East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce

East Dunbartonshire HSCP

Performance Audit & Risk Committee Meeting

10am, Monday 15 September 2025

Meeting will be hybrid with in person attendance in F33a/F33b, Kirkintilloch Health and Care Centre or virtually via MS Teams

AGENDA

Item	Lead	Description	Update	For Noting/ Approval
		STANDING ITEMS		
1.	C Smith	Welcome and Introductions	**Verbal**	**Noting**
2.	C Smith	Draft Minutes of Last Meeting – 19th June 2025	**Paper**	**Approval**
3.	A McCready	Performance Audit and Risk Committee – Terms of Reference Review	**Paper**	**Approval**
4.	T Reid	Forvis Mazars – the Annual Audit Report for Year Ended 31st March 2024	**Paper**	**Approval**
5.	A McCready	Forvis Mazars – Audit of East Dunbartonshire IJB's Financial Statements for the year ending 31st March 2024	**Verbal**	**Noting**
6.	P Brown	Annual Internal Audit Report 2024/2025	**Paper**	**Approval**
7.	A Craig	HSCP Delivery Plan 2025-26 Update Qtr 1	**Paper**	**Noting**
8.	A McCready	HSCP Corporate Risk Register Update	**Paper**	**Approval**
9.	A McCready	HSCP PAR Agenda Planner	**Paper**	**Noting**
10.	C Smith	AOCB	**Paper**	**Noting**

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Item	Lead	Description	Update	For Noting/ Approval
11.	C Smith	Date of next meeting – 6th November 2025	**Verbal**	**Noting**

Minutes of the East Dunbartonshire HSCP Performance, Audit & Risk Committee.

Date: Thursday 19th June 2025, 13.30pm
Location: Via MS Teams, KHCC Room F26

Present:			
	Libby Cairns	**NHS Non – Executive Board Member (Chair)**	**LC**
	Calum Smith	**EDC Councillor, Depute Leader (Vice Chair)**	**CS**
	Derrick Pearce	**HCSP Chief Officer**	**DP**
	Alison McCready	**HSCP Chief Finance and Resources Officer**	**AM**
	Claire Carthy	**Head of Children's Services and Criminal Justice**	**CC**
	Paul Brown	**Internal Audit and Risk Manager**	**PB**
	Jamie Robertson	**EDC CFO and EO for Finance & Digital Services**	**JR**
	Lesley-Anne McDonald	**NHS Non – Executive Board Member**	**LM**
	Tom Reid	**Manager, Mazars External Auditors**	**TR**
	Aanchal Kumar	**Assistant Manager, Mazars External Auditors**	**AK**
	Vandrew McLean	**Corporate Business Manager**	**VM**
	Andy Craig	**Planning, Performance & Quality Officer**	**AC**
	Charles Vincent	**NHS Non – Executive Board Member**	**CV**
Minutes:	**Siobhan McGinley**	**Corporate PA**	**SM**

Item No.	Topic	Action by
1.	**Welcome and Introductions**	**LC**
	LC opened the meeting, welcoming the Committee Members, there were no declaration of interests raised. Apologies: Cllr Pamela Marshall and Ishana Singh.	
2.	**Minutes of last meeting 30th January 2025**	**LC**
	Minutes of the last PAR Committee meeting on 30.01.25 were reviewed for accuracy. Item Approved.	
3.	**Forvis Mazars – Audit Progress Report for year ending 31st March 2024**	**TR/AM**

	AM advised Members that weekly meetings have been taking place with Forvis Mazars and good relationships established. The audit report is progressing well. Some requested items have been removed which were deemed inapplicable to the HSCP. Implementation of new accounting software within the Council has been the factor identified in holding up the process of obtaining final accounts. TR added remarks relating to outstanding matters in the table, pages 15-17 of pack. Further information has been received from the Council on data migration and remaining issues will be discussed at a meeting arranged with Audit Data specialists and EDC officers next week. A revised version of the accounts was received yesterday following a query on expenditure funding analysis covered in the table on page 16. This is currently being reviewed and a response is awaited. It has been almost one year since the Annual Audit Plan has been shared and given the changes to Committee Membership, it was agreed that this will be circulated to update any new members. The Annual Audit Plan is also published on the Audit Scotland website. **ACTION – AM will circulate the Annual Audit Plan 2023/24 to members.** <u>Comments/questions</u> LM sought assurances on the timescale for provision of the 2023/24 accounts given that other Board areas are currently undertaking work on their 2024/25 accounts. LM asked whether any Audit work had begun on the 2024/25 accounts or must this be held until the conclusion of 2023/24. AM advised that until last year's accounts are finalised, the HSCP are not able to undertake work for 2024/25 accounts, nevertheless preparations are underway, and final accounts for 2023/24 are expected by August. Provision of information from the Board is required to make a start on the 2024/25 accounts. LC queried the section on outstanding items at page 16, regarding wider scope review, and asked whether there is enough information at this point to conclude that part of the audit. TR advised that initial work had been carried out last year which requires refreshed. The information obtained last year will be checked to ensure it is as accurate as possible and reassured the Committee that work is underway. Item Approved.	
4.	**Financial Update for Year Ending 31st March 2025**	**AM**

	AM updated that work on the 2024/25 accounts is progressing well. The Board accounts are complete however, as mentioned, due to issues encountered with migration of the Council ledger, period 11 is only now being concluded, with a view to completing period 12 by September this year. It is anticipated that the unaudited accounts 2024/25 will be tabled at the next Committee meeting in September. Comments/questions LC thanked AM for the update and acknowledged the position regarding the accounts. Item Noted.	
5.	**HSCP Internal Audit Update Report**	**PB**

	PB made introductions, explaining his recent secondment to position of Chief Internal Auditor until November, replacing Gillian McConnachie on a temporary basis. PB explained the report details the Audit work which has been completed since the last Committee met in January this year. PB went on to update the Committee that Gillian McConnachie is working within the Finance department, informed that the proposal for 2025/26 plan is set out in the attached report and gave an update on the audit standards. Two audits have been completed since the last Committee meeting. One of the audits was regarding ASER (self-service technology), the other was roll out of a revised HSCP transport policy. No high risks were identified, only med/low which have been highlighted to management and action plans agreed. Appendix 1 is an extract from the proposal for 2025/26 which had been agreed prior to the new CFRO Alison McCready joining the HSCP but which sets out the planned areas and scope. This document also provides an update on Council reports which may impact on the HSCP. Two NHS audits were undertaken with no concerns or high risks concerning the HSCP. New standards were implemented on 1st April, in relation to the Global Internal Audit Standards. A gap analysis will be undertaken to ensure compliance with the revised standards and plans in place to look at Q3 to address any gaps and formulate an action plan. Any gaps identified and improvement actions will come back to this Committee. <u>Comments/questions</u> LM sought more detail regarding the 3 medium risks in relation to the revised transport policy. It appears that some service users are experiencing difficulty in completing forms and LC is keen there will be a resolution to this in time for the next Committee meeting in September. LM also asked whether obtaining the GIAS gap analysis by the autumn as planned, would be sufficient time to implement Standards in time for the 2025/26 accounts. PB reflected on the underlying theme within the GIAS regarding formalisation standards and which will require amendments to the Internal Audit charter and mandate of Internal Audit. Timing is realistic for documenting an action plan however, PB noted that completion of the gap analysis may take slightly longer. Demonstrating that an action plan is in place, and that a series of improvements are set out should provide sufficient assurance. One final point made by LM was regarding the 2025/26 audit plan. Specifically, how the areas subject to audit are identified and any associated risks involved in the process. PB advised that consultation with the Corporate Risk Register, discussions with Senior Management and horizon scanning for anything which is likely to arise in terms of risk over next 12 months would be looked at in order to identify areas. Additionally, high risks or concerns identified in the past would be considered. Discussions around any Policy developments will be explored with Senior Managers in the audit planning stage. The consideration of performance audits will also influence the plan, the scope of which will remain	

	flexible to take account of areas which require immediate change due to emerging risks. DP advised work is ongoing on issues around the transport policy and any further updates will be presented to the Committee. Item Approved.	
6.	**HSCP Annual Performance Report 2024-2025**	**AC**
	AC explained that the Public Bodies Act places a duty for IJBs to publish this report. This report meets and exceeds minimum requirements, statutory operational duties and quality targets. Sections 2 and 3 reflect how highly the HSCP achieved the strategic priorities and enablers within the strategic plan. Section 6 details the wide range of staff achievements delivered, many of which showcase new and innovative ways of working while supporting those most vulnerable in the community. Data relating to a number of National Performance Indicators have not yet been published by Health Improvement Scotland, the final publication is not expected until the end of July. Annex 3 is missing financial information as previously mentioned at item 3 on the agenda. Recommendations include newly released performance data and financial information before the completed report is submitted to the Scottish Government. The draft with recommendations will be submitted for approval at IJB on 26th June. <u>Comments/questions</u> LC touched on the duty to fulfil requirements and voiced some concern on the missing financial information. Notwithstanding the work which is ongoing, can the Committee be assured that duties are being fulfilled despite the figures being unaccounted for and the lack of clarity around timeline of these figures being produced. AM noted that the information for 2023/24 was unavailable at the time the papers were due to be submitted. This information is now available and will be included in the IJB report. AM assured Members that the required activities are taking place. LM commented on the reduction of formal child protection numbers and extended her praise on early intervention. The first query raised by LM related to the area highlighted in red on page 35, in respect of alcohol brief interventions and asked whether the totals would have been higher if there had been data input from Primary Care. The next query was relating to page 36 and PDS. Now there is a full complement of PDS staff how will the backlog be approached. In response to the first question, DA reflected on the challenges of moving from one system to another within PCMHT which meant some data has not been added therefore the totals are expected to be higher. DP updated with regard to PDS. There had been some fluctuation in performance due to reduced staffing levels within a very small team. More staff have been trained which helps mitigate the long waiting times for initial diagnosis. The service has moved entirely in-house now and is meeting the waiting time initiatives. Item Approved.	

7.	**HSCP Annual Delivery Plan update 2024-2025**	**AC**
	The HSCP Delivery Plan draws together the strategic priorities for the HSCP. This plan was monitored throughout the year with quarterly reports submitted to this Committee. The dashboard in Appendix 1 represents the progress outputs of the 33 transformation projects. At year end 25 were either on track or complete and appendix 2 gives a more detailed account for delays of some of the projects. Comments/questions LC referenced the section *actions planned in the next reporting period*, page 157, relating to the digital strategy and questioned if the transformation programme ongoing at NHSGGC had been considered to be included as an action. DP agreed and noted that AC and AM are collaborating on the digital plan, which will be presented at the next IJB meeting. DP also emphasised consideration of the Council's digital and transformation agenda. Item noted.	
8.	**East Dunbartonshire Justice Social Work Self-Evaluation**	**CC**

	CC provided some background and context around why this self-evaluation was carried out. In the aftermath of the pandemic, it was imperative for Ministers and Community Justice to ensure that the standards within the Justice System were sufficiently high, and that convicted offenders were receiving adequate support to reduce the likelihood of re-offending. In 2021, Social Work Scotland commissioned the Care Inspectorate to carry out the evaluation on Justice services across Scotland. In September 2024, Justice teams undertook the self-evaluation which was rolled out across Scotland. The output of this data demonstrated that Social Work services are committed to driving improvement and impacting positively on the lives of those subject to community payback orders. The methodology of data-gathering across Scotland varied. To promote a more systematic approach, East Dunbartonshire was invited to participate in phase 2 of the self-evaluation. This phase included a validation exercise, involving the Care Inspectorate hosting focus groups with service users and staff. Interviews were held with DP, CC and head of Criminal Justice. Feedback from over 100 pieces of evidence indicated that the self-evaluation was thorough and reflective of a strong understanding of local services. Key strengths were identified, including a consistent strategic alignment across planning documents (referred to as a "golden thread"), robust multi-agency public protection systems, and positive service user feedback. Staff were commended for their clarity on expected standards and praised leadership within the service. <u>Comments/questions</u> LM made reference to Appendix 2, last bullet point of page 7 regarding the development of a Quality Improvement Lead and queried whether the addition of this role is planned. LM praised the objectives met so far. DP advised that the team would be looking to utilise the staff resources within the service to cover the QI work. CC added that funding for our Justice Service comes through another budget. There is no scope currently to create a new post, but due to an expected small underspend, it may be possible to increase some capacity in the short term. LC commented on the national report and wondered what the impact had been on the local team. CC responded that the team felt recognised, validated and found it was a positive exercise. LC stated on behalf on this Committee we recognise and appreciate the great work being done in respect of this area. Item Noted.	
9.	**Children And Young People's Community Mental Health and Wellbeing Framework Annual Report 2024/2025**	**CC**

	On emerging from the pandemic, Sottish Government wanted to prioritise support to the mental health and wellbeing of young people. Each HSCP were given a grant of £270,000 to address any deficits for the provision of this service. The Delivering for Children and Young People's Steering Group (DCYPP), provides the strategic overview for all children's services in East Dunbartonshire and includes representation of our Community Planning Partners who support our children and young people. The grant funding is agreed at DCYPP and through continual evaluation, the group have been able to provide a strong, co-ordinated approach to delivering key aspects of the Communities Mental Health and Wellbeing Support Services Framework. CC highlighted some key points within the report presented today for 2024/25. A Nurture pilot has delivered through school resource, educational psychology, a compassionate response service to support children in crisis, and school counselling has been expanded. Thanks to the grant it helps support children who are care- experienced, those who are being home schooled and who have been impacted by drugs and alcohol. Families' decision-making service in 3rd sector are able to work with families and prevent escalation to Social Work services. Grant funding has been allocated again for this year to continue some of these pilots. <u>Comments/questions</u> DP reflected that the grant funding had allocated due to the success of the fantastic work achieved in previous years. LC thanked CC for the excellent report and in particular how this work has been demonstrated through the compassionate distress response service. One query was whether the individual would be able to re-refer to the service if needed. CC advised that they would as the aim is to prevent escalation onto forensic services. Item noted.	
10.	**John St. Inspection**	**KL**

	KL explained that an inspection of John Street care home by the Care Inspectorate had taken place in March 2025, followed by an unannounced inspection in May 2025. Certain requirements had been requested in March with a timeline of 5th May. Recommendations set out within the report related to improvement of Infection Prevention Control measures, activities programme for residents, Quality Assurance and Audit processes and staffing matrix. The re-inspection increased the grading associated to how well the unit supported service user's wellbeing and upgraded the score with regards to how good the setting is. It is evidenced within the report that IPC practices have improved, staff have participated in training, furniture has been replaced, cleaning practices have notably improved, maintenance regime has improved and better relations between Facilities Management Personnel have been established. A subsequent inspection will be carried out in July 2025. <u>Comments/questions</u> CS queried whether there had been any concerns on the impact, particularly of an unannounced inspection, on the residents within the unit and if so, what is done to mitigate this. KL advised that although the CI are robust with their inspection, only one person had attended within day/working hours to limit the impact on residents. LM queried whether the reduction in grading came as a surprise and what monitoring system is in place to alert any dip in quality. KL shared that the grading had been unexpected and perhaps there had been an element of complacency within the unit. The HSCP is about to begin a review of John Street which will include looking at the quality of care being delivered. Monitoring is taken through the Care Home Collaborative group and Operational Response Group meetings where any concerns are rated Red, Amber or Green (RAG). Internal audits are being carried out and more scrutiny to ensure high standards of care are adhered to. LM then asked what issues had been identified in the inspection in March. KL advised it had been general standard of cleanliness; the building itself is old with dated furniture and fixtures. DP noted there had been a considerable length of time between the last inspection prior to March this year. John Street is a registered care home for adults within EDC. The service review will aid a decision on whether this type of setting offers the right support for the service users or whether it would be better suited to supported accommodation type. Item noted. LC called a short comfort break at 14:37 until 14:45	
11.	**HSCP Corporate Risk Register Update**	**AM**

	AM noted at Appendix 1 is the latest copy of the risk register which is formed from the individual service risk registers updated on a monthly basis. There are currently 22 risks, 21 are live. Four are considered very high, 11 are high, and 6 are rated as medium. <u>Comments/questions</u> LC referenced HSCP04, relating to GDPR, and asked what the difficulty in recruiting to the post had been. In addition, the report mentions consideration of a Social Work post to address review of records. LC asked how likely this to happen. DA advised recruitment has been a long-standing issue and there has been significant challenges to fill the Social Work post. There is no financial solution at the moment. LC queried in relation GDPR compliance and whether the Committee can be assured everything is being done with the resources we do have. DP advised that the balance of risk financially, against Information Governance has been particularly difficult. On reflection it has not, in this case, been appropriate to recruit. CS wondered whether outsourcing was an option, rather than recruiting specifically to this project. DA explained that there are certain timescales which must be adhered to, and the role would require an individual with experience and understanding of Social Work legislation and processes in order to undertake this level work. LC commended the work which went into this extremely comprehensive and detailed report. Item Approved.	
12.	**HSCP Directions Log Update**	**VM**
	VM explained that the Directions Log which, in addition to being presented to this Committee, also goes before the IJB. VM was pleased to update that the 2021/22 all directions are complete. There are 2 outstanding directions from 2023. The Older Peoples Report Strategy will return to IJB in March 2026 as will the Carers Strategy. A total of 15 directions were issued in 2024 of which 6 remain current. An update of the 2025 directions is contained within the report. The Local Advocacy Plan will be reviewed in 2027 and the Learning Disability Strategy will return in 2029. Seven directions have been issued in 2025; 3 current directions remain. <u>Comments/questions</u> LC requested the wording of Item 12 at 2.1 be updated from *Note the content of the Report* to *Approve the content of the report.* VM will amend the wording. Item Approved.	
13.	**HSCP PAR Agenda Planner**	**AM**

	AM asked members to note standing items listed. The only item not listed but referenced earlier is the 2024/25unaudited accounts which will come back to this Committee September. Any other items not covered or which the Committee wish to bring can be communicated to AM. Item noted.	
14.	**AOCB**	**LC**
	DP extended thanks on behalf of the Members to LC for chairing today. The next meeting will be chaired by Councillor Calum Smith.	
15.	**Date of next meeting – between 11th – 18th September 2025**	**LC**

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce
AGENDA ITEM NO: 03.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT AND RISK COMMITTEE

DATE OF MEETING:	**15th SEPTEMBER 2025**
REPORT REFERENCE:	**PERF/150925/03**
CONTACT OFFICER:	**ALISON MCCREADY, CHIEF FINANCE AND RESOURCES OFFICER**
SUBJECT TITLE:	**PERFORMANCE, AUDIT AND RISK COMMITTEE TERMS OF REFERENCE REVIEW**

1.0 PURPOSE

1.1 The purpose of this report is to seek approval for the Revised Terms of Reference for the HSCP Performance Audit and Risk Committee.

2.0 RECOMMENDATIONS

It is recommended that the Performance Audit and Risk Committee:

2.1 Note the content of the Report.

2.2 Approve a revised Terms of Reference for the Performance Audit and Risk Committee – **Appendix 1**.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The Audit Committee was established in December 2015 with an agree Terms of Reference signed off at its second meeting in March 2015.

3.2 In 2018 the remit of the Committee was reviewed and the scope extended to include performance monitoring and oversight including outcome of inspections, risk management arrangements, partnership and service delivery performance and an oversight of the partnership's service redesign programme.

3.3 An updated Terms of Reference was agreed and adopted on 27th June 2018 with the Audit Committee, changing to the Performance Audit and Risk Committee (PAR) for the HSCP.

3.4 The Chartered Institute of Public Finance and Accountancy (CIPFA) recommend a self-assessment of Audit Committees annually. The ED HSCP brought a self-assessment in September 2023 reporting that the self-assessment has concluded that the committee generally conforms with best practice.

3.5 Nonetheless, some areas for improvement were identified as follows:

- The terms of reference of the Performance, Audit and Risk Committee should be reviewed and updated to ensure that they remain fit for purpose.

- As part of the review of the terms of reference, consideration should be given as to whether it would enhance governance arrangements to provide the PAR Committee with rights of access and formal engagement with the HSCP Strategic Planning Group.

3.6 A read across to Glasgow HSCP Audit and Performance Committees/Finance Audit and Scrutiny has shown differences in the type of Committee that has been established with varying Terms of Reference.

3.7 A revised draft Terms of Reference – Appendix 1 is available for review and approval.

4.0 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Strategic Plan 2025-2030 Priorities;-

1. Empowering People
2. Empowering and Connecting Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery

4.2 Frontline Service to Customers – None.

4.3 Workforce (including any significant resource implications) – None.

4.4 Legal Implications – None

4.5 Financial Implications – The Performance Audit and Risk Committee will provide assurance on the internal control environment that support the effective financial performance of the partnership.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None.

4.10 Sustainability – None.

4.11 Other – None.

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 The report addresses the risk of non-compliance against the revised CIPFA recommendations for an effective Audit Committee.

6.0 IMPACT

6.1 **STATUTORY DUTY** – None

6.2 **EAST DUNBARTONSHIRE COUNCIL** – The risks identified in the internal audit reports relevant to East Dunbartonshire Council have been highlighted to the Council's Audit & Risk Management Committee.

6.3 **NHS GREATER GLASGOW & CLYDE** – The risks relevant to the NHS Greater Glasgow & Clyde identified in the internal audit reports have been highlighted to the NHSGGC's Audit & Risk Committee.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction required.

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 **Appendix 1** – East Dunbartonshire HSCP Performance, Audit and Risk Committee Draft Terms of Reference September 2025.

East Dunbartonshire Health & Social Care Partnership

Chief Officer: Mr Derrick Pearce

East Dunbartonshire Health & Social Care Partnership Board

Performance and Audit Committee

Terms of Reference

Review – 15th September 2025

Approved by Audit Committee	**March 2015**
Review & Approved by Audit Committee	**27th June 2018**
Review – Performance Audit and Risk Committee	**15th September 2025**

1. PURPOSE

1.1 East Dunbartonshire Health & Social Care Partnership Board is responsible for the strategic planning and reporting of a range of health and social care services delegated to it by NHS Greater Glasgow & Clyde Health Board and East Dunbartonshire Council (described in full within its approved Integration Scheme). The Health & Social Care Partnership Board is responsible for the operational oversight of East Dunbartonshire Health & Social Care Partnership.

1.2 The Partnership Board is a legal entity in its own right created by Parliamentary Order, following ministerial approval of the Integration Scheme. It is accountable for the stewardship of public funds and is expected to operate under public sector best practice governance arrangements, proportionate to its transactions and responsibilities. Stewardship is a major function of management and, therefore, a responsibility placed upon the appointed members and officers of the Partnership Board.

1.3 The Health & Social Care Partnership Board positively promotes the principles of sound corporate governance within all areas of its affairs. Its Performance Audit and Risk Committee is an essential component of the governance of the Health & Social Care Partnership Board detailed within its Financial Regulations.

1.4 The East Dunbartonshire Health & Social Care Partnership Board has established this Performance Audit and Risk Committee as a Committee of the Partnership Board to support it in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge. These Terms of Reference for the Audit Committee reflect the span of responsibilities of the Partnership Board and requirements of its approved Financial Regulations, i.e.:

- The Strategic Plan.
- Financial plan underpinning the Strategic Plan.
- The operational delivery of those integrated services delegated to the Partnership Board (excluding NHS acute hospital services).
- Relevant issues raised by the internal auditors of the Health Board, Council and the Partnership Board.

