Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health and Social Care Partnership Board

Date: Tuesday, 24 November 2026

Time: 14:00

Format: Hybrid Meeting, Civic Space, 16 Church Street, Dumbarton G82 1QL

Contact: Lynn Straker, Committee Officer
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committee.admin@west-dunbarton.gov.uk

Dear Member

Please attend a meeting of the **West Dunbartonshire Health and Social Care Partnership Board** 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

CAROLINE SINCLAIR

Chief Officer
Health and Social Care Partnership Board

Distribution:-

Voting Members

Michelle Wailes (Chair)
Michelle McGinty (Vice Chair)
Libby Cairns
Anne MacDougall
Lesley-Ann MacDonald
Carolyn Ralston
Martin Rooney
Sophie Traynor

Non-Voting Members

Caroline Sinclair
Clare Wilson
John Kerr
Helen Little
Saied Pourghazi
Selina Ross
Julie Slavin
Val Tierney
Andrew McCready
Ann Cameron Burns

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

Date of Issue: 17 November 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 - https://portal.audiominutes.com/public_player/westdc

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AGENDA

TUESDAY, 24 NOVEMBER 2026

STANDING ITEMS

1 STATEMENT BY CHAIR – AUDIO STREAMING

2 APOLOGIES

3 DECLARATIONS OF INTEREST

4 RECORDING OF VOTES

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

5 (a) MINUTES OF PREVIOUS MEETING 7 - 12

Submit for approval, as a correct record, the Minutes of Meeting of the Health and Social Care Partnership Board held on 29 September 2026.

(b) ROLLING ACTION LIST 13 - 14

Submit for information the Rolling Action list for the Partnership Board.

6 VERBAL UPDATE FROM CHIEF OFFICER

The Chief Officer will provide a verbal update on the recent business of the Health and Social Care Partnership.

PLANNING AND DELIVERY

7/

7 IMPROVING LIVES WITH CHILDREN AND YOUNG PEOPLE IN WEST DUNBARTONSHIRE. WHAT WOULD IT TAKE? STRATEGY 2024-2029 **15 - 38**

Submit report by Clare Wilson, Head of Children's Health, Care and Justice and Chief Social Work Officer providing an update on activity from the past six months since the last What Would it Take report provided to the HSCP Board in May 2026.

8 CHANGE PROJECT – CARE AT HOME UPDATE **39 - 50**

Submit report by Fiona Taylor, Head of Service Health and Community Care providing an update on the Care at Home Service. This includes the progress and impact of the Redesign project, Care Inspectorate inspection and financial sustainability.

9 HSCP SEASONAL PREPAREDNESS AND OPERATIONAL RESILIENCE PLAN **51 - 70**

Submit report by Val Tierney, Chief Nurse, presenting the West Dunbartonshire HSCPs Operational Resilience & Seasonal Preparedness Plan 2026/27. The plan includes work underway across West Dunbartonshire HSCP and focussed activity that will strengthen operational resilience through winter 2026/27 ahead of peak winter activity.

PERFORMANCE AND QUALITY

10 2026/27 FINANCIAL PERFORMANCE PERIOD 6 REPORT **71 - 105**

Submit report by Julie Slavin, Chief Financial Officer, providing an update on the financial performance for the six-month period to 30 September 2026 and the projected outturn position to 31 March 2027.

11 MENTAL HEALTH STRATEGY UPDATE **107 - 117**

Submit report by Sylvia Chatfield, Head of Mental Health, Learning Disabilities and Addiction Services, providing an update on the implementation of the NHSGGC Mental Health Strategy 2023–2028, the outcomes of the programme reset undertaken during 2026, and the key priorities and considerations for the next phase of implementation.

12/

12 ALCOHOL AND DRUG PARTNERSHIP UPDATE: MAT STANDARDS, DRUG-RELATED AND ALCOHOL-SPECIFIC DEATHS, AND FUNDING PRESSURES **119 - 152**

Submit report by Sylvia Chatfield, Head of Mental Health, Learning Disabilities and Addiction Services, providing an update on implementation of the Medication Assisted Treatment (MAT) Standards, the latest drug-related and alcohol-specific death figures for West Dunbartonshire, and the funding pressures affecting local alcohol and drug services.

GOVERNANCE, COMPLIANCE AND REGULATIONS

13 JOINT STAFF FORUM **153 - 156**

Submit Approved Minute from Joint Staff Forum meeting held on 10 September 2026 for noting.

14 DATE OF NEXT MEETING

Members are asked to note the next meeting of West Dunbartonshire Health and Social Care Partnership Board will be held on Tuesday, 26 January 2026 at 2.00 p.m. as a Hybrid Meeting in the Civic Space, 16 Church Street, Dumbarton G82 1QL.

For information on the above agenda please contact: Lynn Straker, Committee Officer Regulatory, Municipal Buildings, College Street, Dumbarton G82 1NR.
Email: lynn.straker@west-dunbarton.gov.uk; committee.admin@west-dunbarton.gov.uk

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

At a Hybrid Meeting of the West Dunbartonshire Health and Social Care Partnership Board held in the Civic Space, 16 Church Street, Dumbarton on Tuesday, 29 September 2026 at 2.01 p.m.

Present: Michelle Wailes**,** Libby Cairns and Lesley McDonald, NHS Greater Glasgow and Clyde and Councillors Martin Rooney and Sophie Traynor, West Dunbartonshire Council.

Non-Voting Beth Culshaw, Chief Officer; Julie Slavin, Chief Financial Officer; Helen Little, MSK Manager; Selina Ross, Chief Officer – West Dunbartonshire CVS; Barbara Barnes, Stakeholder Member; Clare Wilson, Head of Children's Health, Care and Criminal Justice and Chief Social Work Officer;

Also Attending: Peter Hessett, Chief Executive; Graeme Forrester, Manager of Legal and Democratic Services (Legal Officer); Alan Douglas, Chief Officer – Regulatory and Regeneration; Sylvia Chatfield, Head of Mental Health, Learning Disabilities and Addiction; Fiona Taylor, Head of Health and Community Care; Karyn Wood, Head of HR; Alastair Handley, Systems, Digital & Information Governance Manager; Neil McKechnie, Contracts, Commissioning and Quality Manager; Dr Saied Pourghazi, Clinical Director; Tom Reid, Forvis Mazars – External Auditor; Carolyn Ralston, Stakeholder Member; Val Tierney, Chief Nurse and Information Governance Manager; and Nicola Moorcroft and Lynn Straker, Committee Officers.

Apologies: Apologies for absence were submitted on behalf of Councillor Michelle McGinty, West Dunbartonshire Council; John Kerr, Housing Development and Homelessness Manager; and Anne MacDougall, Stakeholder Member.

Michelle Wailes in the Chair

DECLARATIONS OF INTEREST

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

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VALEDICTORY – BETH CULSHAW

Michelle Wailes, Chair, noted this would be the last meeting for Beth Culshaw, Chief Officer – HSCP, who was retiring on 30 September 2026 after more than 8 years service as Chair of WD HSCP Board. Ms Wailes wished to thank Ms Culshaw for her hard work, professionalism and dedication shown in her role, in particular her part in the delivery of the new Clydebank Health and Care Centre and Queens Quay Care Home. She noted Ms Culshaw continually demonstrated exceptional strength, a focused calm delivery, and a dedication to exceeding expectations in all her work and on behalf of all Board members, wished her all the best in her hopefully long and happy retirement.

VARIATION IN ORDER OF BUSINESS

After hearing Michelle Wailes, Chair, the Board agreed to vary the order of business as hereinafter minuted.

HSCP BOARD MEMBERSHIP - EXTENSION TO VOTING RIGHTS

A report was submitted by Chief Officer – Regulatory and Regeneration providing an update on the implementation of the Public Bodies Joint Working (Integration Joint Boards) (Scotland) Amendment Order 2025 which makes changes to the voting membership of the integration joint board and associated governance requirements.

After discussion and having heard the Manager of Legal and Democratic Services in further explanation of the report and in answer to Members' questions, the Board agreed:-

(1) to note the implementation of the Public Bodies Joint Working (Integration Joint Boards) (Scotland) Amendment Order 2025;

(2) to note that this Order implements voting rights for three categories of previously non-voting members of the Board;

(3) to note the appointment of Selina Ross as a voting member of the Board in the category of 'third sector bodies which carry out health or social care-related functions in the area of the Board';

(4) to appoint voting members of the Board in the categories of:

(a) service users in the area of the local authority party
(b) persons providing unpaid care in the area of the local authority; and

(5) note the Manager of Legal and Democratic Services will bring back a report to a future meeting of the Board outlining a process for the implementation of changes to legislation including member recruitment, proxies and terms of membership.

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RECORDING OF VOTES

The Board agreed that all votes taken during the meeting be done by a Roll Call vote to ensure an accurate record.

MINUTES OF PREVIOUS MEETING

The Minutes of Meeting of the Health and Social Care Partnership Board, held on 18 August 2026 were submitted and approved as a correct record.

ROLLING ACTION LIST

The Rolling Action list for the Health and Social Care Partnership Board was submitted for information and relevant updates were noted.

VERBAL UPDATE FROM CHIEF OFFICER

Beth Culshaw, Chief Officer, provided a verbal update on the recent business of the Health and Social Care Partnership. Ms Culshaw noted the figures released this week regarding Drug Related Deaths in West Dunbartonshire and across Scotland and advised the Alcohol and Drugs Partnership would shortly be issuing a briefing regarding actions being taken in response to these figures.

Ms Culshaw also noted work being undertaken in relation to the Strategic Plan and advised following discussions, there were now plans to reconvene the Strategic Planning group around November 2026 and would be chaired by Lesley McDonald, Voting Member.

ANNUAL UPDATE ON DELIVERY OF NHSGG&C PRIMARY CARE STRATEGY 2025/26 AND LOCAL IMPLEMENTATION

A report was submitted by Fiona Taylor, Head of Service Health and Community Care, provided an update on the NHSGG&C Primary Care Strategy for 2025/26 (financial year) and West Dunbartonshire progress towards this.

After discussion and having heard Fiona Taylor, Head of Community Health and Care, and Saied Pourghazi, Clinical Director, in further explanation of the report and in answer to Members' questions, the Board agreed to note HSCP progress against the NHSGG&C Primary Care Strategy 2024-2029.

FINANCIAL PERFORMANCE REPORT

A report was submitted by Julie Slavin, Chief Financial Officer, providing an update on financial performance for the five-month period to 31 August 2026 and the projected outturn position to 31 March 2027.

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

(1) to note the updated position on 2026/27 budget allocations from West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board and approve the updated direction to the partners bodies to deliver services in accordance with the HSCP Board's strategic priorities;

(2) to note the year-to-date underspend of £0.126m, equivalent to 0.14% of the phased budget, for the period to 31 August 2026;

(3) to note the forecast year-end overspend of £0.051m, equivalent to 0.02% of the annual budget, after all planned transfers to and from earmarked reserves;

(4) to note the progress in delivering the savings agreed for 2026/27 and the associated risks;

(5) to note the forecast reserves position and the effect of the projected overspend on unearmarked reserves;

(6) to note the capital expenditure update; and

(7) to note the effect of current financial pressures on the 2026/27 position and the forecast budget gaps for 2027/28 and 2028/29.

AUDITED ANNUAL ACCOUNTS 2025/26

A report was submitted by Julie Slavin, Chief Financial Officer, presenting the audited Annual Accounts for West Dunbartonshire Integration Joint Board, commonly known as the HSCP Board, for the year ended 31 March 2026 for consideration and approval.

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

(1) to approve the audited Annual Accounts for the period 1 April 2025 to 31 March 2026 and authorise final signature of the accounts by the Chair, Chief Officer and Chief Financial Officer;

(2) to note the unmodified audit opinion and wider scope conclusions reported by the external auditor; and

(3) to note management's response to the two wider scope recommendations.

Draft

CARE AT HOME - UPDATE ON WORK TO MEET CARE INSPECTORATE REQUIREMENTS

A report was submitted by Fiona Taylor, Head of Health Service and Community Care, outlining progress towards meeting the five Care Inspectorate requirements set out in the June 2026 inspection report.

After discussion and having heard Fiona Taylor, Head of Health and Community Care, in further explanation of the report and in answer to Members' questions, the Board agreed to note the updates within this report.

ANNUAL HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 (HCSSA) IMPLEMENTATION STATUS AND ASSURANCE REPORT – HEALTH 2025

A report was submitted 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.

After discussion and having heard Val Tierney, Chief Nurse, in further explanation of the report, the Board agreed:-

(1) to note that the Act affects Health and Care services differently, with separate reporting requirements and timescales;

(2) to 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 that Quarterly Assurance reporting is not required from Care services; and

(3) to 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 of the report).

ANNUAL HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 (HCSSA) IMPLEMENTATION STATUS AND ASSURANCE REPORT – SOCIAL CARE 2025

A report was submitted by Val Tierney, Chief Nurse, presenting the Annual Health and Care (Staffing) (Scotland) Act 2019 (HCSSA) for consideration and approval.

After discussion and having heard Val Tierney, Chief Nurse, in further explanation of the report, the Board agreed to approve the content of this report and the content within Appendix 1 of the report – HCSSA Social Care Annual Report 2025-26 as part of the report.

Draft

STRATEGIC RISK REGISTER – SIX MONTH REVIEW

A report was submitted by Beth Culshaw, Chief Officer - HSCP, presenting an update on the Strategic Risk Register to the West Dunbartonshire Health and Social Care Partnership (HSCP) Board.

After discussion and having Beth Culshaw, Chief Officer – HSCP, in further explanation of the report, the Board agreed:-

(1) the Strategic Risk Register (Appendix 1 of the report); and

(2) any strategic risks the HSCP Board may wish to consider promoting to either NHS Greater Glasgow and Clyde and West Dunbartonshire Council for inclusion in their respective strategic risk registers.

JOINT STAFF FORUM

The Approved Minutes of Meeting of the Joint Staff Forum were submitted and noted.

DATE OF NEXT MEETING

Members noted that the next meeting of West Dunbartonshire Health and Social Care Partnership Board would be held Tuesday, 24 November 2026 at 2.00 p.m. as a Hybrid Meeting in the Civic Space, 16 Church Street, Dumbarton G82 1QL. Members also noted there is an Informal Session of HSCP Board scheduled for 17 November 2026.

The meeting closed at 3.33 p.m.

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WEST DUNBARTONSHIRE HSCP BOARD

ROLLING ACTION LIST

Agenda Item	Decision / Minuted Action	Officer	Timescale	Progress/ Update/ Outcome	Status
REVIEW OF INTEGRATION SCHEME – August 2024	Query regarding delegated services within the Integration Scheme document. The Chief Officer is to provide revised definitions of delegated services and also to share work done with Scottish Government.	Caroline Sinclair and Graeme Forrester	January 2027	The work is ongoing to agree the revised definitions including the timeline to conclude the review of the Integration Scheme and submit for final approval since noted at Council.	**Open / Ongoing**
EXCEPTION REPORT: DUMBARTON HEALTH CENTRE May 2026	FOI to be submitted to Scottish Government for breakdown and prioritisation of the fund.	Alan Douglas	Ongoing	Update: The FOI was submitted to the Scottish Government and a subsequent review undertaken where further information was sought. The Scottish Government provided additional information on the methodology and prioritisation process, confirming that Dumbarton Health and Care Centre had a strong and valid case for investment but that final decisions on prioritisation were taken by Scottish Ministers, with geographical distribution across Scotland forming part of the consideration. The FOI process requested by the Board has therefore concluded and the action can be closed. Any further engagement regarding future capital investment in Dumbarton Health and Care Centre will be progressed separately.	**To be Closed?**

WD HOMECARE SERVICE August 2026	An update to be provided on the progress of actions/strategies driven from Care Inspectorate Inspection in June 2026 until all actions are completed and level of care being provided is adequate.	Fiona Taylor	Ongoing	Update: Ongoing update to be provided at HSCP Board meetings detailing progress of actions/strategies driven from Inspection.	**To be Closed?**
PROCUREMENT OF COMMISSIONED SERVICES August 2026	Legal Officer and Voting Member to agree exact wording of agreed actions of the report and communicate this back once agreed to the Board.	Lesley McDonald and Alan Douglas	September 2026	Update: Wording to note, 'HSCP Board have noted they are content that Standing Orders enable Chief Officers to act in appropriate manner re recruitment above the 'light touch' scheme. It is understood that HSCP Board will be sited on all actions should this ever be required.'	**To be Closed?**

West Dunbartonshire Health and Social Care Partnership Board

Report by Clare Wilson, Head of Children's Health, Care, and Justice Chief Social Work Officer

24 November 2026

Subject: Improving Lives with Children and Young People in West Dunbartonshire What Would It Take? Strategy 2024 - 2029

1. Purpose

1.1 The purpose of this report is to provide an update on activity from the past six months since the last What Would it Take report provided to the board in May 2026.

1.2 The report details the projects included in the What Would it Take Strategy 2024 – 2029 which seeks to improve outcomes for children and young people, drive improvement in services and ensure sustainability and that West Dumbartonshire keeps The Promise.

2. Recommendations

2.1 Note the considerable work taking place to improve outcomes for children and young people.

2.2 Note the content of the report regarding efficiencies and savings generated to strengthen service sustainability.

3. Background

3.1 In March 2024, the HSCP board approved the Children's Health and Care strategy "Improving Lives with Children and Young People in West Dunbartonshire, What Would It Take? 2024 – 2029".

3.2 The strategy presented a road map to deliver sustainable services, aligned to the Promise and shift the balance of care. The aim is to ensure children and young people, where possible, can remain safely cared for at home with the necessary scaffolding of support, with family or in a community setting. This requires a resource shift over time to reduce expenditure on care services and reinvest in community-based supports for children and young people to be safely supported in their communities where risks and needs of young people are met out with a care environment if safe to do so. The strategy also aligns with the intention to provide early help and support to prevent families reaching crisis and so prevent the need for intensive and higher cost interventions.

3.3 All children need the same things to thrive: a stable home, strong support and steady, loving relationships. The Promise is Scotland's commitment to making sure this is a reality for all children. The Promise emerged from Scotland's Independent Care Review: a comprehensive, participatory process launched in response to longstanding concerns about the experiences and outcomes for children and young people in the care system. The movement for change was driven by activism and advocacy from care-experienced people across Scotland, who sought to ensure that all children grow up loved, safe, and respected. In February 2020, the Review published its findings and recommendations in The Promise. The Scottish Parliament, with cross-party support, committed to implementing these recommendations in full by 2030 at the latest.

3.4 Keeping The Promise requires Scotland to overhaul its care system, moving away from bureaucratic, process-driven approaches and towards a culture that centres on relationships, rights, and the voices of children and families. The Promise is built on five key foundations:

- **Voice:** Children and young people must be listened to and involved in decisions about their care.
- **Family:** Where safe and loved, children should stay with their families and be supported to overcome difficulties.
- **Care:** If children cannot remain with their families, they should stay with their brothers and sisters where possible and belong to a loving, stable home for as long as they need to.
- **People:** The workforce must be supported to build trusting, compassionate relationships and to listen to those they support.
- **Scaffolding:** The broader system-laws, policies, and services-must provide the necessary support for these aims.

3.5 The What Would It Take? Strategy is a five-year plan which recognises the importance of using service design to evaluate Children and Families services. The Scottish Approach to Service Design (SAtSD) encourages service change to be deliberate and purposeful, as opposed to organic and reactive, informed by data and evidence. It also emphasises service users' voices, both providers and recipients of a services should be at the centre of service design and sustainability and future proofing considered throughout.

3.6 The delivery of the plan will take time, resources, and a shared commitment to improve outcomes for children and young people. It recognises our commitment to collaborating with our partners and communities to ensure our children grow up loved, safe, and respected so that they can realise their full potential.

3.7 This change programme aims to deliver sustainable services whilst promoting better outcomes for vulnerable children, young people, and their families aligned to the principles of The Promise. It will ensure service improvements

are realised whilst continuing to respond to the financial challenges that are being experienced across the public sector however the key to sustainability is to ensure preventative supporting and 'scaffolding' as articulated by The Promise are in place.

3.8 The WWIT strategy was approved by the HSCP Board in March 2024 and comprises of the six workstreams to be developed and delivered over the 5 years of the strategy with different sub-projects contained within each workstream. Given the size of this programme, the initiation of each project needs to be considered to ensure the service can maintain operations and undertake each workstream with dedication and commitment.

4.0 Main Issues

WWIT Workstreams

4.1 Table 1 shows the six workstreams and the Senior Manager responsible. Each of the workstream areas contributes to and creates the conditions to enable children to remain in their community where possible with family, with strength-based assessment of risk and need and with clear pathways to service access.

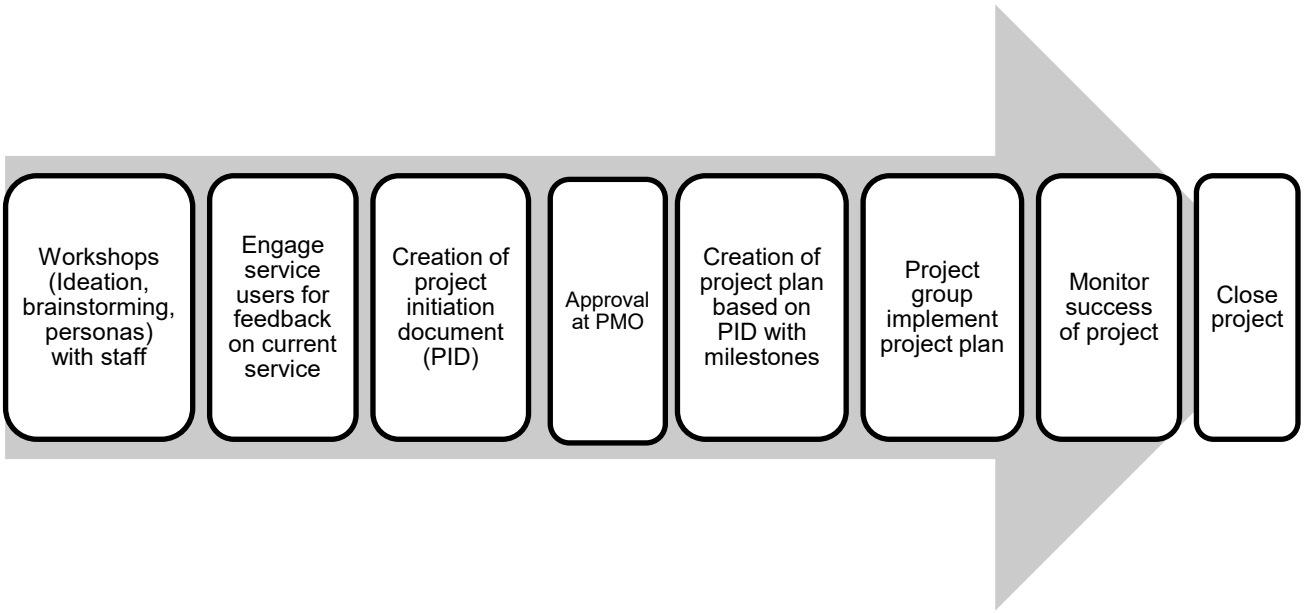
4.2 When a child cannot be safely cared for by family and care provision is required we aim to ensure that local connections with schools and community are maintained. The first consideration is whether foster care can meet the child's needs. For a small number of children, residential care will be required, however we are committed to ensuring children remain with their schools, ensuring a degree of continuity and stability for the child through maintaining important relationship and where this is not possible a joint education and care placement will be sought. For children living out with West Dunbartonshire, we are strengthening our quality assurance and oversight of external provision and ensuring best value is in place with a focus on commissioning arrangements**.**

Table 1

Project	AIM	Senior Manager
Permanence and Care Excellence	We will improve the timescales for planning for children and to reduce the uncertainty for children and young people who require permanent care out with their birth family.	Mark Mulvenna
Redesign of Family Support Services	We will provide family support services to ensure families get the right help at the right time, for as long as it is needed.	Sharon Laing

Best Practice in Child Protection and Safeguarding	We will make sure there is best practice in child protection and risk management arrangements building on families strengthens clearly identify risks and ensure clear action plans are in place.	Sharon Laing
Commissioning Services for Children and Young People.	We will develop local commissioning frameworks for all our fostering and residential care placements and move from Scot Excel Frameworks to achieve best outcomes and Value. In parallel we will strengthen our contract monitoring and oversight of providers where our children are placed.	Clare Wilson
Foster Care Recruitment and Kinship Care support	We will recruit local foster carers over the next five years and increase or support and planning for children in Kinship care.	Mark Mulvenna
Supported Accommodation for Care Leavers	We will ensure our young people leaving care have increased and planned housing support options that meets their needs.	Mark Mulvenna

4.3 As stated in section 3.5, the Scottish Approach to Service Design methodology is used. The following chart provides a visual representation of how each project is scoped, project plan is developed, and project is implemented and closed.



Permanence and Care Excellence

4.4 An 'Aims Refresh' Workshop took place in March 2026, following which 4 draft refreshed aims were developed. Volunteers were identified to establish sub-groups for each aim to progress tests of change to support in the development of local practice related to achieving these stated aims. Subgroup members included local representatives from Social Work, Health, Education, Children's Hearing Scotland and the Scottish Children's Reporters Administration.

4.5 The aims have been established as follows:

Aim 1:
By 31st December 2026, 100% of children/young people who are looked after at home for more than 18 months (on 5th May 2026 36 children), will have had a review at a Team Around the Child Meeting to determine if a Compulsory Supervision Order (CSO) is the correct plan for the child/young person.

Aim 2:
By 31st March 2027, 90% of children/young people who become looked after and accommodated on or after 5th May 2026 will have had a Permanence recommendation (including those who have a plan to return home or are within kinship care) recorded in their plan within 26 weeks of becoming looked after and accommodated.

Aim 3:
By 24th August 2027, 50% of children/young people who have had a recommendation for permanent care away from home, on or after 24th August 2026, will be presented to the Agency Decision Maker (ADM) within 14 weeks of the Legal Advice Meeting that made the Permanence away from home recommendation(Stretch Aim will be 100% by 2029).

Aim 4:
By 24th August 2027, 75% of children/young people whose plans for permanence away from home to be progressed have been approved by the Agency Decision Maker (ADM) on or after the 24th August 2026, will have their application for appropriate legal order lodged in court within 16 weeks of the ADM decision. (Stretch Aim will be 100% by 2029).

4.6 The project team met with WDC Legal Services colleagues to review the current process for Legal Advice Meetings and to identify areas for improvement to address the drift and delay being experienced by children and young people on their journey to permanence. The result of this meeting was a test of change with scheduled six-weekly in person meetings taking place between Legal Services and the Child's Social Worker for the purpose of Legal Advice being provided as opposed to these being scheduled as and when required. This approach has proven to be both effective and efficient in terms of both meetings taking place and legal advice being provided. A pre-meeting guidance document has also been drafted and will be circulated following review. The intention behind this document is to outline for Social Work teams what is required ahead of the Legal Advice Meeting which will seek to support with preparation and better-informed discussions.

4.7 The project team met with staff to gather practice-based insight into how Parenting Capacity Assessments are currently being understood, delivered and recorded across the service, and to identify what is working well and where there are barriers. Parenting Capacity Assessments are central to evidencing whether a child can safely return home. Current practice is inconsistent in approach, timescales and documentation. The intention is to agree key principles and a standardised tool alongside clearer guidance for Social Workers to support and inform timely decision-making. The project team have also liaised with other Local Authorities to gather information on alternative methods or practice in this area.

4.8 The project team will implement a Permanence Tracking Meeting which will provide managers with oversight of children/young people whose plans are out with the timeframes laid out in the aims. The terms of reference for this meeting are in development. The team are focused on ensuring data is accurate and meaningful for the service to use to support prioritisations and decision making and future improvement actions

4.9 The project team have held workshops to focus on the process, what key information is required and when to be in place for staff and stakeholders to make timely decisions. These workshops will generate the ideas to implement the tests of change identified to ensure the aims stated above are met. The project team are also using the learnings from other local authority areas, where CELCIS has supported them to develop best practice.

4.10 Since the introduction of our Adoption & Permanence team in April 2024, Permanence plans for children and young people have been progressed as follows:

- 12 Permanence Orders have been granted.
- 3 Permanence Orders are currently being progressed through Court.
- 6 Permanence Orders ready to be lodged at Court.
- 8 Permanence Order Applications are being prepared for lodging at Court.
- 7 Adoption Order have been granted.
- 4 Adoption Order applications are currently being progressed through Court.
- 0 Adoption Order application are currently being prepared for lodging at Court.

4.11 Prior to this there was only limited evidence that plans were being concluded for young people causing uncertainty and drift and delay in in some instances placement breakdown.

Redesign of Family Support Services

4.12 Family Support Services plays an integral role in the provision of early intervention in social work support within West Dunbartonshire. However, the service is currently not delivering consistent relational intervention and has limited capacity to offer direct work to effectively support families to make the necessary changes to overcome challenges and developing their parenting skills. This means that intervention has been focused on a crisis response rather than prevention. A significant percentage of resource has been deployed for “check in visits” where the immediate safety of the child is assessed, rather working alongside the family to reduce risks. There have also been challenges in meeting the statutory requirements for supervised family time as due to current work patterns there is not always the required number of staff available after school hours or at weekends. The aim is to have a redesigned service that is shaped by the needs of babies, children, young people and families, where the staff team work in a relational way, alongside families to build on their strengths and increase resilience and so reduce the need for further or more intensive social work intervention. There will be an agreed plan with families and young people's voices at the heart of shaping what those supports need to look like.

4.13 Services in the team are currently made up of three distinct teams Family Group Decision Making (FGDM), Family Support Workers and Intensive Support workers, currently known as ATC. FGDM works alongside families to identify their own network of support from within their wider family, friends and community and then to facilitate a meeting where the family and others devise and agree their own plan of support. The family support workers offer direct parenting support including establishing parenting routines and developing skills such as building bonding and attachment with children and working

alongside parents to address poor home conditions. The Family Support workers facilitate and supervise family time and contribute to social work assessments. The Intensive Family Support workers work alongside parents of directly with children and young people, to address the concerns and risks that have been identified through multi-agency assessment, this includes parental substances use, family conflict or with young people in conflict with the law. They also respond to crisis which may involve conflict resolution, mediation or emotional and practical support. This is often out with traditional office hours

4.14 We need to ensure that the interventions and support family service offers is relationship based and supports the family to make the necessary changes to effectively safeguard and care for their children at home. To ensure this is in place, consultation and engagement with families, young people and staff is along with looking at the services data is required.

4.15 Consultation with families and young people undertaken by Action for Children participation is now concluded. These sessions involved a wide range of participants, including those who have experience of receiving family support, those who have worked with family support services, and those who have not previously received or worked with family support. This inclusive approach ensured that both lived experience and broader community perspectives were captured to inform future service development. By AFC undertaking the consultation we ensured that the feedback was fully independent.

4.16 These sessions identified a strong and consistent view across all groups that family support should be accessible, preventative, relation-based, flexible and responsive to families' individual circumstances. Participants emphasised the importance of receiving help earlier before difficulties escalate to crisis, and of developing trusting and consistent relationships with workers who are reliable, non-judgemental and understand the family's circumstances. Mental Health and emotional well-being were identified as key priorities for both adults and young people, alongside the need to reduce stigma and make it easier for families to seek help.

4.17 Participants wanted greater flexibility in how and when support is provided. Evening and weekend availability was particularly important, reflecting concerns that families may experience increased difficulties when fewer services are available.

4.18 Workers of the services have been involved in a series of workshops to inform what best family support looks like and allow us to understand that children and families believe makes a difference to increase their resilience and develop their skills to allow then to effectively navigate the daily challenges of parenting, in often very challenging life circumstances.

4.19 The workshops with staff have been on the following topics:

- Referral pathway
- Relational support
- Best Practice for Family Time Recording referrals and data to capture demand and what is required;
- Deliver parenting programme and structure support as part of working alongside families.
- Review job profiles, review the use of fixed-term contracts and review work patterns across the service.
- Underpinned by Promise Principles to ensure creative consistent and where necessary practical support is in place as long as is required for parenting with enduring and complex needs.
- Increase visibility and understanding and promote positive recognition of Family Support Service.
- With every review of a process, ensure there is a digital lens and if there are any tools which can be adopted to simplify will be used. For example, a tool which allows staff to text family's information about their children.

4.20 Data gathering via asking staff to task capture what their daily workload looks like, reviewing number of referrals and types of asks required from staff have been reviewed.

4.21 The engagement, consultation with young people and families, workshops with staff developed and agreed our Positive Core Principles will inform a report of what the future of Family Support services will look like in West Dunbartonshire.

4.22 The newly developed referral pathway allows us for the first time to measure service demand, both in terms of volumes and the nature of the support that children and families require from us. In September 2026, the team was supporting 195 children and families. A communication was created and circulated to the wider Children and Families Social Work Services, to inform them of the new pathway, and step-by-step guidance on how to submit referrals. This has aided in the adoption and uptake of the new referral process, with all referrals now being received this way.

4.23 In order to develop practice and create consistency, there have been themed working groups, these included Family Time considering from the perspective of the child, the parent and the family support worker, “What does good family time look like”. Key outputs include agreement to create consistency and standards for family time including appointment confirmation using a clear “contract” with families, setting out expectations and practical arrangements such as dates, times, and actions to be taken if a parent or child is unwell and cannot attend. This led to the consideration the child’s experience and what changes could be made, such as creating a calm environment, creating a directory of community resources where parents and their children can be supported to meet. Also, ensuring there are resources are available for all age

groups in our family rooms. Where changes could be made immediately, they were and did not wait until the conclusion of the review.

4.24 Further actions include the development of information leaflets for families, the implementation of pre-visit introductions involving the Social Worker and support workers. These working group outputs have now been completed and now in use across the service as appropriate.

4.25 The most recent workshop was used as an opportunity to discuss the Action for Children engagement and identify opportunities for improvement with the staff teams. The reaction from staff has been positive, with staff feeling that their interventions and support has been validated by the positive comments in the sessions. They acknowledged the areas for improvement as indicated by the engagement sessions and were encouraged that these are processes or areas that are currently being actioned or progressed by the project.

4.26 Project work under the Recording Observations theme has concentrated on improving consistency, clarity, and quality of practice. Agreed outputs include the development of training to support staff on what to record and how to record observations, alongside the creation of a consistent observation template with Social Worker input. The group has also agreed to ensure referral forms are used for all referrals, including those from Area Team Support Workers, explore adding review dates within CareFirst, and consider the establishment of a weekly cross team briefing meeting. Ongoing actions include continued development of lone working procedures and adding the purpose of contact or family time at the top of each observation record.

Best Practice in Child Protection and Safeguarding.

4.27 This workstream is made up of smaller projects all aimed at enabling strengthened focus on risk identification and management, working in partnership with families where children's voice is key and clarity of assessment and planning and what risks and needs require to be the focus of service interventions. The following table shows the scope, and latest update.

Project 1- My Assessment, My Plan

4.28 The last remaining action for this project is to review Chronologies. Social Work teams carried out a Self-Evaluation of the use of Chronologies in their day-to-day practice, using the Self Evaluation Tool developed by IRISS. The finding from this session will inform our learning and development needs, which will be supported by IRISS via training sessions.

Project 2 - Children's Services Area Resource Group

4.29 The joint Area Resource Group is a joint initiative with education, with the senior education manager and principal educational psychologist are key members. The Group is chaired by a senior manager for social work. Other members include team leader, residential services, team manager, family

support manager and family placement senior social worker. Commissioned Services Includem and Functional Family Therapy are also members. This ARG has been live since August 2024.

4.30 There has also been a reduction in the number of requests for external foster placements from 36 in 24/25 to 6 in 25/26. There has not been an increase in the number of children whose names on the Child Protection Register in West Dumbartonshire (in fact it has been decreasing) which may evidence that we are managing to provide scaffolding to families to stay together. Where the agreement is to commission additional services to support the family to remain together, the ARG sets a timescale for review. In the last 6 months, there have been 58 requests at ARG with only 4 rejected; these numbers, compared with the 43 that were rejected at ARG as of April 2026, show that we are managing to support more families to stay together, with fewer children reaching the point that alternative care is being considered.

4.31 The project team are in the final phase of the project and have created an ilearn which explains the process to staff in a visually, educational context. The aim is to roll this ilearn in early 2027. Surveys have been created for panel and stakeholders of the ARG, to gather their experience of the process and if there are any final refinements required before the project is closed.

Project 3- Access, Help and Support Team

4.32 The last remaining action for this project is to finalise the Standard Operating Procedure, following the reinstatement of the Open Case Form on CareFirst. This was reinstated to mitigate the use of the Duty to Inquire Form being used to document when an event or incident received referrals from multiple sources (e.g. Police, Education and Health all refer the same child/young person following one event).

