East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce

East Dunbartonshire HSCP

Performance Audit & Risk Committee Meeting

09.00am Wednesday 17th June 2026

Meeting will be hybrid with in-person attendance at Kirkintilloch Health and Care Centre, Room F33a/F33b 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	Apologies:	**Verbal**	**Noting**
3.	C Smith	Draft Minutes of Last Meeting – 13th March 2026	**Paper**	**Approval**
4.	A McCready	Performance Audit and Risk Committee – Terms of Reference Review	**Verbal**	**Noting**
5.	T Reid	Forvis Mazars – Annual Audit Report for Year Ended 31st March 2025	**Paper**	**Approval**
6.	G McConnachie	Annual Internal Audit Update and Report 2025/26	**Paper**	**Approval**
7.	A Craig	Draft HSCP Annual Performance Report 2025/26	**Paper**	**Approval**
8.	A McCready	HSCP Annual Delivery Plan Update 2025/26 Q4	**Paper**	**Approval**
9.	D Pearce	CMHT Mental Welfare Commission Report	**Paper**	**Noting**
10.	C Carthy	HMP Low Moss Update	**Paper**	**Noting**
11.	T Quinn	Whistleblowing/Speak Up - Update	**Verbal**	**Noting**
12.	A McCready	HSCP Directions Log Update	**Paper**	**Noting**

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Item	Lead	Description	Update	For Noting/ Approval
13.	A McCready	HSCP Corporate Risk Register Update	**Paper**	**Approval**
14.	D Pearce	Care Inspectorate Inspection – Pineview Housing Support Service	**Paper**	**Noting**
15.	A McCready	HSCP PAR Agenda Planner	**Paper**	**Noting**
16.	C Smith	AOCB	**Verbal**	**Noting**
17.	C Smith	Date of next meeting – to be confirmed – 29th June 2026	**Verbal**	**Noting**

East Dunbartonshire Health & Social Care Partnership

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Item 03.

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

Date: Friday 13th March 2026, 10.00am
Location: Via MS Teams and KHCC Rooms F33a/F33b

Present:	**Calum Smith**	**EDC Councillor, Depute Leader (Chair)**	**CS**
	Libby Cairns	**NHS Non-Executive Board Member (Vice Chair)**	**LC**
	Derrick Pearce	**HCSP Chief Officer**	**DP**
	Charles Vincent	**NHS Non-Executive Board Member**	**CV**
	David Aitken	**HSCP Head of Adult Services/CSWO**	**DA**
	Caleb Oguche	**General Manager, Forvis Mazars**	**CO**
	Alison McCready	**HSCP Chief Finance and Resources Officer**	**AMc**
	Gillian McConnachie	**EDC Financial Compliance Manager**	**GM**
	Lesley McDonald	**NHS Non-Executive Board Member**	**LM**
	Aiden Marshall	**EDC Councillor**	**AM**
	Andy Craig	**HSCP Planning, Performance & Quality Officer**	**AC**
	Andrea Blair	**General Manager -Specialist Children's Services**	**AB**
	Jaime Steel	**HSCP Information Governance Officer**	**JS**
Minutes:	**Siobhan McGinley**	**HSCP Corporate PA**	**SM**

Item No.	Topic	Action by
1.	**Welcome and Introductions**	**CS**
	CS welcomed the Committee to the meeting. CS asked all IJB Board members to ensure that they are in receipt of agenda and papers for the forthcoming meeting on 19th March. If there are any issues, they should contact the sender, Lesley McKenzie.	
2.	**Apologies**	**CS**
	Apologies submitted by Karen Lamb, Jamie Robertson, Claire Carthy, Kathleen Halpin, Cllr Pamela Marshall and Vandrew McLean.	
3.	**Draft Minutes of Last Meeting – 9th February 2026**	**CS**
	Minutes of the last meeting were accepted as an accurate record of discussions. **Item Approved**	
4.	**Performance Audit and Risk Committee – Terms of Reference Review**	**AMc**
	AMc referenced the draft ToR presented at the previous meeting and reminded members that approval remained outstanding, as revisions by the standards officer were still required. Request to defer was agreed by members. **Item Noted**	

5.	**2024/25 Audit Progress Report - External Audit (Mazars)**	**CO**
	CO introduced himself in capacity as Senior Manager at Forvis Mazars and presented the progress report for 2024/25. He referenced the 2023/24 report, which had only recently been signed off and submitted due to prolonged issues with the EDC ledger system. CO went on to say, that despite the challenges in delivering audit responsibilities and meeting deadlines the previous year, the 2024/25 audit planning risk assessment is complete. Closing off substantive testing of expenditure is underway and work is on track. CO referenced the IJB Finance Bulletin 2024/25 contained within Item 5a and links to several publications which the Committee may find useful. He subsequently announced that the Public Sector Resilience and Readiness Forum will be held on March 24th, full details are available in Item 5a. He inquired if any IJB members would be attending the event. **Comments/questions** LC inquired about the delay of the 2023/24 signing of accounts and its effect on initiating the 2024/25 report, asking whether any further challenges are anticipated from the finance system in gathering the required information for 2024/25. LC also expressed appreciation for the inclusion of public information in the documentation and for the invitation to the Public Sector Resilience and Readiness Forum and welcomed further information sharing in regard to the event. CO highlighted that the challenges in gathering necessary information for 2023/24 were due to issues with the EDC ledger system but as this has now been rectified, no further issues are foreseen for the 2024/25 audit. AMc will attend the event on 24th March and will provide feedback to members. **Item approved**	
6.	**Performance Management Update Qtr3 25/26**	**AC**
	AC presented the Quarter 3 Performance Management update, referencing appendices 1 and 2 which accompany the report. Of a total of 27 projects, 22 are rated green and on track with 4 sitting at amber and deemed at risk. Members will be aware as these have been discussed at previous meetings. The four at risk projects are:- ➢ Conclude the planning and operationalisation of the West of Scotland Adolescent Intensive Psychiatric Care Unit (40%). ➢ West Locality Premise Feasibility (Milngavie) - progress approved property redesigns in 2025/26 (75%). ➢ Review summary business cases for Woodlands and Milngavie Clinic (60%).	

	➢ Continued delivery of East Dunbartonshire components of the GGC Unscheduled Care Joint Commissioning Plan (0%). The status of the Review Care at Home services remains unknown at present. **Comments/questions** With regard to the Unscheduled Care Joint Commissioning Plan, DP assured members that the amber status reflects the absence of a plan previously as opposed to the absence of work being undertaken. LC made reference to Appendix 2, page 15 and specifically to the section on; *'tri-regional review of adolescent inpatient units is scheduled to report by the end of 2025 and will inform future delivery models, emphasising a continuum of care in line with the Mental Health Strategy'.* LC inquired when a blueprint for a future delivery model might be available. DP advised of a Chief Executive meeting scheduled for April with the expectation that the report will be publicised in May with a view to having the national specification of the IPCU ready in June for government consideration thereafter. AB added that in terms of the IPCU, as part of the regional review, West of Scotland had been asked to take this on. The tri-regional review involves looking at the pathways of children and whether the community-based model is appropriate. Better clarity is expected once the review is concluded and the report is presented to Chief Executives. DP shared that the Care at Home Services review is intrinsically linked to the new Head of Interface role to provide leadership influence therefore the review had deliberately been delayed. The review will form part of the continued transformation programme for 2026/27. Regarding the West Locality Premise Feasibility in Milngavie, CS queried whether any definite timescales are attached to the actions set out. AMc confirmed that the decision remains with the property team at the NHS GG&C Board who will check the appropriateness of this funding and whether it will go forward and added that the Valuation had taken place and been provided. Members will be notified of updates. **Item Noted**	
7.	**Specialist Children Services – Skye House, Inspection Report**	**AB**
	AB referenced the unannounced inspection by Health Improvement Scotland and Mental Welfare Commission to Skye House following the serious concerns raised by a BBC documentary aired in February 2025. Two different methodologies were employed and are described in Annex 1. The visits took place in August 2025 for duration of 2 weeks and included all 4 units.	

	The inspection outcome reported 11 areas of good practice, 9 areas of improvements and 16 areas for requirements. A 12-week evidence gathering exercise followed the inspection period. The service has until the end of June to demonstrate that the improvement plan has been fulfilled, thereafter a re-inspection will take place. The outcome will be brought back to IJB at a future date. All actions contained within the improvement plan are on track. **Comments/questions** DP highlighted to members that in the 6-month period between the report being issued and the inspection being carried out, some of the elements had already been addressed. LM expressed gratitude and thanks for the work which has been undertaken. Firstly, LM queried whether any requirements are likely to present any particular difficulties. She then enquired if there will be ongoing dialogue as it progresses. AB stated that additional clarification regarding safeguarding will be sought, and a meeting with one of the inspectorate teams has been scheduled for next month. It is anticipated that most requirements will be achievable within 18 weeks, perhaps not around culture, but a model to evidence this will be provided. Close communication continues with Estates colleagues around the issue with the heating which has been impacted due to the number of windows. In terms of ongoing dialogue, fortnightly meetings, Executive Oversight Group, and means of escalation identified if needed. 'Authority to Treat' was one of the requirements and is being considered by the Associate Medical Director and Clinical Director who are working with MWC on this. LC requested for communication on the ongoing on reporting of Skye House, even as a verbal update in between PAR and IJB cycle of meetings. DP agreed to capture the progress of the action plan in the Chief Officer's report with the summary action plan. He added that the summary action tracker used for the fortnightly EOG can be and shared at this forum and with Board members. DP wished to clarify that certain workforce-related elements and financial framework are dependent upon the outcome of the regional review and sign off of IPCU specification. DP concurs that progress is being made; however, several aspects remain contingent on the completion of other processes. CS inquired further about the potential risk of conflicting requirements when engaging two separate inspection bodies, HIS and MWC.	

	AB noted some differences due to the structure of reports however, most of requirements/improvement mirror each other. AB reflected that having a joint inspection provided a helpful learning experience. **Item Noted**	
8.	**Specialist Children Services – Ward 4, Inspection Report**	**AB**
	AB continued with the update on Ward 4 which was the second of the units to be inspected in August last year. This is a national commissioned unit for those under 12 in need of psychiatric support. This inspection followed the same format as for Skye house. There were 11 areas of good practice, 2 areas for improvement and 5 areas where requirements were identified. An improvement plan is in place and on track to complete elements of Ward 4 within the prescribed 18 weeks. Some challenges have been identified around improvements regarding the building and environmental issues but staff continue to be in collaboration with Estates colleagues. AB added that this is a very positive report which should be celebrated. **Comments/questions** LC requested that in line with the Skye House reporting, something similar could be arranged to update members on Ward 4 action progress. AB assured LC that this will be provided. LM inquired with regard to the building and environmental issues and what the process will be to work through this. AB advised an action around defective fire doors is already part of a programme in progress with Estates department. Another component is creating a safe space for young people who are dysregulated. Any delay with the actions will be escalated through the fortnightly EOG. DP assured members with regard to the adaption of the building, although part of a wider piece of work, will be undertaken within the 18 weeks and unaffected by other GG&C properties. LM made reference to the phrase 'defective fire door' which was referred to by AB and requested assurance that this has been given urgent attention as opposed to being part of an ongoing programme. AB reassured members that the fire officer has completed an inspection and is satisfied that the fire doors are working effectively and is content with the management of fire safety on the ward. DP informed the Committee that, whilst the fire door does not fully meet the requirements of recently updated specifications, it operates effectively and fulfils its intended function. **Item Noted**	

9.	**Care at Home Service Inspectorate Report**	**DA**
	DA updated the Committee on the unannounced inspection by the Care Inspectorate in November 2025 with the final report being produced in January this year. Improvements are evident throughout the report with scores of 4 and 5 compared to 3 and 4 previously. DA was pleased to announce that all four recommendations had been met within the prescribed timeframes and positive comments received from carers and service users. Both CS and LC commended the improvement in scoring and thanked the teams involved for their hard work. LC asked for comment regarding point 3.9 within in the report where it states, *'There were no Requirements to be met following the outcome of this most recent inspection, and only one area for improvement identified which related to notifications to the Care Inspectorate'.* DA noted that there are designated times at which the service must notify the CI, and it is possible this area for improvement did not occur within the expected timeframe. Some notifications require judgment and a more refined process is needed to prevent similar issues from arising in the future. **Item Noted**	
10.	**HSCP Corporate Risk Register Update**	**AMc**
	AMc provided an update. There are currently 21 live risks in the register being reviewed and updated as required in the month. Three are classed very high, ten are high and eight are medium. In addition to reviewing the corporate risks, service risk registers are reviewed monthly. AMc drew members attention to point 3.21 of the report which referenced an overstatement on live service level risks. This was an admin error and controls have since been put in place to mitigate this moving forward. The newly developed format template, "Risk on a Page," has been designed in response to the challenges presented by the existing Excel risk register. This revised format provides a concise summary of each risk, enhancing readability and accessibility. Additionally, it incorporates a target date to clearly indicate progress. **Comments/questions** CS welcomed the development of this document. LC commended officers for the work and welcomes the new format presented. She added that there remain slight disparities with wording around issues and risks but has confidence in officers that this will be addressed.	

	AMc thanked LC for her feedback and noted that with a view to continuous improvement, the risk policy will be reviewed to assess for appropriateness and will be tabled again for discussion at this forum. **Item Approved**	
11.	**HSCP PAR Agenda Planner**	**AMc**
	The planner contains standing items for each meeting and AMc will include topics raised today such as the SCS reports and the Public Sector Resilience and Readiness Forum to future meetings. If members feel there are any items which ought to be on the planner which are missing, please contact AMc. **Item Noted**	
12.	**AOCB**	**CS**
	Nil of note.	
13.	**Date of next meeting – 17/18/19 June 2026 TBC**	**CS/AMc**
	The preferred date of 17th June has been identified. Members are asked to respond on the suitability of this date and whether am or pm is preferred.	

HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**17TH JUNE 2026**
REPORT REFERENCE:	**PERF/170626/05**
CONTACT OFFICER:	**ALI MCCREADY, CHIEF FINANCE & RESOURCES OFFICER**
SUBJECT TITLE:	**FORVIS MAZARS – ANNUAL AUDIT REPORT FOR YEAR ENDED 31ST MARCH 2025**

1.0 PURPOSE

1.1 The purpose of this report is to update the committee on the progress of Forvis Mazars Annual Audit for East Dunbartonshire IJB for the year ending 31st March 2025.

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 for 2024/25.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The Annual Audit Report (AAR) for year ending 31st March 2025 provides the Performance Audit and Risk Committee with a summary of audit conclusions and findings as at 9th June 2026 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 24/25 audit as substantially complete with an anticipated unqualified opinion, without modification, subject to the satisfactory conclusion of the remaining audit work detailed in the report. This includes evaluating the design and implementation of IT general controls over Oracle Fusion, the system implemented by East Dunbartonshire Council for the purposes of the IJB's financial reporting and the queries which currently remain outstanding with East Dunbartonshire Council officers. Work on gross expenditure is ongoing for the IJB to provide supporting documentation to complete the review of the remaining 10 expenditure samples. The final stages of the audit quality control and completion procedures requires the Engagement Manager and Director to complete further quality and compliance checks including updating post balance sheet event considerations to the point of issuing the final opinion and obtaining final management representations. 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 One risk for financial sustainability was recorded in the audit report where the IJB may be unable to identify and achieve the savings required to ensure financial sustainability. A recommendation for the IJB is that further work is required to transform services and deliver recurring savings. A few further recommendations were made under internal control conclusions to which a management response has been detailed on the report.

3.5 A copy of the Annual Audit Report to 31st March 2025 as at 9th June 2026 is included as **Appendix 1.**

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 report provides an update on the ongoing review of the financial performance of the IJB for 2024/25 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 Alignment to Population Health Framework – None.

4.12 Alignment to Health and Social Care Strategic Renewal Framework – None.

4.13 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 2025 as at 9th June 2026.

Annual Audit Report

East Dunbartonshire Integration Joint Board– year ended 31 March 2025

June 2026

forvis mazars

Performance, Audit and Risk Committee
East Dunbartonshire Integration Joint Board
10 Saramago Street
Kirkintilloch
G66 3BF
09 June 2026

Forvis Mazars
100 Queen Street
Glasgow]
G1 3DN

Dear Committee Members and Controller of Audit,

Annual Audit Report – Year ended 31 March 2025

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

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

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

Yours faithfully

Tom Reid (RI Director)

Forvis Mazars LLP

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05 Significant control deficiencies
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09 Best Value

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

01

Executive Summary

Executive summary

Scope

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

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

Audit status

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

Please refer to the 'Status of our audit' section for a list of significant audit matters outstanding at the date of this report. We will provide an update to Performance, Audit and Risk Committee on completion of those outstanding matters by way of a follow-up letter.

Areas of focus and audit approach, and significant findings

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

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

Significant control deficiencies

We did not identify any significant deficiencies in internal control.

Audit misstatements

We have identified no adjusted or unadjusted misstatements above our reporting threshold to date.

Executive summary (continued)

Audit opinion

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

Wider scope

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

Best Value

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

Management Commentary and Annual Governance Statement opinion

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

Matters on which we report by exception

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

Other information

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

Wider reporting powers

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

We received no objections to the accounts.

Executive summary (continued)

Qualitative aspects of IJB's accounting practices

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

Draft accounts were received from the IJB on 17 November 2025 and were of a good quality.

Significant matters discussed with management

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

Significant difficulties during the audit

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

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

02

Status of our audit

Status of our audit

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

IT General Controls Our work is ongoing to evaluate the design and implementation of IT General Controls over Oracle Fusion, a system operated by East Dunbartonshire Council for the purposes of the IJB's financial reporting. We require responses to outstanding queries from officers at East Dunbartonshire Council to complete this work.	**Low**
Gross services expenditure Our work on gross expenditure is ongoing as we await further supporting documentation and explanations from officers in respect of 10 expenditure samples.	**Medium**
Audit quality control and completion procedures: Our audit work is undergoing final stages of review by the Engagement Manager, Engagement Director 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 and obtaining final management representations.	**Medium**
Annual Report and Accounts and letter of representation: We will complete our final review of the annual report and accounts upon receipt of the signed version of the accounts and letter of representation.	**Low**

Status

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

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

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

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

03

Audit approach and risk summary

Audit approach and risk summary

Changes to our audit approach

There have been no changes to the audit approach we communicated in our Annual Audit Plan, issued on 9 February 2026.

Materiality

Our provisional materiality at the planning stage of our audit was set at £6.076m using a benchmark of 2% of gross revenue expenditure at surplus/deficit level as per the Annual Audit Plan.

Our performance materiality was set at £4.557m and our clearly trivial threshold was £182,000. In determining the overall and performance materiality levels, we made the following significant judgements:

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

There have been no changes to the materiality levels we communicated in the Annual Audit Plan

We maintained a specific materiality of £1,000 for senior officer remuneration disclosed in the Remuneration and Staff Report.

Audit approach and risk summary (continued)

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

forvis mazars

04

Significant findings

Significant findings

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

Significant risks

Management override of controls

Description of the risk

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

How we addressed this risk

We addressed this risk through performing audit work over:

- Accounting estimates: by evaluating the methods and assumptions used by management to develop the estimate;
- Manual adjustments: testing the appropriateness of adjustments made in preparing the financial statements;
- Significant transactions: considering and testing any significant transactions outside the normal course of business or otherwise unusual.

Audit conclusion

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

Significant findings (continued)

Wider responsibilities – statutory reporting

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

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

- Section 102(1) of the 1973 Act allows us to prepare a report to the Commission about the IJB's accounts; matters that have arisen during the audit that should be brought to the attention of the public; or the performance of the IJB in their duties relating to Best Value and community planning. We confirm that no such reports have been prepared.
- Section 102(3) of the 1973 Act allows us to make a special report to the Commission if an item of account is contrary to law; there has been a failure on someone's part to bring into account a sum which ought to have been brought into account; a loss has been incurred or deficiency caused by the negligence or misconduct of a person, or by the failure of a body to carry out a duty imposed on them by any enactment; or a sum which ought to have been credited or debited to one account of a body has been credited or debited to another account and the body has not taken, or is not taking, steps to remedy the matter. We confirm that no such reports have been prepared.
- Section 97A of the 1973 Act allows us to undertake or promote comparative and other studies to make and publish recommendations for the securing by local government bodies of Best Value, improving economy, efficiency and effectiveness in the provision of services by local government bodies and improving the financial or other management of local government bodies. We confirm that no such recommendations have been prepared.

05

Significant control deficiencies

Significant control deficiencies

As part of our audit, we obtained an understanding of the IJB's internal control environment and control activities relevant to the preparation of the financial statements, which was sufficient to plan our audit and determine the nature, timing, and extent of our audit procedures. Although our audit was not designed to express an opinion on the effectiveness of the 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 control that is necessary to prevent, detect, and/ or correct misstatements in the financial statements on a timely basis is missing.

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

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

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

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

Significant deficiencies in internal control

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

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

06

Summary of misstatements

Summary of misstatements (continued)

Adjusted misstatements

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

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

Unadjusted misstatements

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

Summary of misstatements (continued)

Disclosure misstatements

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

Adjusted disclosure misstatements
Management Commentary • Statement corrected to reflect that reserves decreased rather than increased. • Narrative updated/clarified to accurately reflect whether savings were supported by smoothing reserves. • Minor presentational and narrative amendments were made to improve clarity and reader understanding, including clearer explanations of financial performance, improved diagram presentation, and clarification of terminology and abbreviations.
Material Accounting Policies • Reserves. Additional narrative disclosure was included to clarify the level of general reserves, including disclosure of general reserves as a percentage of net expenditure, in line with the requirements of the Code.
Annual Governance Statement • Correction of date and references to ensure accuracy and consistency.
Note 5 – Expenditure and Income Analysis by Nature • Minor reclassification within expenditure categories amended during the audit. This adjustment was presentational in nature and had no impact on total expenditure, the surplus/(deficit) on the provision of services, or reserves.
Note 4- Events After the Reporting Period • Amendment of date to 1 April 2025 to correct the reporting reference.

07

Fraud considerations

Fraud considerations

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

Your responsibilities

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

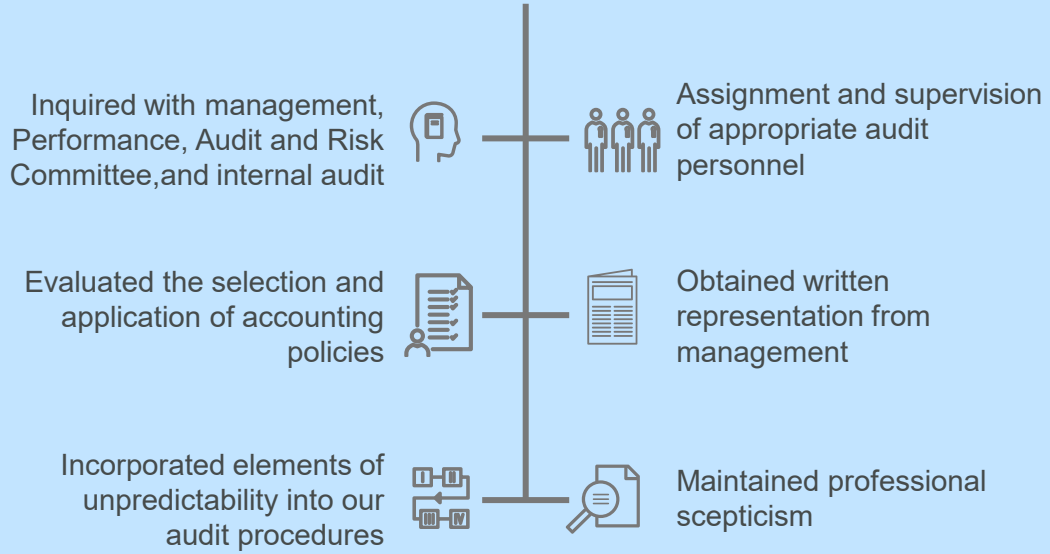
Our responsibilities

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

ISA presumed fraud risks

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

Our overall approach to fraud



Our overall conclusion

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

08

Wider Scope

Commentary on Wider Scope

Overall Summary

Commentary on Wider Scope

Wider Scope summary

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

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

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

Overall summary by reporting criteria

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

Reporting criteria	Commentary page reference	Possible significant risks?	Significant risks identified?	Other recommendations made?
Financial management	26	No	No	No
Financial sustainability	32	Yes – see risk 1 on page 33	Yes – see recommendation on page 35	No
Vision, leadership and governance	36	No	No	Yes- see recommendation on page 42
Use of resources to improve outcomes	43	No	No	No

Commentary on Wider Scope

Financial management

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

Financial management (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Financial management culture	The IJB has broadly effective financial management arrangements, This includes a clear link between its budget setting and Strategic Plan, and the use of structured options appraisal to assess savings proposals. Financial and performance information is reported regularly to the Board, supporting transparency and informed decision making. The IJB also benefits from an experienced finance team, which supports effective financial governance and oversight. The IJB had established savings plans for 2024/25 and monitored these regularly through budget reports and performance updates. Its overall budgetary control is demonstrated by the achievement of a break-even position at year end.	The IJB has a sound financial management framework that supports short term control and stability.	No significant risks identified.

Financial management (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Accountability	The 2024/25 budget was approved by the Board in March 2024, with the initial budget subsequently revised to £280.7m following additional Scottish Government funding and pay uplifts. The IJB reported an overspend of £0.088m against the funding available for the year, with an underlying operational deficit of £1.357m after movements in earmarked reserves. This reflects continued financial pressures on service delivery despite additional funding and planned savings. To achieve financial balance, the IJB relied on the use of savings options and earmarked reserves, as reflected in the movement in reserves during the year. This contributed to a reduction in total reserves from £22.544m at 31 March 2024 to £22.456m at 31 March 2025. General reserves reduced from £4.386m to £3.029m (1.3% of net expenditure), which is below the IJB's reserves policy target of 2%. The IJB regularly reported financial performance to the Board and the Performance, Audit & Risk Committee through in-year monitoring reports, which outlined the in-year position and projected outturn, enabling scrutiny of financial performance and supporting financial accountability. A Month 12 budget report was presented to the Performance, Audit and Risk Committee as well as the final outturn information reported through the unaudited annual accounts. Governance oversight remained effective throughout the year, with regular scrutiny of financial performance, including reporting of a £0.088m overspend and an underlying operational deficit of £1.357m.	The IJB's budget monitoring arrangements support financial accountability. Financial performance is reported regularly to the Board and the Performance, Audit & Risk Committee, enabling appropriate scrutiny and oversight. While reserves can appropriately be used to manage one-off pressures, the IJB's recurring reliance on them to achieve in-year balance increases the risk to its medium-term sustainability.	No significant risks identified. See financial sustainability risk identified on page 33.

Financial management (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Arrangements to prevent and detect fraud, error and other irregularities, bribery and corruption	The IJB does not maintain its own standalone fraud and corruption policies and procedures. Instead, it relies on the established governance, anti-fraud and investigatory frameworks operated by its partner bodies, East Dunbartonshire Council and NHS Greater Glasgow & Clyde, in accordance with the Integration Scheme. Both partner bodies have comprehensive arrangements in place to prevent and detect fraud, error, bribery and corruption. These include dedicated counter-fraud resources, whistleblowing procedures, and Codes of Conduct covering ethical behaviour, gifts and hospitality, and conflicts of interest. Whistleblowing arrangements applicable to partner-body staff are clearly signposted on the IJB's website. The IJB has adopted a Code of Conduct for Board members, and Members' Registers of Interests are publicly available, supporting transparency and ethical governance. Oversight of governance, risk management and internal control arrangements is provided through the Performance, Audit & Risk (PAR) Committee. Internal Audit's Annual Report for 2024/25 concluded that reasonable assurance could be placed on governance, risk management and internal control arrangements.	The IJB has appropriate and proportionate arrangements in place to prevent and detect fraud, error and other irregularities, bribery and corruption. Reliance on partner-body frameworks is appropriate given the IJB's operating model, and these arrangements are supported by clear governance oversight, defined Codes of Conduct and effective whistleblowing mechanisms.	No significant risks identified. See financial sustainability risk identified on page 33.

Financial management (continued)

Follow up of previously-reported recommendations

In February 2026 we reported one recommendation to the IJB to address risks identified from our Wider Scope audit for financial management. As part of our work in 2024/25, we followed up the progress made by the IJB against the recommendations made, and determined whether the risk remained during the year.

	Financial management finding as previously reported	Management response and implementation timeframe	Work undertaken and judgements made in 2024/25	Conclusions reached
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 final financial performance reporting 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.	**Management response:** The final financial outturn 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. **Responsible officer:** Chief Finance and Resources Officer **Implementation date**: 26 June 2025	**Progress against the recommendation** We reviewed the Board and Performance, Audit & Risk Committee papers alongside the Unaudited Annual Accounts for 2024/25. The Integration Joint Board (IJB) continued to present in-year financial performance updates to the Board through budget monitoring reports up to Month 12. The Month 12 report was presented on 13 November 2025, at the first available Board meeting after the information became available, and it supported approval of the final budget position and year-end outturn. Overall, the reporting appears timely and comprehensive, providing a clear basis for informed decision-making and final approval of the financial position.	**Conclusions** **Complete** A Month 12 financial performance report was presented to the Board, supporting transparency and enabling appropriate scrutiny.

Financial management (continued)

Follow up of previously-reported recommendations

	Financial management finding as previously reported	Management response and implementation timeframe	Work undertaken and judgements made in 2024/25	Conclusions reached
	Recommendation 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.	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.		

Commentary on Wider Scope

Financial sustainability

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

Financial sustainability

Significant risks

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

	Significant Risk in Arrangements Identified	Work undertaken and the results of our work
1	**Financial sustainability** East Dunbartonshire Integration Joint Board (the IJB) has identified significant cost pressures. It is forecasting, through its Medium-Term Financial Strategy, a financial gap of £48.9 million over the next five years. Based on projected income and expenditure, the IJB needs to achieve annual recurring savings of between £8.5 million and £11.7 million. The IJB's contingency reserves have fallen below its prudential target of 2% of net expenditure. It has created a smoothing reserve to manage resource pressures expected in 2025/26. The scale of financial savings the IJB needs to make, in the context of the national pressures facing community heath and social care services, put its financial sustainability at risk.	**Work undertaken** As part of our planned procedures, we; • reviewed the IJB's financial performance and updates to its financial planning throughout the year, including the implications for general reserves balances; • evaluated the achievement of planned recurring and non-recurring savings; • reviewed the clarity and frequency of financial reporting to Board members, including updates on in-year performance, savings delivery and key financial risks; and • assessed the IJB's progress in developing plans to close future budget gaps to support longer term financial sustainability. **Results of our work** The IJB reported a net deficit position against its 2024/25 budget of £0.1m which increased to an underlying overspend of £1.4m after adjustments for reserves and earmarked funding movements. The IJB achieved overall financial balance through the planned use of earmarked reserves and budget adjustments. This resulted in the IJB's unearmarked reserves reducing to £3.0m as at 31 March 2025 meaning they remained below the 2% of net expenditure target level. The IJB continues to face challenges and cost pressures in delivering its services with an initial indicative budget gap of £9.5m for 2025/26 closed through savings options and use of reserves. While these measures resulted in a balanced budget for 2025/26, the IJB is projecting cumulative budget gaps of £48.9m over the next five years. Financial monitoring reports demonstrated that while agreed savings were delivered, the IJB relied significantly on non-recurring funding and reserves to balance the 2024/25 position, indicating effective short-term delivery but limited sustainability. Achievement of recurring savings remains constrained, with ongoing challenges in identifying and implementing sustainable options. The establishment of the HSCP financial sustainability group is a positive step to develop recurring efficiencies and reduce reliance on one off measures over the medium to long term. There is a significant risk that the IJB may be unable to identify and achieve the savings required to ensure financial sustainability. See recommendation 1 on page 35.