2. MEMBERSHIP

2.1 The Performance Audit and Risk Committee will be composed of the six voting members of the Partnership Board, with equal representation from East Dunbartonshire Council and NHS Greater Glasgow and Clyde (3:3), plus two non-voting members

2.2 The Chair and Vice Chair must be a Non-Executive Member of the Board or Elected member. The Performance Audit and Risk Committee will be chaired by the Vice-Chair of the Partnership Board.

2.3 Two members of the Strategic Planning Group (a sub-committee of the Partnership Board) will be co-opted as non-voting members of the Performance Audit and Risk Committee. The provisions in relation to the duration of membership, substitution and removal of membership together with those in relation to the Integration Scheme, Standing Orders, Code of Conduct and Declarations of Interest will be those which apply to the Partnership Board.

2.4 As the Performance Audit and Risk Committee will be responsible for overseeing and providing independent assurance on the adequacy of the risk management framework, the internal control environment and the financial governance arrangements of the Partnership Board, other non-voting members of the Partnership Board shall also have the right to attend. A schedule of meetings will be published for all Partnership Board members, and those non-voting members who confirm their intention to attend the meeting will be issued with papers for that meeting.

2.5 The Chief Financial Officer will nominate an Internal Audit Service, led by a named Chief Internal Auditor, to work on behalf of the Performance Audit and Risk Committee.

2.6 The external auditors for the Partnership Board will be appointed by the Accounts Commission.

2.7 The appointed Chief Internal Auditor will normally attend meetings of the Performance Audit and Risk Committee.

2.8 A representative of the external auditors will normally attend meetings of the Performance Audit and Risk Committee.

2.9 The Chief Officer and Chief Financial Officer of the Health & Social Care Partnership Board will normally attend meetings of the Performance Audit and Risk Committee.

2.10 The Performance Audit and Risk Committee will be provided with a secretariat function by East Dunbartonshire Health & Social Care Partnership.

2.11 Other officers of the Health & Social Care Partnership, East Dunbartonshire Council and NHS Greater Glasgow & Clyde may also be invited to attend meetings as required.

3. REPORTING

3.1 The Performance Audit and Risk Committee will formally provide a copy of its minutes to the Partnership Board for inclusion on the agenda's of its subsequent meetings. These minutes will be made publicly available.

3.2 The Performance Audit and Risk Committee will provide the Partnership Board with an Annual Statement, timed to support finalisation of the accounts and the governance statement, summarising its conclusions from the work it has done during the year.

4. RESPONSIBILITIES

4.1 The Audit Committee will advise the Partnership Board and its Chief Financial Officer on the effectiveness of the overall internal control environment and the performance of the HSCP. Specifically the Committee will be responsible for:-

- The strategic processes for risk, control and governance and the governance statement.
- The financial governance and accounts of the Partnership Board, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors.
- The planned activity and results of both internal and external audit as they relate to the activities of the Partnership Board.
- The adequacy of management response to issues identified by audit activity, including external audit's management letter/report.
- The effectiveness of the internal control environment
- Assurances relating to the corporate governance requirements for the Partnership Board.
- Appointment of the internal audit service or for purchase of non-audit services from contractors who provide audit services.
- The preparation and implementation of the strategy for performance review and monitoring of performance of the HSCP towards achieving its policy objectives and priorities in relation to all functions of the IJB.
- Ensuring the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising service performance against set objectives, levels and standard of service and in line with performance indicators and to receive regular reports on these to review the outcomes and improvement actions.
- Overseeing the delivery of value for money and service quality initiatives
- Review the risk register on an annual basis and the effectiveness of risk management plans which ensure sound governance through the identification, controls and measures to mitigate or eradicate known risks to the partnership.
- Reviewing the implementation of the Strategic Plan through an overview of the partnership's Service redesign Programme.
- Promoting the highest of standards of conduct by board members and monitoring and reviewing the Codes of Conduct maintained by the IJB.
- Having oversight of information governance arrangements and the adherence to legislative requirements.

4.2 The Performance Audit and Risk Committee will also periodically review its own effectiveness, how it has discharged its responsibilities and how it has complied with relevant professional guidance, including CIPFA's Position Statement (Chartered Institute of Public Finance and Accountancy) and report the results of that review to the Partnership Board.

4.3 The Performance Audit and Risk Committee will also be able to meet privately and separately with the external auditor and chief internal auditor if considered appropriate.

5. RIGHTS

5.1 The Chief Financial Officer will be responsible for providing assurance on the system of internal financial control to the Performance Audit and Risk Committee on behalf of the Health Board and Council. In doing this, the Chief Financial Officer will be reliant on both the Health Board's and Council's systems of internal control to support compliance with both organisations' policies and promote achievement of each organisation's aims and objectives, as well as those of the Partnership Board as expressed in its Strategic Plan.

5.2 The Audit Committee receive, scrutinise and comment upon the formal submission of reports, findings and recommendations by the appointed Internal Audit service, external auditor (as appointed by the Accounts Commission), Audit Scotland and Inspectorate bodies. The Performance Audit and Risk Committee will review the HSCP's Risk Register at each meeting. The Chief Financial Officer will ensure that follow-up reports on actions required will be provided to the Audit Committee as agreed.

5.3 The Chief Financial Officer will prepare an Annual Governance Statement for the Performance Audit and Risk Committee prior to its being presented to the Partnership Board.

5.4 The Chief Internal Auditor for the Partnership Board will report to the Chief Financial Officer and the Performance Audit and Risk Committee on an annual risk-based audit plan in respect of the activities of the Partnership Board; delivery of the plan and recommendations; and will provide an annual internal audit report, including the audit opinion.

5.5 The Performance Audit and Risk Committee may procure specialist ad-hoc advice at the expense of the Partnership Board, subject to budgets agreed by the Chief Financial Officer and confirmed by the Partnership Board.

5.6 The appointed Chief Internal Auditor and the representative of External Audit (as appointed by the Accounts Commission) will have free and confidential access to the Chair of the Performance Audit and Risk Committee.

6. MEETINGS

6.1 The procedures for meetings are that:

6.1.1 The Performance Audit and Risk Committee will meet as required throughout the year, with a provision for special meetings if required, at the discretion of the Chair of the Audit Committee; and with meetings scheduled at regular intervals between the meetings of the Partnership Board. The Committee reserves the right to hold private meetings with the Internal and External Auditors.

6.1.2 The meetings will be conducted in accordance with the Standing Orders of the Partnership Board, including:

- At least one half (i.e. three) of the six members of the Performance Audit and Risk Committee will be present for the meeting to be deemed quorate.
- Members of the Performance Audit and Risk Committee must disclose any direct or indirect pecuniary or other interest in relation to an item of business to be transacted at a meeting of the Audit Committee, before taking part in any discussion on that item. Where an interest is disclosed, the other members present at the meeting in question shall decide

whether the member declaring the interest is to be prohibited from taking part in discussion of, or voting on, the item of business.

6.1.3 The Performance Audit and Risk Committee meetings will normally be attended by the Chief Officer, the Chief Financial Officer, appointed Chief Internal Auditor and a representative of the External Auditor.

6.1.4 The Performance Audit and Risk Committee may ask any other officers from the Health & Social Care Partnership, East Dunbartonshire Council and NHS Greater Glasgow & Clyde to attend to assist it with its discussions on any particular matter.

6.1.5 The Performance Audit and Risk Committee may by resolution at any meeting exclude the press and public there from during consideration of an item of business where it is likely in view of the nature of the business to be transacted or of the nature of proceedings that if members of the press and public were present there would be a disclosure to them of exempt information as defined in Schedule 7A to the Local Government (Scotland) Act 1973 or it is likely that confidential information would be disclosed in breach of an obligation of confidence. The Performance Audit and Risk Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6.1.6 The Partnership Board or the Chief Financial Officer may ask the Performance Audit and Risk Committee to convene further meetings to discuss particular issues on which they want the Performance Audit and Risk Committee's advice.

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce
AGENDA ITEM NO: 04.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**15th SEPTEMBER 2025**
REPORT REFERENCE:	**PERF/150925/04**
CONTACT OFFICER:	**ALI MCCREADY, CHIEF FINANCE & RESOURCES OFFICER**
SUBJECT TITLE:	**FORVIS MAZARS – ANNUAL AUDIT REPORT FOR YEAR ENDED 31ST MARCH 2024**

1.0 PURPOSE

1.1 The purpose of this report is to update the committee on Forvis Mazars Annual Audit Report for East Dunbartonshire IJB for the year ending 31st March 2024.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.1 Note and agree the content of the Annual Audit Progress Report for the IJB.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The Annual Audit Report (AAR) provides the Performance Audit and Risk Committee with a summary of audit conclusions and findings from considerations of the wider scope audit specified in the Code of Audit Practice 2021 namely, financial management; financial sustainability; vision, leadership and governance; and use of resources to improve outcomes.

3.2 The AAR notes the status of the 23/24 audit as substantially complete with final completion contingent on reconciliation of East Dunbartonshire Council's data migration to financial reporting system Oracle Fusion and completion of associated quality and compliance checks which currently remain outstanding. There are no known matters outstanding that would give cause to change the audit opinion noted.

3.3 Forvis Mazars continue to meet regularly with the Chief Finance and Resources Officer and her team and will continue to do so as the above noted activities outstanding progress.

3.4 A copy of the Annual Audit Report to 31st March 2024 is included as **(Appendix 1).**

3.5 No risks were identified in the 23/24 AAR. A few recommendations were made to which management response has been detailed on the report.

4.0 IMPLICATIONS

The implications for the Committee are as undernoted.

4.1 Relevance to HSCP Strategic Plan 2025-2030 Priorities;-

1. Empowering People
2. Empowering and Connecting Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery

The annual audit plan sets out the arrangements for review of areas related to financial governance, management, sustainability and assurance on value for money across the HSCP financial landscape. This ensures the partnership delivers on these key aspects which in turn supports the continued delivery of priorities set out within the strategic plan.

4.2 Frontline Service to Customers – None

4.3 Workforce (including any significant resource implications) – None

4.4 Legal Implications – None

4.5 Financial Implications – The Annual audit progress plan provides an update on the ongoing review of the financial performance of the IJB for 2023/24 through a review and opinion on the annual accounts for the partnership and considers the wider audit dimensions that frame the scope of public sector audit requirements including financial management arrangements, financial sustainability, governance and transparency and value for money.

4.6 Procurement – None

4.7 ICT - None

4.8 Economic Impact – None

4.9 Sustainability – None

4.10 Equalities Implications – None

4.11 Other – None

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 The report sets out the significant risks for the IJB.

6.0 IMPACT

6.1 **STATUTORY DUTY** – Forvis Mazars are the externally appointed auditors for the IJB. The scope of engagement is set out in the Code of Audit Practice, issued by the Auditor General and the Accounts Commission available from the Audit Scotland website: Code of audit practice | Audit Scotland (audit-scotland.gov.uk). The responsibilities are principally derived from the Local Government (Scotland) Act 1973 (the 1973 Act) and the Code of Audit Practice.

6.2 **EAST DUNBARTONSHIRE COUNCIL** - None

6.3 **NHS GREATER GLASGOW & CLYDE** - None

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 **Appendix 1** – Forvis Mazars Annual Audit Report for the year ending 31 March 2024 as at September 2025.

Annual Audit Report

East Dunbartonshire Integration Joint Board – year ended 31 March 2024

September 2025

forvis mazars

Performance, Audit and Risk Committee

East Dunbartonshire Integration Joint Board

10 Saramago Street

Kirkintilloch

G66 3BF

5 September 2025

Forvis Mazars

100 Queen Street

Glasgow
G1 3DN

Dear Committee Members and Controller of Audit,

Annual Audit Report – Year ended 31 March 2024

We are pleased to present our Annual Audit Report for the year ended 31 March 2024. The purpose of this document is to summarise our audit conclusions and findings from our considerations of the wider scope audit specified in the Code of Audit Practice 2021 namely, financial management; financial sustainability; vision, leadership and governance; and use of resources to improve outcomes.

The scope of our work, including identified significant audit risks, and other key judgement areas, was outlined in our Annual Audit Plan, which we presented to you on 11 June 2024.

We have reviewed our Annual Audit Plan and concluded that the significant audit risks and other key judgement areas set out in that report remain appropriate.

We would like to express our thanks for the assistance of your team during our audit.

If you would like to discuss any matters in more detail, then please do not hesitate to contact me on 07816354994 or via tom.reid@mazars.co.uk.

Yours faithfully

Tom Reid (Audit Director)

Forvis Mazars LLP

Contents

Our reports are prepared in accordance with Terms of Appointment Letter from Audit Scotland dated 18 May 2022 through which the Accounts Commission has appointed us as external auditor of East Dunbartonshire Integration Joint Board (the IJB) for financial years 2022/23 to 2026/27. We undertake our audit in accordance with Part VII of the Local Government (Scotland) Act 1973, as amended; and our responsibilities as set out within Audit Scotland's Code of Audit Practice 2021.
Reports and letters prepared by appointed auditors and addressed to the IJB are prepared for the sole use of the IJB and made available to Audit Scotland and the Accounts Commission, the Controller of Audit. We take no responsibility to any member or officer in their individual capacity or to any other third party.

01

Executive Summary

Executive summary

Audit conclusions and significant findings

The detailed scope of our work as your appointed auditor for 2023/24 is set out in Audit Scotland's Code of Audit Practice 2021. Our responsibilities and powers are derived from Part VII of the Local Government (Scotland) Act 1973 and as outlined in our Annual Audit Plan, our audit has been conducted in accordance with International Standards on Auditing (UK) and means we focus on audit risks that we have assessed as resulting in a higher risk of material misstatement.

In section 4 of this report, we have set out our conclusions and significant findings from our audit. This section includes our conclusions on the audit risks and areas of management judgement in our Annual Audit Plan, which include:

- Management override of controls.

Misstatements and internal control recommendations

Section 5 sets out internal control recommendations and section 6 sets out audit misstatements. Section 7 outlines our work on the IJB's arrangements to achieve economy, efficiency and effectiveness in its use of resources.

Status and audit opinion

At the time of preparing this report, some matters remain outstanding as outlined in section 2.
We will provide an update to you in relation to the matters outstanding through issuance of the final Annual Audit Report
We have the following conclusions:

Audit opinion
We expect to issue an unqualified opinion, without modification, on the financial statements. Our proposed audit opinion is included in the draft auditor's report in Appendix B.

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

forvis mazars

Executive summary (continued)

Conclusions from our audit testing and audit opinion (continued)

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

Management Commentary and Annual Governance Statement
We are required to report on whether the information given in the Management Commentary and Annual Governance Statement is consistent with the financial statements; and has been properly prepared in accordance with the statutory guidance issued under the Local Government in Scotland Act 2003 and Delivering Good Governance in Local Government Framework 2016.
We have no matters to report in respect of the Management Commentary and Annual Governance Statement.

Wider powers
Section 101 of the Local Government (Scotland) Act 1973 requires us to give any person interested, the opportunity to question us about the accounting records of the IJB and to consider any objection made to the accounts. We confirm that no such correspondence has been received.

Executive summary (continued)

Best Value and Wider Scope conclusions

As auditors appointed by the Accounts Commission, our wider scope responsibilities are set out in Audit Scotland's Code of Audit Practice 2021 and sits alongside Best Value requirements detailed the Local Government (Scotland) Act 1973. The Code requirements broaden the scope of the 2023/24 audit and allows us to use a risk-based approach to report on our consideration of the IJB's performance of best value and community planning duties and make recommendations for improvement and, where appropriate, conclude on the IJB's performance.

The Code's wider scope framework is categorised into four areas:

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

It remains the responsibility of the IJB to ensure proper financial stewardship of public funds, it complies with relevant legislation and establishes effective governance of their activities. The IJB is also responsible for ensuring that it establishes arrangements to secure continuous improvement in performance and, in making those arrangements, ensures resources are being used to improve strategic outcomes and demonstrate the economy, efficiency, and effectiveness throughout the use of its resources. These arrangements should be proportionate to the size and type of the IJB, appropriate to the nature of the IJB and the services and functions that it has been created to deliver.

Wider Scope

We anticipate having no risks in arrangements to report in relation to the financial management; financial sustainability; vision, leadership and governance; and use of resources to improve outcomes arrangements that the IJB has in place.

Further detail on our Wider Scope work is provided in section 7 of this report including any significant risks identified.

Best Value

We anticipate having no risks in arrangements to report in relation to the arrangements that the IJB has in place to secure economy, efficiency and effectiveness in its use of resources.

Further detail on our Best Value work is provided in section 8 of this report including any significant risks identified.

02

Status of the audit

Status of our audit

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

Audit area	Status	Description of the outstanding matters
Data migration and journal completeness	Medium	This relates to our review of data migration between the previous and new financial reporting systems and the completeness of journals posted on the system. The IJB's annual accounts are based on information from East Dunbartonshire Council's financial reporting system. The Council transitioned to a new financial reporting system (Oracle Fusion) during 2023/24. We are required to obtain assurance over the completeness and accuracy of the data migrated from the old system to the new system. We engaged our specialist Data Analytics team to assist us with this work, and they are working closely with the Council's finance team. At the time of reporting Council officers have not provided all the information required to complete this work.
Audit review and quality control	Medium	Our audit work is undergoing final stages of review by the Engagement Lead and Engagement Manager and further quality and compliance checks. In addition, there are residual procedures to complete, including updating post balance sheet event considerations to the point of issuing the opinion, obtaining final management representations and agreeing adjustments to the final set of accounts.
Annual report and accounts and letter of representation	Low	We will complete our final review of the annual report and accounts upon receipt of the signed version of the accounts and letter of representation.

Status

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

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

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

03

Audit Approach

Audit Approach

Changes to our audit approach

There have been no changes to the audit approach we communicated in our Annual Audit Plan, issued on 11 June 2024.

Materiality

Our provisional materiality at the planning stage of the audit was set at £4,700k using a benchmark of 2% of gross expenditure. Our Performance materiality was set at £3,200k and clearly trivial threshold was set at £138k.

Based on the final financial statement figures and other qualitative factors, the final overall materiality we applied was £5,815k, final performance materiality: £4,070k and final clearly trivial threshold: £174k.

04

Significant findings

Significant findings

Significant findings, including key areas of management judgement

The significant findings from our audit include:

- our audit conclusions regarding significant risks and key areas of management judgement outlined in the Annual Audit Plan;
- our comments in respect of the accounting policies and disclosures that you have adopted in the financial statements. On page 15 we have concluded whether the financial statements have been prepared in accordance with the financial reporting framework and commented on any significant accounting policy changes that have been made during the year;
- any further significant matters discussed with management;
- any significant difficulties we experienced during the audit.

Significant findings

Management override of controls

Description of the risk

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

How we addressed this risk

We addressed this risk by:

- reviewing the key areas within the financial statements where management has used judgement and estimation techniques and consider whether there is evidence of unfair bias;
- examining any accounting policies that vary from The Code of practice on Local Authority in the United Kingdom (the Code);
- testing the appropriateness of journal entries recorded in the general ledger and other adjustments made in preparing the financial statements; and
- considering and testing any significant transactions outside the normal course of business or otherwise unusual.

Audit conclusion

Except for the work highlighted in section 2 of this report, our work in this area is substantially complete. Based on the results of testing to date, we have no significant issues arising to report.

Significant findings (continued)

Qualitative aspects of the IJB's accounting practices

We have reviewed the IJB's accounting policies and disclosures and concluded they comply with the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom 2023/24, as amended by the Update to the Code and Specifications for Future Codes for Infrastructure Assets, published in November 2022, appropriately tailored to the IJB's circumstances.

Draft accounts were received from the IJB on 4 February 2025 and were of a good quality.

Significant matters discussed with management

During our audit we communicated the following matters to management:

Comprehensive Income and Expenditure Statement and Expenditure and Funding Analysis presentation :- During the audit, we held several discussions with management regarding the presentation of the Comprehensive Income and Expenditure Statement (CIES) and the Expenditure and Funding Analysis (EFA). Our queries focused on ensuring compliance with the CIPFA Code of Practice on Local Authority Accounting 2023/24 and whether the headings accurately reflect the IJB's functions. For example, the EFA included headings such as "Employee Costs" and "Property Costs," despite the IJB not directly employing staff or holding non-current assets on its Balance Sheet.

We highlighted that, under the Code, an EFA is only required where there are statutory adjustments between the General Fund and the CIES. If no such differences exist, the authority should disclose why an EFA is not presented. We also discussed whether the CIES service headings could be consolidated to better reflect the nature of transactions with NHS Greater Glasgow and Clyde and East Dunbartonshire Council.

Following these discussions, management retained the existing CIES format but added a clarifying note. The EFA was renamed the "Expenditure and Income Analysis" and included a footnote to provide transparency on how funding is spent. Management confirmed this is a subjective analysis for context rather than a statutory requirement.

Significant difficulties during the audit

During the course of the audit, we did not encounter any significant difficulties, and we have had the full co-operation of management.

Significant findings (continued)

Wider responsibilities – statutory reporting

The 1973 Act allows any persons interested to inspect the accounts to be audited and the underlying accounting records of the IJB. The act also allows any persons interested to object to the accounts.

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

- Section 102(1) of the 1973 Act allows us to prepare a report to the Commission about the IJB's accounts; matters that have arisen during the audit that should be brought to the attention of the public; or the performance of the IJB in their duties relating to Best Value and community planning.
- Section 102(3) of the 1973 Act allows us to make a special report to the Commission if an item of account is contrary to law; there has been a failure on someone's part to bring into account a sum which ought to have been brought into account; a loss has been incurred or deficiency caused by the negligence or misconduct of a person, or by the failure of a body to carry out a duty imposed on them by any enactment; or a sum which ought to have been credited or debited to one account of a body has been credited or debited to another account and the body has not taken, or is not taking, steps to remedy the matter.
- Section 97A of the 1973 Act allows us to undertake or promote comparative and other studies to make and publish recommendations for the securing by local government bodies of Best Value, improving economy, efficiency and effectiveness in the provision of services by local government bodies and improving the financial or other management of local government bodies.

We confirm that a statutory report is not required.

05

Internal control conclusions

Internal control conclusions

Overview of engagement

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

Deficiencies in internal control

A deficiency in internal control exists if:

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

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

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

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

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

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

Significant deficiencies in internal control

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

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

Other observations

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

Internal control conclusions (continued)

Other observations (continued)

We do not have any other internal control observations to bring to your attention as at the date of this report.

Whether internal control observations merit attention by the Performance, Audit and Risk Committee and/ or management is a matter of professional judgment, taking into account the risk of misstatement that may arise in the financial statements as a result of those observations.

Internal control conclusions (continued)

Follow up on previous internal control points

We set out below an update on internal control points raised in the prior year.

Description of deficiency

Related parties' transactions – Register of Interest

Officers could not provide declaration of interest forms for several non-voting Board members and senior officers.

Several of the declaration forms completed by Board members did not have physical or electronic signatures and instead the individual's name had been typed into the Word documents.

Potential effects

Failure to update the register of interest may result in conflicts of interest going undisclosed leading to incorrect or incomplete disclosure of related party transactions.

There is a risk that the register of interest could be manipulated in the absence of formal signatures.

Recommendation

The IJB should establish robust procedures for disclosure of related party interests and ensure the register is regularly updated for all relevant individuals.

23/24 update

Complete. Officers have implemented processes to ensure the completeness of returns and their publication on the Health and Social Care Partnership website. All declaration of interest forms for 2023/24 were received.

Internal control conclusions (continued)

Follow up on previous internal control points

We set out below an update on internal control points raised in the prior year.

