16.06.2026

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

AUDIT AND PERFORMANCE COMMITTEE

Report by Beth Culshaw, Chief Officer

22 September 2026

Subject: Strategic Risk Register Six-Month Review

1. Purpose

- 1.1** The purpose of this report is to present the Strategic Risk Register to the West Dunbartonshire Health and Social Care Board Audit and Performance Committee.

2. Recommendations

It is recommended that the Audit and Performance Committee:

- 2.1** Comment on the Strategic Risk Register (Appendix 1), prior to its submission to the HSCP Board for approval on 29 September 2026.

3. Background

- 3.1** The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) states that an Integration Joint Board (IJB) must have effective governance arrangements in place, which includes systems for managing strategic risks.
- 3.2** The Integration Scheme confirms that a key element of the required risk management process is the preparation, scrutiny, approval and then annual review of the strategic risk register for the Health and Social Care Partnership.
- 3.3** The Chief Officer is responsible for ensuring that suitable and effective arrangements are in place to manage both strategic and operational risks relating to the Health and Social Care Partnership.
- 3.4** The HSCP Board's Financial Regulations reflect the recommendations of the national Integrated Resources Advisory Group which confirms the responsibility of the Chief Officer to develop a West Dunbartonshire Health and Social Care Partnership Risk Management policy and strategy. The current Risk Management Policy and Strategy was approved by the HSCP Board on the 20 September 2021.

4. Main Issues

- 4.1** Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects. It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that beneficial and defensible decisions are made.
- 4.2** The attached Strategic Risk Register (Appendix 1) has been prepared in accordance with the Risk Management Policy and Strategy, approved by the HSCP Board on the 20 September 2021. Similarly, in accordance with that Policy and Strategy, standard procedures are applied across all areas of activity within the Health and Social Care Partnership in order to achieve consistent and effective implementation of good risk management.
- 4.3** Strategic risks represent the potential for the HSCP Board to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk. These are distinct from operational risks, which represent the potential for impact (opportunity or threat) within or arising from the activities of an individual service area or team operating within the scope of the Health and Social Care Partnership's activities.
- 4.4** The Chief Officer has responsibility for managing operational risks as those are more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders. Operational risk registers are maintained by Heads of Service on behalf of the Chief Officer; and are the "building blocks" for the Strategic Risk Register.
- 4.5** Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership, then these can be proposed for escalation to 'strategic risk' status for the HSCP Board.
- 4.6** Following discussion when the Strategic Risk Register was submitted to the Audit and Performance Committee on 23 June 2026 which identified several concerns around duplication, balance of operational and strategic risks and scoring, a full review of the risk register was undertaken by the HSCP Senior Management Team and appropriate Risk Owners.
- 4.7** Following the review, five risks were identified for consolidation within other risks and were deemed suitable for closure. The remaining risks have been refined to take a wider focus. The five closed risks were related to workforce absence, waiting times and legislative duties in relation to Child Protection, Adult Support and Protection and MAPPA.
- 4.8** Following the review, two additional risks were reviewed and agreed for closure. These risks were in relation to effective and sufficient support services and timelines for the national historical abuse inquiry.

- 4.9** Following the review, one risk was reviewed and updated with an increased risk level moving from High to Very High.
- 4.10** A new risk was added to the HSCP Strategic Risk Register concerning Demand and Access for Neurodevelopmental (ND) Assessment Pathways having been identified as a multi-HSCP risk for inclusion in all six NHS GGC area HSCPs registers. This new risk was evaluated as High.
- 4.11** The number of open strategic risks identified by current risk level are as follows: Very High - 2, High - 11, Medium - 3. Overall target risk levels are as follows: High – 2, Medium – 10, Low – 4.

5. Options Appraisal

- 5.1** Not required for this report.

6. People Implications

- 6.1** Key people implications associated with the identified strategic risks are addressed within the mitigating actions of the Strategic Risk Register.
- 6.2** The Risk Management Policy and supporting strategy affirms that risk management needs to be integrated into daily activities, with everyone involved in identifying current and potential risks where they work.
- 6.2** Individuals have a responsibility to make every effort to be aware of situations which place them, or others at risk, report identified hazards and implement safe working practices developed within their service areas.

7. Financial and Procurement Implications

- 7.1** Key financial implications associated with the identified strategic risks are addressed within the mitigating actions of the Strategic Risk Register.
- 7.2** The Risk Management Policy and supporting strategy affirms that financial decisions in respect of these risk management arrangements rest with the Chief Financial Officer.

8. Risk Analysis

- 8.1** Failure to comply with the legislative requirement in respect of risk management would place the HSCP Board in breach of its statutory duties.
- 8.2** The Strategic Risk Register has been reviewed by the appropriate risk owner which has included the addition of new risks, updates to existing risks including risk levels and closure of risks that no longer apply.

9. Equalities Impact Assessment (EIA)

9.1 An equality impact assessment is not required as the recommendations within this report will not have a differential impact on any of the protected characteristics.

10. Environmental Sustainability

10.1 Not required for this report.

11. Consultation

11.1 The Strategic Risk Register has been reviewed and confirmed by the Health and Social Care Partnership Senior Management Team.

11.2 Relevant Monitoring Officers, including internal auditors, have been consulted in the preparation of this report.

12. Strategic Assessment

12.1 Effective risk management will support local and strategic priorities and national health and wellbeing outcomes. It will prevent or mitigate the effects of loss or harm; and will increase success in delivery of the HSCP Strategic Plan, improving lives with the people of West Dunbartonshire.

13 Directions

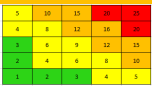
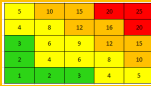
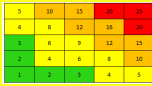
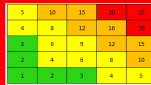
Not required for this report.