Financial sustainability (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Financial planning	East Dunbartonshire IJB's Medium Term Financial Strategy (MTFS) covering 2023–2028 provides a five year financial framework aligned to the Strategic Plan 2025–2030 and Annual Delivery Plan. The MTFS incorporates scenario planning and sensitivity analysis and projects a cumulative funding gap of approximately £48.2m over the period, with required annual savings ranging between £7.6m and £12.7m. Governance and delivery are supported through the Financial Sustainability Group and oversight by the Performance, Audit & Risk Committee. The IJB identified a funding gap of £9.511m for 2025/26, which it agreed to address through savings plans (£6.707m) and the use of earmarked reserves via a Budget Smoothing Reserve (£2.586m), leaving only a minimal residual pressure managed through in year controls. In 2024/25, the IJB also utilised earmarked reserves (£5.284m) to balance the budget and implemented efficiency measures and transformation activities to mitigate short term pressures arising from prescribing volatility, demand growth, and under delivery of savings. The IJB has established a financial recovery approach embedded within its strategic planning, including recurring savings from prescribing efficiencies, workforce management, and service redesign supported by 29 transformation projects within the Annual Delivery Plan. A regular update of financial assumptions and risks is reflected through regular monitoring, sensitivity analysis, and governance reporting to ensure alignment with the current fiscal environment	East Dunbartonshire IJB demonstrates a well developed and structured medium term financial planning framework, with clear alignment to strategic priorities and robust governance arrangements in place. The combination of scenario planning, transformation programmes, and defined savings plans reflects a proactive approach to addressing significant financial challenges.	No significant risks identified. See page 35 for our prior-year recommendation which remains ongoing.

Financial sustainability (continued)

Follow up of previously-reported recommendations

In February 2026 we reported one recommendation to the IJB to address risks identified from our Wider Scope audit for financial sustainability. As part of our work in 2024/25, we followed up the progress made by the IJB against the recommendation made, and determined whether the risk remained during the year.

	Financial sustainability finding as previously reported	Management response and implementation timeframe	Work undertaken and judgements made in 2024/25	Conclusions reached
1	**Savings and transformation plans – Level 1** The IJB should develop a clear plan for identifying the programme of savings, transformation and service redesign required 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 Medium-Term Financial Strategy (2023–2028), financial planning papers, the Unaudited Annual Accounts 2024/25, and Performance, Audit & Risk Committee reporting. The MTFS continues to identify a cumulative financial gap of approximately £48.2 million over five years, requiring annual recurring savings of between £7.6 million and £12.7 million. During 2024/25, the IJB identified and monitored savings plans; however, short-term financial balance was achieved through a combination of savings options and the use of non-recurring reserves. The IJB has established savings, transformation and service redesign activities including the “Towards Sustainability” financial transformation programme. This brought together management actions, efficiency measures and service reviews to address a £9.5m gap in 2024/25, alongside a costed Annual Delivery Plan. In addition, the corporate risk register identifies ongoing efficiency programmes and dis-investment options as controls to mitigate financial sustainability risks.	**Conclusions** **Ongoing** The IJB has made progress in strengthening financial planning, identifying savings and progressing transformation activity. However, the scale of the funding gaps it has identified means that further work is required to transform services and deliver recurring savings. **Management response:** The HSCP continues to have 2 weekly budget savings meetings to monitor progress on previous efficiencies brought forward to SMT and to share and take forward any new ideas brought to the group on financial transformation. An updated MTFS is due to be developed to look at the financial sustainability over a longer period. **Responsible Officer:** Chief Finance and Resources Officer/ HSCP SMT **Implementation date:** 31 March 2027 (updated annually)

Commentary on Wider Scope

Vision, leadership and governance

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

Vision, leadership and governance (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Clarity of plans to implement the vision	The IJB operates under its Strategic Plan 2025–2030, supported by Annual Delivery Plans which set out clear priorities, actions and performance measures aligned to national wellbeing outcomes. Delivery of strategic priorities is monitored through regular reporting to the Board and the Performance, Audit & Risk Committee, with performance also reported through the Annual Performance Report. Evidence from governance reporting indicates that delivery is generally progressing in line with plans, with alignment between strategic priorities and operational activity. While some delivery challenges exist, including financial pressures, these are recognised by management and are actively monitored through established governance and risk management processes. Overall, arrangements in place provide effective oversight of delivery.	The IJB demonstrates a clear and coherent strategic vision, supported by structured planning, delivery and performance reporting arrangements. Plans to implement the vision are appropriate and proportionate, and governance arrangements provide effective oversight of progress against strategic priorities.	No significant issues identified.

Vision, leadership and governance (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Strategy and priorities	The IJB's Strategic Plan 2025–2030 sets out how the Partnership will contribute to achieving the National Health and Wellbeing Outcomes and local community planning priorities. The Strategic Plan was developed in the context of significant ongoing challenges, including financial pressures, demographic change and increasing demand for complex health and social care services. The IJB achieved 25 of 33 planned initiatives in 2024/25, prioritizing prevention, community resilience, and empowerment. Regarding its other wider responsibilities, hosted services saw high performance in public dental care and Alcohol and Drug Recovery programs, specifically for Medication Assisted Treatment standards. In addition, the IJB established a multi-agency "One-Stop-Shop" for improved, integrated justice services. Operationally, the Board increased trauma-informed practices and achieved 100% compliance in child protection social work reporting, despite significant budget constraints.	The IJB has clear and well-defined strategic priorities supported by a structured planning and delivery framework. Strategic intent is aligned to national and local priorities, and governance arrangements provide appropriate oversight of progress against priorities	No significant issues identified.

Vision, leadership and governance (continued)

Our overall assessment (continued)

Area assessed	Our findings	Our judgements	Significant risks identified
Governance arrangements	The Board continues to comprise six voting members, including three councillors from East Dunbartonshire Council and three non-executive directors from NHS Greater Glasgow & Clyde. The Board remains the IJB's key decision-making body. The Board is supported by a range of committees and management groups, including the Performance, Audit & Risk (PAR) Committee, Strategic Planning Group, Locality Planning Groups and the Clinical & Care Governance Committee. These groups provide assurance over governance, risk management, financial control, performance and service quality. Board and PAR papers are publicly available, supporting transparency and accountability. During 2024/25, the PAR Committee operated on a more structured and regular basis compared to the prior year. Our review of committee papers and minutes confirms that meetings were held consistently throughout the year, with governance, risk, financial and performance matters regularly reported and subject to member scrutiny and challenge. Evidence from committee documentation demonstrates active engagement, discussion and follow-up actions, supporting effective oversight arrangements. Internal audit concluded from its review that reasonable assurance could be placed on governance, risk management and internal control systems. The IJB made progress during the year to regularise governance documentation, including working towards finalising an agreed Integration Scheme. However, as at year-end, a formally signed version had not been issued, which presents a governance risk in relation to clarity of roles, responsibilities and accountability between partner organisations.	The IJB demonstrates effective governance arrangements supported by appropriate structures, roles and scrutiny mechanisms. Improvements made during 2024/25 have strengthened oversight, transparency and assurance. While some governance actions remain in progress, these do not represent systemic weaknesses.	See page 42 for our prior year recommendation made to the IJB.

Vision, leadership and governance (continued)

Our overall assessment (continued)

Area assessed	Our findings	Our judgements	Significant risks identified
Financial and performance information	The IJB has established arrangements for reporting financial and performance information to the Board and Performance, Audit & Risk Committee. In-year financial performance is reported through monitoring reports including variance analysis and projected outturns, while performance information is reported alongside financial data to support integrated scrutiny of service delivery. During 2024/25, in-year reporting arrangements operated effectively, with regular scrutiny and challenge evident at Board and PAR Committee meetings. However, a standalone year-end financial performance report was not produced. Equivalent information was subsequently reported through the unaudited annual accounts, but the absence of a dedicated year-end report reduced the timeliness and transparency of reporting to members and limited the opportunity for formal year-end scrutiny and challenge. This represents a minor weakness in reporting arrangements; however, overall oversight remained effective due to regular in-year monitoring and governance arrangements.	The Board and the Performance, Audit & Risk Committee receive sufficient financial and performance information to support effective scrutiny of the IJB's performance. Reporting arrangements are generally effective and support informed decision-making and oversight.	No significant risks identified.

Vision, leadership and governance (continued)

Follow up of previously-reported recommendations

In February 2026 we reported two recommendations to the IJB to address risks identified from our Wider Scope audit for vision, leadership and governance. As part of our work in 2024/25, we followed up the progress made by the IJB against the recommendations made, and determined whether the risks remained during the year.

	Vision, leadership and governance finding as previously reported	Management response and implementation timeframe	Work undertaken and judgements made in 2024/25	Conclusions reached
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.	**Recommendation:** 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 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. **Responsible officer:** Chief Finance and Resources Officer **Implementation date:** 5 August 2025	**Progress against the recommendation** We reviewed Performance, Audit and Risk Committee papers and minutes during 2024/25 and early 2025/26, together with governance updates reported to the IJB Board. Our review confirmed that a formal schedule of Performance, Audit and Risk Committee meetings had been agreed and communicated to members, covering the remainder of 2024/25 and 2025/26. We observed improved regularity of Committee meetings, with enhanced reporting on governance, risk management, internal audit, and financial and performance matters. Evidence from committee papers and our attendance and observation of meetings demonstrated appropriate scrutiny and challenge by members.	**Conclusions** Complete Based on the evidence reviewed, the regularity and effectiveness of PAR Committee meetings have improved and the recommendation has been implemented.

Vision, leadership and governance (continued)

Follow up of previously-reported recommendations (continued)

	Vision, leadership and governance finding as previously reported	Management response and implementation timeframe	Work undertaken and judgements made in 2024/25	Conclusions reached
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.	**Management 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:** Chief Finance and Resources Officer **Implementation date:** 5 September 2025	**Progress against the recommendation** We reviewed Board and Committee papers and updates, and the Annual Governance Statement included within the Unaudited Annual Accounts for 2024/25. Our review confirmed that progress was made during 2024/25 to update the draft Integration Scheme in collaboration with partner bodies, ensuring that it aligns with the required governance framework. However, a final Integration Scheme is yet to be signed.	**Conclusions** **Ongoing** Progress has been made; however, the prior-year recommendation has not yet been fully implemented. **Management response:** Work continues in line with previous management response with all HSCPs across NHSGG&C reviewing Integration Schemes. A final signed document will be available on completion of this exercise. **Responsible Officer:** Chief Finance and Resources Officer **Implementation date:** 31 March 2027

Commentary on Wider Scope

Use of resources to improve outcomes

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

Use of resources to improve outcomes (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Resources deployed to improve strategic outcomes	During 2024/25, the IJB continued to provide regular financial and performance reporting to the Board and Performance, Audit & Risk (PAR) Committee, supporting integrated scrutiny of resource use and service delivery. Performance reporting is aligned to the Strategic Plan 2025–2030 and Annual Delivery Plan, enabling members to assess whether resources are being deployed effectively to deliver agreed outcomes. In practice, this includes actions such as service redesign, early intervention initiatives and transformation programmes aimed at improving outcomes within available resources. Reporting demonstrates that resources are generally aligned to strategic priorities, with performance and financial information considered together to support decision-making. This has supported oversight of delivery and identification of areas requiring improvement. The IJB's self evaluation report for April 2024- March 2025 "How Good is Our Service" focuses on; - Statutory social work services delivered within the integrated Health and Social Care Partnership; - Performance against key indicators and targets; and - Evidence of quality, outcomes and continuous improvement. The report which forms part of the IJB's broader quality management and performance framework concludes that the IJB performed strongly overall with most indicators meeting or exceeding targets, though some specific areas (e.g. looked after children placements) require improvement.	The IJB has appropriate arrangements in place to deploy resources to improve strategic outcomes. Financial and performance information is integrated and reported regularly, enabling effective scrutiny and alignment of resources to strategic priorities.	No significant issues identified.

Use of resources to improve outcomes (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Needs of service users being met	During 2024/25, the IJB focused on supporting continuous improvement and monitoring of service quality as part of its Quality Management Framework. The Health and Care Experience Survey and other engagement activities remain key sources of service-user feedback. The IJB engaged with service users, carers, staff and partners to inform service planning and improvement, supported by the Communications and Engagement Strategy (2024–2029). During the year, the IJB progressed work in priority areas including support for carers, learning disabilities, alcohol and drugs services and dementia care, with performance data and engagement informing service delivery. Performance information indicates that services are generally meeting the needs of service users, with positive outcomes observed across priority areas. However, feedback and performance data also highlight some areas where needs are not fully met, particularly in relation to service capacity and access pressures. These are recognised and addressed through ongoing improvement activity. Overall, arrangements enable the IJB to identify and respond to service user needs effectively, with no significant issues identified.	The IJB maintains appropriate engagement, consultation and quality management arrangements to ensure the needs and experiences of service users inform decision-making, service planning and redesign.	No significant issues identified.

Use of resources to improve outcomes (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Arrangements to deliver continuous improvements in priority services	During 2024/25, the IJB continued to operate established arrangements to support continuous improvement in priority services. The Annual Performance Report 2024/25 includes a self-assessment against Best Value principles and outlines how the HSCP is balancing service quality, performance and financial constraints. The IJB's Annual Delivery Plan aligns service redesign, transformation activity and efficiency measures to strategic priorities set out in the Strategic Plan 2025–2030. Progress against delivery plan actions is monitored through regular reporting to the Board and the Performance, Audit & Risk (PAR) Committee, supporting scrutiny of improvement activity. Transformation and savings activity is overseen through established governance arrangements, including the Financial Sustainability Group, with progress and risks reported to members. While improvement activity and transformation programmes are progressing, the pace of delivery reflects the scale of financial pressures and capacity constraints. As a result, although transformation is supporting improvements, there remains uncertainty over whether it is sufficient to fully address the IJB's longer-term financial challenge.	The IJB has appropriate and established arrangements in place to support continuous improvement in priority services. Governance and oversight arrangements provide sufficient assurance that improvement activity is aligned to strategic priorities and subject to regular scrutiny.	No significant issues identified

09

Best Value

Best Value

Best Value summary

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

Overall summary by reporting criteria

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

Reporting criteria	Commentary page reference	Possible significant risks?	Significant risks identified?	Other recommendations made?	Overall conclusion
Best Value	49	No	No	No	Satisfactory

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's 2024/25 Annual Performance Report, which was approved by the Board in June 2025, details progress made against its strategic plan priorities. The report also includes 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's 2024/25 Best Value self-assessment concluded that it has established and embedded arrangements that support the delivery of Best Value including:

- Annual and quarterly performance reporting
- Monthly budget monitoring, clinical and care governance oversight and regular scrutiny by the Performance, Audit and Risk Committee which demonstrate that the IJB actively monitors performance, financial sustainability and service quality.
- The alignment of the Annual Service Delivery Plan with the IJB's transformation and efficiency priorities supports its approach to continuous improvement and effective resource management.

The Board and senior management team scrutinise the delivery of the IJB's Annual Service Delivery Plan through regular updates and reporting to the Performance, Audit and Risk Committee on key priorities. 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.

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.

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

A: Internal control conclusions

B: Draft management representation letter

C: Draft audit report

D: Confirmation of our independence

E: Other communications

F: Wider scope ratings

G: Current year updates, forthcoming accounting & other issues

Appendix A: Internal control conclusions

Other deficiencies in internal control

A deficiency in internal control exists if:

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

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

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

Appendix A: Internal control conclusions (continued)

Other deficiencies in internal control

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

Year-end financial statements close process- Design/implementation

Description of deficiency

Officers explained that the Chief Finance & Resources Officer reviews the resource transfers and other consolidation adjustments made to prepare of the financial statements. However, during our walkthrough of the financial statements close and year-end consolidation process, we were unable to obtain documentary evidence of the review of the year-end consolidation adjustments. While management confirmed that the review was performed in person on the same working file, no evidence was retained to support that this review took place.

Potential effects

Errors are not identified during the year-end consolidation process, which increases the risk of material misstatement in the financial statements.

Recommendation

Management should ensure that all key review controls are consistently performed and evidenced.

Management response:

Formal process to be set up to retain documentary evidence of the Chief Finance Resources Officer review of the consolidation of the year-end financial statements for the HSCP from NHS and Council systems

Responsible officer:

Chief Finance and Resources Officer

Implementation date:

30 June 2026 (as part of 2025/26 year-end consolidated process)

Appendix A: Internal control conclusions (continued)

Other deficiencies in internal control (continued)

Review of related party disclosure information- Design/implementation

Description of deficiency

Officers are expected on a routine basis to review transactions from East Dunbartonshire Council and NHS Greater Glasgow and Clyde against the direct and indirect interests disclosed by elected councillors and senior officers. We were unable to obtain evidence demonstrating that officers reviewed information prepared by partner organisations to support related party disclosures in the financial statements.

Potential effects

This increases the risk of incomplete or inaccurate related party disclosures within the financial statements.

Recommendation

Management retain evidence of its review of information received from partner organisations supporting related party disclosures.

Management response:

Formal process to be set up to retain evidence of the IJB's review of related parties for the IJB.

Responsible officer:

Chief Finance and Resources Officer/ HSCP SMT

Implementation date:

31 August 2026

Appendix A: 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

Compliance with Local Authority Accounts (Scotland) Regulations 2014

Description of deficiency

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.

24/25 update

Ongoing. The 24/25 annual accounts were not submitted to the auditor by the statutory deadline of 30 June in line with the regulation.

Management response:

The IJB continues to work with the Council finance team to find ways to address the system issues which are resulting in the delays in the figures being available to comply with the statutory deadline of 30th June for annual accounts to be submitted. Significant progress has been made to bring the timeline back in line with statutory guidance for 2025/26.

Responsible officer:

Chief Finance and Resources Officer

Implementation date:

30 June 2026

Appendix B: Draft management representation letter

Forvis Mazars
100 Queen Street
Glasgow
G1 3DN

XX June 2026

Dear Tom Reid,

East Dunbartonshire Integration Joint Board - Audit for Year Ended 31 March 2025

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 2025 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom 2024/25 (the Code), and applicable law.

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

My responsibility for the financial statements and accounting information

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

My responsibility to provide and disclose relevant information

I have provided you with:

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

I confirm as Chief Finance & 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.

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

Appendix B: Draft management representation letter (continued)

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

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

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

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

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

There are no contingent gains which should be disclosed.

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

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

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

Appendix B: Draft management representation letter (continued)

Fraud and error

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

I have disclosed to you:

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

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

Related party transactions

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

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

Charges on assets

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

Future commitments

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

Subsequent events

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

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

Appendix B: Draft management representation letter (continued)

Impacts of Russian Forces entering Ukraine

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

Tariffs

I confirm that I have carried out an assessment of the potential impact of changes in US trade policy in respect of tariffs, including the impact of reciprocal tariffs by other countries, including the impact of mitigation measures and uncertainties, and that the disclosure in the Annual Report and the events after the reporting period note 4 to the financial statements fairly reflects that assessment.

Going concern

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

Performance related allocations

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

Annual Governance Statement

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

Management Commentary and Remuneration Report

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

Unadjusted misstatements

I confirm that there are no unadjusted misstatements.

Appendix B: Draft management representation letter (continued)

Prior period adjustments

A prior period adjustment was identified and impacted upon the figures in the 2023/24 annual accounts.
As a result, the prior period figures have been restated. I confirm that I have disclosed to you all the relevant information to support the prior period adjustment and its disclosure notes within the financial statements and I deem the disclosure to be complete and accurate to the best of my knowledge.

Wider scope and Best Value arrangements

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

Yours faithfully,

Chief Finance & Resources Officer
XX June 2026

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

In our opinion the accompanying financial statements:

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

Basis for opinion

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

Conclusions relating to going concern basis of accounting

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

Appendix C: Draft audit report (Continued)

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

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

Risks of material misstatement

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

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

As explained more fully in the Statement of Responsibilities, the Chief Finance & 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 & 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 & 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 & Resources Officer and Chief Officer as to other laws or regulations that may be expected to have a fundamental effect on the operations of the IJB;

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

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

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

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

Reporting on other requirements

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

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

Other information

The Chief Finance & 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.

Appendix C: Draft audit report (continued)

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

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

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

Matters on which we are required to report by exception

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

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

We have nothing to report in respect of these matters

Conclusions on wider scope responsibilities

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

Use of our report

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

Tom Reid
Director
For and on behalf of Forvis Mazars LLP

forvis mazars

Appendix D: Confirmation of our independence

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

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

Appendix D: Confirmation of our independence (continued)

Fees for work as the IJB's auditor

We reported our proposed fees for the delivery of our work under the Code of Audit Practice in our Annual Audit Plan presented to the Performance, Audit and Risk Committee on 9 February 2026. Having completed our work for the 2024/25 financial year, we can confirm that our fees are as follows:

Area of work	2024/25 fees	2023/24 fees
Auditor remuneration	£37,400	£35,890
Pooled costs	£940	£1,310
Contribution to PABV costs	£7,180	£7,660
Sectoral cap adjustment	(£11,520)	(£11,500)
Total fees	**£34,000**	**£33,360**

Fees for other work

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

Appendix E: Other communications

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

Appendix E: Other communications (continued)

Other communication	Response
Subsequent events	We are required to obtain evidence about whether events occurring between the date of the financial statements and the date of the auditor's report that require adjustment of, or disclosure in, the financial statements are appropriately reflected in those financial statements in accordance with the applicable financial reporting framework. We will obtain written representations from management that all events occurring subsequent to the date of the financial statements and for which the applicable financial reporting framework requires adjustment or disclosure have been adjusted or disclosed.
Matters related to fraud	Our audit was designed to obtain reasonable assurance whether the financial statements as a whole are free from material misstatement due to fraud. Please refer to the section titled '*Fraud considerations*' for our fraud considerations and conclusion. We will obtain written representations from management and, where appropriate, 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: Other communications (continued)

Other communication	Response
System of Quality Management	To address the requirements of ISQM (UK) 1, our firm's System of Quality Management team completes, as part of an ongoing and iterative process, a number of key steps to assess and conclude on our firm's System of Quality Management, including: • Ensuring there is an appropriate assignment of responsibilities under ISQM (UK) 1 and across Leadership • Establishing and reviewing quality objectives each year, ensuring ISQM (UK) 1 objectives align with our firm's strategies and priorities • Identifying, reviewing, and updating quality risks each quarter, taking into consideration a number of input sources (such as FRC / ICAEW review findings, internal monitoring findings, findings from our firm's root cause analysis and remediation functions, etc.) • Identifying, designing, and implementing responses as part of the process to strengthen our firm's internal control environment and overall quality • Evaluating responses and remediating control gaps or deficiencies We perform an evaluation of our system of quality management on an annual basis. Our latest evaluation was performed as of 31 August 2025. Details of that assessment and our conclusion are set out in our 2024/2025 Transparency Report, which is available on our website here.

Appendix F: Wider Scope 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

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Director
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East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce
AGENDA ITEM NO: 06.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**17th JUNE 2026**
REPORT REFERENCE:	**PERF/170626/06**
CONTACT OFFICER:	**GILLIAN MCCONNACHIE, CHIEF INTERNAL AUDITOR, 0791 897 1023**
SUBJECT TITLE:	**ANNUAL INTERNAL AUDIT UPDATE AND REPORT 2025/26**

1.0 PURPOSE

1.1 The purpose of this Report is to present the Committee with the Annual Internal Audit Report for 2025/2026. In addition, an update on internal audit work completed in the period since the last Committee and the Annual Follow Up Report 2025/26 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

The Performance, Audit & Risk Committee is asked to:

2.1 Consider the HSCP Annual Audit Report for 2025/26, including the Internal Audit Opinion for 2025/26.

2.2 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 2025/26 Financial Statements.

2.3 Consider the contents of the Internal Audit Performance and Outputs Report and the Internal Audit Follow Up Report 2025/26.

2.4 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

3.0 BACKGROUND/MAIN ISSUES

Annual Internal Audit Report 2025/26

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 Global Internal Audit Standards in the UK Public Sector (GIAS-UKPS).

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 Chief Internal Auditor on the adequacy and effectiveness of internal controls, governance and risk management within the HSCP. For 2025/26, 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 Global Internal Audit Standards in the UK Public Sector, 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 2026. In reaching the opinion of reasonable assurance, risks raised by Internal Audit are noted in relation to controls over social care payments made via the CareFirst case management system. 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 2025/26 at *Appendix 2.* This report covers risks relevant to the HSCP, albeit some risks require input from Council services to address. There are no High risks currently outstanding, with the High risks raised in the CareFirst Payments audit having been completed.

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

Internal Audit Planning

3.8 An internal audit planning document was presented to the February 2026 PAR with a commitment to bring back more detail on the proposed areas of focus for the internal audit team for 2026/27.

3.9 Following consultation with Senior Management, consideration of risks and other factors such as past audit history consistent with the approach outlined in the Audit Planning document, the detail is now appended at *Appendix 4*.

3.10 The proposed areas of focus are:

- CareFirst Payments

- Application of Social Work Eligibility Criteria

- Absence monitoring

- Annual Reporting and Planning

- Follow Up Work

- Completion of 2025/26 audit plan work in progress including the Standardised Support Package Audit

3.11 The team are currently focussed on completing the 'in progress' audits from the 2025/26 audit plan. Once completed, the above audit plan will commence.

3.12 The team currently has a vacancy at the Lead Auditor level. Filling this post will be important for successful completion of the Audit Plan for 2026/27 and so this is being prioritised.

4.0 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 Alignment to Population Health Framework – None.

4.12 Alignment to Health and Social Care Strategic Renewal Framework – None.

4.13 Other – None.

5.0 MANAGEMENT OF RISK

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

5.1 Internal Audit Reports - Risks identified by Internal Audit are highlighted to management in audit reports. The risks are addressed through agreed action plans, appended to internal audit reports.

5.2 The Annual Audit Opinion and Report – The Annual Report provides assurance over the HSCP's risk management processes that were in place in the year.

5.3 Risks relating to 2026/27 Audit Plan - Staff resources are the biggest risk to the achievement of the 2026/27 audit plan. Recruitment into the vacant Lead Auditor post is being prioritised to enable achievement of the plan.

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 – HSCP Annual Internal Audit Report 2025/26
8.2 Appendix 2 – HSCP Follow Up Report 2025/26
8.3 Appendix 3 – HSCP Performance and Outputs Report January to May 2026
8.4 Appendix 4 – Internal Audit Plan Detail 2026/27

Appendix 1

HSCP Internal Audit

Annual Report
2025/26

Gillian McConnachie

Chief Internal Auditor

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 2025/26 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 Internal Audit Standards - Global Internal Audit Standards in the UK Public Sector (GIAS-UKPS).

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 2026.

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 social care payments made via the Carefirst case management system. These issues, however, do not significantly impair the HSCP's systems of internal control as a whole. Management have reported significant progress towards completion of the actions with all High risks raised deemed to be addressed. Further internal audit work is planned in this area in 2026/27 to verify the correct operation of controls in practice.

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 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 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 6 outputs were completed by 31 March 2026 compared to 9 outputs planned – a completion rate of 67%.

Despite the plan not being achieved in full, sufficient evidence to support the audit opinion was gathered through the audits completed and other sources of assurance.

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 no high risks remain outstanding and that four high risks relating to Care First Payments have been closed off. Further work on Care First payments on the 2026/27 plan to confirm that controls are operating as intended.

Other considerations for the annual opinion are detailed at *Appendix 1.1* and include the internal audit work completed at partner organisations.

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.

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, with updates on this work being provided to each committee.

Comparison of work carried out against work planned

There were 9 planned HSCP internal audit outputs for the year 2025/26 and 5 outputs were completed by the year-end, with three audits being in progress at the year-end: Grant Funding Received, Provider Uplifts Processes and Standardised Support Package. The completed outputs include audits that were carried forward from the previous year – the results of these assurance assignments are provided at *Appendix 1.2*.

Appendix 1.4 provides details of progress towards completion of the 2025/26 Audit Plan. The Interim Follow Up report was not completed due Internal Audit resources issues, but the Final Follow Up report has been completed which provides assurance over progress towards completion of internal audit actions. In addition, an audit of Financial Monitoring – Resource Allocation Processes was not completed. Some aspects of this audit may be covered by the 'Application of Social Work Eligibility Criteria' audit that is planned for 2026/27. Following the conclusion of this work, consideration will be given to further work specifically on the Resource Allocation Process for the 2027/28 audit plan.

The team has completed assurance work on CareFirst Payment and Performance Management, as detailed in *Appendix 1.2*. In addition, the team has provided the Annual Audit Report (this document), and governance reporting, the Annual Follow Up report, and the Internal Audit Plan for 2027/28.

Full details on these audits have been provided in the internal audit updates to Committee which have included relevant updates from Council and NHSGGC audits. 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 2025/26

Audit Type	Completion Number	Completion %
Audit	2 Completed out of 4 Audits Planned	50% Complete
Regularity	4 Completed out of 5 Audits Planned	80% Complete
Total	**6 Completed versus 9 Planned**	**67% Complete**

Table 2 - HSCP Internal Audit Key Performance Indicators 2025/26

Key Performance Indicator	Planned	Actual	Status
Percentage of finalised audit outputs against the number anticipated in the Plan	100%	67%	
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.

67% of the outputs in the Audit Plan was completed due to resource pressures on the Team. The team experienced a vacancy at the Audit & Risk Manager level for six months of the year and at the Senior Auditor post for eleven months. Despite the plan not being achieved in full, sufficient evidence to support the audit opinion was gathered through the audits completed and through other sources of assurance.

Annual Assurance - The follow up report, and the Annual Internal Audit Report (this document) have been produced by Internal Audit as part of their responsibility for annual assurance. 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 where the risks and the format of reporting is actively discussed. 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 GIAS-UKPS, 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.

Global Internal Audit Standards in the UK Public Sector – GIAS-UKPS

The Internal Audit Team is required to work to a set of rules – GIAS-UKPIAS. 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 GIAS-UK. 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 GIAS-UKPS.

The Public Sector Internal Audit Standards (PSIAS) were the previous applicable standards that the Internal Audit team conformed with. From 1 April 2025 GIAS-UKPS became the applicable standards.

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. 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	**Complete** Auditors have encouraged auditees to complete client surveys and a summary of these are included at *Appendix 1.3*.
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** The requirement for audits relating to the Leisure Trust will be an annual consideration when preparing the audit plan for the year.
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.

An initial Self-Assessment and action plan for GIAS-UKPS was completed and presented to the February meeting of the Performance, Audit & Risk Committee. Progress to date has been limited due to the strategic focus of the team having been on the implementation of the decision of Council at the 2026/27 budget meeting to move to a shared Chief Internal Auditor with two other Councils. These actions will be taken forward in 2026/27. Full detail of progress and anticipated completion dates is provided at *Appendix 1.4*.

Questionnaires have been made available to services to complete for each audit assignment and provide an opportunity for the auditee to provide feedback on the planning process, communication and the quality of the internal audit report (consolidated results for the HSCP and Council audits is provided at A*ppendix 1.3*). 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.

Other Issues

I am not aware of any 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 2025/26

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 2026 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 CareFirst Payments. 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 were addressed in 2025/26. 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 remaining issues and advised target dates. Auditors will monitor compliance with the agreed action as part of a six-monthly cycle with updates being 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 2026, 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 2025/26 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,
- Work undertaken by the partners' internal auditors at NHSGGC and East Dunbartonshire Council and their annual audit opinion where available; 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 2026.

Gillian McConnachie CA

Chief Internal Auditor HSCP

17 June 2026

Appendix 1.2 – Summary of Internal Audit Reports With Audit Opinion Finalised 2025/26

Area	H	M	L	Total	Audit Opinion
Health & Social Care Partnership					
CareFirst Payments Follow Up (carried forward from 2024/25)	4	3	0	7	Limited Assurance
HSCP - Performance Management (carried forward from 2024/25)	0	0	0	0	Effective Procedures
Total Risks Identified	**4**	**3**	**0**	**7**	

Appendix 1.3

Internal Audit Survey Results

	% of audits rated Excellent (out of 5 surveys returned)
Consultation on audit coverage	100%
Relevance of stated objectives	100%
Fulfilment of scope and objective	100%
Clarity of report	100%
Accuracy of findings	100%
Presentation of conclusion	100%
Value of audit recommendations	100%
Feedback of findings during audit	100%
Consultation by auditors	100%
Helpfulness of auditors	100%
Professionalism of audit team	100%
Prompt delivery of audit report	100%
Other survey comments	Time was taken to allow for full understanding of the process and what to expect. Planning was well scheduled to ensure adequate time was set aside from both parties with the scope being provided in advance. Very clear process available each year. Recommendations help to support improvements in our service. Again I would say the time given over by the Auditor to ensure I knew exactly what was happening every step of the way was exceptional.