4.33 Since implementation, between April 2025 and October 2026, the team have received the following:

Table 3- Monthly IRD – Child Protection 2025-26

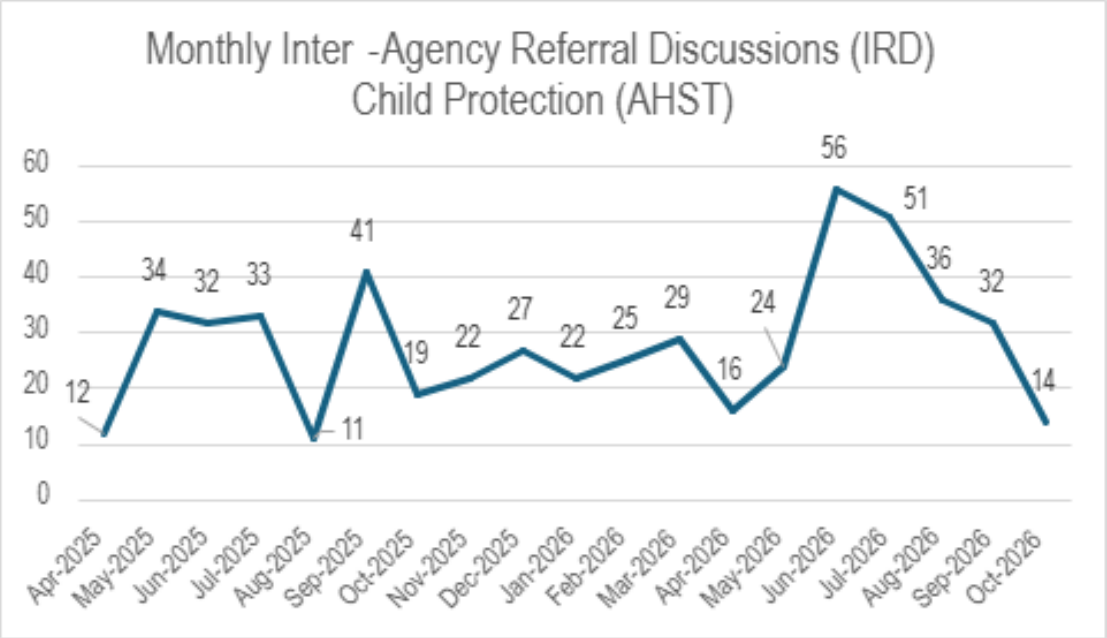


Table 4- Monthly Domestic Violence Initial Assessments 2025-26

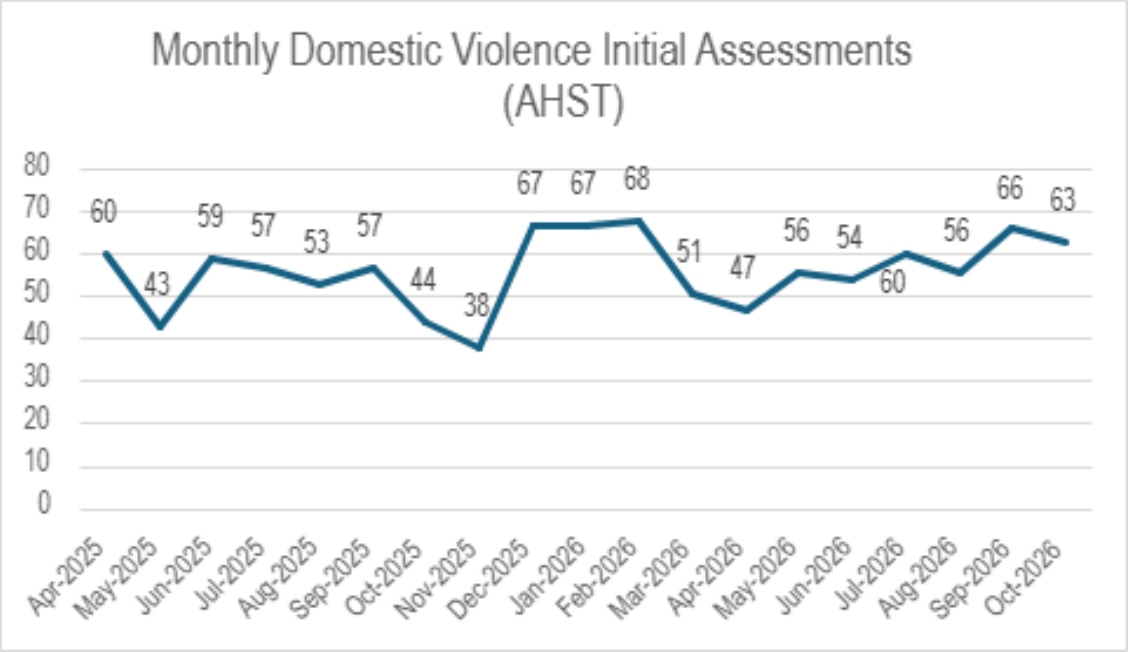
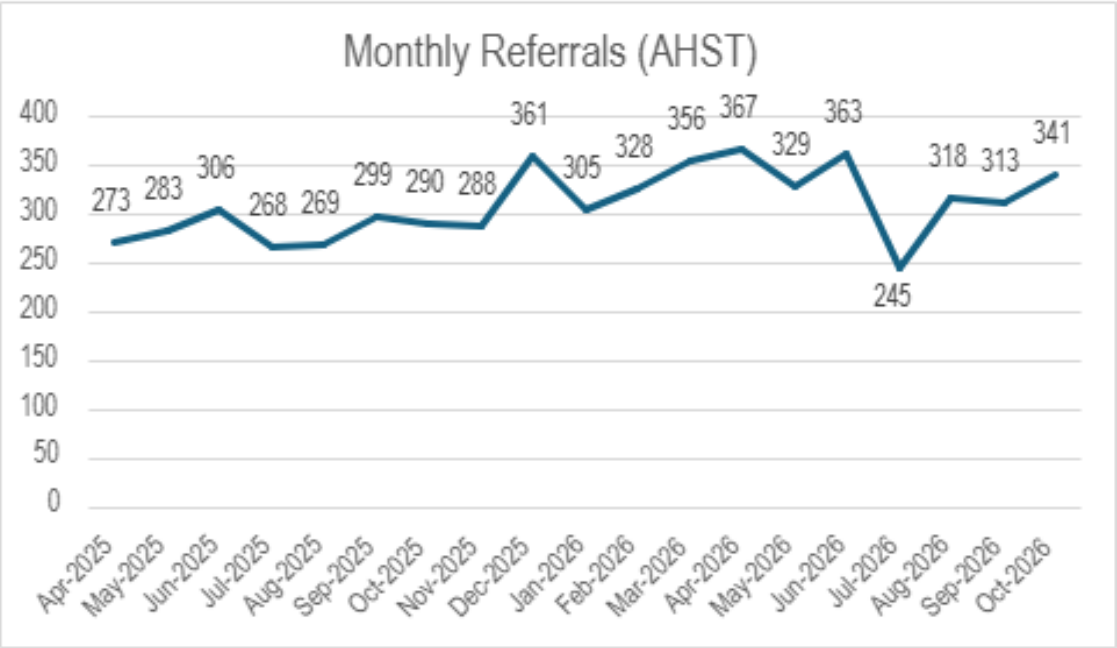


Table 5- Total Monthly AHST Referrals 2025-2026



4.34 These are new referrals to the service and for the first time we can understand new demand for services and the source of the concerns. Our data tells us that 7% of the referrals for children not previously known to social work resulted in onward referral to other social work teams for longer-term intervention. Of those, 27 resulted in a My Help and Support Assessment being carried out. There were 66 My Help and Support Assessments carried out between April and October 2026.

4.35 The team are holding 550 events at present. This is an increase from just below 400 in March of this year. The number of Interagency Referral Discussions fluctuates on a weekly basis; however, it was noted that October saw 35 IRDs conducted, which is the highest amount since the team was launched.

Project 4 - Secure Care Procedures

4.36 Secure Care procedures have been updated in line with National Standards. They have been adopted and have strengthened practice with the focus on Children's Rights and risk management.

4.37 Care and Risk Management training has been delivered by CYCJ and the Care and Risk Management (CARM) procedures are currently being developed. The first draft is ready for review. Both above will strengthen practice to ensure we meet our statutory obligations under the Children (Care and Justice) (Scotland) Act 2024. Further actions are currently paused until a new Team Lead is in post.

Project 5 – "Leading in Best Practice in Child Protection"

4.38 The social work managers will undertake a year programme in 2026 of learning titled “Leading Best Practice in Child Protection”. The previous CSWO commissioned an external independent consultant to support this learning and improvement activity in Child Protection Practice. The first session was self-evaluation by the managers on where the strengths and areas for improvement are across the child protection system which have been identified from external and internal audit and evaluation. We will work together to build on the strengths and explore how we can address those areas where challenges to best practice have been identified. The purpose is to further develop our child protection standards aligned to national guidance and practice, with strengthened management oversight of planning and multi-agency assessments. This work is nearing completion with the consultant providing a report with recommendations for learning and improvement in early 2027.

Project 6 – Signs of Safety

4.39 This work will dovetail with adoption of the Signs of Safety approach across the system. All social worker staff have undertaken the training and leaders and decision makers in partner agencies have undertaken the two-day training. There will one day awareness training rolled out for all partners within the child protection system. There will follow training on skills development and intervention and then with each service area within children and family's social work. The go live date is January 2027, when partners will be invited to join the strategic oversight group.

4.40 As part of this work there has been an audit of 60 assessments to give base line data to measure any improvement over the two-year implementation period. This baseline position also involved seeking the views of children and their families who provided scores against set questions. This audit will be repeated at the end of the first year of implementation to measure impact. All our assessment frameworks will now be reviewed to ensure that it aligns with the principles of Signs of Safety. This work was commissioned through The Child Protection Committee and is a clear multi-agency commitment to strengthen our approach to multi-agency Child Protection identification of risk and planning.

Commissioning Services for Children and Young People Who Require Care

4.41 This project will create two commissioning frameworks. They are:

- Fostering Framework:
- Residential Framework.

4.42 It is anticipated that Frameworks will be in place for 5 (+2) years, allowing local response to changing contexts in supporting care experienced children and young people. It is anticipated that by developing local frameworks to purchase care placements will create flexibility with contracting rather than reliance ScotExcel pricing frameworks which is one source of cost pressure. A local framework also allows us to work with providers to meet West Dunbartonshire families' particular needs. Local frameworks also have 'lots' of service categories that are more aligned to local needs, reducing the risk of purchasing enhanced services that are not required.

4.43 Table 6 below shows the efficiencies generated with discussion to date with residential care providers which are not yet compete and similar discussions have taken place with foster care providers to ensure best value.

Project 1- WDC Fostering Framework

4.44 The Foster Care Framework is ready to publish for an Invitation to Tender. The Contract strategy has been reviewed and approved by Procurement Manager. Once further approvals have been granted by the HoS and CFO, providers will be invited to tender. There have been a series of provider events to ensure open and ongoing dialogue with fostering service providers.

Project 2- WDC Residential Framework

4.45 Two partnership forums have taken place to promote joint working and the co-production of the contract documentation. Joint working with the education department has ensured that the Framework will also meet their needs in relation to Residential Education placements. A further partnership forum will take place to discuss Quality assurance processes and requirements. Developing both frameworks has included engagement with relevant stakeholders, including consultation with people with lived experience where possible. This allows for alignment to principles of ethical commissioning, and the Promise, alongside more robust contracts and process. This is particularly important due to the 5 (+2) year terms. This engagement work has allowed further insight into process and efficiency. Once the Foster framework has been published, the project team will focus on applying learning from invitation to tender clarifications in the next quarter.

Project 3 - Commissioning Services for Children With Disabilities

4.46 The first invitation to tender closed on 8th May. There were no bids provided by providers, due to a high value Scottish Government funding opportunity closing at the same time, so a provider engagement event was held with good interest from a wide range of experienced providers. This also allowed us gather further information as to why previously there were no bids, to aim for more successful invitation to tender. Invitation to Tender is ready to publish in

next quarter. This has been timetabled in around ongoing evaluations for adult services framework.

Foster Carer Recruitment and Kinship Care Support

Project 1- Foster Care Recruitment

4.47 The Foster Carer Liaison Officer role has now been filled on a fixed term basis until 31 March 2027, which will then be reviewed with a potential for further extension of 12 months. It is intended to provide resource within the service to strengthen capacity and coordination within foster carer recruitment activity. local foster carers keep children supported, near family in their own local schools and communities. The management fees and other costs from third sector and independent providers can often mean that costs are significantly increased and there is no evidence that they provide better outcomes for our children. Unfortunately, we continue to seek external placements where our own foster carers are not available.

4.48 An exit survey has been finalised and will be issued to all enquirers who withdraw from the process prior to being approved as foster carers. This will support the service to better understand reasons for withdrawal, identify recurring themes or barriers within the recruitment journey. The service will use feedback to inform continuous improvement of recruitment processes. At the time of writing, we have not had anyone fit the criteria for completion.

4.49 Since beginning to work with CAN Digital (Council Advertising Network) in April 2026 we have received 27 enquiries from individuals interested in becoming Foster Carers, with 6 of these currently being progressed to Preparation Group, which is the first stage on the approval pathway for those individuals. This number of enquiries compares to 1 enquiry having been received between April 2025 and March 2026.

4.50 The local web pages have been reviewed and updated to make sure it is easier for prospective foster carers to find information or apply to become a foster carer. The financial case for local authority foster carers is also clear as detailed in Table 7 below, where the difference in costs is compared with West Dunbartonshire carers and externally purchased care, which can often be a considerable distance from the young person school and family.

4.51 In increasing awareness around the opportunity to become a Foster Carer, there has also been engagement with colleagues within Education Services and agreement for existing Foster Carers and members of the Service to be present at events within local schools such as Parents Evenings in order to provide information to any interested parents/carers.

Table 7 West Dunbartonshire Services vs Commissioned Care Costs annual spend.

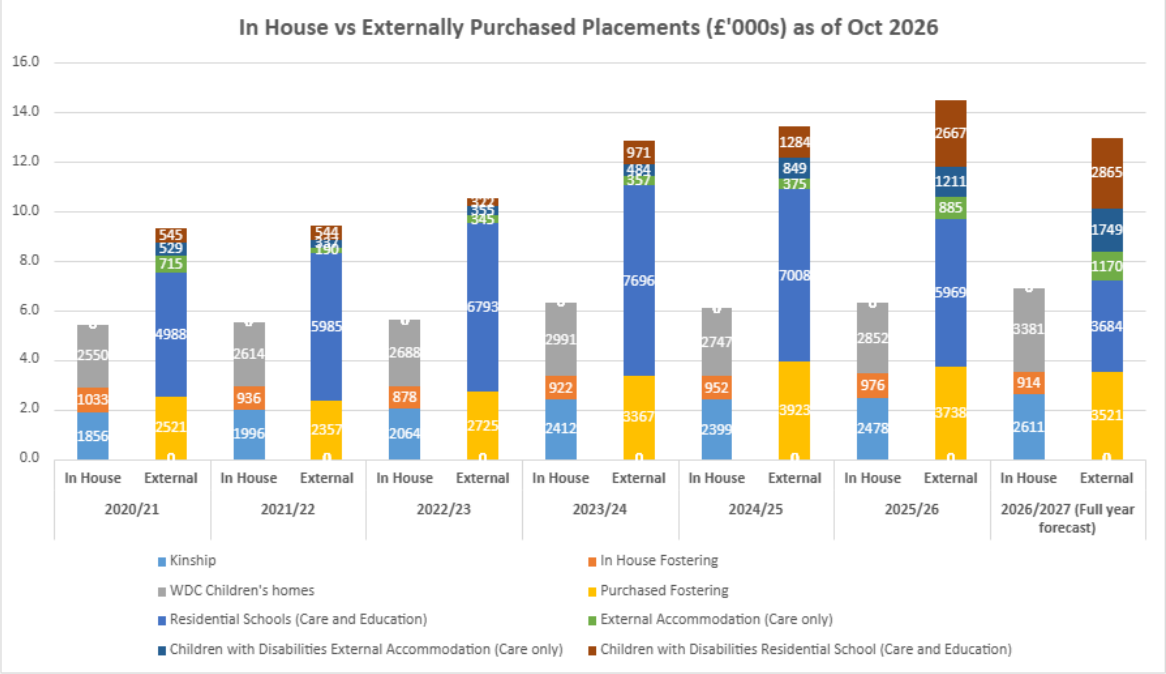
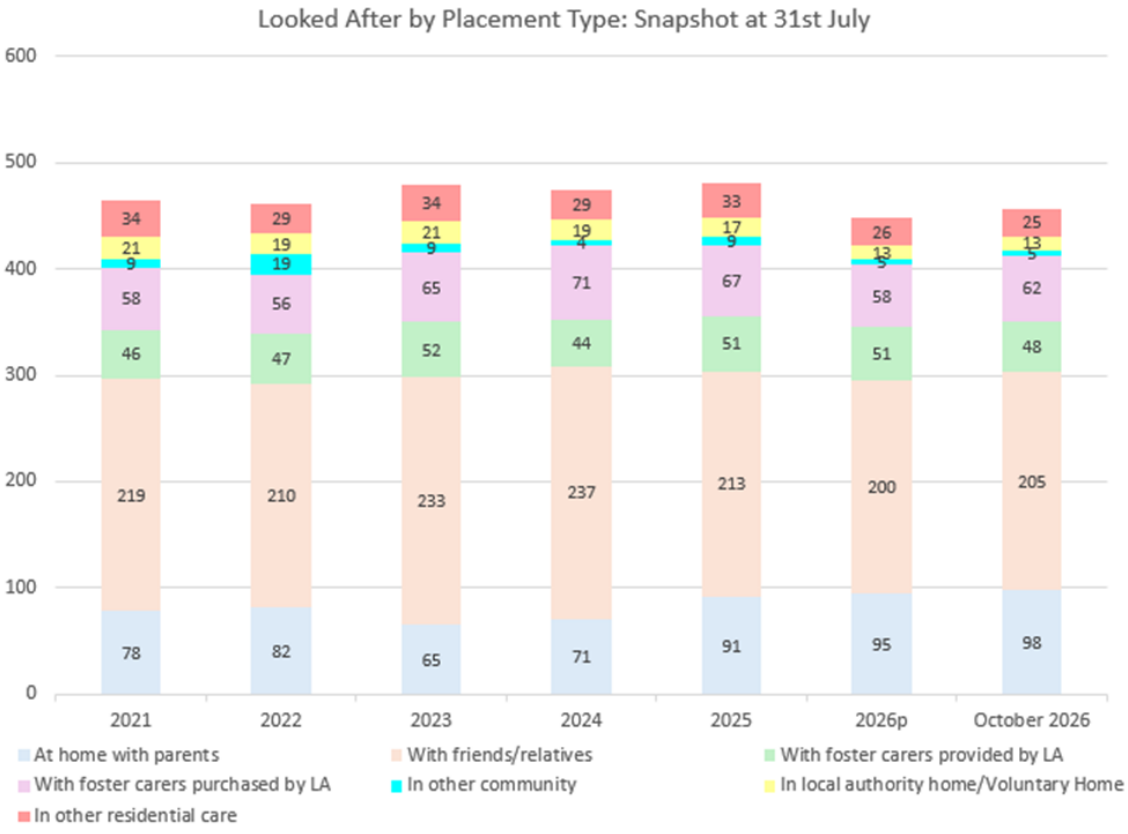


Table 8 Impact and Looked After Children and Young People Profile Table 8 Number of Looked After Children at 31st March 2026



4.52 Spending on externally purchased foster placements decreased from £3.7 million in 2025/2026 to a forecast of £3.5 million in 2026/2027. Spending on residential schools providing care and education also decreased by more than £2 million over the same period. The Area Resource Group (ARG) has contributed to these reductions through the detailed scrutiny of assessments and resource-allocation decisions.

4.53 Since 2023, spending on external accommodation for children with disabilities has increased in both care-only and care-and-education placements. Spending on care and education has increased by £1.9 million, while spending on care-only placements has increased by £1.2 million.

Project 2 – Kinship Support

4.54 The Kinship Panel has been implemented since 6th May 2026, with an independent chair commissioned through the Association for Fostering, Kinship & Adoption Scotland (AKFA) and panel membership established from across Social Work, Education and Health Services.

4.55 Evaluation surveys have been developed to gather feedback from attendees, including kinship carers. The learning from the feedback being used to inform the ongoing development of the Panel.

4.56 A process has also been introduced around visits by Duty Social Workers in relation to Kinship Carers who are caring for children/young people who do not have a named social worker, to ensure the child's plan remains right for the child/young person and there is appropriate support available for Kinship Carers. As of 1st October 2026, the number of unallocated children/young people stands at 44.

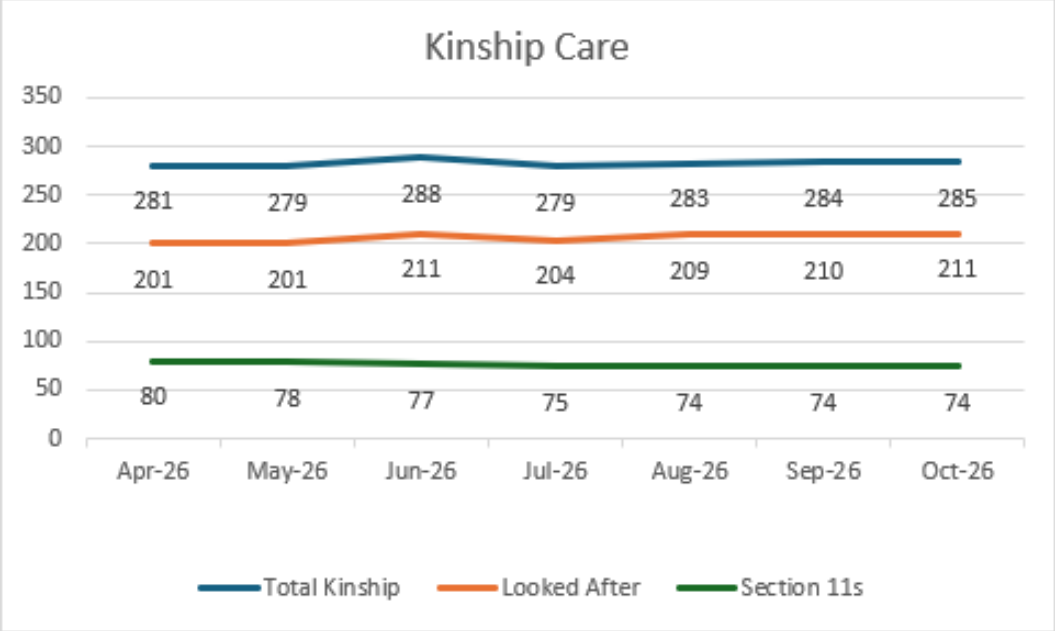
4.57 A new Kinship Assessment has been drafted in line with National Kinship Assessment produced by Scottish Government, with plans to be developed around both testing and piloting the assessment once it has been formally agreed and approved and associated Guidance developed for workers. This assessment aims to improve consistency, clarity and robustness in kinship assessments for local carers.

4.58 Kinship Care Guidance and Procedures have been updated and reviewed by AFKA Scotland (Association for Fostering, Kinship & Adoption). Feedback has been received and will be used to inform final revisions, ensuring alignment with best practice and national guidance.

4.59 Work has begun on the development of a Kinship Carer Communication Plan, including the establishment of clear distribution lists and the use of surveys and feedback mechanisms to strengthen engagement and communication with kinship carers. Engagement has been undertaken with West Dunbartonshire Kinship Carers Support Group as part of the wider approach to strengthening communication and engagement.

4.60 Table 9 below breaks down the profile of Kinship Care and by Kinship Care order or Section 11 of the Children (Scotland) Act within West Dunbartonshire from April 2025 up to March 2026.

Table 9 Profile of Kinship Care



Supported Accommodation for Care Leavers

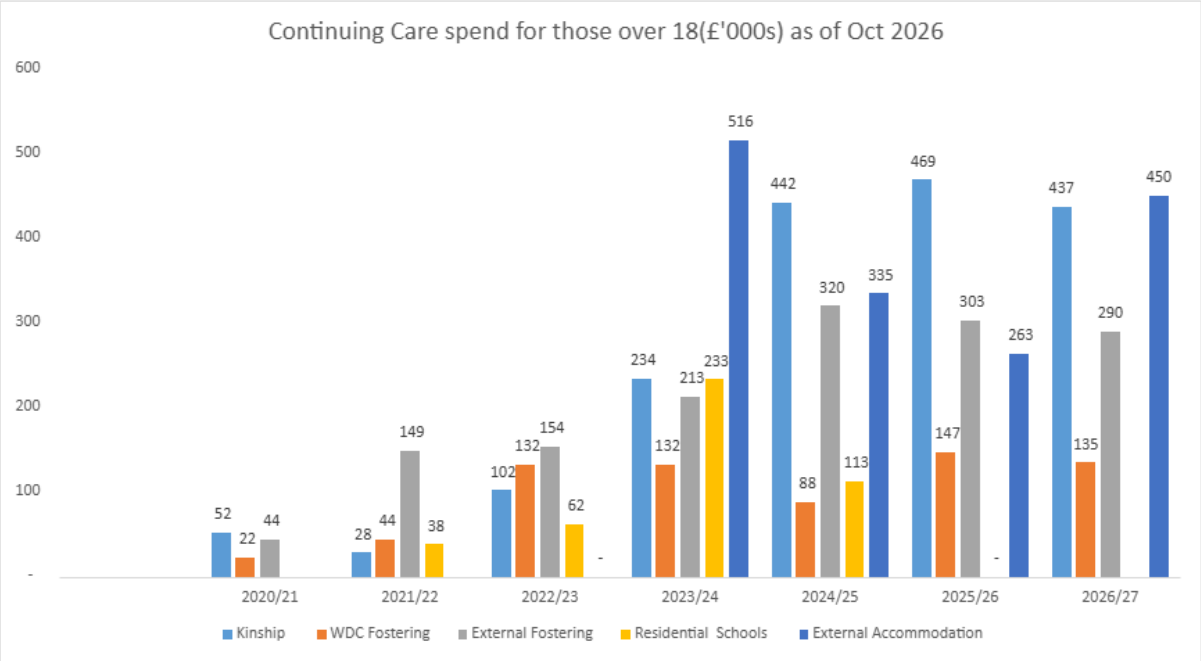
4.61 Young people leave care with varying degrees of support needs and all too often young people leaving care end up within homeless provision. This workstream, alongside colleagues within WDC Housing Services, is overseeing the development of 8 individual 'practice flats' at 28, Bridge Street, Alexandria, within which 24-hour support and advice will be provided to young care leavers. The intention with this approach is to bridge the support gap for young care leavers from care to independent living. The building work is scheduled to commence in November 2026 and is estimated to be completed by October 2027.

4.62 Alongside this development, work has also progressed to develop the proposed service delivery model. Consultation on both the proposed building layout as well as outcomes which should be sought to be achieved from such a provision has taken place with local care experienced children and young people via our Champions Board. Following this a service provider forum was held in September 2026 to provide further information on the Bridge St project and outline to providers the proposed model of support being sought. The event was positively received and generated useful discussion and questions. A follow-up will be arranged to respond to outstanding queries raised on the day ahead of formal tendering process commencing in early 2027.

4.63 As the project progresses, consultation will continue to take place with children and young people who are both currently looked after or have moved on from care to help inform this development.

4.64 Prior to 2023, Continuing Care recognition was not clearly defined locally and was not aligned to placement type and costs which is reflected in the significant rise in our data. This is helpful to understand the associated costs of young people who are transitioning through care, both in terms of projected costs and accommodation requirement following care:

Table 10 - Continuing Care Spends for over 18.



4.65 Clarity of placement movement over 5-year trend with a focus in detail of care experienced placements since April 1st, 2024. There has been a reduction in residential school placements overall since 2023, a reduction in Kinship Placements with Kinship placements ending at aged 18yrs with some young people then being supported in the same placement as continuing care.

<u>Financial implications What Would It Take to Date</u>

4.66 A key development is the reduction in external foster placements, from 67 children and young people in 2025/2026 to a forecast of 62 in 2026/2027. The use of residential school placements fluctuates throughout the year and has been as low as 16 children and young people. Placement decisions are led by demand and risk, with oversight from senior managers to ensure that the threshold for admission to care is met.

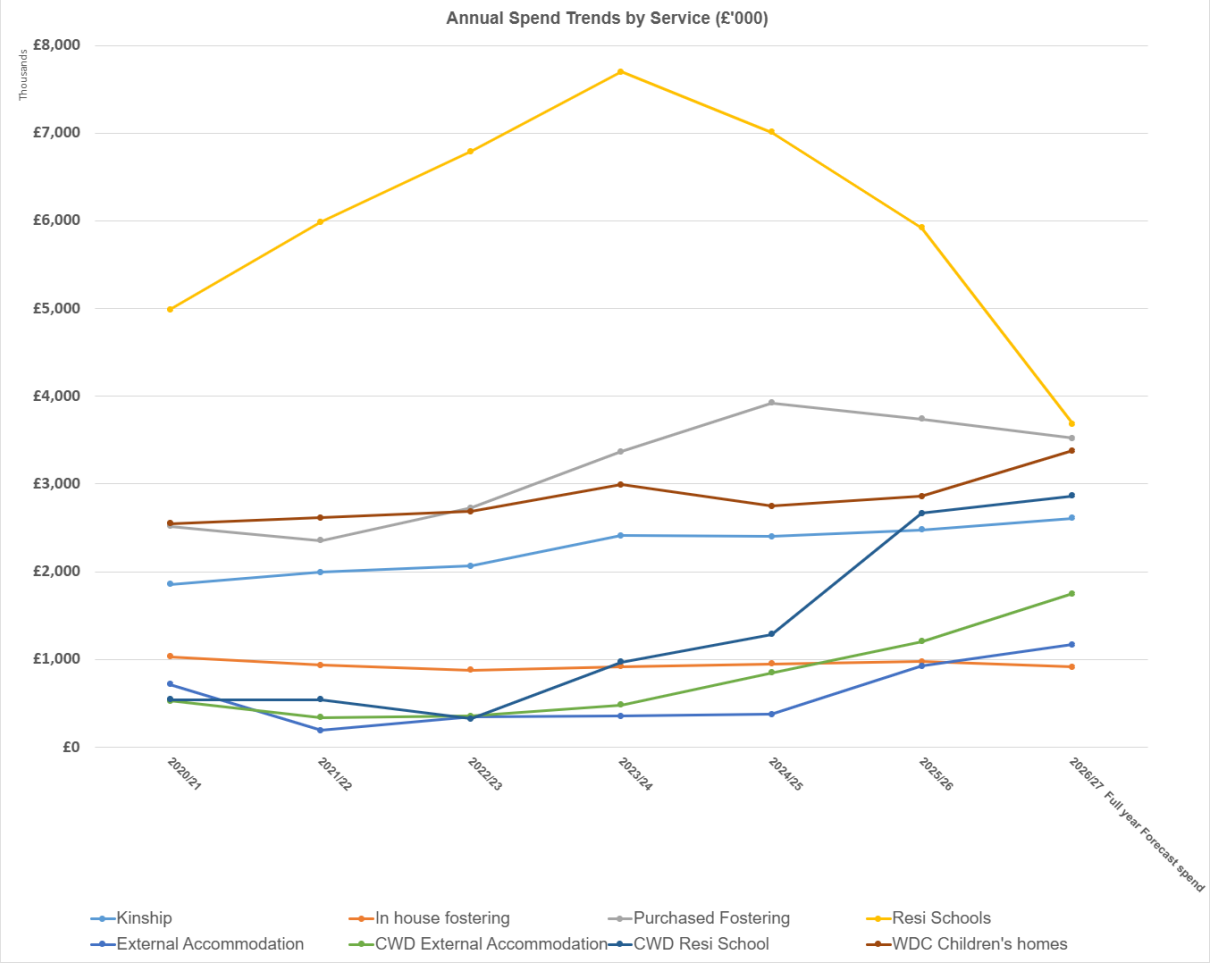
4.67 Over the last six months, there has been an increase of two children and young people with disability-care-only placements. This placement type is now

reported separately. Funding of £0.700 million was redirected to support carers of children and young people with disabilities and complex needs. The specification was developed following an independent consultation with families undertaken by Aberlour. Family support services for families with children and young people with disabilities and complex needs are now progressing through the appropriate commissioning and procurement processes.

4.68 West Dunbartonshire's three children's houses regulated by the care inspectorate are now registered to each support 6 children resulting in a maximum capacity of 18 placements. Residential care requirements out with this local provision requires to be purchased through commissioning frameworks.

4.69 Table 11 below demonstrates the reduction in spend between 2023 and October 2026 in relation to residential school costs. This includes educations 28% share of residential schools costs, and excludes continuing care costs.

Table 11 Spend over past 7 years



4.70 The HSCP Board reviews a Financial Performance Update Report at each meeting, outlining budget variances and required actions to maintain financial balance. In 2026/27, as in previous years, community placements and residential accommodation budgets have faced pressure due to demand, inflation, and care complexity. Table 12 shows the Period 6 forecast outturn. The favourable variance partly stems from the work on reducing external placements in residential schools and external fostering, thanks to the ongoing "What Would it Take" strategy.

4.71 The "What Would it Take" medium-term financial plan for Children and Families will be updated to reflect changes in demand and costs. An underspend is currently reported.

Table 12 – 25/26 Financial Update as at 29th October 2026

Children and Families Financial update Period 6	Annual Budget	Forecast Spend	Forecast Spend	Forecast Variance	Reserves Adjustment	Recovery Plan	Forecast Variance
	£000	£000	£000	£000	£000	£000	£000
Residential Accommodation for Young People	3,418	3,380	3,380	38	0	0	38
Children's Community Placements	8,258	8,340	8,340	(82)	(8)	0	(74)
Children's Residential Schools	7,088	7,351	7,351	(263)	0	0	(263)
What Would It Take	0	0	0	0	0	0	0
Children's Supported Accommodation	909	385	385	524	0	0	524
Childcare Operations	6,512	6,324	6,324	154	(82)	0	236
Other Services - Young People	4,587	4,309	4,309	239	(25)	0	264
Net Expenditure	**30,771**	**30,089**	**30,089**	**609**	**(115)**	**0**	**724**

5. Options Appraisal

5.1 The recommendations within this report do not require an options appraisal to be undertaken.

6. People Implications

6.1 The majority of the people implications in this programme relate to realigning existing employees and financial resources to support the HSCP's strategic aims and meet the needs of our children and young people.

6.2 It is anticipated that the early identification of changes will ensure that individual contributions and concerns are articulated at an early stage of organisational change. It is important to ensure that communication in relation

to changes to service affords sufficient time to consult with employees, Trade Union colleagues and service users, and address any concerns which they may have in a structured and systematic way.

6.3 The strategy will be implemented in line with the relevant West Dunbartonshire Council and NHC Greater Glasgow and Clyde Policies, including the Organisational Change Policy.

7. Financial and Procurement Implications

7.1 The financial impact of sustained demand on supporting young people is illustrated in the tables and charts above.

7.2 The regular financial performance reports to the HSCP Board will continue to track and monitor the current level of placements and reflect any further demand and cost pressures arising from increase in numbers and commissioned services inflationary pressures above budgeted levels.

8. Risk Analysis

8.1 All project risks will be included in the programmes risk register and risks and issues will be presented to the project management office.

8.2 The strategy aims to shift the balance of care to support children in the community. Sufficient capacity in workforce and support to families is required to keep children safety at home.

9. Equalities Impact Assessment (EIA)

9.1 The recommendations within this report do not require the completion of an EIA.

10. Environmental Sustainability

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

11. Consultation

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

11.2 Any formal consultation with employees will be managed in accordance with West Dunbartonshire Councils Organisational Change Policy.

12. Strategic Assessment

12.1 On the 15 March 2023 the HSCP Board approved its Strategic Plan 2024 – 2029 “Improving Lives Together”. The Plan outlines sustained challenges and changes within health and social care, these changes bring with them a host of governance implications: cultural, operational, structural, ethical, and clinical.

12.2 This work seeks to achieve the HSCP Boards vision that “Everyone in West Dunbartonshire lives in a place they can call home, in communities that care, doing things that matter to them, leading healthy, happy and fulfilling lives, and, when they need it, receiving care and support that prioritises independence, control, choice and recovery”, whilst also ensuring good governance and best value.

12.3 It will deliver against the Caring Communities strategic outcome, by meeting the strategic priority of “Shift the balance of care for children and adults by strengthening prevention and our community-based support options, keeping individuals in their community where possible”.

12.4 This work is reflected in the Strategic Delivery Plan which supports the implementation of “Improving Lives Together”, specifically the following action: Develop and implement a five-year strategic approach – What Would It Take? – across Children’s Services, underpinned by a medium-term financial plan and defined work streams for Children’s Services. This will include commissioning child-centred services; supported accommodation for care leavers; best practice in child protection; children at the Centre of residential care; and fostering for the future.

13. Directions

There are no directions required aligned to this report.