Name:	Beth Culshaw
Designation:	Chief Officer
Date:	22 September 2026

Person to Contact:	Alastair Handley Systems, Digital & Information Governance Manager West Dunbartonshire Health and Social Care Partnership 16 Church Street Dumbarton G82 1QL
---------------------------	---

Email: alastair.handley@west-dunbarton.gov.uk

Appendices:	Strategic Risk Register (Appendix 1) Strategic Risk Register Dashboard (Appendix 2)
--------------------	--

Ref No	Description	Cause	Risk Level (previous report)	Controls	Risk level (current)	Risk level (Target)	Status
7	Risk Owner: Chief Social Work Officer Failure to have in place strong social work and social care governance in relation to quality of services and care provided, reliable and accessible data to provide assurance, ability to ensure through measures that statutory requirements are met and reported on, and adequate quality assurance and monitoring methods are in place.	- Gaps in data oversight of statutory functions. - Inadequate structures or accountability for validating and analysing performance data - Fragmented data systems across health and social care service impact on reporting and analysis, particularly given functional limitations of key systems - Limited staff expertise or resource to interpret complex data does not support a performance data driven approach - Resistance to transparency for fear of scrutiny. - Performance data not reviewed regularly or in enough detail. - Reports may lack actionable insights or be misaligned with strategic goals.	3x4 High = 12 	Controls In Place - Regular performance reports are presented to the HSCP Chief Officer and Heads of Services. - Regular performance reports are presented to the Audit and Performance Committee and HSCP Board. - The Senior Management Team reviews performance data at both SMT meetings and via the Programme Management Office. - Establishment of governance around system changes which can impact on reporting - Regular focused meetings on reporting and data within Children's Services Controls in Progress - Roll out of data literacy training. - Ongoing development work to enhance the quality of management information reporting in relation to statutory functions including draft report submission to clinical and care governance boards. - Establishment of focused meetings across remaining services. - Short term work in adult services lead by external consultant with the aim of establishing a core management data set. Challenges remain with the capacity to embed this work in the long term given the pressures on support services. - Terms of reference for Social Work and Social Care Governance Subgroup in development.	3x4 High = 12 	2x4 Medium = 8 	Live/Active
9	Risk Owner: Chief Officer Financial Sustainability and the ability to deliver statutory, safe and effective services. There is a risk that West Dunbartonshire HSCP Board is unable to achieve and maintain financial sustainability within the resources available, while continuing to meet statutory duties and deliver safe, effective and sustainable health and social care services. The risk arises from increasing demand, demographic and public-protection pressures, workforce and commissioned service costs, inflation, insufficient or non-recurring funding, and non-delivery of planned savings. This may result in an unplanned overspend, depletion of reserves, reduced financial resilience and the need for further service redesign, prioritisation or reduction.	- Partner funding allocations do not fully recognise demographic change, deprivation, health inequalities, inflation, workforce costs or the cost of national policy commitments. - Demand and complexity continue to increase, including public-protection, secure-care, prescribing and statutory service pressures that cannot always be constrained within existing budgets. - Approved recurring savings and service-redesign programmes are not delivered in full or within planned timescales. - Workforce pressures, including absence, recruitment, pay costs, temporary staffing and statutory safe-staffing requirements, increase expenditure or limit the pace of redesign. - Financial pressures within externally commissioned services increase provider costs, fee demands and the risk of service interruption or provider failure. - Insufficient recurring financial capacity and continued reliance on non-recurring savings or reserves reduce the HSCP's ability to respond to future pressures.	5x4 Very High = 20 	Controls in place - Annual balanced-budget setting, supported by the Medium-Term Financial Outlook, financial planning assumptions and sensitivity analysis. - Monthly budget monitoring and forecasting, with regular reporting to the Senior Management Team and HSCP Board. - Regular meetings with budget holders to scrutinise expenditure, forecasts, savings delivery and corrective action. - Financial Regulations, Standing Financial Instructions, Procurement Regulations, Partner Scheme of Delegation and Board Directions. - Regular engagement with West Dunbartonshire Council and NHS Greater Glasgow and Clyde on funding, financial performance and emerging pressures. - Service-redesign and savings programmes subject to Programme Management Office and Senior Management Team oversight. - Vacancy-management arrangements that consider financial affordability alongside operational, professional and statutory risk. - Area Resource Group and eligibility arrangements supporting consistent, risk-based and best-value decisions on care and support. - Reserves Policy and regular monitoring of earmarked and unearmarked reserves. - Collaborative working across the six Greater Glasgow and Clyde HSCPs and through relevant regional and national finance and sustainability networks. - Regular review of prescribing, commissioned-service and workforce expenditure as material components of the financial position. - Equality, legal, clinical, care-governance and public-protection considerations incorporated into significant savings and redesign proposals. - Financial sustainability risks affecting service delivery are regularly escalated by the CSWO to ensure senior oversight and timely intervention. Controls in Progress - Review financial recovery and sustainability actions, identifying recurring and non-recurring measures, delivery dependencies and service impacts to improve the current 2026/27 projected outturn position. - SMT to review all approved savings and redesign programmes, confirming forecast delivery, slippage, mitigating action and accountable lead. - Continue to update the Medium-Term Financial Outlook for current partner-funding assumptions, inflation, demand, workforce, prescribing and commissioned-service pressures. - Continue to review and revise forecast reserves and confirm actions required to restore or maintain the approved reserves level. - Review the ongoing implementation and monitoring of the equivalency model, including agreed rates, financial effect and phasing through reviews. With progression to Price per Point model with testing in early 2027. - Continue to refine the explicit assessment of statutory, public-protection, safe-staffing and equality impacts for material savings proposals. - Develop a consolidated view of financial exposure arising from externally commissioned services and provider sustainability. Link to Risks No. 28 and 29.	4x5 Very High = 20 	3x3 Medium = 9 	Tolerated