	Great support throughout and explanation of process. Audit report was well laid out and easy to understand and provide response. Always professional and supportive. Having already gone through one previous audit I was more prepared for this second one. As always communication with the audit team is two way and collaboration is had. The audit team are extremely helpful and no question goes unanswered. The Auditor was always professional in approach, feeding back relevant information and being available to discuss any detail further when necessary.
Survey Completion Rate	**45%**

Appendix 1.4 Internal Audit Plan 2025/26 Completion Summary

Outputs	Area	Review	Rationale	*Status*
1	Audit	**Financial Monitoring – Resource Allocation Processes**	Review of processes for ensuring allocations of care packages are managed within available budgets.	Not completed
2	Audit	**Provider Uplifts Process**	Review of the process for increasing rates paid to social care providers given governance and budgetary risks	In progress
3	Audit	**Grant Funding Received Processes**	Review of HSCP processes for maximising, tracking and ensuring compliance with external grant funding received.	In progress
4	Audit	**Standardised Support Package**	Consultancy time for reviewing standardised support packages. Scope to include monitoring and success measures	In progress
5	Regularity	**Annual Audit Report**	Annual report	Completed
6	Regularity	**Annual Follow Up**	Follow up on previously issued recommendations	Completed
7	Regularity	**Annual Governance Statements**	Annual requirement for accounts and to support Annual Report	Completed
8	Regularity	**Interim Follow Up**	Follow up on previously issued recommendations	Not completed
9	Regularity	**Internal Audit Plan 2026/27**	Preparation of following year's internal audit plan	Completed

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

Code	Title	Service Responsible	Title	Status	Priority	Due Date	Original Due Date	Latest Note
CFO-IA-2324-HSCP BDP	HSCP Bad Debt Provision	Health and Social Care Partnership	Governance Arrangements		3	30-Nov-2026	31-Mar-2024	Actions to be completed relate to the following: <u>Governance Arrangements</u> Financial regulations will be reviewed and updated with references to bad debt provision. <u>Reporting and Oversight:</u> Ledger development and implementation has resulted in limited information in relation to debt information provided to the HSCP.
			Timeliness of Write-Offs		3			
			Reporting and Oversight		2			
			Benchmarking		3			

Code	Title	Service Responsible	Title	Status	Priority	Due Date	Original Due Date	Latest Note
CFO-IA-2223-WFP	Workforce Planning	Health and Social Care Partnership	Feedback from Scottish Government		2	30-Nov-2026	14-Sep-2023	Actions complete subject to IJB final approval.
			Content of the Workforce Plan		2			
CFO-IA-1920-HSCPFOKC	HSCP Financial Outturn and Key Controls	Health and Social Care Partnership	Budgetary Information		2	30-Nov-2026	31-Mar-2020	The outstanding risk relates to data cleansing of the service register. From the Carefirst Steering Group a short life working group has been established to take this forward with the HSCP's Chief Finance and Resources Officer being the lead. The Strategic Commissioning Team is reviewing the service register in sections, with Supported Accommodation and Supported Accommodation being first. The various elements that require amendments have been passed to the Carefirst Team. Following this Residential data will be reviewed and updated. Any changes that can be facilitated through the Council will be progressed but any more fundamental changes to the Carefirst set up which requires input from the software providers OLM will not be progressed at this time given the move to implement a change in the system as the top priority regarding Carefirst.
			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	Service Responsible	Title	Status	Priority	Due Date	Original Due Date	Latest Note
								There continues to be resource issues within the strategic commissioning team and competing priorities which are preventing the completion of this action within the timescales set.
CFO-IA-2425-HSCP TP	Transport Policy	Health and Social Care Partnership	Policy Implementation - Internal Communication		2	30-Oct-2026	31-Mar-2025	One action is outstanding as following: High level details of the new terms of eligibility should be included within the charges for non-residential services booklet, or alternatively a link provided to the new Policy.
			Assistance with Transport Assessment Form		2			
			Policy Implementation - External Communication		2			
			Reduction in Charge Calculation Sheet - Proof of Income		3			
CFO-IA-2526-HSCP CF	CareFirst Payments	Health and Social Care Partnership	1 Downward Adjustments		1	31-Dec-2026	31-Dec-2025	Management have advised completion of the High risk (Priority 1) actions. The action relating to sample checking is in progress. Internal audit has included further work on CareFirst payments on the 2026/27 plan to confirm that controls are operating as intended.
			2 Query Resolution		2			
			3 Authorisation of Upward Adjustments		1			
			4 Sample Checking		2			
			5 Provider Compliance		1			
			6 Management Oversight		1			

Code	Title	Service Responsible	Title	Status	Priority	Due Date	Original Due Date	Latest Note
			7 Data Quality		2			

Appendix 3

HSCP Internal Audit

Internal Audit Performance and Output Monitoring

January to May 2026

Gillian McConnachie

Chief Internal Auditor

Internal Audit Outputs January to May 2026

A total of 6 outputs were completed by 31 March 2026 compared to 9 outputs planned – a completion rate of 67%.

In the period since the last committee the team have concluded on the following outputs:

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 2026. 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 2025/26 Annual Follow Up, has decreased from four to zero. This is the result of the completion of the Carefirst Payments actions. Auditors can conclude that there has been a focus in closing off high risks as they arise.

Assurance Audits

Work in Progress

Work is in progress relating to Grant Funding Received, Standardised Support Package and Provider Uplifts Processes. These audits will be completed in 2026/27 and any findings reported to committee.

EAST DUNBARTONSHIRE COUNCIL INTERNAL AUDIT PROGRESS

Work on the Council's internal audit plan for 2025/26 has concluded, 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 11 June 2026. 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 2026 the NHSGGC's external auditors are expected to provide an opinion of reasonable assurance for 2025/26 to their Audit and Risk Committee.

In relation to internal audit work undertaken at NHSGGC, since the last PAR there were 3 Internal Audit reports issued to the NHSGGC Board which may be considered relevant to the WD HSCP Board as follows:

Audit Title	Rating	Number and Priority of Recommendations			
		4	3	2	1
Whistleblowing	Substantial Improvement Required (1)	0	6	11	0
Workforce Planning	Minor Improvement Required	0	0	6	2
Information Governance	Minor Improvement Required (2)	0	2	7	0
Total		**0**	**8**	**24**	**2**

(1) Whistleblowing - the grade 3 recommendations relate to measuring whistleblowing and wider speak up culture, procedures relating to the sharing of personal information, staff training, and committee reporting on whistleblowing.

(2) Information Governance - the grade 3 recommendations relate to the approach to oversight and recording Subject Access Requests.

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

Appendix 4
Internal Audit Plan – Allocations and Activities

TABLE 1 – Planned Days and Outputs by Audit Area

Outputs	Area	Review	Planned Days	Rationale	Priority
1	Audit	**CareFirst payments**	25	Follow up review to ensure that CareFirst payment controls are operating as intended. To include a review of reporting and roles and responsibilities.	1
2	Audit	**Application of Social Work Eligibility Criteria**	25	Review of controls in place to ensure eligibility criteria are applied consistently across Social Work clients	2
3	Audit	**Absence monitoring**	25	Review of absence monitoring processes including HR support and the application of procedures.	2
4	Regularity	**Annual Audit Report**	2	Annual report	1
5	Regularity	**Annual Follow Up**	2	Follow up on previously issued recommendations	1
6	Regularity	**Annual Governance Statements**	2	Annual requirement for accounts and to support Annual report	1
7	Regularity	**Internal Audit Plan 2027/28**	2	Preparation of following year's internal audit plan	1
8	Consultancy	**Standardised Support Package (carried forward from 2025/26)**	15	Consultancy time for reviewing standardised support packages. Scope to include monitoring and success measures.	1
	Total Days		**98**		

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:	**17TH JUNE 2026**
REPORT REFERENCE:	**HSCP/170626/07**
CONTACT OFFICER:	**ALISON WILLACY, PLANNING PERFORMANCE & QUALITY MANAGER**
SUBJECT TITLE:	**HSCP ANNUAL PERFORMANCE REPORT 2025/26**

1.0 PURPOSE

1.1 The purpose of this report is to present for consideration and approval the HSCP Annual Performance Report 2025/26 that sets out progress towards the delivery of its Strategic Plan and in pursuance of the National Health & Wellbeing Outcomes.

2.0 RECOMMENDATIONS

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

2.1 Considers the HSCP Annual Performance Report 2025/26 at **Appendix 1**;

2.2 Note that data related to several national performance indicators has not yet been published by Public Health Scotland and the final data publication is not scheduled until July 2026, impacting on the completeness of all HSCP Annual Performance Reports;

2.3 Note that financial data reflects the latest in-year budget monitoring available at the time of drafting (to 31 January 2026);

2.4 Grants the HSCP Chief Officer the delegated authority to make final amendments to the Annual Performance Report 2025/26 in relation to any necessary updates to performance and finance data, in consultation with the Chair of the HSCP Board;

2.5 Approves the Annual Performance Report 2025/26 for publication following the relevant updates.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 places an obligation on Integration Joint Boards to publish a performance report annually, for publication by 31 July each year. The minimum contents of annual performance reports are prescribed in regulation and guidance and include:

a) An assessment of performance in relation to the national health and wellbeing outcomes;

b) A description of the extent to which the arrangements set out in the strategic plan and the expenditure allocated in the financial statement have achieved, or contributed to achieving, the national health and wellbeing outcomes;

c) Information about performance against key indicators or measures in relation to the national health and wellbeing outcomes over the reporting year and 5 preceding years where complete;

d) Financial planning and performance;

e) Best Value in planning and carrying out integration functions;

f) Performance in respect to localities;

g) Inspection and regulation of services.

3.2 An Annual Performance Report for 2025/26 is set out at **Appendix 1** for consideration and approval.

3.3 Public Health Scotland (PHS) released Core Suite Integration Indicators as management information in May. A second publication will be published on 7th July which will contain the finalised data required to report against all National Core Integration Indicators set out in Part 2 of the Annual Performance Report.

3.4 PHS have also advised that the next Ministerial Steering Group (MSG) quarterly update, required for reporting performance against the Scottish Government MSG Indicators in Part 2 of the Annual Performance Report, will not be released until June.

3.5 The financial data included in Section 5 of the report is taken from the latest in-year budget monitoring available at the time of drafting (to 31 January 2026).

3.6 The Annual Performance Report will be updated when available and final sign-off of the report for publication will be granted by the Chief Officer.

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

The Annual Performance Report reflects progress towards all of the priorities of the Strategic Plan.

4.2 Frontline Service to Customers – None

4.3 Workforce (including any significant resource implications) – None

4.4 Legal Implications – The publication of the HSCP Annual Performance Report meets duties set out in Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014.

4.5 Financial Implications – None.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None.

4.10 Sustainability – None.

4.11 Alignment to Population Health Framework – All principles and the priority of Embedding Prevention in our Systems

4.12 Alignment to Health and Social Care Strategic Renewal Framework – All principles

4.13 Other – None.

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows: None

6.0 IMPACT

6.1 **STATUTORY DUTY** – The publication of the HSCP Annual Performance Report meets duties set out in Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014.

6.2 **EAST DUNBARTONSHIRE COUNCIL** – None

6.3 **NHS GREATER GLASGOW & CLYDE** – None.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** None

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 Annual Performance Report 2025/26

East Dunbartonshire Health & Social Care Partnership

Annual Performance Report

2025/26

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

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Foreword

This Annual Performance Report sets out how East Dunbartonshire Health and Social Care Partnership performed during 2025/26 and the progress made in delivering our statutory responsibilities and strategic priorities during the first year of our Strategic Plan 2025-30.

The year has been characterised by a combination of genuine achievement and honest challenge. Staff and partners across health, social work, social care and the third and independent sectors have continued to work with commitment and professionalism in a demanding environment shaped by sustained financial pressure, increasing complexity of need and an evolving national policy context. Highlights of the year included the opening of the Bishopbriggs Community Treatment and Care Centre, the achievement of green status across all ten Medication Assisted Treatment Standards for the first time, and the delivery of savings of £6.7m in 2025/26, with further savings to be realised as implementation progresses. Where delivery did not meet the ambitions we set, we have been transparent about the reasons and actions taken forward into 2026/27.

Looking ahead, the financial challenge facing the HSCP remains significant. The current Medium-Term Financial Strategy identifies a potential financial gap of between £46.0m and £88.9m over the next five years, with the most likely scenario indicating a gap of £48.2m. Closing that gap will require continued transformation, difficult decisions about service levels and models, and sustained focus on prevention and early intervention to manage demand. The Integration Joint Board (IJB) remains committed to transparent governance, honest reporting and continuous improvement, ensuring that decisions are informed by evidence, engagement and a clear focus on outcomes for the people of East Dunbartonshire.

We would like to thank everyone who has contributed to delivering services during the year, including staff, partners, carers, volunteers and people with lived experience. Their contribution is central to the continued improvement of health and social care services in East Dunbartonshire.

Libby Cairns

Chair

East Dunbartonshire HSCP Board

Derrick Pearce

Chief Officer

East Dunbartonshire HSCP

2025/26 at a glance

2025/26 was the first year of delivery under the East Dunbartonshire HSCP Strategic Plan 2025-30. The year focused on maintaining safe and effective statutory services, progressing a substantial programme of service review and redesign, and establishing the foundations for delivery across the five-year plan, in the context of sustained demand, financial constraint and workforce pressures.

What we achieved

- The overall financial transformation programme delivered savings of £6.7m in 2025/26 through a combination of approved service reviews and organisational redesign, maintaining safe staffing and protecting statutory functions throughout.
- Bishopbriggs Community Treatment and Care Centre opened December 2025, increasing planned clinical capacity from 22 to 40 sessions in a modern community setting.
- Medication Assisted Treatment Standards achieved green across all ten standards for the first time, providing strong assurance of access and quality in alcohol and drug recovery services.
- HSCP Digital Strategy 2025-30 approved, setting the strategic direction for digital and technology-enabled service delivery.
- HSCP Workforce Plan 2025-30 approved alongside workforce plans for Specialist Children's Services and the Oral Health Directorate.
- John Street House progressed from Weak to Good across all five Care Inspectorate key questions within a single year.
- UNICEF Baby Friendly Initiative Gold Award revalidated, providing independent assurance of quality across community children's services.
- Over £0.5m secured through the national Gambling Levy to deliver a three-year prevention-focused programme addressing gambling-related harm.
- Health Information Hubs established in every local library in East Dunbartonshire, improving community access to health information and signposting.
- The majority of regulated services continue to be graded good or better (see Annex 8).
- CAMHS referral-to-treatment performance maintained above national standards, reaching 100% in February and March 2026.

Where delivery was delayed or partially achieved

- Care at Home reablement expansion postponed to 2026/27.
- Medium-Term Financial Strategy refresh deferred to align with 2026/27 budget setting.
- West of Scotland Adolescent IPCU and Forensic CAMHS regional planning advanced but not fully operationalised within 2025/26.
- Public protection function review scoped but not progressed within the year.
- Service user and carer communication and engagement plans partially achieved, with Learning Disability Services and Social Work Mental Health Services carrying forward to 2026/27.
- Property development for West Locality and Woodlands paused pending NHS Capital Planning decisions.

Looking ahead to 2026/27

The 2026/27 Annual Delivery Plan will build on the foundations established during this baseline year, with a continued focus on service transformation, prevention and early intervention, and delivering on the commitments of the Strategic Plan 2025-30 within the financial envelope available. Closing the medium-term financial gap will require further recurring savings, continued service redesign and sustained focus on shifting the balance of care towards community-based support and prevention.

About this report

This Annual Performance Report sets out how East Dunbartonshire Health and Social Care Partnership (HSCP) performed during 2025/26 in delivering its statutory responsibilities and strategic priorities.

The report is published in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and associated statutory guidance. It reports on progress towards the nine National Health and Wellbeing Outcomes, delivery of the Annual Delivery Plan 2025/26, locality planning and improvement, quality and safety, and the effective use of resources including Best Value.

As the first year of reporting under the Strategic Plan 2025-30, this report also establishes a baseline for measuring progress over the lifetime of the plan. It presents an honest account of what was achieved, what was partially achieved and where delivery was delayed, with explanations provided for each. Where actions were not completed within the year, these are carried forward as confirmed priorities in the Annual Delivery Plan 2026/27.

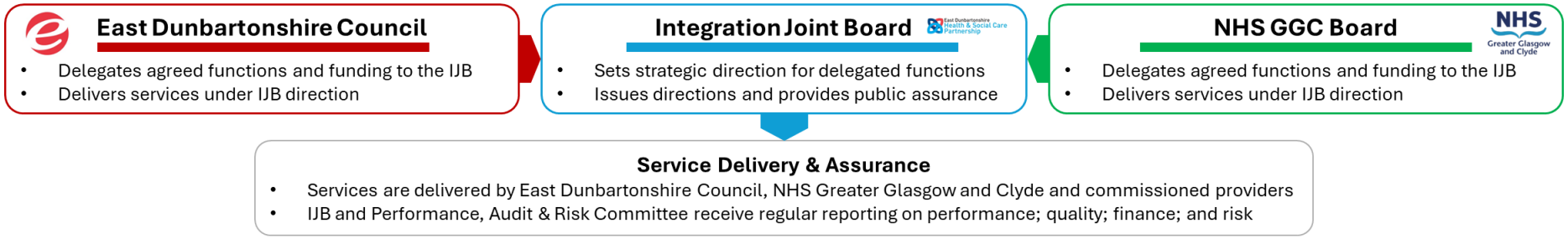
Detailed performance data, inspection findings and methodological notes are provided in the annexes to support transparency and scrutiny. Full inspection reports are available on the Care Inspectorate website and further information on national indicator methodology is available from Public Health Scotland.

Section 1: Who we are and the context we serve

Our role and responsibilities

East Dunbartonshire Health and Social Care Partnership is responsible for planning and delivering a wide range of integrated community health, social work and social care services for the local population. These responsibilities are exercised through the East Dunbartonshire Integration Joint Board, which brings together East Dunbartonshire Council and NHS Greater Glasgow and Clyde under the Public Bodies (Joint Working) (Scotland) Act 2014.

The IJB has responsibility for strategic planning, oversight and direction of delegated functions, while operational delivery is carried out by East Dunbartonshire Council, NHS Greater Glasgow and Clyde, and commissioned partners acting on the IJB's behalf. Delegated services include adult and children's community health services, social work and social care services, criminal justice social work, and a range of associated functions supporting prevention, early intervention, protection and recovery.

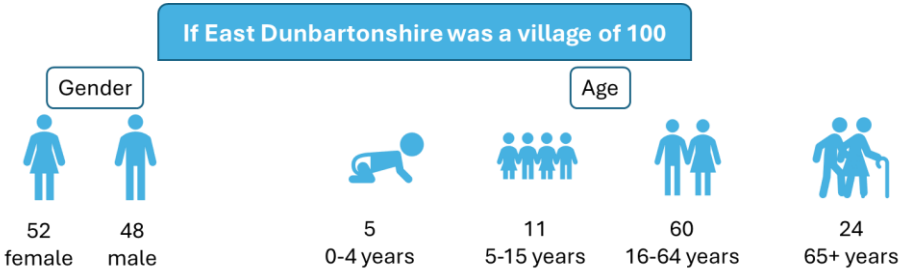


The HSCP operates within a complex and evolving environment, shaped by demographic change, increasing demand, workforce pressures and ongoing financial constraint. In this context, the HSCP is required to balance delivery of statutory duties with longer-term improvement and transformation, ensuring that services remain safe, effective and sustainable.

The IJB is accountable for setting strategic direction through the Strategic Plan, agreeing priorities and allocating resources, and for providing assurance on performance, quality, finance and risk. Governance and scrutiny are supported through established committee arrangements and performance management frameworks, ensuring transparency, accountability and continuous improvement.

Our population and needs

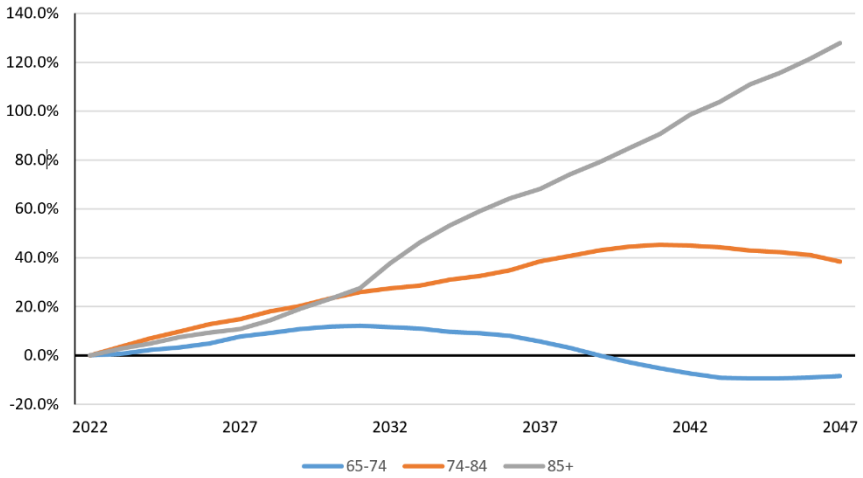
East Dunbartonshire HSCP serves a diverse population with a growing proportion of older people and increasing levels of long-term conditions and complexity of need. These demographic trends continue to place pressure on community health, social work and social care services, particularly those supporting people to remain independent and living at home.



Alongside demographic change, levels of demand are shaped by wider social and economic factors, including inequality, housing pressures and cost-of-living challenges. While East Dunbartonshire performs well against a number of national indicators, there remain inequalities in outcomes and access to services for some population groups, requiring targeted and preventative approaches.

Understanding population needs is central to effective planning and prioritisation. The HSCP uses a range of data sources, including national and local performance indicators, locality profiles and service intelligence, to inform decision-making and to support a focus on prevention, early intervention and reducing avoidable demand on statutory services.

For a comprehensive breakdown of East Dunbartonshire's population profiles and projected demographic changes, please refer to our Joint Strategic Needs Assessments, available at https://health.eastdunbarton.gov.uk/about/performance-governance-and-finance/performance-and-demographics/.

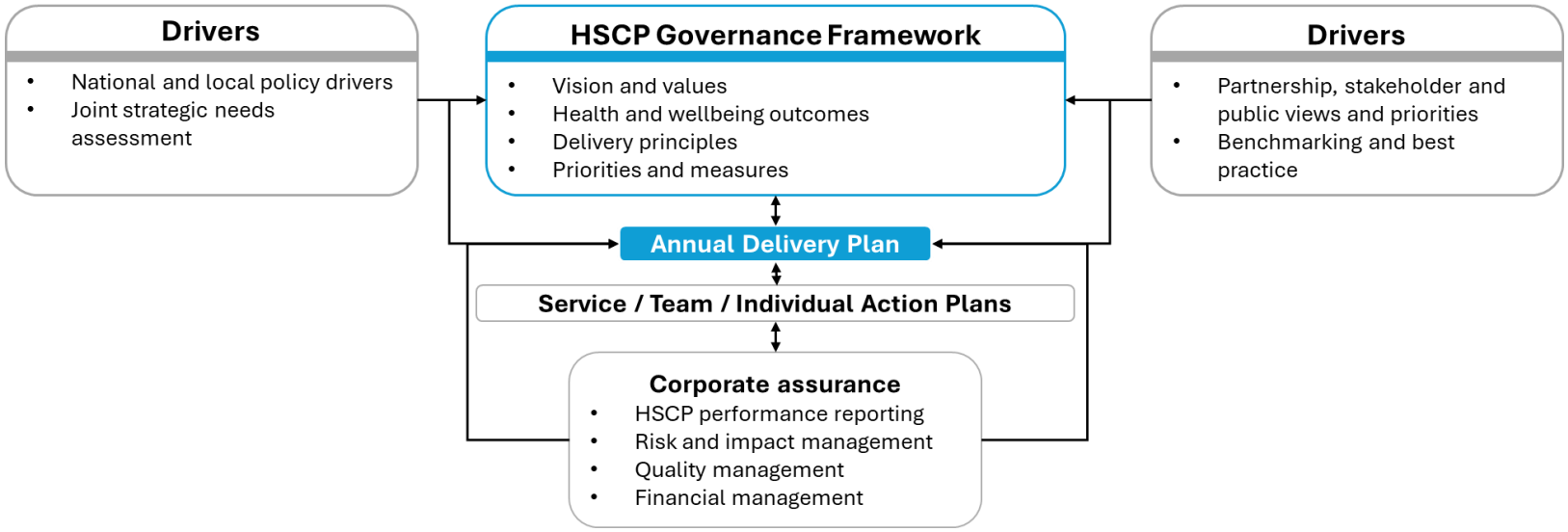


East Dunbartonshire population change projection % by age group 2022-2047

Strategic planning and governance framework

The HSCP's strategic direction is set out in the Strategic Plan 2025-30, approved by the Integration Joint Board in March 2025. The Strategic Plan establishes the HSCP's priorities and enablers, aligned to the National Health and Wellbeing Outcomes, and provides the framework for service planning, improvement and resource allocation.

Delivery of the Strategic Plan is supported through annual delivery planning, locality planning and service level plans, which translate strategic priorities into specific actions. Performance against these plans is monitored throughout the year using the HSCP Performance Management Framework, enabling scrutiny of progress, risks and improvement actions.



The Integration Joint Board is responsible for governance, oversight and assurance, supported by established committee arrangements and partnership governance structures. These arrangements ensure that performance, quality, finance and risk are considered in the round, and that learning from inspection, audit and engagement informs continuous improvement and future planning.

The illustration that follows provides an overview of the Strategic Plan and shows the relationship between the strategic priorities and enablers that have guided delivery during 2025/26.

Strategic Plan on a Page

Strategic objectives and commitments

Empowering People
People are enabled to have power and control over their own lives, ensuring that they can get the support they need that is right for them at that time.

Empowering and connecting communities
Community members will be empowered to support their communities and be involved, and participate in, the ongoing sustainable development of their community. Community members will have access to information, advice and resources to enable them to live independently and without formal intervention.

Prevention and early intervention
Facilitate and enable prevention, and the identification and provision of early support, to improve outcomes for individuals and prevent, stop or slow the progression of need, to safely enable risk and to minimise harm.

Public protection
Prioritising key public protection statutory duties.

Supporting carers and families
Carers and their families will be supported and valued in their caring roles.

Improving mental health and recovery
The mental health services people receive will meet national requirements, support local needs and continue to help people with their mental health and recovery.

Strategic enablers and commitments

Collaborative commissioning
Increase the opportunities for collaborative working across our commissioned service providers with the aim of improving services, outcomes for service users, processes and efficiency

Infrastructure and technology
Maximise the use and development of our infrastructure and technology to help people to self-manage their own health and social wellbeing, as well as supporting our staff in the delivery of services.

Maximising operational integration
Strengthen collaboration, and encourage continuous improvement, amongst staff groups from both partner organisations.

Medium-term financial and strategic planning
Develop and implement a Medium-Term Financial Strategy which ensures financial sustainability for the IJB and the delivery of strategic planning priorities within the financial envelope available, in the context of demand and cost pressures and challenging financial settlements.

Workforce and organisational development
Strengthen our focus on supporting our staff's mental health and wellbeing, the recruitment and retention of staff and ensure that our staff have the necessary skills and training to carry out their job.

Section 2: Delivery against our strategic priorities

Each year, the HSCP agrees an Annual Delivery Plan which sets out the actions to be progressed in support of the Strategic Plan. These actions are informed by service level plans, locality planning and commissioning activity, and together describe how the strategic priorities and enablers will be taken forward during the year.

During 2025/26, the IJB monitored progress against the Annual Delivery Plan through established governance arrangements, including the Strategic Planning Oversight Group and the Performance, Audit and Risk Committee. This provided ongoing oversight of delivery, risks and dependencies, and supported proportionate scrutiny of progress throughout the year.

The 2025/26 plan included a programme of 29 actions spanning multiple strategic priorities and enablers. Over the course of the year, 21 actions were completed as planned, 6 were partially achieved with elements continuing into 2026/27, 1 was delayed and carried forward in full, and 1 action was cancelled. A summary of Annual Delivery Plan actions and their status is provided in Annex 5.

The sections below summarise progress during 2025/26 by strategic priority. Some strategic priorities are phased across the life of the Strategic Plan. Where specific delivery actions were not included in the 2025/26 Annual Delivery Plan, this report describes the foundational activity undertaken during the year and how this positions the HSCP for future delivery.

2.1 Empowering people

What we aimed to achieve

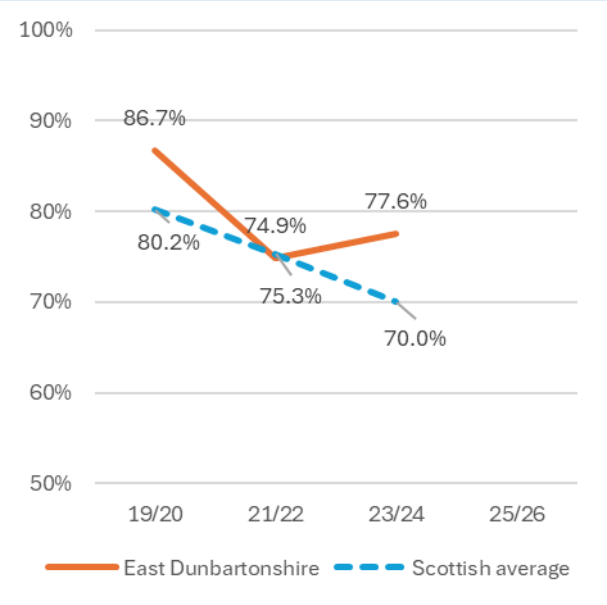
During 2025/26, the first year of delivery under the Strategic Plan 2025-30, the HSCP set out to strengthen the conditions in which people can exercise genuine power and control over their own health and wellbeing. This meant improving the quality, accessibility and relevance of information available to the public, so that people are better equipped to navigate services and manage their own needs without unnecessary formal intervention. It also meant progressing Year 1 of the East Dunbartonshire Public Health Framework, a programme designed to build prevention capacity across the HSCP, address inequalities in health outcomes, and ensure that local activity is grounded in evidence and coordinated across community planning partners. Alongside these commitments, the HSCP continued to develop the structures and culture through which service users and carers can meaningfully influence how services are shaped and delivered, supporting a shift towards genuine co-production and rights-based practice.

Delivery highlights

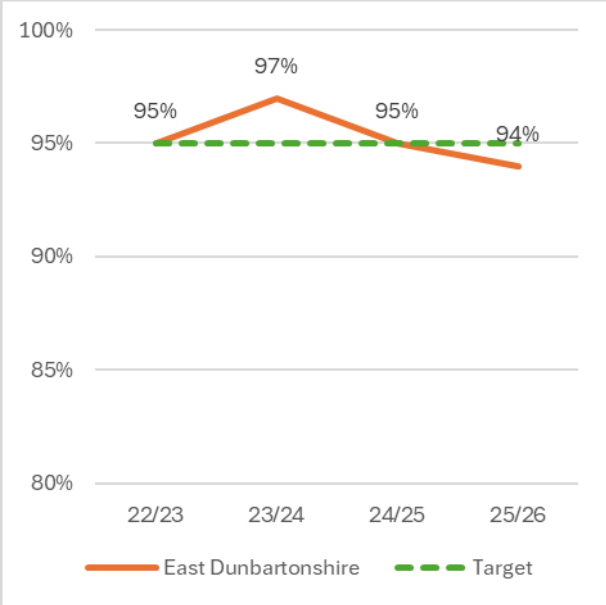
- Completed Year 1 of the East Dunbartonshire Public Health Framework, including partner engagement, programme mapping across life course themes, and capacity-building sessions for HSCP and community planning partners.
- Strengthened the HSCP website through a short-life working group, improving content quality and governance arrangements to support public access and self-management.
- Enhanced service user and carer representation arrangements in HSCP governance, with clearer induction and support structures for planning and oversight group members.
- Developed service user and carer communication and engagement plans across Alcohol and Drug Recovery Services (ADRS), the Community Mental Health Team (CMHT) and the Primary Care Mental Health Team (PCMHT), with plans for Learning Disability Services and Social Work Mental Health Services carrying forward to 2026/27.