Name	Clare Wilson
Designation	Head of Children’s health, care, and justice services. Chief Social Work Officer
Date	29th October 2026

Person to Contact	Clare Wilson: Head of Children's Health Care and Criminal Justice West Dunbartonshire HSCP 16 Church Street Dumbarton.
Appendices:	N/A
Background Papers	N/A

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

Report by Fiona Taylor, Head of Service Health and Community Care

24 November 2026

Subject: Care at Home Update

1. Purpose

1.1 The purpose of this report is to update the HSCP Board on the Care at Home service. This includes the progress and impact of the Redesign project, Care Inspectorate inspection and financial sustainability.

2. Recommendations

2.1 It is recommended that the HSCP Board:

a) The Board is asked to note the good progress that has been made taking forward the requirements as part of the inspection of the service.

b) Approve the purchase of the Medicines Management Service with Medication Administration Record (MAR) Chart for eligible service users open to our Care at Home Service.

c) Issue the Council with the Direction included with this report to commence the procurement process and enter contractual arrangements required on behalf of the HSCP.

d) Note the aggregated maximum contract value of £194,987.52 over the total contract term including any extensions.

e) Note that the implementation of the Medicines Management Service with Medication Administration Record Chart service in quarter 4 of the 2026-27 financial year will increase the currently reported Care at Home overspend by £7,500, however this will be offset by unallocated contingency budget held for demographic pressures.

f) Note the updates provided in this report relating to the Care at Home Service.

3. Background

3.1 Since summer 2021, the HSCP Care at Home Service has been subject to sustained quality improvement activity. This has included the implementation of a service redesign, delivery of improvements arising from Care Inspectorate inspections, and strengthened management oversight to enhance governance, quality assurance and financial accountability.

3.2 In addition, there has been ongoing Trade Union involvement and two periods of industrial action. Trade Union involvement escalated during Phase 3. There has also been involvement from Councillors within West Dunbartonshire Council.

Redesign

3.3 On the 28th of March 2024, the HSCP Board approved the proposed Redesign changes: document-pack-bookmarked-and-agenda-hscp-board-28-march-2024.pdf

Stage 1: Home Carer Rostering Implementation of a standard working roster across three phases:

- Phase 1 (December 2024): Voluntary early movers and staff already on standard patterns
- Phase 2 (March 2025): Staff given 12 weeks' notice to move to standard patterns
- Phase 3 (March 2026)**:** Remaining staff meeting agreed criteria, with appeals considered

Stage 2: Care Co-ordination Workforce Enhancement of office-based care co-ordination roles to improve oversight, scheduling and governance.

Stages 1 and 2 are now complete.

Care Inspectorate

3.4 The Care at Home Service has been inspected annually since March 2023. Grades awarded have highlighted areas of risk across the service, and action plans have been in place to meet the Requirements and Areas for Improvement placed on the service.

Table 1: Grades awarded by Care Inspectorate

Key Questions	June 2026	Dec 2025	April 2025	March 2025	March 2023
How well do we support people's wellbeing?	2 - Weak	3 - Adequate	2 - Weak	2 - Weak	3 - Adequate
How good is our leadership?	2 - Weak	3 - Adequate	3 - Adequate	2 - Weak	3 - Adequate
How good is our staff team?	2 - Weak	3 - Adequate	2 - Weak	2 - Weak	3 - Adequate
How well is our care and support planned?	2 - Weak	3 - Adequate	3 - Adequate	2 - Weak	3 - Adequate

Cost effectiveness

3.5 The redesign is a key mechanism for improving the financial sustainability of the Care at Home service, reducing overtime and agency costs by effective alignment of service capacity against planned hours of care.

3.6 Significant financial pressures remain, driven in part by high absence levels and the need to recruit to align the 'post redesign' workforce establishment with planned hours of care.

3.7 2026/27 budget was agreed at the March 2026 budget setting meeting and was constructed using the same approach as 2025/26 to ensure it accurately reflects the redesigned staffing structure. Budget allowances made for travel time, sickness, holiday and training cover will be kept under review as the Standard Operating Procedures are fully embedded and further scheduling efficiencies emerge from robust work patterns that support the demands of the service.

3.8 The HSCP Board agreed to remove a proportion of identified excess hours, generating a recurring saving of £1.716m per annum. The approved staffing budget is based on the staffing establishment required to deliver average weekly planned hours of care rather than the hours of staff in post. This approach retains sufficient flexibility to allow the new rotas to fully embed and to identify any service delivery gaps that may require short-term use of overtime or agency cover.

4. Main Issues

Redesign

4.1 As outlined in section 3.3, Stages 1 and 2 of the redesign are now complete with 92% of the workforce now in standard 'back-to-back' rosters. While this provides greater stability of care delivery, staffing capacity is not yet fully aligned with service user demand across localities. This results in surplus capacity in some areas while additional cover is required in others, contributing to the continuing reliance on overtime and agency staffing.

4.2 Stage 3 of the redesign will determine the appropriate balance between internal and externally commissioned Care at Home provision, making best use of the skills and capacity of the internal workforce. Any phased change in the balance of provision will need to be considered within the available financial envelope and demonstrate that it is sustainable. As reported in the May 2026 IJB report, a 'Supporting Community Independence - Care at Home Framework' was established in April 2026 in response to a need to provide a governance framework when commissioning external packages of care. This includes assurance that all providers are operating under standard terms and conditions.

4.3 In April 2026, the Vacancy Panel approved the recruitment to 756 hours, equating to 21.6 FTE. These hours would have brought the service to 10,398 contracted hours, however due to staff turnover and not being able to fill all vacancies, the contracted hours currently stand at 9,440.

4.4 Weekly planned hours of care fluctuate, depending on the service user profile and care needs. On average the workforce is required to deliver more than 5,600 hours per week to over 982 service users.

4.5 Planned hours and the number of service users have reduced by over 1000 hours and 120 service users over the past four years. This is in part due to an increase in service users moving to external Care at Home providers. This was due to capacity challenges within the Reablement service that necessitated commissioning packages to reduce the risk of people being delayed in discharge from hospital.

4.6 The workforce capacity required to deliver direct care while allowing for annual leave, sickness, training and travel is approximately 8,532 staff hours per week. This is due to an allowance of an additional 52.35% to the staff hours.

4.7 The Care at Home budget allows for 9,731 hours. This means there is currently a gap of 291 hours (9,731 budgeted hours minus 9,440 contracted hours) which equates to 8.3 full-time equivalent posts. In the next 3 months the service anticipates a further reduction of 502 contracted hours due to ill health retiral, retiral and leaving due to capability. Discussions around options to fill these anticipated gaps are in progress.

4.8 Key to delivering the service within budget is effective rostering across each area to deliver complete and comprehensive rostering and allocation of staff hours against planned care. This responsibility lies with Organisers, with management oversight from the Team Leads.

4.9 During the period of movement towards the application of the agreed criteria and consideration to recruitment, there are areas with gaps in workforce incurring overtime and agency costs.

Care Inspectorate

4.10 The Care Inspectorate undertook an unannounced inspection in June 2026. Inspectors noted the three requirements made in January 2026 had not been met, and made two further requirements of the service, bringing the total requirements to five.

Requirement 1: Medication

4.11 *By 10th Oct 2026, we must ensure that people are supported safely with their medication to support their health and wellbeing.*

4.12 What we are doing:

- New Medication Management SOP now in place with the majority of workforce trained.

- Training in the new SOP is shown in Table 2.

Table 2: Number of staff trained in Medication Management

Medication Management SOP training (dated 9th Nov 2026)	
Number of staff trained	319
Number of staff with training to be scheduled	152

- A structured programme of medication care plan and risk assessment audits is underway. Organisers are receiving individual feedback, coaching and direction to strengthen person-centred medication planning and ensure records accurately reflect current needs, preferences, outcomes and risks. Ongoing audits are being used to monitor progress, identify gaps and target further learning where required.

- A Medicines Management Service with Medication Administration Record (MAR) Chart Service Level Agreement has been developed in partnership with the Pharmacy Development Team and representatives from the national Pharmacy Contractors service.

- The service will be in place for 3 years with an option to extend for a further period of up to 24 months, with a total aggregated contract spend of £194,987.52. Table 3 below details the contract spend split across the full contractual period:

Table 3: MAR Chart Service Level Agreement spend

	Year 1	Year 2	Year 3	Year 4	Year 5
Number of Service Users per month	100	100	100	100	100
Total monthly cost (£)	3,000.00	3,120.00	3,244.80	3,374.59	3,509.57
Annual cost (£)	36,000.00	37,440.00	38,937.60	40,495.08	42,114.84
Total contract spend (£)					194,987.52

- The service is available to service users who have been assessed by the HSCP as requiring this service against set criteria. The contract spend has been calculated using demand assumptions (up to 100 service users per month), provisions for fluctuations in service demand and assumed uplifts of 4% over the contract term.

- To manage the contract spend, expenditure will be managed in an aggregated way in line with how contract expenditure is managed and monitored within a Framework.

- Approval of the aggregated contract value does not commit the HSCP to spend the full amount. Rather, it establishes a maximum expenditure ceiling that provides sufficient flexibility to respond to changing service demands whilst maintaining appropriate financial governance and control. The estimated annual costs will be incorporated into future year's budget estimates.

- The service is expected to commence during Quarter 4 of financial year 2026-27. The projected cost of £7,500 will be accommodated within the overall contingency budget held for demographic pressures.

- There is the possibility for NHS GGC Board wide discussion relating to Medicines Management Services with MAR Chart during the lifespan of the service. The HSCP has built in provision within the Service Level Agreement to allow that agreement to be terminated without liability to participate in the NHS GGC Board agreement should that be more efficient.

Requirement 2: Quality Assurance

4.13 *By 10 October 2026, we must ensure that there are quality assurance systems and processes in place to support good standards of practice.*

4.14 What we are doing:

- An annual QA Schedule covering all audits, observations, incidents, complaints, and compliance checks has been developed, with progress reviewed monthly by the Management Team.

- All audits have an associated SMART action plan recorded on the Quality Assurance database, including identified root causes, named leads, measurable outcomes, and completion timescales. This is reported at weekly management meetings for IOM oversight.

- The first cycle of audits has been completed, with findings being communicated through individual feedback sessions and management discussions to support practice improvement and accountability.

Requirement 3: Complaints Management

4.15 *By 10 October 2026, we must ensure that people can be assured their complaints will be investigated and reported in line with the provider's complaints policy and procedure.*

4.16 What we are doing:

- Manual weekly checks are being completed as an interim quality assurance measure. A new process will be implemented following training for managers and the administration team, commencing on 16 November 2026.

- Complaints management and organisational learning is being strengthened to ensure complaints and concerns help to drive meaningful change where appropriate.

Requirement 4: Supervision

4.17 *By 5 November 2026, we must establish regular, meaningful supervision for all staff and incorporate competency checks into quality assurance processes.*

4.18 What we are doing:

- A supervision oversight matrix is in operation, with the initial round of supervision audits in progress. Findings will inform further improvements if indicated.

- A Care at Home supervision template has been implemented

- The 26/27 supervision matrix allows a balanced mix of individual and group supervisions.

- Work is underway to incorporate competency checks and oversight arrangements into the wider quality assurance framework.

Requirement 5: Personal Plans

4.19 *By 5 November 2026, we must ensure that staff, including agency workers, have access to accurate and up-to-date personal plan information for the people they support.*

4.20 What we are doing:

- A revised care and support plan format has been implemented.

- An initial audit cycle has been completed with feedback to Organisers to ensure good practice is recognised, and areas for improvement are acted upon.

- Plans are visible on phones meaning carers and agency workers have access to accurate and up to date information.

Financial sustainability

4.21 The 2026/27 projected outturn for period 6 for Care at Home services is included within the 2026/27 Financial Performance Period 6 Report, contained within a

separate item to this meeting agenda, and reports an adverse variance of £1.587m. The adverse variance represents a significant financial risk; however, this is being managed in-year through the overall contingency budget, including provision for demographic pressures and the element of the early draft Care at Home staffing budget above the 9,731 hours referenced at paragraph 4.7 above.

4.22 The projected overspend is mainly due to ongoing reliance on overtime and agency staffing to maintain service delivery in the context of workforce vacancies and demand pressures. While recent recruitment had brought staffing levels closer to the approved budgeted establishment this has been offset by other staff leaving the service. The forecast assumes a gradual reduction in temporary staffing costs to the end of the financial year.

4.23 High staff absence continues to impact capacity and absence management is being actively managed through the Council's absence management policy.

Social care governance

4.24 Robust governance underpins the delivery of the Care at Home Service. The Chief Officer chairs a fortnightly meeting to review performance and the service also reports into the Chief Social Work Officer's Social Care Governance group. This governance oversight ensures performance, Care Inspectorate action plans and complaints are monitored.

5. Options Appraisal

5.1 The recommendations within this report do not require an option appraisal to be undertaken.

6. People Implications

6.1 The improvements will provide employees with stability and deliver fair work principles for all employees. The changes to the current operational infrastructure will ensure that the workforce has capacity to deliver a consistently high standard of care.

6.2 The overall impact of this model will be to have sufficient employees available at the right time to deliver a consistent and high-quality service. This should also reduce the use of overtime and unplanned agency use. The impact of any potential employee changes is being managed in accordance with West Dunbartonshire Council Organisational Change Policy.

7. Financial and Procurement Implications

7.1 As described in section 4.20, the Care at Home Service has a projected overspend of £1.587m in financial year 2026-27, excluding the cost of the Medicines Management Service with MAR Chart. The financial impact in the 2026-27 financial year is expected to increase the overspend by £7,500, however this will be offset by unallocated contingency budget held for demographic pressures. For future years, budget provision will be built into the

corresponding annual budgets.

7.2 The HSCP is requesting specific approval from the WD HSCP Board for the Medicines Management Service with MAR Chart to ensure it complies with West Dunbartonshire Council's Standing Orders and Financial Regulations.

8. Risk Analysis

8.1 Redesign changes are implemented but the service does not achieve budget balance. If efficiencies are not achieved there may be a need to review the eligibility criteria for the service. There may also be a need to consider alternative ways to provide support to service users assessed as requiring support from a home care service.

8.2 Failure to implement the Medicines Management Service with MAR Chart would present a significant risk to our Care at Home Service's ability to sustain the improvements required to increase its Care Inspectorate grades. Without this service we may adversely impact the HSCP's ability to demonstrate compliance with the Care Inspectorate requirements.

9. Equalities Impact Assessment (EIA)

9.1 There is no requirement to provide an EIA for this report.

10. Environmental Sustainability

10.1 The recommendations within this report do not require a Strategic Environmental Assessment (SEA) to be undertaken.

11. Consultation

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

12. Strategic Assessment

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

12.2 This review seeks to achieve the HSCP Boards vision that "Everyone in West Dunbartonshire lives in a place they can call home, in communities that care, doing things that matter to them, leading healthy, happy and fulfilling lives, and, when they need it, receiving care and support that prioritises independence, control, choice and recovery", whilst also ensuring good governance and best value, specifically: "Our services both in-house and commissioned will achieve sustainable outcomes at a sustainable cost, ensuring the optimal use of resources to achieve the intended outcomes. They will focus on person-centred

care and outcomes and will be inclusive, well led and promote a sustainable and diverse market."

13. Directions

13.1 Subject to the HSCP Board approving the recommendations noted in section 2, there will be a requirement for a direction to be issued to the Council recommending the commencement of the procurement of the Medicines Management Service with MAR Chart and to take the necessary steps for the Council to issue the relevant contract award and contract documentation to those third party pharmacy contractors who will deliver these services under the terms of the Service Level Agreement. The direction template is included as an appendix to this report.

Name:	Fiona Taylor
Designation:	Head of Health and Community Care
Date:	24 November 2026

Person to Contact:	Fiona Taylor Head of Health and Community Care Fiona.Taylor21@nhs.scot

Background Papers:	West Dunbartonshire Council Financial Regulations and Standing Orders (*Council Financial Regulations)*
Appendices:	Direction Template – Medicine Management Services with MAR Chart

Appendix 1: Direction from Health and Social Care Partnership Board

The Chief Officer will issue the following direction email directly after Integration Joint Board approval:

From: Chief Officer, HSCP
To: Chief Executive(s) WDC
CC: HSCP Chief Finance Officer, HSCP Board Chair and Vice-Chair
Subject: Direction(s) from HSCP Board (24 November 2026) FOR ACTION
Attachment: HSCP Board Report – Medicines Management with Medication Administration Record Chart Service
Following the recent HSCP Board meeting, the direction below has been issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014. Attached is a copy of the original HSCP Board report for reference.

DIRECTION FROM WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD		
1	Reference number	HSCPB0000105FT24112026
2	Date direction issued by Integration Joint Board	24 November 2026
3	Report Author	**Report Author:** Fiona Taylor, Head of Health and Community Care Fiona.taylor21@nhs.scot **Person to Contact:** Neil McKechnie – Contracts, Commissioning and Quality Manager Neil.McKechnie@west-dunbarton.gov.uk
4	Direction to:	West Dunbartonshire Council only
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	No.
6	Functions covered by direction	Procurement of the Medicines Management with Medication Administration Record Chart Service detailed in the HSCP Board Report – Medicines Management Service November 2026.

7	Full text and detail of direction	Subject to compliance with the Council's Financial Regulations and Standing Orders direct the Council to award contracts to pharmacy contractors up to a maximum contract spend of £194,987.52.
8	Specification of those impacted by the change	This purchase of this service will have a positive effect on service users open to the Council's Care at Home Service who are assessed as requiring this service. Such assessment and eligibility is determined by suitably trained and qualified Council staff.
9	Budget allocated by Integration Joint Board to carry out direction	Please see HSCP Board Paper – Medicines Management Service.
10	Desired outcomes detail of what the direction is intended to achieve	This direction is to ensure compliance with the Council's Financial Regulations and Standing Orders and to give assurances that Best Value is being achieved in relation to the procurement of this service. This direction also supports the service improvement plan for our Care at Home Service.
11	Strategic Milestones	These will vary depending on the pharmacy contractor
12	Overall Delivery timescales	All activities to be completed by 31 January 2027 or earlier.
13	Performance monitoring arrangements	This will be conducted by the service area using the Service Level Agreement to measure compliance.
14	Date direction will be reviewed	31 January 2032.

WEST DUNBARTONSHIRE HEALTH AND SOCIALCARE PARTNERSHIP BOARD

Report by Val Tierney, Chief Nurse

24 November 2026

Subject: HSCP Seasonal Preparedness and Operational Resilience Plan

1. Purpose

1.1 This paper presents West Dunbartonshire HSCPs Operational Resilience & Seasonal Preparedness Plan 2026/27. The plan includes work underway across West Dunbartonshire HSCP and focussed activity that will strengthen operational resilience through winter 2026/27 ahead of peak winter activity.

2. Recommendations

2.1 Agree West Dunbartonshire HSCP's Operational Resilience and Seasonal Preparedness plan and note this replaces the previous practice of presenting a separate winter improvement plan.

2.2 Approve the revised allocation and alignment of Operational Improvement Plan (OIP) funds to support local implementation as outlined in Appendix 1 to this report.

3. Background

3.1 Winter planning for 2026–2027 reflects the Scottish Government's National Planning Priorities and Principles for Surge and Winter Preparedness in Health and Social Care, published in October. This framework advocates a shift from seasonal planning to year-round surge preparedness, recognising that pressures occur throughout the year.

4. Main Issues

4.1 The plan builds on lessons learned during winter 2025/26 where actions largely fell into two categories; Business as Usual (core business) such as local service resilience continuity and contingency planning and Additionality; West Dunbartonshire HSCPs contribution to whole system winter pressures optimising the opportunities associated with transforming and rebalancing the provision of care in West Dunbartonshire.

4.2 In the absence of dedicated additional winter funding, the focus is on bringing together the relevant existing commitments related to 2026/27 NHSGGC Annual Delivery Plan (ADP), Transforming Together, Urgent and Unscheduled Care, Primary and Community Care, Planned Care, Public Health and Workforce plans.

4.3 The Operational Improvement Plan funding has been realigned to support necessary changes to local intermediate care provision and targeted, time-limited work to accelerate reductions in delayed discharge. The proposal also supports the ongoing commitment and requirement to shift the balance of care and support necessary transformation of local services.

4.4 The plan is underpinned by a Community First approach strengthening local multidisciplinary services to shift more care into communities, supporting people earlier and preventing their health from getting worse.

4.5 Planning is based on coordinated action across the health and social care partnership to strengthen resilience and maintain safe, effective and person-centred services. The approach continues to prioritise keeping people safe at home through expanded Community Health and Care Services. In line with national priorities, local arrangements focus on Home First, enhanced community health and care provision, support to care homes, vaccination, planned care investment, improvement activity to address delayed discharges and efforts to support improved patient flow, enabling people to remain safely at home and access and receive the right care in the right place at the right time.

4.6 The HSCP will also participate in the three-week Scotland West System Reset (30th November – 13th December). This involves coordinated operational effort across NHS health boards and HSCPs to manage acute pressures, reduce backlogs and improve patient flow through hospitals.

5. Options Appraisal

5.1 The recommendation within this report does not require an options appraisal**.**

6. People Implications

6.1 Recruitment, diminished staff resilience and increased absence are identified as credible risks within the plan particularly during periods of surge activity.

6.2 Contingency plans include investing in increasing staff capacity, revising staff rotas and where necessary the management of annual leave.

6.3 The HSCP recognises that supporting the health and wellbeing of the workforce is critically important at any time, and especially during periods of surge activity. An ongoing focus on staff wellbeing will be maintained within the context of financial pressures, staff vacancies and anticipated increased demand.

6.4 The additional operational pressures the HSCP faces during periods of surge activity is acknowledged and a number of important wellbeing supports and interventions are available, for example the provision of mental health first aiders; one to ones and supervision where staff are encouraged to access

support from their line manager, trade union representative or professional body; access to corporate and national wellbeing resources; access to occupational health services; access to appropriate PPE; and emphasising the importance of vaccination in protecting our staff, those we care for and the resilience of the HSCP over winter.

7. Financial and Procurement Implications

7.1 Dedicated funding was allocated via the Operational Improvement Plan (OIP) to help create more capacity across the HSCP. This is not recurring and is subject to performance review by Scottish Government. Future funding is contingent on progress being demonstrated against the HSCP OIP.

8. Risk Analysis

8.1 The absence of dedicated additional winter funding will restrict the scope of system reset activity.

8.2. OIP funding is non-recurring, with future funding dependent on performance review and measurable results demonstrated by the HSCP. Associated recruitment, retention and financial risks will need to be managed. Proposals have been designed for sustainability and deliverability, following careful consideration of recruitment options.

8.3 The risk of increased demand during the winter period may result in the HSCPs performance, being adversely affected. All efforts are directed towards mitigating potential risks.

8.4 Recruitment, diminished staff resilience, good will and potential increased absence are central pillars within the plan and are areas of risk during period of surge activity**.** Contingency plans include investing in increasing staff capacity and wellbeing and revising staff rotas and where necessary the effective management of annual leave.

9. Equalities Impact Assessment (EIA)

9.1 The recommendation within this report does not require the completion of an EIA. No adverse equality impacts are anticipated.

10. Environmental Sustainability

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

11. Consultation

11.1 The proposal outlined have been created in consultation with SMT and EMT, Clinical Directors, Professional Leads and in consultation with local delivery teams.

12. Strategic Assessment

12.1 The report is aligned to the Scottish Government's key strategic priorities outlined in the attached background papers and the HSCP Boards Strategic Plan 2023 - 2026, Improving Lives Together. This ensures that the HSCP provides the right care in the right place at the right time for every person, developing new models of care and services to meet the needs of the population.

13. Directions

13.1 Direction Reference Number HSCPB0000104VT24112026, Title: Operational Resilience and Seasonal Preparedness Plan 2026/27 is attached at Appendix 2 of the report.

Name
Valerie Tierney

Designation
Chief Nurse

Date
24 November 2026

Person to Contact:
Val Tierney Chief Nurse West Dunbartonshire HSCP
Val.Tierney@ggc.scot.nhs.uk

Appendix1:
West Dunbartonshire HSCP Seasonal Preparedness and Operational Resilience Plan 2026-2027.

Appendix 2:
Direction Reference Number HSCPB0000104VT24112026, Title: Operational Resilience and Seasonal Preparedness Plan 2026/27 is attached at Appendix 2 of the report.

Background Papers

New winter health plan to ease hospital pressures - gov.scot

Waiting list funding - Letter to the Convener of Health, Care and Sport Committee - gov.scot

Health and Care Improving Flow Plan 2026 - 2031 - gov.scot

Health and social care - surge preparedness: national planning priorities and principles - gov.scot

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

Appendix1: OPERATIONAL RESILIENCE AND SEASONAL PREPAREDNESS PLAN 2026/27

Report detail	Information
Report by	Val Tierney, Chief Nurse
Date of meeting	24 November 2026
Subject	West Dunbartonshire HSCP Operational Resilience and Seasonal Preparedness Plan 2026/27
Status	Consolidated draft for IJB consideration
Planning period	2026/27, with transformation investment aligned to 2026–28

Executive Summary

This consolidated plan brings together West Dunbartonshire HSCP's seasonal preparedness arrangements and its wider Transformation and Shifting the Balance of Care program. It replaces a stand-alone winter improvement plan with a year-round approach to surge preparedness, operational resilience, and improvement, while retaining clear arrangements for periods of peak winter pressure.

The plan is built around a Community First model: preventing deterioration, intervening earlier, providing credible alternatives to hospital admission, supporting timely discharge, and enabling people to receive safe, effective, and person-centered care at home or in the most appropriate community setting. It aligns operational delivery, urgent and unscheduled care, primary and community care, planned care, public health, workforce, and the Transforming Together program.

Strategic shift	What it means for West Dunbartonshire
From seasonal response to year-round preparedness	Business continuity, demand and capacity monitoring, escalation and improvement activity maintained throughout the year.
From crisis response to prevention and early intervention	Earlier identification of frailty, frequent attenders, and people at risk, with anticipatory and future care planning.
From hospital default to community alternatives	Stronger Scottish Ambulance Service (SAS) and Flow Navigation Centre (FNC) pathways, Focused Intervention Team (FIT), District Nursing, Community Treatment and Care Centres (CTAC), Outpatient Parenteral Antimicrobial Therapy (OPAT), virtual care, urgent community response, and future Hospital at Home capability.
From fragmented response to integrated MDT decision-making	Clear interfaces across acute, primary care, community health, social work, care homes, and commissioned services.
From activity reporting to outcomes-based improvement	A single dashboard, agreed baselines, trajectories, benefits measures, and routine reporting to the Transforming Together Tactical Group, SMT and IJB.

The immediate priorities are to reduce delayed discharge, strengthen Home First and Discharge to Assess, restore and redesign intermediate care capacity, recruit advanced nursing practitioners, increase care-at-home and discharge capacity, improve seven-day support, strengthen care-home pathways and establish robust data and governance arrangements. The plan recognises that delivery is constrained by non-recurring funding, recruitment and retention challenges, care-home capacity, care-at-home pressures, staff absence, and the need to demonstrate measurable impact.

1. Purpose

1.1 This paper presents West Dunbartonshire HSCP Operational Resilience and Seasonal Preparedness Plan 2026/27. It combines seasonal readiness, operational continuity and the transformation program required to shift the balance of care into the community.

1.2 The plan sets out the HSCP contribution to whole-system flow, admission avoidance, timely discharge, community capacity, care-home support, frailty, workforce resilience, vaccination, infection prevention, communication, and escalation. It also describes how Operational Improvement Plan funding will support delivery during 2026–28.

2. Recommendations

2.1 Agree the West Dunbartonshire HSCP Operational Resilience and Seasonal Preparedness Plan 2026/27 and note that it replaces the previous practice of presenting a separate winter improvement plan.

2.2 Approve the strategic direction of the Transformation and Shifting the Balance of Care program including the Community First model and the priority improvement areas in this plan.

2.3 Approve the revised alignment of Operational Improvement Plan funding for 2026–28, subject to confirmation of the final costed allocation and affordability within the £1.8 million non-recurring envelope.

2.4 Agree that the Transforming Together Tactical Group will coordinate delivery, with defined workstream leads, monthly performance reporting, escalation to SMT and routine assurance to the IJB.

2.5 Note requirement for further refinement of the outstanding baselines, improvement trajectories, benefits measures to provide robust evidence of aligned improvements.

3. Background and Strategic Context

3.1 National planning priorities support a shift from seasonal planning to year-round surge preparedness recognising that operational pressures occur throughout the year. The approach requires integrated planning across health and social care, clear escalation arrangements and a focus on prevention, flow and community capacity.

3.2 West Dunbartonshire faces sustained urgent and unscheduled care pressures, an ageing population increasing long-term conditions, emergency admissions, Emergency Department (ED) attendances unscheduled bed days and delayed discharge. Improvement cannot be achieved through hospital flow measures alone and requires a whole-system model spanning prevention, primary care, urgent community response, discharge, care at home, frailty, and complex care.

3.3 The plan aligns the NHSGGC Annual Delivery Plan, Transforming Together, Urgent and Unscheduled Care, Primary Care Improvement, Planned Care, Public Health, workforce planning, and local service continuity arrangements. It also supports participation in coordinated West of Scotland system-reset activity.

3.4 The program is organised around four shifts:

- crisis response to prevention and early intervention.
- hospital default to credible community alternatives.
- fragmented service responses to integrated multidisciplinary decision-making; and
- activity reporting to outcomes-based performance and benefits management.

4. Main Issues and Delivery Plan

4.1 Operating model

The HSCP will maintain safe business-as-usual services while preparing for escalation and surge. A Community First approach will strengthen multidisciplinary community services, identify people at greatest risk earlier, and support timely decisions across hospital, primary care, community services, social work, care homes, and commissioned provision.

4.2 Learning from 2025-26

Area	Position and learning
Core resilience	Business continuity and contingency planning supported service continuity. Plans now require consistent review, recorded escalation actions, and stronger links to demand, capacity and workforce information.
Intermediate care	Seven care-home intermediate-care beds were introduced from September 2025 and reached full planned capacity by February 2026. Across the review period there were 1,087 bed nights, average occupancy of 62.2% and a February peak of 83%. Fifteen people used the beds; twelve were discharged, including nine to long-term care, two home and one to hospital.
Care-home bed availability	The care-home intermediate-care model was reduced from seven to five beds from 31 May 2026 following review of demand. Care-quality concerns and a moratorium on admissions subsequently made the provision unavailable. No alternative local care home was identified as willing and able to provide the service at the time of drafting.
Virtual intermediate care	Seven domiciliary or virtual intermediate-care beds remain available to support Discharge to Assess in the community. Activity and outcome data must be inserted into routine reporting.
OIP workforce	The Social Worker, Physiotherapist, Occupational Therapist and Rehabilitation Support Worker posts were filled, but delayed recruitment, absence and turnover limited the realised impact on admission avoidance and delayed discharge.
Vaccination and infection prevention	Winter vaccination and infection-prevention activity supported resilience, but uptake was suboptimal and requires targeted review using resident and workforce uptake data.

Area	Position and learning
System resets	The HSCP participated in whole-system reset activity, supporting coordinated operational review and action on backlogs and flow.

4.3 Priorities and actions for 2026/27

Priority	Key actions	Measures and assurance
Service resilience and continuity	Maintain business-as-usual services with reviewed resilience, business-continuity, and contingency plans. Use a Community First approach and prepare flexible deployment arrangements for escalation.	Plans reviewed; disruptions, risks and escalation actions recorded; demand and workforce reviewed through oversight arrangements.
Delayed discharge and patient flow	Make delayed discharge an immediate improvement priority. Strengthen Hospital Discharge Team oversight, maintain HSCP participation in MDT discharge planning at the Vale of Leven and Royal Alexandra hospitals, and continue monthly effectiveness reviews.	In addition to daily operational leadership and oversight of performance. agreed trajectories for delayed discharge, discharge performance, and average length of stay; monthly review of causes, actions, and impact.
Home First and Discharge Without Delay	Start discharge planning at admission; increase Home First, Discharge to Assess and criteria-led discharge; use the most appropriate community setting as soon as treatment is complete.	Proportion of plans started on admission; pathway use; avoidable delay; return-home rate; length of stay.
Community capacity and alternatives to admission	Strengthen direct SAS and Flow Navigation Centre referrals into District Nursing, FIT and other alternatives. Expand virtual care, telephone and online advice, remote monitoring, CTAC diagnostics, OPAT, and post-discharge monitoring.	Referrals, response times, admission avoidance, bed days saved, virtual pathway activity, care-at-home capacity, and outcomes.
Frailty and anticipatory care	Embed frailty identification, multidisciplinary review, future care planning, and coordinated support for older people living with frailty. Restore or redesign the frailty-practitioner function.	Frailty score completion; anticipatory and future care plans; MDT activity; outcomes for people supported at home.
Care homes and Call Before Convey	Implement and evaluate the care-home urgent-care pathway, FNC+Plus clinical review, Introduce DOCCLA remote monitoring Call Before Convey, UTI tools, falls prevention, COPD support, and future care planning.	Avoidable conveyance; FNC+Plus reviews; pathway use; resident outcomes; care-home feedback; outbreak and quality intelligence.
Seven-day services and weekend discharge	Identify barriers to weekend discharge and care-home admissions. Consider extending Care Home Liaison Nurse support to seven days and clarify management, digital, support and contractual arrangements.	Weekend discharge rate; delays due to service availability; seven-day coverage; weekend care-home admissions.
Intermediate care and reablement	Complete the options appraisal for sustainable bed-based, virtual, and domiciliary intermediate care, including capacity, quality, workforce, finance, and flow. Strengthen reablement and review arrangements.	Approved model; occupancy and length of stay; discharge destinations; throughput; cost per episode; people returning home.
Vaccination and infection prevention	Maximise uptake among eligible residents and staff; complete care-home vaccination; continue District Nursing peer clinics; maintain infection-prevention communications and controls.	Resident and staff uptake; clinic activity; infection, outbreak, and staff-absence trends.
Workforce, wellbeing, and cost-of-living support	Manage vacancies, absence, rotas, and annual leave; maintain supervision, occupational-health, mental-health-first-aid, PPE, professional and welfare support.	Vacancy, absence, overtime, and agency trends; well-being-support use; staffing risks and mitigations.
Communication, monitoring, and escalation	Provide clear information for staff, partners, service users, and the public. Ensure thresholds, responsibilities and escalation routes are understood.	Situation reports; dashboard review; escalation against thresholds; completed actions; feedback and communication reach.

Proposed Amendment to Funding Allocation OIP

WDHSCP Unscheduled Care/OIP Estimated Costs - 2 year plan 2026/27 - 2027/28

Description	Non Recurring Earmarked Reserves nce - Unscheduled Care/OIP £	Year 1 cative Costs £	Year 2 cative Costs £	Cumulative 2 year costs £
Total Funding Available	**1,825,012**			
Current Committments:				
Intermediate Care Beds (Beds reduced gradually to 0/1		**117,223**	**0**	**117,223**
Virtual Beds:				
Band 6 Physio		71,684	73,835	**145,519**
Band 6 OT		71,684	73,835	**145,519**
0.92wte Band 4 RSW		39,205	40,381	**79,586**
Grade 8 Social Worker		66,521	68,517	**135,038**
Total Virtual Beds		**249,094**	**256,567**	**505,661**
OPAT:				
0.5wte Band 5 Nurse		29,215	30,091	**59,305**
0.5wte Band 4 HCSW		23,208	23,904	**47,112**
0.5wte Band 3 HCSW		21,219	21,855	**43,074**
Total OPAT		**73,641**	**75,850**	**149,491**
Total Current Committments		**439,958**	**332,417**	**772,375**
Revised Available/Uncomr	**1,052,637**			
New Proposals:				
ANP Band 8a		63,944	98,793	**162,737**
Band 7		55,844	86,279	**142,123**
Band 7		55,844	86,279	**142,123**
Band 6		47,789	73,835	**121,624**
2 Grade 8 Social Workers		33,261	137,033	**170,294**
Care at Home Packages		62,747	250,989	**313,736**
Total New Proposals		**319,429**	**733,208**	**1,052,637**
Remaining Balance	**0**			

The provision of seven intermediate care beds within a local care home was discontinued in May 2026 as evaluation revealed sustainability challenges and limited impact against intended outcomes. It is proposed that the remainder of the 2026 funding is reallocated towards short term measures to address delayed discharge pressures; namely

I. Recruitment of 2.0 wte Social Workers to accelerate assessment processes (recruit to substantive posts)

II. Commission of additional new fast access home first external packages of care, as a test of process change, for a limited fixed term period to address immediate service issues and support a home first approach.

The remaining funding will support longer-term improvements to shift care into the community and develop local Hospital at Home and virtual-care capability through standardised pathways, point-of-care testing, remote monitoring, ward-round models and a single, clearly defined access point.

III. Advanced Nurse Practitioner (ANP) posts; 1.0 wte Band 8a, 2 wte Band 7 (recruit as substantive posts)

. OIP funding is non-recurring, with future funding dependent on performance review and measurable results demonstrated by the HSCP. Associated recruitment, retention and financial risks will need to be managed. Proposals have been designed for sustainability and deliverability, following careful consideration of recruitment options.