10	Risk Owner: Head of HR There is a risk that the HSCP is unable to recruit, retain, develop, deploy and support a sufficient number of suitably qualified and skilled staff to meet current and future service demands. Sustained vacancies, workforce shortages, sickness absence, turnover, workload pressures, gaps in management capacity and limited access to profession-specific learning and development may reduce workforce resilience and the HSCP's ability to deliver safe, effective and sustainable services. This may affect the HSCP's ability to meet its statutory and professional responsibilities, including its duties under the Health and Care (Staffing) (Scotland) Act 2019, and to ensure appropriately trained staff are available to undertake risk assessment, risk management and public-protection functions.	1. National and local shortages within Social Work, Social Care, Nursing, Allied Health Professions and other specialist or hard-to-fill occupations. 2. Difficulties attracting, recruiting and retaining suitably qualified and experienced employees. 3. Sustained sickness absence, workforce turnover and employee wellbeing pressures. 4. Increasing demand, workload pressures, financial constraints and continued service redesign. 5. An ageing workforce, potential loss of organisational knowledge and insufficient succession planning for critical and management roles. 6. Reliance on temporary, bank, sessional or agency staffing to maintain service delivery. 7. Insufficient workforce capacity to release employees for statutory, mandatory and profession-specific learning and development. 8. Inconsistent systems and management information for monitoring vacancies, turnover, absence, skills, training compliance and safe-staffing requirements across Council and NHS-employed staff. 9. Failure to fully embed workforce-planning and assurance requirements under the Health and Care (Staffing) (Scotland) Act 2019, including the Common Staffing Method where applicable	3x3 Medium = 9 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls In Place 1. HSCP workforce-planning and governance arrangements monitor workforce capacity, vacancies, recruitment, retention and emerging service pressures. 2. Workforce information is monitored through relevant Council and NHS systems, including vacancy, turnover and sickness-absence reporting. 3. Vacancy-management arrangements assess recruitment requests alongside service need, financial pressures and operational risk. 4. Governance and assurance arrangements oversee implementation of the Health and Care (Staffing) (Scotland) Act 2019, including quarterly NHS assurance reporting. 5. Workload and workforce-planning tools, including the Common Staffing Method, are used where required. 6. Temporary, bank and sessional staffing arrangements support service continuity and reduce agency reliance where possible. 7. Attendance-management policies, procedures and professional HR support are available to managers. 8. Employee wellbeing support, training and resources are available across the partnership. 9. Statutory and mandatory training arrangements are in place, with profession-specific learning and development managed through the relevant services and professional governance structures. 10. Operational staffing pressures are monitored and escalated through service-management arrangements and operational risk registers, with enhanced situation reporting in areas of particular pressure. 11. Recruitment campaigns, newly qualified practitioner support and professional development initiatives are in place for identified shortage occupations. 12. Succession-planning activity is underway for critical, specialist and management roles. Controls In Progress 1. Complete and implement the Workforce and Organisational Development Plan aligned with the new Strategic Plan. 2. Develop integrated workforce reporting that triangulates vacancies, turnover, sickness absence, workforce wellbeing, temporary staffing, skills and service pressures. 3. Strengthen recruitment and retention plans for shortage occupations and hard-to-fill roles. 4. Develop a consistent approach to succession planning and the identification of critical roles. 5. Strengthen assurance reporting under the Health and Care (Staffing) (Scotland) Act 2019. 6. Clarify responsibility for monitoring statutory, mandatory and profession-specific training across Council and NHS-employed workforces. 7. Improve arrangements for identifying and escalating workforce-related risks to service quality, public protection and statutory compliance. 8. Continue targeted work to address persistent absence and workforce pressures within higher-risk services	3x3 Medium = 9 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	2x3 Medium = 6 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
15	Risk Owner: Head of LD, Mental Health and Addictions & Head of MSK Physiotherapy Service Failure to meet waiting times targets - specifically Psychological therapies (waiting times target is 90% of people should commence treatment within 18 weeks of referral) and MSK Physiotherapy Services (AHP MSK waiting times target is that 90% of patients are seen within 4 weeks).	1. Ongoing increased demand on service provision. 2. Capacity impacted by turnover of staff, length of recruitment process to fill vacant posts, sickness absence rates and maternity leave. 3. Demand continues to be greater than capacity.	4x3 High = 12 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls In Place Psychological Therapies 1. Full data cleanse has taken place with ongoing admin support around accurate data recording. 2. Continue to maximise staff capacity and use of peripatetic psychology for additional weekly session. 3. Impact has been substantially due to vacancies and absence however staffing position is improving. The data for these services is impacted due the small number of staff and service users. This will continue to be monitored and reporting is board wide. 4. Senior managers meet with staff fortnightly to ensure that allocation is more streamlined and throughput improves. Procedural issue has been identified with how data is entered which is being resolved. This should show an improvement on the data. 5. Improvement plan is in place. Controls In Place MSK Physiotherapy 1. Clinical vetting to ensure all patients are clinically vetted and those identified as having urgent clinical need are seen within 4 week target. 2. Service continues to have a QJ approach to address waiting times as a priority project. 3. Scrutiny monthly by Health Board and monthly reporting. 4. Ongoing filling of vacancies as they arise. 5. Operational SOPs in place to ensure maximum efficiency.	4x3 High = 12 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	1x2 Low = 2 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
17	Risk Owner: Chief Social Work Officer Failure to meet legislative duties in relation to Child Protection, Adult Support & Protection and MAPPA. There is a statutory requirement to ensure users of adult and children's services receive an assessment of their needs, individualised care plans are in place and that these are subject to review as defined in relevant statute. Services where this applies will be subject to external regulation and the impact of not meeting these requirements presents a risk to service users, appropriate service access and more broadly reputational damage to the HSCP.	1. Failure to embed in practice Integrated and Initial Assessments across Adult and Children's Services. 2. Failure to ensure each service user receiving a service has a written and up to date care plan. 3. Failure to ensure every service user has a review of their plan in line with statutory regulation. 4. Rising demand of Multi Agency Public Protection Arrangements (MAPPA) 5. Within Justice Social Work, pay awards for staff have not been passed on to the HSCP in this ringfenced budgeted area causing use of reserves to support operational delivery. 6. Staffing recruitment within Justice has been unable to be progressed at times where budget is projected as insufficient and use of reserves required.	4x4 High = 16 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls In Place 1. The Adult Area Resource Group standard operational guide defines the roles and responsibilities across services and ensures there is consistent governance across adult services where new service requirements are made. 2. There have been significant improvement in ensuring that care plans and reviews are in place for service users who receive a care at home service, and these have been key requirements as specified by the Care Inspectorate. Development work has taken place to ensure this is now reportable and management oversight has been strengthened with more to do to ensure all statutory reviews and care plans are in place. 3. In 2023 HSCP agreed with the CSWO recommendation to utilise ring fenced CSWO funding from Scottish Government in the development of an Independent Review Team to support statutory reviews for community packages of support in adult services. The team is now partially in place and a pathway developed. 4. The Children's ARG reviewed and re-implemented in September 2024 with Education now being a core member for all children's care placement considerations. 5. The Independent Review Coordinators in Children's Social Work Services are now permanent posts. A system of regular statutory reviews is in place for all looked after children with their care plans being reviewed in line with statutory requirements. 6. Self-evaluation regarding the quality of the assessment require to be progressed in order activity is required to determine quality beyond implementation and this has been taken forward by Team Leader and practitioner agreed by the Strategy Board for What Would It Take? 7. Close working with Children's reporter in relation to the duty to carry out enquiries is in place with agreed processes and solution being developed to ensure information is shared appropriately with the reporter. 8. Strengthened reporting and recording of Care at Home assessments and care and support plans. This includes Organiser specific reports to target areas with poor performance and implement mitigation processes to ensure risk is managed effectively. 9. Strengthened referral pathways into Care at Home to ensure everyone has a My Life Assessment screening prior to transfer to Care at Home. 10. Residential and Sheltered Housing care residents have 6 monthly reviews completed by managers. 11. West Dunbartonshire is part of the North Strathclyde Partnership and oversight reporting structures (SOG/MOG) meet regularly in relation to all MAPPA activity where reporting of activity and the associated risk register is in place. MAPPA activity forms part of reporting to PPCOG to ensure effective oversight and scrutiny. 12. Meeting with SG Justice Team and communication drafted in respect of Justice Pay award which has not been passed over by local authority in 22/23 & 23/24 with a cumulative impact on available budget. Confirmation of Caledonian Funding to support programmed interventions delivery will ease pressure on budget Controls In Progress 1. The implementation of My Assessment and Plan concluded in July 2023. An evaluation on implementation and quality of assessment concluded early in 2024. 2. The work has started regarding the review of My Life Assessment Framework for Adult service, and aligned to that an Initial Assessment is in place for all access to single service provision in Adult services. As yet there is no reportable data to ensure this development can be effectively monitored. 3. Concern that duty to assess for report requests from the reporter not being fully met due to staffing shortages with required assessment provision not able to be undertaken. Ongoing liaison with SCRA /Panel Chairs in place to implement shared solutions to social background requests. Significant improvement identified earlier in year, however performance has declined in recent months. Active management by Team Leaders promoted and oversight of the reports requested. 4. A number of improvements and actions are identified from the independent evaluation being progressed led by Head of Service in Adults. 5. An action plan is in development and review of the assessment documentation with consultation with practitioners is planned. 6. Evaluation on quality of the assessment part of external review, further self-evaluation required to understand the quality of revised assessment tools. 7. Work is taking place with the Information Team to ensure all children looked after reviews can be reported from CareFirst as this oversight is currently captured on spreadsheet. Implementation of a Signs of Safety approach across social work and partners agencies has started and associated training for managers and practitioners. The current My Assessment and Planning tools will be reviewed and strengthened as part of the implementation of the model. 8. Further development of CareFirst reporting on adult statutory reviews is required. 9. Residential care 6 monthly reviews to be completed also by the Care Home Review Team.	3x4 High = 12 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	2x4 Medium = 8 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														