Performance snapshot

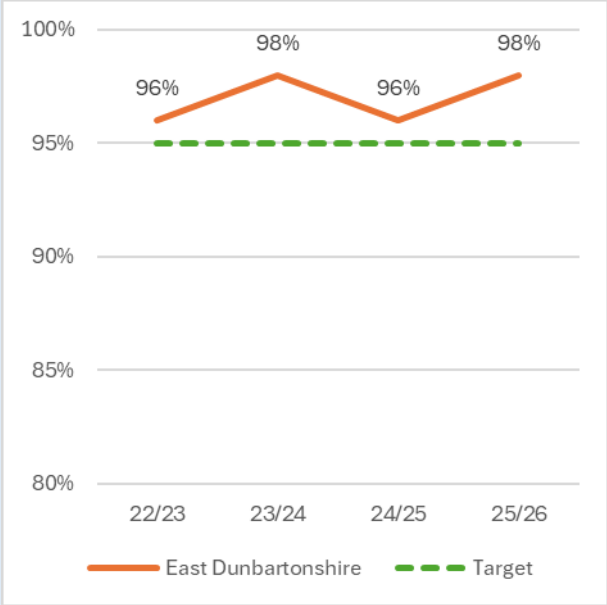
Total percentage of adults receiving any care or support who rated it as excellent or good



Percentage of people 65+ indicating satisfaction with their social interaction opportunities



Percentage of service users satisfied with their involvement in the design of their care packages



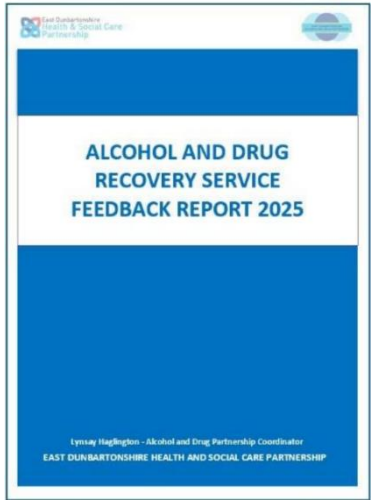
Performance across the three measures cited reflects a broadly positive picture. Service user satisfaction with involvement in the design of care packages reached 98% in 2025/26, above the 95% target and the strongest result across the period shown. Satisfaction among people aged 65 and over with their social interaction opportunities reached 94% in 2025/26, marginally below the 95% target but broadly stable, indicating generally positive outcomes for this group. These results support a picture of strong person-centred practice in care planning and delivery, with continued effort required to sustain and build on this performance across all service areas.

Summary

Delivery in 2025/26 made measurable progress in strengthening the conditions for people to access information, engage with services on their own terms, and participate in shaping how support is provided. Both planned actions were achieved: Year 1 of the Public Health Framework was delivered and the HSCP website was reviewed through a short-life working group. Service user and carer communication and engagement plans were partially achieved, with plans established across ADRS, CMHT and PCMHT, and completion for Learning Disability Services and Social Work Mental Health Services carried forward to 2026/27. Performance data indicates strong involvement of service users in care planning and broadly positive satisfaction levels, and 2026/27 will build on this foundation through continued prevention activity and co-production development.

Spotlight on good practice

Alcohol and Drug Recovery Service: "Have Your Say" survey and service improvement priorities



During 2025/26, the Alcohol and Drug Recovery Service strengthened how people's views shape service improvement through its "Have Your Say" survey. Participation increased compared with the previous year, reflecting more proactive approaches to supporting people to share feedback during their engagement with services. This increase in participation is itself significant, indicating that people using the service feel more confident and supported in sharing their experiences and that the conditions for meaningful engagement are improving. Feedback highlighted the importance of compassionate, trauma-informed practice and consistent communication, with respondents reporting that support helped build confidence and hope. People also identified practical improvement priorities, including accessibility, flexibility and options for quicker routes into support. Critically, these findings were not treated as passive information but were used directly to inform service planning and improvement actions, supporting a clearer focus on what matters most to people using the service. This approach to embedding lived experience in service development reflects the HSCP's broader commitment to co-production and rights-based practice. It demonstrates that meaningful involvement is not a standalone activity but is integrated into how the service continuously learns and improves, ensuring that the people most affected by decisions about alcohol and drug recovery services have a genuine voice in shaping them.

2.2 Empowering and connecting communities

What we aimed to achieve

Empowering and connecting communities is a long-term priority that recognises the essential role of community capacity, local assets and partnership working in supporting prevention, resilience and wellbeing. The Strategic Plan acknowledges that the greatest gains in population health and independence will come not from formal services alone, but from enabling people, families and communities to draw on their own strengths and the resources around them. No specific actions for this priority were included in the 2025/26 Annual Delivery Plan, reflecting the foundational nature of this work and its dependence on sustained investment across the lifetime of the Strategic Plan. Activity during the year focused on maintaining and developing community-connected approaches and partnerships that support this longer-term ambition, with more targeted delivery planned from 2026/27 onwards through the refreshed locality planning framework.

Delivery highlights

- Continued implementation of the Children's House Project model, providing relationship-based support for young people leaving care, with a focus on building confidence, practical skills and connections to community resources.
- Progressed Whole Family Wellbeing engagement activity, creating opportunities for families to access information and connect with local services, with feedback describing improved access and confidence in navigating support.
- Established a refreshed locality planning framework through the Locality Planning Action Group, piloting community-focused activity in two localities to strengthen local partnership working and inform future delivery aligned to the Strategic Plan

Outcomes for this priority are primarily evidenced through qualitative feedback, engagement activity and locality-based intelligence rather than quantitative indicators. Available evidence from 2025/26 points to improved access to information, stronger connections to local services and increased confidence among people engaging with community-based support. More structured measurement of community empowerment outcomes will be developed through the locality planning framework in 2026/27.

Summary

Outcomes for this priority are primarily evidenced through qualitative feedback, engagement activity and locality-based intelligence rather than quantitative indicators. Available evidence from 2025/26 points to improved access to information, stronger connections to local services and increased confidence among people engaging with community-based support. More structured measurement of community empowerment outcomes will be developed through the locality planning framework in 2026/27.

Spotlight on good practice

Whole Family Wellbeing Engagement

During 2025/26, the HSCP progressed Whole Family Wellbeing engagement activity, bringing together families and services to improve access to information and local support. Feedback from participants highlighted the value of being able to access information and speak with services in one place, describing the experience as making a practical and meaningful difference to their ability to navigate support. This approach reflects the HSCP's commitment to reducing barriers to access and enabling people to connect with community resources without the need for formal referral pathways.

Health Information Hubs in local libraries

During 2025/26, the HSCP worked in partnership with East Dunbartonshire Leisure and Culture Trust to develop Health Information Hubs across every local library in East Dunbartonshire. Each hub provides residents with access to trusted health and wellbeing information and clear signposting to local services, creating a low-barrier, community-based route to support that does not require a clinical referral or formal contact with services. The hubs reach people who may not actively seek out health services, including those less confident in navigating formal care pathways, reflecting the HSCP's commitment to enabling informed decision-making and self-management before need escalates.

2.3 Prevention and early intervention

What we aimed to achieve

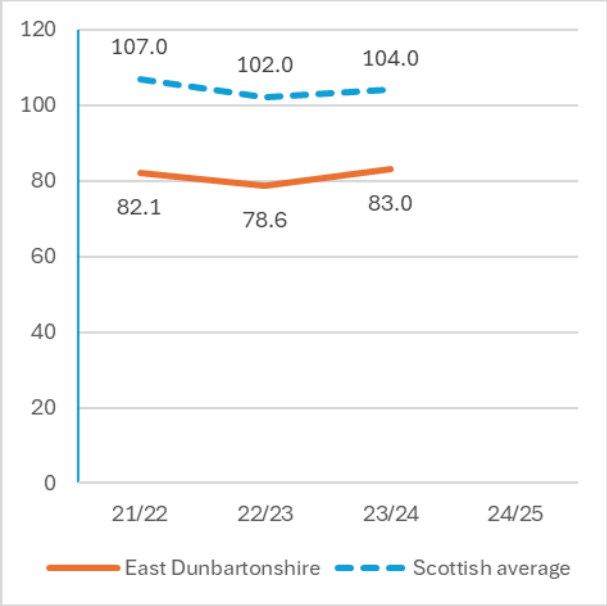
During 2025/26, the HSCP aimed to strengthen prevention and early intervention by ensuring people receive timely, effective support that prevents, reduces or delays the escalation of need. This meant embedding reablement approaches within community services to sustain independence, improving access to planned clinical care closer to home, and undertaking review activity to inform future delivery models for community occupational therapy and sensory impairment services. Alongside these specific actions, the HSCP continued to progress its wider focus on early identification of frailty and proactive support for older people, recognising that investment in prevention at the right time reduces avoidable escalation and improves outcomes for individuals and for the system as a whole.

Delivery highlights

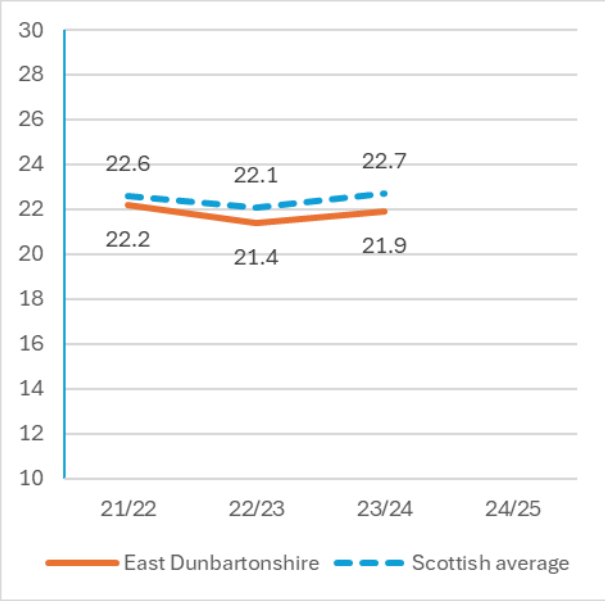
- Completed the review of the Social Work Community Occupational Therapy Service as part of the wider Adult Social Work Services review, securing governance approval and progressing into implementation, supporting timely access to advice, aids and adaptations and contributing to a more sustainable community response to demand.
- Opened the Bishopbriggs Community Treatment and Care Centre in December 2025, expanding access to planned clinical treatments in a community setting and increasing capacity from 22 to 40 clinical sessions. The service reduces the need for people to attend GP practices or acute settings for routine care, supporting earlier intervention and improved system flow.
- Progressed frailty identification and management through development of integrated locality-based working, with increased frequency of frailty huddles and closer collaboration across community health and care teams.
- Maintained strong performance in the timely delivery of community care support for older people, with 100% of customers aged 65 and over receiving services within six weeks of completion of their community care assessment in 2025/26, exceeding the 95% target.
- The planned review and expansion of Care at Home reablement services was not progressed within 2025/26. Initial project documentation was developed but full review activity was postponed, with the work formally rescheduled to 2026/27.

Performance snapshot

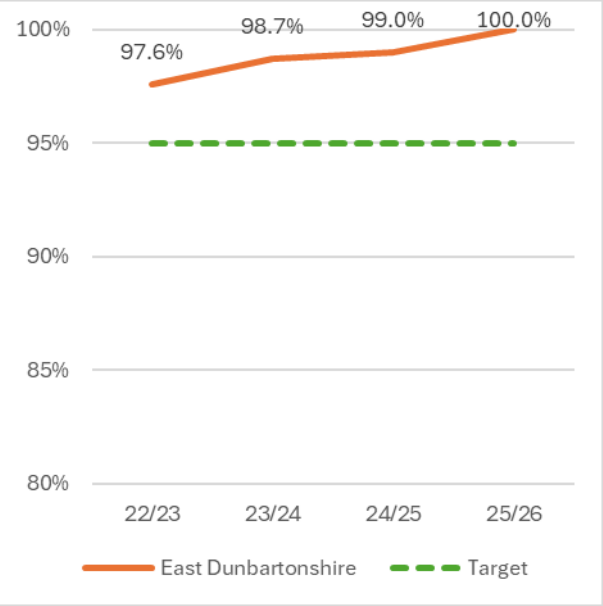
Readmission to hospital within 28 days for adults per 1,000 population



Falls rate per 1,000 population aged 65+



Percentage of customers (65+) meeting the target of 6 weeks from completion of community care assessment to service delivery



Performance across the three measures shows a mixed but generally positive position. The proportion of customers aged 65 and over receiving services within six weeks of community care assessment improved year on year, reaching 100% in 2025/26 and consistently exceeding the 95% target throughout the period shown. This indicates strong and sustained performance in ensuring timely access to community services. Rates of readmission to hospital within 28 days and falls per 1,000 population aged 65 and over have remained broadly stable, with local performance consistently below the Scottish average, indicating comparatively favourable outcomes. Whilst there is some year-on-year variation in both measures, there is no evidence of sustained deterioration over the period shown.

Summary

Delivery in 2025/26 strengthened prevention and early intervention through the opening of the Bishopbriggs Community Treatment and Care Centre, completion of the community occupational therapy review, and sustained strong performance in timely community care delivery. The planned expansion of Care at Home reablement services was not achieved within the year and has been carried forward to 2026/27, where it remains a priority action. Progress on frailty identification and integrated locality working provides a further foundation for prevention-focused delivery in future years. Performance data indicates broadly stable outcomes across key indicators, with continued focus required on shifting care closer to home and reducing avoidable escalation.

Spotlight on good practice

Bishopbriggs Community Treatment and Care Centre and NHSGGC Chair's Award for Innovation

The opening of the Bishopbriggs Community Treatment and Care Centre in December 2025 marked a significant milestone in the HSCP's commitment to delivering planned clinical care closer to home. The service provides a range of nursing-led interventions from a modern, purpose-built community setting, increasing clinical capacity from 22 to 40 sessions and offering greater flexibility in appointment times than was previously available through GP practice accommodation. Early feedback from patients highlighted the accessibility and quality of the environment, with people valuing consistency of staffing and improved convenience of access.

The Community Treatment and Care Service team also received the NHSGGC Chair's Award for Innovation during 2025/26, recognising their work in supporting the self-administration of vitamin B12 by patients. This initiative enables people to manage their own treatment at home rather than attending a clinical setting for each injection, reducing unnecessary contact with services and supporting greater independence and self-management. The award provides independent external recognition of the team's commitment to person-centred, innovative practice and reflects the broader principle that prevention and early intervention are most effective when people are empowered to take an active role in managing their own health.

2.4 Public protection

What we aimed to achieve

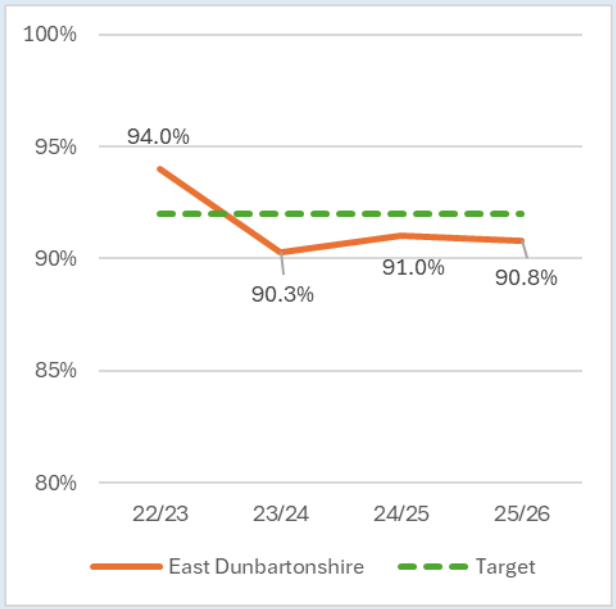
During 2025/26, the HSCP prioritised its statutory public protection duties, with a focus on ensuring consistently high standards in identifying and responding to risk to vulnerable children and adults. This included implementing improvement actions arising from the Joint Adult Support and Protection Inspection, maintaining robust child protection processes and timescales, and strengthening the capacity, training and support arrangements for the public protection workforce. The HSCP also continued to develop trauma-informed approaches across services, recognising the role that safe, person-centred environments play in supporting people who have experienced harm.

Delivery highlights

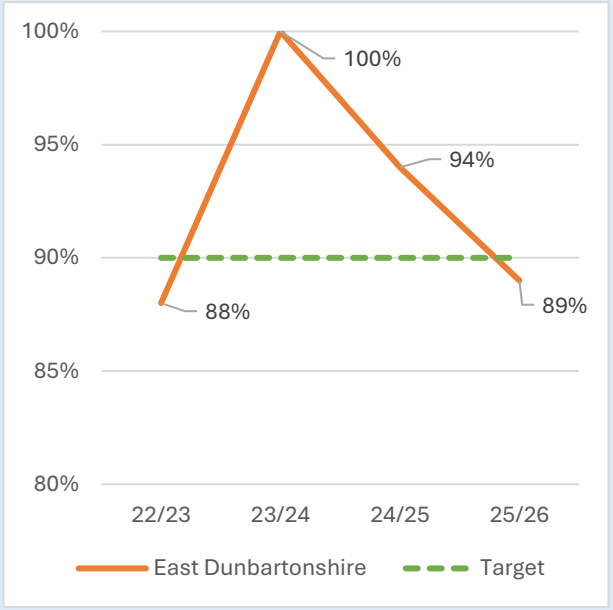
- Progressed implementation of the improvement plan arising from the Joint Adult Support and Protection Inspection, with actions overseen through the Adult Support and Protection (ASP) Committee Delivery Group meeting on a six-weekly basis, providing structured governance and accountability for improvement.
- Strengthened the Public Protection Service workforce model, including updates to administrative roles and skill mix changes to support service delivery, digital improvements and more consistent recording practice.
- Maintained a structured programme of learning and development across child protection and adult support and protection, including Level 3 training sessions delivered remotely and promoted through the public protection learning calendar.
- Progressed trauma-informed practice development, including engagement with staff and service users on how Kirkintilloch Health and Care Centre could become more trauma-informed, and securing endowment funding to improve treatment room environments.
- The planned review of the HSCP public protection function was scoped but not progressed within 2025/26, with the work formally deferred to 2026/27 following prioritisation of other service review activity.

Performance snapshot

Percentage of Adult Protection cases where the required timescales have been met



Percentage of initial Child Protection Planning Meetings taking place within target timescale



Percentage of first Review Child Protection Planning Meetings taking place within 6 months of registration

Performance across the three measures was mixed during 2025/26. The proportion of ASP cases meeting required timescales remained below the 92% target, reflecting a combination of increased demand, workforce vacancies affecting capacity, and administrative pressures. Improvement actions are progressing to address these pressures. Performance against child protection timescales showed variation during the year, with initial Child Protection Planning Meetings achieving 89% against a 90% target and first review meetings achieving 93% against a 95% target. These annual figures were affected by a small number of cases falling outwith timescales in individual quarters, with 100% performance achieved in three of the four quarters for one measure. The small volumes involved mean that individual cases have a proportionately significant impact on annual performance figures, and the overall picture reflects broadly consistent practice with targeted improvement activity focused on the areas of greatest pressure.

Summary

Delivery in 2025/26 maintained the HSCP's focus on public protection as a statutory priority, with continued implementation of the ASP improvement plan, sustained workforce training and development activity, and progress on trauma-informed practice. Performance against key timescale measures remained mixed, with Adult Support and Protection below target and child protection performance broadly maintained but subject to variation. The planned review of the public protection function was not progressed within the year and is carried forward to 2026/27. Improvement actions across adult and child protection processes are being progressed and will continue to be monitored through established governance arrangements.

Spotlight on good practice

Trauma-informed environments and lived-experience partnership working

During 2025/26, the HSCP progressed work to embed trauma-informed practice across services, with a particular focus on the physical environment and the involvement of people with lived experience. A partnership project supported people with lived experience of trauma and recovery to contribute directly to improving the environment at Kirkintilloch Health and Care Centre, with endowment funding secured to enable improvements to treatment room settings. This work reflects a preventative, rights-based approach to public protection, recognising that safe, welcoming environments and meaningful involvement reduce distress and support recovery. The project also generated learning that is informing wider consideration of trauma-informed practice across HSCP settings, demonstrating how locally driven improvement activity can have an impact beyond its immediate context.

2.5 Supporting carers and families

What we aimed to achieve

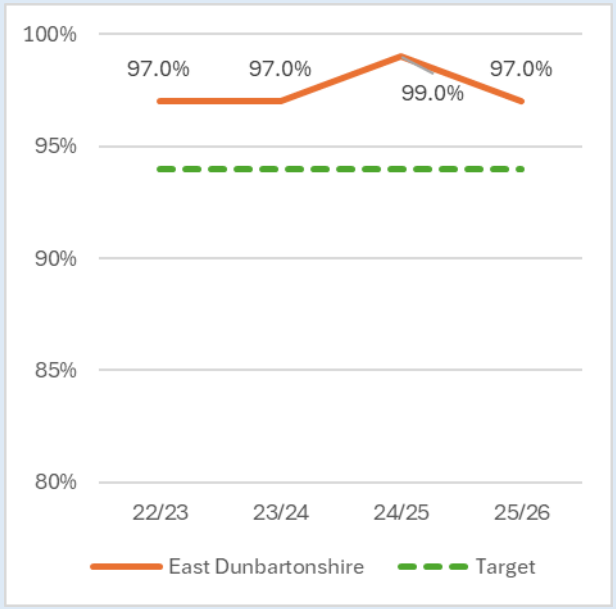
During 2025/26, the HSCP sought to support carers, young carers and families to identify and achieve their personal outcomes, and to ensure that the services supporting people with learning disabilities and their families are sustainable, high quality and fit for purpose. This included progressing a programme of reviews across learning disability services, addressing financial sustainability, reducing high-cost care packages where appropriate, and exploring new models of provision. Alongside this, the HSCP continued to implement its Carers Strategy 2023-26, maintaining focus on carer identification, support planning and access to respite, while also exploring the potential of developing an all-age approach to learning disability social work. Underpinning all of this activity was a commitment to involving people, families and carers meaningfully in decisions about the services they rely on.

Delivery highlights

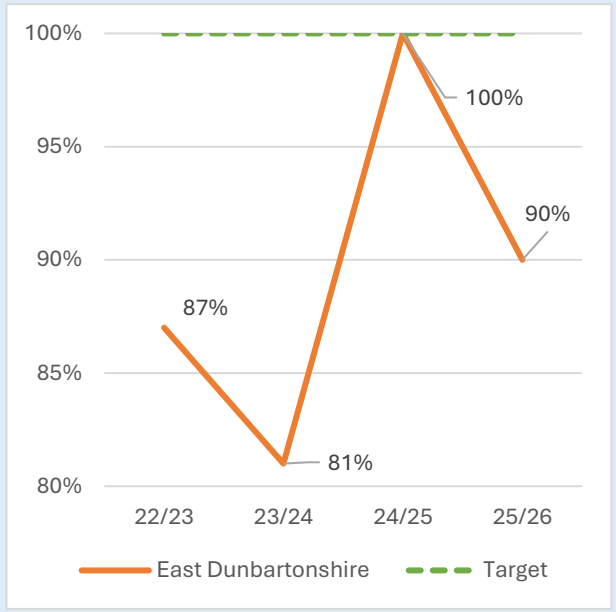
- Progressed multiple strands of the Learning Disability Strategy review, including completing the Pineview Supported Accommodation Service review with the recommended model approved by the IJB, advancing the commissioned respite review through consultation and service specification development, and progressing a programme of individual care package reviews to address high-cost packages.
- Commenced the review of the supported accommodation estate, completing demand analysis, baseline assessment and governance work, establishing the foundation for a Support with Accommodation Strategy with priorities identified for 2026/27.
- Progressed the review of John Street House Care Home Service, with the service achieving Good grades across all five Care Inspectorate key questions by July 2025 following targeted improvement activity throughout the year.
- Completed the exploration of developing an all-age learning disability function, securing governance approval following option appraisal and stakeholder engagement, with the project transitioning to implementation planning in 2026/27.
- Continued implementation of the Carers Strategy 2023-26, with Young Carer ID cards introduced in schools during 2025/26 and increased uptake of Adult Carer Support Plans and Young Carer Statements across the year.
- Continued implementation of the Children's House Project model, providing relationship-based support for young people leaving care and contributing to the HSCP's commitment to delivering on The Promise.

Performance snapshot

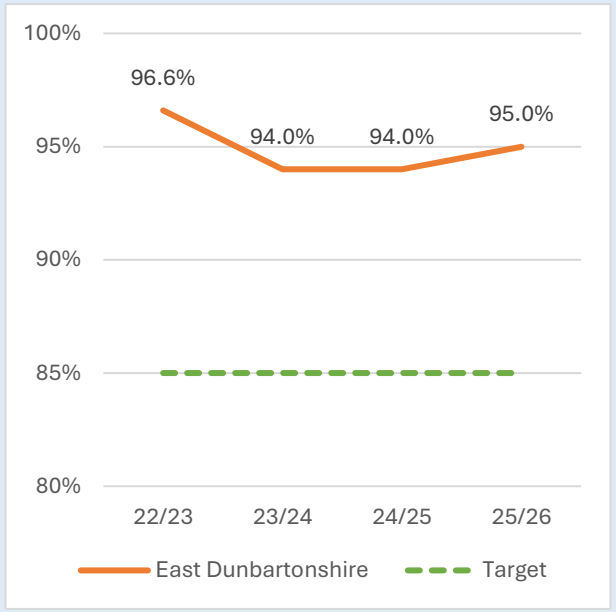
Percentage of carers who feel supported to continue in their caring role



Percentage of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated



Percentage of children receiving 27-30 months assessment



Performance across the three measures shows a mixed but generally positive picture. The proportion of first Looked After and Accommodated reviews taking place within four weeks of a child being accommodated was 90% in 2025/26, below the 100% target, with one review of ten taking place outwith timescale. The proportion of children receiving their 27 to 30 month assessment reached 95%, above the 85% target, reflecting strong performance in early identification of additional developmental needs. Locally reported data on carer support shows a year-end figure of 97% based on 179 reviews where a caring role was identified. This local measure is not directly comparable with the national Core Integration Indicator on carer support, which reflects the broader experience of unpaid carers across the general population including those with no contact with formal HSCP services, and the two figures should be read accordingly.

Summary

Delivery in 2025/26 was substantial across this priority, with multiple strands of the Learning Disability Strategy review progressed alongside implementation of the Carers Strategy, which was extended to March 2027. The John Street House improvement journey is a particular highlight, demonstrating the capacity for rapid and sustained improvement when governance, leadership and practice are aligned. Work on Care at Home reablement expansion was delayed and is carried forward to 2026/27, alongside implementation of review recommendations across supported accommodation, respite and the all-age learning disability function.

Spotlight on good practice

Care at Home customer experience survey

During June and July 2025, the HSCP surveyed all in-house Care at Home service users, receiving 174 responses representing a 43.3% response rate. Overall feedback was strongly positive, with 95.4% of respondents rating their experience as Excellent, Very Good or Good and no responses indicating Weak or Unsatisfactory. Where concerns were raised, follow-up engagement took place to understand issues and identify improvements. Feedback highlighted consistency of carers and reliability of visit times as priorities for ongoing service development, and these findings are informing continued improvement activity.

Rating	%
Excellent	47.2%
Very Good	36.8%
Good	11.4%
Adequate	4.6%
Weak/Unsatisfactory	0%

John Street House: improvement through governance, leadership and practice

John Street House was subject to an unannounced Care Inspectorate inspection in March 2025 which identified significant improvement needs, particularly in relation to infection prevention and control and care planning. The HSCP responded with targeted improvement activity supported by strengthened leadership and quality assurance arrangements. A follow-up inspection in May 2025 confirmed that the infection prevention and control requirement had been met within timescales. A further inspection in July 2025 found the service achieving Good grades across all five Care Inspectorate key questions, with inspectors noting a warm and welcoming environment, positive outcomes associated with changes to the management team, and evidence of active, individualised lifestyles for residents. The trajectory from Weak to Good across all key questions within a single year reflects the commitment of staff and leadership to rapid and sustained improvement.

2.6 Improving mental health and recovery

What we aimed to achieve

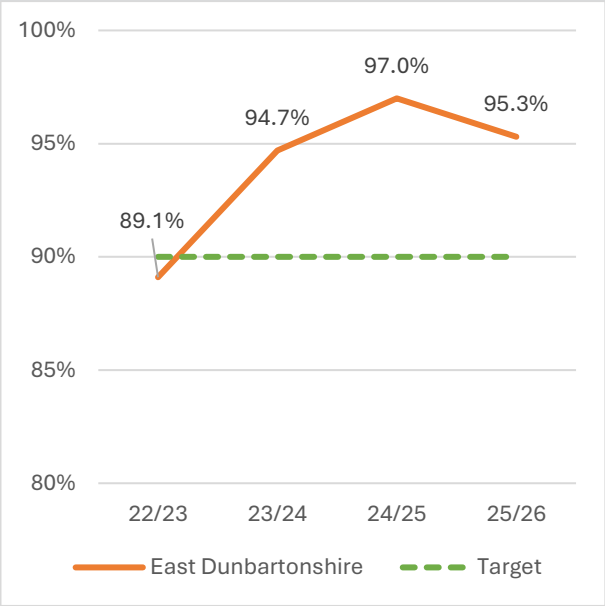
During 2025/26, the HSCP aimed to progress the redesign and delivery of mental health and alcohol and drug recovery services to ensure they are responsive to local need, recovery-focused and aligned with national and regional priorities. This included completing formal service reviews of community mental health provision, resolving cross-boundary service arrangements, strengthening access to timely treatment, and working in partnership to advance regional specialist provision for children and young people. Underpinning all of this activity was a commitment to sustaining performance against national standards while progressing the longer-term transformation of services towards more community-based, person-centred and financially sustainable models of care.

Delivery highlights

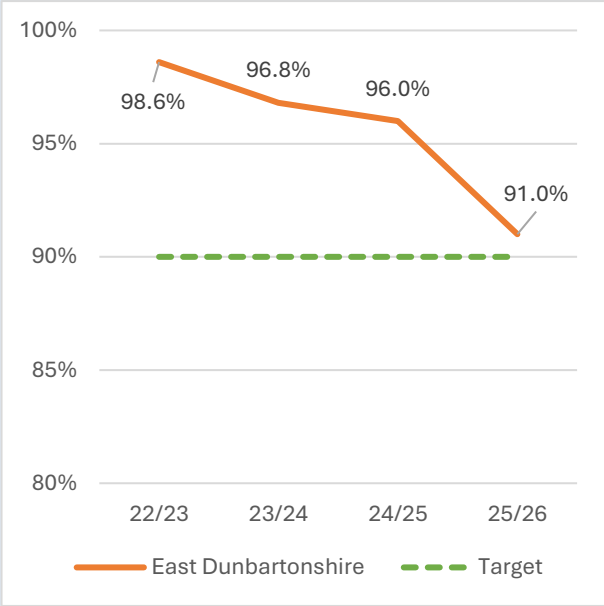
- Completed the Strategic Review of Mental Health and Alcohol and Drug Recovery Services, securing governance approval and progressing implementation through provider engagement and revised contract arrangements.
- Completed the Community Mental Health Team and Older People's Community Mental Health Team Service Review, delivering recurring savings of £132,492 per annum through role redesign and revised skill mix while maintaining safe staffing.
- Achieved green status across all Medication Assisted Treatment Standards for the first time, providing strong assurance of access, quality and person-centred approaches across alcohol and drug recovery services.
- Maintained strong performance against national waiting time standards for drug and alcohol treatment, psychological therapies and Child and Adolescent Mental Health Services (CAMHS), and recovered post-diagnostic dementia support to 98% in 2025/26 following a period of reduced performance.
- Advanced regional planning for the West of Scotland Adolescent Intensive Psychiatric Care Unit (IPCU) and West of Scotland Forensic and Secure CAMHS, with both projects progressed but not fully operationalised within 2025/26 and carried forward.
- Resolved the North Lanarkshire Corridor Service Level Agreement, concluding cross-boundary service and governance arrangements with agreed continuation of provision.
- Launched an 8-week digital Cognitive Behavioural Therapy group programme through the Primary Care Mental Health Team, with patient feedback indicating 100% satisfaction and 100% reporting improvement in symptoms.

Performance snapshot

Percentage of People Waiting less than 3 weeks for Drug & Alcohol Treatment



Percentage of people waiting less than 18 weeks to start treatment for psychological therapies



Percentage of people newly diagnosed with dementia receiving Post Diagnostic Support within 12 weeks

Performance during 2025/26 highlights sustained strength in access to alcohol and drug treatment, with the national standard consistently achieved and performance remaining above target across the year. Access to psychological therapies remained strong, with the 18-week standard maintained at 91%, though the downward trend compared with previous years reflects increasing demand and wider system pressures that will require continued attention. Post-diagnostic support for people newly diagnosed with dementia recovered significantly in 2025/26, reaching 98% against a 90% target following a period of reduced performance in 2024/25 primarily driven by staffing vacancies. This recovery provides assurance that stabilisation actions have been effective, while ongoing workforce planning will be important to sustaining this improvement. CAMHS performance was strong, with 99% of young people seen or discharged experiencing a wait of less than 18 weeks, well above the 90% national standard.

Summary

Delivery in 2025/26 represented significant progress, with two formal service reviews concluded and approved, cross-boundary service arrangements resolved, and MAT Standards achieved green across all ten measures for the first time. Performance against national waiting time standards was broadly sustained, with dementia post-diagnostic support recovering strongly after a difficult 2024/25. Regional planning for specialist CAMHS provision advanced during the year but full operationalisation of the West of Scotland Adolescent IPCU and Forensic CAMHS services was not achieved within 2025/26 and remains a priority for 2026/27. The HSCP also secured over £0.5m through the national Gambling Levy to deliver a three-year prevention-focused programme addressing gambling-related harm, providing a significant platform for early intervention in the years ahead.