Description of deficiency

Compliance with Local Authority Accounts (Scotland) Regulations 2014

The unaudited annual accounts do not comply with the Local Authority Accounts (Scotland) Regulations 2014

Potential effects

There is a risk that there will be non-compliance in the current year.

Recommendation

The IJB should ensure it has procedures in place to ensure that the unaudited annual accounts comply with the requirements of the Local Authority Accounts (Scotland) Regulations 2014.

23/24 update

Ongoing. The annual accounts were not submitted to the auditor by the statutory deadline of 30 June due to delays in the IJB receiving the financial reporting information required to prepare them. The IJB needs to ensure appropriate procedures are in place to achieve compliance in future years.

06

Summary of misstatements

Summary of misstatements

We set out below and on the following pages a summary of the misstatements we identified during our audit, above the trivial threshold for adjustment of £174k.

We identified no misstatements, adjusted or unadjusted, above our reporting threshold as at the date of this report.

Our overall materiality, performance materiality, and clearly trivial (reporting) threshold were reported in our Annual Audit Plan, issued on 11 June 2024. The subsequent changes to those figures are set out in the section 3 of this report.

Summary of misstatements (continued)

Disclosure misstatements

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

Remuneration Report:- Amendments were made to address narrative and presentation inconsistencies identified in the remuneration report relating to unclear wording, ambiguous dating of senior roles, and unexplained references in pension disclosures.

Management Commentary:- Minor presentation and narrative inconsistencies identified, including diagram presentation issues, hyperlink issues, and formatting errors. We also recommended updates to improve clarity and reader understanding.

Comprehensive Income and Expenditure Statement and Expenditure and Funding Analysis:- Additional disclosure included to better reflect the nature of the IJB's transactions with the Health Board and Council.

Usable Reserve General Fund:- Inclusion of description of the purpose and nature of material earmarked reserves as required by the Code.

07

Wider scope

Commentary on Wider Scope

Overall Summary

Commentary on Wider Scope

Wider scope summary

As auditors appointed by the Accounts Commission, our wider scope responsibilities are set out in the Code of Audit Practice 2021 and sits alongside Best Value requirements detailed in the Local Government (Scotland) Act 1973. The Code requirements broaden the scope of the 2023/24 audit and allow us to use a risk-based approach to report on our consideration of the IJB's performance of best value and community planning duties and make recommendations for improvement and, where appropriate, conclude on the IJB's performance.

The Code's wider scope framework is categorised into four areas:

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

Overall summary by reporting criteria

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

Reporting criteria	Commentary page reference	Identified risks?	Actual risks identified?	Other recommendations made?
Financial management	28	No	No	Yes – see commentary on page 31
Financial sustainability	32	No	No	Yes – see commentary on page 34
Vision, leadership and governance	35	No	No	Yes – see commentary on page 39 and 40
Use of resources to improve outcomes	40	No	No	No

Commentary on Wider Scope

Financial management

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

Financial management (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Risks identified
Financial management culture	The IJB does not have any non current assets, nor does it directly incur expenditure or employ staff. All funding and expenditure for the IJB is incurred by partner bodies and processed in their accounting records. The IJB's finance team works closely with NHS and Council finance colleagues to identify and properly record its income and expenditure. The management within the IJB maintain good communication and coordinate effectively with both NHS and Council partners. There is a culture of ensuring financial regulations are monitored and adhered to. The Performance, Audit and Risk Committee receives update reports on internal audit work carried out in both partner organisations, East Dunbartonshire Council and NHS Greater Glasgow and Clyde. An annual internal control checklist is prepared by senior management and requires Chief Officer sign off on the effectiveness of internal controls during each financial year.	The IJB has appropriate and effective financial management in place. There are sufficient financial skills, capacity and capability in the IJB.	No significant issues identified
Accountability	The 2023/24 budget was approved by the IJB Board in March 2023. While resources allocated to the IJB are expected to increase, the impact of inflation and rising demand for services meant the IJB could not achieve a balanced budget without the use of reserves. To address this, a savings programme of £3.894m was agreed, focusing on efficiencies, service redesign, and transformation. The IJB regularly reported financial performance to the Board during 2023/24, with budget monitoring reports up to Month 10 clearly outlining the in-year position and projected year-end outturn. However, there was no separate financial performance report presented to the Board at year-end (Month 12) reflecting the revised budget and actual outturn. This was primarily due to delays in finalising the 2023/24 accounts and the IJB not receiving final budget information from East Dunbartonshire Council in time to report it during 2024. The final budget position was instead incorporated into the unaudited annual accounts, which were subsequently presented to the Board in March 2025.	Regular in-year financial reporting was in place; however, the absence of a final year-end reporting limits transparency. Reliance on reserves and under-achievement of savings remain key risks to financial sustainability.	No significant issues identified. See page 31 for further information and our recommendation made to the IJB.

Financial management (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Risks identified
Accountability (continued)	The final outturn for 2023/24 reported an underspend of £2.344m against total resources of £268.269m. After adjusting for in-year reserve movements, this represents an underlying negative variance of £0.123m. The underspend has been retained within the general reserve, increasing the overall reserves position from £20.062m at 31 March 2023 to £22.406m at 31 March 2024.		
Arrangements to prevent and detect fraud, error and other irregularities, bribery and corruption	The IJB does not maintain its own policies relating to the prevention and detection of fraud and error but instead depends on those in place at its partner bodies. A whistleblowing policy is in place within each partner agency to cover their respective staff groups and is signposted on the IJB's website. The IJB also has a Code of Conduct for members and the Members' Registers of Interests are publicly available on the IJB's website.	The IJB depends on the established procedures of its partner bodies for preventing and detecting any breaches of standards including any instances of corruption.	No significant issues identified.

Financial management (continued)

Identified risks in financial management arrangements and recommendations for improvement

Sno	Financial management risks identified	Recommendation for improvement	IJB's response and implementation timescale
1	**Financial Performance Reporting and Oversight – Level 2** The IJB regularly reported financial performance to the Board during 2023/24, with budget monitoring reports up to Month 10 clearly outlining the in-year position and projected year-end outturn. However, there was no separate financial performance report presented to the Board at year-end (Month 12) reflecting the revised budget and actual outturn. This was primarily due to delays in finalising the 2023/24 accounts and the IJB not receiving final budget information from East Dunbartonshire Council in time to report it during 2024. The final budget position was instead incorporated into the unaudited annual accounts, which were subsequently presented to the Board in March 2025.	The IJB should ensure that a final year-end financial performance report, including the revised budget and actual outturn, is presented to the Board to provide full transparency and enable effective scrutiny. Where delays in receiving final financial information from the partner bodies occur, the IJB should communicate this to the Board in a timely manner. Where year-end financial performance reporting cannot be provided in the usual format, the IJB should consider alternative approaches such as interim updates or explanatory notes to maintain transparency and support effective scrutiny.	**Management's response** The final financial out turn for 23/24 went to IJB on 20th March 2025 in the form of the standard Unaudited Accounts Pack. There was no updated financial performance reporting pack produced to reflect the same as it was considered sufficient to issue members with the Unaudited Accounts Pack. The Chief Finance and Resources Officer post was also vacant at the time the final financial information for 23/24 from EDC became available, which presented a resource constraint. The production of the Unaudited Accounts Pack was prioritised in order to avoid any further delay in supplying auditors with the information required in order to commence the 23/24 annual audit. It is however acknowledged that good practice would be to produce a final financial performance reporting pack for the year which reflects the closing financial out turn for completeness. **Responsible officer** Alison McCready, Chief Finance and Resources Officer **Implementation date** 26 June 2025

Commentary on Wider Scope

Financial sustainability

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

Financial sustainability (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Risks identified
Financial planning	In March 2024, the Board approved its updated Medium-Term Financial Strategy (MTFS) covering the period 2023–2028. This strategy outlines the financial outlook and provides a framework to support sustainability. The strategy highlights significant cost pressures, with funding levels not meeting demand, requiring transformation and service redesign. The IJB is forecasting a financial gap of £48.2m over the next five years which is expected to extend to £94.3m over the next ten years. Based on projected income and expenditure figures the IJB will need to achieve savings of between £7.6 m and £12.7m each year from financial year 2024/25 onwards. The financial outlook remains uncertain, particularly in the longer term, due to potential changes in the operating environment. This reinforces the need for proactive financial planning, robust governance, and continued innovation in service delivery to ensure the sustainability of health and social care services.	The IJB's financial strategy identifies significant cost pressures and funding gaps. While the MTFS provides a structured approach, the scale of the challenge has increased substantially. The reliance on reserves to balance the 2024/25 budget highlights the need for recurring savings and transformational change.	See page 34 for our prior year recommendation made to the IJB.

Financial sustainability (continued)

Follow up of previously-reported recommendations

In October 2023 we reported one recommendation to the IJB to address risks identified from our Wider Scope audit for financial sustainability. As part of our work in 2023/24, we followed up the progress made by the IJB against the recommendations made and determined whether the risk remained during the year.

	Financial sustainability finding as previously reported	Management response and implementation timeframe	Work undertaken and judgements made in 2023/24	Conclusions r.eached
1	**Savings and transformation plans – Level 3** The IJB should develop a clear plan for identifying the programme of savings, transformation and service redesign, needed to meet its financial challenges in upcoming years.	**Management Response :** The scale of the financial challenge is significant and depends on annual financial settlements from SG which makes future financial planning difficult. The HSCP will continue to work to identify transformation and service redesign programmes with a medium / longer term focus in support of delivering a balanced budget. **Responsible officer**: Chief Finance and Resources Officer / HSCP SMT **Implementation date**: 31 March 2025 (updated annually)	**Progress against the recommendation** We reviewed the updated Medium-Term Financial Strategy (2023–2028), which now forecasts a financial gap of £48.2m over five years. The IJB has established a Financial Sustainability Group and identified savings plans totalling £6.408m for 2024/25, with £5.284m of reserves used to balance the budget. The IJB's medium to long-term financial plan projects significant budget gaps in future years. In common with most public sector organisations, the IJB faces significant financial challenges, including inflation and pay awards exceeding funding allocations. In addition, the IJB faces several specific issues, including the requirement to fund current service overspending, the reduction in the formula allocation of NHS funding and on-going challenges in identifying and delivering savings which do not have adverse impacts on service delivery. The impact of these challenges means that the IJB's longer term financial sustainability remains at risk	**Conclusions** Ongoing. The IJB has made progress in identifying savings, however further action is required to identify and deliver recurring savings and ensure long-term financial sustainability.

Commentary on Wider Scope

Vision, leadership and governance

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

Vision, leadership and governance

Our overall assessment

Area assessed	Our findings	Our judgements	Risks identified
Clarity of plans to implement the vision	The IJB continues to operate under its Strategic Plan 2022–2025, which guides service delivery. The IJB's strategic plan is supported by a delivery plan which details the actions it will take over the next three years to achieve its strategic outcomes. The delivery plan provides details of the work programme and projects relating to each of its priorities. The HSCP Annual Delivery Plans for 2023/24 and 2024/25 have provided a structured and forward-looking framework to implement the IJB's Strategic Plan. Both plans clearly set out the operational priorities aligned with national and local strategies, including the NHS Moving Forward Together programme and the East Dunbartonshire Local Outcome Improvement Plan. In 2023/24, the delivery plan focused on addressing immediate financial pressures through targeted savings and transformation initiatives. The 2024/25 plan builds on this by continuing to drive service redesign and efficiency, while integrating new statutory and policy requirements. Progress is reported quarterly to the Board and annually through the Performance Report.	The IJB continues to demonstrate a clear and consistent strategic vision, supported by structured planning and performance reporting.	No significant issues identified.
Strategy and priorities	The HSCP Strategic Plan 2022–2025 sets out how the Partnership will contribute to achieving the National Health and Wellbeing Outcomes, reflecting on past progress and defining priorities for the next three years. Developed in the context of significant challenges including financial pressures, rising demand for complex care, and the lasting impact of COVID-19 the plan aims to create a fair, sustainable, and modern system of care. Its core focus is on early intervention and prevention, empowering communities through informal support networks, and improving access to timely information so people can receive the right support at the right time.	The IJB has clear strategic priorities and a robust annual planning process.	No significant issues identified.

Vision, leadership and governance (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Risks identified
	Delivery is supported by an Annual Delivery Plan, operational workstreams, and financial frameworks, with strong alignment to the Local Outcome Improvement Plan. While some redesign initiatives will extend beyond 2025, the plan emphasizes efficiency, sustainability, and adaptability to meet future demographic and environmental challenges, including climate change.		
Governance arrangements	The Board continues to comprise six voting members – three non-executive directors from NHS Greater Glasgow and Clyde and three councillors from East Dunbartonshire Council. The Board is the IJB's key decision-making body. The Board is supported by a range of committees and management groups, including the Performance, Audit and Risk (PAR) Committee, Senior Management Team, Strategic Planning Group, Locality Planning Group, and Clinical and Care Governance Committee. The PAR Committee plays a key role in providing assurance over risk management, internal control, performance, and governance. Board and PAR papers are publicly accessible on the IJB's website, and we observed a good level of scrutiny and challenge during meetings. The IJB's Performance, Audit & Risk Committee has not been meeting on a regular basis. The Committee met only twice in 2024 (March and June) and, to date, twice in 2025. Meetings have been arranged on an ad hoc basis without an agreed schedule, creating a governance risk by reducing the timeliness of oversight, scrutiny and assurance. In addition, at the time of our review, a signed version of the Integration Scheme between East Dunbartonshire Council and NHS Greater Glasgow and Clyde was not available. The Integration Scheme is a key governance document that sets out the arrangements for planning, delivering, and monitoring health and social care integration within the local partnership area. The absence of a formally signed copy presents a governance risk, as it may impact clarity of roles, responsibilities, and accountability of the parties involved.	While the IJB demonstrates effective scrutiny and challenge, the absence of a formal meeting schedule for the Performance, Audit & Risk Committee represents a governance weakness that could undermine timely oversight of risk, performance, and internal control.	No significant issues identified. See page 39 and 40 for further information and our recommendations made to the IJB.

Vision, leadership and governance (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Risks identified
Financial performance information	During 2023/24, officers presented regular financial performance reports up to Month 10 to the IJB Board, ensuring members were kept informed of the financial position. However, there was no separate financial performance report presented to the Board at year-end (Month 12) reflecting the revised budget and actual outturn. This was primarily due to delays in finalising the 2023/24 accounts and the IJB not receiving final budget information from East Dunbartonshire Council in time to report it during 2024. The final budget position was instead incorporated into the unaudited annual accounts, which were subsequently presented to the Board in March 2025.	This is addressed on page 31 within financial management section of the report.	No significant issues identified. See page 31 for further information and our recommendation made to the IJB.

Vision, leadership and governance (continued)

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

	Financial management risks identified	Recommendation for improvement	IJB's response and implementation timescale
1	**Regularity of Performance, Audit and Risk Committee Meetings – Level 2** The IJB's Performance, Audit and Risk Committee has not been meeting on a regular basis. The Committee met only twice in 2024 (March and June) and twice in 2025 to date. Meetings have been arranged on an ad hoc basis without an agreed schedule, creating a governance risk by reducing the timeliness of oversight, scrutiny and assurance.	The IJB should establish and approve a timetable for Performance, Audit and Risk Committee meetings to ensure regular and timely oversight of governance, risk, and performance matters.	**Management's response** Due to an inconsistency in available information for reporting throughout 2024, and on the instruction of the PAR Chair, the Vice Chair of the IJB, the decision was taken to cancel two of the previously scheduled quarterly PAR committee meetings. However, the importance of the Performance, Audit and Risk Committee is acknowledged within the HSCP and members have now been issued with a schedule of dates throughout 2025/26 to March'26. Reporting has also been addressed with an agreed process in place to ensure regular updates. A third meeting is confirmed this year for 15th Sept 2025 for which papers are currently being finalised. **Responsible officer** Alison McCready, Chief Finance and Resources Officer **Implementation date** 5 August 2025

Vision, leadership and governance (continued)

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

	Financial management risks identified	Recommendation for improvement	IJB's response and implementation timescale
2	**Signed Integration Scheme – Level 3** At the time of our review, a signed version of the Integration Scheme between East Dunbartonshire Council and NHS Greater Glasgow and Clyde was not available. The Integration Scheme is a key governance document that sets out the arrangements for planning, delivering, and monitoring health and social care integration within the local partnership area. The absence of a formally signed copy presents a governance risk, as it may impact clarity of roles, responsibilities, and accountability of the parties involved.	The IJB should ensure that a formally signed and approved version of the Integration Scheme is finalised and retained on record to provide assurance over governance arrangements and compliance with statutory requirements.	**Management's response** The Integration Scheme is acknowledged as a key governance document between EDC and NHSGG&C and integral to the operations of the HSCP. While a copy of the final version which would have been sent to partner bodies for signature is held locally, there is not a signed copy held on record. While the expectation would be for the signed copy of the integration scheme to be held by the signatory parties, the importance of the HSCP having a signed copy on record is recognised. The integration scheme is currently under review with partner bodies and in consultation with other HSCPs within NHSGG&C in order to ensure consistency where applicable and to further ensure that it accurately reflects the required governance framework. On completion, a signed copy will be obtained as recommended. **Responsible officer** Alison McCready, Chief Finance and Resources Officer **Implementation date** 5 September 2025

Commentary on Wider Scope

Use of resources to improve outcomes

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

Use of resources to improve outcomes

Our overall assessment

Area assessed	Our findings	Our judgements	Risks identified
Resources deployed to improve strategic outcomes	The IJB officers provide regular budget and performance monitoring reports to the Board and Performance, Audit and Risk Committee. These reports give an overview of the IJB's performance against agreed targets with narrative covering rationale, contextual information and improvement actions for areas where performance is off target. The Annual Performance Report 2023/24, approved in June 2024, outlines progress against 24 initiatives in the Annual Delivery Plan. Of these, 11 were completed, 5 are continuing into 2024/25, and 8 were delayed. The IJB has also updated its Workforce and Organisational Development Plan to reflect current pressures and priorities.	The IJB has appropriate arrangements in place for managing and reporting performance, with clear alignment to strategic priorities.	No significant issues identified.
Needs of service users being met	The IJB continues to operate under its Quality Management Framework, which supports continuous improvement. The Health and Care Experience Survey remains a key tool for gathering feedback from service users. In addition, the IJB, through the HSCP, undertakes regular engagement activities. This included the Communications and Participation and Engagement Strategy (2024-29) survey, which informed the updated strategy approved in June 2024. This survey sought views from residents, carers, staff, and partners on improving communication and engagement practices. During 2023/24, the IJB also developed updated strategies for carers, learning disabilities, alcohol and drugs, and dementia, all shaped by consultation and engagement exercises. These activities demonstrate a commitment to ensuring that the needs and experiences of service users inform strategic planning and service delivery.	The IJB maintains a robust consultation and engagement framework and uses national and local surveys to assess service user experience and inform service redesign.	No significant issues identified.

Use of resources to improve outcomes

Our overall assessment

Area assessed	Our findings	Our judgements	Risks identified
Arrangements to deliver continuous improvements in priority services	The 2023/24 Annual Performance Report includes a refreshed self-assessment against Best Value principles. It outlines how the HSCP is balancing service quality with financial constraints, considering the £48.2m projected financial gap over five years. The Annual Delivery Plan continues to align service redesign and transformation with efficiency savings. The Financial Sustainability Group was established in 2023/24 to support recurring savings and transformation. The Performance, Audit and Risk Committee provides scrutiny of transformation activity.	The IJB has strengthened its arrangements for continuous improvement, with clearer governance and financial oversight mechanisms in place.	No significant issues identified.

08

Best Value

Best Value

Best Value summary

Under the Code of Audit Practice, the audit of Best Value is fully integrated within our annual audit work. We are required to report on how the IJB demonstrates and reports that it has Best Value arrangements in place, to secure continuous improvement.

Best Value (continued)

Overall summary by reporting criteria

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

Reporting criteria	Commentary page reference	Identified risks?	Actual risks identified?	Other recommendations made?
Best Value	47	No	No	No

Best Value (continued)

Overall commentary on the Best Value reporting criteria.

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

The IJB has completed its 2023/24 Annual Performance Report, which was approved by the Board in June 2024 and notes progress made against its strategic plan priorities.

The Annual Performance Report also includes of a self-assessment template to demonstrate how the IJB is delivering Best Value and reviewing itself against the Best Value framework.

The Best Value self-assessment template includes information on how the IJB ensures:

- management of resources is effective and sustainable;
- steps are taken to ensure the quality of care and services provided is not compromised by saving measures;
- there is a culture of continuous improvement.

The IJB reports its annual assessment of Best Value to the Performance, Audit and Risk Committee, with the most recent update for 2023/24 presented on 20 June 2024. Officers also present performance reports to the Board on a quarterly basis. The Board and senior management team scrutinise the delivery of the IJB's annual delivery plan through regular updates and reporting to the Performance, Audit and Risk Committee on key priorities. Officers prepare monthly budget monitoring reports at service level and regular budget meetings are carried out with managers across the IJB.

The IJB's Clinical and Care Governance Group provides oversight of improvement activity through service reviews, inspection reports, incident reporting and complaints learning. This is reported through the senior management team, Performance, Audit and Risk Committee and Board to ensure areas of high risk with scope for most improvement are prioritised.

The Annual Service Delivery Plan aligns key priorities for service redesign and transformation to the delivery of efficiency savings. The IJB's progress in achieving savings is regularly reported in financial monitoring reports and the Performance, Audit and Risk Committee provides scrutiny of the transformation plan.

Overall, we have concluded that the IJB has appropriate arrangements in place for managing and monitoring performance and reporting on its efforts to secure Best Value.

Appendices

A: Draft management representation letter

B: Draft audit report

C: Confirmation of our independence

D: Other communications

E: Wider scope and Best Value ratings

Appendix A: Draft management representation letter

Forvis Mazars
100 Queen Street
Glasgow
G1 3DN

Date

Dear Tom

East Dunbartonshire Integration Joint Board - Audit for the Year Ended 31 March 2024
This representation letter is provided in connection with your audit of the financial statements of East Dunbartonshire Integration Joint Board (the IJB) for the year ended 31 March 2024 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with the Part VII of the Local Government (Scotland) Act 1973 and UK adopted international accounting standards, as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2023/24 (the 2023/24 Code).
I confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy myself that I can properly make each of the following representations to you.

My responsibility for the financial statements and accounting information
I believe that I have fulfilled my responsibilities for the true and fair presentation and preparation of the financial statements in accordance with the Part VII of the Local Government (Scotland) Act 1973 and UK adopted international accounting standards, as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2023/24 (the 2023/24 Code).

My responsibility to provide and disclose relevant information

I have provided you with:

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

I confirm as Chief Finance and Resources Officer that I have taken all the necessary steps to make me aware of any relevant audit information and to establish that you, as auditors, are aware of this information.
As far as I am aware there is no relevant audit information of which you, as auditors, are unaware.

Appendix A: Draft management representation letter

Accounting records
I confirm that all transactions undertaken by the IJB have been properly recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all management and Board meetings, have been made available to you.

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

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

Contingencies
There are no material contingent losses including pending or potential litigation that should be accrued where:

- information presently available indicates that it is probable that an asset has been impaired, or a liability had been incurred at the balance sheet date; and
- the amount of the loss can be reasonably estimated.

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

There are no contingent gains which should be disclosed.

All material matters, including unasserted claims, that may result in litigation against the IJB have been brought to your attention. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with the Part VII of the Local Government (Scotland) Act 1973 and UK adopted international accounting standards, as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2023/24 (the 2023/24 Code).