18	Risk Owner: Chief Social Work Officer Failure to ensure all social work staff are appropriately trained and developed, and where required this aligns with SSSC standards, to achieve the standards required across social work services. This should include specific areas such as public protection but is wider in terms of achieving other legislative requirements and best practice standards.	1. Interlinked with Risk Ref 10 the challenges across recruitment and retention further impact on the ability to maintain standards of training and development in line with SSSC standards. 2. Inability to recruit to Learning and Development posts compounded by temporary nature of posts. 3. Operational demands, compounded by recruitment and retention issues, may limit and impact on attendance at learning and development opportunities. 4. Training and development in National child Protection Guidance required	4x4 High = 16 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls In Place 1. Reporting mechanisms are at early stages to ensure both Training needs analysis of staff and training delivered and attended is both captured and able to be reported within social work and social care. 2. NHS staff have statutory APC and CPC training modules which are reportable 3. Care at Home has an inhouse trainer who ensures all new starts undergo APC and CPC training. 4. Raising Concerns pathway is in place as a platform to ensure concerns are discussed in a multi disciplinary forum. 5. Skills passports for council staff are in place and self serve arrangement to managers are available to ensure compliance on mandatory training 6. The learning and developments of staff is identified in a number of learning reviews across adult and children services and training is being commissioned , however there remains some gaps . 7. The use of agency staff is in place across service to support service gaps in vacancies and overseen by the Vacancy Panel Chaired by the CO. 8. Learning and Development posts have now been agreed as recurring permanent posts and recruitments is underway to ensure learning and development is in place for social work staff which is currently being commissioned. At this time 1 post has been recruited. Controls in Progress 1. On an interim basis training and development opportunities are being promoted through a range of commissioned training and through ilearn modules and scheduled management training. 2. Significant improvements have been made in developing reporting for care at home in order to evidence the requirements in relation to staff learning and training with an agency member of staff dedicated to delivering this for the service . This is to support organisers to ensure care plans and review are in place for those receiving care at home services. 3. Signs of Safety and Healing implementation within Children's Services. 4. Refreshed Terms of Reference and focus for the Social Work and Social Care Governance Group which will support workforce development.	3x4 High = 12 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	4x2 Medium = 8 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
24	Risk Owner : Head of Health and Community Care Care at home service delivery	1. The 26/27 budget has been agreed based on planned hours of care, workforce required to deliver this with 52% addition (annual leave, travel time, unplanned absences, training). The budget is sufficient for employee costs, but there is a risk of unbudgeted agency and overtime spend relating to high absence rates, and as scheduling is not efficiently managing the available workforce. There is also an unknown cost relating to commissioning external packages of care. 2.The Service must also deliver safe and effective care, meeting Care Inspectorate standards. 3. Standardised rosters commenced on 20th April 2026 and there is ongoing review of FTE to align with planned hours of care. 4. Criteria has been agreed to define those in scope for mainstream Care at Home services. Application of these criteria require budget identification and has workforce implications. This has still to be finalised.	4x4 High = 16 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls In Place 1. Weekly reporting to CO / Head of Service inclusive of agency and overtime spend. Controls in Progress 1. Process in development to apply eligibility criteria and align resultant planned hours of care per area with an appropriate FTE. 2. Indicative budget allocation per area. This means Organisers have responsibility to ensure they remain in budget, and will be monitored regularly over the financial year to ensure compliance or flag staffing challenges, which in turn allows managerial oversight and decision making is agency spend is indicated to deliver planned care.	4x4 High = 16 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	3x3 Medium = 9 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
25	Risk Owner : Head of Health and Community Care Speech & Language Therapy Resource	1. The HSCP currently holds responsibility for Speech and Language Therapy (SLT) for in patient adult wards at the Vale of Leven, community referrals Dumbarton and Alexandria, and a service level agreement for Helensburgh and Lochside. 2. Agreement in principle for a whole system review of SLT across NGS GGC led by the AHP Director. 3. Pending redesign, the current risk remains due to WTE capacity versus demand.	3x3 Medium = 9 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls In Place 1. Risk raised with SLT leads across GG&C, professional SLT Lead and AHP Director. Leads report no ability to reallocate their resources to support the HSCP during this period of absence. 2. Additional SLT hours offered across SLT workforce, with minimal uptake Resource being targeted to high risk community referrals. 3. No Staff bank SLT resource. Controls in Progress 1. AHP Director reviewing SLT across GG&C. 2. Workload analysis taking place within GG&C led by Alison Gray, SLT Service Manager, to quantify appropriate WTE required for the HSCP service	3x3 Medium = 9 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	1x2 Low = 2 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
26	Risk Owner : Head of Health and Community Care Residential and Nursing Care Home Bed availability.	External factors: 1. Challenges in terms of availability, residential and nursing care home beds within the HSCP. This causes increased delays in discharging people from hospital and also increases risk for these assessed as requiring long term care in the community if no beds are available. 2. In addition, bed availability is also at risk when Homes have moratoriums placed on them if standards of care fall below contractual agreements. When care homes have moratoriums in place or infection prevention control procedures in place e.g. covid outbreak.	3x3 Medium = 9 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls In Place External: 1. Daily monitoring of bed availability and interim beds provided pending moves to place of choice to reduce risk of delays. 2. HSCP Care Home Oversight Group and also Care Inspectorate reports to monitor standards of care across all care homes. 3. Contracts Monitoring Officer works in collaboration with Care Home managers to provide support and early identification of emerging issues. 4. 6 monthly HSCP quality assurance visits. Internal: 5. ARG process ensures all placements meet criteria, and that long term care is indicated due to high level of risk of living at home. Approval and authorisation up to £52,000 by an IOM. Over £52K required Head of Service authorisation. 6. Monitoring process in progress for oversight of budget with escalation process if financial regulations will be breached if an emergency placement is indicated but no budget available.	3x3 Medium = 9 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	2x2 Medium = 4 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														