Spotlight on good practice

Medication Assisted Treatment (MAT) Standards

During 2025/26, the HSCP's Alcohol and Drug Recovery Service, working closely with the Alcohol and Drug Partnership, achieved green status across all ten MAT Standards, as assessed by Public Health Scotland and published in June 2025. This was the first time all ten standards had been rated green, representing a sustained programme of improvement since the standards were introduced in 2022. The standards span access, treatment, harm reduction, psychosocial support and person-centred care, and achieving green status across all ten provides strong independent assurance that people accessing alcohol and drug recovery services in East Dunbartonshire receive consistent, high-quality treatment in line with national expectations.

Primary Care Mental Health: digital and peer-supported approaches

During 2025/26, the Primary Care Mental Health Team launched an 8-week digital Cognitive Behavioural Therapy group programme, delivered via Microsoft Teams in partnership with the Renfrewshire Doing Well Service. The programme combined psychoeducation, interactive group exercises and structured between-session work across core CBT strategies. Between August and November, the team received 561 referrals and delivered 1,281 individual sessions, with patient feedback indicating 100% satisfaction, with 100% reporting improvement in symptoms and 95.2% reporting improved day-to-day functioning. Planning is under way for a rolling 2026 programme with consideration being given to evening sessions to improve access for people of working age and those with caring responsibilities.

Section 3: Strategic enablers

Delivery during 2025/26 was supported by a range of strategic enablers set out in the Strategic Plan and reflected in the Annual Delivery Plan. These enablers underpin progress across multiple priorities, supporting service redesign, efficiency and improvement. This section summarises how the key enablers contributed to delivery during the year, recognising that progress varied across areas and that some activity remains developmental and foundational in nature.

3.1 Collaborative commissioning

What we aimed to achieve

During 2025/26, the HSCP aimed to strengthen collaborative commissioning and contracting approaches to better align resources with strategic priorities, improve the use of data and analysis to inform commissioning decisions, and support service redesign to improve outcomes, efficiency and long-term sustainability.

Delivery highlights & Summary

- Progressed reviews of adult and children's commissioned services, providing an evidence base to inform future commissioning intentions and support alignment with Strategic Plan priorities.
- Undertook analysis of commissioned spend across service areas, including investment in the voluntary sector, to improve understanding of resource allocation and inform future financial and commissioning decisions.
- Advanced work to develop more consistent and strategic approaches to commissioning and contracting, including strengthening governance and planning arrangements to support service modernisation and efficiency.
- Supported wider service redesign and transformation activity through commissioning input, ensuring that commissioned services are aligned to emerging models of care and delivery priorities.

Activity in 2025/26 strengthened the analytical and governance foundations for collaborative commissioning, providing a clearer evidence base for future commissioning decisions and improving alignment between commissioned services and Strategic Plan priorities. More targeted commissioning reform will be progressed in 2026/27, building on the review activity undertaken during the year.

3.2 Infrastructure and technology

What we aimed to achieve

The HSCP aimed to maximise the use and development of infrastructure and technology to support high-quality, community-based service delivery, enable self-management, and improve efficiency through modern facilities and digital solutions.

Delivery highlights

- Completed the Bishopbriggs Community Treatment and Care Centre development, with the service opening on 1 December 2025, increasing clinical capacity from 22 to 40 sessions and providing modern, fit-for-purpose community-based facilities. Early patient feedback was positive, with people valuing consistency of staffing, improved appointment flexibility and the quality of the new environment.
- Progressed feasibility and planning work for the West Locality premises in Milngavie, with further development paused pending NHS Capital Planning decisions, and officers continuing to work with NHSGGC Capital Planning on longer-term requirements.
- Reviewed summary business cases for Woodlands and Milngavie Clinic, with outputs informing future estate planning and service delivery decisions.
- Developed, approved and published the HSCP Digital Strategy 2025-30 at the November 2025 IJB, providing a clear strategic framework for digital and technology-enabled service delivery over the life of the Strategic Plan.
- Progressed implementation of the digital telecare project, supporting modernisation of telecare services across sheltered housing and community settings.
- Equalities Mainstreaming and Outcomes Progress Report (2023–2025) approved, providing assurance on delivery of Equality Outcomes and compliance with statutory duties.

Summary

Infrastructure and technology delivery in 2025/26 was anchored by two significant achievements: the opening of the Bishopbriggs Community Treatment and Care Centre and the approval of the Digital Strategy 2025-30. Together these provide both immediate improvements in community-based service capacity and a clear strategic direction for digital enablement across the HSCP. Property development activity progressed where capital planning allowed, with West Locality and Woodlands work continuing into 2026/27 subject to NHS Capital Planning decisions. The approval of the Equalities Mainstreaming and Outcomes Progress Report (2023–2025) provides assurance that equality considerations are embedded in service planning, decision-making and delivery, supported by the routine application of Equality Impact Assessments.

Spotlight on good practice

HSCP Digital Strategy 2025-30

During 2025/26, the HSCP developed, approved and published its Digital Strategy 2025-30, setting out how digital and technology-enabled approaches will support delivery of the Strategic Plan. The Strategy was developed through established governance arrangements including the Digital Health and Care Strategy Board, with input from clinical, operational and partner representatives to ensure alignment with local priorities and national policy. It positions digital as a key enabler for integrated, person-centred services, supporting improved access to information, more joined-up working across health and social care, and more efficient use of resources. Its publication provides assurance that the HSCP has a clear and agreed approach to digital development, with appropriate governance and a focus on enabling sustainable service improvement over the life of the Strategic Plan.

3.3 Maximising organisational integration

What we aimed to achieve

The HSCP aimed to strengthen collaboration across health, social work and social care through more integrated pathways and whole-system approaches, improving coordination across services, reducing avoidable escalation and supporting more effective joined-up community-based care.

Delivery highlights

- Completed the review of the Care Home Support Team, delivering recurring savings of £64,240 per annum through deletion of two posts and introduction of a Social Work Assistant role, while maintaining the multidisciplinary model and statutory functions.
- Completed a test of change to pilot enhanced multidisciplinary working across health and community care, with learning informing the development of more integrated working approaches across services and contributing to future locality-based delivery models.
- Delivery of the East Dunbartonshire components of the GGC Unscheduled Care Joint Commissioning Plan was not progressed within 2025/26, as the overarching regional plan was not ratified during the year. Local actions were progressed through the frailty workstream and locality-based working, and will be aligned to the regional plan when finalised.

Summary

Operational integration activity in 2025/26 delivered tangible improvements through the Care Home Support Team review and the multidisciplinary working test of change, both of which are evidenced achievements with clear outcomes. The GGC Unscheduled Care Joint Commissioning Plan was not progressed as planned due to the regional plan not being ratified, and this remains an area of focus for 2026/27. The locality planning framework established during the year provides a stronger foundation for whole-system working in future years.

3.4 Medium-term financial and strategic planning

What we aimed to achieve

During 2025/26, the HSCP aimed to strengthen medium-term financial and strategic planning to support sustainability, affordability and delivery of strategic priorities within a challenging financial environment characterised by increasing demand and constrained resources. A central component of this was the Towards Sustainability programme, a structured programme of service reviews and redesign activity designed to identify savings and ensure organisational structures are fit for purpose.

Delivery highlights

- Completed the Operating Model and Senior Leadership Review, launched in April 2025 and concluded in October 2025, with the new structure approved at the November 2025 IJB. The review delivered savings of £100,860, meeting the target set at the outset, and established a revised senior leadership structure organised around three functional service groups to support whole-system working and strategic delivery.
- Completed the Adult Social Work Services Review, delivering savings of £124,167 per annum through enhanced skill mix and role redesign, while protecting statutory functions and avoiding compulsory redundancies.
- Completed the Community Mental Health Team and Older People's Community Mental Health Team Service Review, delivering savings of £132,492 p/a through role redesign and revised skill mix while maintaining safe staffing arrangements.
- Completed the Business Support Service Review, with the recommended option approved in March, delivering a target saving of £50,000 in 2025/26, an expected in-year saving of £60,794 in 2026/27 and a recurring saving of £160,794 from 2027/28.
- Completed the Care Home Support Team Review, delivering savings of £64,240 per annum as noted under Section 3.3.
- Delivered a focused programme of de-prescribing and realistic medicine activity across GP practices, contributing to more appropriate use of resources and supporting person-centred approaches to long-term condition management.
- The refresh of the Medium-Term Financial Strategy was not completed within 2025/26. Initial review and stakeholder engagement work was undertaken but the full refresh was deferred to align with the 2026/27 Annual Delivery Plan and budget setting process.

Summary

The Towards Sustainability programme delivered substantial and evidenced savings during 2025/26, with five service reviews concluded and approved through governance, generating confirmed savings of over £0.5m per annum across the programme. In addition, further savings have been identified through management actions and efficiency measures. This represents a significant achievement in the context of the financial pressures facing the HSCP and provides a stronger recurring baseline for future years. The Medium-Term Financial Strategy refresh was not completed within the year and remains a priority for 2026/27, where it will inform future savings requirements and service redesign priorities across the life of the Strategic Plan.

3.5 Workforce and organisational development

What we aimed to achieve

The HSCP aimed to strengthen workforce planning, recruitment, retention and wellbeing, ensuring staff have the capacity, skills and support required to deliver high-quality services now and in the future.

Delivery highlights

- Developed and approved the HSCP Workforce Plan 2025-2030, aligned to the Strategic Plan and developed using the six-step methodology for integrated workforce planning, with the action plan subject to six-monthly review.
- Approved the Specialist Children's Services Workforce Plan 2025-2030 and the Oral Health Directorate Workforce Plan at the January 2026 IJB, providing workforce planning frameworks across all three service areas hosted or delivered by the HSCP.
- Reviewed supervision policies and practices within Specialist Children's Services, developing standards aligned to the values of empowerment, self-management, shared decision-making and co-production, with a monitoring strategy in development.
- Achieved revalidation of the UNICEF UK Baby Friendly Initiative Gold Award in October 2025, providing independent assurance of high standards of infant feeding support and staff culture across community children's services.
- Progressed reviews of management structures and organisational design through the Towards Sustainability programme, supporting improved alignment with service delivery priorities and more effective deployment of workforce capacity.

Summary

Workforce and organisational development activity in 2025/26 delivered a comprehensive suite of workforce planning frameworks across the HSCP, Specialist Children's Services and the Oral Health Directorate, providing a clear baseline for future workforce development and sustainability. The UNICEF Baby Friendly Initiative Gold revalidation provides external assurance of quality and staff culture in a key service area. Looking ahead, implementation of the workforce plan action plans and progression of recruitment and retention priorities will be central to ensuring the HSCP has the workforce capacity needed to deliver the Strategic Plan.

Spotlight on good practice

UNICEF Baby Friendly Initiative – Gold revalidation

In October 2025, the HSCP successfully achieved revalidation of its UNICEF UK Baby Friendly Initiative Gold Award, confirming that high standards of infant feeding support and care continue to be embedded across community children's services. The revalidation process recognised strong leadership, a positive and supportive staff culture, effective monitoring and audit arrangements, and clear evidence of continuous improvement and integrated working. The HSCP was highly commended for the quality of evidence submitted and for the way Baby Friendly standards are sustained and developed in practice. This revalidation provides independent assurance of the HSCP's approach to quality improvement, staff engagement and governance, and demonstrates how national standards can be embedded and maintained over time to support improved outcomes for families.

Section 4: Hosted services

Health and Social Care Partnerships operate within a statutory framework that allows services and functions to be delegated to an Integration Joint Board (IJB). While most delegated services are planned and delivered locally, some specialist services are not suited to local division due to the need for scale, consistency or specialist expertise. In these circumstances, it is agreed that one IJB will host services on behalf of some or all the IJBs across NHS Greater Glasgow and Clyde.

Hosting arrangements support efficient delivery while maintaining clear governance and accountability. East Dunbartonshire HSCP hosts two services on behalf of the wider family of IJBs within NHS Greater Glasgow and Clyde: Specialist Children's Services and Oral Health Services. The summaries below highlight key developments and priorities for each hosted service, with full updates provided in Annex 6 (Specialist Children's Services) and Annex 7 (Oral Health Directorate).

4.1 Specialist Children's Services

Specialist Children's Services deliver specialist health and wellbeing services for children and young people across NHS Greater Glasgow and Clyde, including CAMHS, specialist community paediatrics, neurodevelopmental pathways and Tier 4 services including inpatient provision.

Key developments during 2025/26 included: maintaining CAMHS referral to treatment performance above the national standard, with 100% achieved in both February and March 2026; targeted work to reduce waits between first or assessment appointments and subsequent appointments, supported by £1m of reserves and reducing the median wait from 50.9 weeks in July 2025 to 21 weeks in March 2026; continued service improvement work in eating disorders including Scottish Government audit tool priorities, data and training improvements; development of MyApp: My Mental Health content informed by school-based feedback; and ongoing regional Tier 4 review and scrutiny activity including Healthcare Improvement Scotland and Mental Welfare Commission inspection reports and an invited review of Skye House.

Priorities for 2026/27 include: strengthening parent and family involvement in Skye House; implementing the Intensivised CAMHS model and actions from national work on adolescent inpatient care; progressing Year 2 actions of the SCS Workforce Plan including recruitment and wellbeing priorities; further MyApp resource development and dissemination; improving completeness of the CAPTND dataset; and sharing and piloting learning from the CAMHS engagement study to support improved attendance and engagement.

4.2 Oral Health Services

The Oral Health Directorate (OHD) is hosted within East Dunbartonshire HSCP and is responsible and accountable for Primary Care Dental services across NHS Greater Glasgow and Clyde. This includes General Dental Services, the Public Dental Service, Oral Health Improvement, Secondary Care Dental Services and Dental Public Health.

Key developments during 2025/26 included: updating and approval of the OHD Workforce Plan; the Mobile Dental Unit becoming fully operational in October 2025, supporting dental care for vulnerable and socially excluded individuals where delivery from fixed estate is not practicable; appointment of a permanent Project Manager and progress in establishing the Directorate Strategic and Operational Plan; and continued action to address access challenges to NHS dentistry, particularly in Inverclyde, including support for Scottish Dental Access Initiative activity. The new Public Dental Service department at Parkhead Hub became fully operational in August 2025, expanding capacity across priority and vulnerable groups and supporting training and workforce development. A suite of Lifelong Smiles animations was also developed to help children, adults and carers prepare for dental appointments.

Priorities for 2026/27 include: monitoring de-registrations to identify emerging access issues; formal launch activity for the Mobile Dental Unit; progressing recruitment of a temporary Consultant in Dental Public Health; finalising the Oral Health Needs Assessment and progressing recommendations; continued work with Inverclyde HSCP on access solutions; continued development of the Directorate Strategic and Operational Plan; and completing key service reviews and pathway improvements including waiting list management.

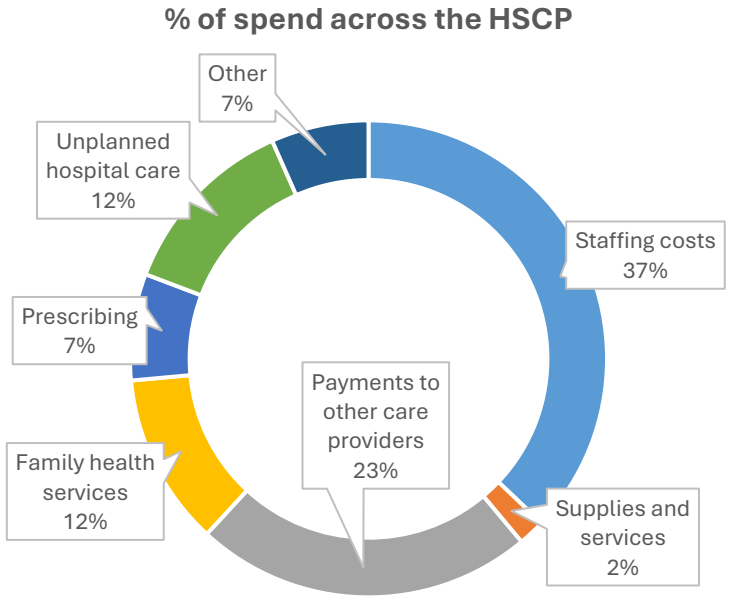
Section 5: Financial performance and Best Value

5.1 Financial context

The IJB is responsible for stewardship of public funds delegated for integrated health and social care services by East Dunbartonshire Council and NHS Greater Glasgow and Clyde. The IJB is required to set a balanced budget and report on financial planning and performance and Best Value as part of its annual performance reporting duties. Unless otherwise stated, the financial figures in this section are taken from the latest in-year budget monitoring available at the time of drafting (to 31 January 2026).

For 2025/26, the IJB approved a total original net budget of £287.347m, including £42.474m set aside for acute hospital services. Following in-year changes agreed through governance, the annual budget increased to £295.254m (a net increase of £7.907m). These changes reflected finalisation of rollover budgets, additional Scottish Government allocations for policy initiatives (including Primary Care Improvement Programme, Alcohol and Drug Partnership and Dementia), and additional funding to meet pay uplift pressures above baseline assumptions.

Overall, financial planning continued to be shaped by sustained demand and rising costs, including pay and contractual pressures, demographic change and increasing complexity of need, and volatility in specific areas such as prescribing. Where funding is non-recurring or time-limited, this increases the importance of recurring efficiencies and service redesign to maintain financial sustainability over the medium term.



5.2 Financial performance during 2025/26

Financial performance was monitored throughout 2025/26 through regular budget reporting to the IJB, reflecting both the underlying cost pressures facing the HSCP and the management action taken in-year to maintain financial balance. At this point in the year, the projected outturn position (inclusive of hosted services) showed a forecast underspend of £4.254m.

After accounting for planned in-year use of reserves and movements to earmarked reserves (including movements relating to specific policy initiatives, hosted services and the proposed earmarking of prescribing underspend), the forecast position reduced to an adjusted underspend of £0.002m (around £2k).

The in-year forecast also highlighted offsetting pressures across delegated services. Delegated health services were forecast to underspend by £0.743m, while delegated social work and social care services were forecast to overspend by £0.740m.

Overall, the forecast position reflects planned reserve movements and other non-recurring measures, alongside ongoing action to manage underlying pressures and deliver the agreed savings and transformation programme.

Care Group / Service Area	Annual budget (£m)	Projected actual spend (£m)	Proportion of total spend	Projected variance (£m)
Strategic & Resources	4.014	3.014	1.04%	1.000
Older People & Adult Community Services	62.580	63.677	21.88%	(1.098)
Physical Disability	5.320	5.202	1.79%	118
Learning Disability	26.581	25.771	8.86%	811
Mental Health	5.074	4.646	1.60%	428
Addictions	1.828	2.611	0.90%	(0.783)
Planning & Health Improvement	0.611	0.468	0.16%	0.143
Children's Services	18.476	19.248	6.61%	(0.772)
Criminal Justice Services	0.044	(0.035)	0.01%	0.079
Other Non-Social Work Services	1.922	1.621	4.50%	0.302
Family Health Services	36.760	36.875	16.69%	(0.115)
Prescribing	24.348	23.761	12.67%	0.586
Oral Health Services	13.667	13.108	8.17%	0.559
Specialist Children's Services	51.555	48.558	0.56%	2.997
Set Aside	42.474	42.474	14.60%	0
TOTAL	**295.254**	**291.000**	**100%**	**4.254**

To comply with statutory requirements, the HSCP expenditure is also categorised into the following national service groupings.

National Service Groupings	Projected actual spend (£m)	Proportion of total spend
Emergency Care (including hospital set aside)	TBC	TBC%
Inpatient care	TBC	TBC%
Community health	TBC	TBC%
Social care	TBC	TBC%
Self-directed support	TBC	TBC%
TOTAL	**291.000**	**100%**

While the HSCP plans and delivers services operationally across its localities, the integrated budget is managed, monitored, and reported as a single budget for the whole of East Dunbartonshire. Consequently, financial performance and expenditure are not disaggregated into individual locality budgets for this reporting period. The opportunity to do so going forward will be reviewed.

5.3 Reserves position and financial resilience

The IJB's reserves are an important indicator of financial resilience and help the HSCP manage volatility and unplanned pressures. The IJB's reserves policy references a prudent general reserve level of 2% of net expenditure (around £4.9m). Based on the in-year forecast position, general reserves were projected to be below this level at year end, noting the final position may change as the year-end financial close is finalised. In addition to general reserves, the HSCP holds earmarked reserves which are set aside for specific purposes, including policy commitments and planned investment. The in-year position described an expected year-end position of £24.328m in earmarked reserves and noted proposals to re-designate elements of earmarked reserves to support budget balancing and provide limited contingency. Re-designating earmarked reserves can support short-term budget balance, but it reduces flexibility for planned investment, including transformation activity and resilience measures.

5.4 Best Value service delivery

Statutory guidance requires the HSCP to assess whether Best Value has been achieved in planning and delivering services, including identifying opportunities for further efficiencies where appropriate. In 2025/26, the HSCP progressed a programme of service review and redesign activity to support sustainability and affordability, alongside management action to mitigate cost pressures. Several reviews approved through governance during the year identified recurring efficiencies through redesign and revised skill mix, while aiming to protect statutory delivery and safe staffing. For example:

- The Adult Social Work Services Review recommended option achieved a recurring saving of £124,167 per annum, largely through redesign and reconfiguration using vacant posts and new role profiles intended to release qualified staff time for statutory functions.
- The Community Mental Health Team & Older People's Community Mental Health Team Service Review recommended options achieved recurring savings of £132,492, primarily through use of vacancies and role redesign, while maintaining safe staffing arrangements and avoiding adverse impact on existing staff.
- The Business Support Service Review set out a redesigned model aligned to the HSCP operating model, with longer-term recurring savings identified (including a recurring saving of £160,794 in 2027/28 under the recommended option), alongside interim savings expectations across the implementation period.

Looking ahead, achieving Best Value will continue to require a focus on recurring savings and service redesign, recognising that difficult decisions may be required on service levels and delivery models to remain within available resources.

5.5 Forward look: affordability and medium-term financial sustainability

The HSCP's current Medium-Term Financial Strategy (MTFS) for 2023–2028 describes a range of potential scenarios for future cost increases and funding settlements. On that basis, the estimated savings requirement over the next five years is £46.0m to £88.9m, with the most likely scenario indicating a financial gap of £48.2m. The MTFS makes clear that the scale of the challenge is such that the HSCP cannot assume it will continue to deliver the same range and levels of service without significant change, and that closing the gap will require a programme of recurring efficiencies, service redesign and transformation. Key future risks include the combined impact of

pay awards, inflation, demand and economic volatility, and workforce capacity, all of which can materially affect cost projections and the deliverability of savings plans.

Looking ahead, workforce-related pressures include the reduction in the Agenda for Change working week from April 2026, which could have service capacity and/or cost implications and how any lost hours are covered. Additional board funding was made available to the HSCP which was prioritised to directly patient facing services to mitigate the impact of the reduced working week. A refresh of the MTFS is underway and will inform future priorities, including the development of recurring savings proposals and service redesign activity, supported by planned stakeholder engagement.

Financial Year	Total Budget (£m)	Total Spend (£m)	Variance (£m)
2021/22	212.712	198.566	14.146
2022/23	208.479	215.407	(6.928)
2023/24	268.269	265.925	2.344
2024/25	280.704	280.792	(0.088)
2025/26 (projected)	295.254	291.000	4.254

Section 6: Scrutiny and inspection

This section provides a concise overview of scrutiny and inspection activity during 2025/26, focusing on key findings, requirements and follow-up actions. A full list of Care Inspectorate evaluation grades for relevant services is included in Annex 8.

Care Inspectorate – Home Care Services (Care at Home), Mainstream Team

A full unannounced Care Inspectorate inspection of Home Care Services – Mainstream Team took place on 4th to 7th November 2025. At the time of inspection, the service was supporting 403 people across East Dunbartonshire, including people with physical and mental health conditions, dementia and palliative care needs, and included a small reablement function.

The Care Inspectorate evaluated the service as:

- How well do we support people's wellbeing? – 5 (Very Good)
- How good is our leadership? – 5 (Very Good)
- How good is our staff team? – 4 (Good)
- How well is our care and support planned? – 4 (Good)

Key messages from the inspection highlighted kind, respectful and person-centred care; consistently positive feedback from people and families; supportive leadership and effective quality assurance; and improvements in care planning and medication procedures through training, review and audit activity. The report also confirms that previous requirements relating to personal planning, moving and handling, and medication management were met within required timescales.

One area for improvement was identified in relation to statutory notifications to the Care Inspectorate, noting that some incidents (including medication errors, accidents, incidents, or adult protection concerns) had not always been notified when required, and that strengthening notification processes would support openness and accountability.

Care Inspectorate inspection – John Street House Care Home Service

Initial inspection (March 2025)

A full unannounced Care Inspectorate inspection of John Street House Care Home Service took place on 5th to 7th March 2025. The service is a small care home for 11 adults with learning disabilities and mental health difficulties, operated by East Dunbartonshire Council. Key messages from the inspection recognised positive relationships between people and staff and that people generally enjoyed living at the service, but identified significant improvement needs, particularly in relation to infection prevention and control (IPC) and environmental cleanliness/maintenance, alongside the need for more planned activities, improved staff/management communication, and care planning improvements.

The Care Inspectorate evaluated the service as:

- How well do we support people's wellbeing? – 2 (Weak)
- How good is our leadership? – 3 (Adequate)
- How good is our staff team? – 3 (Adequate)
- How good is our setting? – 3 (Adequate)
- How well is our care and support planned? – 3 (Adequate)

The inspection set requirements including action to ensure the environment is well-maintained and supports good IPC by 5 May 2025, and ensuring people have an up-to-date personal plan reviewed at least six-monthly by 8 July 2025.

Follow-up inspection (May 2025)

A subsequent unannounced follow-up inspection was completed on 9th May 2025 and was explicitly undertaken to follow up a requirement from the previous inspection. Inspectors reported improved IPC practice and training, improved cleaning practice, replacement furnishings being purchased (with some further orders pending), and ongoing repairs and maintenance, supported by enhanced quality assurance activity.

At this follow-up, the service was evaluated as:

- How well do we support people's wellbeing? – 3 (Adequate)
- How good is our setting? – 4 (Good)

The report confirms the IPC/environment requirement was met within timescales, noting improvements including staff IPC training, enhanced cleaning systems, repairs completion (including previously outstanding works), and strengthened audit and walkround arrangements. Areas for improvement relating to activities, quality assurance, and staffing assessment were noted as making progress and to be reviewed at the next inspection.

Follow-up inspection (July 2025)

A further unannounced inspection took place on 9th to 14th July 2025. Inspectors reported significant improvement in the home environment (warm, welcoming, well maintained), positive outcomes associated with changes to the senior/management team, improved quality assurance and leadership, and evidence of active, individualised lifestyles for residents.

The Care Inspectorate evaluated the service as Good (Grade 4) across all key questions:

- How well do we support people's wellbeing? – 4 (Good)
- How good is our leadership? – 4 (Good)
- How good is our staff team? – 4 (Good)
- How good is our setting? – 4 (Good)
- How well is our care and support planned? – 4 (Good)

The inspection confirms that the personal planning requirement was met within timescales, with care plans updated to be more person-centred and reviewed in an outcomes-focused way. It also records that the earlier areas for improvement relating to planned activities, quality assurance, and staffing assessment were met, with evidence of improved activity planning and oversight, strengthened audit processes with action planning, and clearer evidence used to inform staffing arrangements (with one individual support issue noted for review and action).

Care Inspectorate – Pineview Housing Support Service

An unannounced Care Inspectorate inspection of Pineview Housing Support Service took place on 18th to 19th June 2025. The service provides housing support and care at home support to adults with learning disabilities living in a shared home and in the community, with capacity to support three people (two people were living at the service at the time of inspection).

The Care Inspectorate reported that people received excellent care and support, with families describing their relatives' quality of life as "very good" and noted a consistent staff team and very high standards of communication with families and key professionals. The service was evaluated as 6 (Excellent) for supporting people's wellbeing and 5 (Very Good) for staff team. No complaints were upheld since the last inspection.

Section 7: Locality planning

East Dunbartonshire is divided into two areas, known as localities, to support operational service delivery and to enable planning to be responsive to local needs. These locality areas relate to the following natural communities: Bearsden and Milngavie in the West and Bishopbriggs, Kirkintilloch, Lennoxtown, Lenzie and Torrance in the East.

The area is also organised into three primary care clusters: Kirkintilloch and the Villages; Bishopbriggs and Auchinairn; and Bearsden and Milngavie. Most community health, social work and social care services are organised into either locality or cluster teams.

As part of a refreshed approach to locality planning in 2025/26, the HSCP established a Locality Planning Action Group (LPAG), which reports to the Strategic Planning Oversight Group (SPOG). The LPAG brings together a broad range of local stakeholders across Health, Social Work and Social Care to progress locality-based priorities aligned to the Strategic Plan, with SPOG providing governance and oversight.

The refreshed approach places an increased emphasis on delivery and learning, with locality planning activity adopting a test-of-change model. The LPAG agreed to pilot locality planning within two communities, one in each locality, to enable more targeted action before wider roll-out. This work is informed by local data, partner insight and lived experience, with a focus on prevention, early intervention, community assets and strengthening early and community-based support, reflecting differing needs across the East and West localities.

The LPAG provides a collaborative forum through which partners, services and communities can influence locality-level priorities, ensuring alignment with the HSCP Strategic Plan and wider Community Planning Partnership priorities. The HSCP Board is an equal partner in the East Dunbartonshire Community Planning Partnership and has responsibility for leading on key outcomes within the Local Outcome Improvement Plan, as well as contributing to others.

Annex 1: Core Integration Indicators

Indicators 1-9 are reported by a national biennial Health and Social Care Experience Survey that reports every two year. In 2025/26, East Dunbartonshire had a response rate of X%, which equates to X returns, compared to a Scotland response rate of X%. It is important to note the limitations of the survey due to small numbers, which introduces a margin of error at a local level. Comparison of performance using this data should therefore be seen as an approximation. Please note figures for the years from 2019/20 for indicators 2, 3, 4, 5, 7 and 9 are not directly comparable to figures in previous years due to changes in methodology. More information on the survey and changes in the methodology are available here: Scottish Government Health Care Experience Survey *[update link]* 2025/26 data will be released by Public Health Scotland in July 2026.

Ref	Description	East Dunbartonshire HSCP				Scottish Average 25/26	National Rank	Trend
		19/20	21/22	23/24	25/26			
C1	Percentage of adults able to look after their health very well or quite well	95.2%	92.9%	93.8%	TBC	TBC	TBC	TBC
C2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	77.8%	87.9%	79.8%	TBC	TBC	TBC	TBC
C3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	73.6%	74.1%	67.7%	TBC	TBC	TBC	TBC
C4	Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated	77.2%	64.0%	66.4%	TBC	TBC	TBC	TBC
C5	Total percentage of adults receiving any care or support who rated it as excellent or good	86.7%	74.9%	77.6%	TBC	TBC	TBC	TBC
C6	Percentage of people with positive experience of the care provided by their GP Practice	85.9%	69.1%	69.4%	TBC	TBC	TBC	TBC

Ref	Description	East Dunbartonshire HSCP				Scottish Average 25/26	National Rank	Trend
		19/20	21/22	23/24	25/26			
C7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	85.8%	77.0%	69.8%	TBC	TBC	TBC	TBC
C8	Percentage of carers who feel supported to continue in their caring role	37.6%	30.2%	25.8%	TBC	TBC	TBC	TBC
C9	Percentage of adults supported at home who agree they felt safe	79.0%	83.5%	84.6%	TBC	TBC	TBC	TBC

Indicators 11-20 are based on nationally collected Scottish Morbidity Records. In line with Public Health Scotland guidance, calendar year 2025 is used as the most recent reporting period as a proxy for 2025/26, reflecting the most complete data available. Indicator 20 is reported up to financial year 2019/20 only, in accordance with PHS advice. Further detail is available in the PHS Core Suite of Integration Indicators – Background and Glossary.