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

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

Appendix A: Draft management representation letter

Fraud and error
I acknowledge my responsibility as Chief Finance and Resources Officer for the design, implementation and maintenance of internal control to prevent and detect fraud and error. I have disclosed to you:

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

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

Related party transactions
I confirm that all related party relationships, transactions and balances, have been appropriately accounted for and disclosed in accordance with the Part VII of the Local Government (Scotland) Act 1973 and UK adopted international accounting standards, as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2023/24 (the 2023/24 Code).
I have disclosed to you the identity of the IJB's related parties and all related party relationships and transactions of which I are aware.

Future commitments
I am not aware of any plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

Ultimate parent company
I confirm that the ultimate parent company for East Dunbartonshire Integration Joint Board is the Scottish Government.

Other Matters
I confirm in relation to the following matters that:

- COVID-19 – I have assessed the continued impact of the COVID-19 Virus pandemic on the IJB and the financial statements, including the impact of mitigation measures and uncertainties, and am satisfied that the financial statements and supporting notes fairly reflect that assessment.
- Ukraine – I confirm that I have carried out an assessment of the potential impact of the continued conflict in Ukraine on the IJB and there is no significant impact on the IJB's operations from restrictions or sanctions in place.
- I confirm that I have assessed the impact on the IJB of the on-going Global Banking challenges, in particular whether there is any impact on the IJB's ability to continue as a going concern, and on the post balance sheet events disclosures.

Appendix A: Draft management representation letter

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

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

Subsequent events
I confirm all events subsequent to the date of the financial statements and for which the Part VII of the Local Government (Scotland) Act 1973 and UK adopted international accounting standards, as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2023/24 (the 2023/24 Code), require adjustment or disclosure have been adjusted or disclosed.

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

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

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

Unadjusted misstatements
I confirm that there are no uncorrected misstatements.

Yours faithfully,
Chief Finance and Resources Officer

Appendix B: Draft audit report

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

Report on the audit of the financial statements

Opinion on the financial statements

We certify that we have audited the financial statements in the annual accounts of East Dunbartonshire Integration Joint Board for the year ended 31 March 2024 under Part VII of the Local Government (Scotland) Act 1973. The financial statements comprise the Comprehensive Income and Expenditure Statement, the Movement in Reserves Statement, the Balance Sheet, and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards, as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2023/24 (the 2023/24 Code).

In our opinion the accompanying financial statements:
give a true and fair view of the state of affairs of the East Dunbartonshire Integration Joint Board as at 31 March 2024 and of its income and expenditure for the year then ended;
have been properly prepared in accordance with UK adopted international accounting standards, as interpreted and adapted by the 2023/24 Code; and
have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Basis for opinion

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

Conclusions relating to going concern basis of accounting

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

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

Risks of material misstatement

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

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

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

This description forms part of our auditor's report.

Appendix B: Draft audit report

Reporting on other requirements

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

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

Other information

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

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

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

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

In our opinion, based on the work undertaken in the course of the audit:
the information given in the Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with statutory guidance issued under the Local Government in Scotland Act 2003; and
the information given in the Annual Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with the Delivering Good Governance in Local Government: Framework (2016).

Matters on which we are required to report by exception

We are required by the Accounts Commission to report to you if, in our opinion:
adequate accounting records have not been kept; or
the financial statements and the audited part of the Remuneration Report are not in agreement with the accounting records; or
we have not received all the information and explanations we require for our audit.

We have nothing to report in respect of these matters.

Conclusions on wider scope responsibilities

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

Appendix B: Draft audit report

Use of our report

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

[*Signature*]

Tom Reid,
Audit Director
For and on behalf of Forvis Mazars LLP

100 Queen Street
Glasgow
G1 3DN

Date

Appendix C: Confirmation of our independence

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

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

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Appendix C: Confirmation of our independence (continued)

Fees for audit and other services

Our fees (exclusive of VAT and disbursements) for the audit of the East Dunbartonshire Integration Joint Board's financial statements for the year ended 31 March 2024 are outlined below.

Fees for work as the IJB's auditor

We reported our proposed fees for the delivery of our work under the Code of Audit Practice in our Annual Audit Plan presented to the Performance, Audit and Risk Committee on 11 June 2024. Having substantially completed our work for the 2023/24 financial year, we can confirm that our fees are as follows:

Area of work	2023/24 fees	2022/23 fees
Auditor remuneration	£35,890	£33,860
Pooled costs	£1,310	£0
Contribution to PABV costs	£7,660	£6,440
Audit support costs	£0	£1,280
Sectoral cap adjustment	(£11,500)	-£10,110
Total fees	**£33,360**	**£31,470**

Fees for other work

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

Appendix D: Other communications

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

Appendix D: Other communications (continued)

Other communication	Response
Subsequent events	We are required to obtain evidence about whether events occurring between the date of the financial statements and the date of the auditor's report that require adjustment of, or disclosure in, the financial statements are appropriately reflected in those financial statements in accordance with the applicable financial reporting framework. We will obtain written representations from management that all events occurring subsequent to the date of the financial statements and for which the applicable financial reporting framework requires adjustment or disclosure have been adjusted or disclosed.
Matters related to fraud	We have designed our audit approach to obtain reasonable assurance whether the financial statements as a whole are free from material misstatement due to fraud. In addition, we have assessed the adequacy of the IJB's arrangements for preventing and detecting fraud or other irregularities as part of the wider scope audit and concluded that they are sufficiently designed and implemented. We will obtain written representations from management, and where appropriate the Performance, Audit and Risk Committee, confirming that: a) they acknowledge their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud; b) they have disclosed to the auditor the results of management's assessment of the risk that the financial statements may be materially misstated as a result of fraud; c) they have disclosed to the auditor their knowledge of fraud or suspected fraud affecting the entity involving: i. Management; ii. Employees who have significant roles in internal control; or iii. Others where the fraud could have a material effect on the financial statements; and d) they have disclosed to the auditor their knowledge of any allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

Appendix E: Wider scope and Best Value ratings

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

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

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

Contact

Forvis Mazars

Tom Reid
Audit Director
Tel: +44 (0) 781 635 4994
tom.reid@mazars.co.uk

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce
AGENDA ITEM NO: 6

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**15th SEPTEMBER 2025**
REPORT REFERENCE:	**PERF/150925/06**
CONTACT OFFICER:	**PAUL BROWN, CHIEF INTERNAL AUDITOR (TEMPORARY), 0141 574 5655**
SUBJECT TITLE:	**ANNUAL INTERNAL AUDIT UPDATE AND REPORT 2024/25**

1.0 PURPOSE

1.1 The purpose of this Report is to present the Committee with the Annual Internal Audit Report for 2024/2025. In addition, an update on internal audit work completed in the period since the last Committee and the Annual Follow Up Report 2024/25 is also provided.

1.2 The information contained in this report relating to East Dunbartonshire Council or NHSGGC audits has been presented to the Council's Audit & Risk Management Committee (A&RMC) and the NHSGGC Audit & Risk Committee (ARC) as appropriate, where it has received scrutiny. Once noted by these committees, this report provides details on the ongoing audit work, for information, to the HSCP Performance, Audit & Risk (PAR) Committee and to allow consideration from the perspective of the HSCP.

2.0 RECOMMENDATIONS

2.1 The Performance, Audit & Risk Committee is asked to:

- Consider the HSCP Annual Audit Report for 2024/25, including the Internal Audit Opinion for 2024/25.
- Agree that the opinion on the adequacy and effectiveness of the HSCP's framework of governance, risk management and control be applied in the completion of the HSCP's 2024/25 Financial Statements.
- Consider the contents of the Internal Audit Performance and Outputs Report and the Internal Audit Follow Up Report 2024/25.
- Request the Chief Finance & Resources Officer to submit performance monitoring reports detailing progress against Plan and audit results to future meetings of the Committee.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

BACKGROUND / MAIN ISSUES

3.1 East Dunbartonshire Council's (the Council) Internal Audit Team provides an independent and objective assurance service to the HSCP that is guided by an overriding objective of adding value to improve systems, controls and operations. The team provides a systematic and disciplined approach to the evaluation of the internal controls and governance processes in accordance with the Public Sector Internal Audit Standards.

3.2 One of the primary objectives of the Internal Audit team is to provide a high quality and effective internal audit service, which complies with professional best practice, meets the needs of stakeholders and assists the HSCP's Performance, Audit & Risk Committee to effectively discharge its roles and responsibilities. The team's purpose, authority and responsibilities are set out in more detail in the Internal Audit Charter.

3.3 The presence of an effective internal audit team contributes towards, but is not a substitute for, effective control and it is primarily the responsibility of management to establish internal control so that the activities are conducted in an efficient and well-ordered manner, to ensure that management policies and directives are adhered to and that assets and records are safeguarded.

3.4 Internal Audit activity is planned to enable an independent annual opinion to be provided by the Council's Audit & Risk Manager as the Chief Internal Auditor on the adequacy and effectiveness of internal controls, governance and risk management within the HSCP. For 2024/25, this opinion is included in the Annual Audit Report at *Appendix 1*, which also includes the 'Statement on the Adequacy and Effectiveness of the Internal Control Environment of the HSCP' for the year.

3.5 The annual statement and opinion includes:

- Summary of work supporting the opinion,
- Comparison of work carried out against work planned,
- Performance of the Internal Audit Team,
- Impairments or restriction of scope,
- Conformance with Public Sector Internal Audit Standards, and
- Consideration of any other relevant issues.

3.6 The conclusion is that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP's internal control systems in the year to 31 March 2025. In reaching the opinion of reasonable assurance, risks raised by Internal Audit are noted in relation to controls over the Carefirst payment arrangements process. These issues do not, however, significantly impair the HSCP's systems of internal control as a whole.

3.7 Two additional documents are attached in support of the annual audit opinion:

- The Internal Audit Follow Up Report 2024/25 at *Appendix 2.* This report covers risks relevant to the HSCP, albeit some risks require input from Council services to address.

- The Internal Audit Performance and Output Monitoring Report is attached at *Appendix 3*.

4 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan;- None.

4.2 Frontline Service to Customers – None.

4.3 Workforce (including any significant resource implications) – None.

4.4 Legal Implications – Legal risks are presented in the body of internal audit reports with reference to relevant legislation where appropriate.

4.5 Financial Implications – Internal Audit reports are presented to improve financial controls and aid the safeguarding of physical and intangible assets.

4.6 Procurement – Where applicable these are referenced in the body of internal audit reports with associated management actions for improvement.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None

4.10 Sustainability – None

4.11 Other – None.

5 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 The Risks are highlighted to management in audit reports. The risks are addressed through agreed action plans, appended to internal audit reports.

6 IMPACT

6.1 STATUTORY DUTY – None

6.2 EAST DUNBARTONSHIRE COUNCIL – The risks identified in the internal audit reports relevant to East Dunbartonshire Council have been highlighted to the Council's Audit & Risk Management Committee.

6.3 **NHS GREATER GLASGOW & CLYDE** – The risks relevant to the NHS Greater Glasgow & Clyde identified in the internal audit reports have been highlighted to the NHSGGC's Audit & Risk Committee.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction required.

7 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8 APPENDICES

8.1 Appendix 1 – HSCP Annual Internal Audit Report 2024/25

8.2 Appendix 2 – HSCP Follow Up Report 2024/25

8.3 Appendix 3 – HSCP Performance and Outputs Report April to July 2025

Appendix 1

East Dunbartonshire Council

Internal Audit Services

HSCP Internal Audit Annual Report 2024/25

Paul Brown

Chief Internal Auditor

East Dunbartonshire Council

This HSCP Internal Audit Annual Report is a summary of the internal audit work completed by East Dunbartonshire Council's Internal Audit team for the financial year 2024/25 for East Dunbartonshire Integration Joint Board (IJB). In East Dunbartonshire, the IJB is known as the East Dunbartonshire Health and Social Care Partnership Board (HSCP). The internal audit opinion, following an assessment of the internal audit work and other sources of assurance, is provided at *Appendix 1.1*. The opinion provided concludes on the adequacy and effectiveness of the HSCP's framework of governance, risk management and control. It supports the annual governance statement, which is included in the annual financial accounts. It considers the expectations of senior management, the Performance, Audit & Risk (PAR) Committee and other stakeholders. It is supported by sufficient, reliable, relevant and useful information, as referenced in the body of this report. Through utilising such information, Internal Audit demonstrates compliance with relevant Public Sector Internal Audit Standards.

Internal Audit Opinion

The full statement and opinion provided at *Appendix 1.1*, confirms my opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP's internal control systems, governance and risk management systems in the year to 31 March 2025.

This means that members can be assured that proper processes are in place to enable the achievement of the HSCP's objectives.

Key Areas for Improvement

In reaching this conclusion, I note risks raised by Internal Audit in relation to controls over the Carefirst Payments and the administration of Allpay cards. These issues, however, do not significantly impair the HSCP's systems of internal control as a whole.

The opinion represents a consolidated view, informed by several sources and, in bringing these together, considers whether there is evidence that key controls are absent, inadequate or ineffective. The work includes an assessment of any weaknesses identified and whether these, taken independently or with other findings, significantly impair the HSCP's system of internal control that is in place to allow the HSCP to achieve its objectives. Action taken by management since the issuing of internal audit reports and wider issues relating to the HSCP's corporate governance framework and risk management arrangements have also been considered in providing the opinion.

The outstanding risks will continue to be kept under review, with auditors monitoring compliance with the agreed actions as part of an established follow up cycle and updates being reported to the Performance, Audit & Risk Committee.

The risk of fraud is also considered in each assignment, together with any governance or risk management implications; this allows the HSCP's Chief Internal Auditor to draw sustainable conclusions.

Summary of Work Supporting the Opinion

A total of 9 outputs were completed by 31 March 2025 compared to 10 outputs planned – a completion rate of 90%. In January 2025 it was reported to the PAR Committee that the Team, due to a change in available resources, would be targeting an 80% completion of the Audit Plan. By the year-end a target of 90% was achieved.

Despite the plan not being achieved in full, sufficient evidence to support the audit opinion was gathered through the audits completed and those work in progress to conclude on the sufficiency of controls

A detailed comparison of the work carried out against the Plan are provided in subsequent sections.

The opinion is also informed by Internal Audit's programme of follow up activities, which reviews the extent to which those risks previously identified have been subsequently managed or mitigated. Internal Audit have prepared a follow up report covering risks across the HSCP, as attached at *Appendix 2*. Our consolidated follow up work has identified that four high risks from the Carefirst Payments report remain outstanding. A separate follow up report was developed for this that has resulted in an updated action plan with revised target dates of December 25, for the action plan to be concluded in its entirety. In the Interim Follow Up 2024/25 review a high risk was noted from the Interim Care Home Funding report as being outstanding, relating to the process following the award of guardianship. This action has now been closed off, in addition to the high risk noted in the Allpay report relating to procedures. Details of the Allpay review were reported to the PAR Committee in January-25, outlining one high risk and the Annual Follow-Up 24/25 has concluded that this has been addressed.

In 2023/24 Auditors performed a review of Carefirst Payments and in 2024/25 undertook an in-depth follow-up of the high risks noted within the report. Progress has been slower than anticipated in addressing these risks with auditors continuing to note that the original high risks noted still require to be fully mitigated.

Other considerations for the annual opinion are detailed at *Appendix 1.1* and include the assessment of the Annual Governance Statements Internal Checklist relating to 2024/25, as completed by the Chief Officer.

Auditors take due consideration of risks including fraud risks in preparing the annual audit plan and in approaching individual assignments to maximise the assurance that can be provided. However, the level of assurance provided by the Internal Audit Team can never be absolute. This reflects the sample nature of the work carried out, the relative scope and objectives of audit assignments and those explanations offered, and evidence provided by officers. In addition, factors external to the audit process including human error, collusion or management overriding controls create the potential for systems, historically highlighted as being satisfactory, to become exposed to risk or loss.

Reliance on Other Assurance Providers

The internal audit opinion also includes consideration of the work of other assurance providers, including those reports issued by the HSCP's external auditors, Forvis

Mazars. There have been delays in the production of audited financial accounts for both 2023/24 and 2024/25, with work on-going to progress these.

Furthermore, the work undertaken by the Council's and the NHSGGC's Internal Audit teams are considered, where it may be relevant to the HSCP. In June 2025 the NHSGGC's external auditors provided an opinion of reasonable assurance at the NHSGGC's Audit and Risk Committee.

The Council's audit work for 2024/25 has been reviewed and it has been concluded that there are no material issues that would impact the HSCP's governance statement.

Comparison of work carried out against work planned

There were 10 planned HSCP internal audit outputs for the year 2024/25 and 9 outputs were completed by the year-end, with Carefirst Payments being finalised after the year-end. Some changes from the original plan were made during the year such as the reprofiling of audits such as Financial Monitoring into 2025/26 due to changes in officer personnel and the implementation of new financial systems. Private Sector Housing grants, as notified to the PAR Committee in January 2025, was de-prioritised and to be considered as part of the 2025/26 plan. The team has been able to provide assurance over several areas, as detailed in *Appendix 1.2*.

The team has been able to provide assurance over a range of areas, as detailed in the section below. This, together with other sources of assurance, provides adequate assurance across the activities of the HSCP for the provision of the annual audit opinion.

Full details on these audits have been provided in the internal audit updates to Committee. Where internal audit has identified risks in the areas reviewed, action plans have been agreed. The agreed actions are logged on the Performance and Risk System, Ideagen, and will be followed up on and progress reported back to the Performance, Audit and Risk Management Committee.

Internal Audit Performance Key Performance Indicators (KPIs) for the year are provided in Table 1 and Table 2 below.

Table 1 - Analysis of HSCP Internal Outputs by Audit Type 2024/25

Audit Type	Completion Number	Completion %
Systems	3 Completed out of 5 Audits Planned	60% Complete

Audit Type	Completion Number	Completion %
Regularity	5 Completed out of 5 Audits Planned	100% Complete
Consultancy	1 Completed out of 0 Audits Planned	>100% Complete
Total	**9 Completed versus 10 Planned**	**90% Complete**

Table 2 - HSCP Internal Audit Key Performance Indicators 2024/25

Audit Type	Planned	Actual	Status
Percentage of finalised audit outputs against the number anticipated in the Plan	100%	90%	
Percentage of productive days worked against the target productive days in the Plan.	100%	>100%	
Percentage of audit reports issued within 20 days of completion of fieldwork.	95%	100%	

In reviewing the performance of the team, it was noted that all HSCP reports were issued within the target of 20 days of fieldwork, giving a compliance rate with this Performance Indicator of 100%, against a target of 95%. The target is set at 95% rather than 100% as, at times, a management decision will be taken to prioritise time critical pieces of work, meaning that a finite number of audits may not be issued in accordance with our internal timescales.

90% of the Audit Plan was completed due to the need to rephase the initial plan because of resource pressures on the Team. In the January-25 update to the PAR Committee the adjustments required to the Audit Plan, because of an auditor leaving the Internal Audit Team, were communicated with a revised 80% target completion being set. The actual completion rate, at 90%, exceeded this. This was done with no detriment to the provision of the annual audit opinion.

Annual Assurance - Several documents that collate the work of the Internal Audit team have been produced by the team as part of their responsibility for annual assurance. These are the follow up report, the Annual Internal Audit Report (this document), the current drafting of the Annual Governance Statement for inclusion in the accounts and signature by the IJB Chair and Chief Officer. Internal Audit have also reviewed the HSCP's Risk Management arrangements and have concluded that the HSCP has a reasonably well-developed risk management maturity. The Risk Management Policy sets out the process and responsibilities for managing risk in the HSCP. The Corporate Risk Register is revised and approved at each meeting of the Performance, Audit & Risk Committee. The HSCP Board is required to develop and review strategic risks linked to the business of the Board twice yearly.

Progress against improvement plans

The Internal Audit service takes a 'continuous improvement' approach to our internal audit work. This is reflected in our reports and recommendations made to services and also in the approach to the internal audit work itself, with a focus in making incremental improvements to our work through efficiencies, and/or improved quality. This helps us to improve our quality and adherence to Public Sector Internal Audit Standards, and to focus on the areas of greatest risk and where we can add the most value.

Impairments or Restriction of Scope

There have been no impairments or restrictions of scope during the year.

Progress & Results of the Quality Assurance Improvement Programme

The Internal Audit Team is required to work to a set of rules - PSIAS. These rules apply to all public sector internal auditor teams. It is a requirement of these standards that periodic self-assessments are conducted to evaluate conformance with the Code of Ethics and the PSIAS. Under Section 7 (1) of the Local Authority Accounts (Scotland) Regulations 2014, the Council must operate a professional and objective internal auditing service in accordance with recognised standards and practices in relation to internal auditing. The Council defines such standards as those set out within the PSIAS.

An external assessment was completed of the Internal Audit function's compliance with PSIAS in 2023, in order to meet the PSIAS requirement for an external assessment at least once every five years, with the previous report having been published in 2018. It was found that, in the opinion of the qualified independent assessor, the Internal Audit team fully conforms to all thirteen standards. Nonetheless, three minor areas for improvement were identified by the assessor. An update on progress against these actions is provided below.

Recommendation	**Update**
East Dunbartonshire Internal Audit should consider what actions could be taken to improve the response rate for client surveys. A summary of the results of these surveys should be considered for inclusion in the Internal Audit Annual Report which is reported to the Audit & Risk Management Committee.	**Outstanding** To be taken forward in 2025/26. At the same time of issuing the final audit report attention to the completion of this will be highlighted which will hopefully improve response rates. Work will be undertaken in reviewing compliance with the new standards be taken forward as part of that exercise.
The Audit and Risk Manager should consider if a specific annual Internal Audit Plan should be developed for the East Dunbartonshire Leisure & Culture Trust.	**Complete** This was included in the 2024/25 Plan but due to resourcing and service pressures this planned work was deferred until 2025/26, whereby the Key Financial Controls of the Trust will be reviewed.
The Audit & Risk Manager should consider if it would be helpful to revise the standard template for audit reports to include details of any recognised areas of good practice that are identified during the audit.	**Complete** Template has been amended and has been used for 2024/25 audits onwards.

A self-assessment against PSIAS was completed by the Chief Internal Auditor in 2023/24, with a refresh performed in 2025. 2024/25 is the final year that compliance will be assessed against the PSIAS with the first compliance statement with the Global Internal Audit Standards (GIAS) coming into effect on 31st March-26. Work

will be undertaken in 2025/26 to assess the Internal Audit Teams compliance with the new standards. Any gaps in compliance will be identified by way of an Action Plan and the results of which will be communicated to the PAR Committee.

Internal Audit have also issued questionnaires on completion of each audit assignment, providing an opportunity for the auditee to provide feedback on the planning process, communication and the quality of the internal audit report. All audit files are reviewed by the Chief Internal Auditor to ensure high standards are maintained and to encourage a continuous improvement approach by the team.

Statement of Conformance with Public Sector Internal Audit Standards

Internal Audit is required to comply with PSIAS. This is assessed herewith by the Audit & Risk Manager.

The Audit & Risk Manager deems the Internal Audit service to fully conform with PSIAS.

Other Issues

I am aware of no other material issues that require to be reported at this time.

STATEMENT ON THE ADEQUACY AND EFFECTIVENESS OF THE INTERNAL CONTROL ENVIRONMENT OF THE HSCP FOR 2024/25.

To the Members of the Health and Social Care Partnership Board's Performance, Audit & Risk Committee, the Chief Officer and the Chief Finance & Resources Officer of the HSCP

As the appointed Chief Internal Auditor of the HSCP, I am pleased to present my annual statement on the adequacy and effectiveness of the internal control system of the HSCP for the year ended 31 March 2025 to the PAR Committee.