4.4 Transformation opportunities 2026–28

- Shift from hospital default to community alternatives through Scottish Ambulance System (SAS) and Flow Navigation Centre (FNC) pathways, Call Before Convey, Focused Intervention Team (FIT), District Nursing, Community Treatment and Care (CTAC), Outpatient Parental Antimicrobial Therapy (OPAT), urgent community response and developing virtual care pathways.
- Strengthen frailty as a cross-system priority through consistent identification, anticipatory care, interface working, and multidisciplinary coordination.
- Use care homes as a priority improvement setting, with proactive clinical support, falls and UTI pathways, respiratory support, and future care planning.
- Target frequent attenders using dashboards, the Interface Patient Portal and service flags, beginning with Chronic Obstructive Pulmonary Disease (COPD), frailty, mental health, and addictions cohorts.
- Develop local Hospital at Home and virtual-care capability through standard pathways, point-of-care testing, pharmacy support, remote monitoring, ward-round models, and a clear single point of access.
- Develop an HSCP-integrated advanced community clinical-practice model, with senior advanced nurse practitioner and advanced nurse practitioner roles supporting community teams, care homes, intermediate care, and urgent response.
- Reframe investment as preventative spend and evaluate it against reductions in bed days, delayed discharge, admission, attendance, and conveyance, alongside experience and outcomes.

4.5 Operational Improvement Plan funding 2026–28

The HSCP has a £1.8 million Operational Improvement Plan funding envelope for 2026–28. Funding is non-recurring and continuation is contingent on demonstrated progress and impact. The final costed allocation must be approved through SMT and reflected in the financial schedule. The proposed areas for alignment are:

Proposed investment	Purpose	Key assurance requirement
1.0 WTE Senior ANP and 2.0 WTE ANPs (Substantive)	Provide advanced assessment, prescribing, clinical leadership, and integrated decision-making; strengthen the single point of contact for the Flow Navigation Centre; support urgent response, care homes, intermediate care, and future Hospital at Home.	Approved clinical model, governance, supervision, referral criteria, recruitment plan, activity, and outcomes. Substantive recruitment includes mitigation through NHSGGC redeployment if funding ends.
Data analyst / improvement intelligence (2 years Fixed term)	Improve forecasting, case finding, dashboard development, impact analysis, and benefits reporting.	Single dashboard, agreed definitions, baselines, trajectories, and monthly benefits report.
Additional new fast access home first external packages of care, as a test of process change, for a limited fixed term period to address immediate service issues.	Support discharge and reduce delay while longer-term capacity and commissioning solutions are developed. A test of process change, for a limited fixed term period to address immediate service issues.	Packages commissioned, waiting time, discharge impact, duration and exit plan.
Hospital Discharge Team / social-work capacity	Provide time-limited capacity to improve assessment, review, and response, including consideration of the Social Work Review Team or reablement service.	Caseload, assessment timeliness, delay reduction, statutory compliance, and sustainability plan.
Seven-day care-home support	Consider extension of the Care Home Liaison Nurse function and improved weekend access arrangements.	Weekend pathway access, admissions, conveyance, response times, and provider feedback.
Intermediate care redesign	Redirect funding previously attached to unavailable care-home beds toward an agreed, safe, and affordable intermediate-care model.	Options appraisal, quality requirements, capacity, occupancy, throughput, outcomes, and cost-benefit analysis.

4.6 Measuring impact and improving outcomes.

Outcome domain	Core measures
Avoiding hospital use	Emergency admissions; A&E attendances; unscheduled bed days; SAS conveyance; FNC and community referrals; admissions avoided.
Improving flow	Delayed discharges; delay reasons; average length of stay; weekend discharge; criteria-led discharge; discharge destination.
Community delivery	FIT, District Nursing, CTAC, OPAT, virtual-care, and urgent-response activity; response time; care-at-home capacity; intermediate-care occupancy and throughput.
Frailty and proactive care	Frailty identification; future and anticipatory care planning; frequent-attender MDT review; repeat attendance.
Quality and experience	Clinical outcomes; service-user, family, and staff experience; complaints; adverse events; care-home feedback; equity of access.
Workforce and finance	Vacancy, absence, turnover, overtime, and agency use; recruitment milestones; spend against allocation; cost per intervention; estimated bed days and cost avoided.
Delivery assurance	Milestones, RAG status, risks, dependencies, benefits realised and actions completed.

4.7 Governance, monitoring, and escalation

Level	Responsibility	Frequency
Workstream leads	Deliver actions, maintain milestones, measures, risks, and benefits; escalate barriers.	Weekly or fortnightly as required
Transforming Together Tactical Group	Coordinate the integrated programme, resolve dependencies, review dashboard, and RAG status, and align with Primary Care Improvement activity.	Monthly
Senior Management Team	Approve resource decisions, review delivery and risks, and provide executive direction.	Monthly or aligned to SMT cycle
Integration Joint Board	Receive assurance on preparedness, outcomes, financial position, and material risks. Approve proposed use of funding and overview performance.	Through scheduled performance and governance reporting
Operational escalation arrangements	Monitor demand, capacity, workforce, flow, outbreaks, and service disruption against agreed thresholds.	Routine and increased during surge

5. Options Appraisal

5.1 The overall direction is consistent with national priorities and the local case for change. Individual investment decisions require proportionate options appraisal and cost-benefit assessment, particularly for intermediate care, care at home, seven-day services, urgent community response, and advanced practice.

5.2 The intermediate-care appraisal should compare bed-based, domiciliary, virtual, and blended models across quality, capacity, workforce, affordability, utilisation, discharge destinations, impact on delay and sustainability.

6. People Implications

6.1 Recruitment, retention, diminished staff resilience, and higher absence are central operational risks. Delivery depends on sufficient nursing, AHP, social-work, care-at-home, care-home, and support capacity.

6.2 Contingency arrangements may include flexible deployment, additional capacity, rota changes, and proportionate management of annual leave during escalation. These measures must maintain safe staffing, professional governance, and staff wellbeing.

6.3 The HSCP will maintain access to supervision, line-management support, trade unions and professional bodies, occupational health, mental-health-first-aid, corporate and national wellbeing resources, PPE, and vaccination.

6.4 Recruitment of scarce ANPs may affect other NHSGGC services, including primary care. Recruitment and workforce planning must therefore be coordinated, with trainee pathways considered where qualified applicants are unavailable, recognising this may delay impact.

7. Financial and Procurement Implications

7.1 The £1.8 million OIP allocation is non-recurring and subject to performance review. Future funding is contingent on the HSCP evidencing measurable improvement and investment impact.

7.2 Substantive appointments create potential future financial exposure if funding ends. This must be managed through affordability review, agreed redeployment mitigation, workforce turnover assumptions, and clear benefits reporting.

7.3 Financial assurance must include the final allocation, expenditure profile, procurement requirements, cost-benefit analysis and planned exit or sustainability arrangements for time-limited investment.

7.4 There is no dedicated additional winter funding. Seasonal resilience therefore relies on existing resources, OIP alignment, service prioritisation, and coordinated system action.

8. Risk Analysis

Risk	Potential impact	Mitigation / assurance
No dedicated additional winter funding	Restricts additional surge capacity and scope of reset activity.	Prioritise highest-impact actions; maintain escalation plans; track benefit and capacity.
Financial	As OIP is currently non-recurring Posts or services may become unaffordable if funding stops.	Costed approvals, benefits framework, use of turnover if required, redeployment mitigation, sustainability and exit planning.
Recruitment and retention	Delayed implementation and reduced clinical or operational capacity.	Substantive recruitment where approved; coordinated workforce planning; trainee pathways; milestone reporting.
Care-home and care-at-home capacity	Delayed discharge, longer stays and limited intermediate care throughput.	Capacity monitoring, provider engagement, short-term packages, redesign options, and escalation.
Intermediate-care quality or availability	Loss of bed-based options and reputational impact.	Quality-led options appraisal, alternative models, commissioning assurance, and service-user communication.
High staff absence and reduced resilience	Service disruption, overtime, pressure on quality and continuity.	Contingency plans, rota and leave management, well-being support, flexible deployment, and escalation.
Insufficient data and evaluation	Unable to identify cohorts, demonstrate outcomes or secure future funding.	Data analyst capacity, standard definitions, dashboard, baselines, trajectories, and benefits reporting.
Culture and expectations favour hospital care	Low uptake of community alternatives and slower transformation.	Clinical engagement, public communication, consistent pathways, experience feedback, and evidence of safety.
Winter demand exceeds assumptions	Deterioration in flow and performance.	Demand and capacity surveillance, thresholds, daily/weekly operational oversight, and whole-system escalation.

9. Equalities Impact Assessment

9.1 The plan aims to improve access to the right care, in the right place and at the right time. Existing equality impact assessments should be reviewed and updated for material service changes and investment decisions.

9.2 Monitoring should consider differential access and outcomes by protected characteristic, geography, deprivation, communication need, digital access, and carer status. No adverse equality impact should be assumed without review of the detailed delivery model.

10. Environmental Sustainability

10.1 The Community First model may reduce avoidable travel and hospital use, while increased home visiting and distributed provision may create additional travel. Material service changes should consider travel, digital delivery, estates, and procurement impacts through established sustainability assessment processes.

11. Consultation

11.1 The proposals have been informed by the West Dunbartonshire Transforming Together Tactical Group HSCP Clinical Directors, Senior Management Team, Unscheduled Care Group, and local care-home providers.

11.2 Further engagement should accompany detailed pathway redesign, including frontline staff, primary care, acute services, Scottish Ambulance Service, Flow Navigation Centre, commissioned providers, people who use services and unpaid carers.

12. Strategic Assessment

12.1 The plan aligns with the NHSGGC transformation agenda, the HSCP Strategic Plan, Improving Lives Together, and the ambition to provide the right care in the right place at the right time through prevention integrated community care and new models of support.

12.2 It also supports urgent and unscheduled care improvement, primary care improvement, Discharge Without Delay, Home First, frailty improvement and year-round surge preparedness.

13. Directions -

13.1 A formal IJB Direction will be submitted for approval, specifying the required delivery actions accountable body or bodies, financial resources, timescale, reporting requirements, and review arrangements.

Appendix 1: Consolidated Delivery and Improvement Action Plan

Action	Lead / proposed lead	Timescale	Measure of success
Confirm governance structure, terms of reference, leads, and reporting route.	Chief Nurse / Transforming Together leads	Immediate	Approved ToR; named leads; monthly report to SMT.
Review service resilience, business continuity and contingency plans and confirm escalation thresholds.	All service leads / resilience leads	Before winter peaks, review monthly	Plans signed off; gaps addressed; escalation actions recorded.
Agree delayed-discharge baselines and trajectories and strengthen HDT oversight at VOL and RAH.	HDT / operational leads / performance	Immediate and monthly	Reduced delays and length of stay; monthly cause-and-action review.
Develop a single performance dashboard.	Performance / analyst / operational leads	In progress; initial version within 8 weeks of approval	Dashboard used routinely; measures include admissions, A&E, bed days, conveyance,

Action	Lead / proposed lead	Timescale	Measure of success
			delay, frequent attenders, and care-home pathways.
Implement and evaluate care-home urgent-care and Call Before Convey pathways.	Care-home lead / SAS / FNC+Plus / FIT / urgent-care lead	Implemented; report monthly	Avoidable conveyance, clinical reviews, resident outcomes, and experience.
Embed frailty identification and future care planning.	Frailty lead / Senior Nurse / MDT leads	12 months	Increased frailty scoring and care-plan uptake; MDT outcomes.
Progress frequent-attender MDT test of change for COPD, frailty, mental health, and addictions.	FIT / Respiratory / Frailty / MH and Addictions	Underway	Cohort reviewed; fewer repeat attendances; updated care plans.
Complete intermediate-care options appraisal and agree replacement model.	Chief Nurse / HHCC / Commissioning / Finance / operational leads	Within 3 months	Approved recommendation covering quality, workforce, capacity, finance and 7–14 bed scenarios or equivalent virtual/domiciliary capacity.
Develop advanced nursing practice model and recruit 1 Senior ANP and 2 ANPs.	Chief Nurse / professional leads / Primary Care / Clinical Directors	Model immediate; recruitment milestones to be agreed	Governance, supervision, prescribing, referral criteria, workforce plan, and outcome framework approved.
Standardise Hospital at Home and virtual-care pathways.	Hospital at Home Integration Group / local leads	Phased through 2026/27	SOPs, single point of access, point-of-care testing, pharmacy, remote monitoring, discharge, and transport arrangements.
Review care-home digital access, weekend admission barriers, and contractual levers.	Commissioning / digital / operational leads	12–18 months, with early actions within 3 months	Improved access and escalation arrangements; weekend barriers reduced.
Continue OPAT test of change and consider extension to people supported by virtual hospital pathways.	Chief Nurse / OPAT leads	Immediate / ongoing	Referrals, completion, bed days saved and safety outcomes.
Expand CTAC capacity for diagnostics, point-of-care testing, urgent response, and post-discharge monitoring.	Senior Nurse Adults / Primary Care leads	Underway	Monthly activity, response times, and avoided hospital use.
Finalise OIP allocation and financial schedule.	Chief Officer / Chief Finance Officer / SMT sponsors	Before implementation approval	Costed allocation within £1.8m; start dates, budget holders, procurement and exit plans.
Undertake targeted vaccination and infection-prevention improvement.	Public Health / District Nursing / care-home leads	Before and during winter	Improved eligible resident and workforce uptake; outbreak data reviewed.
Maintain workforce resilience and well-being arrangements.	Service managers / HR / professional leads	Ongoing	Vacancy, absence, overtime, and wellbeing reviewed and acted upon.
Agree communication plan for staff, partners, service users, and the public.	Communications / operational leads	Within 6 weeks	Clear key messages, routes to care, escalation information, and feedback mechanisms.
Complete equality, sustainability, and benefits assessments for material service changes.	Programme leads / governance support	Before final decisions	Assessments completed and actions integrated into delivery plans.

Appendix 2: Information Required to Finalise the Plan

- Final approved OIP funding allocation and annual cost profile.
- Current delayed-discharge baseline and agreed improvement trajectory.
- Activity and outcomes for the seven domiciliary or virtual intermediate-care beds.

- Date the final resident left the unavailable care-home intermediate-care provision.
- Care-home resident and workforce vaccination uptake.
- Named owners and implementation dates for the ANP model, data analyst role, and time-limited capacity investments.
- Confirmed escalation thresholds and situation-reporting frequency.
- Completed IJB Direction, equality review, and financial assurance schedule.

Appendix 2: Direction from Health and Social Care Partnership Board

The Chief Officer will issue the following direction email directly after Integration Joint Board approval:

From: Chief Officer, HSCP
To: Chief Executive(s) WDC and NHSGGC
CC: HSCP Chief Finance Officer, HSCP Board Chair and Vice-Chair
Subject: Direction(s) from HSCP Board 21.11.2026 FOR ACTION
Attachment: OPERATIONAL RESILIENCE AND SEASONAL PREPAREDNESS PLAN 2026/27

Following the recent HSCP Board meeting, the direction below has been issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014. Attached is a copy of the original HSCP Board report for reference.

DIRECTION FROM WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD		
1	Reference number	*HSCPB0000104VT24112026*
2	Date direction issued by Integration Joint Board	24.11.2026
3	Report Author	Val.tierney@outlook.com
4	Direction to:	West Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly
5	Does this direction supersede, amend, or cancel a previous direction – if yes, include the reference number(s)	No
6	Functions covered by direction	Unscheduled Care and NHSGGC Transformational Change Agenda
7	Full text and detail of direction	The HSCPB is directing the Council and Health Board that the direction is to be exercised in line with the delivery plan set out in Appendix 1 of this report • Commission additional Care at Home Capacity – fixed term test of change • Recruit staff as detailed in revised Operational Improvement Plan Using OIP Funding which has been has been awarded for 24 months
8	Specification of those impacted by the change	Service users at risk of delayed discharge. Staff delivering community services – HSCP District Nurse Service, Care at home, Hospital Discharge team
9	Budget allocated by Integration Joint Board to carry out direction	The allocated budget to enable the Council, Health Board, or both to carry out the direction: -

10	Desired outcomes detail of what the direction is intended to achieve	Deliver West Dunbartonshire HSCP Strategic Plan NHSGGC Better Health Better Care Better Outcomes Promote implementation of Right Care Right Place Right Time Right Person. Enhanced service user experience and outcomes. Decrease delayed discharge. Shift in balance of care from acute services to community through use of virtual and actual intermediate care beds. Shift in balance of care from acute outpatient Anti-Microbial Therapy (OPAT) Clinics to monitoring bloods, wound and sign of toxicity to community. Increase access to and capacity of OPAT service.	
11	Strategic Milestones	*Recruitment ANP x 1 Band 8 x2 Band 7 Substantive*	*End Nov 2026*
		Care at home Commissioned Package – fixed term	*End Nov 2026*
		Data analyst Post – 2 year fixed term	*January 2027*
		Recruit Social Woker x 2 w.t.e	January 2027
12	Overall Delivery timescales	End March 2028	
13	Performance monitoring arrangements	In line with the agreed Performance Management framework this direction will be monitored and progress reported twice per year.	
14	Date direction will be reviewed	*March 2028*	

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Report by Julie Slavin, Chief Financial Officer

24 November 2026

Subject: 2026/27 Financial Performance Period 6 Report

1. Purpose

1.1 To provide the Health and Social Care Partnership (HSCP) Board with an update on the financial performance for the six-month period to 30 September 2026 and the projected outturn position to 31 March 2027.

2. Recommendations

2.1 The HSCP Board is recommended to:

a) **Note** the updated position on 2026/27 budget allocations from West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board and **approve** the updated direction to the partner bodies to deliver services in accordance with the HSCP Board's strategic priorities;
b) **Note** the year-to-date underspend of £0.540m, equivalent to 0.50% of the phased budget, for the period to 30 September 2026;
c) **Note** the forecast year-end underspend of £0.443m, equivalent to 0.20% of the annual budget, after all planned transfers to and from earmarked reserves;
d) **Note** the progress in delivering the savings agreed for 2026/27 and the associated risks;
e) **Note** the forecast reserves position and the effect of the projected underspend on unearmarked reserves;
f) **Note** the capital expenditure update; and
g) **Note** the effect of current financial pressures on the 2026/27 position and the forecast budget gaps for 2027/28 and 2028/29.

3. Background

3.1 At its meeting on 24 March 2026, the HSCP Board approved the indicative 2026/27 revenue budget of £225.270m (excluding the £48.139m of Set Aside), subject to formal NHSGGC Board approval of the health allocation. The approved budget comprised partner contributions of £220.134m and planned use of reserves of £5.136m to address the forecast 2026/27 budget gap.

3.2 Several budget adjustments have subsequently been processed. The revised net budget funded by partner contributions is £224.754m, as detailed in Appendix 1. Planned reserve movements are reported separately within the reserves analysis.

4. Main Issues

Summary Position

4.1 At 30 September, the year-to-date underspend is £0.540m (0.50%), with a potential year-end underspend of £0.443m (0.20%) after planned transfers to and from reserves. Appendix 3 provides the consolidated position, with separate Health Care and Social Care summaries in Appendix 4.

4.2 The overall HSCP summary and the individual Head of Service positions are reported within Tables 1 and 2 below.

Table 1 – Summary Draft Financial Information as at 31 March 2027

Summary Financial Information	Annual Budget	Year to Date Budget	Year to Date Actual	Year to Date Variance	Forecast Spend	Forecast Variance	Reserves Adjustment	Forecast Variance	Forecast Variance
	£000	£000	£000	£000	£000	£000	£000	£000	
Health Care	132,293	68,101	67,620	481	133,462	(1,169)	(1,498)	329	0.25%
Social Care	137,291	62,512	62,612	(100)	138,821	(1,530)	(1,322)	(208)	-0.15%
Expenditure	**269,584**	**130,613**	**130,232**	**381**	**272,283**	**(2,699)**	**(2,820)**	**121**	**0.04%**
Health Care	(5,792)	(1,091)	(1,091)	0	(5,794)	2	0	2	-0.03%
Social Care	(39,038)	(20,527)	(20,686)	159	(34,222)	(4,816)	(5,136)	320	-0.82%
Income	**(44,830)**	**(21,618)**	**(21,777)**	**159**	**(40,016)**	**(4,814)**	**(5,136)**	**322**	**-0.72%**
Health Care	126,501	67,010	66,529	481	127,668	(1,167)	(1,498)	331	0.26%
Social Care	98,253	41,985	41,926	59	104,599	(6,346)	(6,458)	112	0.11%
Net Expenditure	**224,754**	**108,995**	**108,455**	**540**	**232,267**	**(7,513)**	**(7,956)**	**443**	**0.20%**

Table 2 – Draft Financial Information as at 31 March 2027 by Head of Service

Summary Financial Information	Annual Budget	Year to Date Budget	Revised Year to Date Actual	Year to Date Variance	Forecast Spend	Forecast Variance	Reserves Adjustment	Forecast Variance	Forecast Variance
	£000	£000	£000	£000	£000	£000	£000	£000	
Children's Health, Care & Justice	35,510	15,786	15,353	433	34,992	518	(289)	807	2.27%
Health and Community Care	57,950	24,745	26,993	(2,248)	62,408	(4,458)	(550)	(3,908)	-6.74%
Mental Health, Learning Disability & Addictions	34,396	17,468	17,230	238	35,422	(1,026)	(1,182)	156	0.45%
Strategy & Transformation	2,693	1,175	1,012	163	2,356	337	(53)	390	14.48%
Family Health Services	36,384	20,290	20,407	(117)	36,604	(220)	0	(220)	-0.60%
GP Prescribing	23,024	11,592	11,111	481	22,765	259	0	259	1.12%
Hosted Services	10,305	5,131	5,235	(104)	10,851	(546)	(606)	60	0.58%
Other	24,492	12,808	11,114	1,694	26,869	(2,377)	(5,276)	2,899	11.84%
Net Expenditure	**224,754**	**108,995**	**108,455**	**540**	**232,267**	**(7,513)**	**(7,956)**	**443**	**0.20%**

4.3 The forecast takes account of progress against the 2026/27 savings programme of £5.080m. Appendix 2 provides further detail on delivery and identifies savings assessed as being at risk, with a summary position shown in Table 3 below.

Table 3 – Monitoring of Savings and Efficiencies

Efficiency Detail	Total Saving to be Monitored £000	Saving achieved £000	Saving on track to be achieved £000	Saving at low/medium risk of not being achieved £000	Saving at high risk of not being achieved £000
Health Care	1,141	36	1,105	-	-
Social Care	3,939	662	973	341	1,963
Total	**5,080**	**698**	**2,078**	**341**	**1,963**

4.4 Progress against savings is monitored by the Senior Management Team, with a RAGB (Red, Amber, Green and Blue) status applied to inform further actions. At September 2026, approximately 55% of savings have been achieved or are on track to be achieved, with the balance requiring further management action, which may include application of reserves.

4.5 Appendix 6 sets out the forecast reserves position, including the planned use of £5.136m of reserves approved as part of the 2026/27 budget to address the budget gap and support delivery of the financial plan. This includes the full application of the local authority superannuation earmarked reserve of £3.084m, established during 2024/25 and 2025/26, to mitigate the impact of the increase in employer contribution rates from 6.5% to 17.5% in 2026/27.

4.6 If the forecast underspend of £0.443m is realised, the unearmarked reserve balance would increase from its opening balance of £4.773m to a forecast closing balance of £5.216m. In addition, a further £2.820m of earmarked reserves is forecast to be drawn down during the year to meet planned expenditure commitments. Continued reliance on reserves to support recurring expenditure reduces financial resilience and reinforces the need to identify and deliver sustainable recurring savings.

4.7 Appendix 5 provides analysis of projected annual variances exceeding £0.050m. Despite the improved overall forecast, ongoing demand and cost pressures within Adults and Older Adult services continue to present a financial risk.

4.8 The forecast has improved from a £0.051m overspend at Month 5 to a £0.443m underspend at Month 6. Table 4 below summarises the principal factors contributing to this movement, including the effect of management action and updated forecast assumptions.

Table 4 – Projected Variance Movement between Period 5 and Period 6

Movement since period 5	Service	Health Care £000	Social Care £000	Total £000
Period 6 favourable variance as reported to HSCP Board 24 November		331	112	443
Period 5 adverse variance		27	(78)	(51)
Movement since period 5		**304**	**190**	**494**
Represented By:				
Prescribing Costs	GP Prescribing	259	-	259
Packages of Care	Supported Accommodation		151	151
Staffing	Care at Home		89	89
Other		45	(50)	(5)
Movement since period 5		**304**	**190**	**494**

Update on Prescribing 2026/27

4.9 Prescribing remains a significant and volatile component of the Health Care budget, with expenditure affected by drug prices and demand-led activity. Current analysis indicates that the assumptions supporting the approved budget remain reasonable and are tracking ahead of the latest forecast price and volume growth. However, prescribing data is reported two months in arrears and expenditure information is currently available only to July 2026. Although the full-year position remains uncertain, regular discussions with the NHSGGC Head of Finance for FHS and Prescribing provide assurance to report a prudent pro-rata underspend based on actual expenditure to date.

4.10 Current monitoring indicates that 69% of the prescribing savings target has been achieved. Expenditure and savings delivery will continue to be monitored, with changes in prescribing volumes, drug prices, national market conditions or savings performance reflected in future forecasts.

Update on General Medical Services 2026/27

4.11 General Medical Services (GMS), within Family Health Services, continues to present a financial risk, as highlighted to the HSCP Board in August. Funding for pension contributions and locum cover remains unresolved despite representations to the Scottish Government. The HSCP's share of the forecast overspend has reduced from £0.250m to £0.220m, reflecting a reduction in the overall NHS Greater Glasgow and Clyde forecast overspend from £3.1m to £2.7m. This improvement reflects underspends retained within the budget and lower forecast premises rates costs.

Bad Debt Write-Off and Bad Debt Provision

4.12 As agreed by West Dunbartonshire Council and the HSCP Board in March 2022, the Board is responsible for accounting for bad debt arising from

charges for delegated social care services. The Board's balance sheet therefore includes a provision for debts that may not be recovered.

4.13 West Dunbartonshire Council retains the legal power to set and levy charges, with collection governed by its Corporate Debt Policy. The Council and HSCP will take all necessary action to recover amounts due and minimise write-off costs. Where debt cannot be recovered, the policy supports prompt and regular write-off as good accounting practice. Approval is required from:

- The HSCP Chief Financial Officer for debt under £5,000; or
- The HSCP Board for debt over £5,000.

4.14 No bad debt is proposed for write-off in this reporting period.

4.15 A refreshed approach to debt recovery is being developed. Meetings have been arranged between HSCP Finance, service representatives, Corporate Debt Recovery and Legal colleagues to review arrangements, strengthen working relationships and clarify responsibilities. This work aims to improve collection, including continuing to target use of direct debit and limit further debt accumulation. Recovery action will remain proportionate, sensitive to individual circumstances and consistent with the Council's Corporate Debt Policy.

Housing Aids and Adaptations

4.16 Housing Aids and Adaptations forms part of the minimum adult services delegated to the HSCP Board. Its budget is managed by the Council's Housing and Employability Services on behalf of the HSCP Board and should be treated as additional to the Council's £98.326m allocation to the HSCP Board for 2026/27.

4.17 The draft outturn position for the period to 31 March 2027 is included in Table 5 below and will be reported as part of WDC's financial update position.

Table 5 – Draft Outturn Financial Performance as of 31 March 2027

Budgets Managed on Behalf of WD HSCP by West Dunbartonshire Council	Annual Budget	Year to Date Budget	Revised Year to Date Actual	Year to Date Variance	Forecast Spend	Forecast Variance
	£000	£000	£000	£000	£000	£000
Aids & Adaptations	71	18	18	0	53	18
Total	**71**	**18**	**18**	**0**	**53**	**18**

2026/27 Capital Expenditure

4.18 Detailed capital updates to West Dunbartonshire Council are provided on an exception basis, however in relation to HSCP capital projects the following spend is anticipated in 2026/27:

- ICT Upgrades - £0.136m
- Aids and Adaptations - £0.783m
- Community Alarm Upgrade - £0.055m

Update on Reserves

4.19 The 2026/27 budget report recommended using £5.136m of earmarked reserves to balance the budget, including funding for employer's pension contributions as outlined above. Table 6 summarises the forecast reserve balances, based on the audited balance at 31 March 2026 and planned use of earmarked reserves during the year. Appendix 6 provides the detail.

Table 6 – Reserves Analysis

Analysis of Reserves	Opening Balance as at 1 April 2026 £000	Usage of Reserves applied to Balance the 2026/27 Budget £000	Other £000	Forecast Balance as at 31 March 2027 £000
Unearmarked	4,773	-	443	5,216
Earmarked	18,541	(5,136)	(2,820)	10,585
Total	**23,314**	**(5,136)**	**(2,377)**	**15,801**

4.20 The audited balance brought forward from 2025/26 of £4.773m (2.07%) is marginally more than the 2% target of net expenditure of £4.731m contained within the Reserves Policy. The Policy is clear that a sufficient level of un-earmarked reserves should be held to "cushion the impact of unexpected events or emergencies" in any given financial year.

Budget Gap Analysis 2027/28

Update on Local Authority Superannuation Contributions

4.21 Following the 2026 actuarial valuation, Strathclyde Pension Fund has agreed revised employer contribution rates for the Main Employer Group. The rate will reduce to 6.5% from 1 April 2027 and remain at that level from 1 April 2028. This is a significant improvement on the assumptions in the HSCP's medium-term financial outlook. The estimated benefit of £3.8m in 2027/28 is included in Table 7 – Budget Gap Analysis.

4.22 Financial planning currently assumes that the full £3.8m benefit will be available in 2027/28, reducing the projected budget gap for that year. This differs from the approach taken in 2024/25 and 2025/26, when the benefit of lower employer pension contributions was spread over a longer period.

4.23 For 2029/30, the employer pension contribution rate is currently set at 15% but may remain at 6.5% if specified pension funding conditions are met. The Pension Fund will monitor these conditions and report quarterly through its governance arrangements, providing early warning of any change to the rate.

4.24 The 2027/28 revenue estimates and projected budget gap in Table 7 below reflect pay and non-pay inflation, demand and prescribing pressures, national funding assumptions and the cost of replacing non-recurring measures used in 2026/27. They also include the estimated £3.8m benefit from lower employer pension contributions.

Table 7 – Budget Gap Analysis 2027/28

WD HSCP - Composition of Budget Gaps	Health Care £000	Social Care £000	Total HSCP £000
Recurring Budgets (excluding Set Aside)	123,080	98,252	221,332
Net Expenditure Pressures as at September 2026			
Pay Pressures			
202728 Pay Uplift - based on 3% forecast	1,208	1,758	2,966
Non Pay Pressures			
Other Inflationary Pressures	93	313	406
Cost of Current Level of Service Adjustments			
Service Reductions		(2,511)	(2,511)
Increased Service User Care Packages		2,241	2,241
GMS Pressure	220		220
New Burdens / New Policy Initiatives / Budget Removal		756	756
Resource Transfer	196	(196)	
Prescribing	1,398		1,398
National Budget Pressures			
Scottish Living Wage		2,724	2,724
Demographic Pressures		2,910	2,910
Continuation of Previously Approved Savings - WWIT		(800)	(800)
Reversal of Non Recurring Savings Options			
Application of Reserves		5,136	5,136
Non Recurring Turnover		378	378
Non Recurring Increase to RT	(771)	771	-
2027/28 Estimated Budget	**125,424**	**111,733**	**237,157**
Rollover Funding	(122,309)	(98,252)	(220,561)
Share of £30m reduction in funding based on NRAC	840		840
Assumed Uplift	(1,719)		(1,719)
Additional Health Pay Funding	(403)		(403)
Scottish Government Policy Funding		(2,456)	(2,456)
2027/28 Assumed Funding from Partners	**(123,590)**	**(100,709)**	**(224,299)**
Estimated Funding Gap	**1,834**	**11,025**	**12,858**

WD HSCP - Closing the Budget Gaps	Health Care £000	Social Care £000	Total HSCP £000
Reduction on Employers Superannuation Contribution Rate			
Recurring - 17.5% to 15%		1,125	1,125
Non Recurring - 15% to 6.5%		3,824	3,824
Total Measures Summarised Above	**-**	**4,949**	**4,949**
Revised Budget Gap	**1,834**	**6,075**	**7,909**

4.25 The Scottish Government is scheduled to publish its 2027/28 Budget on 3 December 2026, after the November HSCP Board meeting. The level of funding ultimately available to the HSCP will depend on Scottish Government spending decisions and the contributions subsequently agreed by West Dunbartonshire Council and NHS Greater Glasgow and Clyde. At this stage, therefore, a degree of uncertainty remains regarding partner funding allocations and the overall financial settlement for 2027/28.

4.26 West Dunbartonshire Council's latest Financial Update Report continues to assume a flat cash allocation to the HSCP, with no increase in core funding other than the pass-through of specific social care allocations. NHS Greater Glasgow and Clyde's current planning assumptions include full funding of any national pay award but also assume that the HSCP will share in the impact of reduced funding associated with NHS Scotland Resource Allocation Committee (NRAC) allocations. These assumptions are being used for financial planning purposes and do not represent confirmed funding commitments.

4.27 The projected budget gap represents the best estimate based on information currently available and remains subject to change as expenditure forecasts are refined and partner funding decisions become clearer. In line with prudent financial planning principles, the estimates do not assume any additional resources beyond those currently identified. Updated projections will be reported to the Board following the publication of the Scottish Budget and as further clarity emerges regarding partner contributions. The financial planning process will continue to be aligned with the Partnership's Medium Term Financial Outlook and wider programme of service transformation and sustainability.

4.28 Addressing the projected budget gap will require a combination of recurring savings, service transformation and demand management measures. Work is ongoing across the Partnership to identify options that support the delivery of sustainable, high-quality services while improving long-term financial resilience. This work is being informed by the priorities and actions set out within the Medium-Term Financial Outlook, including service redesign, commissioning and procurement reviews, workforce planning, prevention and early intervention approaches, digital transformation and the redesign of care pathways.

4.29 Consideration will also be given to the continued application of measures that have supported financial sustainability in previous years where these remain appropriate and deliverable. These may include the management of vacancy and turnover levels, review of charging arrangements, prescribing efficiency initiatives, targeted demand management actions, and the implementation of recommendations arising from service reviews. While such measures can make an important contribution to financial sustainability, the primary focus

remains on delivering recurring savings through service transformation and redesign that address underlying cost and demand pressures.

4.30 The Board should take assurance that work to identify and develop options remains ongoing, building on both the actions delivered in previous years and the longer-term transformation programme set out in the Medium-Term Financial Outlook. Proposals will continue to be developed and brought forward through the Partnership's established governance arrangements for consideration and approval.

5. Options Appraisal

5.1 None required for this report.

6. People Implications

6.1 Other than the position noted above within the explanation of variances there are no other people implications known at this time.

7. Financial and Procurement Implications

7.1 Other than the financial position noted above, there are no other financial implications known at this time.

8. Risk Analysis

Health and Social Care Risk

8.1 The main risks to the 2026/27 financial position are demand-led pressures across health and social care, particularly Older People Services, Care at Home, externally commissioned care packages and General Medical Services. Locally, these pressures reflect increasing complexity of need, internal capacity constraints and greater reliance on external provision where assessed eligible needs cannot be met through HSCP delivered services.

8.2 These risks are closely linked to wider system pressures, including demographic change, higher levels of dependency, recruitment and retention challenges, provider sustainability and access to prevention and reablement services. If demand cannot be managed through the most appropriate pathway, there is a risk of increased use of higher-cost care models and further pressure on available budgets.

8.3 Nationally, uncertainty remains around pay settlements, provider fee rates, inflation, prescribing costs and future Scottish Government and Local Government funding settlements. Any divergence between funding growth and the cost of delivering delegated health and social care services would increase the requirement for recurring savings, service redesign and transformation activity.

Medium-Term Financial Sustainability

8.4 The medium-term financial outlook remains challenging. Recurring demand, workforce and inflationary pressures could widen the budget gaps for 2027/28 if recovery actions in 2026/27 do not deliver sustainable recurring savings.

8.5 The HSCP will continue to monitor local activity, care package demand, prescribing trends, provider cost pressures and national funding assumptions through regular financial reporting, progress of service redesign programmes and medium-term financial planning arrangements.

9. Equalities Impact Assessment (EIA)

9.1 None required for this report however any recovery plan may require equality impact assessments to be undertaken.

10. Environmental Sustainability

10.1 None required.

11. Consultation

11.1 This report and the projections and assumptions contained within it has been discussed with both council and health board finance colleagues.

12. Strategic Assessment

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

12.2 Strategic enablers being workforce, finance, technology, partnerships, and infrastructure will support delivery of our strategic outcomes as below:

- Caring Communities;
- Safe and Thriving Communities;
- Equal Communities and
- Healthy Communities

13. Directions

13.1 The recurring and non-recurring budget adjustments up to 31 March 2027 (Appendix 1) will require the issuing of a direction, see Appendix 7.