Ref	Description	East Dunbartonshire HSCP						Latest Scottish Average	National Rank	Trend
		20/21	21/22	22/23	23/24	24/25	25/26			
C11	Premature mortality rate for people aged under 75yrs per 100,000 population	299	283	300	303	TBC	N/A	TBC	TBC	TBC
C12	Emergency admission rate for adults per 100,000 population	9,947	10,799	11,035	11,233	TBC	N/A	TBC	TBC	TBC
C13	Emergency bed day rate for adults per 100,000 population	101,481	109,610	126,098	121,134	TBC	N/A	TBC	TBC	TBC

Ref	Description	East Dunbartonshire HSCP						Latest Scottish Average	National Rank	Trend
		20/21	21/22	22/23	23/24	24/25	25/26			
C14	Readmission to hospital within 28 days for adults per 1,000 population	86.3	82.1	78.6	83.0	TBC	N/A	TBC	TBC	TBC
C15	Proportion of last 6 months of life spent at home or in a community setting	89.7%	88.7%	88.1%	88.3%	TBC	N/A	TBC	TBC	TBC
C16	Falls rate per 1,000 population aged 65+	21.0	22.2	21.4	21.9	TBC	N/A	TBC	TBC	TBC
C17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	89.7%	86.2%	86.7%	85.6%	93.5%	TBC	TBC	TBC	TBC
C18	Percentage of adults with intensive care needs receiving care at home	59.6%	65.2%	65.8%	65.0%	65.5%	TBC	TBC	TBC	TBC
C19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	303.9	340.5	457.9	412.4	480.7	TBC	TBC	TBC	TBC
C20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Annex 2: Scottish Government Ministerial Strategic Group Indicators

This section provides the HSCP's performance against Scottish Government Ministerial Strategic Group indicators.

2025/26 data will be released by Public Health Scotland in June 2026. The approach to presenting this data (numbers or rates) will be confirmed following publication, depending on the availability of comparable local and national data.

Ref	Description	East Dunbartonshire HSCP						Scottish Average 25/26	Trend
		20/21	21/22	22/23	23/24	24/25	25/26		
M1a	Emergency admissions (all ages) – rate per 1,000 population	6.9	7.8	8.2	8.2	7.9	TBC	TBC	
M1b	Unplanned admissions from A&E – rate per 1,000 population	4.0	4.6	4.6	4.7	4.5	TBC	TBC	
M2a	Unplanned bed days (acute) - rate per 1,000 population	59.4	66.6	76.5	72.9	73.3	TBC	TBC	

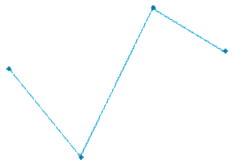
Ref	Description	East Dunbartonshire HSCP						Scottish Average 25/26	Trend
		20/21	21/22	22/23	23/24	24/25	25/26		
M2b	Unplanned bed days (geriatric long stay) - rate per 1,000 population	0.0	0.1	0.0	0.0	0.0	TBC	TBC	
M2c	Unplanned bed days (mental health) - rate per 1,000 population	8.5	7.4	9.0	8.8	9.3	TBC	TBC	
M3a	A&E attendances - rate per 1,000 population	15.2	20.6	20.4	20.2	19.9	TBC	TBC	
M4	Delayed discharge bed days - rate per 1,000 population	4.08	4.58	6.75	7.08	9.50	TBC	TBC	

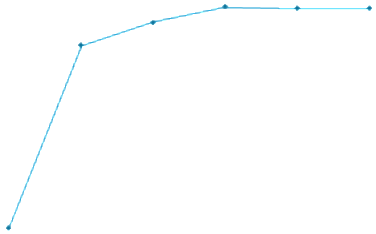
Ref	Description	East Dunbartonshire HSCP						Scottish Average 25/26	Trend
		20/21	21/22	22/23	23/24	24/25	25/26		
M5	Percentage of last six months of life spent in the community (includes care homes and people living at home)	89.7%	88.7%	88.1%	88.2%	89.8%	TBC	TBC	
M6	Percentage of the population in institutional settings (hospital/ hospice/care home)	0.8%	0.9%	1.0%	1.0%		TBC	TBC	

Annex 3: Local Performance Indicators

This section sets out the HSCP's performance against other national and local indicators of performance and quality.

Ref	Description	2024/25	2025/26	Target	Status	Trend	Note
L1	Percentage of people 65+ indicating satisfaction with their social interaction opportunities	95%	94%	95%	▲		2025/26 figure based on a total of 190 reviews. 58 additional reviews took place but were omitted due to no response.
L2	Percentage of service users satisfied with their involvement in the design of their care packages	96%	98%	95%	✓		2025/26 figure based on a total of 257 reviews. 74 additional reviews took place but were omitted due to no response.
L3	Number of homecare hours per 1,000 population aged 65+	517	522	389	✓		This is the total hours of care for customers aged 65+ receiving homecare on the last week of the year.

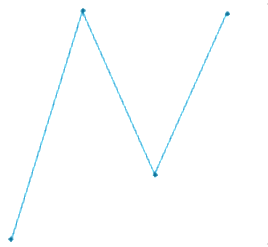
Ref	Description	2024/25	2025/26	Target	Status	Trend	Note
L4	Percentage of adults in receipt of social work / social care services who have had their personal outcomes fully or partially met	100%	98.7%	90%	✓		As a minimum, outcomes should reduce risks from a substantial to a moderate level, but the arranging of informal support may also contribute to improving quality of life.
L5	Smoking quits at 12 weeks post quit in the 40% most deprived areas	26	18	21	✗		This service is delivered by the NHSGGC Quit Your Way Service and not directly in the HSCP. Data is based on January to December 2025.
L6	% of customers (65+) meeting the target of 6 weeks from completion of community care assessment to service delivery	99%	100%	95%	✓		The national standard is to operate within a six week period from assessment to service delivery, which encourages efficiency and minimises delays for service users.

Ref	Description	2024/25	2025/26	Target	Status	Trend	Note
L7	% of CJSW Reports submitted to court by due date	100%	100%	95%	✓		National Outcomes & Standards (2010) states that the court will receive reports electronically from social work, no later than midday on the day before the court hearing.
L8	The % of individuals beginning a work placement within 7 working days of receiving a Community Payback Order	99%	99%	80%	✓		The criminal justice social work service has responsibility for individuals subject to a Community Payback Order beginning a work placement within 7 days.
L9	% of Court report requests allocated to a Social Worker within 2 Working Days of Receipt	100%	99.8%	100%	▲		During 2025/26 there were 430 requests, with only one allocated outwith timescale due to an administrative error.

Ref	Description	2024/25	2025/26	Target	Status	Trend	Note
L10	Percentage of Adult Protection cases where the required timescales have been met	91%	TBC	92%	▲		This measures the speed with which sequential Adult Support and Protection actions are taken against timescales laid out in local social work procedures.
L11	Percentage of initial Child Protection Planning Meetings taking place within target timescale	94%	89%	90%	▲		During 2025/26, 19 meetings were held, with two taking place outwith target timescales.
L12	Percentage of first Review Child Protection Planning Meetings taking place within 6 months of registration	100%	93%	95%	▲		During 2025/26, 15 meetings were held, with one taking place outwith the expected timescale.

Ref	Description	2024/25	2025/26	Target	Status	Trend	Note
L13	Percentage of child care Integrated Comprehensive Assessments for Scottish Children's Reporter Administration (SCRA) completed within target timescales (20 days)	98%	96%	75%	✓		During 2025/26, 49 assessments were completed, with two taking place outwith the expected timescale.
L14	Percentage of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated	100%	90%	100%	✗		During 2025/26, 10 reviews were held, with one taking place outwith the expected timescale.
L15	Balance of Care for looked after children: percentage of children being looked after in the Community	82%	76%	89%	✗		There was a decrease in community placements but an increase in residential placements, leading to a shift in the balance of care.
L16	Percentage of children receiving 27-30 months assessment	94%	95%	85%	✓		This indicator relates to early identification of children with additional developmental needs and can then be referred to specialist services.

Ref	Description	2024/25	2025/26	Target	Status	Trend	Note
L17	Percentage of people waiting less than 18 weeks to start treatment for psychological therapies	96%	91%	90%	✓		This includes the Community, Primary and Older People's Mental Health Teams.
L18	Total number of Alcohol Brief Interventions delivered during the year	433	297	487	✗		Performance reduced in 2025/26 and remained below target, reflecting capacity pressures and changes in reporting arrangements, with primary care data no longer available.
L19	Percentage of Young People seen or otherwise discharged from the CAMHS waiting list who had experienced a wait of less than 18 weeks	96%	99%	90%	✓		Performance remained strong in 2025/26, with 99% of young people seen within the national 18-week standard.
L20	Percentage of People Waiting less than 3 weeks for Drug & Alcohol Treatment	97.7%	95.3%	90%	✓		Due to routine delays with data finalisation, the figures provided relate to calendar years.

Ref	Description	2024/25	2025/26	Target	Status	Trend	Note
L21	Percentage of people newly diagnosed with dementia receiving Post Diagnostic Support within 12 weeks	28%	98%	90%	✓		Performance has shown variability over recent years, influenced by periods of reduced staffing due to vacancies.

Annex 4: National outcomes

The tables below show the alignment between the National Health and Wellbeing Outcomes and the East Dunbartonshire HSCP Strategic Priorities and Enablers, highlighting the most direct areas of contribution.

HSCP Strategic Priority / Enabler	National Outcome								
	1	2	3	4	5	6	7	8	9
Empowering people	X	X	X	X	X	X	X		X
Empowering and connecting communities	X	X	X	X	X	X			X
Prevention and early intervention	X	X		X	X	X			X
Public Protection				X	X		X		
Supporting carers and families	X	X	X	X	X	X	X		
Improving mental health and recovery	X	X	X	X	X	X	X		
Collaborative commissioning	X	X	X	X	X	X	X	X	X
Infrastructure and technology		X			X		X		
Maximising organisational integration			X	X			X	X	X
Medium-term financial and strategic planning	X	X	X	X	X	X	X	X	X
Workforce and organisational development	X	X	X	X	X	X	X	X	X

National outcomes:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

7. People who use health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

Annex 5: Annual Delivery Plan Progress Tracker

Strategic Priority / Enabler	Action	RAG Status	Progress Summary
Empowering People	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	Complete ☑	• Established governance and a short life working group to improve structure, consistency and quality of website content. • Ongoing review of website content through short life working group.
	Implement year one of the East Dunbartonshire Public Health Framework	Complete ☑	• Progressed targeted prevention activity aligned to inequality priorities. • Embedded poverty-aware approaches and completed Year 1 delivery, informing priorities for 2026/27.
Prevention and Early Intervention	Review Care at Home services to focus on reablement expansion to mitigate demand growth	Delayed	• Developed initial project documentation; however, full review activity was not progressed within 2025/26. • Project formally delayed, with review activity rescheduled to 2026/27.
	Service Review Social Work Community Occupational Therapy Service	Complete ☑	• Completed Occupational Therapy review as part of wider Adult Social Work service review. • Secured approval through governance processes, progressing into implementation phase.

Strategic Priority / Enabler	Action	RAG Status	Progress Summary
Public Protection	Review of the HSCP public protection function/team	Delayed	• Initial scoping completed but review formally postponed due to prioritisation of other service reviews. • Project deferred to 2026/27 with no further delivery in 2025/26.
Supporting Carers and Families	Complete review of Respite (Commissioned)	Complete	• Completed review activity, including impact assessment, consultation and development of new service specifications. • Progressed commissioning and contractual arrangements, with implementation continuing into 2026/27.
	Commence the Review of the Supported accommodation estate	Complete	• Completed preparatory and governance work, including demand analysis, baseline assessment and project documentation. • Established foundation for a Support with Accommodation Strategy and identified priorities for delivery in 2026/27.
	(Commissioned) Review and implement recommendations to reduce high-cost care packages (LD)	Complete	• Progressed programme of individual care package reviews, including identification of high-cost cases. • Completed planned 2025/26 activity, with continuation of reviews and implementation of changes into 2026/27.

Strategic Priority / Enabler	Action	RAG Status	Progress Summary
	Explore potential of developing an all-age learning disability function	Complete ☑	• Completed service review process, including option appraisal and stakeholder engagement. • Secured approval through governance processes, with the project transitioning to implementation planning in 2026/27.
Improving Mental Health and Recovery	Strategic Review of Mental Health and Alcohol and Drugs Services	Complete ☑	• Completed strategic review, including development of service models, specifications and contractual frameworks. • Secured approval through governance processes and progressed implementation through engagement with providers and contract arrangements.
	Service Review Community Mental Health Team (CMHT) and Older Peoples Community Mental Health Team (OPCMHT)	Complete ☑	• Completed service review of CMHT and OPCMHT, including option appraisal and stakeholder engagement. • Secured approval of recommended approach through governance processes, progressing implementation activity.

Strategic Priority / Enabler	Action	RAG Status	Progress Summary
	Resolution of North Lanarkshire Corridor Service Level Agreement (NHS GGC/NHS Lanarkshire)	Complete	• Secured confirmation of Service Level Agreement arrangements between NHS partners. • Resolved cross-boundary service and governance issues, concluding the project with agreed continuation of arrangements.
	Conclude the planning and operationalisation of the West of Scotland Adolescent Intensive Psychiatric Care Unit	Delayed	• Progressed planning and development activity, including governance and preparatory work. • Project delayed and carried forward due to delivery challenges, with further work required in 2026/27.
	Conclude the planning and operationalisation of a West of Scotland Regional Planning Regional Forensic and Secure Care CAMH services	Delayed	• Progressed regional planning and development work to support establishment of forensic and secure CAMHS provision. • Planning activity advanced during the year, however full operationalisation was not achieved within 2025/26.
Collaborative commissioning	Adult and Children & Families Services Commissioning Review	Cancelled	• Project did not proceed as a discrete workstream during 2025/26. • Related activity was progressed through business as usual delivery and wider strategic review work.

Strategic Priority / Enabler	Action	RAG Status	Progress Summary
Infrastructure and technology	Bishopbriggs Premises - progress approved property redesigns in 2025/26	Complete ☑	• Completed delivery of approved property redesigns at Bishopbriggs, including development and opening of new facilities. • Work has supported improved estate utilisation and service delivery arrangements.
	West Locality Premise Feasibility (Milngavie) - progress approved property redesigns in 2025/26	Delayed	• Significant progress made on feasibility, design and planning work for Milngavie locality premises. • Work remained ongoing at year end, with final delivery extending beyond 2025/26.
	Review summary business cases for Woodlands and Milngavie Clinic	Complete ☑	• Completed review and development of summary business cases for Woodlands and Milngavie Clinic. • Outputs have informed future estate planning and service delivery decisions.
	Refresh Digital Strategy in line with the new Strategic Plan 2025-30	Complete ☑	• Delivered a refreshed Digital Strategy aligned to the HSCP Strategic Plan 2025–2030. • Strategy informed by digital maturity work and sets direction for future digital transformation.

Strategic Priority / Enabler	Action	RAG Status	Progress Summary
Maximising operational integration	Continued delivery of East Dunbartonshire components of the GGC Unscheduled Care Joint Commissioning Plan	Delayed	• Progress was dependent on development of the overarching GGC plan, which was not finalised during 2025/26. Local actions were progressed and will be aligned to the regional plan when finalised.
	Complete the Review of the Care Home Support Team	Complete	• Completed review of the Care Home Support Team, including assessment of current model and identification of improvement opportunities. • Secured agreement on future model through governance processes, supporting strengthened multidisciplinary input.
	Undertake a test of change in relation to enhanced multi-disciplinary working in health and community care	Complete	• Undertook and completed a test of change to enhance multi-disciplinary working across health and community care. • Learning has informed development of integrated working approaches across services.
Medium-term financial and strategic planning	Review and refresh the HSCP Medium-Term Financial Strategy	Delayed	• Initial work undertaken to review and refresh the HSCP Medium-Term Financial Strategy. • Full refresh was not completed within the year and has been carried forward into 2026/27.

Strategic Priority / Enabler	Action	RAG Status	Progress Summary
	Implement focussed programme of de-prescribing and realistic medicine	Complete ☑	• Delivered focused programme activity to support de-prescribing and embed realistic medicine principles. • Work has contributed to improving prescribing practice and supporting person-centred care.
	Review of Business Support Function	Complete ☑	• Completed review of Business Support functions, including assessment of structure, processes and capacity. • Secured approval of recommended approach through governance processes, supporting future implementation and organisational improvement.
	Review of HSCP Management Structure	Complete ☑	• Completed review of HSCP management structure, including assessment of roles, responsibilities and reporting arrangements. • Agreed revised structure through governance processes, supporting alignment with service delivery and strategic priorities.

Strategic Priority / Enabler	Action	RAG Status	Progress Summary
	Service Review of Adult Social Work Services	Complete ☑	• Completed comprehensive review of Adult Social Work Services, including options appraisal and stakeholder engagement. • Outputs are informing implementation of a revised service model.
Workforce and organisational development	Develop the 2025-2030 HSCP Workforce Plan	Complete ☑	• Developed and finalised a Workforce Plan aligned to the HSCP Strategic Plan 2025–2030. • Plan sets out priorities to ensure workforce capacity, capability and sustainability.
	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	Complete ☑	• Reviewed supervision policies and practices within Specialist Children's Services. • Developed standards aligned to values of empowerment, self-management, shared decision-making and co-production.

Annex 6: Specialist Children's Services 2025/26 Update

Specialist Children's Services (SCS) support the health and wellbeing of children and young people across Greater Glasgow and Clyde. We offer a range of services within Child and Adolescent Mental Health Services (CAMHS), Specialist Community Paediatric Teams (SCPT), Neurodevelopmental Pathway, and Tier 4 Services. SCS has a large workforce based throughout the NHSGGC area. Some of these staff work within the local communities, such as health centres, in hospitals and inpatient units, schools (mainstream and additional support for learning), and within the patient's home, and SCS have many office bases throughout NHSGGC and the six partnership areas.

Across Scotland, there is a tiered approach to mental health services in the public sector. Getting It Right for Every Child principles underpin service delivery in each tier, and these are built into service specifications. Tier 1 mental health support is delivered locally and as part of universal services such as Health Visiting and Education. Tier 2 covers mild mental health presentations and is targeted towards those who need it. These services are usually delivered by voluntary and community organisations and offer short term interventions. Tier 3 community CAMHS services are targeted at children and young people with moderate to severe mental health needs who require assessment, intervention and management which is more specialist than that which can be provided by universal services. Tier 4 CAMHS services focus on highly specialist services operating on a GGC level with small numbers of children who require specialist care. GGC CAMHS also host the West of Scotland regional child and adolescent psychiatric in-patient unit at Skye House, and the national children psychiatric in-patient unit for under 12s at the Royal Hospital for Children.

Areas of Development and Progress achieved in 2025/26

CAMHS and ND

- The CAMHS waiting times standard of 90% of children and young people starting treatment within 18 weeks (referral-to-treatment, RTT) has been maintained above the national target since June 2023. In February and March 2026, the RTT was 100 %.
- The national standard reflects waits for initial appointments, however, the number of children and length of wait from first or assessment appointment to subsequent appointment is also a focus for CAMHS. £1m of reserves have been allocated to address this, resulting in a reduction in the median waiting time from first or assessment to subsequent appointment, from 50.9 weeks in July

2025 to 21 weeks in March 2026. This is expected to improve further as the team work to prioritise reducing long waits wherever possible.

- To improve understanding of mental health and support provided by CAMHS, content for young people and families has been set up on MyApp: My Mental Health. To ensure this meets young people's needs, feedback workshops have taken place in schools. This feedback is informing ongoing developments.

Eating Disorders Services

- A comprehensive review of CAMHS eating disorder services was undertaken using the Scottish Government's Audit Tool, resulting in the identification of four key priorities. Work has already commenced on these areas, including efforts to ensure a cohesive approach during the transition to adult mental health services. Progress includes reviewing data collection processes to better align with national standards, joining the National Eating Disorder network for collaboration and sharing of good practice, and engaging with young people to enhance community-based care options. The service has also communicated with NES to address training and development needs and continues to focus on staff training across all service tiers, with particular emphasis on Family-Based Therapy (FBT). A training and development package for mealtime support is nearing completion, and ongoing mapping of service provision is underway.

Regional CAMHS Tier 4

- There are several ongoing reviews concerning adolescent inpatient care. The ongoing tri-regional review of adolescent inpatient units will inform future delivery models in line with the Mental Health Strategy and the Service Renewal Framework. Additional activity includes Healthcare Improvement Scotland (HIS) and Mental Welfare Commission (MWC) inspection reports, recent Scottish Government communication regarding the restrictive practice review led by MWC, and an invited review of Skye House.
- A standard reporting template for Regional Forensic CAMHS was developed, with planned submission to the West of Scotland Alliance via the Regional Planning Team once the service is fully operational. An outline of the spoke clinician role was produced to support other Boards with recruitment and role development. A proposed CPD and training plan was developed, including two New to Forensics sessions and two spoke shadowing sessions with GGC FCAMHS.

Service wide Developments

- Supervision standards for various SCS professions have been compiled and reviewed by professional leads, supported by feedback from staff survey. The monitoring strategy is currently being agreed upon.
- Key data regarding waiting times across SCS has been reviewed, with gaps identified and efforts made to improve data quality. Internal waiting times for paediatric pathways were assessed to inform service reviews. A short Life Working Group completed work on CAMHS, highlighting blockages in flow navigation which will inform workforce planning. Mapping of neurodevelopmental waiting lists is underway.
- The CAMHS engagement study is researching what influences young people's attendance & engagement with mental health services. Data collection, interviews with young people and clinicians, were completed in 2025.
- SCS research included a review of the literature on Social media - its use and impact on mental health and wellbeing on young people, with a focus on self-harm and suicidality. This review has been shared widely within and outside NHSGGC. The review provides an update on the state of knowledge about social media usage and shares insights into its potential for harm and good. It specifically covers the impact of social media on young people with experience of self-harm or suicidality.
- The 2025 SCS Research Conference brought together over 60 academics, health practitioners, and researchers for a vibrant day of learning, collaboration, and innovation. Hosted by the University of Glasgow, the event showcased cutting-edge research and service development across Specialist Children's Services. Another conference is planned for 2026.

Key Priorities in 2026/27

- Refresh parent and family involvement approach in Skye House through development of Skye House Chater and Champions Board.
- Implement Intensivised CAMHS services model and wider actions from the outcome of the national review of adolescent inpatient psychiatric care.
- Improve support and services around Mental Health, Neurodiversity and Learning Disability
- Implement year 2 actions of 2025 - 2030 SCS Workforce Plan. Workforce priorities include reviewing the Tier 3 and Tier 4 workforce, achieving 80% PDP+R compliance, developing a robust recruitment strategy for Specialist Children's Services, and reviewing the Staff Wellbeing Action Plan and Peer Support Network.

- As part of the MyApp: My Mental Health developments, additional materials will be published this year. Dissemination activities for young people, referrers, and local teams are also planned.
- CAMHS is part of the Child, Adolescent and Psychological Therapies National Dataset (CAPTND). During 2026/27, the service will be taking forward an action plan to address technical and clinical practice changes to extend the completeness of the NHSGGC submission. This will include improvements to recording of ethnicity, presenting problem, and treatment intervention, among others.
- Findings from the CAMHS engagement study will be disseminated via publications and in NHSGGC. Within SCS, this will lead to piloting different approaches to improve, for example, how staff help young people to prepare for their CAMHS treatment.

Annex 7: Oral Health Directorate 2025/26 Update

The Oral Health Directorate (OHD) is hosted within East Dunbartonshire Health and Social Care Partnership and has responsibility and accountability for Primary Care Dental services within NHS Greater Glasgow and Clyde (NHSGGC) Health Board. The responsibility and accountability for Secondary Care Dental services sits with the Regional Services Directorate, part of the Acute Sector of NHSGGC.

The OHD structure incorporates:

- General Dental Services, including Greater Glasgow & Clyde Emergency Dental Service
- Public Dental Service
- Oral Health Improvement
- Secondary Care Dental Services
- Dental Public Health

General Dental Services (GDS)

The role of the OHD General Dental Services administration team is to provide a comprehensive administrative support service to 272 practices and over 800 General Dental Practitioners in Greater Glasgow and Clyde in accordance with The National Health Services (General Dental Services) (Scotland) Regulations 2010. The department acts as an enabling function providing practitioners with the necessary support and expertise associated with their terms and conditions obligations. The department supports the organisation by ensuring that its statutory responsibilities are fulfilled in relation to this group of NHS independent contractors.

Public Dental Service (PDS)

The PDS service operates on a board-wide basis across 19 community sites, three prisons, three secure schools, and five secondary care sites. It provides comprehensive dental care and oral health education to priority group patients, including those with additional support needs, adult and paediatric learning disabilities, medically compromised and children who are unable to be seen routinely by GDS (these will include higher levels of treatment complexity and behavioural factors). Treatment is provided in clinics, schools and nurseries, care homes, outpatient daycentres, hospital settings, domiciliary visits, prisons, and undergraduate outreach clinics.

Oral Health Improvement (OHI)

Incorporating strategic and organisational leadership to reduce oral health inequalities, including fulfilling NHSGGC responsibilities in relation to the Oral Health Improvement Plan (2018), delivery of national Oral Health Improvement Programmes (such as Childsmile and Caring for Smiles), local oral health strategy, and for oral health improvement requirements and ambitions across other programmes in NHSGGC.

Secondary Care Dental (SCD) Service

SCD services, also known as Hospital Dental services, are the main referral centre for specialist dental services for NHSGGC and the West of Scotland. SCD services accept patients on referral from medical and dental practitioners as well as tertiary referrals from other areas or specialties, including the Emergency Dental Treatment Centre (EDTC) and the Out of Hours (OOH) service.

Patients can be treated in outpatient clinics or, depending on the treatment required, patients are admitted as inpatients or day cases. Treatment is carried out in the Glasgow Dental Hospital (outpatients) as well as many hospital sites (inpatients/day cases) within the Acute Sector of NHSGGC.

Dental Public Health (DPH)

DPH is the speciality of dentistry that deals with the prevention of oral disease, promotion of oral health, and improvement of quality of life through the organised and collective efforts of society. DPH practitioners also have roles in health protection related to dentistry and provide strategic input to the management of healthcare services. The NHSGGC Consultant in Dental Public Health sits within the OHD and works alongside colleagues in the Public Health Directorate and Health Improvement in the Health Board and HSCPs.

Areas of Development and Progress during 2025/26

Over the last year, development and improvement work has continued within Primary and Secondary Care dental services. Some highlights include:

- The OHD Workforce Plan has been updated, taking account of any impact of the Health and Care Safe Staffing Act and the reduction to 36 hours for all agenda for change staff.
- We took delivery of the Mobile Dental Unit which became fully operational in October 2025.The unit will help to address some service challenges in the PDS, in particular the management of dental care for vulnerable and socially excluded individuals, where delivery of care is not possible or practicable from within fixed estate.
- The Project Manager was appointed within OHD on a permanent basis, he has progressed the creation of the Directorate Strategic and Operational Plan and is also supporting a number of key projects within the Directorate.
- Access to NHS GDS remains a key challenge, particularly within the Inverclyde area. One SDAI application has been approved and the grant offer was issued week commencing 22nd September 2025. The timeline for estimated completion of Capital Works is the end May 2026. In addition, another new formal SDAI application has been received (January 2026) to open a new 2 surgery practice within the Greenock area. The draft grant offer letter was shared with S.G colleagues (4/3/26) with a request seeking confirmation SDAI funds are available prior to formal offer being issued to the applicant. This confirmation has now been received and the letters will be issued to the applicant.
- Lifelong Smiles is a suite of animations designed to support children, adults, and carers when attending dental appointments. The animations explain what to expect and outline available services, including the Mobile Dental Unit. These have been developed over the last year following the Q-Exchange project. There are 11 videos in total. Some animations present the experience from the perspective of carers and/or parents, while others are shown from the child's perspective.
- The new PDS dental department at Parkhead Hub became fully operational in August 2025. The department includes 6 surgeries designed to specifically meet the needs of our various patient groups including:
    - Paediatric services with facilities for general anaesthetic assessment
    - Special Care Dentistry for patients with complex medical, physical, or social needs supported with a special care surgery fitted with a ceiling track hoist
    - Unscheduled dental care for unregistered patients requiring urgent treatment
    - Priority and vulnerable patient group
    - Inhalation sedation services to support anxious or phobic patients
    - Training opportunities, including dental core training, enhancing workforce development and clinical experience

Areas for Focus during 2026/27

- Continue to monitor the number of de-registrations from practices to ensure we have an overview on any other areas where there may be a significant access issue developing.
- Facilitate the formal launch of the Mobile Dental Unit.
- Progress the recruitment of a new temporary Consultant in Dental Public Health.
- Finalise work on the Oral Health Needs Assessment and take forward any recommendations.
- Continue to work with colleagues within Inverclyde HSCP to seek solutions to the limited access to NHS dentistry within the area. Offering support and guidance to any practitioner who wishes to apply for Scottish Dental Access Initiative funding to establish a new NHS dental practice in the Inverclyde area.
- Continue to monitor and update the OHD Strategic and Operational Plan which captures all significant projects and allow us to effectively chart progress against these areas of work.
- Preparations are in the final stages to allow the transfer of the Special Care waiting list to TrakCare. The training was completed in April 2026 and the transfer will take place shortly afterwards. Similar to the Paediatric patient pathway work this will allow us to track/monitor patient progress through the pathway. This ensures we maintain an accurate waiting list, streamline the patient pathway and provide robust data.
- The Oral Health Directorate Management Team will meet with each HSCP to discuss the national refocus of Childsmile and to introduce the draft NHS GG&C Childsmile outcome measures. These measures clarify the key roles and responsibilities, the structure of the Oral Health Directorate, and the core elements of Childsmile programmes. The document is designed to support HSCPs in identifying priorities aligned to the outcome measures, outlining staffing and budget arrangements for the Childsmile programme, and reviewing the current status of the programme within each HSCP sector.
- Continued engagement with Health Board colleagues, PSDS, SG and Sword colleagues to develop a national database for the listing of dentists.
- Conclude the review of the Greater Glasgow & Clyde Emergency Dental Service and action any recommendations.
- Undertake a further review of the Public Dental Service in particular in relation to the current use of the estate.

Annex 8: Care Inspectorate evaluation grades

The Care Inspectorate is the national regulator for care services in Scotland. It inspects services and publishes evaluation grades against key quality themes, reflecting how well services meet expectations set out in the Health and Social Care Standards.

Grades are awarded on a six-point scale: 6 Excellent, 5 Very Good, 4 Good, 3 Adequate, 2 Weak, 1 Unsatisfactory.

The HSCP has a statutory responsibility to provide, or arrange, services to meet assessed needs. Services may be delivered directly by the Council or commissioned from third and independent sector providers. The table below sets out the latest published Care Inspectorate grades available at the time of publication. Full inspection reports are available on the Care Inspectorate website.

Service	Evaluation Date	Wellbeing	Leadership	Staffing	Setting	Care Planning
HSCP / Council in-house services						
Adoption Service	Nov 2023	5	-	-	-	5
Allander Resource Centre*	Feb 2017	5	-	5	-	N/A
Community Support Team for Children and Families	Jan 2025	6	6	6	-	5
Ferndale Care Home for Children & Young People	Jun 2024	Children and young people's rights and wellbeing - 6				
Ferndale Outreach for Children & Young People	Apr 2022	5	-	-	-	6
Fostering Service	Nov 2023	5	-	-	-	4
John Street House	Jul 2025	4	4	4	4	4
Homecare Service	Nov 2025	5	5	4	-	4
Pineview	Jun 2025	6	-	5	-	-
Commissioned – Supported accommodation						
Cornerstone Community Care	Feb 2026	5	-	5	-	-
Key Dunbartonshire	Mar 2025	5	5	5	-	5
Living Ambitions (Glasgow North & West)	May 2025	5	-	5	-	-
Orems Care Services	Sep 2025	5	-	4	-	-

Service	Evaluation Date	Wellbeing	Leadership	Staffing	Setting	Care Planning
Quarriers (Phase 1)	Oct 2025	5	-	5	-	4
Quarriers (Phase 2)	Sep 2025	5	-	5	-	-
Quarriers (Phase 3)	Nov 2025	5	-	5	-	-
Real Life Options East Dunbartonshire Service	Mar 2026	5	-	5	-	-
The Richmond Fellowship East & West Dunbartonshire Support Living Services	Oct 2025	5	-	5	-	-
Independent Care Homes						
Abbotsford House	Jul 2025	5	-	5	-	-
Antonine House	Jul 2025	5	-	-	5	-
Ashfield House	Sep 2025	5	4	5	4	5
Birdston Care Home	Mar 2026	5	-	-	5	-
Boclair Care Home	May 2025	5	-	-	5	-
Buchanan House	Oct 2025	5	-	5	5	-
Buchanan Lodge	May 2025	5	-	-	4	-
Buttercup House	N/A	-	-	-	-	-
Campsie View	Feb 2026	5	5	5	4	4
Lillyburn	Jan 2026	5	-	-	5	-
Mavisbank	Feb 2026	5	-	-	5	-
Milngavie Manor	Oct 2025	5	5	5	5	5
Mugdock House	Feb 2026	6	-	-	5	-
Springvale	Nov 2025	5	-	-	4	-
Westerton	Jan 2026	4	-	4	5	-
Whitefield Lodge	Dec 2025	4	-	-	4	3
Commissioned – Care at Home services						
Bluebird Care	Oct 2025	5	-	5	-	-
Cornerstone	Feb 2026	5	-	5	-	-
Delight Supported Living	Nov 2025	5	4	5	-	-

Service	Evaluation Date	Wellbeing	Leadership	Staffing	Setting	Care Planning
Extended Personal Care	Jun 2025	5	-	5	-	5
Hands-On Homecare	Sep 2025	4	-	4	-	-
Home Instead	Dec 2025	5	-	4	-	-
The Richmond Fellowship – East and West Dunbartonshire	Oct 2025	5	-	5	-	-

*Not yet assessed under current assessment model. Allander Resource Centre assessment relates to previous inspection of Kelvinbank Day Service.

PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**17th JUNE 2026**
REPORT REFERENCE:	**PERF/170626/08**
CONTACT OFFICER:	**ALISON MCCREADY, CHIEF FINANCE & RESOURCES OFFICER**
SUBJECT TITLE:	**HSCP ANNUAL DELIVERY PLAN UPDATE 2025/26 Q4**

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 fourth 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 position for each project attached as **Appendix 2.**

3.4 There is a total of 27 projects to be delivered within the Delivery Plan for 2025/26 and 21 are complete. Six projects have been delayed for completion or review in 2026/27.

3.5 The six delayed projects are:

- Review Care at Home services to focus on reablement expansion to mitigate demand growth
- Conclude the planning and operationalisation of the West of Scotland Adolescent Intensive Psychiatric Care Unit
- 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
- Review and refresh the HSCP Medium-Term Financial Strategy

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	Complete	At Risk	In Exception
27	**21**	**0**	**6**

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			100%	31-Mar-2026	31-Mar-2026
Implement year one of the East Dunbartonshire Public Health Framework			100%	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			100%	31-Mar-2026	31-Mar-2026
Complete review of Respite (Commissioned)			100%	31-Mar-2026	31-Mar-2026
Commence the Review of the Supported accommodation estate			100%	31-Mar-2026	31-Mar-2026
(Commissioned) Review and implement recommendations to reduce high-cost care packages (LD)			100%	31-Mar-2026	31-Mar-2026
Explore potential of developing an all-age learning disability function			100%	31-Mar-2026	31-Mar-2026
Strategic Review of Mental Health and Alcohol and Drugs Services			100%	31-Mar-2026	31-Mar-2026
Service Review Community Mental Health Team (CMHT) and Older Peoples Community Mental Health Team (OPCMHT)			100%	31-Mar-2026	31-Mar-2026
Resolution of North Lanarkshire Corridor Service Level Agreement (NHS GGC/NHS Lanarkshire)			100%	31-Mar-2026	31-Mar-2026

Project Name	Previous Status	Current status	Progress	Original Project End Date	Forecast Project End Date
Conclude the planning and operationalisation of the West of Scotland Adolescent Intensive Psychiatric Care Unit (IPCU)			40%	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			70%	31-Mar-2026	31-Mar-2026
Bishopbriggs Premises - progress approved property redesigns in 2025/26			100%	31-Mar-2026	31-Mar-2026
West Locality Premise Feasibility (Milngavie) - progress approved property redesigns in 2025/26			90%	31-Mar-2026	31-Mar-2026
Review summary business cases for Woodlands and Milngavie Clinic			100%	31-Mar-2026	31-Mar-2026
Refresh Digital Strategy in line with the new Strategic Plan 2025-30			100%	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			100%	31-Mar-2026	31-Mar-2026
Undertake a test of change in relation to enhanced multi-disciplinary working in health and community care			100%	31-Mar-2026	31-Mar-2026
Review and refresh the HSCP Medium-Term Financial Strategy (MTFS)			25%	31-Mar-2026	31-Mar-2026
Implement focussed programme of de-prescribing and realistic medicine			100%	31-Mar-2026	31-Mar-2026
Review of Business Support Function			100%	31-Mar-2026	31-Mar-2026
Review of HSCP Management Structure			100%	31-Mar-2026	31-Mar-2026
Service Review of Adult Social Work Services			100%	31-Mar-2026	31-Mar-2026
Develop the 2025-2030 HSCP Workforce Plan			100%	31-Mar-2026	31-Mar-2026
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			100%	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			100%	Complete

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	14-Apr-2026

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**
• Short life working group established and meeting to review and improve the structure, consistency and quality of the information presented on the HSCP website.	• Ongoing review of website content through short life working group.

Reason for RAG Status
Planned work for 2025/26 complete.

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			100%	Complete

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**
• Targeted prevention activity progressed with focus on inequality priorities, informing ongoing delivery and learning. • Poverty aware approaches further embedded across partnership, supporting alignment to national policy and local framework priorities. • Early scoping initiated to support future development of a whole-system healthy weight approach. Reconnection with relevant partnerships, with a clear focus on targeted communities. • Year-end activity reviewed and synthesised to evidence Year 1 delivery and inform Year 2 planning.	• Progress targeted prevention and early intervention in internal and external partnerships and priority communities. Alignment to national and local population health frameworks. • Further embed poverty-aware practice across services to support equitable access and outcomes. • Commence early development of a whole-system healthy weight approach, building on Year 1 scoping • Use Year 1 learning to inform refined Year 2 planning, delivery and reporting.

Reason for RAG Status
Planned work for 2025/26 complete.

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%	Red - Project delayed

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 has been postponed to 2026/27.	• Review to commence in 2026/27.

Reason for RAG Status
Project delayed for completion in 2026/27.

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				100%	Complete
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**		
• OT Review completed as part of Adult SW review. Approved at March IJB and progressing now to implementation.			• Review now complete.		
Reason for RAG Status					
Planned work for 2025/26 complete.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
£50k					
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)			100%	Complete

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**
• Integrated Impact Assessment complete; • Consultation Stage 2 (LD) held to 2026/27; • Service Specs for new contract carried forward pending paper to IJB in June 2026; • Staff workshop with survey complete; • Commence separate Respite consultation/review for other care groups in 2026/27.	• Review to be extended to other care groups in 2026/27, prior to implementation. • Paper to IJB in June 2026 highlighting risks associated with residential respite proposed outcomes.

Reason for RAG Status
Planned work for 2025/26 complete.

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			100%	Complete

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**
• A range of preparatory and governance actions were completed, including reporting to the IJB on resource demand, development of pen profiles, restructuring of DSR meetings, and key project documentation for supported accommodation. Baseline reviews identified low-risk positions in priority areas, with further assessments and impact work to continue into 2026/27.	• Resources, systems and processes now in place to support the development of a Support with Accommodation Strategy. • Support with accommodation challenges will continue to be explored via SMT and IJB in 2026/27.

Reason for RAG Status
Planned work for 2025/26 complete.

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)			100%	Complete

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**
• Programme of individual community care reviews ongoing including high cost packages and those under service review; • Only 1 of 2 Social Workers successfully recruited to undertake reviews;	• Recruitment of second SW post and continuation of reviews will carry forward to 2026/27.

Reason for RAG Status
Planned work for 2025/26 complete.

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			100%	Complete

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**
• • IJB Recommendation Paper approved Mar 26.	• Implementation plan 2026/27.

Reason for RAG Status
Planned work for 2025/26 complete.

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			100%	Complete

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**
• Contracts issued to all providers for signing. • Review completed	• Next and final stage of the review includes development and implementation of contractual arrangements.

Reason for RAG Status
Planned work for 2025/26 complete.

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)				100%	Complete
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			Lorriane Currie		
HIGHLIGHT REPORT					
Actions completed within the last reporting period			**Actions planned in the Next Reporting Period**		
• Service review completed and options approved at HSCP SMT and IJB in March 2026. • Review complete & implementation now led by relevant service manager.			• Review now complete and approved by IJB. • Implementation phase now being led by Service Manager.		
Reason for RAG Status					
Planned work for 2025/26 complete.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
£62k					
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)			100%	Complete

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	Lorriane Currie

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Confirmation from NHS Lanarkshire/GGC that Service Level Agreement to remain in place for 'Norther Corridor'/Chryston area in NHS Lanarkshire. • Issue now resolved at this time.	• None; written confirmation from NHS Lanarkshire has now been received regarding the continuation of the Service Level Agreement.

Reason for RAG Status
Planned work for 2025/26 complete.

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)			40%	Red - Project delayed

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**
• There are several ongoing reviews concerning adolescent inpatient care. The tri-regional review of adolescent inpatient will inform future delivery models, emphasising a continuum of care in line with the Mental Health Strategy. Additional activity includes Healthcare Improvement Scotland (HIS) and Mental Welfare Commission (MWC) inspection reports, recent Scottish Government communication regarding the restrictive practice review led by MWC, and an invited review of Skye House by the Royal Colleague of Psychiatrists. As a result, and in order to ensure all learning from these reviews is capitalised the IPCU will not develop in 2025/26.	• The West of Scotland Alliance will take forward the IPCU stocktake to inform the future model, as agreed with SG. The Munro Ward has now been permanently allocated to Adult Learning Disability within NHSGGC. • This action is deferred beyond 2025/26 pending the outcome of regional redesign.

Reason for RAG Status
This action is deferred beyond 2025/26 pending the outcome of regional redesign.

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			70%	Red - Project delayed

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**
• Key infrastructure for Regional FCAMHS was progressed, alongside continued Secure Care Pathway delivery and draft pathway standards. However, recruitment remains constrained pending confirmation of long-term funding, with interim extensions sought for existing posts.	• This action is expected to conclude in 2026/27, subject to recruitment and implementation progressing as planned.

Reason for RAG Status
Project delayed for completion in 2026/27.

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	✅	✅	100%	Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	30-Oct-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**
· Site operationally opened and snagging work.	• Project complete.

Reason for RAG Status
Planned work for 2025/26 complete.

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			90%	Red - Project delayed

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	20-Aug-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**
• District Valuer has confirmed valuation, with Capital Planning and Property Team (NHSGGC) to review. • Await timescales for proposed Health and Care Facility site via infrastructure investment through Scot Government.	• Ongoing discussions with NHSGGC Capital and Property Team on possible investment into an East Dunbartonshire Health and Care Facility.

Reason for RAG Status
Project delayed for completion in 2026/27.

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			100%	Complete

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2026	31-Mar-2026	29-Oct-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 remains on hold for both sites pending progress of investigations into a Milngavie site and discussions with Capital Planning/Property re proposed site for a Health and Care Facility. • Woodlands Feasibility paused pending discussions re East Locality accommodation requirements. There would be a requirement to revisit feasibility for both sites to review future need, and potential capital and revenue costs.	• Await outcome of valuation of a Milngavie Premise via DV valuation process • Await update from NHS Capital Planning/Property re East Dun being put forward as a site for a Health and Care Facility • Ongoing work on staff accommodation at KHCC/Southbank/Council premises

Reason for RAG Status
Planned work for 2025/26 complete.

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	✅	✅	100%	Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	14-Apr-2026

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**
• HSCP Digital Strategy approved by IJB in November.	• Digital Health & Care Strategy Board to develop workplan.

Reason for RAG Status
Planned work for 2025/26 complete.

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%	Red - Project delayed

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.	• Unscheduled Care delivery plan may be superseded by NHSGGC transformation agenda.

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	✅	✅	100%	Project Complete

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**
• Following conclusion of the review, the outcome report was presented at SMT and IJB and preferred option approved.	• Review complete and preferred option will be actioned with the Care Home Support team.

Reason for RAG Status
Planned work for 2025/26 complete.

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				100%	Complete
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**		
• Pathway established. • Weekly meetings in place for clinical decision making and advice.			• Project complete.		
Reason for RAG Status					
Planned work for 2025/26 complete.					
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)			25%	Red - Project delayed

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**
• 2026/27 budget concluded and approved by IJB, informing the MTFS.	• MTFS refresh is in progress and has been delayed for completion as part of the 2026/27 Annual Delivery Plan.

Reason for RAG Status
Project delayed for completion in 2026/27.

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			100%	Complete

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**
	Carolyn Fitzpatrick

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Actions required (HSCP support) for the deadline of March 2026 are complete. • Practice compliance is unknown until data from prescribing support is received (June 2026). Where this has not been achieved the Pharmacotherapy team will continue to support.	• Agreement at Board level for the continuation of repeat prescribing Local Enhanced Service for 2026/27. • Continue to support practices with actions required.

Reason for RAG Status
Planned work for 2025/26 complete.

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			100%	Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2026	31-Mar-2026	10-Sep-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**
• Options presented to SMT for discussion. • Preferred option and outcome of review approved by IJB in March.	• Set up Implementation Board • Prepare Implementation plan, consider phasing and next steps

Reason for RAG Status
Planned work for 2025/26 complete.

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	✓	✓	100%	Complete

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**
• The Review of the HSCP Leadership Structure and Operating Model was concluded and approved by the IJB in December.	• Recruitment/matching will continue to populate the new structure, in partnership.

Reason for RAG Status
Planned work for 2025/26 complete.

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				100%	Complete
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**			
• Service Review completed within 2025-26. Final options appraisal approved by HSCP SMT Transformational Meeting and IJB in March 2026. • Implementation phase now being led by relevant service manager.		• Service Review completed within 2025-26 implementation of the approved review outcomes now being led by relevant service manager.			
Reason for RAG Status					
Planned work for 2025/26 complete.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
£50k					
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	✅	✅	100%	Project Complete

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**
• HSCP Workforce Plan 2025-30 was approved in January.	• Project complete.

Reason for RAG Status
Planned work for 2025/26 complete.

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				100%	Complete
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**		
• Monitoring strategy agreed. Implementation approach for community settings is being developed, including use of a QR code system.			• Implement monitoring strategy.		
Reason for RAG Status					
Planned work for 2025/26 complete.					
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: 09.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**17 JUNE 2026**
REPORT REFERENCE:	**PERF/170526/09**
CONTACT OFFICER:	**DAVID AITKEN, HEAD OF ADULT SERVICES/CHIEF SOCIAL WORK OFFICER TELEPHONE NUMBER: 0141 232 8237**
SUBJECT TITLE:	**MENTAL WELFARE COMMISSION FOR SCOTLAND VISIT / INSPECTION REPORT EAST DUNBARTONSHIRE COMMUNITY MENTAL HEALTH TEAM**

1.0 PURPOSE

1.1 The purpose of this report is to provide the Committee with the outcome of the recent visit and inspection of the East Dunbartonshire Community Mental Health Team by the Mental Welfare Commission for Scotland which was published on the 18th March 2026.

2.0 RECOMMENDATIONS

It is recommended that the Committee:

2.1 Note the contents of the report.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 This report provides the Committee with a summary and outcome from the most recent visit undertaken by the Mental Welfare Commission to East Dunbartonshire's Community Mental Health Team (CMHT) which was published by the Commission in March 2026.

3.2 The Mental Welfare Commission have an established visiting programme to hospital settings to review mental health care, which has recently been extended to include community settings and services; this was the first visit to an adult CMHT in NHS Greater Glasgow and Clyde.

3.3 The CMHT in East Dunbartonshire ('The Larkfield Centre') provides community based mental health assessment, care and treatment to individuals who are under sixty-five years of age in East Dunbartonshire and who require secondary mental health services which are characterised as being complex, severe and enduring. The CMHT includes mental health nursing, psychiatry, peer support, occupational therapy (OT) and psychology. Currently there are 2,355 patients receiving/awaiting treatment from the CMHT.

3.4 The Commission's visit took place over the 19th and 20th January 2026.

3.5 As part of their visit the Commission reviewed records and procedures and undertook interviews with patients/carers, professional leads and operational staff from nursing, social work, OT, psychiatry, peer support, advocacy, alcohol and drug recovery as well as learning disability services. They also met with the HSCP Clinical Director, and Chief Social Work Officer.

3.6 The Commission published their report on the 18th of March 2026. The report reflected very positively on the care and treatment provided by the CMHT and identified particular strengths and positive practice examples which were illustrated within the final report.

3.7 Patient and carer feedback was noted to be particularly positive and reflected a positive staff culture of value-based care and treatment. The service was reported to be responsive and that which helped people to avoid either a crisis or a deterioration in their mental health. Those interviewed advised that staff were 'kind', 'caring' and 'accessible', and that individuals and their families, felt listened to and that staff were interested in how people were.

3.8 The Commission highlighted the positive joint work between the multidisciplinary team and peer support and local advocacy services which had developed information and support for people to complete advance statements.

3.9 Throughout the report multidisciplinary working and the involvement of all disciplines was highlighted as a particular strength with multidisciplinary decision-making frameworks used to support individuals with complex needs and to manage the risk of harm.

3.10 The environment and building was also reported to welcoming and it was noted that principles of trauma informed practice had been applied, which had led to environmental changes, including softer lighting, calm colours on the walls of the interview rooms and display of artwork created by individuals involved with a local trauma informed art project.

3.11 There were four recommendations all of which related to specific points regarding recording practice;

- 1. Managers should audit care plans to ensure they address all individual care needs, with the views of individuals and/or their families clearly recorded.
- 2. Managers should audit risk assessment documentation to ensure historical risks are recorded, reviews are carried out timeously and information on risk management is detailed.
- 3. Managers should audit MDT records to ensure those who attend meetings and agreed actions are clearly recorded
- 4. Medical staff should establish a process to ensure that the authority under which medication is prescribed and given under the mental health act is recorded and that this is communicated with the person's GP.

3.12 In summary the Mental Welfare Commission visit and report reflects very positively on the service and the staff and compares favourably with other similar visits to CMHTs in other parts of Scotland. The report identifies strengths in patient care and value-based treatment which was commented upon and highly valued by patients and carers. Multidisciplinary strengths were also identified to support individuals with complex needs and to manage the risk of harm. An Action Improvement Plan is being finalised in response to the four recommendations related to recording which have been made by the Commission.

3.13 The Committee are asked to note the contents of this report and the Commission's Report, attached at appendix (1).

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

4.2 Frontline Service to Customers – None.

4.3 Workforce – None.

4.4 Legal Implications – None.

4.5 Financial Implications – None.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None

4.10 Sustainability – None.

4.11 Alignment to Population Health Framework – None.

4.12 Alignment to Health and Social Care Strategic Renewal Framework – None.

4.13 Other – None.

5.0 MANAGEMENT OF RISK

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

5.1 Not applicable

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** – Mental Welfare Commission for Scotland Report on unannounced visit to the Larkfield Community Mental Health Team, Kirkintilloch Health & Care Centre

mental welfare commission for scotland

announced visit to:

Larkfield Community Mental Health Team, Kirkintilloch Health & Care Centre, 10 Saramago Street, Kirkintilloch, G66 3BF

Date of visit: 19 and 20 January 2026

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The Commission visits people wherever they are receiving care and treatment. Often this is in hospital, but it might be in their own home, or a care home or local community setting. With the shift in the balance of care, that is, delivery of mental healthcare in the community, rather than in mental health inpatient wards and units, the Commission's visiting programme has to reflect this change so that we can continue to find out about an individual's views of their care and treatment in the setting it is provided.

On this occasion, we visited Larkfield community mental health team (CMHT). We had the opportunity to speak with individuals who received care and treatment, family members, nursing, and medical staff, as well as the wider multidisciplinary team (MDT).

The service provides community based mental health assessment, care and treatment to individuals who are under 65 years old and are living in the East Dunbartonshire area. The CMHT includes mental health nursing, psychiatry, peer support, occupational therapy (OT) and psychology.

This was the first time that the Commission has visited an adult CMHT service in NHS Greater Glasgow and Clyde (NHS GG&C) area. Prior to this visit, the Commission has made several enquiries across NHS GG&C CMHT's, including the East Dunbartonshire service, in relation to assessment and management of risk, as well how communication takes places with families and/or unpaid carers.

On the day of this visit, we wanted to look at whether there were any issues that had an impact on care and treatment, including the implementation of updated policy and procedures in relation to risk documentation, as well as communication with families and/or unpaid carers.

Who we met with

We met with and/or spoke to 16 people, reviewing the care of 12 of these individuals and reviewed the care notes of a further two individuals. We also spoke with two relatives during our visit.

We met with professional leads and/or operational staff from nursing, social work, OT, psychiatry, peer support, advocacy, alcohol and drug recovery as well as learning disability services.

We also met with the clinical director, the chief social work officer and the service manager (SM).

Commission visitors

Gemma Maguire, social work officer

Mary Leroy, nursing officer

Laura Young, nursing officer

Sheena Jones, consultant psychiatrist

Justin McNicholl, social work officer

What people told us and what we found

People we spoke with told us that staff were 'kind', 'caring' and 'accessible'. We consistently heard that individuals and their families, felt 'listened' to and that staff were 'interested' in how people are doing. Some individuals felt being involved with the service has helped them to understand how trauma had an impact on their mental health and what best supported their recovery

One person reported that peer support service had helped them overcome anxiety when leaving their home. Several individuals told us that they valued speaking to someone who they had a shared experience with. We met with the peer support service on the day of our visit and heard about individuals developing wellness and recovery plans, with referrals being made by staff across the MDT.

We were pleased to hear about the joint work between the MDT, peer support and local advocacy services. We heard how this has developed information and provides support for people to complete advance statements.

Many individuals we met with valued having a named nurse and input from health care support workers (HCSW). We were told that if the named nurse or the HCSW was unavailable, the person could contact the 'duty' service. Several people told us this service was 'responsive' and helped them to avoid either a crisis or a deterioration in their mental health.

When reviewing individual care records, we found detailed notes of home visits that had taken place, as well telephone calls.

Family members we spoke with told us they felt 'involved' in their loved one's care. One relative reported that the transition from the child and adolescent mental health (CAMH) team was 'tricky', but that support from the CMHT was 'going well'. We were pleased to hear the service has been working to improve communication and support for family /unpaid carers, with links to local carer groups and that they provide information leaflets.

Larkfield CMHT has a standardised procedure to optimise attendance and provide appropriate follow up when someone does not attend an appointment. This includes informing people about appointments in advance by letter and text message, with reminders also being sent. Appointments can be offered by telephone or face to face with options for individuals to rearrange.

Where someone does not attend, and the reason for this is unknown, the service will consider the urgency of the referral including risk of harm. The service may then carry out a home visit and/or offer further appointments. Staff would also contact referrers to inform them when a person did not attend.

The Commission are aware of national concerns around access to assessment and support for neurodivergent individuals. NHS GG&C have previously informed the Commission of increasing pressures on CMHTs with significantly high numbers of people waiting a service in relation to attention deficit hyperactivity disorder (ADHD).

We have been told that competing demands across all areas of care is challenging but that pathways for people with ADHD are being developed. During this visit we were pleased to hear that Larkfield CMHT were making improvements for people specifically referred to the service for ADHD support. Referrals are considered within the main functions of the service, including MDT and allocation meetings. We were informed that people with ADHD who are on the waiting list were provided with self-help advice and could access the telephone duty line. We were advised that physical health screening and access to health clinics was available to individuals. Staff across the MDT were also provided with training to support their understanding of neurodivergence.

We were pleased to hear the service provides complex case discussions which are led by psychology with contribution from the wider MDT. Several staff members told us discussions were 'helpful' when supporting individuals who may have complex needs and/or at be at significant risk of harm.

We heard that psychology and members of the MDT have steered a program of self-assessment to compare how well the service performs against core mental health standards. We were advised that this has led to meaningful improvements being made to the service, including the building being made more accessible for people with sensory needs and using media technology to help gather continual feedback from individuals and their families.

Care, treatment, support, and participation

Care records

We found detailed information about individuals' care and treatment, as well consultation with people and their families, in the chronological notes. We also found evidence in the care records that physical health screening was being carried out with individuals.

People we spoke with on the day of our visit told us they were regularly asked for their views. When reviewing care plans, we did not find that the views of individuals or their families, were explicitly recorded. We also found care plans to be written from a nursing perspective as opposed to language and terminology used by the individual.

Care plans provided details about an individuals' medication and their physical health needs. We found that wider needs, such as psychological or social needs, were not consistently covered in the plans. We discussed these issues with nursing

staff and managers on the day of our visit and heard that a new person-centred care plan template was introduced by the service last year. Some staff we met with told us they had difficulty understanding the new template, while others felt this has improved their practice. We heard how practice development leads were providing training and support regarding person-centred care planning. The SM and nurse team leader informed us about auditing processes being undertaken in relation to person centred care plans.

Recommendation 1:

Managers for Larkfield CMHT should audit care plans to ensure they address all individual care needs, with the views of individuals and/or their families clearly recorded.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

Risk assessment documentation was in place for all the individual care records that we reviewed on the day of our visit. While several records contained relevant historical information, we found that in some documents, historical information was missing, particularly following review.

We also found that some documents had not been reviewed timeously, and information on how staff could support individuals to manage risk to themselves or others was lacking in detail. We discussed this with managers on the day of our visit and were advised that a mental health 'dashboard' has been developed to support the audit of care records. We heard that that the dashboard identified where risk documentation required completion and review. We advised the SM and nurse team lead that information recorded in documents should also be audited to ensure that practice was in line with local policy.

Recommendation 2:

Managers responsible for Larkfield CMHT should audit risk assessment documentation to ensure historical risks are recorded, reviews are carried out timeously and information on risk management is detailed.

Multidisciplinary team (MDT)

Larkfield MDT consists of consultant psychiatrists, junior doctors, higher trainee medics, nursing staff, HCSW, psychologists and OT. The pharmacy service has a hub in the same building as Larkfield CMHT, offering advice and support regarding medication when required.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

On the day of our visit, we met with staff from across the service and heard how being co-located with colleagues had strengthened MDT working. We were informed that staff from all disciplines were involved with the MDT, at allocation and with complex case meetings. We also found evidence from speaking with staff and in reviewing the care records that MDT decision making frameworks were regularly being used to support individuals and to manage risk of harm. This included appropriate use of the care program approach, adults with incapacity case conferences or adult support and protection case conferences. Staff we met with told us that MDT frameworks have been particularly effective in supporting individuals with complex needs.

MDT meetings happen weekly with individuals being invited to attend. Some individuals will be discussed at MDT meetings more frequently than others, based on level of need, risk and intervention. When we reviewed care records, it was not always clear when MDT meetings had taken place, particularly for those individuals whose mental health was stable.

We found that some staff used chronological notes to record MDT meetings, which made it difficult to review progress and any actions that had been agreed from previous meetings. Some records did not note who had attended meetings, as we would have expected to see. We discussed these issues with managers on the day of our visit and heard that the service has recently introduced an MDT template which records who attended meetings, as well as any actions agreed. We were advised that the template will be audited to ensure meetings are held timeously and that records are consistent.

Recommendation 3

Managers from Larkfield CMHT should audit MDT records to ensure those who attend meetings and agreed actions are clearly recorded.

Use of mental health and incapacity legislation

On the day of our visit, 24 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All individuals detained under the Mental Health Act were aware of their rights. Several people we met with had nominated a named person, were receiving legal advice and accessing advocacy services.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. We heard from nursing staff that there was a standard document to record that the appropriate legal authority was in place when a person attended for their depot anti-psychotic medication, in addition to physical health monitoring.

We saw good evidence of this in the electronic care records and in the results of the audit which is completed by nursing staff in relation to consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. We also heard from nursing staff that similar processes were being developed in relation to treatment with Clozapine, an oral anti-psychotic, when people attended the Clozapine clinic to have their bloods and physical health monitoring.

We did not find the same level of detail in people's care records in relation to other medication that was recommended by medical staff and prescribed by the person's general practitioner (GP). We found that medical staff sent a standard letter to the GP to request changes to medication, but this did not detail under what authority the medication was to be given, where the person was subject to the mental health act.

In total, we found six errors in relation to T2 or T3 certificates. Errors included prescribed medication that was not included on a person's T2 or T3 certificate, and we found one certificate that had expired. We followed up on each of these issues with medical staff and provided advice to ensure audit processes were implemented.

Recommendation 4

Medical staff in Larkfield CMHT should establish a process to ensure that the authority under which medication is prescribed and given under the mental health act is recorded and that this is communicated with the person's GP.

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where someone had nominated a named person, we found documentation to be accessible and the named person had been appropriately consulted.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. On the day of our visit, no one we met with or reviewed the care records for required to have a section 47 certificate in place.

Rights and restrictions

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements.

Several individuals we spoke to and where we reviewed their care records, had a statement in place. We were pleased to hear about the work being undertaken by advocacy services and Larkfield CMHT in providing information sessions about advance statements. We also found that improvements were being made to ensure appropriate reviews of advance statements were taking place. Those with statements in place were sent letters about reviews, including contact details for independent advocacy services and specialist advocacy for those who had care experience.

Activity and occupation

Larkfield CMHT provided individual and group based psychological and occupational therapies which were delivered by nursing, OT, psychology and HCSW. Individuals we met with were attending emotional coping skill groups, talking therapy groups and self-help groups.

Several people told us they have developed wellness and recovery plans with the peer support service. Many people were also being supported with activities including attending the local gym, participating in art projects or undertaking further education or vocational training.

The physical environment

The Larkfield CMHT is in the centre of the town and shares a building with other community-based services, including a GP practice. The building was bright and welcoming. The waiting area had a display of posters and information that included online self-help guides, health and wellbeing advice, advocacy services and carers support and information.

We were advised that managers and staff have applied the principles of trauma informed practice in relation to the environment, which had led to changes, including softer lighting and calm colours on the walls of interview rooms. We heard how this has been particularly helpful for those who have experienced trauma or who had sensory needs. The walls in the waiting and clinical areas of the service were beautifully decorated with artwork created by individuals involved with a local trauma informed art project.

Summary of recommendations

Recommendation 1:

Managers for Larkfield CMHT should audit care plans to ensure they address all individual care needs, with the views of individuals and/or their families clearly recorded.

Recommendation 2:

Managers responsible for Larkfield CMHT should audit risk assessment documentation to ensure historical risks are recorded, reviews are carried out timeously and information on risk management is detailed.

Recommendation 3

Managers from Larkfield CMHT should audit MDT records to ensure those who attend meetings and agreed actions are clearly recorded.

Recommendation 4

Medical staff in Larkfield CMHT should establish a process to ensure that the authority under which medication is prescribed and given under the mental health act is recorded and that this is communicated with the person's GP.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

Contact details

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East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce
AGENDA ITEM NO: 10.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**17th JUNE 2026**
REPORT REFERENCE:	**PERF/170626/10**
CONTACT OFFICER:	**CLAIRE CARTHY, HEAD OF CHILDREN'S SERVICES AND CRIMINAL JUSTICE**
SUBJECT TITLE:	**HMP LOW MOSS UPDATE**

1.0 PURPOSE

1.1 The purpose of this report is to inform the Committee of the pressures facing the Prison Based Social Work (PBSW) Team at HMP Low Moss.

2.0 RECOMMENDATIONS

It is recommended that the Committee:

2.1 Note the content of the report.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 Scotland has one of the highest imprisonment rates in western Europe (149 per 100,000 population as noted in August 2025). In 2025 the average daily prison population was the highest ever recorded, with 8,441 people in custody on 11 November 2025. It remains significantly over capacity. Prison based and community-based social work services and partners continue to be impacted by the increasing prison population. Responding to increasing numbers, Parliament approved a programme of Emergency Early Release (EER) of certain short-term prisoners who had served 40% of their sentence in November 2025. In May 2026 this changed to 30%.

3.2 Prison-based social work (PBSW) services have reached critical capacity levels across most of the SPS estate. Limited resources often delay assessments and reduce opportunities for staff to build consistent relationships with people in custody. This means that, at times, prison-based social workers are providing views about a person's risk in key decision-making forums based on very limited contact with the person.

3.3 The Memorandum of Understanding signed in 2018 agreed a structure for the PBSW Team at HMP Low Moss. Since this time the prison population has increased as well as the complexity of cases. The PBSW Team are no longer able to deliver services, and an immediate review of the MOU is required. A Business Case requesting additional funding was submitted to SPS in 2024, and a further Business Case and Recovery Plan were submitted in 2025.

3.4 HMP Low Moss was designed to accommodate 784 individuals, however there are currently 852. The team have a statutory caseload of 445 at the present time with 4 permanent social workers (although there is 1 vacancy due to be filled on 24th June), 1 Team Manager and 1 Business Support. Short term additional funding, to be spent by September 2026, has been awarded to the service to employ 4 part time agency staff to clear the backlog of Parole Reports and Throughcare Assessment for Release on Licence reports.