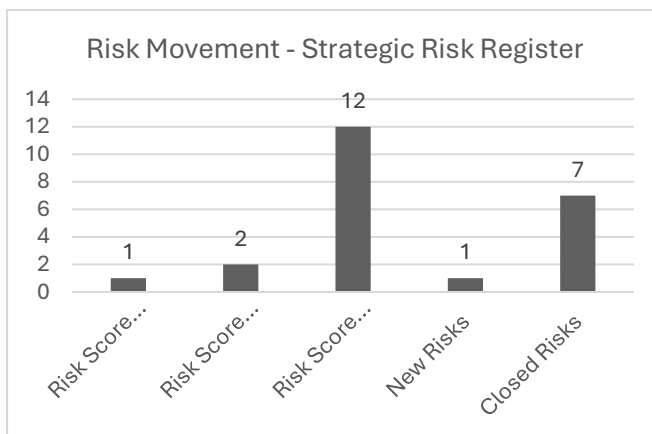
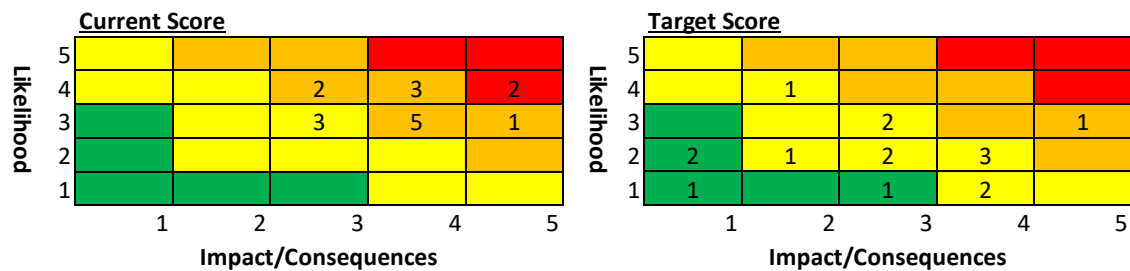
27	Risk Owner : Head of Health and Community Care Risk of failure to discharge timeously leading to increased number of people delayed in being discharged.	1. Workforce capacity to assess timeously to support earlier interventions. This creates risk as earlier interventions could prevent / slow functional and / or social care needs decline. 2. Delayed discharge data remains high, inclusive of people being delayed due to AWI legislation, requiring Guardianship applications before discharges can be implemented. Interdependent with care at home and care home bed availability risk.	4x3 High = 12 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>9</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>8</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	9	12	16	20	3	8	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls In Place 1. Transforming Together workstreams to identify priority areas as a whole system approach to manage flow and prevent unnecessary admissions. Partnership working with Care Homes, the HSCP and Scottish Ambulance Service to reduce admissions from Care Homes. Completion of Future Care Plans. Focused Intervention Team to prevent admissions. Frailty Practitioner and the Home First Response Service. Non Medical Prescribing to allow early treatment e.g. antibiotics for cellulitis / UTI's. 2. POA initiative with Citizens Advice in Dumbarton and Alexandria. Improved processes within the discharge team to ensure fast assessments through to discharge. Controls In Progress 1. Review of community hospital discharge social work workforce and standard operating procedures to enhance flow and target effective use of resources. 2. Front Door redesign will improve flow, link with the FNC+, and ensure timeous and appropriate health and social care interventions.	4x3 High = 12 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>9</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>8</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	9	12	16	20	3	8	9	12	15	2	4	6	8	10	1	2	3	4	5	2x3 Medium = 6 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>9</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>8</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	9	12	16	20	3	8	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	9	12	16	20																																																																														
3	8	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	9	12	16	20																																																																														
3	8	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	9	12	16	20																																																																														
3	8	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
28	Risk Owner: Chief Financial Officer Failure to commission, procure and assure the quality and value of externally commissioned services effectively. There is a risk that the HSCP does not commission, procure, contract-manage and quality-assure externally commissioned services effectively and in accordance with the governance requirements of HSCP Board, West Dunbartonshire Council and NHS Greater Glasgow and Clyde. This may result in services that do not meet assessed need, agreed outcomes, quality standards, statutory requirements or value-for-money expectations, leading to harm or poorer outcomes for individuals, service disruption, financial loss, contractual or regulatory non-compliance and reputational damage.	1. Commissioning plans and service specifications are not sufficiently informed by needs, outcomes, equality, demand, market and financial analysis. 2. Responsibilities across commissioning, operational services, finance, legal, procurement and quality assurance are unclear or fragmented. 3. Contracts, variations, extensions and delegated approvals are not managed consistently or within applicable governance frameworks. 4. Contract monitoring is inconsistent or is not supported by reliable performance, financial and quality information. 5. The HSCP does not have a fully embedded, risk-based quality assurance framework covering regulated, non-regulated and other commissioned services. 6. Workforce capacity, skills, systems and records are insufficient to support effective strategic commissioning and contract management. 7. Operational intelligence, inspections, complaints, incidents, safeguarding activity and provider financial information are not triangulated and escalated consistently. 8. Short-term operational or financial pressures result in reactive rather than strategic commissioning decisions.	3x4 High = 12 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>9</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>8</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	9	12	16	20	3	8	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls in place 1. Strategic commissioning arrangements aligned to the HSCP Board Strategic Plan. 2. Commissioning governance and agreed senior-management oversight. 3. Provider forums and engagement arrangements. 4. Partnership working with service areas, finance, legal and procurement colleagues in relevant commissioning and contracting activity. 5. Contract register and operational monitoring arrangements. 6. Quarterly reporting on externally commissioned regulated services to HSCP Board Audit and Performance Committee. 7. Annual procurement of commissioned services report. 8. Quality monitoring through Care Inspectorate and other external inspection or regulatory intelligence. 9. Established safeguarding, complaints and incident-escalation arrangements. 10. Care-home oversight, provider liaison and contracts-monitoring arrangements. 11. Workforce planning oversight applicable to commissioned services. 12. Existing financial authorisation, procurement and contract-governance requirements. Controls in Progress 1. Approve and implement the HSCP-wide quality-assurance framework, defining minimum standards, evidence requirements, escalation thresholds and reporting routes. 2. Complete the Scheme of Delegation review, clarifying authority and accountability for commissioning, procurement, contract variation and contract management. 3. Validate the contract register, confirming ownership, value, term, expiry, procurement route, monitoring category and risk rating for each material contract. 4. Introduce a risk matrix for externally commissioned service providers, with monitoring intensity proportionate to each providers risk status. 5. Develop an exception-reporting dashboard that triangulates quality, performance, safeguarding, complaints, regulatory and provider sustainability intelligence. 6. Complete CarePay and CareFinance implementation within children and families services. 7. Review the commissioning and contract-management skills and capacity required across the HSCP, not solely within the central commissioning team.	3x4 High = 12 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>9</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>8</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	9	12	16	20	3	8	9	12	15	2	4	6	8	10	1	2	3	4	5	2x4 Medium = 8 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>9</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>8</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	9	12	16	20	3	8	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	9	12	16	20																																																																														
3	8	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	9	12	16	20																																																																														
3	8	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	9	12	16	20																																																																														
3	8	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
29	Risk Owner: Chief Financial Officer Failure or withdrawal of an externally commissioned care and/or support provider. There is a risk that one or more externally commissioned providers becomes financially, operationally or regulatorily unsustainable, withdraws from the market, or is unable to continue delivering services at the required capacity or quality. This could lead to interruption or loss of care and support, risk of harm or distress to individuals and carers, emergency re-provision, workforce displacement, increased costs, reduced market capacity and significant operational, financial and reputational consequences for the HSCP.	1. Workforce shortages, high turnover, sickness absence and competition for suitably skilled employees. 2. Loss, suspension or restriction of sponsorship licences and reliance on overseas recruitment. 3. Pay, National Insurance, utilities, insurance, property, food and other operating-cost pressures. 4. Provider fees or national contract settlements that do not reflect the sustainable cost of delivery. 5. Limited access to reserves, borrowing or working capital. 6. Increasing complexity of need, regulatory requirements and safe-staffing expectations. 7. Quality concerns, enforcement action, moratoriums or loss of registration. 8. Reliance on a small number of providers, limited alternative capacity or concentration within particular service sectors. 9. Wider provider-group failure affecting more than one service or local authority area. 10. Required service redesign or savings reducing certainty over future demand or income.	3x5 High = 15 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>9</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>8</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	9	12	16	20	3	8	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls in place 1. Regular provider forums and direct engagement across high value and high volume commissioned services. 2. Quality assurance activities informed by provider risk profile, allowing a targeted approach to monitoring arrangements, taking cognisance of the small team structure. 3. Care Inspectorate and other regulatory intelligence. 4. Escalation of provider concerns through operational and senior-management governance. 5. Engagement with providers on annual uplifts and material commissioning changes. 6. Collaborative intelligence sharing across Greater Glasgow and Clyde HSCPs and relevant national networks. 7. Business-continuity and emergency response arrangements. 8. Monitoring of care-home capacity, moratoriums and emerging operational concerns. 9. Strategic commissioning intended to support a diverse and sustainable provider market. 10. Existing safeguarding and service-user review arrangements. Controls in Progress 1. Complete a risk assessment relating to provider-sustainability for all Heads of Service, identifying providers of concern and the basis for concern. 2. Explore the possibility of an early warning framework for externally commissioned service providers using indicators and themes aligned to the risk matrix ensuring a consistent approach to managing and monitoring risk. 3. Identify critical providers and services where loss would have the greatest service-user or continuity impact. 4. Develop proportionate contingency plans for each critical provider or service category, including communication, service-user information, workforce, records, payments and alternative capacity. 5. Through existing provider forums, tender documentation and ongoing monitoring arrangements, review where possible exposure to sponsorship-licence changes and overseas recruitment dependency within externally commissioned services. 6. Report provider sustainability by exception to SMT and agree immediate actions.	3x5 High = 15 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>9</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>8</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	9	12	16	20	3	8	9	12	15	2	4	6	8	10	1	2	3	4	5	3x5 High = 15 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>9</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>8</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	9	12	16	20	3	8	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	9	12	16	20																																																																														
3	8	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	9	12	16	20																																																																														
3	8	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	9	12	16	20																																																																														
3	8	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														