Respective Responsibilities of Management and the Internal Audit Team in Relation to Governance, Risk Management and Internal Control

It is the responsibility of the HSCP's senior management to establish appropriate and sound systems of governance, risk management and internal control to monitor the continuing effectiveness of those systems. It is the responsibility of the Chief Internal Auditor to provide an annual overall assessment of the robustness of governance, risk management and internal control.

The HSCP's Framework of Governance, Risk Management and Internal Controls

The main objectives of the HSCP's framework of governance, risk management and internal controls are to ensure that resources are directed in accordance with agreed plans, policies and priorities and to ensure that there is sound decision−making and clear accountability for the use of those resources to achieve the desired outcomes for service users and communities.

This includes ensuring that appropriate internal controls and risk management arrangements are in place to effectively manage issues which might impact on the delivery of HSCP services, the achievement of corporate and service objectives and public confidence in the HSCP. The HSCP also requires effective internal controls and risk management arrangements to protect its assets, to maintain effective stewardship of public funds, to ensure good corporate governance, to ensure compliance with statutory requirements and to ensure it continues to deliver best value.

Any system of control can only ever provide reasonable and not absolute assurance that control weaknesses or irregularities do not exist or that there is no risk of material errors, losses, fraud, or breaches of laws or regulations. Accordingly, the HSCP is continually seeking to improve the effectiveness of its systems of governance, risk management and internal controls.

The Work of the Internal Audit Team

Internal audit services were provided by East Dunbartonshire Council Internal Audit Team. The EDC Internal Audit Team objectively examines, evaluates and reports on the adequacy of internal controls as a contribution to the proper, economic, efficient and effective use of the HSCP's resources.

The Internal Audit Team has undertaken a programme of work in the year. All Internal Audit reports identifying system weaknesses, risks and/or non-compliance with expected controls are brought to the attention of senior management and significant findings presented to the Performance, Audit and Risk Committee. Notable risks identified in the year related to the administration of Allpay cards within the Partnership and to Carefirst Payments. The Carefirst Payments review was initially performed in 2023/24, with a more detailed follow-up review of the audit performed in 2024/25. Audit reports and action plans provide insight into the risks identified and include an agreed narrative highlighting the intended course of action, including the timescales involved to mitigate and manage the risk. It is management's responsibility to ensure that proper consideration is given to internal audit reports and that appropriate action is taken on those risks identified.

The Internal Audit team are required to ensure that appropriate arrangements are made to determine whether action has been taken on agreed reports or, where appropriate, that management has understood and assumed the risk of not taking action. Significant matters (including non-compliance with audit recommendations) arising from internal audit work are reported to the Performance, Audit & Risk Committee and the Senior Management Team.

Follow up work has identified that the four high risks identified within the Carefirst Payments have yet to be fully mitigated in 2024/25. In the previous year it was reported that a residual high risk was still outstanding with respect to Interim Care Home Fundings and follow-up work performed in 2024/25 confirmed that this has now been resolved. A high risk was noted within the 2024/25 Allpay report has also been resolved. The outstanding risks will continue to be kept under review, with auditors monitoring compliance with the agreed action as part of an established follow up cycle and updates being reported to the Performance, Audit & Risk Committee. Management have reported progress towards mitigation of these issues and advised target dates. Auditors will monitor compliance with the agreed action as part of a six-monthly cycle. Updates will be reported to the Performance, Audit & Risk Committee.

Impairments or Restriction of Scope

There have been no impairments or restrictions of scope during the year.

Basis of Opinion

My evaluation of the control environment is informed by several sources:

- The HSCP internal audit work completed by the EDC Internal Audit Team during the year to 31 March 2025, an assessment of the materiality of the findings during and since the year end;

- The audit work undertaken by the Internal Audit Team in previous years;
- The assessment of the Annual Governance Statement Internal Checklist relating to 2024/25 as completed by the Chief Officer;
- The assessment of audit risk to internal and financial controls determined during the preparation of the annual Internal Audit Plan;
- Reports issued by the HSCP's external auditors and other review agencies, where appropriate
- Work undertaken by the partners' internal auditors; and
- My own knowledge of the HSCP's governance, risk management and performance management arrangements.

Opinion

It is my opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP's internal control system in the year to 31 March 2025.

Paul Brown FCCA

Chief Internal Auditor,
HSCP

Audit & Risk Manager

East Dunbartonshire Council

29 August 2025

Appendix 1.2 – Summary of Internal Audit Reports Finalised 2024/25

Area	H	M	L	Total	Audit Opinion
Health & Social Care Partnership					
Delayed Discharges			1	1	Substantial Assurance
Transport Policy		3	1	4	Limited assurance
Allpay	1	2		3	N/a - Consultancy
Use of Self-Service Technology – AskSARA			1	1	Substantial Assurance
Total Risks Identified	**1**	**5**	**3**	**9**	

Appendix 2

East Dunbartonshire Council
Internal Audit Services

HSCP Internal Audit
Annual Follow Up Report
2024/25

Paul Brown

Chief Internal Auditor
August 2025

1 INTRODUCTION

1.1 The 2024/25 Internal Audit Plan included provision for the follow up and evaluation of risks identified in all previously issued Internal Audit reports.

1.2 This annual follow up report demonstrates the HSCP's ongoing commitment to maintaining compliance with the Public Sector Internal Audit Standards. These require that the Audit & Risk Manager, as the Chief Internal Auditor, *'establish a process to monitor and follow up management actions to ensure that they have been effectively implemented or that senior management have accepted the risk of not taking action'*. As part of this process, the following areas have also been considered:

- Where issues have been noted as part of the follow up process the Audit & Risk Manager may consider revising the initial overall audit opinion,
- The results of monitoring management actions may be used to inform the risk-based planning of future audit work; and,
- The review extends to all aspects of audit work including consulting engagements.

2 SCOPE and OBJECTIVES

2.1 The scope of the audit is to review those risks identified in prior audit work and establish, through a combination of testing, corroboration and interview, whether the agreed control measures have been adequately implemented, and the associated risks addressed.

2.2 The objective of the review is to provide assurance to key stakeholders that management actions have been effectively implemented. Where this is not the case, auditors will establish the reasons for non-compliance, including consideration of the extent to which senior management have accepted the risk of inaction.

2.3 The purpose of this follow up report is as follows: **-**

- Provide a summary of outstanding audit reports at *Table 2* at the end of this report.
- Detail areas where significant progress has been made since the last follow up report; and
- Inform the Annual Internal Audit Report and Opinion.

3 METHODOLOGY

3.1 Auditors have evaluated the extent to which management have mitigated individual risks allocated to them. Where risks have been fully managed and closed off by management, auditors have sought to validate a sample of these actions and ensure that they mitigate the risk, with a focus on risks that were classified as 'High'. Where there has been substantial progress in closing off a report that had identified several issues, Auditors may schedule a separate follow up review to allow time to consider these issues in detail. This may be beneficial

when the original report was issued some time ago and when there have been significant changes in the system controls.

4 FINDINGS - ALL RISKS DUE FOR COMPLETION

4.1 *Table 1* provides a summary of the 15 individual risks and improvement actions of relevance to the HSCP that were outstanding for implementation as of March 2025, by risk rating. The risk rating (High/Medium/Low) answers the question, '*in internal audit's professional opinion, what is the risk that the issue identified could impair the achievement of the system's objectives*?'

Table 1 - Individual Audit Report Action Points by Risk Rating

Risk rating	Total Per Original Reports[1]	Completed Actions	Outstanding
High	**4**	**-**	**4**
Medium	17	7	10
Low	4	3	1
Total	25	10	**15**

1 There were 25 issues raised in the original reports and 10 issues have since been closed. The figure of 25 relates only to the total number of issues originally raised in reports with outstanding audit actions past their due date. Reports for which all issues have been fully completed, or which are in progress and not yet past their due date, are not included in the figures. This approach allows a focus on outstanding actions that have not been completed within agreed timescales.

4.2 The 15 outstanding risks represents an increase of 9 from the interim follow-up that was presented to the PAR Committee in January 25. The increase is represented by the follow-up of the Carefirst Payments review which was work in progress at the time of 2024/25 Interim follow-up. All four high risks noted above relate solely to this audit. Given the risks noted in this review a separate report, with revised management comments, has been reported upon. In addition to this, the HSCP Transport Policy was concluded after the last follow-up, with risks noted still requiring actions to be implemented.

4.3 Since the last report the following high risks have been addressed:

- *Interim Care Home Funding* – a risk relating to delays in notifications of the awarding of guardianship has been addressed by the establishment of procedural documentation. A process has also been put in place whereby a monthly list of interim funding cases is sent to management to cross check with the relevant team. This action now concludes the entirety of the action plan.
- *Allpay* – a risk relating to the establishment of procedures has been addressed with guidance being developed and staff being briefed over the newly developed procedures. With the other two, medium risks, also being addressed, this now concludes the report.

4.4 Auditors acknowledge service pressures, demands and competing priorities in the progression of the mitigation of reported issues and risks within internal audit reports. With respect to the outstanding risks noted in Table 1 it is important to progress those issues which are now overdue for mitigation in material excess of their original due date. Worthy of note is the data cleansing risk still outstanding from the 2019/20 Financial Outturn Report and the Carefirst Payments report noted above.

5 CONCLUSION

5.1 Our consolidated follow up work has identified that 15 risks identified by audit remain outstanding across the HSCP. This does represent an increase from the last follow-up report which is mainly attributable to the following up of the Carefirst Payments Audit in this annual follow-up whereby, as noted, progress has been slower than anticipated.

5.2 Responding to the requirement of the Public Sector Internal Audit Standards, the Audit & Risk Manager has not revised any opinions previously reported to members. All residual issues will be considered in the 2025/26 follow up work and will inform future areas of audit focus.

Table 2 – List of Outstanding Audit Reports with Revised Target Dates

The table below details the Internal Audit reports with outstanding audit actions.

Key:

- Complete

- On track for Due date/Revised Due Date

- Due date this month

- Action is past due date. Revised target date is required

Priority 1 – High Risk
Priority 2 – Medium Risk
Priority 3 – Low Risk

Code	Title of Audit	Service Responsible	Title of Issue	Status	Priority	Due Date	Original Due Date	Latest Note
CFO-IA-1920-HSCPFOKC	HSCP Financial Outturn and Key Controls	Health and Social Care Partnership	Budgetary Information		2	30-Sept-2025	31-Mar-2020	The data cleansing action is still to be fully closed off. Work had progressed between the Commissioning and Carefirst Team, led by the HSCP Chief Finance and Resource Officer. Reports were produced and reviewed. The result of this was that there needed to be a HSCP sign off for the CC4's and CC5's to amend and correct this data. This was not performed but the processes have been restarted with a consolidated report of all the required changes due to be sent to the HSCP for approval as a bulk change, removing the need for individual CC4/5 approvals. The due date has been pushed back to Sept-25 as this action aims to be closed out. The
			Monitoring of Payment Adjustments		2			
			Data Cleansing - Service Register		2			
			Information Outside Carefirst		2			
			Management Information Systems - Carefirst		2			
			Management Information System - CM2000		2			
			Roles and Responsibilities		2			

Code	Title of Audit	Service Responsible	Title of Issue	Status	Priority	Due Date	Original Due Date	Latest Note
								actioning of this is important for accurate financial/budgetary information.
CFO-IA-2223-WFP	Workforce Planning	Health and Social Care Partnership	Feedback from Scottish Government		2	31-Aug-2025	31-Mar-2024	A revision to the Workforce Plan, covering 2025-28, is due for completion in August 2025 and will incorporate Scottish Government feedback. Once done, this will close off both actions.
			Content of the Workforce Plan		2			
CFO-IA-2324-HSCPCPC	Carefirst Payments	Health and Social Care Partnership	Downward Adjustments		1	01-Dec-2025	31-May-2024	A separate report issued to the PAR outlines the level of progress across all 8 reported issues in detail as this was followed up separately. At the time of review one issue, Report Content, was concluded to be implemented with the other issues reported to be at various levels of completion. Progress has been made with respect to downward adjustments with a backlog of those to be actioned no longer an issue. However, issues with the quality of the data in the reports has been reported as being an issue. A new process has been implemented with regards to upward adjustments with auditors reporting on the need for controls to be established alongside this. Provider compliance requires improvements to demonstrate a formal review of non-returns, together with clear demonstration of any escalations.
			Query Resolution		2			
			Authorisation of Upward Adjustments		1			
			Sample Checking		2			
			Provider Compliance		1			
			Management Oversight		1			
			Data Quality		2			
			Report Content		2			

Code	Title of Audit	Service Responsible	Title of Issue	Status	Priority	Due Date	Original Due Date	Latest Note
								Further work is also required to embed management oversight of the area. There has been a change to roles and responsibilities since the last review with ownership of the reports moving to the HSCP. Auditors understand a revised Protocol is in draft format and seeking agreement across stakeholders.
CFO-IA-2324-HSCP BDP	HSCP Bad Debt Provision	Health and Social Care Partnership	Governance Arrangements		3	TBC	31-Mar-2024	Actions to be completed relate to Governance Arrangements and Reporting & Oversight. The Financial Regulations were due for review in March-25 but there has been a delay in the completion of this. Once done this should close off the Governance Arrangements report reference. Ledger development and implementation has resulted in limited information in relation to debt information provided to the HSCP. This is in the process of being resolved.
			Timeliness of Write-Offs		3			
			Reporting and Oversight		2			
			Benchmarking		3			

Code	Title of Audit	Service Responsible	Title of Issue	Status	Priority	Due Date	Original Due Date	Latest Note
CFO-IA-2425-TP	Transport Policy	Health and Social Care Partnership	Policy Implementation - Internal Communication		2	TBC	31-Mar-2025	Roll out of the policy is still on-going and at various stages across the care groups. An internal communication has been shared with teams as the roll out continues, along with the transport form requiring completion. External communication was to take place by way of the new terms of eligibility being included within the non-residential services booklet but this has still to be performed. Auditors are awaiting the supply of revised due dates. The low risk has been addressed.
			Assistance with Transport Assessment Form		2			
			Policy Implementation - External Communication		2			
			Reduction in Charge Calculation Sheet		3			

Appendix 3

East Dunbartonshire Council
Internal Audit Services

HSCP Internal Audit Performance and Output Monitoring

April to July 2025

Paul Brown

Audit & Risk Manager

Internal Audit Outputs April to July 2025

In the months of April to July 2025, the Internal Audit Team finalised and reported on the areas as shown in *Table 1* below. These are summarised as follows:

In relation to the period since the last monitoring report, Auditors highlight the following:

Table 1 – Analysis of Internal Audit Outputs April to July 2025

	Audit Area and Title	Areas Noted	High Risk	Medium Risk	Low Risk
	Regularity				
1	Annual Audit Report	**-**	-	-	-
2	Internal Audit Annual Follow Up Report	**-**	-	-	-
	Systems				
3	Carefirst Payments Follow-Up	**7**	4	3	-

The above figures for Carefirst payments represent the risks still requiring to be fully mitigated.

Regularity

Annual Audit Report –The Council's Audit & Risk Manager, as the Chief Internal Auditor of the HSCP, has concluded that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP's governance, risk management and control systems in place for the financial year ended 31 March 2025. This opinion is based on the Internal Audit Team's work for the year and other sources of assurance as is detailed at *Appendix 1*.

Internal Audit Follow Up Report – This report is presented at *Appendix 2* and supports the Annual Audit Report and opinion referred to above. The number of outstanding high risks, in comparison to the 2023/24 Annual Follow Up, has increased from one to four. This is primarily the result of the specific follow up of the Carefirst Payments audit from 2023/24. The outstanding high risk from the 2023/24 Annual Follow Up, within Interim Care Home Funding, has been fully addressed and one high risk arising during 2024/25, within the Allpay report, was addressed in year Auditors can conclude that there has been a focus in closing off high risks as they arise but would ask for continued efforts in closing off the high risks noted within the Carefirst Payments audit.

Three outputs were completed between April and July 2025, representing 33% completion of the 9 outputs planned for the year, at 33% through the year.

Work continues on specific audit areas such as Provider Uplift Arrangements, with auditors liaising with management to program the remaining audits over the course of the year.

Systems

Carefirst Payments Follow-Up

Auditors undertook work to follow up on the Carefirst Payments Audit which was originally presented to the PAR Committee in June 2024. Changes were made to the current payments processes with the primary objective being to mitigate against overpayments to providers.

Auditors concluded the review with an opinion of limited assurance, reporting 4 high risks and 4 medium risks.

While improvements have been made in some areas, such as the format of the monitoring reports, further enhancements are still necessary to fully address the issues identified in the previous report. Of the eight issues reported in June 2024, auditors determined that only one—the content of the variation report—has been resolved. The remaining seven issues, including the four high risks, have yet to be fully addressed.

Appendix 3.1 includes the updated action plan, along with current management comments regarding the four high risks. There is still work needed to progress on the remaining medium risks, and updated management comments for these have been received.

EAST DUNBARTONSHIRE COUNCIL INTERNAL AUDIT PROGRESS

Work on the Council's internal audit plan is ongoing, providing assurance in several areas. No additional high risks relevant to the HSCP have been identified.

The provision of the Council's annual audit opinion will be presented to the Council's Audit and Risk Committee on the 18th September 2025. It is not anticipated that there will be any matters that will affect the provision of an audit opinion of reasonable assurance.

NHSGGC INTERNAL AUDIT PROGRESS

In June 2025 the NHSGGC's external auditors provided an opinion of reasonable assurance for 2024/25 to their Audit and Risk Committee. The June 2025 report by Azets provided assurance over the remaining areas of their 2024/25 audit plan:

- Staff Training and Development – Substantial improvements required. There were no specific actions for the H&SCP.

- Strategic and Operational Planning – Minor improvement required. The report highlighted the challenges in aligning NHSGGC strategic planning with H&SCP's given varying timescales and improvements via collaborative working.

- Medicines Governance - Substantial improvements required. There were no specific actions for the H&SCP

Appendix 3.1 – Extract of High Risks from Carefirst Payments Follow-Up

Observation	Risk and Recommendation	Management Response & Allocated Officer	Target Date
Downward Adjustments Issues have arisen with the accuracy of the data within the monitoring report which led to additional check work being performed to ensure the veracity of reports. Whilst Auditors confirmed with that there were no outstanding downward adjustments to be made for 2024/25, issues in the process and the additional work being required to validate the monitoring reports has led auditors to conclude that this action has partially being partially implemented.	**HIGH** *Inaccurate data on monitoring reports will result in inaccurate adjustments being performed.* **Recommendation** The current issues surround the accurate completion of the monitoring reports should be investigated and addressed by management.	**Accepted** The existing protocol has been reviewed July/August 2025 and updated to reflect developments in staffing and resources now allocated to this process. Two Resource Workers have been recruited to support the process across both Adult Services and Homecare. All stakeholders including Strategic Commissioning, Shared Services Finance, Adult SW Services and Care at Home have been involved and approved sign off. It is anticipated that the new workers now in post will develop and drive improvements in the delivery and outcomes achieved as part of the protocol review which will be reviewed regularly. **Responsible Officer(s) – Head of Adult Services, Joint Services Manager – Adults & Older People, Registered Services Manager, supported by Shared Services.**	**30/09/25**

Observation	Risk and Recommendation	Management Response & Allocated Officer	Target Date
Authorisation of Upward Adjustments A change to the process has occurred whereby the HSCP staff review the provider return spreadsheet, complete the paperwork for each individual's variation and send this over email to Shared Services for processing. Additional controls need to be implemented to give management assurances that all payments requiring an upward adjustment, as indicated in the variation report, have been processed. The original documented protocol has not been revised to incorporate any changes with respect to roles, responsibilities and processes.	**HIGH** *As the process is being managed via emails there is a risk that if any adjustments are missed, social care providers are being underpaid for the delivery of certain services to individuals. This may result in inaccurate financial reporting information being produced as part of the budget monitoring process and a financial pressure emerging at a later stage.* **Recommendations** The documented protocol should be revised to incorporate recent changes in roles and responsibilities and in the authorisation processes. A control, such as the performance of a reconciliation or tracker between the upward adjustments spreadsheet and the individual service agreements, should be put in place. In the longer term, a system workflow solution should be sought to further reduce risks in this area to eliminate the managing of payments via emails.	**Accepted** Where provider returns identify costs above the planned amount these should be checked individually for accuracy; where returns are at the planned level or below they will be paid (paid therefore on actual and not planned) and so the aim/objective has been in essence achieved, However, we would accept that there remains a risk that providers may be underpaid if these upward adjustments are not being prepared timeously or accurately. Consistent reconciliations between the report and the individual paperwork will be completed as part of new process and with addition of new staff whereby all 'red' returns (those which are above planned level) will be individually reviewed and checked as per the updated protocol. **Responsible Officer – Head of Community Health and Care Services/ Head of Adult Services / Team Leader, Finance – Shared Services/ Strategic Commissioning Manager**	**01/12/25**

Observation	Risk and Recommendation	Management Response & Allocated Officer	Target Date
Provider Compliance Auditors noted that the data submitted by the providers was generally reasonable, with reasons being given for the variation in hours. Auditors did, however, note that four providers appear not to have submitted returns for a sampled period. The responsibility for monitoring the provider returns has passed to the HSCP and a revised protocol should be reflective of this.	**HIGH** *In the absence of providers submitting variation reports there is no assurance that planned and actual hours are the same, resulting in overpayments going uncorrected.* *In the absence of supporting evidence there is a lack of assurance that outstanding returns have been flagged for investigation.* **Recommendations** The tracking of any issues with providers, in terms of both completion and the quality of the data requires to be firmed up. Where suppliers fail to provider a return this should be clearly documented and evidence held as to the steps taken to obtain this and, failing this, escalation made for potential non-payment. The protocol should be amended to capture the changes in roles and responsibilities.	**Accepted** Additional briefing to be completed with providers now that protocol/procedure has been updated. The return form has also been amended and it anticipated that this should be more straightforward and will ensure consistency in returns. **Responsible Officer(s) – Head of Adult Services, supported by Shared Services.**	**01/11/25**

Observation	Risk and Recommendation	Management Response & Allocated Officer	Target Date
Management Oversight In the previous report it was stated that HSCP Management should, in assessing the improvements being made by way of this revised process and ensuring that any issues are addressed, ensure that key data in relation to this process is being captured, reported on, and escalated, where appropriate. This risk is in progress of being implemented. Senior Management capacity has been a limiting factor in progressing this.	**HIGH** *In the absence of key data being reviewed, there is a lack of assurance over the process's effectiveness.* *Without robust escalation arrangements, issues will go untreated*. **Recommendation** Following further changes to the roles and responsibilities of this process, further work is required to embed a cycle of oversight at the Senior Management level.	**Accepted** Quarterly reporting to relevant heads of service to be established with key data reported/made available to HSCP SMT to ensure sufficient governance, oversight, and scrutiny. Quarterly reporting will be established within new SW Governance Meeting which is being established from September 2025. **Responsible Officer(s) – Head of Adult Services, Joint Services Manager – Adults & Older People, Registered Services Manager.**	**01/10/25**

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce
AGENDA ITEM NO: 07.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**15th SEPTEMBER 2025**
REPORT REFERENCE:	**PERF/150925/07**
CONTACT OFFICER:	**ALISON WILLACY, PLANNING PERFORMANCE & QUALITY MANAGER**
SUBJECT TITLE:	**HSCP ANNUAL DELIVERY PLAN UPDATE 2025/26**

1.0 PURPOSE

1.1 The purpose of this report is to update the Committee on the performance of the HSCP Delivery Plan for 2025/26 as at the end of the first quarter.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.1 Note the update to the HSCP Delivery Plan for 2025/26.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The HSCP Board agreed the HSCP Delivery Plan 2025/26 at the IJB meeting on the 20th March 2025. The HSCP Delivery Plan draws together our strategic development priorities for the year, informed by the Strategic Plan's development priorities, the NHS Moving Forward Together Strategic Plan, the priorities of East Dunbartonshire Council as set out in the Community Planning Partnership's Local Outcome Improvement Plans, new statute and policy drivers, and identified areas for transformation change and our savings requirements.