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Designation: Chief Financial Officer
Date: 2 November 2026

Person to Contact:	Julie Slavin – Chief Financial Officer Telephone: 07773 934 377 E-mail: julie.slavin@nhs.scot
Appendices:	Appendix 1 – Budget Reconciliation Appendix 2 – Monitoring of Savings Appendix 3 – Revenue Budgetary Control 2026/27 (Overall Summary) Appendix 4 – Revenue Budgetary Control 2026/27 (Health Care and Social Care Summary) Appendix 5 – Variance Analysis over £50k Appendix 6 – Reserves Appendix 7 – Directions
Background Papers:	2026/27 Annual Budget Setting Report – 24 March HSCP Board 2026/27 Financial Performance Period 3 Report – 18 August HSCP Board 2026/27 Financial Performance Period 5 Report – 29 September HSCP Board

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026

2026/27Budget Reconciliation	Health Care £000	Social Care £000	Total £000
Budget Approved at Board Meeting on 24 March 2026	**121,730**	**103,540**	**225,270**
Health Rollover Budget Adjustments	1,325		1,325
Budget Adjustments			
Removal of Bairns Hoose Requisition from budget - now confirmed as specific grant funding		(160)	(160)
2026/27 Scottish Recommended Allowance Funding		82	82
Removal of Care Leavers Requisition from budget - now confirmed as specific grant funding		(73)	(73)
Additional Uplift applied to Income	(66)		(66)
2026-27 - Non-Recurring Prescribing Adjustment - CPS Contribution	(88)		(88)
2026-27 - Non-Recurring Additional Alcohol & Drugs Partnership, (ADP), Scottish Government Funding Allocation	638		638
2026-27 - Non-Recurring Primary Care Improvement Plan, (PCIP), Scottish Government Funding Allocation	3,214		3,214
Reduced Working Week and Agenda for Change Reform (1)	(594)		(594)
2026-27 - Non-Recurring Post Diagnostic Support Dementia, (PDS), Scottish Government Funding Allocation	63		63
AFC Uplift for PCIP	121		121
AFC Uplift for ADP	24		24
Camchp56 Uplift 26.27 Wd Med	8		8
Camchp56 Uplift 26.27 Wd Pds	2		2
Outstanding Funding Allocations			
FVCV Delivery Allocation (Vaccinations)	124		124
Revised Budget 2026/27	**126,501**	**103,389**	**229,890**
Drawdown from Reserves	**-**	**(5,136)**	**(5,136)**
Budget Funded from Partner Organisations	**126,501**	**98,253**	**224,754**

(1) Funding for the continued implementation of the reduced working week and ongoing agenda for change reform was included in the March budget report based on the data available at the time of writing. Subsequent to the March budget report £0.771m was allocated to West Dunbartonshire on a non-recurring basis from NHSGGC at the year end and is being held in an earmarked reserve to fund costs in 2026/27. This is not included within the baseline for 2026/27 at this time, however actual expenditure in-year will be monitored by NHSGGC, with further in-year funding allocated if existing funding is insufficient. NHSGGC has confirmed that recurring funding will be confirmed as part of the 2027/28 budget preparation.

West Dunbartonshire Health & Social Care Partnership
Monitoring of Efficiencies and Management Adjustments 2026/27

Head of Service	Partner	Efficiency Detail	Comment	Saving Target	Saving at Risk
				£000	£000
Savings at high risk of not being achieved					
Fiona Taylor	Social Care	Removal of Care at Home Contingency	While there has been a slight improvement in the overall spend projection the majority of the saving is still considered to be high risk of not being achieved taking into consideration the financial projection based on continued high use of overtime and agency.	1,716	1,587
All	Social Care	Additional Staff Turnover	While the saving has been partially achieved, £0.106m is at high risk due to projected overspend in staffing at quarter one for internal care homes. Vacancy management controls will be utilised across the HSCP to deliver the full saving.	378	106
Sylvia Chatfield	Social Care	Ongoing review of Community Care social care packages	The full savings is considered at high risk of not being achieved due to both an increasing number of service users and a slower than anticipated pace of reviews being undertaken.	270	270
Savings at low/medium risk of not being achieved					
All	Social Care	Removal of Demographic Growth	While there has been a reduction to some packages of care, on a non recurring basis, achievement of the remaining saving is currently assessed as being at medium risk. This reflects the projected overspend on a number of service packages, particularly within Older People Non-Residential Services and Physical Disability Services. Further work is underway to understand the underlying drivers of these pressures, including the relative impact of demand growth, increasing complexity of care needs, and the completion of package reviews. This analysis will be critical in determining the sustainability of current expenditure levels and identifying any opportunities to mitigate future financial pressures while continuing to meet assessed care needs.	905	341
		Total		**3,269**	**2,304**
		Health Care		**0**	**0**
		Social Care		**3,269**	**2,304**

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026

Consolidated Expenditure by Service Area	Annual Budget	Year to Date Budget	Year to Date Actual	Year to Date Variance	Forecast Spend	Forecast Variance	Reserves Adjustment	Forecast Variance	% Variance	RAG Status
	£000	£000	£000	£000	£000	£000	£000	£000		
Older People Residential, Health and Community Care	41,647	17,420	18,603	(1,183)	43,954	(2,307)	(549)	(1,758)	-4.22%	↓
Care at Home	12,524	5,560	6,354	(794)	14,111	(1,587)	0	(1,587)	-12.67%	↓
Physical Disability	3,010	1,563	1,846	(283)	3,574	(564)	0	(564)	-18.74%	↓
Childrens Residential Care and Community Services	35,174	15,646	15,241	405	34,604	570	(178)	748	2.13%	↑
Strategy, Planning and Health Improvement	2,693	1,175	1,012	163	2,356	337	(55)	392	14.56%	↑
Mental Health Services - Adult and Elderly, Community and Inpatients	14,078	8,168	8,291	(123)	14,751	(673)	(535)	(138)	-0.98%	↓
Addictions	4,046	1,583	1,330	253	4,420	(374)	(329)	(45)	-1.11%	↓
Learning Disabilities - Residential and Community Services	16,272	7,717	7,607	110	16,251	21	(317)	338	2.08%	↑
Family Health Services (FHS)	36,384	20,290	20,407	(117)	36,604	(220)	0	(220)	-0.60%	↓
GP Prescribing	23,024	11,592	11,111	481	22,765	259	0	259	1.12%	↑
Hosted Services	10,305	5,131	5,235	(104)	10,851	(546)	(606)	60	0.58%	↑
Criminal Justice (Including Transitions)	335	141	112	29	388	(53)	(111)	58	17.31%	↑
Resource Transfer	19,184	9,519	9,860	(341)	19,184	0	0	0	0.00%	→
Contingency	2,824	1,412	0	1,412	0	2,824	0	2,824	100.00%	↑
HSCP Corporate and Other Services	3,254	2,078	1,446	632	8,454	(5,200)	(5,276)	76	2.34%	↑
Net Expenditure	**224,754**	**108,995**	**108,455**	**540**	**232,267**	**(7,513)**	**(7,956)**	**443**	**0.20%**	↑

Consolidated Expenditure by Subjective Analysis	Annual Budget	Year to Date Budget	Year to Date Actual	Year to Date Variance	Forecast Spend	Forecast Variance	Reserves Adjustment	Forecast Variance	% Variance	RAG Status
	£000	£000	£000	£000	£000	£000	£000	£000		
Employee	101,171	47,821	47,988	(167)	102,541	(1,370)	(2,277)	907	0.90%	↑
Property	1,248	492	525	(33)	1,299	(51)	0	(51)	-4.09%	↓
Transport and Plant	1,091	312	287	25	1,042	49	0	49	4.49%	↑
Supplies, Services and Admin	5,481	2,761	1,898	863	5,566	(85)	102	(187)	-3.41%	↓
Payments to Other Bodies	97,057	44,995	45,530	(535)	98,617	(1,560)	(645)	(915)	-0.94%	↓
Family Health Services	37,886	20,712	21,238	(526)	37,590	296	0	296	0.78%	↑
GP Prescribing	23,025	11,592	11,111	481	22,766	259	0	259	1.12%	↑
Other	2,626	1,929	1,656	273	2,859	(233)	0	(233)	-8.87%	↓
Gross Expenditure	**269,585**	**130,614**	**130,233**	**381**	**272,280**	**(2,695)**	**(2,820)**	**125**	**0.05%**	↑
Income	(44,831)	(21,619)	(21,778)	159	(40,013)	(4,818)	(5,136)	318	-0.71%	↑
Net Expenditure	**224,754**	**108,995**	**108,455**	**540**	**232,267**	**(7,513)**	**(7,956)**	**443**	**0.20%**	↑

West Dunbartonshire Health & Social Care Partnership
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Health Care Net Expenditure	Annual Budget	Year to Date Budget	Year to Date Actual	Year to Date Variance	Forecast Spend	Forecast Variance	Reserves Adjustment	Forecast Variance	% Variance	RAG Status
	£000	£000	£000	£000	£000	£000	£000	£000		
Planning & Health Improvements	1,018	481	436	45	867	151	0	151	14.83%	↑
Childrens Services - Community	4,476	2,412	2,369	43	4,515	(39)	(63)	24	0.54%	↑
Adult Community Services	12,163	5,964	6,267	(303)	12,444	(281)	(281)	0	0.00%	→
Community Learning Disabilities	932	466	526	(60)	1,045	(113)	(112)	(1)	-0.11%	↓
Addictions	3,254	1,356	1,081	275	3,015	239	239	0	0.00%	→
Mental Health - Adult Community	5,354	3,407	3,120	287	5,159	195	0	195	3.64%	↑
Mental Health - Elderly Inpatients	4,245	2,837	3,170	(333)	4,956	(711)	(535)	(176)	-4.15%	↓
Family Health Services (FHS)	36,384	20,290	20,407	(117)	36,604	(220)	0	(220)	-0.60%	↓
GP Prescribing	23,024	11,592	11,111	481	22,765	259	0	259	1.12%	↑
Other Services	6,162	3,555	2,947	608	6,263	(101)	(140)	39	0.63%	↑
Resource Transfer	19,184	9,519	9,860	(341)	19,184	0	0	0	0.00%	→
Hosted Services	10,305	5,131	5,235	(104)	10,851	(546)	(606)	60	0.58%	↑
Net Expenditure	**126,501**	**67,010**	**66,529**	**481**	**127,668**	**(1,167)**	**(1,498)**	**331**	**0.26%**	↑

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026

Social Care Net Expenditure	Annual Budget	Year to Date Budget	Year to Date Actual	Year to Date Variance	Forecast Spend	Forecast Variance	Reserves Adjustment	Forecast Variance	% Variance	RAG Status
	£000	£000	£000	£000	£000	£000	£000	£000		
Strategy Planning and Health Improvement	1,675	694	576	118	1,489	186	(53)	239	14.27%	↑
Residential Accommodation for Young People	3,418	1,546	1,527	19	3,380	38	0	38	1.11%	↑
Children's Community Placements	8,258	3,578	3,616	(38)	8,340	(82)	(8)	(74)	-0.90%	↓
Children's Residential Schools	7,088	2,857	2,989	(132)	7,351	(263)	0	(263)	-3.71%	↓
Children's Supported Accommodation	909	630	368	262	385	524	0	524	57.65%	↑
Childcare Operations	6,478	2,970	2,852	118	6,324	154	(82)	236	3.64%	↑
Other Services - Young People	4,548	1,652	1,520	132	4,309	239	(25)	264	5.80%	↑
Residential Accommodation for Older People	8,797	2,234	2,615	(381)	9,560	(763)	0	(763)	-8.67%	↓
External Residential Accommodation for Elderly	11,835	5,804	5,209	595	10,801	1,034	(156)	1,190	10.05%	↑
Sheltered Housing	1,850	969	1,012	(43)	1,937	(87)	0	(87)	-4.70%	↓
Older People Non Residential Care	3,103	1,090	2,248	(1,158)	5,419	(2,316)	0	(2,316)	-74.64%	↓
Community Alarms	145	(447)	(365)	(82)	309	(164)	0	(164)	-113.10%	↓
Community Health Operations	3,687	1,802	1,615	187	3,426	261	(113)	374	10.14%	↑
Residential - Learning Disability	13,502	6,409	6,398	11	13,686	(184)	(205)	21	0.16%	↑
Physical Disability	2,660	1,281	1,564	(283)	3,224	(564)	0	(564)	-21.20%	↓
Day Centres - Learning Disabilty	1,837	842	684	158	1,520	317	0	317	17.26%	↑
Justice	335	141	112	29	388	(53)	(111)	58	17.31%	↑
Mental Health	4,480	1,924	2,002	(78)	4,635	(155)	0	(155)	-3.46%	↓
Care at Home	12,524	5,560	6,354	(794)	14,111	(1,587)	0	(1,587)	-12.67%	↓
Addictions Services	792	227	249	(22)	1,406	(614)	(569)	(45)	-5.68%	↓
Equipu	350	282	282	0	350	0	0	0	0.00%	→
Frailty	66	4	0	4	57	9	0	9	13.64%	↑
Carers	1,290	309	323	(14)	1,319	(29)	0	(29)	-2.25%	↓
Contingency	2,824	1,412	0	1,412	0	2,824	0	2,824	100.00%	↑
HSCP - Corporate	(4,198)	(1,785)	(1,824)	39	873	(5,071)	(5,136)	65	-1.55%	↑
Net Expenditure	**98,253**	**41,985**	**41,926**	**59**	**104,599**	**(6,346)**	**(6,458)**	**112**	**0.11%**	↑

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
Health Care Variances					
Planning & Health Improvements	1,018	867	151	15%	↑
Service Description	This service covers planning and health improvement workstreams				
Main Issues / Reason for Variance	The projected underspend is due to staffing vacancies assumed to continue for the full financial year at this time.				
Mitigating Action	If the vacant posts are recruited to prior to the end of the financial year the projected underspend will reduce accordingly.				
Anticipated Outcome	An underspend is anticipated.				
Mental Health - Adult Community	5,354	5,159	195	4%	↑
Service Description	This care group provides mental health services for adults				
Main Issues / Reason for Variance	The projected underspend is due to staffing vacancies assumed to continue for the full financial year at this time.				
Mitigating Action	If the vacant posts are recruited to prior to the end of the financial year the projected underspend will reduce accordingly.				
Anticipated Outcome	An underspend is anticipated.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
Mental Health - Elderly Inpatients	4,245	4,421	(176)	-4%	↓
Service Description	This care group provides mental health services for the elderly				
Main Issues / Reason for Variance	The projected overspend is due to high cost medical vacancy covers partially funded from earmarked reserves.				
Mitigating Action	The service will continue to focus on recruitment to reduce the reliance on high cost locum cover.				
Anticipated Outcome	An overspend is anticipated.				
Family Health Services (FHS)	36,384	36,604	(220)	-1%	↓
Service Description	Family Health Services / Independent Primary Care Contractors including GP and NHS Dental Practices, Opticians and Optometry services and Pharmacies and Pharmaceutical services				
Main Issues / Reason for Variance	The projected overspend is the West Dunbartonshire share of an estimated £2.7m Board wide forecast overspend in FHS (GMS) mainly linked to unfunded superannuation and locum costs.				
Mitigating Action	While the projected overspend has reduced from the period 5, the position continues to be closely monitored and remains subject to ongoing discussions with the Health Board and Scottish Government re allocation models.				
Anticipated Outcome	An overspend is anticipated at this time pending a response from Scottish Government.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
GP Prescribing	23,024	22,765	259	1%	↑
Service Description	GP prescribing costs				
Main Issues / Reason for Variance	The projected underspend is mainly due to price and volume growth being less than budgeted, however prescribing data is reported two months in arrears and expenditure information is currently available only to July 2026. A tentative underspend position is therefore forecast at this stage, subject to review as further data becomes available.				
Mitigating Action	Officers will continue to engage with the NHSGGC prescribing lead to closely monitor price and volume variances.				
Anticipated Outcome	An underspend is anticipated at this time.				
Hosted Services	10,305	10,245	60	1%	↑
Service Description	Hosted Services to include MSK Physio and Diabetic Retinal Screening				
Main Issues / Reason for Variance	The projected underspend is mainly due to staffing vacancies and career breaks within Retinal Screening.				
Mitigating Action	None required at this time.				
Anticipated Outcome	An underspend is anticipated at this time, however the position may change if the underspend is utilised to fund non pay and equipment purchases.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
Social Care Variances					
Strategy Planning and Health Improvement	1,675	1,436	239	14%	↑
Service Description	This service covers planning and health improvement workstreams				
Main Issues / Reason for Variance	The projected underspend is mainly due to a delay in recruitment for the charging and payments team.				
Mitigating Action	Recruitment activity is ongoing.				
Anticipated Outcome	While the delay in recruitment is anticipated to generate a financial benefit in year this may delay transfer of activity from services to the new team.				
Children's Community Placements	8,258	8,332	(74)	-1%	↓
Service Description	This service covers fostering, adoption and kinship placements				
Main Issues / Reason for Variance	The projected overspend is mainly due to an increase in external fostering and kinship numbers partially offset by a reduction in continuing care and inhouse fostering.				
Mitigating Action	The team continue to implement the 5 year strategy.				
Anticipated Outcome	An overspend is anticipated at this time.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
Children's Residential Schools	7,088	7,351	(263)	-4%	↓
Service Description	This service area provides residential education for children				
Main Issues / Reason for Variance	The projected overspend is mainly due to anticipated client activity to the end of the financial year.				
Mitigating Action	The team continue to implement the 5 year strategy shifting the focus from expensive high cost residential packages towards more community based support.				
Anticipated Outcome	An overspend is anticipated at this time.				
Children's Supported Accommodation	909	385	524	58%	↑
Service Description	This service area provides supported accommodation for children and young people				
Main Issues / Reason for Variance	The projected underspend is mainly due to a reduction in the number of supported accommodation placements.				
Mitigating Action	None required at this time.				
Anticipated Outcome	An underspend is anticipated.				
Childcare Operations	6,478	6,242	236	4%	↑
Service Description	This service area is mainly comprised of staffing costs and includes the cost of social workers				
Main Issues / Reason for Variance	The projected underspend is mainly due to vacant posts				
Mitigating Action	None required at this time.				
Anticipated Outcome	An underspend is anticipated.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
Other Services - Young People	4,548	4,284	264	6%	↑
Service Description	This service area is mainly comprised of staffing costs and includes the cost of social workers				
Main Issues / Reason for Variance	The projected underspend is mainly due to vacant posts and recruitment delay along with a saving on the cost of externally commissioned services due to ongoing discussions regarding the best use of this budget.				
Mitigating Action	None required at this time.				
Anticipated Outcome	An underspend is anticipated.				
Residential Accommodation for Older People	8,797	9,560	(763)	-9%	↓
Service Description	WDC owned residential accommodation for older people				
Main Issues / Reason for Variance	The projected overspend is staff related. There are additional costs being incurred covering staffing pressures related to absence, recruitment to permanent care staff vacancies and to ensure staffing levels are sufficient to address safer staffing legislative requirements including 1:1 support for some residents.				
Mitigating Action	Queens Quay are strenghtening their oversight through the implementation of a staffing dependancy tool, recommended by the Care Inspectorate. The "safe to start" approach requires a real time staffing assessment and considers whether risk escalation is required. The data collected will also inform budget modelling going forward.				
Anticipated Outcome	An overspend is anticipated.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
External Residential Accommodation for Elderly	11,835	10,645	1,190	10%	↑
Service Description	External residential and nursing beds for over 65s				
Main Issues / Reason for Variance	The projected underspend is due to service users being supported in the community for longer with one external care home being closed to admissions.				
Mitigating Action	No action is required at this time in relation to external care homes, however consideration should be given to possible virement of budget resource to support the pressure within Older People Non Residential Care re the cost of supporting individuals to remain at home safely.				
Anticipated Outcome	An underspend is anticipated.				
Sheltered Housing	1,850	1,937	(87)	-5%	↓
Service Description	Warden Service for Housing run sheltered housing service				
Main Issues / Reason for Variance	The projected overspend is mainly due to agency staff				
Mitigating Action	The service will continue to monitor staffing to mitigate agency spend.				
Anticipated Outcome	An overspend is anticipated.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
Older People Non Residential Care	3,103	5,419	(2,316)	-75%	
Service Description	Queens Quay Daycare, Crosslet House Daycare, Over 65 SDS/Direct payments.				
Main Issues / Reason for Variance	The projected overspend is mainly due to increased demand for older people non residential care packages in excess of budgeted projections.				
Mitigating Action	Further opportunities to mitigate the projected overspend are being explored through maximising income generation where appropriate. This includes increasing utilisation of day care provision and reviewing existing care packages to ensure that social support and practical support elements are assessed consistently and that charges are applied appropriately in accordance with the HSCP's charging policy and eligibility criteria. Any additional income realised will be reflected in future monitoring reports.				
Anticipated Outcome	A significant overspend is anticipted at this time.				
Community Alarms	145	309	(164)	-113%	
Service Description	Installation and response service for Community Alarms				
Main Issues / Reason for Variance	The projected overspend is mainly due to vacant mobile attendant posts underspend offset by spend on agency cover and the annual cost of sim renewals.				
Mitigating Action	The service will continue to monitor staffing to mitigate agency spend.				
Anticipated Outcome	An overspend is anticipated.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
Community Health Operations	3,687	3,313	374	10%	↑
Service Description	This service includes the cost of social workers and occupational therapists for adult services				
Main Issues / Reason for Variance	The projected underspend is due to a large number of vacancies, some of which are being held pending service redesign.				
Mitigating Action	Restructure in progress, some may be required for virement.				
Anticipated Outcome	An underspend is anticipated.				
Physical Disability	2,660	3,224	(564)	-21%	↓
Service Description	This service provides physical disability services				
Main Issues / Reason for Variance	The projected overspend is due to an increase in service user packages both new and existing.				
Mitigating Action	It is anticipated that as reviews take place this may increase income from charging and some packages may be reduced.				
Anticipated Outcome	An overspend is anticipated.				
Day Centres - Learning Disability	1,837	1,520	317	17%	↑
Service Description	This service provides day services for learning disability clients				
Main Issues / Reason for Variance	The projected underspend is mainly due to a number of staffing vacancies.				
Mitigating Action	None required at this time.				
Anticipated Outcome	An underspend is anticipated.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
Justice Services	335	277	58	17%	↑
Service Description	This service provides support and rehabilitation for offenders				
Main Issues / Reason for Variance	The projected underspend is mainly due to anticipated Scottish Government income in relation to a specific package of care.				
Mitigating Action	None required at this time.				
Anticipated Outcome	An underspend is anticipated.				
Mental Health	4,480	4,635	(155)	-3%	↓
Service Description	This service provides mental health services				
Main Issues / Reason for Variance	The projected overspend is due to the cost of current and potential residential client packages.				
Mitigating Action	The service will continue to review packages to ensure they meet the outcomes of service users.				
Anticipated Outcome	An overspend is anticipated.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
Care at Home	12,524	14,111	(1,587)	-13%	↓
Service Description	This service provides care at home which includes personal care				
Main Issues / Reason for Variance	The projected overspend is mainly due to ongoing reliance of the use of overtime and agency to maintain service delivery in the context of workforce vacancies and demand pressures. While recent recruitment had brought staffing levels closer to the approved budgeted establishment this has been offset by other staff leaving the service. The forecast continues to assumes a gradual reduction in temporary staffing costs to the end of the financial year. Overall the service shows an improved position compared to last reported.				
Mitigating Action	While the recent recruitment activity has not resulted in the increased establishment FTE as anticipated a reduction in the number of internal planned hours of care has not resulted in a corresponding increase in overtime and agency. This supports the assumed gradual reduction in agency and overtime expenditure as anticiptated. The service will continue to actively monitor staffing capacity, establishment levels and expenditure performance to support the delivery of sustainable service provision and minimise the forecast overspend.				
Anticipated Outcome	A significant overspend is anticipated, but has reduced by circa 6% since last reported.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Forecast Spend £000	Forecast Variance £000	% Variance	RAG Status
Contingency	2,824	0	2,824	100%	↑
Service Description	This consists of elements of budget transferred from services where elements are no longer required and/or unlikely to show any spend against it in the current financial year due to recovery planning actions.				
Main Issues / Reason for Variance	The projected underspend is due to funds held in contingency mainly for stafing and demographic pressures not yet reallocated to services.				
Mitigating Action	Further analysis is underway to understand the underlying drivers of expenditure pressures across individual service areas, including demand growth, increasing complexity of need and the impact of package reviews. This will inform assessment of the sustainability of current expenditure levels and help identify opportunities to mitigate future financial pressures whilst continuing to meet assessed care needs. Where appropriate, consideration will be given to the reallocation of centrally held budgets to reflect a clearer understanding of recurring service pressures and demand.				
Anticipated Outcome	An underspend is anticipated.				

West Dunbartonshire Health & Social Care Partnership
Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis of Reserves 2026/27

Analysis of Reserves	Actual Opening Balance as at 1 April 2026	Forecast Movement in Reserves	Forecast Closing Balance as at 31 March 2027
	£000	£000	£000
Unearmarked Reserves			
Unearmarked Reserves	4,773	443	5,216
Total Unearmarked Reserves	**4,773**	**443**	**5,216**
Earmarked Reserves			
Scottish Govt. Policy Initiatives	**2,040**	**(982)**	**1,058**
Carers Funding	189	(80)	109
Informed trauma	130	(130)	0
Additional Social worker capacity	659	(232)	427
Mental Health Recovery and Renewal Fund	432	0	432
New Dementia Funding	63	0	63
Scottish Government Alcohol and Drug Partnership (including various National Drugs Priorities)	329	(329)	0
Children's Mental Health and Wellbeing	0	0	0
TEC and Analogue to Digital Project	0	0	0
PEF Funding – Speech & Language Therapy Projects	26	0	26
Winter Planning Funding - Interim Care	204	(203)	1
Winter Planning Funding - Enhance Care at Home	8	(8)	0
HSCP Initiatives	**2,409**	**(1,323)**	**1,086**
Service Reviews and Redesign	1,234	(991)	243
Justice Services	311	(114)	197
Unscheduled Care Services	200	(200)	0
Public Protection Officers	284	0	284
Digital Transformation	173	(18)	155
Training and Development	207	0	207
Health Care	**8,722**	**(2,516)**	**6,206**
DWP Conditions Management	26	(16)	10
Physio Waiting Times Initiative	103	0	103
Retinal Screening Waiting List Grading Initiative	35	0	35
Prescribing Reserve	1,513	0	1,513
Planning and Health Improvement	307	(257)	50

Financial Year 2026/27 Period 6 covering 1 April 2026 to 30 September 2026
Analysis of Reserves 2026/27

Analysis of Reserves	Actual Opening Balance as at 1 April 2026	Forecast Movement in Reserves	Forecast Closing Balance as at 31 March 2027
	£000	£000	£000
West Dunbartonshire Mental Health Services Transitional Fund	1,384	(475)	909
Enhanced Mental Health Outcome Framework	82	(82)	0
Property Strategy	1,161	(335)	826
Cora Grant	97	0	97
Health Board 2 yr Unscheduled Care Funding	1,825	(474)	1,351
Health Board 2 yr MSK Investment	1,200	(292)	908
Health Board RWW & AFC Reform B5-6 funding	771	(725)	46
Social Care Admin Saving - RT Addition for 27/28	0	140	140
DBI Seed Funding	50	0	50
IT Project Funding	9	0	9
Health Visiting	160	0	160
Social Care	**5,370**	**(3,135)**	**2,235**
Complex Care Packages/Supporting delay discharges	581	0	581
CYMPH and Promise	136	(25)	111
C&F 5 year MTFP "What Would it Take"	1,527	(26)	1,501
Equipu Surplus	42	0	42
Local Authority Superannuation	3,084	(3,084)	0
Total Earmarked Reserves	**18,541**	**(7,956)**	**10,585**
Total Reserves	**23,314**	**(7,513)**	**15,801**

Direction from Health and Social Care Partnership Board.
The Chief Officer will issue the following direction email directly after Integration Joint Board approval.

From: Chief Office HSCP
To: Chief Executives WDC and NHSGCC
CC: HSCP Chief Finance Officer, HSCP Board Chair and Vice-Chair
Subject: For Action: Directions from HSCP Board 24 November 2026

Attachment: **2026/27 Financial Performance Report**

Following the recent Integration Joint Board meeting, the direction below have been issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014. Attached is a copy of the original HSCPB report for reference.

DIRECTION FROM WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD			
1	Reference number	HSCPB0000102JS24112026	
2	Date direction issued by Integration Joint Board	24 November 2026	
3	Report Author	Julie Slavin, Chief Financial Officer	
4	Direction to	West Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	HSCPB0000100JS29092026	
6	Functions covered by direction	All delegated Health and Care Services as set-out within the Integration Scheme	
7	Full text and detail of direction	West Dunbartonshire Council is directed to spend the delegated net budget of £98.253m in line with the Strategic Plan and the budget outlined within this report. NHS Greater Glasgow and Clyde is directed to spend the delegated net budget of £126.501m in line with the Strategic Plan and the budget outlined within this report	
8	Specification of those impacted by the change	2026/27 Revenue Budget for the HSCP Board will deliver on the strategic outcomes for all delegated health and social care services and our citizens.	
9	Budget allocated by Integration Joint Board to carry out direction	The total 2026/27 budget aligned to the HSCP Board is £272.893m. Allocated as follows: West Dunbartonshire Council - £98.253m NHS Greater Glasgow and Clyde - £126.501m Set Aside - £48.139m	
10	Desired outcomes detail of what the direction is intended to achieve	Delivery of Strategic Priorities	
11	Strategic Milestones	Maintaining financial balance in 2026/27	30 June 2027
12	Overall Delivery timescales	30 June 2027	
13	Performance monitoring arrangements	Each meeting of the HSCP Board will consider a Financial Performance Update Report and (where appropriate) the position regarding Debt Write Off's.	
14	Date direction will be reviewed	The next scheduled HSCP Board - 26 January 2027	

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

Report by Sylvia Chatfield, Head of Mental Health, Learning Disability & Addictions

24 November 2026

Subject: Mental Health Strategy Update

1. Purpose

1.1. The purpose of this report is to provide the IJB with an update on implementation of the NHSGGC Mental Health Strategy 2023–2028, the outcomes of the programme reset undertaken during 2026, and the key priorities and considerations for the next phase of implementation.

1.2. This paper is presented for assurance and awareness.

2. Recommendations

2.1 The Integration Joint Board is asked to:

- Note this report for assurance and awareness.

3. Background

3.1 In summary, the mental health strategy was developed to:

- Rationalise and redesign a complex system.
- Provide a system of stepped/matched care, allowing for progression through different levels of care, with people entering at the right level of intensity of treatment (right care, right place, right time).
- Enhance capacity in community and emergency provision of Mental Health care.
- Avoid unnecessary hospital admission and reduce length of hospital stay.
- Shift the balance of care from hospital inpatients to community.

3.2 The strategy continues to provide the overarching framework for service redesign across NHSGGC mental health services and supports ambitions regarding:

- Earlier intervention and prevention.
- Improved access to services.
- More effective navigation through the system.
- Enhanced community alternatives.
- Reduced dependence on inpatient care.

- Improved use of digital technology and virtual models of care.
- Better patient flow and experience.

4. Main Issues

Programme Reset and Prioritisation

4.1 While progress continues across multiple projects, programme leaders recognised that the strategy included multiple initiatives of varying scale and maturity. During early 2026, a structured Reset process was therefore undertaken to review progress against existing commitments, to consider emerging system pressures, re-assess priorities against strategic impact, improve programme governance and develop a clearer delivery model.

4.2 The reset sessions took place from September 2025 to July 2026 and were attended by Heads of Service and Clinical Leads across NHSGGC, Staffside, the Mental Health Network representing lived experience, and NHSGGC planning colleagues to ensure alignment with Transforming Together priorities. Sessions were supported by Glasgow City's Organisational Development Head of Service.

Vision

4.3 A revised vision and principles for the Mental Health Strategy were developed and approved, following consultation with reset members, lived experience groups and the Mental Health Strategy Board, as detailed below:

- Our vision is to give kind and caring mental health support that is easy for everyone to get. We want to help people feel better and learn how to look after their wellbeing. We will work with families, friends and communities to make people's experiences better. Together, we will create services that include everyone and help improve people's lives.

4.4 Principles**:**

- We encourage prevention and self-care, supporting people to build resilience and independence.
- Care is offered by the right person, in the right place, at the right time.
- We will focus our support on those that need it the most.
- We will be clear about the services we can offer.
- We will work closely with partners, communities, people with lived and living experience and carers to improve pathways.
- We are committed to co-designing service models with staff and service users to ensure we are getting this right.
- We will use technology to help our services work better and faster, but we

will always make sure there are other ways to get help if technology does not work for someone.

- We are committed to ensuring our services remain inclusive, sustainable and responsive to changing needs.
- We will develop a workforce strategy that takes account of current demand.
- We aim to enhance effective collaboration and accountability across HSCPs through strong governance, staff training and shared performance.

4.5 The work undertaken through reset sessions has introduced strengthened Programme Board oversight; updated executive, operational and clinical leadership arrangements; and improved Programme/Project Management methodology, including project briefs, improved reporting, milestone tracking and accountability mechanisms.

4.6 A review of the workstreams led to the development of five strategic workstreams, aligned more closely to the programme and intended strategy outcomes:

- Wellbeing
- Access
- Assessment
- Treatment and Care
- Moving Between and Out of Services.

Long Stay and Delayed Discharge Audit

4.7 A significant focus of the latter reset sessions related to inpatient demographics, specifically in reviewing and understanding the drivers for long stays and delayed discharges. Data analysis and outcomes are provided below, which are critical to the bed strategy and overall Mental Health Strategy in shifting the balance of care from hospital to community. The analysis of inpatient data clearly highlights that admission numbers are not causing pressure on bed capacity, and instead pressures are driven mainly by patients remaining in hospital beyond clinical need.

4.8 The main findings from the length of stay deep dive highlighted that there were 70 patients in short-stay wards for more than six months; 107 patients in long-stay wards for more than three years; 21 patients for more than five years; and 10 patients for more than ten years, across NHSGGC Mental Health hospitals. There was a concentration effect in certain wards and sites, indicating a culture, practice and/or resource disparity in particular areas.

4.9 Thematic causes of long stays included clinical complexity, behavioural risk,

frailty, placement gaps and system delays. It was noted that prolonged length of stay was not simply a delayed discharge issue, as many people are not yet clinically fit for discharge. However, where people are fit for discharge, planning is not sufficiently robust.

4.10 Further analysis of delayed discharges in Glasgow hospitals, separate to long stays, indicated a significant range of bed days lost due to delayed discharges, from 1–291 days, with 23% at 120 days delayed or more.

4.11 Key barriers to discharge include accommodation, securing suitable placement, care package availability, guardianship/legal issues, assessment pathways and lack of movement within hospital pathways. Commissioning structures are varied across NHSGGC HSCPs and availability of placements is variable.

4.12 It was further highlighted that Adults and Older People require different responses. For Older People, flow is particularly affected by nursing home capacity, HBCC pathways, family disagreement, guardianship and care home refusals. Adults require pathways for complex mental health, risk and supported accommodation.

4.13 Work is now ongoing to develop system responses to the findings of the deep dive into delayed discharges and long stays. These include:

- Development of a step-down/pre-discharge model, particularly for patients who are medically fit for discharge.
- Developing a Board-wide discharge planning protocol.
- Updating patient cohorts to support bed consolidation.
- Analysis of barriers to, and gaps in, provision and commissioning of care/packages.
- Testing a multi-disciplinary discharge planning service in Glasgow City.

Progress with Workstreams

4.14 Significant progress has been made in several areas across previously agreed and new priorities arising from Reset.

4.15 These include implementation of the Community Mental Health Acute Care Service (CMHACS) model, progression of remote monitoring initiatives, further development of Borderline Personality Disorder (BPD) pathways, ongoing work to improve patient flow and discharge, and advancement of planning for inpatient bed reconfiguration.

Community Mental Health Acute Care Service

4.16 The Community Mental Health Acute Care Service (CMHACS) and Mental

Health Assessment Unit (MHAU) model became established as key components of the unscheduled mental health care pathway. The CMHACS model, offering rapid specialist assessment and intensive home or community treatment as an alternative to hospital admission wherever it is safe to do so, was implemented across Glasgow City in early 2026. Development is now ongoing to scope how the CMHACS framework can be embedded into existing arrangements across all HSCPs and to identify gaps/barriers to implementation. These are likely to relate to medic recruitment and resourcing and redesign of existing crisis services.

Borderline Personality Disorder Pathway Expansion

4.17 Work has continued to develop an expanded and proportionate service model, recognising the need for different levels of intervention according to acuity and complexity, ranging from core services delivering co-ordinated clinical care (CCC), to specialist Dialectical Behaviour Therapy and Mentalisation-Based Therapy services (DBT/MBT). A costed workforce model will be presented to the end-September Mental Health Strategy Programme Board.