30	Risk Owner: Head of HR CareFirst is the HSCP's principal social-work case-management system and supports the recording and management of sensitive service-user information, statutory activity and provider financial payments. The HSCP has been informed that supplier support for CareFirst will cease after 2028. There is a risk that the HSCP and West Dunbartonshire Council do not select, fund, procure, configure and implement a suitable replacement system, and safely migrate the required data, before the existing system is no longer supported. Failure to complete the transition within the required timescale could result in continued reliance on an unsupported system, increased system vulnerability, loss or disruption of essential functionality, an inability to access reliable service-user information, interruption to statutory processes and provider payments, and significant operational, financial, information-governance and reputational consequences.	1. The requirement to identify and implement a replacement within a fixed timescale before support ends after 2028. 2. The need for Council prioritisation and approval within its capital-planning and digital-governance arrangements. 3. The absence of confirmed capital and revenue funding for procurement, implementation, migration, licensing and ongoing support. 4. Competing organisational priorities and limited capacity across the HSCP and Council digital, procurement, finance and operational teams. 5. The complexity of procuring and implementing a system supporting social-work case management, statutory recording and provider financial payments. 6. The volume, quality and complexity of existing data requiring cleansing, retention, archiving and migration. 7. Integration requirements with other Council, NHS and third-party systems. 8. The need to redesign existing processes, train users and manage significant organisational change. 9. Potential delays arising from procurement, governance, technical assurance, information governance or supplier implementation capacity.	3x5 High = 15 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls In Place 1. Formal notification has been received that supplier support for CareFirst will cease after 2028. 2. A project lead is in place to coordinate development of the replacement approach and supporting business case. 3. An options appraisal is underway to consider available replacement systems, procurement routes and implementation requirements. 4. Engagement is taking place with relevant Council colleagues, including Digital, Procurement, Finance and senior leadership. 5. The current system continues to be supported pending replacement, with existing operational and information-governance controls remaining in place. 6. Current governance arrangements provide oversight of system issues, risks and required developments. 7. Initial consideration has been given to the data, reporting, integration and service requirements that a replacement system will need to meet.	4x5 Very High = 20 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	1x1 Low = 1 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
32	Risk Owner: Chief Officer Ability to effectively respond to a major emergency incident, for example a Black Start event or a major cyber security failure.	Major response failures in health and social care during incidents like a Black Start or cyber security attack can be caused by several factors: for example, a lack of training; poor planning; ineffective communication channels; insufficient resources; staff fatigue; decision making failures; system failures and cybersecurity vulnerabilities.	3x4 High = 12 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls In Place 1. HSCP essential services list developed and agreed. 2. Support provided by the relevant civil contingencies services within both NHS and local authority. 3. Senior Management participation in desk top training exercises. 4. Cyber security and data protection training embedded across all teams. 5. System back ups in place. 6. Cyber Incident Response Plans in place with our partner bodies. 7. Strategic Resilience Group (SRG) approach embedded within HSCP SMT meeting structure. Controls In Progress 1. Business continuity plans under development or review in all service areas. 2. Identification and sharing of training opportunities to support skills development. 3. Business Impact Assessments in progress.	3x4 High = 12 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	3x4 High = 12 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
34	Risk Owner: Chief Officer A significant incident, such as structural failure, fire, flooding, contamination, renders Dumbarton Health Centre partially or fully unusable. If the outage extends beyond short-term business continuity assumptions, the organisation may be unable to sustain essential clinical and administrative services at required capacity. This would significantly disrupt patient access, service delivery, workforce stability, and operational performance across the Dumbarton area.	1. Severe weather incidents (storms, flooding, high winds) 2. Fire or smoke damage 3. Structural issues, ageing infrastructure, or accelerated building degradation 4. Burst pipes, major plumbing failures, or water ingress 5. Electrical Faults 6. Hazardous material contamination (e.g., asbestos disturbance, mould) 7. Security incidents rendering the site unsafe 8. No identified medium or long term alternative premises 9. Limited capacity in partner sites to absorb displaced services 10. Insufficient clinical space/equipment for sustained relocation 11. Over reliance on digital access without contingency for increased demand	4x4 High = 16 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Controls In Place 1. Regular building inspections and maintenance 2. Fire safety systems and alarms 3. Backup power for critical systems 4. Emergency Response procedures 5. Business Continuity Plan (BCP) with short term relocation options 6. Agreements with nearby facilities for temporary service relocation 7. Remote working capability for administrative staff 8. Remote access to critical systems 9. Mutual aid arrangements 10. Emergency Communication procedures Controls In Progress 1. Identification and pre approval of medium term alternative accommodation options 2. Formal agreements with local NHS sites, community facilities, or modular building providers 3. Development of scalable relocation plans for 1 week, 1 month, and 3+ months 4. Maintaining an inventory of portable clinical equipment for rapid deployment 5. Periodic scenario testing and BCP validation 6. Continued building resilience improvements 7. Feasibility study underway to progress roof replacement 8. Workshop in planning stages to maximise space utilisation with all practices and services	4x4 High = 16 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	1x4 Medium = 4 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	Live/Active
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														
5	10	15	20	25																																																																														
4	8	12	16	20																																																																														
3	6	9	12	15																																																																														
2	4	6	8	10																																																																														
1	2	3	4	5																																																																														