3.2 The Delivery Plan was monitored throughout the year through the HSCP Annual Delivery Plan Board comprising the Chief Officer, Chief Finance & Resources Officer, HSCP Heads of Services and organisational development and HR support from both the Council and NHS.

3.3 The dashboard setting out progress on delivery of the projects to be delivered during 2025/26 is attached as **Appendix 1** with a more detailed update on the final position for each project attached as **Appendix 2.**

3.4 There were a total of 29 projects to be delivered within the Delivery Plan for 2025/26:-

- 24 are considered at Green status and on track for delivery.
- 5 are considered to be at risk.

3.5 The five projects which are considered to be at risk are:

- Conclude the planning and operationalisation of the West of Scotland Adolescent Intensive Psychiatric Care Unit (IPCU)
- Bishopbriggs Premises - progress approved property redesigns in 2025/26
- West Locality Premise Feasibility (Milngavie) - progress approved property redesigns in 2025/26
- Review summary business cases for Woodlands and Milngavie Clinic
- Continued delivery of East Dunbartonshire components of the GGC Unscheduled Care Joint Commissioning Plan

4.0 IMPLICATIONS

The implications for the Committee are as undernoted.

4.1 Relevance to HSCP Strategic Plan 2025-2030 Priorities;-

1. Empowering People
2. Empowering and Connecting Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery

4.1 Frontline Service to Customers – None

4.2 Workforce (including any significant resource implications) – None

4.3 Legal Implications – None

4.4 Financial Implications – The HSCP Delivery Plan includes the transformation and service redesign priorities for the year including the areas requiring investment and disinvestment.

4.5 Procurement – None

4.6 ICT - None

4.7 Economic Impact – None

4.8 Sustainability – None

4.9 Equalities Implications – None

4.10 Other – None

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 The risks to the delivery of each priority are set out in the highlight report specific to each area.

6.0 IMPACT

6.1 **STATUTORY DUTY –** None

6.2 **EAST DUNBARTONSHIRE COUNCIL** - None

6.3 **NHS GREATER GLASGOW & CLYDE** - None

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required.

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 Appendix 1 – HSCP Delivery Plan Dashboard 2025/26
8.2 Appendix 2 – HSCP Delivery Plan Highlight Report 2025/26

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HSCP TRANSFORMATION PROGRAMME 2025/26			
Programme overview	**Summary of RAG Status**		
Projects	On Track	At Risk	In Exception
29	**24**	**5**	**0**

Project Name	Previous Status	Current status	Progress	Original Project End Date	Forecast Project End Date
Improve quality and relevance of information on HSCP website and maximise the potential of HSCP website to enable people to manage their own health and care needs			25%	31-Mar-2026	31-Mar-2026
Implement year one of the East Dunbartonshire Public Health Framework			25%	31-Mar-2026	31-Mar-2026
Review Care at Home services to focus on reablement expansion to mitigate demand growth			20%	31-Mar-2026	31-Mar-2026
Service Review Social Work Community Occupational Therapy Service			20%	31-Mar-2026	31-Mar-2026
Review of the HSCP public protection function/team			0%	31-Mar-2026	31-Mar-2026
Complete review of Respite (Commissioned)			25%	31-Mar-2026	31-Mar-2026
Commence the Review of the Supported accommodation estate			25%	31-Mar-2026	31-Mar-2026
(Commissioned) Review and implement recommendations to reduce high-cost care packages (LD)			20%	31-Mar-2026	31-Mar-2026
Explore potential of developing an all-age learning disability function			25%	31-Mar-2026	31-Mar-2026
Strategic Review of Mental Health and Alcohol and Drugs Services			75%	31-Mar-2026	31-Mar-2026
Service Review Community Mental Health Team (CMHT) and Older Peoples Community Mental Health Team (OPCMHT)			20%	31-Mar-2026	31-Mar-2026

Project Name	Previous Status	Current status	Progress	Original Project End Date	Forecast Project End Date
Resolution of North Lanarkshire Corridor Service Level Agreement (NHS GGC/NHS Lanarkshire)			20%	31-Mar-2026	31-Mar-2026
Conclude the planning and operationalisation of the West of Scotland Adolescent Intensive Psychiatric Care Unit (IPCU)			20%	31-Mar-2026	31-Mar-2026
Conclude the planning and operationalisation of a West of Scotland (WoS) Regional Planning Regional Forensic and Secure Care CAMH services			20%	31-Mar-2026	31-Mar-2026
Adult and Children & Families Services Commissioning Review			0%	31-Mar-2026	31-Mar-2026
Bishopbriggs Premises - progress approved property redesigns in 2025/26			60%	31-Mar-2026	31-Mar-2026
West Locality Premise Feasibility (Milngavie) - progress approved property redesigns in 2025/26			25%	31-Mar-2026	31-Mar-2026
Review summary business cases for Woodlands and Milngavie Clinic			50%	31-Mar-2026	31-Mar-2026
Refresh Digital Strategy in line with the new Strategic Plan 2025-30			25%	31-Mar-2026	31-Mar-2026
Continued delivery of East Dunbartonshire components of the GGC Unscheduled Care Joint Commissioning Plan			0%	31-Mar-2026	31-Mar-2026
Complete the Review of the Care Home Support Team			50%	31-Mar-2026	31-Mar-2026
Undertake a test of change in relation to enhanced multi-disciplinary working in health and community care			25%	31-Mar-2026	31-Mar-2026
Review and refresh the HSCP Medium-Term Financial Strategy (MTFS)			0%	31-Mar-2026	31-Mar-2026
Implement focussed programme of de-prescribing and realistic medicine			25%	31-Mar-2026	31-Mar-2026
Review of Business Support Function			30%	31-Mar-2026	31-Mar-2026
Review of HSCP Management Structure			20%	31-Mar-2026	31-Mar-2026
Service Review of Adult Social Work Services			20%	31-Mar-2026	31-Mar-2026
Develop the 2025-2030 HSCP Workforce Plan			34%	31-Mar-2026	31-Mar-2026

Project Name	Previous Status	Current status	Progress	Original Project End Date	Forecast Project End Date
Review supervision policies and practises, and develop standards aligned with values such as empowering people, self-management, shared decision-making, and co-production within Specialist Children's Services			50%	31-Mar-2026	31-Mar-2026

HSCP TRANSFORMATION 25

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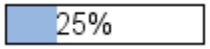
PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-01 Improve quality and relevance of information on HSCP website and maximise the potential of HSCP website to enable people to manage their own health and care needs				Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	21-Jul-2025

Project Description

Project Sponsor	**Project Manager**
Alison McCready	Andy Craig; Jane Jeffrey

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Approach discussed at Digital Health & Care Strategy Board with decision taken to set up a short life working group to review and recommend improvements for the website. • Website updates are ongoing.	• Short life working group to meet and review website content.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✘	✔	✘	✔

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-02 Implement year one of the East Dunbartonshire Public Health Framework			25%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	Project Manager
Alison McCready	Sarah McChristie; Connie Williamson

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Progress achieved in promoting and uptake of EQIA training across the HSCP • Increased social media audience • Strengthened partnership working between HI and wider HSCP, EDC, EDVA and other CPPs • Re-established Substance Use Prevention Group (SUPG) and strategic groups for sexual health and relationships • Delivered timely responses and representation to licensing applications/boards, including 2 objections under the "Protecting Children and Young People from Harm" objective • Initiated a local vaping needs assessment to deliver targeted awareness • Gambling harm exploration initiated and aligned to the Alcohol and Drug Partnership (ADP) • Collaborative engagement with local and GGC partners	• Public Sector Equality Duty (PSED) - report on 2-yearly update on Equality Outcomes • Continued promotion of EQIA training and monitoring across the HSCP • Implement the SUPG development session and finalise action plan aligned to the ADP and ED Public Health Framework • Continued responses to licensing applications and maintaining representation at relevant forums • Enhance ABI delivery through strengthened partnerships, particularly focusing on Criminal Justice (delivery plan) • Complete recruitment and initiate project plan for vaping in young people needs assessment • Progress tailored data development for young people's sexual health and advance the re-establishment of strategic groups • Alignment to the recently launched National Population Health Framework

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits					
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	Other Intended Benefits			
Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
	✔		✔		

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-03 Review Care at Home services to focus on reablement expansion to mitigate demand growth			20%	Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	**Project Manager**
David Aitken	Richard Murphy

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• The Project Initiation Document for the Care at Home review has been prepared.	• The Care at Home review is expected to commence in October.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-04 Service Review Social Work Community Occupational Therapy Service			20%	Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	**Project Manager**
David Aitken	Richard Murphy

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Review of Social Work Occupational Therapy service is now being considered within Service Review for Adult Social Work Services.	• PEST / SWOT Analysis to be completed in next reporting period. • Communication and Engagement Plan also to be agreed in this period.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-05 Review of the HSCP public protection function/team			0%	Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	**Project Manager**
David Aitken	Claire Carthy

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Public Protection Review postponed pending the outcomes of other priority reviews.	

Reason for RAG Status
Review has been postponed to 2026/27. This action will be removed from future 2025/26 progress reports.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-06 Complete review of Respite (Commissioned)			25%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	Project Manager
Karen Lamb	Gillian Healey; Richard Murphy; Gayle Paterson

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Commenced stage 1-3 of EDC 10 stage review process. • Completed Project Initiation Document (PID). • Finalised feedback from public consultation. • Agreed and implemented a new assessment Matrix for eligibility and fair access.	• Agree revised TOR with Provider of residential respite. • Stage 4-7 of EDC 10 stage review process to be completed. • Stage 2 of Planning with People consultation and engagement process to be completed. • EQIA to be commenced. • SWOT/PEST analysis to be undertaken. • Agree a CAP to be applied and agree maximum occupancy requirement. • Implement new booking system. • Reduce waiting list.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✔	✔	✘	✘

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-07 Commence the Review of the Supported accommodation estate			25%	Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	**Project Manager**
Karen Lamb	Gillian Healey; Richard Murphy; Gayle Paterson

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Commenced stage 1-3 of EDC 10 stage review process. • Complete Project Initiation Document (PID) and TOR. • Engaged with Commissioned Providers. • Formalised review approach and developed a supporting framework. • Identification of all clients in receipt of overnight support. • Implementation of sleepover monitoring process. • Reviewed the current model for client assessment. • Agreed the need for a Voids management protocol.	• Programme of individual community care reviews. • Analyse feedback from monitoring. • Identify target geography's and analyse establishments within Geography. • Continue regular review of Voids to maximise occupancy. • Develop a mid to long term plan in relation to ongoing projected need.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-08 (Commissioned) Review and implement recommendations to reduce high-cost care packages (LD)			20%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	Project Manager
Karen Lamb	Gillian Healey; Richard Murphy; Gayle Paterson

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• This work is being led through the Supported Accommodation strategy review group. • Commenced stage 1-3 of EDC 10 stage review process. • Completed Project Initiation Document (PID) and TOR. • Identified high cost packages and associated service users. • Identified resource to undertake the reviews. • Commenced the individual assessments.	• Programme of individual community care reviews. • Develop a mid to long term plan in relation to ongoing projected need and alternative care models. • Recruit 2 new social workers to undertake the care assessments.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-09 Explore potential of developing an all-age learning disability function				25%	Green - Project on track
Original Project End Date	**Forecast Project End Date**		**Date of last project board**		
31-Mar-2026	31-Mar-2026				
Project Description					
Project Sponsor			**Project Manager**		
David Aitken; Claire Carthy			Karen Lamb		
HIGHLIGHT REPORT					
Actions completed within the last reporting period			**Actions planned in the Next Reporting Period**		
• Workshop 1 successfully completed, attended by JLDT, CWD and TU.			• Workshop 2 • Review Group Meetings		
Reason for RAG Status					
There are no significant risks or issues at this time.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-10 Strategic Review of Mental Health and Alcohol and Drugs Services			75%	Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	**Project Manager**
David Aitken	Gillian Healey; Simon Reilly

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Models of support, service specifications and financial framework established.	• Next and final stage of the review includes development and implementation of contractual arrangements.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-11 Service Review Community Mental Health Team (CMHT) and Older Peoples Community Mental Health Team (OPCMHT)			20%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	Project Manager
David Aitken	Lorraine Currie

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Review of Community Mental Health Team and Older Peoples Community Mental Health Team Project initiation document completed. • Strategic Review Group established with dates fortnightly to progress service review.	• SWOT and PEST analysis to be completed within next reporting period. • Communication and engagement plans to be established within this period as well.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-12 Resolution of North Lanarkshire Corridor Service Level Agreement (NHS GGC/NHS Lanarkshire)			20%	Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	**Project Manager**
David Aitken	Lorraine Currie

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Plans to transfer patients within North Lanarkshire Corridor remain unclear. Clarity required from NHS Lanarkshire in respect of their current position and perspective, and this is being sought by NHS Greater Glasgow and Clyde.	• Confirmation re whether proposed transfer of patients NHS GGC to Lanarkshire will progress. • Meeting with NHS GGC planning and review within Mental Health Head of Service Meeting.

Reason for RAG Status
Complexity of process and agreements required but these are known issues. Nothing additional which requires escalation at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-13 Conclude the planning and operationalisation of the West of Scotland Adolescent Intensive Psychiatric Care Unit (IPCU)		⚠	20%	Amber - Project at risk

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	Project Manager
Andrea Blair	Jackie Hardie

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Progress is currently delayed pending confirmation of funding from the Scottish Government and awaiting regional approval.	• Awaiting regional approval.

Reason for RAG Status
Progress is currently delayed.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
	✔		✔		

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-14 Conclude the planning and operationalisation of a West of Scotland (WoS) Regional Planning Regional Forensic and Secure Care CAMH services			20%	Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	**Project Manager**
Andrea Blair	Jackie Hardie

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Regional approval for the FCAMHS Hub has been secured from the West of Scotland. • SG funding has been allocated for 2025/26, with confirmation of recurrent funding still pending.	

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-15 Adult and Children & Families Services Commissioning Review				0%	
Original Project End Date	**Forecast Project End Date**		**Date of last project board**		
31-Mar-2026	31-Mar-2026				
Project Description					
Project Sponsor			**Project Manager**		
David Aitken; Claire Carthy			Gillian Healey		
HIGHLIGHT REPORT					
Actions completed within the last reporting period			**Actions planned in the Next Reporting Period**		
• Services in scope aligned to and currently being progressed as part of wider and separate Children & Families business as usual workstream.					
Reason for RAG Status					
Related services captured via business as usual or ongoing strategic reviews. This action will be removed from future 2025/26 progress reports.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
	✔	✔			

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-18 Bishopbriggs Premises - progress approved property redesigns in 2025/26		⚠	60%	Amber - Project at risk

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	10-Jul-2025

Project Description

Project Sponsor	Project Manager
Alison McCready	Vandrew McLean

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Project expected completion by contractors 19th September 2025 • Water testing will take place for 2 weeks from 19th September 2025 • Commissioning and handover to take place thereafter • Anticipated operational open mid October 2025	• Updated project plan timeline expected from Contractor • Procurement of Group 2 & 3 Items to proceed • Procurement of IT to proceed

Reason for RAG Status
• Delay to the project • Impact on provision of the service from GP Practices

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
	✔		✔		

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-19 West Locality Premise Feasibility (Milngavie) - progress approved property redesigns in 2025/26		⚠	25%	Amber - Project at risk

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	Project Manager
Alison McCready	Vandrew McLean

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Feasibility Study complete December 2025 • Taken to Informal Directors for approval to proceed discussions via Property and Partners • Discussions ongoing re the premise tenure/feasibility with Capital Planning and Property Leads	• Update from Capital Planning Leads on next steps

Reason for RAG Status
• Requirement for update on feasibility of project

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
	✔		✔		

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-20 Review summary business cases for Woodlands and Milngavie Clinic		⚠	50%	Amber - Project at risk

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	26-Jun-2025

Project Description
Progress approved Property Redesigns in 2025/2026

Project Sponsor	Project Manager
Alison McCready	Vandrew McLean

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Feasibility studies completed in 2024 • Held pending progress and viability of Milngavie premises and plans for East Locality • Update provided to IJB - June 2025	• Require update on Milngavie Premise discussions with Capital Planning and Property Leads • Meetings to be arrange to progress redevelopment and move of staff at KHCC

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-21 Refresh Digital Strategy in line with the new Strategic Plan 2025-30			25%	Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	21-Jul-2025

Project Description

Project Sponsor	**Project Manager**
Alison McCready	Andy Craig; Alison Willacy

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Approach discussed and agreed at the Digital Health & Care Strategy Board, with review of current Digital Strategy commenced in the context of progress to date, and new partner and Scottish Government strategies and frameworks.	• Continue review of current Digital Strategy and commence development of refreshed Strategy.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-22 Continued delivery of East Dunbartonshire components of the GGC Unscheduled Care Joint Commissioning Plan			0%	Amber - Project at risk

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	Project Manager
Kathleen Halpin	Fiona Munro; Alison Willacy

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• GGC Unscheduled Care delivery plan has not been ratified due to the emerging transformation agenda. Actions that had been included within the Unscheduled Care delivery plan aligned with the HSCP frailty workstream and has continued to align. • HSCP are working closely with GGC on the local contribution to urgent and unscheduled care planning.	

Reason for RAG Status
Unscheduled Care delivery plan may be superseded by NHSGGC transformation agenda.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-23 Complete the Review of the Care Home Support Team			50%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	Project Manager
David Aitken	Kathleen Halpin

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Commenced the review group and staff engagement meetings. • Completed spotlight sessions for each function within the Care Home Support Team. • Completed engagement with stakeholders.	Conclude review and prepare proposal for IJB

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-24 Undertake a test of change in relation to enhanced multi-disciplinary working in health and community care				25%	Green - Project on track
Original Project End Date	**Forecast Project End Date**		**Date of last project board**		
31-Mar-2026	31-Mar-2026				
Project Description					
Project Sponsor			**Project Manager**		
Kathleen Halpin			Fiona Munro		
HIGHLIGHT REPORT					
Actions completed within the last reporting period			**Actions planned in the Next Reporting Period**		
• Undertook development sessions with community health and care leadership relating to frailty interface.			• Commence MDT test of change with South Sector.		
Reason for RAG Status					
There are no significant risks or issues at this time.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-25 Review and refresh the HSCP Medium-Term Financial Strategy (MTFS)			0%	Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	**Project Manager**
Alison McCready	Anne Getty; Fiona Shields

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Work to review and refresh the HSCP Medium-Term Financial Strategy will commence in Q2. • Existing and emerging pressures continue to be tracked with particular focus on financial sustainability and transformation but mainly in year only at this stage. This will be extended to develop a broader 5-year revised view.	• Work to review the MTFS will commence in Q2.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✔	✔		✔		

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-26 Implement focussed programme of de-prescribing and realistic medicine			25%	Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	**Project Manager**
Calum Patrick	Carolyn Fitzpatrick

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Repeat Prescribing LES being implemented in practices. • All practices to receive deprescribing training session from Pharmacy Team. By the end of the next quarter, training will be complete in Bishopbriggs and Auchinairn in cluster.	• Training completion within remaining two cluster (Kirkintilloch & Lennoxtown / Bearsden & Milngavie). • Support to practices to identify patients for review.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-27 Review of Business Support Function			30%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	09-Jul-2025

Project Description

Project Sponsor	Project Manager
Alison McCready	Vandrew McLean

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Business Review Project Board now fortnightly • Focus Groups/Surveys ongoing • Benchmarking underway	• Data Analysis • Focus Group in person • Last call for staff/service information • Benchmarking • Working Groups to be established

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✔	✔		✔		

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-28 Review of HSCP Management Structure			20%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	Project Manager
Derrick Pearce	David Aitken; Claire Carthy; Karen Lamb

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Portfolio mapping, considering appropriate portfolio sizing and benchmarking with other HSCPs.	• Stage 1 - Options to be developed by core SMT on 9th Sept for consideration with and input from key stakeholders including staff side and union partners. • Stage 2 - Options development, appraisal and selection of preferred option. • Intend to present to Nov IJB.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-29 Service Review of Adult Social Work Services			20%	Green - Project on track

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	**Project Manager**
David Aitken	Stephen McDonald

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Project Initiation Document agreed. • Strategic Review group established and meetings established from July 2025 on a fortnightly basis to take forward this project.	• Planned actions include the completion of PEST/SWOT analysis and agreement of Communications and engagement plan.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-30 Develop the 2025-2030 HSCP Workforce Plan			34%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	Project Manager
Tom Quinn	Margaret Hopkirk

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Workforce Groups established with Terms of Reference in the HSCP / OHD / SCS, and working towards compliance with the first 2 steps of the 6-step methodology for integrated teams (identifying the purpose of the plan and identifying the challenges facing service delivery).	• Establishing final Workforce plans that comply with parts 3, 4 and 5 of the 6-step methodology: identifying the current and future workforce needs and the action plan to achieve the future workforce challenges. • Target date for completed plans is 31 August 2025.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-31 Review supervision policies and practises, and develop standards aligned with values such as empowering people, self-management, shared decision-making, and co-production within Specialist Children's Services			50%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	Project Manager
Andrea Blair	Andrea Blair

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• The supervision standards for various SCS professions have been compiled into a table for review by professional leads.	• Staff have been surveyed re their supervision experiences and the results are being analysed.

Reason for RAG Status
There are no significant risks or issues at this time.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
	✔		✔		

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce
AGENDA ITEM NO:08

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**15th SEPTEMBER 2025**
REPORT REFERENCE:	**PERF/150925/08**
CONTACT OFFICER:	**ALISON MCCREADY, CHIEF FINANCE AND RESOURCES OFFICER**
SUBJECT TITLE:	**HSCP CORPORATE RISK REGISTER UPDATE**

1.0 PURPOSE

1.1 The purpose of this report is to provide an update on the Corporate Risks and how risks are mitigated and managed within the HSCP.

2.0 RECOMMENDATIONS

It is recommended that the Performance Audit and Risk Committee:

2.1 Consider and approve the Corporate Risk Register attached as **Appendix 1**.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The Corporate Risk register reflects the HSCP Board's Commitment to a culture of improved performance in the management of Corporate Risks.

3.2 Individual Service Risk Registers are reviewed and updated on a monthly basis, as appropriate, by the Operational Leads within the HSCP. These capture a more detailed picture of individual service risks and include those services hosted within ED HSCP. This aligns to the policy requirements which states that all high and very high service levels risks should be reviewed monthly to ensure the risk in being managed with lower level risks reviewed quarterly.

3.3 The Corporate Risk Register is reviewed at least monthly by the Senior Management Team to ensure scrutiny, review and updating.

3.4 The Corporate Risk Register provides full details of all current risks across the HSCP and hosted services, in particular very high and high level risks, and the control measures that are in place to manage these.