Remote Monitoring

4.18 Remote monitoring initiatives have continued to develop as part of wider ambitions regarding digital transformation and new models of care.

4.19 A Community Clozapine Titration remote monitoring pilot was implemented in early 2026 and the catchment area was subsequently expanded across the Glasgow City Community Mental Health Teams to support onboarding and reach the recruitment target required for effective evaluation. Given its potential to reduce inpatient stays by 14 bed days per patient, the Community Clozapine Titration pilot has been extended because of lower-than-expected uptake.

4.20 Development of an ADHD medication monitoring pathway for patients on existing caseloads is also progressing, with a pilot started in August 2026 comparing two digital platforms against current in-person practice to determine the most appropriate and sustainable future solution.

Wellbeing

4.21 Work has commenced to map community, third-sector and non-clinical support available across NHSGGC. This is intended to inform future redesign models and improve integration between specialist mental health services and wider community resources.

Access

4.22 An extensive Board-wide mapping exercise was previously completed

reviewing Community Mental Health Team pathways from referral to discharge. This work identified considerable variation in referral pathways, triage arrangements, referral criteria and service navigation processes. With the potential for integration with FNC Plus, it now provides the evidence base for development of a future Unified Referral Management model and planning for unplanned, non-emergency contact.

Inpatient Bed Reconfiguration

4.23 The inpatient reconfiguration programme has progressed through refinement of potential service configuration options. An independent facilitator has been appointed to support the formal option appraisal process.

4.24 A review has been undertaken to consider whether the current thirteen-option long list can reasonably be reduced before moving to formal option appraisal. Applying Site Modelling principles and Principal Adjacencies provides a framework for assessing options, but these do not generally prescribe specific sites or operate as gateway exclusion criteria. Options with the same number of retained sites may still differ materially in geography, accessibility, workforce implications and future flexibility.

4.25 An intermediate stage can reduce duplication within the option set while retaining the principal strategic alternatives, site-concentration models and representation of all currently identified inpatient sites, where reasonably practicable.

4.26 This allows for progression informed by stakeholder assessment of strategic merit in a way that balances transparency, fairness, stakeholder involvement and practical decision-making.

4.27 Option appraisal is currently planned for late 2026.

Strategic Alignment with Transforming Together

4.28 An important development during the reporting and Reset period has been recognition of opportunities to align Mental Health Strategy priorities with wider NHSGGC transformation programmes.

Flow Navigation Centre Plus

4.29 The emerging priority for Unified Referral Management shares many of the same objectives as FNC Plus, including more consistent access routes, navigation, triage and pathway matching.

4.30 Work is currently underway to review referral management, unplanned contact and urgent care pathways to consider how mental health services might benefit from FNC Plus development.

Virtual Hospital

4.31 The remote monitoring programme provides an early opportunity to align mental health pathways with wider Virtual Hospital developments.

4.32 Existing work on Clozapine and ADHD monitoring may provide opportunities to explore digitally enabled care pathways, remote review arrangements and improved use of specialist clinical resources.

Priorities for 2026/27

4.33 The next phase of the strategy will focus on moving from design into implementation.

4.34 Key priorities include:

- Completion of the inpatient option appraisal process.
- Testing a step-down inpatient model and integrated multi-disciplinary discharge service and processes.
- Development of a future-state Unified Referral Management model.
- Expansion of distress response and non-clinical support proposals.
- Continued implementation and evaluation of remote monitoring pathways.
- Ongoing refinement of Community Mental Health Acute Care arrangements.
- Strengthening patient flow and discharge support.
- Refinement of the supporting financial framework, which sets out an approach where release of funding from phased bed reduction will provide investment in community services that then support further disinvestment. That cycle will support longer-term investment in community services and shift the balance of care.
- Continued alignment with the NHSGGC Transforming Together and associated digital programmes.

West Dunbartonshire HSCP

4.35 A defining feature of the Mental Health Strategy is its emphasis on integration across NHS Greater Glasgow and Clyde and the six Health and Social Care Partnerships (HSCPs). A monthly Board-wide forum of HSCP Heads of Service supports strategic and operational decision-making. Alongside their responsibilities within their respective HSCPs, Heads of Service lead specific workstreams in partnership to deliver the strategic plan. These roles align with the strategy's direction and vision for integrated mental health services, creating opportunities for shared oversight of operational challenges, collective problem-solving and coordinated action across the system. The forum is chaired by the Glasgow City Assistant Chief Officer in their capacity

as strategic lead.

4.36 Glasgow City delivers pan-HSCP integration through hosted services, which supports access across West Dunbartonshire to services including: digital Psychological Group Therapies, Psychological Trauma, Perinatal Services, Mental Health Assessment Units, Adult Eating Disorders and Esteem. (Helensburgh Community Mental Health Team do not get access to Esteem, Perinatal or MHAU during the day).

4.37 Commissioned mental health services in West Dunbartonshire HSCP are managed through the Contracts, Commissioning and Quality Assurance Team. The formal purchasing arrangements are supported by West Dunbartonshire Council's Corporate Procurement Unit and Legal Services Team.

4.38 Strategic commissioning, quality assurance and procurement work in partnership with colleagues in the service area to support the redesign, delivery and development of mental health services across West Dunbartonshire.

4.39 Current provision is delivered by a mix of third sector organisations and services provided directly by West Dunbartonshire HSCP, including integrated teams within NHS GGC. Services include, community support, residential step down, housing support, crisis intervention, distress brief intervention, self-management (digital), counselling services (for lower-level needs), carer and advocacy services.

4.40 West Dunbartonshire HSCP's future commissioning plans align with our Mental Health Strategy and have a focus on community asset mapping, reducing wait times and supporting pressures faced by our Community Mental Health Team, ensuring residents have timely and straightforward access to mental health services aligned to our demographic need.

4.41 West Dunbartonshire HSCP is in the process of developing its new strategic plan, of which mental health will be a key focus area. This will support greater partnership working with teams across West Dunbartonshire whilst building long term strategic partnerships with our third sector.

4.42 Early intervention and prevention services that promote wellbeing, provide non-clinical support and reduce demand on specialist mental health services sit largely within public mental health and health improvement. These include services such as Community Link Workers, and Distress Brief Intervention Service. Work is ongoing to consider longer-term funding sources to improve sustainability, strengthen integration across clinical, non-clinical and social support, and enable more substantial redesign.

5. Options Appraisal

5.1 Option appraisal is currently planned for late 2026. Benefits Criteria to be used for option comparison have been derived from all of the work undertaken to date by many stakeholders. This includes previous public engagement as well as clinical principles and analysis from other recent NHS option appraisals.

6. People Implications

6.1 Staff have opportunity to shape implementation through their line management and staff partner representation on the Strategy Programme Board and through the proposed community engagement approach, which aims to support staff and system resilience and improve capacity. Personnel implications will be educated by future direction following public consultation on bed reconfiguration.

7. Financial and Procurement Implications

7.1 The financial framework proposes a staged approach to delivery, with reinvestment linked to, and following, phased retraction in inpatient beds. Implementation is subject to ongoing development with the six Chief Officers and Chief Finance Officers across NHSGGC.

7.2 Implementation supports the shift in the balance of care within available resources. Over the next two decades, however, expanded and recurring funding for public mental health, wellbeing promotion and early intervention will be needed to more effectively create the infrastructure that prevents or reduces the need for downstream psychiatric service responses in secondary mental health care.

8. Risk Analysis

8.1 Mitigation of risk will initially focus on where there is existing/spare capacity in inpatients, and then at subsequent stages to ensure bed number retractions remain pragmatic and valid.

9. Equalities Impact Assessment (EIA)

9.1 Mental Health is not experienced equally across the population, with higher risk of poor mental health in specific groups. These inequalities are driven by the wider determinants of mental health. In addition to social determinants, the strategy recognises the need to focus on inequalities, including people with protected characteristics, in developing equalities-sensitive services matching care to need. Programmes of work will be developed to address mental health wellbeing within such communities and groups.

9.2 The 2018–2023 strategy was Equalities Impact Assessed, and this applies to the 2023–2028 Refresh. There is commitment to developing/updating equalities impact assessments as part of implementation and ensuring engagement with people with protected characteristics.

10. Environmental Sustainability

10.1 The recommendations within this report do not require a Strategic Environmental Assessment (SEA) to be undertaken.

11. Consultation

11.1 Inpatient Bed Reconfiguration: NHSGGC is taking a three-phase approach to public engagement, including services users, carers, staff and other interested groups on the Mental Health Strategy. Feedback from phase one established there is broad support for providing more care at home, in communities and in partnership with local services while ensuring hospital care remains available for those who need it.

11.2 A review has been undertaken to consider whether the current thirteen-option long list can reasonably be reduced before moving to formal option appraisal which will form the second phase of engagement.

11.3 The third phase of engagement will include wider public engagement on the output from the non-financial option appraisal and other relevant information.

12. Strategic Assessment

12.1 The NHS Greater Glasgow and Clyde (NHSGGC) Mental Health Strategy 2023–2028 aims to shift the balance of care into the community, improve access to services, and focus on recovery, prevention and early intervention. This involves expanding community-based services, offering mental wellbeing and suicide prevention training, and enhancing psychological therapies, including computerised CBT and group programmes.

12.2 Key elements of the strategy for adults include:

- **Stepped/matched care and improved effectiveness of community services:** People will enter the mental health system at the appropriate level of treatment intensity and be able to move between different levels of care as needed, with the aim of resolving their issues and reducing the need for re-referral following deterioration.
- **Community-based care:** A significant emphasis is placed on delivering care in the community, closer to people's homes, to improve accessibility and reduce the need for specialist hospital care.
- **Prevention and early intervention:** The strategy focuses on preventing

mental health problems before they develop and intervening early when issues arise. This includes training staff in mental wellbeing and suicide prevention, expanding access to cCBT, supporting wellbeing in primary care and having distress support available for all.

- **Recovery-focused approach:** Community teams and inpatient settings will adopt a recovery-oriented approach, empowering individuals to actively participate in their own care and support their journey towards recovery.
- **Cross-sector collaboration:** The strategy is underpinned by six core public health programmes that require collaboration across various sectors to address the root causes of poor mental health and inequalities.
- **Reducing stigma and inequality:** A key vision of the strategy is to create a Scotland free from stigma and inequality, where everyone can achieve the best possible mental health.

12.3 These strategic priorities will help guide the Committee as to the priority to be placed on the report.

13. Directions

13.1 None required

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Appendices: None

Background Papers: None

Wards Affected: All Council Wards

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Report by Sylvia Chatfield
Head of Mental Health, Learning Disabilities and Addiction Services

24 November 2026

Subject: Alcohol and Drug Partnership update: MAT Standards, drug-related and alcohol-specific deaths and financial update

1. Purpose

1.1 This report provides the HSCP Board with an overview of progress in implementing the Medication Assisted Treatment (MAT) Standards, the latest available drug-related and alcohol-specific death figures for West Dunbartonshire, and current financial commitments against available funding. It also considers how future resource allocation can best support agreed strategic priorities for local alcohol and drug services.

2. Recommendations

The HSCP Board is asked to:

i. Note the progress made in implementing and sustaining the MAT Standards;
ii. Note the drug-related and alcohol-specific death figures and the continuing level of harm experienced in West Dunbartonshire;
iii. Note the current financial position and the challenges this presents for the future planning and delivery of alcohol and drug services, particularly in addressing locally identified gaps and priorities within available resources and maintaining alignment with the Scottish Government's Alcohol and Drugs Strategic Plan and Partnership Delivery Framework.

3. Background

3.1 West Dunbartonshire Alcohol and Drug Partnership (ADP) is a strategic, multi-agency group tasked by the Scottish Government to reduce harm caused by alcohol and drug use. The ADP is the framework where statutory and non-statutory service providers assess, plan and deliver services that are developed to prevent problem substance use and provide treatment services for people directly and indirectly affected by problematic substance use.

<u>Medication Assisted Treatment (MAT) Standards</u>

3.2 The Medication Assisted Treatment (MAT) Standards set out the treatment and support people should be able to access consistently across Scotland. They aim to improve access to and retention in treatment, support informed choices about care, involve families or nominated supporters where

appropriate, and strengthen accountability for delivery. Implementation requires coordinated working across treatment services, primary care, mental health, social care and community partners.

4. Main Issues

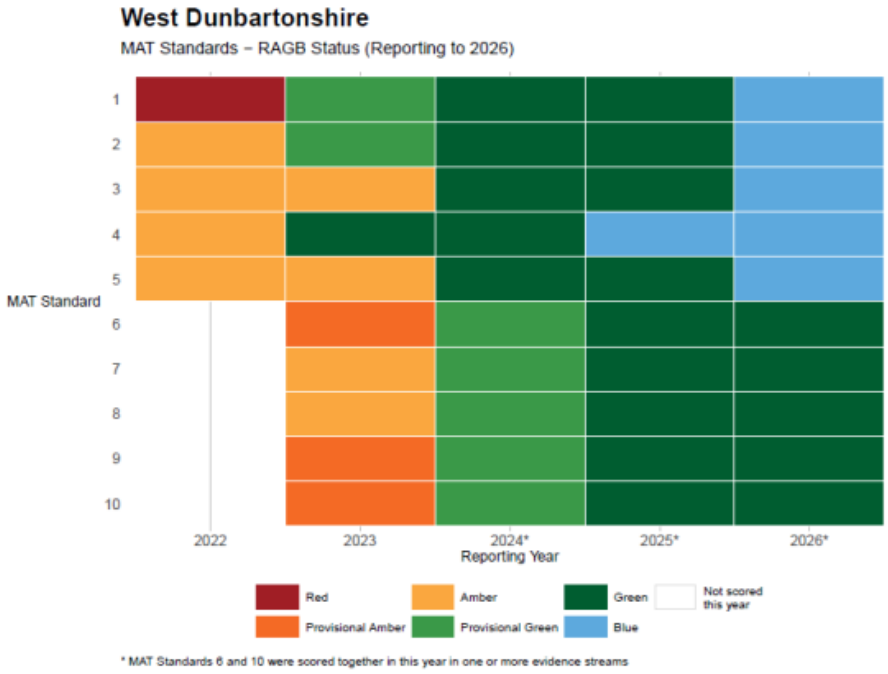
Medication Assisted Treatment (MAT) Standards

4.1 Public Health Scotland published its latest MAT Standards benchmarking report in July 2026, covering implementation during 2025/26 across Scotland's 30 ADP areas. Assessment draws on evidence of service processes, numerical measures and the experiences of people using services. Assessment criteria for several standards changed during this reporting cycle, which limits direct comparison with earlier years.

4.2 As shown in Figure 1, West Dunbartonshire achieved blue ratings for MAT Standards 1–5, indicating sustained implementation, and green ratings for Standards 6–10, indicating full implementation. These results demonstrate progress across all ten standards and reflect the contribution of treatment services, partner organisations and people with lived and living experience.

4.3 Maintaining these standards requires continued attention to service capacity, timely access, the quality of care and people's experiences of treatment. The benchmarking results should therefore be considered alongside local performance information and evidence of alcohol and drug harms. Figure 1 summarises progress over time, with further detail provided in Appendix 1.

Figure 1 – MAT Standards Benchmarking Report for West Dunbartonshire ADP

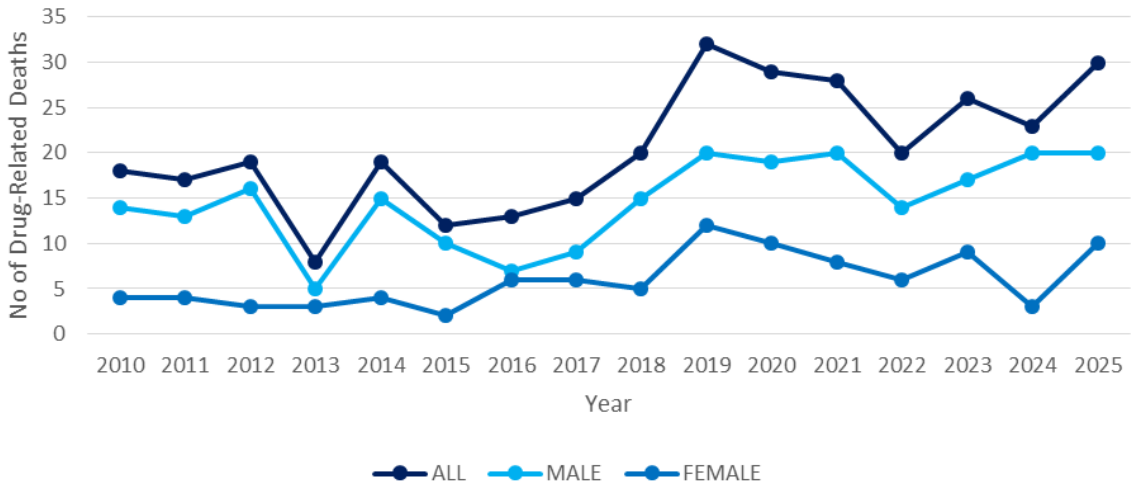


RAGB Rating	Meaning	In practice
Red	Not implemented	Little or no evidence that the standard is in place
Amber	Partially implemented	Some progress and change, but gaps remain
Provisional Amber	Early/limited implementation	Initial steps taken, but limited evidence overall
Provisional Green	Largely implemented (not fully evidenced)	Good progress, but not yet supported across all evidence sources (e.g. experiential)
Green	Fully implemented	Standard is in place with evidence of meaningful change
Blue	Sustained implementation	Standard is embedded, maintained over time, and monitored

Drug-Related Deaths

4.4 West Dunbartonshire recorded 30 drug-related deaths in 2025, compared with 23 in 2024, an increase of seven deaths (30.4%). Across Scotland, deaths increased from 1,017 to 1,133 (11.4%). Locally, male deaths remained at 20, while female deaths increased from three to ten.

Figure 2 - Drug-related deaths in West Dunbartonshire by sex, 2010–2025

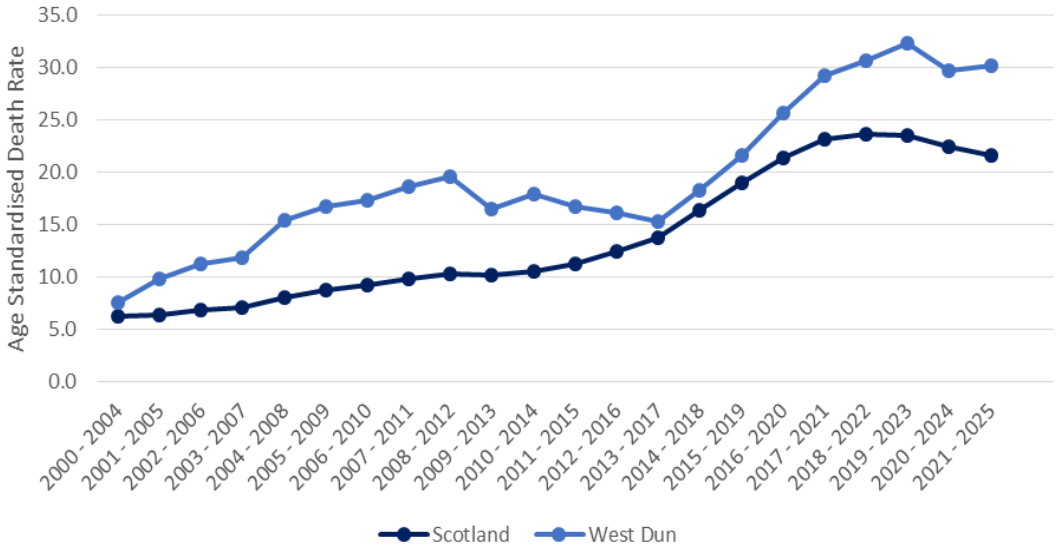


4.5 The 2025 total was the highest since 2019, when 32 deaths were recorded. Annual figures can fluctuate considerably in an area the size of West Dunbartonshire. However, the longer-term figures show that drug-related mortality remains persistently above the Scottish average.

4.6 Figure 3 compares age-standardised death rates over rolling five-year periods from 2000–2004 to 2021–2025. These rates account for differences in population size and age structure, allowing a more meaningful comparison between areas. West Dunbartonshire's rate was above the Scottish rate throughout the period shown.

4.7 For 2021–2025, the local rate was approximately 30 deaths per 100,000 people, compared with 22 across Scotland. The local rate increased slightly from the previous rolling five-year period, while the Scottish rate continued to fall. Both remained below their recent peaks. Five-year rates provide a more stable comparison than individual annual figures, although successive periods overlap and should not be treated as independent observations.

Figure 3 - Age-standardised death rates per 100,000 people for rolling five-year periods, 2000–2004 to 2021–2025

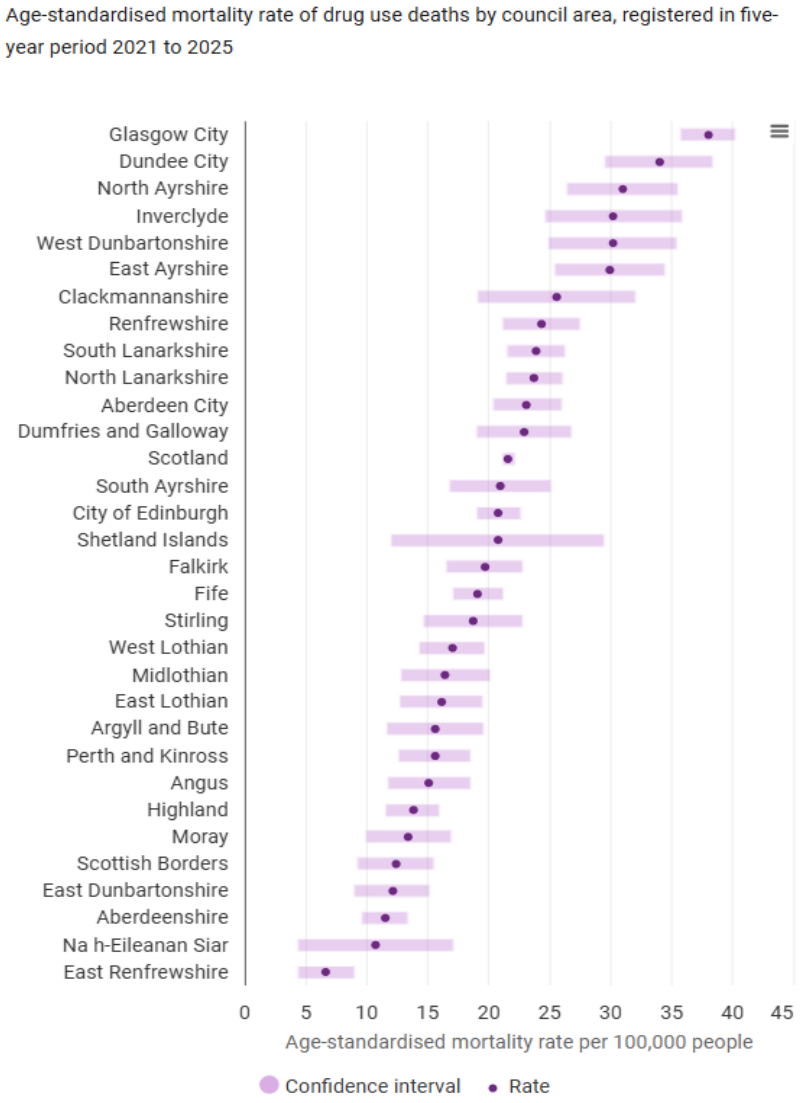


Comparison with other council areas

4.8 Glasgow City had the highest age-standardised death rate for 2021–2025, at approximately 38 deaths per 100,000 people. West Dunbartonshire was among the areas with the highest rates, at approximately 30 per 100,000, similar to Inverclyde and East Ayrshire and above the Scottish average of 22.

4.9 Figure 4 shows the estimated rate for each council area and the associated confidence interval. These intervals indicate the uncertainty around each estimate. Several overlap, so small differences between areas should be interpreted cautiously.

Figure 4 - Age-standardised mortality rates per 100,000 people by council area, 2021–2025



4.10 The substances implicated in deaths also changed:

- Opioids were implicated in 25 deaths (83%), compared with 18 (78%) in 2024.
- Nitazenes were implicated in 14 deaths (47%), up from three (13%). The national proportion in 2025 was 22%.
- Cocaine was implicated in 17 deaths (57%), up from eight (35%). The national proportion in 2025 was 52%.
- Benzodiazepines were implicated in 12 deaths (40%), and gabapentin and/or pregabalin in 10 (33%).

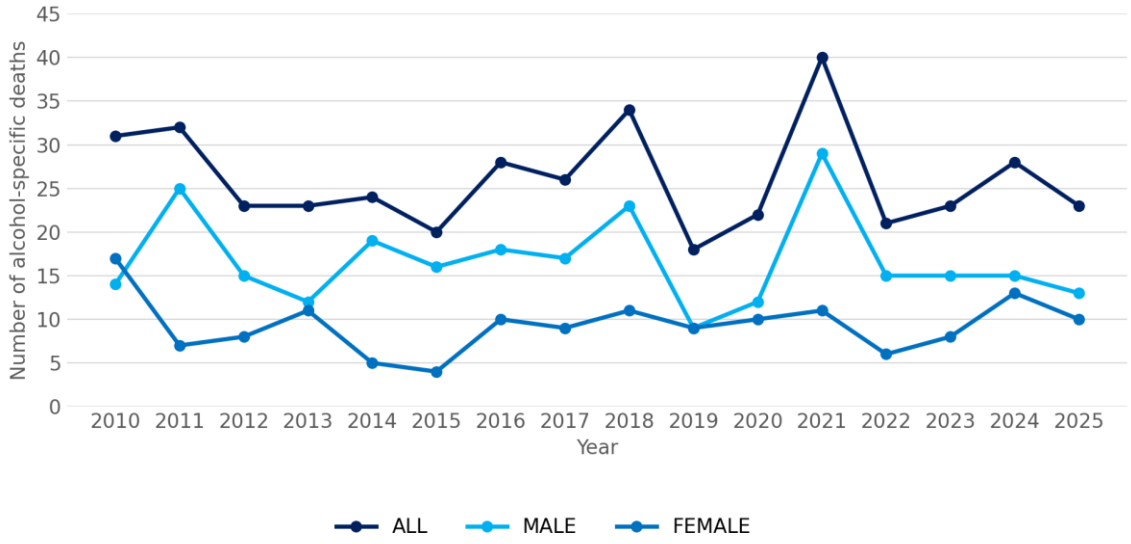
4.11 Several substances can be implicated in the same death, so these figures cannot be added together. The ADP needs to respond to the growing role of cocaine and the risks from using several drugs together, alongside continued opioid overdose prevention. The increased involvement of nitazenes reinforces the need for rapid sharing of information about changes in the local drug supply, targeted overdose prevention advice, and ready access to naloxone and training in its use.

Alcohol-Specific Deaths

4.12 West Dunbartonshire recorded 23 alcohol-specific deaths in 2025, compared with 28 in 2024, a reduction of five deaths (17.9%). Male deaths decreased from 15 to 13, while female deaths decreased from 13 to 10. Men accounted for 56.5% of deaths in 2025 and women for 43.5%.

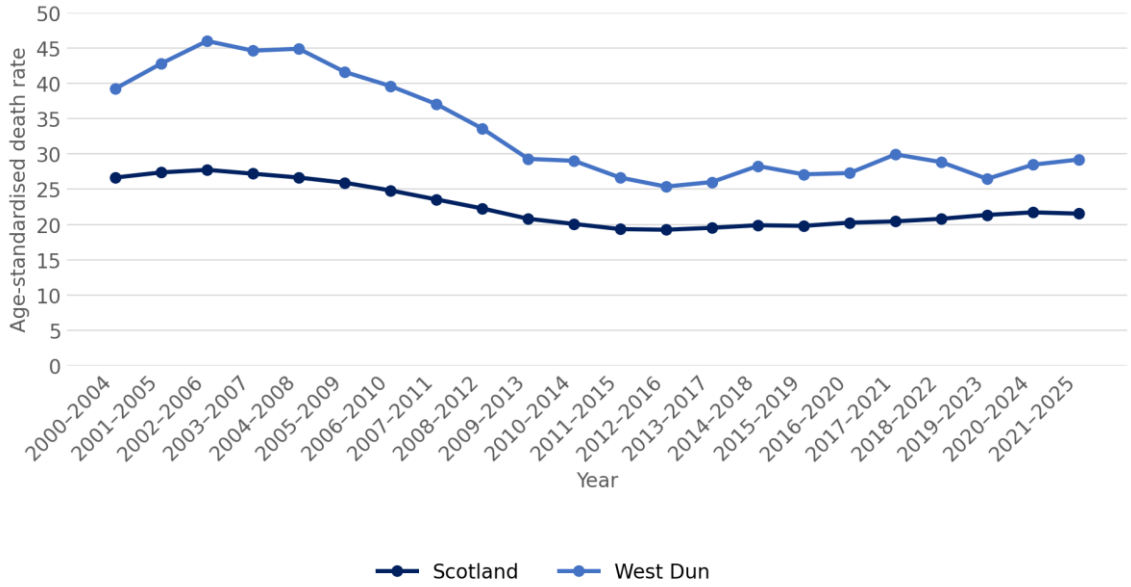
4.13 Figure 5 shows annual alcohol-specific deaths by sex from 2010 to 2025. The 2025 total was below the peak of 40 deaths in 2021 and returned to the level recorded in 2023. Annual numbers fluctuate considerably, so the reduction in 2025 should not, on its own, be interpreted as a sustained improvement.

Figure 5 - Alcohol-specific deaths in West Dunbartonshire by sex, 2010–2025



4.14 Figure 6 compares age-standardised alcohol-specific mortality rates over rolling five-year periods. West Dunbartonshire remained above the Scottish average throughout the period shown. For 2021–2025, the local rate was approximately 29 deaths per 100,000 people, compared with approximately 21 across Scotland. Although substantially below the levels recorded in the early 2000s, the local rate has risen over the two most recent rolling periods.

Figure 6 - Age-standardised alcohol-specific death rates per 100,000 people, rolling five-year periods, 2000–2004 to 2021–2025

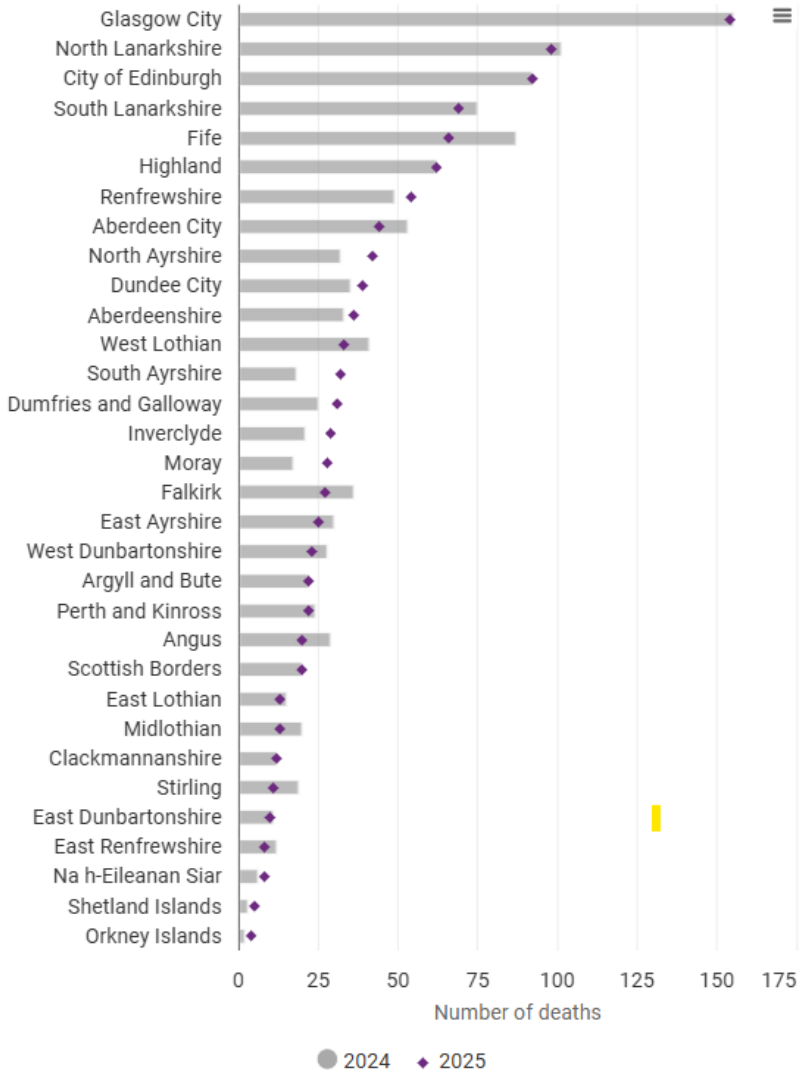


4.15 The annual reduction should therefore be considered alongside the continuing gap with Scotland. Five-year rates provide a more stable comparison, although successive periods overlap and are not independent observations. The findings reinforce the need for continued alcohol prevention, early intervention, accessible treatment and recovery support, alongside the response to drug-related harm.

4.16 Figure 7 compares the number of alcohol-specific deaths across council areas in 2024 and 2025. West Dunbartonshire recorded fewer deaths in 2025 than in 2024. These are counts rather than population-adjusted rates: differences between council areas reflect population size as well as levels of harm. The age-standardised rates in Figure 6 therefore provide the more appropriate comparison of local mortality with Scotland.

Figure 7 - Alcohol-specific deaths by council area, 2024 and 2025

Number and change in alcohol-specific deaths by council areas, registered in 2024 and 2025



Local Response

4.17 The level of drug-related harm in West Dunbartonshire requires a sustained and coordinated response across treatment services, public health, community organisations and wider partners. During 2026, the ADP and NHSGGC Public Health convened a Public Health Assessment Group to examine the increase in deaths and non-fatal overdoses, consider changes in the local drug supply and identify priorities for further investigation and action. This included consideration of the concentration of harms in the G83 area.

4.18 A local harm reduction group has been established to coordinate practical responses and improve the sharing of intelligence between partners. Priorities include identifying emerging risks, strengthening overdose prevention and improving engagement with people at greatest risk, particularly those who are not regularly accessing treatment. The increasing involvement of nitazenes and cocaine reinforces the need for support that responds to changing patterns of drug use.

4.19 The WithYou community recovery service commenced in January 2026, providing additional outreach in the G83 area, extended access and opening times, and a 24-hour support line. WithYou has reported demand above initial expectations, highlighting the need to monitor referrals, caseloads and waiting times to assess whether capacity is sufficient. Additional family support groups, including in the G83 area, have also been established to support people affected by a family member's substance use.

4.20 These developments complement ongoing work to sustain the MAT Standards and strengthen links between treatment, harm reduction and recovery services. However, successful implementation of the standards does not, on its own, demonstrate that everyone who needs support is being reached. Continued attention is required to people's experiences of access, continuity of care and the barriers faced by those with co-existing mental health and substance use needs.

4.21 The impact of this response will need to be assessed through continued monitoring of drug-related and alcohol-specific deaths, non-fatal overdoses, service demand, waiting times and feedback from people using services and their families. The ADP will need to use this evidence to identify gaps, review priorities and bring any unmet resource requirements through HSCP planning and governance arrangements. The priority is to establish whether current provision has the capacity and reach needed to support those at greatest risk, and to address any gaps identified.

Current Financial Position and Future Challenges

4.22 West Dunbartonshire Alcohol and Drug Partnership (ADP) funding comprises three main elements: the recurring Scottish Government ADP baseline allocation; recurring Programme for Government funding; and additional in-year Scottish Government allocations for specific priorities. These resources

complement core Health and Social Care funding for alcohol and drug services.

4.23 The ADP baseline allocation was fully delegated by NHS Greater Glasgow and Clyde to HSCPs in 2015. It supports alcohol and drug prevention, treatment and support services alongside core HSCP Alcohol and Drug Recovery Services (ADRS), including community addiction teams, harm reduction services and commissioned Third Sector recovery support.

4.24 For 2026/27, core Health and Social Care funding for these services is approximately £2.2m (gross expenditure), with a further £1.2m available through the ADP baseline allocation. The current forecast year-end position shows a small overspend within the Social Care core ADRS budget. Health and ADP baseline funding elements are fully committed and are currently forecast to break even.

4.25 Programme for Government funding of £0.3m was initially provided as a non-recurring in-year allocation in 2018/19 and became part of recurring baseline funding in 2023/24. The ADP and HSCP Board previously approved the use of this funding to support permanent investment in 1.0 WTE ADP Strategy Officer, 2.0 WTE Addiction Workers and 1.0 WTE Advanced Prescribing Pharmacist. All posts have been successfully recruited and contribute to the delivery of ADP priorities, including the MAT Standards.

4.26 In addition, £0.637m of Scottish Government in-year funding has been allocated for 2026/27, comprising:

- £0.158m for MAT Standards;
- £0.089m for Residential Rehabilitation; and
- £0.390m for Local Priorities, Preventing Harm, Promoting Recovery.