35	Risk Owner: Sylvia Chatfield Demand and Access for Neurodevelopmental (ND) Assessment Pathways. There is a risk that increasing demand for neurodevelopmental (ND) assessment, including Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) will exceed available service capacity, resulting in the inability to assess, prioritise and treat both ND and patients referred to core services within clinically appropriate timescales.	1. Specialist mental health services have seen an unprecedented increase in referrals for individuals seeking assessment for attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD). This represents new work for Community Mental Health (CMHTs), the board-wide Adult Autism (AAT) Team and GPs / Primary Care. For children and young people's services this also includes Learning Disability, Foetal Alcohol Spectrum Disorder and other conditions under NDD umbrella. The Adult Community Mental Health Team (CMHT) core specification, for example, includes assessing for ADHD only where ADHD is linked to more complex clinical need, significant impact on day-to-day functioning, or cognitive disability. It does not include ADHD-only assessment.	New Risk	Controls in Place 1. Supportive online resources have been developed for individuals who will not meet National Autism Implementation Team (NAIT) level 4 for CMHT input; including NHSGGC MyApp: My Mental Health - ADHD available as an app and on the NHS Scotland Right Decision Service website, Autism Spectrum Disorder and general Mental Health and Wellbeing support on the NHSGGC website, and ADHD / ASD specific information and Service Directory signposting (more specifically for ADHD) to multiple resources available across Scotland on the NHS Inform website. 2. A project to trial remote monitoring of, and more self management by, stable patients on the existing CMHT caseload with the aim of releasing clinical capacity will commence August 2026 however this will have no impact on demand.	4x4 High = 16 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	1x3 Low = 3 <table><tr><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td></tr><tr><td>4</td><td>8</td><td>12</td><td>16</td><td>20</td></tr><tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td></tr><tr><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table>	5	10	15	20	25	4	8	12	16	20	3	6	9	12	15	2	4	6	8	10	1	2	3	4	5	New
5	10	15	20	25																																																					
4	8	12	16	20																																																					
3	6	9	12	15																																																					
2	4	6	8	10																																																					
1	2	3	4	5																																																					
5	10	15	20	25																																																					
4	8	12	16	20																																																					
3	6	9	12	15																																																					
2	4	6	8	10																																																					
1	2	3	4	5																																																					