3.5 There are a total of 22 risks (HSCP1-HSCP22), with 21 live risks included within the HSCP Corporate Risk register.

3.6 HSCP15 is a de-escalated risk relating to the appointment of an Infection Control Doctor mitigating the risk to Oral Health Services and input to ventilation and any projects requiring HAI signoff.

3.7 There has been no additional risks added to the Corporate Risk Register from the last update to Performance, Audit and Risk Committee in June 2025.

3.8 Of the 21 live risks identified within the Corporate Risk register, 3 are considered to be very high risk (priority 1), 12 are considered to be high risk (priority 2) and 6 are considered to be a medium risk (priority 3).

Very High Risk – Priority 1, Risk Score 20-25

3.9 There are 3 Very High Risk, Priority 1 risks reported in this period, which is a reduction of 1 Very High Risk previously reported in June 2025.

3.10 HSCP01 and HSCP09 relate to the ability to deliver a balanced budget and the failure to achieve transformational change and completion of transformational service redesign plans within the necessary timescales and at the pace required. Both risks have been reviewed and although both remain at a score of 25, Priority 1 which is the highest possible risk score further risk management actions have been updated. Transformational change and service reviews have commenced and will run through 2025/2026 which should bring both risk scores to a target score of 16 and Priority 2. The HSCP has continued engagement with Chief Finance Officers, Scottish Government, NHSGG&C and East Dunbartonshire Council.

3.11 HSCP01 There has been development of a "pipeline" to generate further savings with the involvement of HSCP staff through the Wider Leadership Team and with

updates and monitoring through the Senior Management Team as a risk management action.

3.12 HSCP09 has an additional control measure of continual monitoring of emerging macro financial pressures.

3.13 HSCP20 relates to Skye House this remains as a Very High Risk (20), with mitigating actions including enhanced level of monitoring and support. Internal and external reviews are underway. A review of all complaints and feedback has been undertaken and will help determine future plans. Staffing models are being revisited in line with safe staffing legislation. This will seek to reduce the risk score to a target - Low Risk (4).

High Risk - Priority 2, Risk Score 12-16

3.14 There are 12 High Risks, which is an increase of 1 High Level risk in this reporting period but a decrease in risk score for HSCP17, from Very High to High.

3.15 There is ongoing review of the previously reported risk scores and management actions identified to seek to mitigate risks. There has been a minimal impact on the High Risk scores to date

3.16 HSCP17 is a financial risk and has been reviewed from Very High Risk to High Risk. This risk details the lack of and/or insufficient funding from central government to offset the increase in employers' national insurance rate across commissioned services resulting in additional and significant financial pressures for the HSCP and Providers / services. This will continue to be closely monitored, aligning approach with other HSCP's Chief Finance Officers and Commissioners Group.

3.17 There is one High financial and service delivery risk (HSCP22) relating to regional Specialist Children's Services developments for Forensic Children and Adolescent Mental Health Services (FCAMHS) and Inpatient Psychiatric Care Unit (IPCU), updated to reference the requirement for a regional agreement for IPCU. There is ongoing engagement with NHSGG&C Capital Planning for IPCU to understand feasibility.

3.18 10 risks relate to service delivery (HSCP02 /HSCP07/HSCP08/HSCP10/HSCP12/HSCP13/HSCP14/HSCP16/ HSCP18 and HSCP21). There has been a minimal impact on the High Risk scores to date which have remained largely the same as those previously reported for risks. Following review there is some updated narrative on the risk event, cause, effect and control measures detailed.

3.18.1 HSCP12 – this risk relates to the inability to deliver on the Memorandum of Understanding (MOU) commitments within the Primary Care Implementation Plan (PCIP), highlighting that the reliance on goodwill of GPs to support delivery of PCIP services is diminishing and collective action is being considered as part of the GP dispute with Scottish Government.

3.18.2 HSCP13 - A NHSGG&C Primary Care Property Strategy refresh exercise took place summer 2025 with outcomes expected Autumn 2025, which will help inform a refresh of the ED HSCP Property Strategy which will include hosted services, Oral Health and Specialist Children Services.

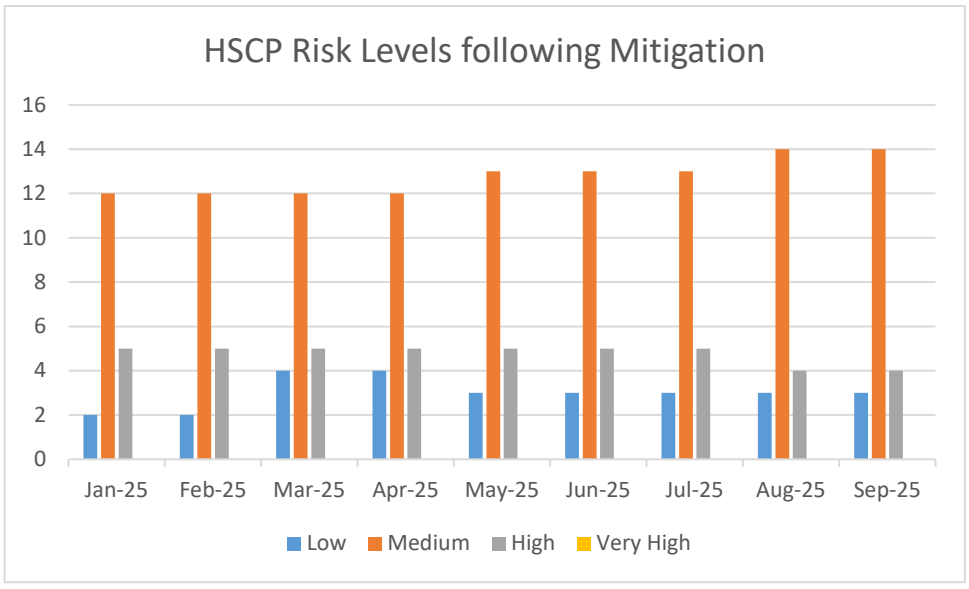
3.18.3 HSCP14 – replacement for Carefirst system remains part of East Dunbartonshire Council (EDC) digital strategy with project initiation projected for 26/27 as a result of resource issues within EDC IT team. Status continues to be monitored as part of Digital Board.

3.18.4 HSCP18 relates to Senior Management Team Vacancies/Capacity, highlighting recruitment has concluded for Chief Finance Officer, Clinical Director and Chief Nurse with all now filled. Interim support plans remain in place allocating workload across the SMT until review of the management structure concludes. Initial discussions have commenced but remain at high level with options yet to be developed and discussed with the support of union colleagues.

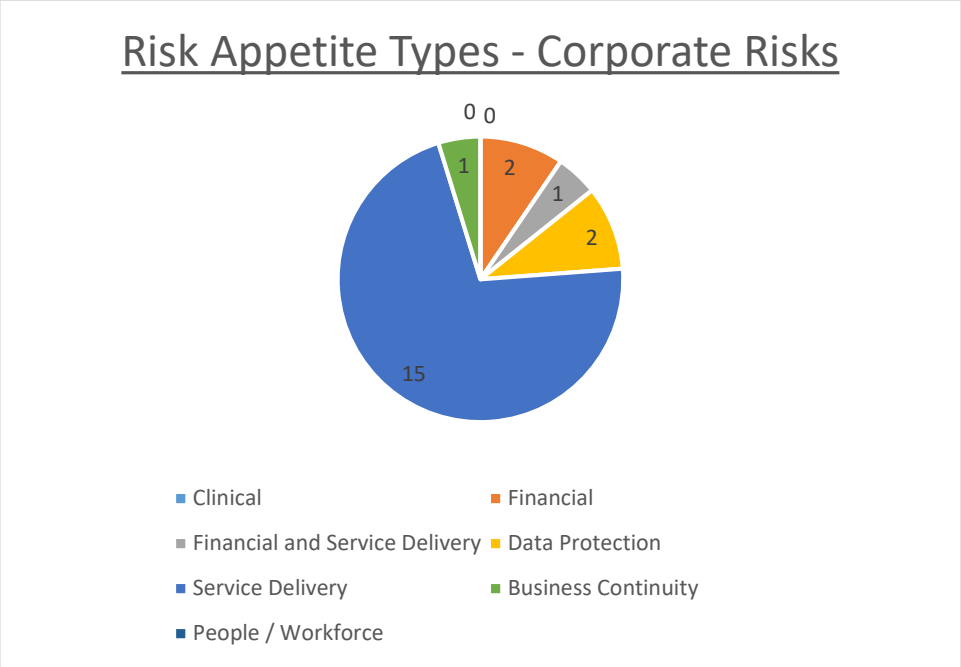
3.18.5 HSCP21 – detailing the ability to deliver on the Neurodevelopmental Service, has been updated to note that this risk has been discussed at Corporate Management Team and an agreement to apply Access Policy to referrals will progress and be in place by the end of December 2025. additional risk management action

3.18.6 There is ongoing review of the previously reported risk scores and management actions identified to seek to mitigate risks.

3.19 Following the risk management actions set out, this reduces to 4 as high risk, and the remaining 17 risks reducing to 14 medium and 3 low risks.



3.20 The majority of risks on the corporate risk register can be categorised as risk to Service Delivery, followed by Finance and Data Protection. There are no Corporate Risks categorised as Clinical or People/Workforce risks.



3.21 A copy of the HSCP Corporate Risk Register is included as **Appendix 1**.

3.22 In terms of horizon scanning, there may be an emerging risk for the HSCP due to the delay in the UK Government issuing their budget resulting in delays in confirmation of the Scottish Government budget which is typically issued mid December 2025. Current indications are that this will now be delivered in January 2026. This will adversely impact budget planning for the HSCP.

3.23 The HSCP also has a number of service risk registers in place which provides a systematic and structured method to support the risk management process. Information informing the risk register will be captured using Datix system and Social Work recording. The risks included are of a more operational nature, service specific and tend to be more fluid in how they appear on the register the risk score attached and the management actions to mitigate the risks.

3.24 There are a total of 21 service risk registers with 137 live/active risks associated with these registers. Of the 137 risks, 43 are Low risks, 65 are Medium level risks, 26 are High level risks and 4 are Very High risks.

3.25 There are 3 Very High level risks on the service level risk registers which relate to:-

Specialist Children's Services – no change to the three previously reported Very High risks since reporting in June 2025.

- Neurodevelopmental Pathway – demand for assessments is in excess of limited resource available.
- PECOS – child health ordering financial risk as growth continues annually at 18%
- Skye House – confidence in Service delivery has been affected following a documentary on the care of young people.

3.26 The process for escalation or de-escalation to the corporate risk register will depend on a number of factors such as risk score, ability to continue to manage risk at a service level or where risks have an impact across the HSCP and are not solely within one service area.

4.0 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Strategic Plan 2025-2030 Priorities;-

1. Empowering People
2. Empowering and Connecting Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery

4.2 Frontline Service to Customers – This facility will provide locally accessible community treatment and care services as part of the Primary Care Improvement Programme, for East Dunbartonshire HSCP.

4.3 Workforce (including any significant resource implications) – there are particular workforce issues highlighted throughout the risk register, particularly related to the challenges in recruitment and retention of staff into key frontline services and managing ongoing absence across critical services. Workforce issues will be addressed through the HSCP Workforce Strategy.

4.4 Legal Implications – The HSCP Board is required to develop and review strategic risks linked to the business of the Board twice yearly.

4.5 Financial Implications – There are key high level risks to the HSCP which will have a financial impact going forward and where there will require to be a focus on the delivery of transformation and service redesign to support financial sustainability and the delivery of financial balance in future years.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None

4.10 Sustainability – None.

4.11 Other – None.

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 This risk register is an aggregate of all service specific Risk Registers and control measures must be reviewed and updated regularly to reduce risk.

6.0 IMPACT

6.1 **STATUTORY DUTY** – None

6.2 **EAST DUNBARTONSHIRE COUNCIL** – The HSCP Board Risk Register contributes to East Dunbartonshire Council Corporate Risk Register and ensures the management of the risks with robust control measures which are in place.

6.3 **NHS GREATER GLASGOW & CLYDE** – The HSCP Board Risk Register contributes to NHS GG&C Corporate Risk Register and ensures the management of the risks with robust control measures which are in place.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required.

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 **Appendix 1** - HSCP Corporate Risk Register September 2025

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Completed by	**Ali McCready (CFO)updated by Vandrew McLean**	**Date created/ updated**	**Updated 04.09.25**

Risk is the chance of something happening which will cause harm or detriment to the organisation, staff or patients. It is assessed in terms of likelihood of an event occurring and the severity of its impact upon the organisation, staff or patients.

The Integration Joint Board has adopted the following scoring system which enables risks to be prioritised.

Likelihood (L)		**Consequence (C)**		**Risk (LxC)**	**=**	**Priority**
Almost certain	5	Extreme	5	20 - 25	=	Priority 1: VERY HIGH
Likely	4	Major	4	12 - 16	=	Priority 2: HIGH
Possible	3	Moderate	3	6 - 10	=	Priority 3: MEDIUM
Unlikely	2	Minor	2	1 - 5	=	Priority 4: LOW
Rare	1	Negligible	1			

The Boards Shared Risk Register comprises those risks that have been assessed as being high or very high.

Risk Appetite/Tolerance matrix

Likelihood	Consequence /Impact				
	1 - Negligible	2 - Minor	3 - Moderate	4 - Major	5 - Extreme
Almost Certain - 5	5	10	15	20	25
Likely - 4	4	8	12	16	20
Possible - 3	3	6	9	12	15
Unlikely-2	2	4	6	8	10
Rare - 1	1	2	3	4	5

IJB Corporate Risk Register @ 04.09.25

Risk Reference	Risk Event	Cause	Effect	Category of risk	Control Measures	Residual Likelihood	Residual Impact	Current Risk Score (Equals H*I)	Priority	Strategy for Risk	Risk Management Actions	Acceptable Likelihood	Acceptable Impact	Target Risk Score (Equals N*O)	Priority	Risk Lead	Risk Owner
HSCP01 - Updated August 2025	Inability to achieve recurring financial balance	Rising demand for services due to demographics, new legislation, new national policy, changing societal profile due to economic downturn, post covid service demand impacts, increasing complexity of demand, increasing public expectations re service provision, public service financial challenges resulting in requirements to make financial efficiencies. Cost of living price increases across in house and commissioned services. SG funding settlements not as expected / non recurring nature of funding, challenging budget settlements from partner organisations. Challenging savings programmes in place with increased reliance on reserves balances to achieve a balanced budget.	Reduced ability to maintain service levels leading to service reductions / cessation ; potential risk of poor service / harm to individuals; inability to offer competitive rates to service providers with potential loss of provider / risk to provider sustainability locally; cuts to staffing numbers in post; reputational risk to the HSCP, negative impact on performance and meeting set targets. Contracts for services being terminated and individuals waiting longer for access to services. A balanced budget can only be delivered through the use of reserves which is not a sustainable position.	Financial	Annual budget setting process undertaken in discussion with finance leads for Council and Health Board. Specific investment from SG to support HSCP strategic and national objectives. Annual Delivery Plan incorporating dis-investment / savings options developed and delivering. Internal Budget controls/Management systems and regular financial meetings with Council and NHS finance leads. Programme of efficiency plans established for coming year. Reserves Strategy in place to ensure minimum prudential levels of contingency reserves based on complexity / scale of budgets delegated to the HSCP.	5	5	**25**	**1**	Treat	Continued liaison with other Chief Finance Officers network / engagement with SG. (ongoing) Monitoring of delivery of efficiency plans for the coming year through the HSCP Annual Delivery Plan board. (March 2025) Review and update of a medium term financial plan to support longer term sustainability updated annually to reflect current financial landscape. (March 2025) Ongoing review / re designation of earmarked reserves.(March 2025) Budget working group established including staff partnership to review budget savings options through the financial year. (March 2025). Development of a "pipeline" to generate further savings. (August 2025)	4	4	**16**	**2**	Chief Finance & Resource Officer	Chief Officer
HSCP02 - Reviewed July 2025	Failure to implement adult support and protection improvement plan.	Quality assurance capacity in professional roles is limited due to focus on other areas of work including provision of ASP training as identified by recent joint ASP Inspection	Some adults at risk may not receive the structured statutory intervention and support that they require. Impact on outcome of inspection action improvement plan delivery.	Service Delivery	Social Work and Multi-agency Adult Support & Protection (ASP) procedures, including quality assurance and audit measures, and an appropriate training programme are in place and up to date. Improvement actions identified through the recent Joint Inspection of Adult Support and Protection Services. Funding identified to support the recruitment to the ASP Training post to create capacity to support wider ASP agenda	3	4	**12**	**2**	Treat	Delivery of the improvement action plan arising from the Joint Inspection of Adult Support & Protection Services (October 2026). Recruitment to ASP Training post (April 2025). Plan to review Public Protection Team activity over 2025.	2	4	**8**	**3**	Head of Adult Services	Chief Officer
HSCP03 - Update May 2025	Failure to comply with General Data Protection Regulations - loss of sensitive personal data (this risk and mitigation relates to personal data held which is the data controller responsibility of NHS GG&C or ED Council)	Structural changes require new and more sophisticated forms of data management. Lack of understanding and awareness of Data Protection legislation Increasing demand and competing priorities cause workers to have decreased awareness and lessened regard for Information Security. Inadequate training for staff and use of technologies.	Breach of Information management legislation. Harm or reputational risk to individuals whose data is lost or inappropriately shared. Financial penalty Increased external scrutiny Reputational damage to NHS GG&C, ED Council or the HSCP Litigation	Data Protection	Professional Codes of Practice Procedures are in place on all sites for use/release of data. Monitoring of Information Governance Standards and agencies' Security Policy, Caldicott Guardian responsibilities, NHSGGC-wide Information Governance Steering Group. Information Sharing Protocol (endorsed by the Information Commissioner) in place for HSCP. An on-going programme of awareness and training will continue. Policies updated to reflect GDPR and new e-mail policies in place to meet government's secure email standards. All laptops (now including University equipment) encrypted. Extended use of electronic records. A programme of work re the systematic audit of access to electronic records is being extended beyond the Emergency Care Summary includes the Fair Access process. Access to health records is controlled via a role based access protocol signed off by senior clinicians and the Caldicott Guardian.	3	3	**9**	**3**	Treat	SMT implements and reviews governance arrangements to comply with legislative requirements. Action plan in place to manage staff's adherence to GDPR including Information Asset register and Information Management Liaison Officer (IMLO) role. Digital GDPR training now mandatory for staff with network access along with specific training delivered by Information Governance Leads for NHSGG&C. (March 2025) A new Records Management Code of Practice for Health and Social Care 2024 has been released principally for NHS, training expected via NHSGG&C on new Code of Practice.	2	3	**6**	**3**	HSCP Corporate Business Manager	Chief Officer
HSCP04 - Update 04.09.25	Failure to comply with General Data Protection Regulations - failure to destroy records in line with schedule of destruction dates	Lack of understanding and awareness of Data Protection legislation, increasing demand and competing priorities cause workers to have decreased capacity and lesser regard for record destruction requirements. Volume of information assets / records is significant and duplicated across shared drive. Classification of records is cumbersome and clunky and difficult to understand. New Records Management Code of Practice for health and social care which will change retention periods for digital records, lack of resource capacity in HSCP staffing and EDC to support this agenda. Additional requirements for records related to the Scottish Covid Inquiry records retention.	Breach of Information management legislation. Financial penalty Increased external scrutiny Reputational damage to NHS GG&C, ED Council or the HSCP Litigation	Data Protection	A programme of work to catalogue, assign destruction dates to, and destroy records has been developed but not yet implemented due to staff capacity issues across HSCP records. IMLO reports to SMT on status of work. Delays in delivery due to Covid which has compounded position. Record Management Plan in place for HSCP with actions for continuous improvement.	4	2	**8**	**3**	Treat	New retention and destruction protocols for social work records (integrating paper and electronic records) being rolled out which will require capacity to address paper records at site. Review of staffing position to prioritise task. Development of an approach for delivery for 2024-25.Review of file classification and rationalisation of number of information assets continuing. (March 2025). SW post being considered to address review of records - ongoing 2025. HSCP Records post NHSGG&C (business support) health post 12 months fixed term readvertised June 2025 with appointment made August 2025.	2	2	**4**	**4**	HSCP Corporate Business Manager	Chief Officer