4.27 The Local Priorities allocation consolidates a number of previous National Mission funding streams, including Drug Stabilisation, Whole Family Approach, Lived and Living Experience and Agenda for Change uplifts. Commitments against these allocations are monitored through the ADP Financial Plan. This includes any planned use of earmarked reserves where expenditure commitments exceed the funding available within the financial year. These funding streams and associated expenditure also form part of the overall Addictions financial position reported to the HSCP Board through regular Financial Performance Reports.

4.28 Although additional in-year allocations have remained broadly consistent at around £0.6m per annum over the past five years, their timing and confirmation have created ongoing uncertainty for longer-term financial planning and commissioning. Previous requirements to offset expenditure against earmarked reserves have reinforced the need for a cautious approach, particularly where services may create commitments extending beyond the period of confirmed funding.

4.29 The ADP has sought to maximise the resources available locally through additional external and national funding. This includes £0.5m of Corra

Foundation match funding, which supplements Scottish Government funding and supports the commissioning of the Near Fatal Overdose and Multiple Complex Needs Service, currently delivered by Turning Point Scotland. The ADP has also accessed supplementary Residential Rehabilitation funding through the Scottish Government Additional Placement Fund, delivered with Scotland Excel, helping to maximise the number of residential rehabilitation requests that can be approved each year.

4.30 The ADP Financial Plan is regularly reviewed and updated to provide a clear picture of current commitments, available funding and any planned use of earmarked reserves. The next update will also include the end dates of all commissioned service contracts, supporting timely evaluation of outcomes and informing future commissioning and investment decisions.

4.31 Alongside ongoing ADP activity and analysis, this will enable partners to take a refreshed strategic overview of current service provision, identify gaps and assess future funding requirements. This should support consideration of whether existing resources remain aligned with local need, agreed priorities and the outcomes the Partnership is seeking to achieve.

4.32 All available funding is currently committed to existing alcohol and drug services and agreed priorities, including the MAT Standards and Residential Rehabilitation. This significantly limits the ADP's capacity to respond to identified gaps or unmet need through additional investment. In the context of persistently high levels of alcohol- and drug-related harm and deaths, this presents a significant challenge.

4.33 The wider national financial outlook across the public sector also means that significant additional public funding cannot be assumed. It is therefore important that the ADP, HSCP Board and strategic partners continue to review existing priorities, service provision and funding commitments to ensure that available resources are directed where they can achieve the greatest impact.

4.34 Alongside this, partners should continue to maximise opportunities to secure external funding, including relevant grant programmes such as those provided through the Corra Foundation and National Lottery funding. Information on funding opportunities and routes to application should be communicated effectively across ADP partners and eligible organisations.

4.35 The ADP and HSCP are required to ensure that local planning, delivery and governance arrangements reflect the expectations set out in the Scottish Government's Alcohol and Drugs: Partnership Delivery Framework 2026 and Preventing Harm and Preventing Harm, Promoting Recovery: Scotland's Alcohol & Drugs Strategic Plan 2026–2035. The Partnership Delivery Framework provides a particular focus on roles, responsibilities, accountability and effective partnership arrangements for the planning, delivery, reporting and evaluation of alcohol and drug services.

4.36 Further guidance on funding, Ministerial priorities, and planning and reporting requirements is set out in the 2026/27 Scottish Government ADP funding allocation letter dated 7 July 2026 (Appendix 2).

4.37 Scottish Government officials are actively engaging with ADPs and Integration Authorities in relation to these requirements. A recent request from the Cabinet Secretary sought assurance from Chief Finance Officers and NHS Board Directors of Finance regarding ADP funding, reporting, resource allocation, governance and audit arrangements.

4.38 The West Dunbartonshire HSCP Board's Chief Financial Officer has provided the requested assurance, based on the established governance, financial management and reporting arrangements of the HSCP Board and ADP.

4.39 These arrangements will require ongoing review to ensure that the necessary level of assurance continues to be provided. This will include a continued focus on transparency and accountability; effective financial monitoring and reporting; demonstrable outcomes; robust governance; and alignment of local priorities and investment with the national strategic direction.

5. Options Appraisal

5.1 No alternative options are presented. The report provides an update for the Board's consideration. The ongoing assessment of funding and service pressures identified will inform future planning, taking account of local need, available resources and the wider financial position of the HSCP.

6. People Implications

6.1 The ADP work programme is being progressed through existing staffing resources and partnership arrangements. Sustaining MAT Standards and responding to local harms depend on sufficient workforce capacity, appropriate skills and continuity of staffing. Any workforce implications identified through future financial planning or subsequent service proposals will be reported through the relevant governance arrangements.

7. Financial and Procurement Implications

7.1 The ADP Financial Plan will continue to be reviewed and updated to reflect current funding and expenditure commitments, in-year specific allocations, recurring funding, commissioned service commitments and contract end dates, together with any planned use of earmarked reserves.

7.2 The updated Financial Plan will support future financial and service planning, including consideration of service demand, identified unmet need and local and national strategic priorities. It will also provide a basis for scenario planning and consideration of the financial implications of any potential reprioritisation of existing resources, while maintaining appropriate transparency, governance and financial assurance.

7.3 Given that available funding is currently committed, any proposal to redirect existing resources would require consideration of the impact on current services and outcomes and would be subject to the appropriate governance and approval arrangements.

7.4 No new procurement or commissioning decisions are sought through this report. Any future proposal to commission new services, materially change existing commissioned provision or redirect resources will be subject to the relevant financial, commissioning and procurement requirements and approval processes.

8. Risk Analysis

8.1 There is a risk that available funding may not be sufficient to sustain current service capacity while responding to identified need and strategic priorities. This reflects uncertainty over future additional ADP funding, reliance on finite earmarked reserves for some planned expenditure, and wider cost pressures including pay, provider rates and inflation.

8.2 These pressures could reduce the flexibility available to maintain existing services or respond to emerging priorities. The risk will be managed through regular review of the ADP Financial Plan, financial monitoring and scenario planning, with any proposed reprioritisation of resources or changes to service provision subject to appropriate ADP and HSCP Board governance and approval arrangements.

8.3 There is a risk that people at greatest risk of harm are not reached by existing services, even where MAT Standards are fully implemented. Monitoring should therefore consider barriers to access, engagement with people outside treatment, and continuity between treatment, harm reduction and recovery support. Feedback from people with lived and living experience and their families should inform improvements.

8.4 Regular financial monitoring will be considered alongside waiting times, service demand, workforce capacity, MAT implementation and evidence of alcohol and drug harms. Any emerging gaps in provision or risks to service continuity will be reported to the ADP and HSCP Board, with an identified responsible lead, details of proposed mitigating actions and an agreed timescale for implementation where appropriate.

9. Equalities Impact Assessment (EIA)

9.1 No separate Equalities Impact Assessment is required for this update report, as no service change or commissioning decision is proposed. Any subsequent proposal to change service provision or redirect resources will be subject to equality impact assessment in accordance with the relevant requirements.

10. Environmental Sustainability

10.1 Not applicable

11. Consultation

11.1 No formal consultation is required in relation to this update report.

12. Strategic Assessment

12.1 This work demonstrates the WDADP and WDHSCP contribution to actions in the following national and local strategies:

- Scotland's Public Health Priorities: Priority 4 - A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs
- Preventing Harm, Promoting Recovery: Scotland's Alcohol and Drugs Strategic Plan 2026-2035
- West Dunbartonshire HSCP Strategic Plan 2023-2026 Improving Lives Together: All 4 Strategic Priorities

13. Directions

13.1 No Direction is required, as the report is for noting and does not seek approval for a change to delegated services or resource allocation.

Name: Sylvia Chatfield
Designation: Head of Mental Health, Learning Disabilities and Addiction Services
Date: 12 November 2026

Person to Contact: Chris Kelly
Email chris.kelly@ggc.scot.nhs.uk

Appendices:
Appendix 1: MAT Standards Benchmarking
Appendix 2: Supporting the delivery of Alcohol and Drugs Services: 2026-27 Funding Allocation, and Ministerial Priorities

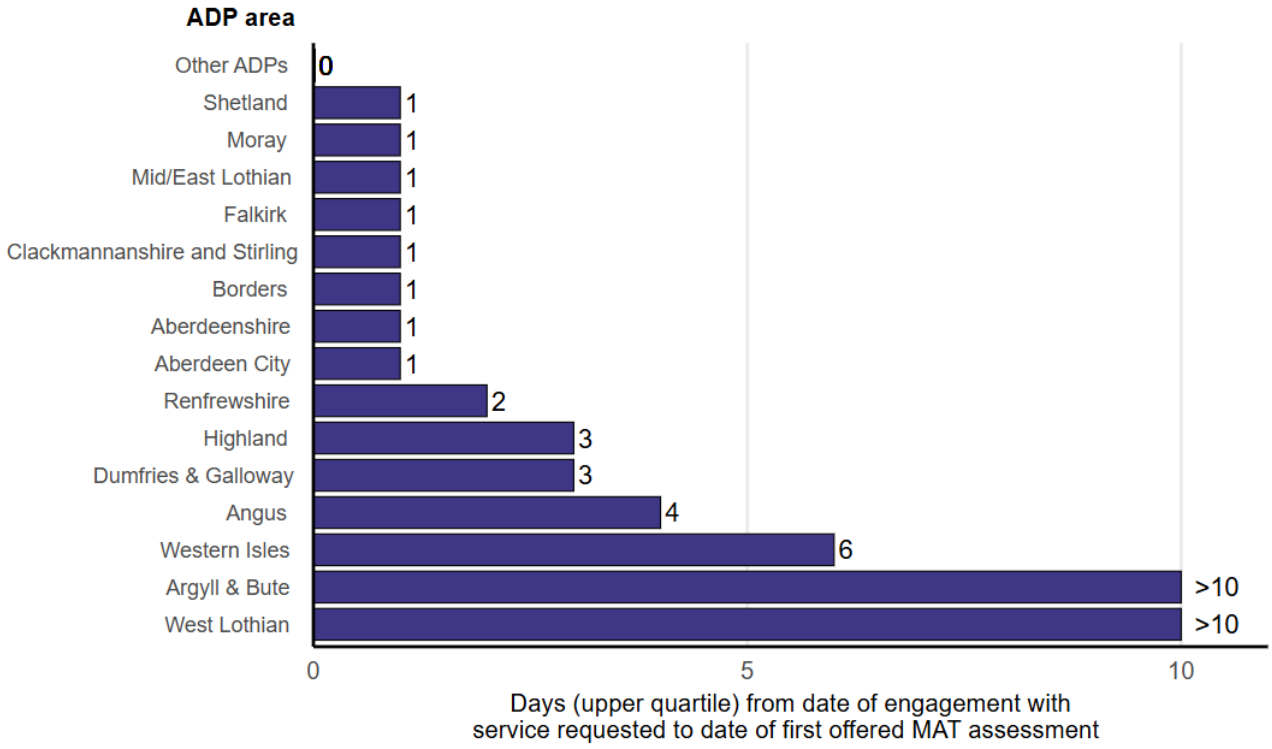
MAT standards benchmarking 2025/26

The following summarises the 2025/26 MAT benchmarking results, with a focus on West Dunbartonshire. Assessment criteria have changed since 2024/25, so overall ratings are not directly comparable between years. Individual activity measures are discussed below with the relevant reporting context.

MAT standard 1 Same day access

The intention of MAT standard 1 is to ensure that all people accessing services have the option to start the medication assisted treatment appropriate for them from their first day of presentation. This includes psychosocial care as well as medication where appropriate.

Figure 1 - Days from engagement with a service to first offered MAT assessment for at least 75% of service users, by ADP area, Scotland 2025/26



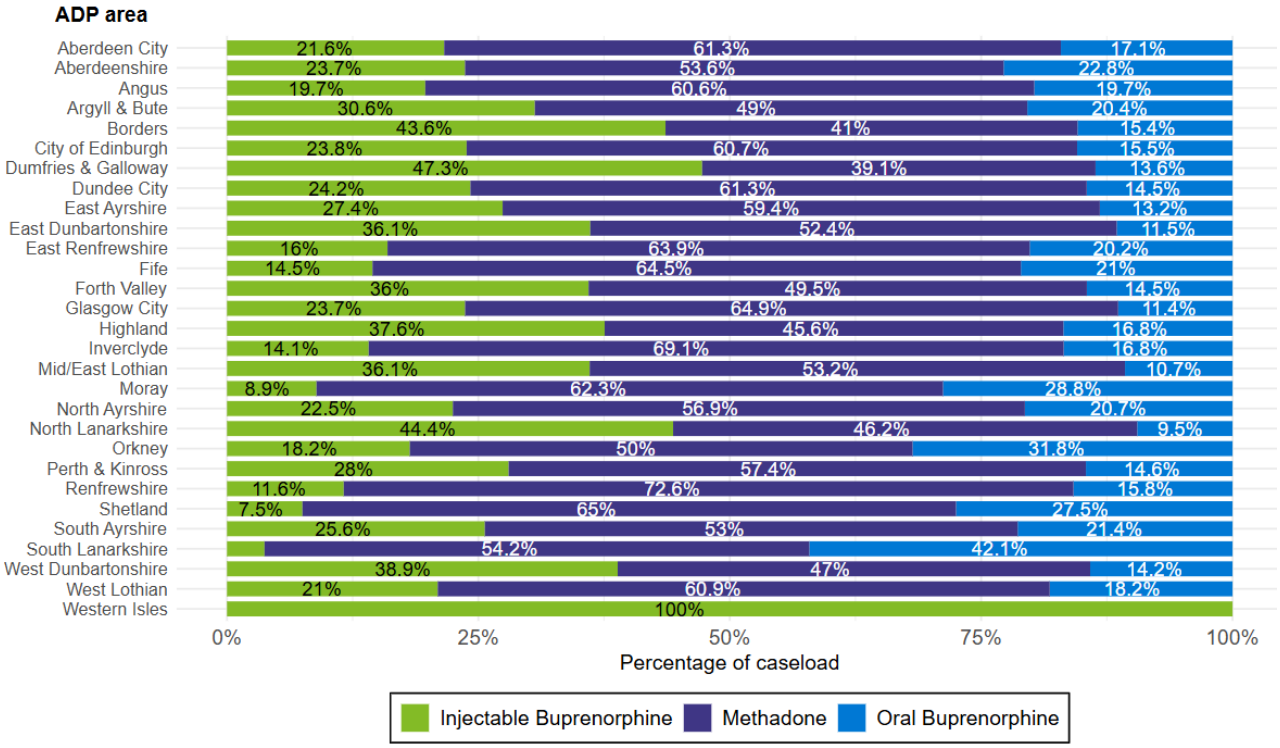
West Dunbartonshire achieved the target, with at least 75% of service users receiving their first MAT assessment on the same day they engaged with the service. West Dunbartonshire is included within the “Other ADPs” group shown at zero days in Figure 1. This maintains the same-day position reported in 2024/25.

Nationally, 15 ADPs achieved zero days for at least 75% of service users. A further eight reported one day and seven reported more than one day.

MAT standard 2 Choice

The intention of MAT standard 2 is to ensure that all people are supported to make an informed choice about medication, if any, alongside psychosocial interventions as part of MAT. The medication types reported are methadone, oral buprenorphine and long-acting injectable buprenorphine, collectively described as opioid agonist therapy (OAT).

Figure 2 - Percentage of caseload prescribed OAT by medication type and ADP area, Scotland 2025/26



Within West Dunbartonshire, 38.9% of the caseload was prescribed long-acting injectable buprenorphine, 47.0% methadone and 14.2% oral buprenorphine. Percentages may not total exactly 100% because of rounding. Injectable buprenorphine therefore accounts for almost two in five people receiving OAT locally.

The previous appendix reported an injectable buprenorphine proportion of 40.7%. The current figure is 1.8 percentage points lower than that previously published figure.

The dashboard identifies the cost of long-acting injectable buprenorphine as the issue raised by ADPs in relation to this standard. Maintaining access to a range of treatments remains important in supporting informed choice.

MAT standard 3 Assertive outreach and anticipatory care

This standard aims to ensure that people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT, or other treatment of their choice. Services should respond to high-risk events and offer support at the earliest opportunity.

Figure 3 - High-risk event notifications by source across Scotland, 2025/26

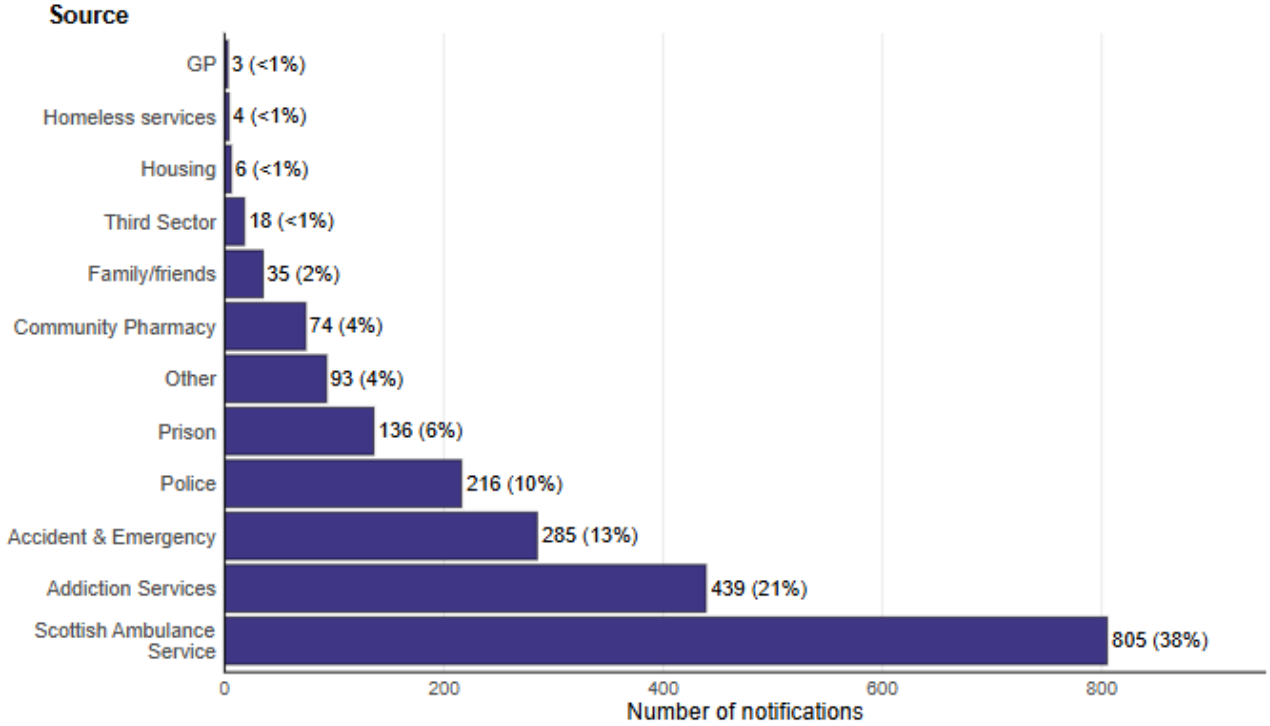


Figure 3 shows national notification sources. The Scottish Ambulance Service accounted for 805 notifications (38%), addiction services for 439 (21%), Accident and Emergency for 285 (13%) and Police for 216 (10%). These are Scotland-wide figures, rather than West Dunbartonshire totals.

Nationally, 19 ADPs attempted contact on the day of notification for at least 75% of notified events. A further seven reported one day and three reported two days. Falkirk and Clackmannanshire and Stirling submitted jointly as Forth Valley. These national results do not establish West Dunbartonshire's individual contact time.

MAT standard 4 Harm reduction

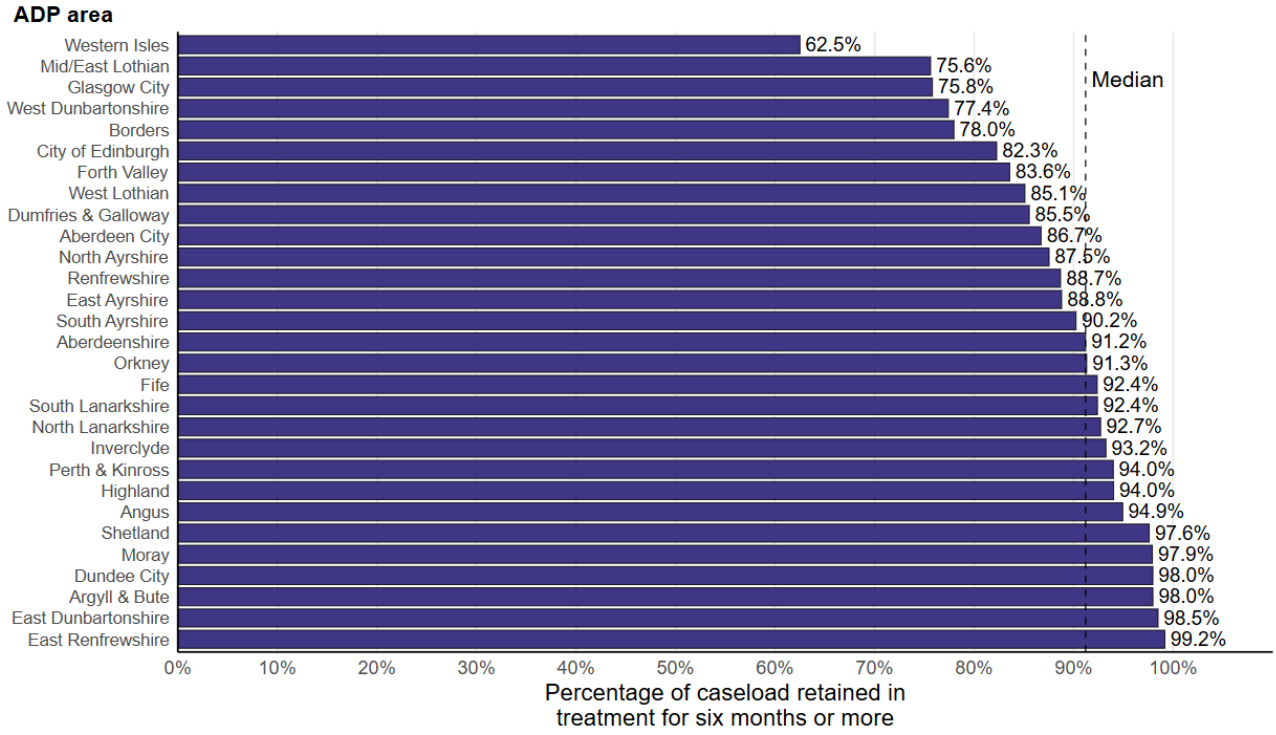
MAT standard 4 aims to ensure that evidence-based harm reduction is offered at the same time and place as MAT, tailored to individual need. The four core measures are blood-borne virus testing, injecting equipment provision, naloxone and overdose awareness, and wound care.

No ADPs reported issues meeting the numerical measure in 2025/26. However, assessment also considers process and experiential evidence. The strengthened requirements around Hepatitis B vaccination affected overall ratings: nationally, 17 ADPs were assessed as green or blue and 13 as provisional green. A change in rating may therefore reflect the revised criteria rather than a reduction in existing harm reduction provision.

MAT standard 5 Retention as long as needed

MAT standard 5 aims to ensure that people receive support to remain in treatment for as long as requested. The proportion of the current caseload retained for at least six months is used as a measure of retention, with an expected benchmark of at least 75%.

Figure 4 - Percentage of caseload retained in treatment for six months or more, by ADP area, Scotland 2025/26



West Dunbartonshire achieved the benchmark, with 77.4% of its caseload retained in treatment for six months or more. This is an increase of 0.6 percentage points from the 76.8% reported in 2024/25.

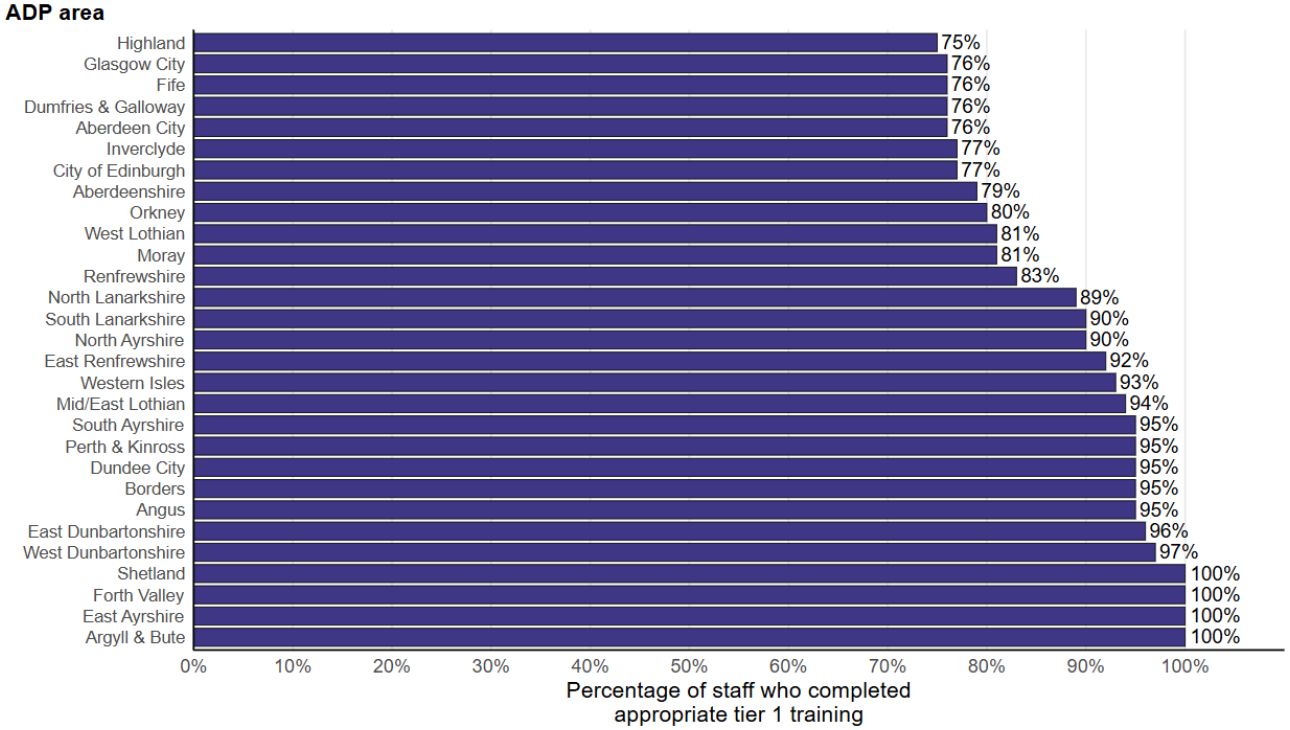
Nationally, 17,036 of the reported caseload of 19,773 people had been in treatment for at least six months, equivalent to 86.2%. The median across ADP areas was 91.2%; this differs from the national proportion because each area contributes equally to the median, regardless of caseload size.

The local result is above the benchmark but below both national measures. Interpretation should take account of the number of people newly entering treatment: recent admissions reduce the proportion who have reached six months. The figure alone does not establish how many people left treatment early or explain the difference from other areas.

MAT standards 6 and 10 Psychological support and trauma informed care

MAT standard 6 aims to ensure that the system providing MAT is psychologically informed, delivers psychosocial interventions and supports people to develop social networks. MAT standard 10 aims to ensure that trauma informed principles underpin care and support.

Figure 5 - Percentage of eligible staff completing appropriate Tier 1 training, by ADP area, Scotland 2025/26



In West Dunbartonshire, 97% of eligible staff had completed appropriate Tier 1 training, exceeding the 75% benchmark by 22 percentage points. The threshold increased from 50% to 75% for 2025/26 and covers training completed within the preceding two calendar years.

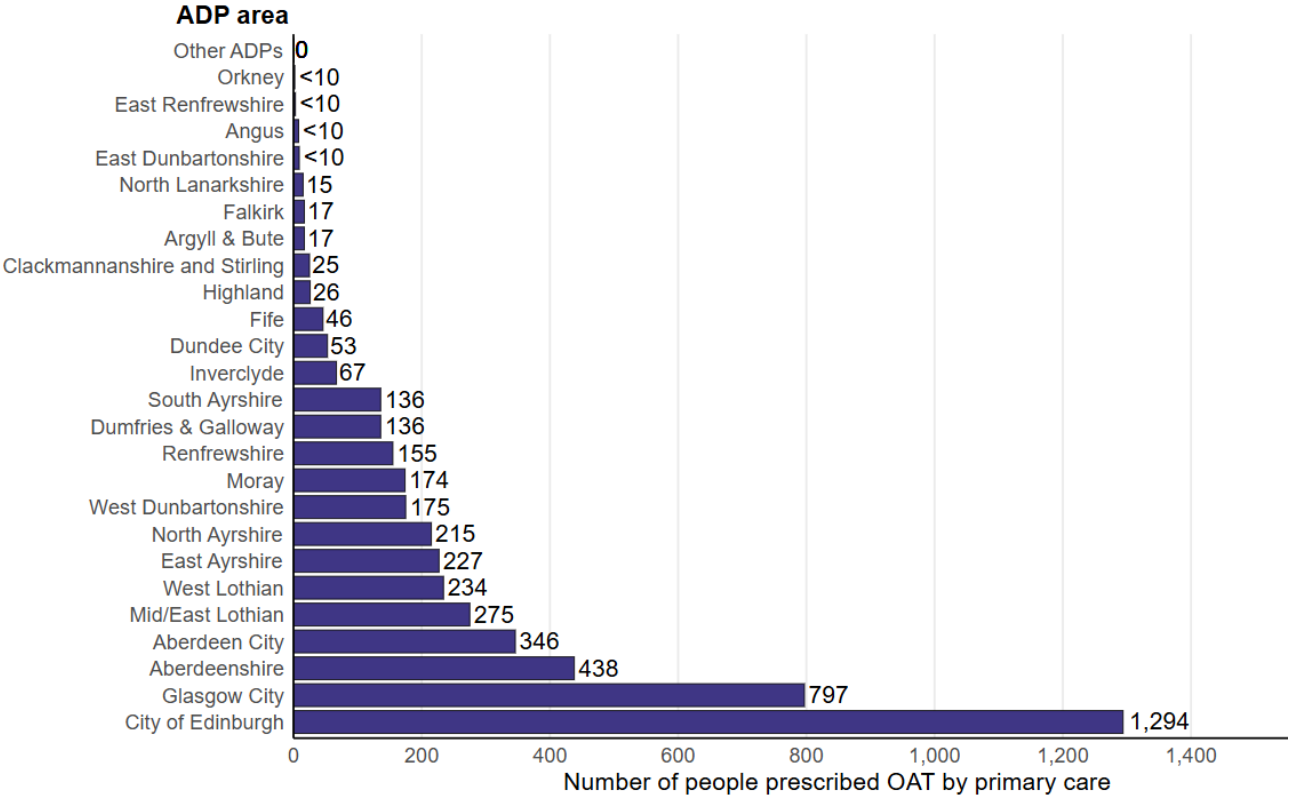
All 29 reported ADP submissions achieved at least 75%, with 16 reporting 90% or more. Four reported 100% completion. Training requirements are defined through local plans, so differences between areas should be interpreted with care. West Dunbartonshire is separately identified in this year's chart, whereas last year's appendix described a Greater Glasgow and Clyde submission.

The assessment also uses the Lead Psychologists for Addiction Services Scotland (LPASS) self-assessment tool to assess implementation of psychological and trauma informed practice. All ADPs were assessed as provisional green or green for these standards. Staff training completion is one component and should not be treated as the overall rating.

MAT standard 7 Primary care

The aim of MAT standard 7 is to ensure that people have the option of substance use treatment and support, including MAT, shared with primary care. This should also support access to care for general health needs.

Figure 6 - Number of people prescribed OAT through primary care, by ADP area, Scotland 2025/26



West Dunbartonshire reported 175 people prescribed OAT through primary care, compared with 184 in last year's appendix, a difference of nine people. Nationally, the dashboard reports 4,890 people receiving OAT through primary care, with five ADPs reporting none.

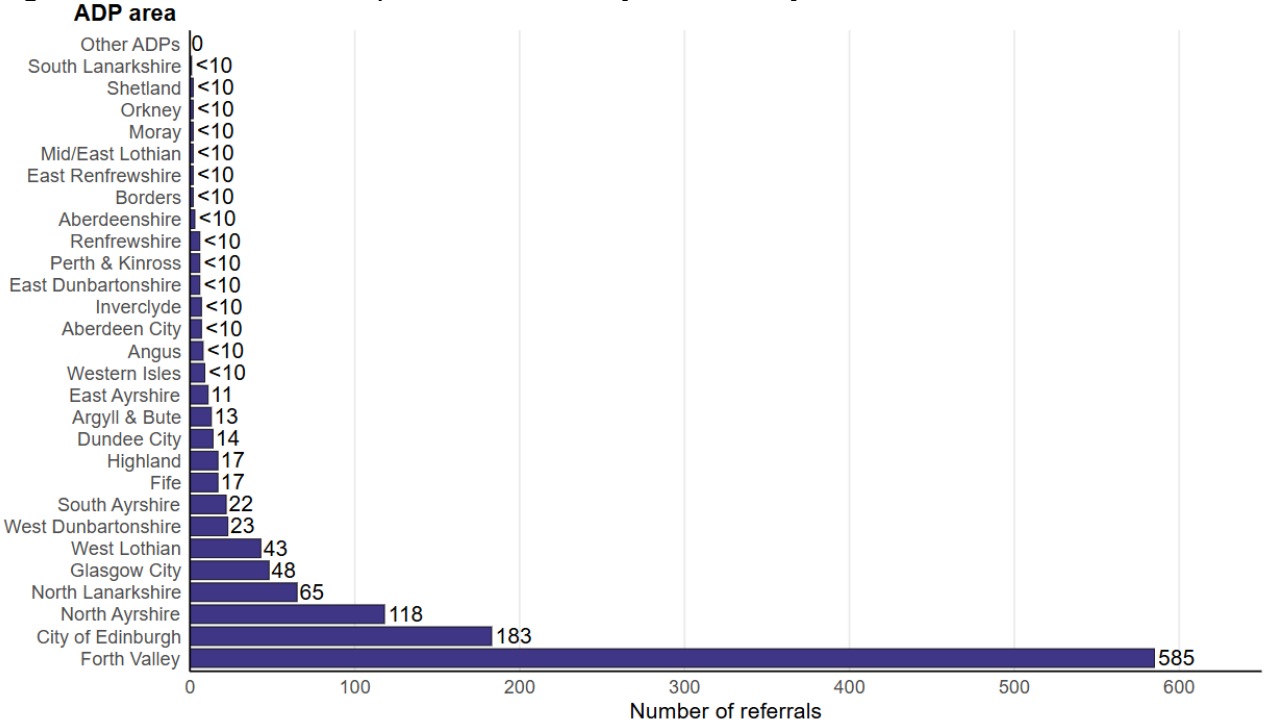
The 2025/26 measure uses a snapshot date of 28 February 2026, subject to local considerations. Last year's appendix described a three-month reporting period. The figures above therefore describe the published totals and should not be interpreted as a directly comparable annual change in activity.

The updated assessment recognises a wider range of shared care models, including advanced nurse practitioners and community pharmacies. Nationally, ADPs continue to report challenges at the interface between specialist substance use services and primary care. Local arrangements need to support treatment choice alongside access to wider healthcare.

MAT standard 8 Independent advocacy and social support

MAT standard 8 aims to ensure that all people have access to independent advocacy and support with housing, welfare and income needs.

Figure 7 - Referrals to independent advocacy services by ADP area, Scotland 2025/26



West Dunbartonshire reported 23 referrals to independent advocacy services during the selected reporting period, compared with 13 reported in 2024/25. This is ten more referrals than the figure in last year's appendix. Nationally, the dashboard reports 1,224 referrals. The data cover a selected three-month period between November 2025 and March 2026 and are not annual totals. The numerical requirements changed for 2025/26, combining the previously separate requirements for referrals offered and accepted. The difference from last year should therefore be interpreted in that context.

The dashboard also notes that the Forth Valley submission may include referrals not specifically related to substance use. This affects interpretation of the national total and comparisons between areas.

The standard extends beyond advocacy referrals. Services are also required to report whether people were informed about access to expert advice on housing, welfare and income. Delivery depends on effective working arrangements across alcohol and drug services, the HSCP and third-sector providers.

MAT standard 9 Mental health

The intention of MAT standard 9 is to ensure that people with co-occurring drug use and mental health difficulties receive mental health care at the point of MAT delivery in an integrated way.