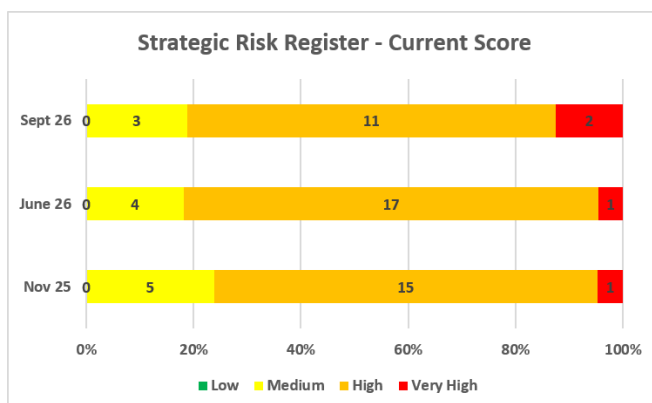
West Dunbartonshire HSCP – Strategic Risk Dashboard Sept 2026

The Strategic Risk Register currently comprises of 16 risks.



Commentary

The latest review of the Strategic Risk Register maintained the Risk Scoring Levels on 12 risks, increased 1 Risk Score, decreased 2 Risk Scores and added 1 new risk. 7 Risks were closed following review.



Commentary

Risk Score Profile Charts provide comparison of current risk score profile and target risk score.



Strategic Risk Summary

Area of Risk	RAG Status	Current Score	Target Score
People and Change			
There is a risk that the HSCP is unable to recruit, retain, develop, deploy and support a sufficient number of suitably qualified and skilled staff to meet current and future service demands.		9	6
Failure to secure an alternative case management system		20	1
Finance and Commissioning			
Financial Sustainability and the ability to deliver statutory, safe and effective services.		20	9
Failure to commission, procure and assure the quality and value of externally commissioned services effectively.		12	8
Failure or withdrawal of an externally commissioned care and/or support provider.		15	15
Chief Social Work Officer			
Failure to have in place strong social work and social care governance in relation to quality of services and care provided		12	8
Failure to meet legislative duties in relation to Child Protection, Adult Support and Protection and MAPPA.		12	8
Failure to ensure all social work staff are appropriately trained and developed, and where required this aligns with SSSC standards, to achieve the standards required across social work services.		12	8
Waiting Times			
Failure to meet waiting times targets		12	2
Demand and Access for Neurodevelopmental (ND) Assessment Pathways.		16	3
Older People Services			
Care at Home Service Delivery		16	9
Failure to manage staffing resource within the Speech and Language Therapy service		9	2
Residential and Nursing Care Home bed availability		9	4
Risk of failure to discharge timeously leading to increased number of people delayed in being discharged.		12	6
Resilience			
A significant incident renders Dumbarton Health Centre partially or fully unusable.		16	4
Ability to effectively respond to a major emergency incident		12	12