HSCP05 - Update 04.09.25	Failure in service delivery through failure of business continuity arrangements in the event of a civil contingency level event	Poor/ineffective Civil contingencies planning, Lack of suitably trained resource, Disjointed partnership working.	Reputational damage Legislative requirements not being complied with. Disruption to services. Loss of life or injury to public and or staff across the HSCP. We do not fully meet the requirements of the Civil Contingency (Scotland) act 2005.	Business Continuity	Regular testing and updating of emergency plans (multi-agency response) and Business Continuity Plans; Comprehensive plans for a Pandemic outbreak, and updated PARD / Critical Persons List.	2	5	**10**	**3**	Tolerate	Business Continuity plans. Multi agency working. Compliance with national alerts. Civil contingency. Prevent training. Winter planning. Pandemic specific business continuity approach to be regularly refreshed. (updated annually) Engagement in Council / NHS business	2	5	**10**	**3**	Planning, Performance & Quality Management Manager	Chief Officer
HSCP06 - Update March 2025	Failure to secure effective and sufficient support services from NHS GG&C and EDC to plan, monitor, commission, oversee and review services as required including functions delivered by business support services.	Limited resources across NHS GG&C and ED Council to manage increasing demands and competing priorities HSCP reliance on NHS GG&C and EDC IT infrastructure and systems, performance reporting support, finance. HR, information governance etc. Frequency of change demands for CareFirst and NHS GG&C systems such as EMIS high and outwith our control, arising from new reporting requirements and changing legal/policy etc. underpinning requirements. Tightening budgets result in focus on efficiencies within support functions.	Failure to effectively and securely store and retrieve records - case management systems become outdated; inability to effectively and timeously share information; inability to be effective in digital development and communication (e.g. arranging meetings, integrated systems); inability to meet statutory reporting requirements; inability to deliver Commissioning Strategy; inability to progress service reviews / redesign to meet budget requirements for savings	Service Delivery	Engaged in Board wide process to ensure proportionate allocation of support resources. Chief Officer attends constituent body CMT / SMT meetings to represent HSCP requirements for support. Groups established to develop and progress work plans in collaboration with partners represented on the groups. Regular meetings with Key Managers to review support arrangements in place aligned to strategic priorities and Annual delivery plan actions.	3	3	**9**	**3**	Tolerate	Collaborative work and engagement with NHS GG&C and ED Council to share understanding of support requirements and reach agreement as to how this is delivered in the most efficient manner.(ongoing) Streamline and prioritise processes where appropriate.(31 March 2025)	3	3	**9**	**3**	Chief Finance & Resource Officer	Chief Officer
HSCP07 - Reviewed May 2025	Inability to recruit and retain the appropriate numbers of trained staff to meet requirements resulting in reduction in service or failure to meet statutory duties. Specific workforce pressure areas are Mental Health Officers, qualified Social Workers, Personal Carers, Health Visitors, Psychologists and General Practitioners (independent contractors)and Business Support staffing	Risk reflects national and local workforce pressures. The reduction in numbers of registered staff in post. Ageing workforce able to retire, limited numbers of staff in training to take up post requiring a secondary qualification, lack of remuneration for specialist qualifications (MHOs) leading to inability to retain staff after training. Local pay and grading comparable to other areas, low rates of pay for care at home staff with year on year increases limited to SLW increases. High caseloads within health visiting service compared to other areas across GG&C. National shortage of social care workforce. National recruitment and retention challenges in relation to GPs.	Failure to accurately assess and respond to risk. Unable to provide/arrange care services Inability to meet statutory requirements/duties Service is reduced or reliance on agency cover at premium cost. Fragmented services, increased complaints, service user detriment, reputational damage. Inability to support the shift in the balance of care between secondary and primary care. Inability to support the transformational change agenda in relation to GMS contract, unscheduled care. Poorer patient/service user outcomes. Reduction / consolidation in the number of steps within the health visiting pathway.	Service Delivery	Local workforce plan in place. Vacancy management process in place. Implementation of MHO Role within Social Work Mental Health Team will mitigate MHO workforce risk and reliance upon agency MHOs. Work with Chief Nurse to raise concerns corporately and nationally re community nursing and health visiting workforce and make ongoing representation for funding allocation to East Dunbartonshire. Progress innovative methods for recruitment of staff across the HSCP but particularly promoting a rolling programme of recruitment for care at home staff. Increase staff supervision, prioritise high risk / complex cases. Support national conversation re GP recruitment and retention.	4	3	**12**	**2**	Treat	Develop and regularly review workforce plan from 2025 in line with HSCP Strategic Plan. (March 25). Revised recruitment protocol in place to support SMT overview of workforce issues. Review options for 'market forces' review of pay and grading. (ongoing) Further amalgamate health visiting contacts, consider skill mix where appropriate and other mechanisms for delivery of services.(March 25)	3	3	**9**	**3**	Heads Of Services	Chief Officer
HSCP08 - Reviewed August 2025	Failure of external care providers to maintain delivery of services particularly related to care home and care at home provision.	Uncontrollable market forces (recruitment /retention, increasing cost pressures associated with living wage and wider cost of living crisis, capacity implications due to Scottish Living Wage (SLW) / benefit cap), Increasing Care Inspectorate /Public Health demands, limits on public sector finances to meet uplifts in provider costs. Challenging contractual discussions related to the NCHC / SXL contracts and affordability. Reducing resources available via SCT to provide the level of support, oversight and intervention required across the market	Service continuity disrupted / ceases. Home /accommodation at risk, large scale / volume reprovisioning required in event of care home closure, impact on any other local related homes. Reduction in available capacity across care at home sector to meet current / future demand. Fragmented services. Increased risk of assessed needs not being met, service user detriment through lack of services or timely intervention. Unable to meet statutory requirements & duty service user detriment through lack of services or timely intervention. Increased complaints Reputational risk to the HSCP	Service Delivery	Contract Management Framework Enhanced Risk Assessment (RAG's) / monitoring & oversight of Care Home sector Regular checks / audits of Business Continuity Plans & alignment to HSCP BC Plan. Assurance Visits. Established Care Home & Care at Home Sector Leads to help support oversight arrangements CI Regulation/Inspection framework SXL team - providing national oversight of providers , SCT prioritise business daily and direct support accordingly SCT structure currently under review	3	4	**12**	**2**	Treat	Enhanced support and monitoring across care home services, daily /weekly checks via Turas, RAG rating, Provider Forums, Established Sector Leads, Weekly oversight via ORG, early notification alerts via SXL & Network groups, process for review of provider sustainability and adequacy of rates for service delivery. (ongoing). Local engagement with providers on sustainable fixed rates for care at home / supported living contracts (25/26)	2	4	**8**	**3**	Head of Health & Community Care	Chief Officer
HSCP09 - Update August 2025	Risk of failure to achieving transformational change and service redesign plans within necessary timescales and at the pace required.	Lack of capacity within HSCP services and those supporting transformational change to deliver full change programme. Options for delivering transformation through efficiency / cost reduction diminishing without significant impact on levels of service delivery and performance. Scale of financial challenge is growing.	Significantly negative impact on ability to delivery medium to long term organisational outcomes as per the Strategic Plan. Inability to achieve financial balance. Increased risks to patients / service users who may wait longer for access to services. Negative impact on performance targets with increased waiting lists / times.	Service Delivery	Development and scrutiny of annual delivery plans including actions for investment / dis investment. HSCP Delivery Plan Board oversees progress. Annual Business Plan in place. Performance reporting framework established to support tracking of progress. Support through Council and NHS transformation teams to progress priorities where these are significant organisational change. Early collaborative planning with ED Council and NHS GG&C re support requirements. Continual monitoring of emerging macro financial pressures (August 2025).	5	5	**25**	**1**	Treat	Work through staff and leadership teams to identify further efficiency and redesign options to bring forward in year. Fundamental shift in how services are delivered with a medium / longer term focus. Review of reserves to support redesign / smooth in any change programme. Budget working group established including staff partnership to review budget savings options through the financial year. (March 2025). Continual monitoring of emerging macro financial pressures	4	4	**16**	**2**	Chief Finance & Resource Officer	Chief Officer

HSCP10 - Update March 2025	Failure to deliver on actions to support the implementation of the Un-scheduled Care Commissioning Plan and inability to support early, effective discharge from hospital	Lack of recurring funding to deliver on key actions. Increasing number of admissions placing increasing demands on discharge planning, capacity and ability of care homes to take individuals, additional pressure on care at homes services to support individuals to remain safely at home. Budget savings options in relation to care home placement impacting on timeframes for admission to care homes from hospital and community. Demands for complex care at home packages outstrips ability to supply through in house / commissioned providers. AWI legislation impacts ability to move individuals and those exercising choice and awaiting preferred care home.	Adverse impact on achievement of reductions in occupied bed days and delayed discharge performance. May adversely impact on wait times for people in community being admitted to care homes when assessed need identified.	Service Delivery	Identification of non recurring funding streams. Hospital assessment team staffing cohort maintained to ensure sufficient assessment function to meet demand, working closely with care providers to determine real time capacity to support discharge, commission additional care home places to meet demand, monitoring absence and enhancing capacity within care at home services to support discharge home.	4	4	**16**	**2**	Treat	Review further options for increasing capacity within care home provision and care at home through recruitment drive and further re-direction of staff. Prioritise ongoing investment through Adult Winter Planning funding to increase capacity across the HSCP in direct care services to support early and effective discharge. (March 2025) Risk management approach to ensure oversight of people who are awaiting admission to hospital. Robust assurance and reporting processes in place to monitor impact on unscheduled care targets.	3	4	**12**	**2**	Head of Health & Community Care	Chief Officer
HSCP11 - Updated 04.09.25	Failure of some or all of General Practice to deliver core services.	Demand levels rise above available capacity within existing General Practice(s) or staffing levels fall below a level where General Practice(s) can safely operate to deliver urgent and/or vital services. This includes failure to retain / recruit GPs, increased workload created due to delays in the acute sector (longer wait times for specialist input leading to increased interactions with primary care services) or intentional collective action by GP practices as part of their dispute with SG (particularly urgent care and pharmacotherapy).	Local population no longer able to access timely, safe and effective medical or nursing care within their usual General Practice setting and a delay in access to specialist assessment and treatment. Potential increase in all cause morbidity and mortality, from physical and psychological causes, and an increased reliance on acute sector at a time when they are already likely to be overwhelmed.	Service Delivery	Escalation protocols have been developed including; deffering non urgent work streams at a practice level prioritising the least urgent and escalating as necessary; encouraging Business Contingency Plans, and clear pathways, within each Practice, with confirmed 'Buddy' arrangements, consolidation of primary care at cluster levels (agreed) and HSCP level 4 planning around potential single point of GP level care.	2	4	**8**	**3**	Treat	HSCP taking a proactive approach to liaising with local practices to offer early support with redeployment of staff or assisting buddying arrangements including the redeployment of HSCP PCIP staff where possible. Active work to maintain and/or improve relationships between GP practices and HSCP.	2	3	**6**	**3**	Head of Health & Community Care	Chief Officer
HSCP12 - Update 04.09.25	Failure to deliver the MOU commitments within the Primary Care Improvement Plan	Lack of adequate funding to support full delivery of the core MOU commitments, inability to recruit the required staff, lack of accommodation to support additional staffing. Cost of Vaccination Programme(VTP) greater than funding allocation available. Reliance on goodwill of GPs to support delivery of PCIP services is diminishing and collective action is being considered as part of the GP dispute with SG.	Failure to deliver contractual requirements, financial implications to meet contract defaults in the form of transitionary payments, continued pressure on GPs to deliver non specialist functions identified to be met through other professional staff groups (and GPs may reject this responsibility increasing the burden on acute colleagues).	Service Delivery	Prioritisation of MOU commitments, maximising use of reserves to meet commitments where appropriate and non recurring, accommodation strategy to expand space capacity.	3	4	**12**	**2**	Treat	Representation to SG for funding to support full extent of MOU commitments, prioritisation of current funding allocation to core contractual commitments where appropriate. Active work to maintain and/or improve relationships between GP practices and HSCP.	2	4	**8**	**3**	Head of Health & Community Care	Chief Officer
HSCP13 - Update August 2025	Inability to secure sufficient accommodation in the West Locality to deliver effective integrated health and social work services in that area.	Lack of suitable options and capital funding available to progress development of an integrated solution, competition / prioritisation of need across NHSGGC and other HSCP priorities taking precedence, inability to effectively evidence need in context of NHSGGC priority matrix i.e. deprivation. Options for refurbishment / extension across HSCP and GP premises in the area very limited due to nature and location of current estate. Development of two retail units in Bishopbriggs (expected practical completion September 2025) will provide some capacity to deliver clinical treatments. There remains some pressure in the West Locality with options being explored and investigated with NHSGG&C and other partners. (August 2025)	Inability to offer integrated working and limited service delivery offering due to lack of available space to accommodate all service demand, lack of delivery on key strategic priorities eg PCIP, GPs remain in dated premises with little / no options for expansion to accommodate increasing demand related to housing / care home developments in the area, risk of GP Practice closure due to nature of tenure within the area with no ability of HSCP to respond. Development in Bishopbriggs will relieve pressures in this locality area.	Service Delivery	NHSGG&C Primary Care Property Strategy has been developed which sets out board priorities for primary care accommodation, ED HSCP Property Strategy in place 2023-2025 and regular engagement with colleagues within the Council / NHS board to scope options for progressing strategic priorities, GG&C HSCP Capital Planning Group established to review board wide HSCP priorities. A Primary Care Property Strategy Refresh exercise took place summer 2025 with outcomes expected Autumn 2025, which will help inform a refresh of the ED HSCP Property Strategy (August 2025) which will include hosted services, Oral Health and Specialist Children Services working with NHSGG&C board colleagues. (August 2025)	4	4	**16**	**2**	Treat	Progression of actions within ED HSCP Property Strategy have progressed and secured premises in Bishopbriggs. There is a need to revisit the business case for an Integrated Health & Care Centre in the West Locality, continue to apply pressure locally and with the NHS Board for re-prioritisation of this option, explore opportunities for allocation of capital funding within NHSGG&C and use of HSCP accommodation funding in collaboration with partners. Bishopbriggs expected practical completion September 2025. Continue to explore alternative solutions to address remaining capacity within HSCP accommodation. Continue to explore additional accommodation options within the West locality. (March 2025). Alignment with EDC Property Strategy through Autumn 2025.	3	4	**12**	**2**	Chief Finance & Resource Officer	Chief Officer

HSCP14 - Update 04.09.25	Failure to secure an alternative system to Carefirst for Social Work case management and provider financial payments.	Reliance on Council prioritisation of project in context of competing priorities across other Council services, lack of resources within the HSCP and Council support functions to progress implementation.	Current system not fit for purpose to meet the needs of system users. New cloud based systems in development and industry moving on leaving HSCP with out of date system and no opportunity for any further development beyond legislative requirements only. Lack of support in the event system malfunctions as system becomes obsolete. Limits opportunity for service redesign and efficiencies in working practices. Significant financial risks related to payment on planned service requiring manual processes to support variations. Lack of ability to interface to other key systems.	Service Delivery	Business case developed to support new system solution for SW caseload management and financial payments to care providers. Carefirst updates through HSCP Digital Board in place to support collaborative working across HSCP and Council services and promote importance and requirement for new system. Continued engagement with current system provider to ensure continued support available. Technical upgrades to most up to date version of system to ensure applicable for any system upgrades - legislative and reporting requirements being met only. This remains part of EDC digital strategy with project initiation projected for 26/27 as a result of resource issues within EDC IT team. Status continues to be monitored as part of Digital Board.	4	3	**12**	**2**	Treat	Escalation of business case to ensure prioritised for progression, identification and planning of resource requirements through care first steering group. Project Lead to be identified (June 2025)	3	3	**9**	**3**	Chief Finance & Resource Officer	Chief Officer
HSCP16 - new 17/10/24	Failure to deliver Prison Based SW in line with the Memorandum of Understanding (MOU) at HMP Low Moss.	The current funding received from SPS is insufficient to provide PBSW services to the prison population in Low Moss. Demand has increase as the prison population has grown, risk and complexity have increased, prison demographics have changed. Additional pressure arises from the fact that 1xFTE is on maternity leave.	The current team capacity is in sufficient to deliver on the statutory requirements and terms of the MoU. The needs of the prison population may not be met and Public Protection compromised. Staff are under extreme pressure and have approach TU for support. Failure to deliver on contractual arrangements.	Service Delivery	Regular meetings with PBSW. Submission of Business Case to SPS to request increased funding. Regular meetings with the Governor.	4	4	**16**	**2**	Treat	Escalation of business case to ensure prioritised for progression, identification and planning of resource requirements through SPS and SG.	3	3	**9**	**3**	Head Of Children's Services and Criminal Justice	Chief Social Work Officer
HSCP17 - new 8/01/25. Update on 25.08.25 with risk scoring reviewed.	current /future service levels reduce or cease following increase in employers national insurance contributions (eNIC's) - effective 6th April 25.	No central /additional funding available to support or offset Employers Ni rate Providers currently absorbing but unable to maintain longer term - concerns escalated via Scot Care/CCPG. HSCP unable to support due to lack of funding & wider budget pressures - resulting in limited direct approaches via providers to date	current or future service levels reduce and/or cease to offset the increase to eNIC's	Financial	Pending clarification from the Scot Govt re funding, working with providers to support any related sustainability issues, aligning approach with other HSCP's via CFO and Commissioners groups. This will continue to be closely monitored.	3	4	**12**	**2**	Treat	Ongoing liaison between the Council and HSCP, Commissioners from other HSCP's, Chief Finance Officers network / engagement with SG and Provider Reps. Limited action pending determination from the Scot Govt	3	3	**9**	**3**	Chief Finance & Resource Officer	Chief Officer
HSCP18 - new 8/01/25. Update 04.09.25	Senior Management Team Vacancies/Capacity	Due to promotions and planned absence key HSCP posts including CFO and Heads of Service are vacant.	Failure to meet all roles and responsibilities for key posts, such as Section 95 duties within the HSCP. Inability to meet statutory requirements/duties requiring support from Council and NHSGG&C.	Service Delivery	CFO, CD and Chief Nurse recruitment has now concluded with all now in post. Some interim support plans remain in place allocating workload across SMT until review of management structure concludes. Initial discussions have commenced but remain at high level with options yet to be developed and discussed with the support of union colleagues.	4	3	**12**	**2**	Treat	Interim Management cover arrangements in place, with support from NHSGG&C and EDC. Continue to develop and regularly review cover arrangements until recruitment progresses and management structure is reviewed. Consider other mechanisms for delivery of services.	3	3	**9**	**3**	Heads Of Services	Chief Officer
HSCP19 - new 8/01/25. Update 20.02.25. Update 29.08.25	Impact of further reductions to 36hrs working week for NHSGG&C "Agenda for Change " staff on 1 April 2026	Reduction from 37 hours per week to 36 hours per week for f/t staff and pro rata reduction for p/t staff to be in place from April 2026 following Scot Govt Directive.	Reduced ability to maintain service levels leading to service reductions / cessation ; potential risk of poor service / harm to individuals. Increased complaints, service user detriment	Service Delivery	Local workforce plan in place for all services requiring to review impact on reduction across HSCP. Review of priorities within services and impact of reduction in capacity/operating hours which may also impact on other services (internal or external). Services require to work on plans to implement this reduction by August 2025.	3	3	**9**	**3**	Treat	Review service workforce plans and capacity for both reductions, investigate skill mix, opportunities for integrating access to services (single points of access) and other mechanisms for delivery of services.(August 25) identify approximate costs of this reduction	3	3	**9**	**3**	Heads Of Services	Chief Officer
HSCP20 SCS - approved SMT 19.03.25. Reviewed 01.09.25	Skye House subject to a BBC Disclosure documentary about the care and treatment of young people. The persons exposed are young people, families and staff.	The documentary describes poor care and treatment. This impacts on the a number of areas: 1. Care and treatment 2. Public confidence in services 3. Young people and family wellbeing 4. Staff wellbeing 5. Reputational damage 6. Media attention 7. Political scrutiny	As described confidence in service delivery is affected by a range of stakeholders including young people and their families. Confidence in delivering care by staff is affected and level of assurance required means workload has increased.	Service Delivery	Active communication to all young people and families who are current inpatients, SMT following communication strategy and engagement with range of stakeholders. Internal and external review commissioned re assurance. Continued review process of all emerging complaints.	5	4	**20**	**1**	Treat	Enhanced level of monitoring and support at present. Review of all feedback within system and review feedback to determine future action plans. Staffing model being revisited.	2	2	**4**	**4**	Heads Of Services	Chief Officer
HSCP21 SCS - new - approved SMT 19.03.25. Updated 01.09.25	Ability to deliver on the neurodevelopmental service specification due to clinical and service reputational risk associated with a large existing waiting list for diagnosis across all ND profiles and increase in new referrals with low capacity within the workforce.	Demand for ND assessments is in excess of limited resource available for ND assessments, this is a pattern nationally with limited additional funding	Comprehensive work plan and oversight now in place but limited/ no reduction in waiting times due to demand	Service Delivery	ND pathway for school age children and transfer of all children to this so that scale of issue now known. Every area has local teams. Efficient models have been developed and upskilling across professional groups so that system can be as efficient as possible	4	4	**16**	**2**	Treat	Describe demand/ capacity, develop reduced criteria for access to service and consult. This has been discussed at CMT and an agreement to apply Access policy to referrals - this work is progressing and will be in place by end of Dec 25	2	2	**4**	**4**	Heads Of Services	Chief Officer

HSCP22 SCS - new - approved SMT 19.03.25. Updated 01.09.25	Regional SCS developments - FCAMHS/ Secure and IPCU	NHSGGC has been ask to develop a regional IPCU and a FCAMHS/ Secure model	This will place demand on service to support developments and risk to board where recurring funding is not established and decision making challenging to progress. Risk to destabilising current workforce	Financial and Service Delivery	Monthly meetings with all partners, raised to CMT for agreement with agreement in principle, phased approach to developments to stagger demand. Requirement for regional agreement for IPCU	4	4	**16**	**2**	Treat	Enhanced level of monitoring and support at present. For FCAMHS/ Secure as funding in non recurring recruitment on fixed term basis. Engagement with capital planning for IPCU to understand feasibility.	3	3	**9**	**3**	Heads Of Services	Chief Officer

IJB Corporate Risk Register @ 12th May 2025_ for SMT Review and Approval 14.05.25

Risk Reference	Risk Event	Cause	Effect	Category of risk	Control Measures	Residual Likelihood	Residual Impact	Current Risk Score (Equals	Priority	Strategy for Risk	Risk Management Actions	Acceptable Likelihood	Acceptable Impact	Target Risk Score (Equals N*O)	Priority	Risk Lead	Risk Owner	Comment/Date of Update
HSCP15 - resubmitted to register	Ongoing negative impact to a range of Oral Health services by lack of Infection Control Doctor (ICD) input e.g current and upcoming ventilation/air handling upgrades across various Primary Care sites; any and all projects which require HAI scribe or Infection Control input, advice or signoff.	ICD postholder stood down from role in April 2022 and not replaced. Service has not been allocated to another ICD. In addition, service advised that Infection Prevention Control Nurse (IPCN) was unable to provide advice.	Delay to ventilation upgrades projects and switch-on of recently upgraded ventilation services. Heating/cooling issues impacting on suitability of some clinics in colder weather.	Service Delivery	Issue escalated within NHSGGC but no resolution to date.	4	4	**16**	**2**	Treat	CO to raise within board wide forums to secure a solution (March 2025)	2	2	**4**	**4**	General Manager - Oral Health	Chief Officer	Appointment made to Infection Control Doctor role - mitigated to lower level risk on 02.04.25

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce

East Dunbartonshire HSCP Performance, Audit & Risk (PAR) Committee Agenda Planner

Meetings

January 2025 – October 2026

Updated 19/06/2025

Standing items (every meeting)
Minutes of last meeting (CFO)
Internal Audit Update (GMcC/PB)
HSCP Annual Delivery Plan Update (CFO)
HSCP Corporate Risk Register (CFO)
HSCP Performance Management Reports (AW / AC)
Committee Agenda Planner (CFO/CO/SMT)
Care Inspectorate Reports as available
Relevant Audit Scotland reports as available
HSCP PAR Committee Agenda Items – January 2025
Internal Audit Update (GMcC)
Internal Audit Follow Up Report (GMcC)
Performance Management Update Qtr2/3 24/25 (AC / AW)
Accounts Commission – Integration Joint Boards Finance and Performance 2024
Unaudited Accounts 2023/2024
Corporate Risk Register Update
HSCP PAR Committee Agenda Items – 13th March 2025 (tentative)
Internal Audit Plan 2025/26 and Audit Update (GMcC)
Final Audited Accounts 2023/2024 (CFO) - tbc

Performance Management Update Qtr3 22/23 (AC / AW)
HSCP Directions Log Progress Update
Corporate Risk Register Update
HSCP PAR Committee Agenda Items – 19th June 2025
Internal Audit Plan 2025/26 and Audit Update (PB)
Annual Audit Progress Report – External Audit (Mazars)
Criminal Justice Validation Report (CC)
Community Wellbeing Funding (CC)
Performance Management Update Qtr4 24/25 (AC / AW)
HSCP Directions Log Progress Update
Corporate Risk Register Update
Audit Scotland Report into GP practices and the Primary Care Strategy (FMcJ)
HSCP PAR Committee Agenda Items – 11-18th September 2025 (to be confirmed)
Final Audited Annual Accounts 2024/25 (CFO)
Mazars Annual Audit Report (TR)
PAR Terms of Reference
Unaudited Accounts 2024/2025 (tbc) (CFO)
Performance Management Update Qtr 1 (AW)
HSCP PAR Committee Agenda Items – 6th November 2025 (tentative)
Final Audited Annual Accounts 2024/25 (tbc) (CFO)
Mazars Annual Audit Report (TR)
Whistleblowing Policy (tbc)
Performance Management Update Qtr 2 25/26 (AC / AW)
HSCP PAR Committee Agenda Items – 15th January 2026 (tentative)

HSCP PAR Committee Agenda Items – 12th March 2026 (tentative)
Internal Audit Plan 2026/27 (GMcC)
Annual Audit Plan – External Audit (Mazars)
Whistleblowing Policy Update
Performance Management Update Qtr3 25/26 (AC / AW)
HSCP PAR Committee Agenda Items – June 2026
Annual Internal Audit Report (GMcC)
Final Internal Audit Follow Up Report (GMcC)
Unaudited Annual Accounts 2025/26 (CFO)
Performance Management Update Qtr4 25/26 (AC / AW)
HSCP Directions Log Progress Update
HSCP Board Agenda Items – October 2026
Internal Audit Report
HSCP Delivery Plan 2026-2027 Qtr 2
HSCP Corporate Risk Register Update