Figure 8 - Mental health screening outcomes among new MAT referrals, Scotland 2025/26

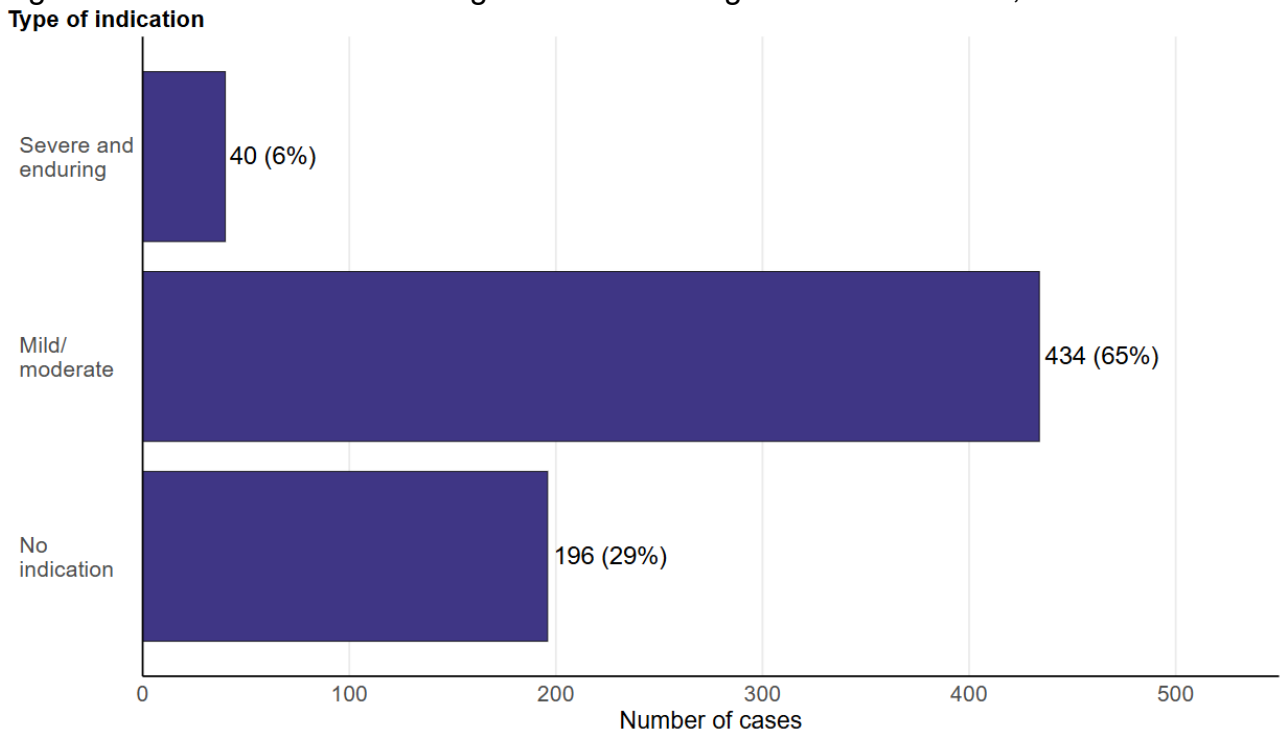


Figure 8 presents national screening outcomes. Of the 670 cases shown, 434 (65%) had indications of mild or moderate mental health difficulties and 40 (6%) had severe and enduring indications. The remaining 196 (29%) had no indication. Together, 71% had an indication of a mental health difficulty.

These findings demonstrate the importance of access to mental health support alongside substance use treatment. The national report states that 95% of people entering treatment were screened. For 2025/26, the numerical benchmark requires initial mental health screening for more than 75% of new referrals.

The screening results are national and do not establish West Dunbartonshire's local prevalence, access to mental health treatment or overall rating. Screening should lead to an appropriate response, supported by effective joint working between alcohol and drug services, primary care and mental health services.

Sources and reporting

Figures reproduced from the supplied Public Health Scotland MAT benchmarking dashboard screenshots for 2025/26. Supporting definitions and assessment changes are drawn from the national report published 7 July 2026. Previous local figures are from Appendix 1 to Item 11 of the HSCP Board papers, 25 November 2025, pages 226 to 233. MAT 1 local same-day performance has been confirmed by West Dunbartonshire ADP. The dashboard is available at https://scotland.shinyapps.io/phs-mist-benchmarking/.

Population Health Directorate
Alcohol and Drugs Support Division & Health Improvement Division
E: Drugsmissiondeliveryteam@gov.scot

Scottish Government
Riaghaltas na h-Alba
gov.scot

Integration Authority Chief Finance Officer
Integration Authority Chief Officer
ADP Chair

Copies to:
ADP Coordinators
NHS Board Chief Executive
Local Authority Chief Executive
NHS Director of Finance

7 July 2026

Dear Integration Authority Chief Finance Officer, Integration Authority Chief Officer, and ADP Chair,

This letter is issued in the first instance to Integration Authority Chief Finance Officers as accountable officers for the receipt, stewardship, and reporting of these specific funds, working in conjunction with Integration Authority Chief Officers, and ADP Chairs.

SUPPORTING THE DELIVERY OF ALCOHOL AND DRUGS SERVICES: 2026-27 FUNDING ALLOCATION, AND MINISTERIAL PRIORITIES

1. We are writing to set out the funding arrangements, Ministerial priorities and planning and reporting arrangements for Alcohol and Drug Partnership (ADP) work for 2026-27. These arrangements are in line with Preventing Harm, Promoting Recovery: Scotland's Alcohol & Drugs Strategic Plan 2026-2035 (PHPR), and the Partnership Delivery Framework (PDF) and support the Scottish Government's wider Public Service Reform agenda.

2. Central to PHPR and wider public service reform is an ambition for strengthened local leadership and accountability, the framework for which is set out in the PDF. Published jointly with COSLA, PHPR and the PDF reinforce the role of ADPs in enabling joined-up systems, bringing partners together to plan and deliver integrated rights-based, person-centred services that respond to local need.

3. As you will be aware, the Scottish Government's total funding to support ADP projects in 2026-27 is transferred via NHS Boards for total onward delegation to Integrated Authorities (IAs) to be invested, in its entirety, through ADPs. The funding should not be subject to any wider savings targets.

4. Integration Authorities are expected to be able to evidence that funding has been allocated in full to alcohol and drugs activity agreed with the ADP, with this forming part of local financial reporting and assurance arrangements. Further detail on these requirements is set out in paragraphs 36 - 40.

Funding Allocations

5. For 2026/27, ADPs have received a baseline allocation (via NHS Boards), ringfenced programme funding for MAT Standards and Residential Rehabilitation and a flexible programme allocation supporting delivery of PHPR priorities.

6. Funding for 2026/27 has been provided as a single total allocation, enabling greater flexibility for ADPs to deploy resources in a coherent and outcomes-focused way. Please see **appendix 2** for allocations by Health Board and IA.

7. The funding arrangements are summarised in the following table.

Table 1: ADP funding arrangements

Alcohol and Drugs Strategic Plan	**National 2026/27 budget**
NHS Board Baseline contribution	£80,512,635*
In-year allocation – programme funding	
Local priorities in line with Preventing Harm, Promoting Recovery	£21,003,887**
MAT Standards	£10,313,775
Residential Rehabilitation	£5,000,000
Sub total	**£36,317,662**
Total	**£116,830,297**

* Including 2026-27 2% baseline uplift.
**Includes legacy Agenda for Change uplift of £3,003,887

8. Collectively this funding represents a national investment of £116.8 million for ADPs. This means that funding has increased from the 2025-26 level by nearly £2 million.

9. Local breakdowns can be found in **appendices 2 and 3**. The total allocated across all funding lines and across all local areas maintains the breakdowns and totals for 2025/26. Each local area's share of funding previously ringfenced for stabilisation (£3m) has been calculated based on drug death prevalence, as per 2025/26; the legacy Agenda for Change funding uplift (£3m) has been calculated based on Health Board returns, as per 2025/26 breakdown.

10. Per paragraph 3, direct funding to support ADP projects in 2026-27 has been transferred to NHS Boards via their baseline allocations for onward delegation to IAs. Where there is more than one IA within the Health Board area, the level of funding should be agreed jointly by the IAs within the Health Board area.

Purpose of funding

11. This year marks a transition to delivery of PHPR. While we do not expect significant changes to planned activity in 2026/27, we do expect a step change in how funding is used and evidenced, with increased flexibility matched by a stronger focus on outcomes and a clearer line of sight between investment, delivery and impact.

12. In line with the emphasis on local leadership, ADPs will have more flexibility in 2026/27 in the use of funding. Funding should be used to embed and sustain progress made under the National Mission, while aligning investment with the national outcomes and priorities set out in PHPR.

Preventing Harm, Promoting Recovery Delivery - £21 million

13. ADPs have flexibility in the use of the £21 million PHPR delivery funding. The Scottish Government expects clear alignment between local plans, investment decisions and the national priorities set out in PHPR. **Appendix 4** contains further detail on PHPR in the context of local delivery.

Medication-Assisted Treatment (MAT) Standards - £10.3 million

14. Funding for the implementation and improvement of the MAT standards remains the same as 2025-26. This implementation remains a key priority for Ministers, Chief Officers and other leaders in IAs.

15. The allocation of funding was calculated at the outset of MAT implementation and was based on what each area already had in place and what was required for implementation. This has meant that allocation decisions have not been based only on NRAC. Full details of the MAT funding allocation are detailed in **appendix 2**.

16. The funding can be used flexibly by ADPs to continue to build improvement-based capacity and capability with regards to implementing and sustaining the MAT standards. It can be used to support services with regards to new and emerging alcohol and drug trends as a move is made towards wider treatment standards for all substances.

17. Public Health Scotland, through the MAT Implementation Support Team (MIST), will continue to help local areas monitor their progress in implementing the standards over the year. Performance against standards will be captured in ADP annual reporting cycles and Scottish Government Implementation Plan Progress Reporting.

Residential Rehabilitation - £5 million

18. Ministers have committed to maintain 1000 publicly funded residential rehabilitation placements per year. This is the fourth year of this funding uplift to support residential recovery, and the services associated with preparation or aftercare. Rehabilitation-associated service placements in detox, crisis care and stabilisation are valid uses of this funding.

19. Each ADP is asked to publish an operational Residential Rehab pathway to support an increase in the number of people being referred to residential rehab in their local areas, with an updated link to be sent to SG via the alcoholanddrugsimprovement@gov.scot mailbox by November 2026.

20. Public Health Scotland will continue the regular monitoring of referrals and spend on residential rehab. ADPs are asked for their continued support of this data collection. Public Health Scotland is developing a comprehensive evaluation framework to support the residential rehabilitation programme and further details of this work will be shared in due course.

21. Scotland Excel's National Commissioning Framework (NCF) for residential rehab placements went live on 1 April 2024. We expect that ADPs utilise this framework as a tool to make commissioning of RR placements (including those supported through the separate Additional Placements Fund) easier and more efficient.

Governance, Progress Monitoring and Reporting

22. ADPs should deliver and commission their work in line with the underpinning enablers of PHPR:
    - A Human Rights-Based Approach, as set out in the Charter of Rights for People Affected by Substance Use, ensuring that the voices of people with lived and living experience shape the design and delivery of services, and that people receive person-centred care and support
    - A locally-led, responsive and sustainable system that is accountable and works effectively in partnership, and able to demonstrate the impact of investment on outcomes

23. Decisions about the use of funding must be grounded in evidence and aligned with PHPR. Transparency in how funding is used will remain important, alongside a strengthened focus on outcomes and impact. Expectations for reporting and monitoring are set out below.

Alcohol and Drugs Death Reviews

24. Throughout the design and development of Preventing Harm, Promoting Recovery, a number of concerns were raised about the quality, speed and transparency of death reviews following an alcohol or drug related death. In particular, concerns were raised about families being excluded from processes despite wishing to be involved.

25. ADPs are required to update and implement plans to carry out death reviews to help drive service improvements, aimed at reducing deaths from alcohol and drugs, and are encouraged to consider ways of better involving families and loved ones. Integration Authorities are asked to make sure reviews are taking place consistently in health and social care settings and are overseen with appropriate senior level input - and that reviews are reported on appropriately. There are fewer alcohol death reviews carried out at present than drug death reviews. To help deliver on the Audit Scotland recommendation to increase focus on alcohol, ADPs are asked to enhance their alcohol death review process in 2026/27. ADPs should refer to the Public Health Scotland 'Preventing substance related harms by case review, learning and action following a death' currently available through their knowledge hub (access available on request) and the Alcohol Deaths Review Guidance developed by Alcohol Focus Scotland: alcohol-deaths-reviews-practical-guidance-for-alcohol-and-drug-partnerships-and-public-health-teams.pdf.

Monitoring and Reporting Arrangements

26. A clear commitment to monitoring, reporting and evaluation at the local level is vital, including demonstrating how funding contributes to improved outcomes and providing a clear line of sight between investment and impact.

27. ADPs will also continue to play a key role in supporting national evaluation, monitoring and research activity. It is, therefore, important that accurate data recording and reporting is prioritised by ADPs and the services they fund.

28. In particular, the Partnership Delivery Framework (PDF) sets out the Scottish Government's expectations for proactive, continuous and transparent reporting.

29. In 2026-27, Integration Authorities and ADPs are expected to:
    - publish clear annual delivery plans, including financial allocations linked to priorities
    - provide regular public reporting on progress and spend (not limited to year-end reports)
    - demonstrate how decisions have been made, including the role of lived and living experience
    - ensure financial transparency, showing how national funding has been used in practice
    - evidence impact and outcomes, not just activity

30. These requirements represent a shift from retrospective reporting towards ongoing, proactive accountability to local communities and national government.

<u>The Drug and Alcohol Information System (DAISy)</u>

31. DAISy has been live in all NHS Board areas since 1 April 2021. The system was built and is maintained by Public Health Scotland and it primarily functions as a national database which gathers key demographic and outcome data on people who engage in alcohol/drug treatment services. This information contributes to strategic planning.

32. Submission of complete and timely data to DAISy is a mandatory requirement for services receiving public funding. Integration Authorities must ensure that this is enforced through commissioning and grant conditions.

33. PHS has concluded its review of DAISy and is implementing improvements, in line with feedback from delivery partners. Aspects of MAT implementation reporting have now been incorporated into the DAISy system, to reduce duplication and data-entry burden. Local MAT evaluation and benchmarking will, therefore, become reliant on robust submission of data to the system.

34. In particular, the Local Delivery Plan (LDP) standard requires that 90% of people referred for drug or alcohol treatment start appropriate treatment within three weeks of referral. This should be considered alongside MAT Standard 1, which sets expectations for timely and, where appropriate, same-day access to treatment.

35. There is an expectation that, as a measure of quality and equity, no individual should wait longer than six weeks to receive appropriate treatment.

36. Performance against this standard is monitored through the Drug and Alcohol Information System (DAISy), with Public Health Scotland publishing national statistics on waiting times. This data will be used to identify areas of underperformance, inform improvement activity, and support national and local assurance of access to treatment.

Spend this financial year

37. We previously highlighted the significant accumulation of reserves held by IAs on behalf of ADPs. In 2025-26, financial returns were commissioned to minimise reserve balances being carried forward to 2026-27. We do not intend to continue this process for financial year 2026-27.

38. SG is unable to roll forward any underspends from 2026-27. Therefore, the funding set out in the table above and associated appendices is the **maximum** allocated. However, where there is a need to hold reserves for specific, defined, non-recurring commitments, these will be considered on a case-by-case basis. The process for this will be confirmed towards the end of quarter 2.

39. Integration Authorities are expected to actively manage in-year spend to avoid underspend and ensure that resources are deployed in line with agreed priorities.

40. If you have any queries on the content of this letter, please contact: Drugsmissiondeliveryteam@gov.scot.

Yours sincerely

Richard Foggo
Director, Population Health

Appendix 1: Alcohol and Drugs Strategic Plan Outcomes and Priorities

Human Rights-Based Approach

People affected by alcohol and drugs have their human rights fulfilled.

- Charter of Rights
- Lived and living experience
- Stigma
- Non-discrimination and equality

Prevention & Early Intervention Fewer people develop problem alcohol and drug use.	**Harm Reduction** Harm is reduced for people who use alcohol and drugs.	**Treatment & Care** People affected by alcohol and drugs receive high quality treatment and care services.	**Wider Circle of Support** People affected by alcohol and drugs have their wider needs supported by compassionate joined-up services.
• Availability, affordability and attractiveness of alcohol • Healthy development of children and young people • Targeted support for at risk communities • Early intervention for at risk individuals	• Connection and outreach • Scotland's surveillance and early warning system • Naloxone programme • Harms from injecting • Established and emerging ways to reduce drug harms • Alcohol related harms	• Overarching system for improved quality of services • Equal focus on alcohol and drug treatment • Responding to changing trends • Residential services • Wider communities of care	• Joined up and person-centred approach across all services • Co-occurring substance and mental health issues • Wider health system • Welfare services • Public health approach to justice

Delivering in Partnership

Partners collaborate effectively to support delivery and continuous improvement, driven by evidence and clear lines of accountability.

- Local accountability for delivery
- Voluntary sector
- Workforce
- National governance arrangements
- Data, research and evidence

Appendix 2: In-Year Funding breakdown by ADP

Funding stream		Local Priorities in line with Preventing Harm, Promoting Recovery	MAT Standards	Residential Rehab	IA NRAC Share 26/27	Total
Distribution Formula		**-**	***Refer to ADP letter**	**NRAC**	**-**	**-**
NHS Board Name	**National 2026/27 allocation**	**£21,003,887**	**£10,313,775**	**£5,000,000**	**-**	**£36,317,662**
Ayrshire & Arran	East Ayrshire HSCP	£484,149	£215,080	£118,163	2.36%	**£817,392**
	North Ayrshire HSCP	£538,486	£250,360	£134,329	2.69%	**£923,175**
	South Ayrshire HSCP	£433,117	£340,000	£111,376	2.23%	**£884,493**
	NHS Ayrshire & Arran (programme management)	£3,980	£67,000	-		**£70,980**
Borders	Scottish Borders HSCP	£418,839	£200,154	£110,231	2.20%	**£729,224**
Dumfries & Galloway	Dumfries and Galloway HSCP	£586,583	£269,206	£147,862	2.96%	**£1,003,651**
Fife	Fife HSCP	£1,171,453	£613,148	£341,661	6.83%	**£2,126,262**
Forth Valley	Clackmannanshire and Stirling HSCP	£660,886	£230,899	£130,588	2.61%	**£1,022,373**
	Falkirk HSCP	£492,311	£259,191	£143,179	2.86%	**£894,681**
Grampian	Aberdeen City HSCP	£884,426	£462,000	£184,782	3.70%	**£1,531,208**
	Aberdeenshire HSCP	£935,157	£436,600	£217,225	4.34%	**£1,588,982**
	Moray HSCP	£352,689	£154,319	£83,591	1.67%	**£590,599**
Greater Glasgow & Clyde	East Dunbartonshire HSCP	£378,521	£166,874	£92,993	1.86%	**£638,388**
	East Renfrewshire HSCP	£310,325	£172,622	£79,467	1.59%	**£562,414**
	Glasgow City HSCP	£2,826,629	£1,066,000	£586,082	11.72%	**£4,478,711**
	Inverclyde HSCP	£411,722	£212,767	£81,145	1.62%	**£705,634**
	Renfrewshire HSCP	£762,658	£305,726	£172,528	3.45%	**£1,240,912**
	West Dunbartonshire HSCP	£390,535	£158,000	£89,500	1.79%	**£638,035**
	NHS Greater Glasgow & Clyde (programme management)	-	£132,000	-		**£132,000**
Highland	Argyll and Bute HSCP	£315,060	£171,171	£95,255	1.91%	**£581,486**
	Highland HSCP	£788,799	£422,129	£238,521	4.77%	**£1,449,449**
Lanarkshire	North Lanarkshire HSCP	£1,147,893	£570,866	£319,858	6.40%	**£2,038,617**
	South Lanarkshire HSCP	£1,120,932	£532,991	£303,896	6.08%	**£1,957,819**
Lothian	East Lothian HSCP	£466,662	£402,230	£97,847	1.96%	**£966,739**
	Edinburgh HSCP	£1,966,868	£753,003	£413,087	8.26%	**£3,132,958**

Funding stream		Local Priorities in line with Preventing Harm, Promoting Recovery	MAT Standards	Residential Rehab	IA NRAC Share 26/27	Total
	Midlothian HSCP	£337,402	Included in East Lothian	£84,146	1.68%	**£421,548**
	West Lothian HSCP	£660,476	£250,000	£156,671	3.13%	**£1,067,147**
	NHS Lothian (Programme management)	-	£132,000	-		**£132,000**
Orkney	Orkney Islands HSCP	£74,852	£45,119	£24,428	0.49%	**£144,399**
Shetland	Shetland Islands HSCP	£151,446	£43,960	£23,851	0.48%	**£219,257**
Tayside	Angus HSCP	£465,687	£194,443	£106,946	2.14%	**£767,076**
	Dundee City HSCP	£730,021	£710,034	£140,235	2.80%	**£1,580,290**
	Perth and Kinross HSCP	£620,008	£247,718	£138,180	2.76%	**£1,005,906**
	NHS Tayside (programme management)	-	£66,000	-		**£66,000**
Western Isles	Western Isles HSCP	£115,312	£60,165	£32,376	0.65%	**£207,853**

Notes

All funding is distributed by NRAC with the exception of MAT Standards (Adjusted NRAC), Stabilisation Fund (based on prevalence of problem drug use) and "Other" Agenda for Change Uplift (allocation based on Health Board returns).

MAT standards funding includes £397k which is distributed direct to Health Boards for Board level project management in Ayrshire and Arran, Greater Glasgow and Clyde, Lothian and Tayside.

Breakdown of funding previously shown separately for Stabilisation Fund and Legacy Agenda for Change

Funding stream		Local Priorities in line with Preventing Harm, Promoting Recovery	Funding previously under: Stabilisation Fund	Funding previously under: "Other" Agenda for Change Uplift	TOTAL: Local Priorities in line with Preventing Harm, Promoting Recovery
Distribution Formula		NRAC	Drug prevalence	Per Health Board returns	-
NHS Board Name	**National 2026/27 allocation**	£15,000,000	£3,000,000	£3,003,887	**£21,003,887**
Ayrshire & Arran	East Ayrshire HSCP	£354,490	£83,698	£45,961	**£484,149**
	North Ayrshire HSCP	£402,988	£83,698	£51,800	**£538,486**
	South Ayrshire HSCP	£334,128	£49,173	£49,816	**£433,117**
	NHS Ayrshire & Arran (programme management)			£3,980	**£3,980**
Borders	Scottish Borders HSCP	£330,692	£26,679	£61,468	**£418,839**
Dumfries & Galloway	Dumfries and Galloway HSCP	£443,587	£57,542	£85,454	**£586,583**
Fife	Fife HSCP	£1,024,982	£146,471	£0	**£1,171,453**
Forth Valley	Clackmannanshire and Stirling HSCP	£391,763	£85,221	£183,902	**£660,886**
	Falkirk HSCP	£429,538	£62,773	£0	**£492,311**
Grampian	Aberdeen City HSCP	£554,347	£125,547	£204,532	**£884,426**
	Aberdeenshire HSCP	£651,674	£62,773	£220,710	**£935,157**
	Moray HSCP	£250,772	£14,124	£87,793	**£352,689**
Greater Glasgow & Clyde	East Dunbartonshire HSCP	£278,980	£37,141	£62,400	**£378,521**
	East Renfrewshire HSCP	£238,401	£41,850	£30,074	**£310,325**
	Glasgow City HSCP	£1,758,247	£622,504	£445,878	**£2,826,629**
	Inverclyde HSCP	£243,435	£78,467	£89,820	**£411,722**
	Renfrewshire HSCP	£517,584	£141,240	£103,834	**£762,658**
	West Dunbartonshire HSCP	£268,500	£57,542	£64,493	**£390,535**
	NHS Greater Glasgow & Clyde (programme management)	£0	£0	£0	**£0**
Highland	Argyll and Bute HSCP	£285,766	£29,294	£0	**£315,060**
	Highland HSCP	£715,563	£73,236	£0	**£788,799**
Lanarkshire	North Lanarkshire HSCP	£959,573	£188,320	£0	**£1,147,893**
	South Lanarkshire HSCP	£911,688	£209,244	£0	**£1,120,932**
Lothian	East Lothian HSCP	£293,542	£48,126	£124,994	**£466,662**
	Edinburgh HSCP	£1,239,260	£313,867	£413,741	**£1,966,868**
	Midlothian HSCP	£252,439	£39,757	£45,206	**£337,402**
	West Lothian HSCP	£470,012	£68,004	£122,460	**£660,476**
	NHS Lothian (Programme management)	£0	£0	£0	**£0**
Orkney	Orkney Islands HSCP	£73,283	£1,569	£0	**£74,852**
Shetland	Shetland Islands HSCP	£71,553	£8,893	£71,000	**£151,446**
Tayside	Angus HSCP	£320,838	£41,849	£103,000	**£465,687**
	Dundee City HSCP	£420,705	£120,316	£189,000	**£730,021**
	Perth and Kinross HSCP	£414,541	£78,467	£127,000	**£620,008**
	NHS Tayside (programme management)	£0	£0	£0	**£0**
Western Isles	Western Isles HSCP	£97,127	£2,615	£15,570	**£115,312**

Appendix 3: Total Funding breakdown by Health Board

Funding stream	NHS Board Baseline Contribution	Local Priorities in line with Preventing Harm, Promoting Recovery	Stabilisation Fund	"Other" Agenda for Change uplift	TOTAL: Local Priorities in line with Preventing Harm, Promoting Recovery	MAT Standards	NRAC Share 26/27	Residential Rehab	Total
Distribution formula	**Amount Baselined**	**NRAC**	**Drug Prevalence**	**Per Health Board returns**		***Refer to ADP letter**		**NRAC**	
National 2026/27 allocation	**£80,512,635**	**£15,000,000**	**£3,000,000**	**£3,003,887**	**£21,003,887**	**£10,313,775**		**£5,000,000**	**£116,830,297**
Ayrshire & Arran	£5,396,992	£1,091,606	£216,569	£151,557	£1,459,732	£872,440	7.28%	£363,869	**£8,093,033**
Borders	£1,641,666	£330,692	£26,679	£61,468	£418,839	£200,154	2.20%	£110,231	**£2,370,890**
Dumfries & Galloway	£2,285,144	£443,587	£57,542	£85,454	£586,583	£269,206	2.96%	£147,862	**£3,288,795**
Fife	£5,250,718	£1,024,982	£146,471	£0	£1,171,453	£613,148	6.83%	£341,661	**£7,376,980**
Forth Valley	£4,066,086	£821,301	£147,994	£183,902	£1,153,197	£490,090	5.48%	£273,767	**£5,983,141**
Grampian	£7,094,812	£1,456,794	£202,444	£513,035	£2,172,273	£1,052,919	9.71%	£485,598	**£10,805,602**
Greater Glasgow & Clyde	£20,689,144	£3,305,147	£978,744	£796,500	£5,080,391	£2,213,989	22.03%	£1,101,716	**£29,085,239**
Highland	£4,486,059	£1,001,329	£102,530	£0	£1,103,859	£593,300	6.68%	£333,776	**£6,516,994**
Lanarkshire	£8,415,583	£1,871,260	£397,564	£0	£2,268,824	£1,103,857	12.48%	£623,753	**£12,412,018**
Lothian	£12,997,872	£2,255,254	£469,754	£706,401	£3,431,409	£1,537,233	15.04%	£751,751	**£18,718,265**
Orkney	£580,424	£73,283	£1,569	£0	£74,852	£45,119	0.49%	£24,428	**£724,823**
Shetland	£617,125	£71,553	£8,893	£71,000	£151,446	£43,960	0.48%	£23,851	**£836,382**
Tayside	£6,273,174	£1,156,084	£240,632	£419,000	£1,815,716	£1,218,195	7.71%	£385,361	**£9,692,447**
Western Isles	£717,835	£97,127	£2,615	£15,570	£115,312	£60,165	0.65%	£32,376	**£925,688**

Notes

All funding is distributed by NRAC with the exception of MAT Standards (Adjusted NRAC), Stabilisation Fund (based on prevalence of problem drug use) and "Other" Agenda for Change Uplift (allocation based on Health Board returns).

Baseline allocation includes 2023/24 recurring allocation for Programme for Government (£17 million),2024/25 PfG Agenda for Change uplift (£2 million) and 3% increase on 2024/25 baseline added to Boards' baseline budgets.

Appendix 4: Local delivery context under Preventing Harm, Promoting Recovery

Preventing Harm, Promoting Recovery

1. For 2026/27 ADPs are being allocated £21.3 million to support delivery of priorities in line with PHPR. ADPs are expected to deliver work that aligns with local needs and supports the four ambitions in PHPR of:
    - Prevention – fewer people develop problem alcohol and drug use
    - Harm reduction – harm is reduced for people who use alcohol and drugs
    - Treatment and care – people receive high-quality treatment and care services
    - Wider circle of support – people have their wider needs supported by joined-up services

2. This funding represents previously ringfenced funding lines that have been pooled.
   It also encompasses legacy Agenda for Change uplift funding.

3. Funding is expected to cover both alcohol and drugs activity. Preventing Harm, Promoting Recovery is a long-term strategy for alcohol and drugs, ensuring the two are treated with equal weight where appropriate.

Prevention in the context of local delivery

4. The renewed focus on prevention and early intervention within PHPR takes a long-term, sustainable outlook, recognising that prevention activity often does not have an immediate influence but a delayed impact from intervention. Within the PHPR we have focused on:
    - Targeting the affordability, attractiveness and availability of alcohol
    - Supporting the healthy development of children and young people
    - Targeted support for at risk communities
    - Early intervention for at risk individuals.

   Prevention activities are not limited to the above and can be informed by outcomes of local needs assessments. This shift to prevention is further outlined in the Population Health Framework (Scotland's Population Health Framework 2025-2035).

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Meeting: **Meeting of Joint Staff Forum**

Date: **Thursday 10 September at 10.00am**

Venue: **Ballantine Meeting Room, Church Street**

Present: Beth Culshaw, (Chair); Karyn Wood; Michelle McAloon; Alex Johnstone, Unite; Ali McCulloch, Unison; Davy Scott GMB; Linda McHaffie; Fiona Taylor; Val Tierney; Joyce Habo (Minutes)

Apologies: Andrew McCready; Moira Wilson; Freya Smith, Unison; Clare Wilson; Sylvia Chatfield; Leanne Galasso; Connor Farmer Unite; Helen Little; Julie Slavin;

Item	Description	Action
1.	**Welcome, Introduction, Apologies**	Chair
2.	**Standing Agenda Items**	
	a) **Minutes of Last Meeting**	Chair
	Agreed as an accurate record of the meeting.	
	b) **Rolling Action List**	Chair
	There was no update re: IJB Vacancy There was no update re: Admin Situation SALA – 2 current attendees provided a report on this training for information, item closed.	
	c) **Chief Officer Update**	BC JS
	Beth advised the last few weeks have been particularly busy, with a significant amount of handover activity now underway. She has met with Caroline Sinclair, and further handover sessions are planned. Each Head of Service has also prepared a handover briefing for Caroline in relation to their respective service areas. Members noted that Caroline will be welcomed to her first Joint Staff Forum meeting in November.	
	Beth also highlighted that the focus of the Audit and Performance Committee and the Integration Joint Board in September had been the CCG and Annual Accounts. The auditors' input was noted, including the positive commentary received and recognition of the strong work taking place across the HSCP. Julie will provide an update at the next Joint Staff Forum in relation to these papers.	
	Beth advised the financial gap currently facing the HSCP remains uncertain, with further clarity expected after Christmas once the budget announcement has been made. Work will continue to identify potential savings in preparation for this.	
	Beth also referred to the national announcements made, including suggestions around social care potentially moving into health. It was noted that the First	

Minister has announced a three-month consultation period. Members acknowledged the implications of this are not yet clear, and there is currently a great deal of discussion and consideration taking place around what the proposals may mean in practice.

Davy advised that the recent announcements had not come as a surprise, particularly in relation to the potential reduction in the size and structure of local authorities, although further detail is still awaited. Linda welcomed the proposals, noting her view is, there are too many senior posts and that duplication across similar roles could be reduced, with resources potentially directed elsewhere. Reference was made to the substantial number of senior posts and associated salary costs within structures.

Davy noted that, if only a small number of roles were reduced, it was unclear what impact this would have. He suggested that a more joined-up model across local authorities may be required, potentially with groupings across different areas, while recognising that city and rural authorities may require different arrangements. Ali noted the consultation will be important in clarifying the proposals and helping to address rumours, which can be damaging. She acknowledged that some local authorities already share services and agreed that any change would need to be carefully managed, with sufficient time and effort. Beth noted that it is still early days and that further information is required.

Davy also expressed the view that HSCPs should sit outside councils and operate more closely within NHS structures, accessing council services where required. Beth highlighted that the HSCP budget is currently split across health and local authority funding. Ali reiterated the importance of the consultation process, noting that organising meaningful engagement and meetings will take time.

It has been stated there would be no legislation plans, however with no legislative changes you cannot do much without that.

Beth referenced IJB membership and voting arrangements, noting there had been changes to voting rights in relation to those members who can and cannot vote. It was highlighted that some members represent specific interests or groups, carers, and locality representatives.

Beth noted that voting rights currently sit with three health members and three councillor members, while HSCP representatives are non-voting members. It was suggested that the current arrangements may provide an opportunity to consider whether voting rights should be extended to a wider range of representatives. Members also noted that, with a Trade Union colleague vacancy, this may be an appropriate time for the matter to be picked up and considered further.

The budget report will go to IJB at the end of September and will note there are cost pressures in some areas, home care, and people services. For the first time there is an underspend in children and families which goes back to the strategy WWIT started by Lesley James.

d) Finance Update

3. HR & OD Update

HR Report(s) MM/LG

Michelle provided an update on HR data. July information was available; however, August data was not yet available. NHS absence showed a further positive reduction, decreasing from 5.71% to 4.73% in August, which was noted as very encouraging and the lowest level recorded in the previous year. Council absence also reduced slightly. The cumulative average from April to date was 6.06% for NHS and 9.52% for Council.

The main reasons for NHS absence were anxiety, stress-related illness, injuries, musculoskeletal issues, gastro-related illness, and other general illness. No detailed Council absence reasons were available, as there was no access to this information. NHS PDP compliance has increased by 4.1%, with thanks noted to managers and staff for their continued efforts to improve completion rates. Addictions have now reached 81%, which is a positive improvement. A survey has been issued to staff and managers to identify any issues, support needs or barriers affecting compliance, with the aim of reaching the 80% target by the end of the year.

NHS statutory and mandatory training continues to perform well, achieving 93% in July against a target of 90%. Fire Safety compliance is particularly strong at 96%, and it was noted that this training is now required every two years. The new Fraud Awareness course is currently at 81%, which was considered positive given it was only introduced earlier this year. Beth noted this was overall positive.

NHS workforce figures showed thirteen new starters and six leavers in July. Council figures showed two new starters and fourteen leavers. Beth highlighted a query in relation to health care and justice, and Michelle agreed to provide further information, which she will request from Leanne.

Michelle also highlighted upcoming line manager training scheduled for 24 September. Michelle will request this information from Leanne and share their workforce update.

Davy highlighted ongoing Council absence levels. Beth acknowledged the need to backfill absences and the associated financial pressures this creates. Discussion focused on how best to communicate the importance of improving absence levels, while also ensuring staff are appropriately supported to return to work, particularly in the context of current financial challenges.

a) OD Update MMc

Michelle shared iMatter information noting there has been a 56% response rate and 58% have uploaded.

In advance of the meeting Moira had forwarded information re: SALA

Civility Saves Lives training is also available.

4. **Combined Updates (Services and TU's)** All

a) **TU/Staff side Update**

There were no updates from TU colleagues.

b) **Head of Service by exception**

Fiona advised there were no updates and a recent JCC meeting did not raise any issues.

5. **Any Other Business** All

Three key elements for Area Partnership Forum

1. Absence Levels continue to improve

2. Stronger Workforce Voice at the IJB

The Joint Staff Forum welcomed recent legislative changes to Integrated Joint Board voting arrangements, which provide greater opportunities for a wider range of members to contribute to decision-making. With a vacancy currently existing for a Council Trade Union representative, now is an ideal time for staff side colleagues to consider becoming involved and helping to represent the workforce voice3. Celebrating a Lasting Contribution

3. The Joint Staff Forum would like to thank Beth Culshaw for her outstanding contribution to West Dunbartonshire HSCP over the past nine years, and for her many years of dedicated service across health and local government. As Beth prepares to retire at the end of September, members also look forward to welcoming Caroline Sinclair as Chief Officer in October.

4. Welcoming New Staff Side Representation

The Joint Staff Forum was pleased to welcome Linda McHaffie to her first JSF as an NHS staff side representative. Members look forward to working with Linda and value the important contribution that staff side colleagues make in representing and supporting the workforce.

6. **Papers for Information**

APF Workforce – Agenda – 12.08.26
APF Workforce – Info Exchange – 12.08.26
APF Workforce – Minutes – 13.05.26

Dates of Future Meetings

19 November 2026