3.5 Scottish Prison Service (SPS) has advised they have secured an uplift of up to £2.7m to the SPS budget to support PBSW services, this is in addition to the £6.58m currently in the budget. This will be an annual uplift, subject to annual budget setting processes, with an additional allocation of up to £1.8m available this year. ED PBSW Team has not yet had confirmation of any allocation.

3.6 In April 2026, the Scottish Government brought together partners across the justice system through a Bronze, Silver and Gold command structure to better understand what was driving the numbers, identify further action that could be taken at a system level to help ease pressure on the prison estate and to consider contingencies that could be activated if required. The ED CSWO has been contacted by the National Social Work Agency and the PBSW Team have been contacted by Community Justice Scotland, both raising concerns about the backlog of reports, through this Gold Command Structure. Assurance has been given that the PBSW Team are working at capacity and are taking every available action to address this.

3.7 This pressure on the PBSW Team, the level of scrutiny and risk of failing to deliver the MOU are recorded on the HSCP Risk Register.

4.0 IMPLICATIONS

The implications for the Board are as undernoted.

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

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

4.2 Frontline Service to Customers – Individuals in Low Moss may not have assessments or interventions which are relationship based and meet their needs.

4.3 Workforce – Staff in the PBSW are exhausted and need additional wellbeing support.

4.4 Legal Implications – Risk of failure to comply with the MOU.

4.5 Financial Implications – Additional allocation of resource from SPS is required.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – There is variation across the prison estate with regards access to relationship based assessment and intervention.

4.10 Sustainability – None.

4.11 Alignment to Population Health Framework – None.

4.12 Alignment to Health and Social Care Strategic Renewal Framework – None.

4.13 Other – None.

5.0 MANAGEMENT OF RISK

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

5.1 The MOU urgently needs to be updated and the needs of the growing prison population prioritised.

6.0 IMPACT

6.1 **STATUTORY DUTY** – The PBSW have a statutory caseload of 445.

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 Care Inspectorate: Prison Based Social Work Review

prison-based-social-work-review-phase-2-report.pdf

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce
AGENDA ITEM NO: 12.

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

DATE OF MEETING:	**17TH JUNE 2026**
REPORT REFERENCE:	**PERF/170626/12**
CONTACT OFFICER:	**ALISON MCCREADY, CHIEF FINANCE & RESOURCES OFFICER**
SUBJECT TITLE:	**HSCP DIRECTIONS LOG UPDATE**

1.0 PURPOSE

1.1 The purpose of this report is to update members on the status of the Integration Joint Board's Directions which are recorded and issued to East Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

2.0 RECOMMENDATIONS

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

2.1 Note the content of the Report.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 Directions are the mechanism by which the Integration Joint Board (IJB) signals to the Health Board and Local Authority the details of how the objectives of its Strategic Plan, and any other strategic decisions taken during the lifetime of the plan, are to be delivered.

3.2 The use of Directions is a legal requirement for IJB's, Health Boards and Local Authorities and as such their use is subject to internal/external audit and scrutiny.

3.3 Each IJB report which has an accompanying Direction is submitted through each IJB for consideration noting the Direction to be issued, revised, superseded or revoked.

3.5 The Directions Log is updated and maintained by the HSCP Corporate Business Manager.

3.6 The recommendation from Internal Audit as part of HSCP governance processes is that to comply with statutory guidance Directions are regularly reviewed with a robust follow up and review process.

3.7 The Directions Log is taken to the Senior Management Team for review, highlighting impending review dates and asking for an update on the progress of the Direction.

3.8 An update on the Directions Log will be brought in January and June each year to the Performance, Audit & Risk Committee and IJB.

3.9 All Directions issued in 2021 and 2022 are Superseded or Complete.

3.10 **Appendix 1** details the Directions Log for 2023, 2024, 2025 and 2026 IJB cycles. There are 16 current Directions issued between 2023 to March 2026.

3.11 There have been 15 Directions issued across the IJB meetings in 2023 the status of the Directions are noted as being:

Current	2
Complete	5
Superseded	8
Revoked	0

Of the 2 current Directions, the Older Peoples Social Support Strategy had a review date of January 2026, noting an initial extension to March 2026 and then to June 2026. The Older Peoples Social Support Strategy will be presented to IJB at the 18th June 2026 meeting.

The Carers Strategy received IJB approval at the 19th March 2026 meeting to extend review to 31st March 2027.

3.12 There have been 15 Directions issued across the IJB meetings in 2024, the status of the Directions are noted as being:

Current	2
Complete	6

Superseded 7

Revoked 0

Of the 2 current Directions;

- The East Dunbartonshire HSCP Local Advocacy Plan 2024-2027 is to be reviewed in 2027
- The Learning Disability Strategy 2024-2029 is to be reviewed in 2029.

3.13 There have been 17 Directions issued to date from the IJB meetings in 2025.

Current 8

Complete 2

Superseded 7

Revoked 0

Of the 8 current Directions, 4 are due for review in 2026 with the remaining 4 Directions due for review between 2027-2030.

2026 Directions

- Learning Disability Service Respite Redesign Proposal was due for review by 1st April 2026, and will be brought to IJB on 18th June 2026.
- NHSGGC Reform Update and East Dunbartonshire Approach to be reviewed by the IJB on 18th June 2026.
- Mental Health Alcohol and Drug Recovery Review and Redesign will return to IJB on 18th June 2026.
- Alcohol & Drugs Partnership (ADP) Annual Report and Medication Assisted Treatment Standards Update 2024/25 to be reviewed September 2026.

2027 Directions

- Financial Performance Budget 2024/25 – Month 12 will be superseded by financial 2025/2026 reports to the IJB in March 2027.
- Overview Report On Current Demand And Capacity Within NHSGGC In Relation To Neurodevelopmental Provision For Children And Young People will return to IJB in June 2027.
- HSCP Operating Model and Senior Leadership Structure Review is due to be reviewed in November 2027.

2030 Directions

- The HSCP Strategic Plan 2025-2030 will be reviewed April 2030.

3.14 There have been a total of 5 directions issued in 2026.

Current 4

Complete 0

Superseded 1

Revoked 0

Of the current Directions 2 are due for review at 18th June 2026 IJB meeting, with the remaining 2 Directions to be reviewed in 2027.

2026 Directions

- HSCP Financial Planning & Annual Budget Setting 2026/27 will be reviewed at the June 2026 IJB meeting.
- Financial Performance Month 10 2025/2026 will be superseded by update report presented at the June 2026 meeting.

2027 Directions

- East Dunbartonshire Frailty Hospital at Home is due for review in January 2027
- HSCP Annual Delivery Plan 2026-27 will come to the IJB meeting in March 2027.

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 – The Public Bodies (Joint Working) (Scotland) Act 2014 required the IJB to issue Directions in writing. Directions must set out how each integrated health and social care function is to be exercised and the budget associated with that function.

4.5 Financial Implications – The IJB have statutory responsibility for the delivery of transformational service delivery within budget allocations.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – The Strategic Plan acknowledges that some individuals, or groups of individuals may face difficulties in accessing services and he Plan identifies

some additional supports to address this issue. Directions issued by the IJB are likely to be instrumental in improving access to services.

4.10 Sustainability – None.

4.11 Alignment to Population Health Framework – None

4.12 Alignment to Health and Social Care Strategic Renewal Framework – None

4.13 Other – None.

5.0 MANAGEMENT OF RISK

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

5.1 The Strategic Plan and the IJB Risk Register identify risk factors which have an impact on a range of financial, governance, capacity and partnership issues. Directions from the IJB form part of the ongoing risk mitigation and management processes.

6.0 IMPACT

6.1 **STATUTORY DUTY** – The HSCP have a statutory duty to record and issue Directions to East Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

6.2 **EAST DUNBARTONSHIRE COUNCIL** – The Council must comply with a Direction from the Integration Joint Board.

6.3 **NHS GREATER GLASGOW & CLYDE** - The Health Board must comply with a Direction from the Integration Joint Board.

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

7.1 POLICY CHECKLIST

7.2 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 Directions Log.

DIRECTIONS - 2023

Update: **19.03.26**

Complete or Superseded

Reference no.	Report Title	Direction to	Full Text	Functions Covered by Direction	Budget Allocated by IJB to carry out direction(s)	Date Issued	With Effect From	Review Date	Current	Does this supersede, revise or revoke a previous Direction	Direction Reference superseded, revised or revoked	Link to IJB paper	Link to New Direction	Responsible Officer	Service Area	Comments	Most Recent Review (Date)
190123-05	Older People's Social Support Strategy	East Dunbartonshire Council only	The IJB herby directs East Dunbartonshire Council to: • Progress the activities associated with enacting the preferred delivery option for centre based day services and social support for older people. • Support the preferred option and its associated activities as determined by the Service Review carried out by the Older People's Day Care Delivery Group.	• Centre based day care for older people • Centre based day care for older people from BAME communities • Alternatives to day care social support • Older People Local Area Co-ordination • Human Resources • Strategic Commissioning	The total budget relating to older people's social support in 2022/23 is £1,568,423	19.01.2023	19.01.2023	01.01.26 - * see comment. 04.02.26 - * see comment	Current	Yes	300622-04	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Chief Officer	Community Health and Care Services	To be extended to March 2026. Update on progress of OPSS being taken to IJB on 20.03.25. To be extended and taken to IJB on 27.06.26 .	04.02.26
290623-07	Carers Strategy	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	The IJB hereby directs East Dunbartonshire Council and Greater Glasgow & Clyde NHS Board to: • Support the new Carers Strategy 2023-26, which will be presented for IJB approval in June 2023.	Implementation of the Carers' (Scotland) Act 2016	The total budget to support the Carers' (Scotland) Act 2016 is £441,818 in 2022/23.	29.06.23	23.03.23	01/03/2026 Extended to 31/03/27 at IJB of 19/03/26	Current	Yes	230323-10	https://www.eastdunbarton.gov.uk/health-and-social-care/health-and-social-care-services/east-dunbartonshire-health-and-social-care	Item10. EDC Carers Strategy 2023-2026	Caroline Sinclair, Chief Officer	Adult Services	To be extended to 31st March 2027 - IJB approval at 19.03.26	29.06.23

DIRECTIONS - 2024

Update: **23.12.25**

Complete or Superseded

Reference no.	Report Title	Direction to	Full Text	Functions Covered by Direction	Budget Allocated by IJB to carry out direction(s)	Date Issued	With Effect From	Review Date	Current	Does this supersede, revise or revoke a previous Direction	Direction Reference superseded, revised or revoked	Link to IJB paper	Link to New Direction	Responsible Officer	Service Area	Comments	Most Recent Review (Date)
280324-04	Learning Disability Strategy 2024 - 2029	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	The IJB hereby directs East Dunbartonshire Council and Greater Glasgow & Clyde NHS Board to: • Support implementation of the Learning Disability Strategy 2024-29.	Provision of Social Work and NHS services to adults with learning disabilities.	Core funding	28.03.2024	28.03.2024	Mar-29	Current	No	N/A	https://www.eastdunbarton.gov.uk/health-and-social-care/health-and-social-care-services/east-dunbartonshire-health-and-social-care	file:///C:/Users/MCLEAV~1/AppData/Local/Temp/Microsoft/IEdgeDownloads/ea68b7e8-202c-4cdc-ae77-01e77703f2622/HSCP%20Board%20Meeting%20Paper%20%2028_03_2024.pdf	Caroline Sinclair, Chief Officer	Adult Health and Social Care	N/A	28.03.2024
190924-07	East Dunbartonshire HSCP – Local Advocacy Plan 2024-2027	East Dunbartonshire Council and Greater Glasgow & Clyde NHS Board	The IJB hereby directs East Dunbartonshire Council and Greater Glasgow & Clyde NHS Board to: • Approve the Local Advocacy Plan 2024-2027 which supports the delivery of the NHS GGC Advocacy Strategy.	Provision of advocacy services to adults and children in East Dunbartonshire.	Provision of advocacy services in East Dunbartonshire is funded through a mixture of Scottish Government funded national initiatives, NHS GGC and funding directly on behalf of the IJB for locally commissioned services.	19.09.24	19.09.24	Sep-27	Current	No	N/A	https://www.eastdunbarton.gov.uk/health-and-social-care/health-and-social-care-services/east-dunbartonshire-health-and-social-care	https://www.eastdunbarton.gov.uk/health-and-social-care/health-and-social-care-services/east-dunbartonshire-health-and-social-care	Derrick Pearce, Interim Chief Officer	Adult Health and Social Care	N/A	19.09.24

DIRECTIONS - 2025

Update: **19.03.26**

Complete or Superseded

Reference no.	Report Title	Direction to	Full Text	Functions Covered by Direction	Budget Allocated by IJB to carry out direction(s)	Date Issued	With Effect From	Review Date	Current	Does this supersede, revise or revoke a previous Direction	Direction Reference superseded, revised or revoked	Link to IJB paper	Link to New Direction	Responsible Officer	Service Area	Comments	Most Recent Review (Date)
200325-04	HSCP Strategic Plan 2025-30	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	Integration Authorities require a mechanism to action their strategic plans and this is laid out in sections 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act. This mechanism takes the form of binding directions from the Integration Authority to both of the Health Board and Local Authority. The Integration Joint Board directs partners to support the agreed areas of development as set out in the HSCP	All delegated functions as set out in the current East Dunbartonshire Integration Scheme	The budget allocated to the HSCP Strategic Plan 2025-30 is notionally set out in the medium term financial plan and will be specified in more detail annually as the total HSCP budget for each of the years 2025 to 2030, to be detailed at the time of the budget setting process and as approved by the HSCP Board.	20.03.25	01.04.25	01.04.30 - but at least annually	Current	Yes	240322-05	Public reports pack 20032025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Public reports pack 20032025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Derrick Pearce, Chief Officer	East Dunbartonshire HSCP wide services		20.03.25
260625-08	NHSGGC Reform Update and East Dunbartonshire Approach	NHS Greater Glasgow and Clyde only	Direction to NHSGGC to recruit appropriate workforce in line with the paper and commensurate with available funding.	Adult Community Nursing Services Community Rehabilitation services Intermediate Care	£1.6 million	26.06.25	27.06.25	26.06.26	Current	No	N/A	Public reports pack 26062025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Public reports pack 26062025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Derrick Pearce, Chief Officer	East Dunbartonshire HSCP wide services		26.06.25
260625-17	Overview Report On Current Demand And Capacity Within NHSGGC In Relation To Neurodevelopmental Provision For Children And Young People	NHS Greater Glasgow and Clyde only	Direction to NHSGGC to recruit appropriate workforce in line with the paper and commensurate with available funding within earmarked reserves.	The diagnosis of Neurodevelopmental disorders for children and young people in NHSGGC. The ongoing treatment for children and young people diagnosed with ADHD.	£1,997,590.25 million earmarked reserves	26.06.25	26.06.26	Jun-27	Current	No	N/A	Public reports pack 26062025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Public reports pack 26062025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Derrick Pearce, Chief Officer	Specialist Children's Services		26.06.25
170925-04	Alcohol & Drugs Partnership(Adp) Annual Report And Medication Assisted Treatment Standards Update 2024/25	East Dunbartonshire Council and Greater Glasgow & Clyde NHS Board	Full text of direction The IJB hereby directs East Dunbartonshire Council and Greater Glasgow & Clyde NHS Board to: • Note the contents and approve the Alcohol and Drug Partnership Annual Report for 2024/25. • Note the update for the Medications Assisted Treatment Standards status for 2024/25	Alcohol and Drug Partnership / Alcohol and Drugs Recovery Service	Funding for the implementation of the East Dunbartonshire Alcohol and Drug Partnership priorities is provided centrally by Scottish Government.	17.09.25	17.09.25	Sep-26	Current	Yes	180124-08 270624-08	Public reports pack 17092025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Public reports pack 17092025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Derrick Pearce, Chief Officer	Adult Services, Health and Community Care, Specialist Children's Services		17.09.25
170925-20	Mental Health Alcohol and Drug Recovery Review and Redesign	East Dunbartonshire Council only	The IJB hereby directs East Dunbartonshire Council to note IJB approval of proposed Mental Health and Alcohol and Drug Recovery commissioned service implementation model and in principle approvals subject to delegated Council approval.	Commissioned Mental Health and Alcohol and Drug Recovery Services.	£668,349.68	17.09.25	17.09.25	Jun-26	Current	No	N/A	Public reports pack 17092025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Public reports pack 17092025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Derrick Pearce, Chief Officer	Adult Services, Health and Community Care, Specialist Children's Services	Post 17.09.25 update of 02.10.25 that this Direction supersedes 190924-08	02.10.25
131125-09	Learning Disability Service Respite Redesign Proposal	East Dunbartonshire Council only	IJB to direct the council to support novation of existing arrangements and support development of future contractual arrangements.	Residential respite for children and Adults with a disability/learning disability	£837,578.10.	13.11.25	13.11.25	01.04.26	Current	No	N/A	Public reports pack 13112025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Public reports pack 13112025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Derrick Pearce, Chief Officer	Adult Services, Children Services	*Deferred to June 2026 IJB	13.11.25
131125-10	HSCP Operating Model and Senior Leadership Structure Review	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	IJB to direct East Dunbartonshire Council and NHS GGC to alter HSCP senior leadership structures to reflect the outcome of this service review and implement the HR changes and recruitment actions necessary to populate the approved structure.	Senior Leadership roles to support the HSCP	£2,216,003 – revised budget after savings	13.11.25	13.11.25	Nov-27	Current	No	N/A	Public reports pack 13112025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Public reports pack 13112025 0930 Health and Social Care Partnership Integration Joint Board.pdf Supplement Supplementary Pack - Agenda Item 10 13112025 0930 Health and Social Care Partnership.pdf	Derrick Pearce, Chief Officer	East Dunbartonshire HSCP wide services		13.11.25
131125-14	Financial Performance Budget 2024/25 – Month 12	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2025 - 2030, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1.	Budget 2024/25 – all functions set out within Appendix 1.	The budget delegated to NHS Greater Glasgow and Clyde is £208.016m and East Dunbartonshire Council is £72.688m as per this report.	13.11.25	13.11.25	Reviewed for IJB – budget monitoring reports for 2025/26 will supersede this direction.	Current	Yes	260625-16	Public reports pack 13112025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Public reports pack 13112025 0930 Health and Social Care Partnership Integration Joint Board.pdf	Derrick Pearce, Chief Officer	Finance and Resources		13.11.25

DIRECTIONS - 2026
Update: 19.03.26
Complete or Superseded

Reference no.	Report Title	Direction to	Full Text	Functions Covered by Direction	Budget Allocated by IJB to carry out direction(s)	Date Issued	With Effect From	Review Date	Current	Does this supersede, revise or revoke a previous Direction	Direction Reference superseded, revised or revoked	Link to IJB paper	Link to New Direction	Responsible Officer	Service Area	Comments	Most Recent Review (Date)
220126-15	East Dunbartonshire Frailty Hospital at Home	NHS Greater Glasgow and Clyde	IJB to direct NHS GGC to implement the HR processes and recruitment actions necessary to staff the EDHSCP Hospital at Home.	Healthcare practitioner roles to deliver Hospital at Home	£1,163,600	22nd January 2026	22nd January 2026	Jan-27	Current	No	N/A	Health and Social Care Partnership Integration Joint Board - Thursday, 22nd January, 2026 9.30 am	Item 15b. Appendix 2 Direction HSCP Frailty Hospital at Home.pdf	Derrick Pearce, Chief Officer	Community Health and Care Services		22.01.26
190326-08	HSCP Financial Planning & Annual Budget Setting 2026/27	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council is directed to spend the delegated net budget of £86.025m in line with the Strategic Plan and the budget outlined within this report. NHS Greater Glasgow and Clyde is directed to spend the delegated net budget of £212.825m (incl. £44.959m related to set aside) in line with the Strategic Plan and the budget outlined within this report.	Budget 2026/27 – all functions set out within Appendix 7.	The budget delegated to NHS Greater Glasgow and Clyde is £212.825m and East Dunbartonshire Council is £86.025m as per this report.	19th March 2026	1st April 2026	Jun-26	Current	No	N/A	Health and Social Care Partnership Integration Joint Board - Thursday 19th March, 2026 at 9.30am	Item 8h. Appendix 8 Direction Financial Planning and Budget Setting 2026-2027	Derrick Pearce, Chief Officer	Finance and Resources		19.03.26
190326-09	HSCP Annual Delivery Plan 2026-27	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	The Integration Joint Board directs partners to support the agreed areas of development as set out in the HSCP Annual Delivery Plan 2026-27. The Annual Delivery Plan draws together the 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. The Annual Delivery Plan is attached as appendix 1 to the cover report.	HSCP Annual Delivery Plan 2026-27: The business planning intentions of the HSCP Board for the period 2026-27 in pursuance of the implementation of the current Strategic Plan which covers all delegated functions of the IJB.	The funding implications, both spend and disinvestment, are set out within the body of the Annual Delivery Plan which is attached as appendix 1 to the cover report.	19th March 2026	1st April 2026	31/03/2027	Current	Yes	200325-06	Health and Social Care Partnership Integration Joint Board - Thursday 19th March, 2026 at 9.30am	Item 9b. Appendix 2 HSCP Annual Delivery Plan 26-27 Directions	Derrick Pearce, Chief Officer	East Dunbartonshire HSCP wide services		19.03.26
190326-14	Financial Performance Budget 2025/26 – Month 10	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2025 - 2030, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1.	Budget 2025/26 – all functions set out within Appendix 1.	The budget delegated to NHS Greater Glasgow and Clyde is £210.859m and East Dunbartonshire Council is £84.395m as per this report.	19th March 2026	19th March 2026	25/06/2026	Current	Yes	220126-13	Health and Social Care Partnership Integration Joint Board - Thursday 19th March, 2026 at 9.30am	Item 14b. Appendix 5 Directions Template Financial Performance Mth 10 25_26.pdf	Derrick Pearce, Chief Officer	Finance and Resources		19.03.26

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce
AGENDA ITEM NO: 13.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**17th JUNE 2026**
REPORT REFERENCE:	**PERF/170626/13**
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 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 Integration Joint Board's Commitment to a culture of improved performance in the management of Corporate Risks **(Appendix 1).**

3.2 The Risk Register provides full details of all current risks, in particular very high and high level risks, and the control measures that are in place to manage these.

3.3 A review of the HSCP Corporate Risk Register in relation to the revised NHSGGC Risk Management Policy, Risk Management Strategy, Risk Appetite Statement and Risk Management Procedure approved by NHSGGC Board in October 2025 is ongoing.

3.4 There was an agreement to schedule regular focussed sessions with Senior Management Team (SMT) members as lead risk owners to review and agree corporate and escalated service risks collectively.

3.5 Members were advised at the PAR committee on 9th February 2026 of the implementation of a revised Corporate Risk Register pack including a Risk on a Page format, risk matrix heat map and a Risk Dashboard consistent with wider NHSGGC risk reporting providing an overview of current risks scores v target scores and any movements in the period.

3.6 The Chief Finance and Resource Officer led two focussed Risk Review sessions with Senior Management Team and Risk Owners in Dec 2025 and early May 2026 to review all risks and transfer of all risks onto the approved risk on a page reporting format.

CORPORATE RISK REGISTER – June 2026

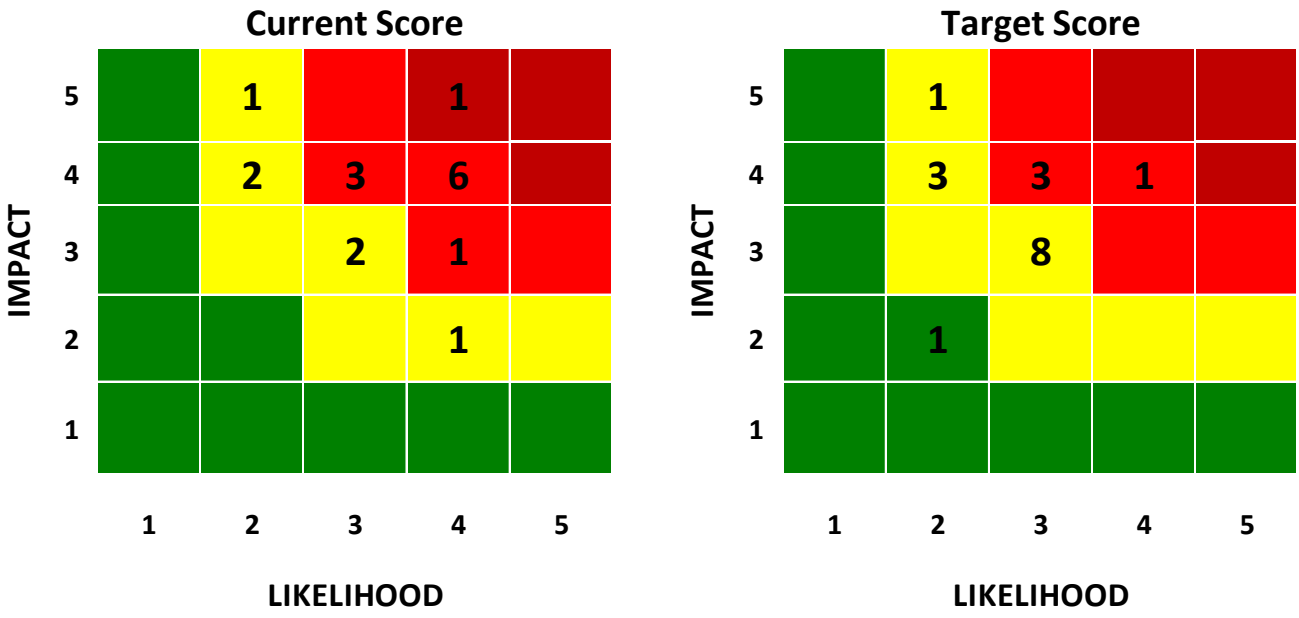
3.7 The Corporate Risk Register captures the high level risks across the HSCP and the hosted services. At the point of review, there were a total of 22 risks, 21 of which were live as detailed below:

	Financial	Service Delivery	Data Protection	Business Continuity
Number of Risks	2	16	2	1
Risks Reviewed	2	16	2	1
% Reviewed this month	100%	100%	100%	100%

3.8 Following review by SMT and Risk owners there are now 17 live risks included within the HSCP Corporate Risk Register, below is the updated Risk Dashboard detailing the original, current and target risk scores and illustrates the trend in risk score changes the details of which are on each individual Risk on a Page (See Appendix 1).

Risk Reference	Risk Category	Risk Title	Risk Score			Target Risk Score	Trend	Risk Reviewed in Mont
			Original	Previous	Current			
HSCP01	Financial	Inability to achieve recurring financial balance	25	25	20	16		✓
HSCP02 - Closed	Service Delivery	Failure to implement adult support and protection improvement plan.	12	12	8	8		✓
HSCP03	Data Protection	Failure to comply with General Data Protection Regulations (GDPR) resulting in loss, inappropriate sharing or unlawful processing of sensitive personal data, including risks arising from emerging technologies (e.g. AI/LLMs)	9	9	16	12		✓
HSCP04	Data Protection	Failure to comply with General Data Protection Regulations - failure to destroy records in line with schedule of destruction dates	8	8	8	4		✓
HSCP05	Business Continuity	Failure in service delivery through failure of business continuity arrangements in the event of a civil contingency level event.	10	10	10	10		✓
HSCP06	Service Delivery	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.	9	9	9	9		✓
HSCP07	Service Delivery	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	12	12	9	9		✓
HSCP08	Service Delivery	Failure of external care providers to maintain delivery of services.	12	12	12	8		✓
HSCP09	Service Delivery	Risk of failure to achieving transformational change and service redesign plans within necessary timescales and at the pace required.	25	25	12	9		✓
HSCP10	Service Delivery	Failure to deliver actions to drive performance on unscheduled care with adverse impact on whole system flow.	16	16	16	12		✓
HSCP11	Service Delivery	Failure of some or all of General Practice to deliver core services.	8	8	8	8		✓
HSCP12	Service Delivery	Failure to deliver the MOU commitments within the Primary Care Improvement Plan	8	8	8	8		✓
HSCP13	Service Delivery	Inability to secure sufficient accommodation in the West Locality to deliver effective integrated health and social work services in that area.	16	16	16	12		✓
HSCP14	Service Delivery	Failure to secure an alternative system to Carefirst for Social Work case management and provider financial payments.	12	12	12	9		✓
HSCP16	Service Delivery	Failure to deliver Prison Based SW in line with the Memorandum of Understanding (MOU) at HMP Low Moss.	16	16	16	9		✓
HSCP17	Financial	Current /future service levels reduce or cease following increase in employers national insurance contributions (eNIC's) - effective 6th April 25.	12	12	12	9		✓
HSCP18 - Closed	Service Delivery	Senior Management Team Vacancies/Capacity	9	9	9	9		✓
HSCP19 - Closed	Service Delivery	Impact of further reductions to 36hrs working week for NHSGG&C "Agenda for Change " staff on 1 April 2026	9	9	9	9		✓
HSCP20 - Closed	Service Delivery	Skye House there is a risk that the demands of the team mean that they cannot meet all expectations whilst delivering a front	20	20	8	8		✓
HSCP21	Service Delivery	Inability to meet the demand for neurodevelopment disorder assessment and treatment.	16	16	16	9		✓
HSCP22	Service Delivery	Inability to deliver an intensivised CAMHS pathway for Scotland West	16	16	16	9		✓

3.9 Of the 17 live risks identified within the Corporate Risk Register, 1 is considered to be very high risk (priority 1), 10 are considered to be high risk (priority 2) and 6 are considered to be a medium risk (priority 3). Achieving the Target Risk Scores will change these to a total of 4 high risk (priority 2), 12 medium risk (priority 3) and 1 low risk (priority 4), as detailed on the below risk matrices.



3.10 There were 4 Risks closed in the period - HSCP02, HSCP18, HSCP19 and HSCP20.

3.11 HSCP02 which detailed the Risk of Failure to implement Adult Support and Protection improvement plan was closed as it was confirmed that the improvement plan had now been developed and implemented, a governance framework was now in place and training plans have reduced the risk from high to medium in line with the target and the risk was closed.

3.12 HSCP18 Senior Management team vacancies/capacity. Recruitment for all senior management team vacant posts has now concluded. The risk is now medium in line with target and risk can now be closed.

3.13 HSCP19 The reduced working week of 36 hours as part of Agenda for Change has now been implemented. Measures were put in place in order to mitigate the impact of this change with funding being made available to be allocated as required. With no ongoing actions required, the risk has now been closed.

3.13.1 HSCP20 Risk on service delivery due to increased demand on teams with Skye House. Enhanced level of monitoring and support now in place. Review of all feedback within system and review feedback to determine future action plans. These mitigations have reduced the current risk score to medium which is in line with target, allowing the risk to be closed.

3.13.2 All other risks reviewed have either remained the same or risk scores have improved with the exception of HSCP03 which covers Data Protection. This risk was updated to include AI specific data risks for which mitigations have been

identified but not yet fully implemented and as a result have caused the risk score to increase from medium to high.

Service Risk Registers – June 2026

3.14 The HSCP also has a number of service risk registers in place which provide 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.

3.15 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.

3.16 There are a total of 21 service risk registers with 119 live/active risks associated with these registers. 0 are Very High risks, 22 are High level risks, 56 are Medium level risks and 41 are Low level risks. This is a variance of 15 live/active risks last reported.

3.16.1 In this period, there has been a decrease of 4 Very High level risks, and a decrease of 3 High level risks. Medium risks have reduced by 2 and there has been a decrease of 7 Low Level risks last reported to the PAR Committee.

Service Risk Level	**Total Number**	**Variance in Period**
Very High	0	-4
High Level	22	-3
Medium	56	-2
Low Level	41	-6
Total	**119**	**-15**

3.17 The 4 Very High level risks on the service risk registers that related to Specialist Children Services have closed due to improving staffing and risk reduction

3.18 The process for 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 – None.

4.3 Workforce (including any significant resource implications) – there are 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 IJB 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 Alignment to Population Health Framework – None

4.12 Alignment to Health and Social Care Strategic Renewal Framework - None

4.13 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 IJB 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 IJB 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 June 2026

Risk Reference	Risk Name	Risk Owner (Role)
HSCP01	Inability to achieve recurring financial balance	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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, 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	01/04/2025	Treat	Chief Finance & Resources Officer

Control Measures

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.

Risk Management Actions

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)

Original				Previous				Current				Target			
Original Date:			01/04/25	Last Update:			04/02/26	Latest Update:			04/03/26	Target Date:			31/03/26
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
5	5	25	1 - VERY HIGH	5	5	25	1 - VERY HIGH	4	5	20	1 - VERY HIGH	4	4	16	2 - HIGH

Risk Reference	Risk Name	Risk Owner (Role)
HSCP02	Failure to implement adult support and protection improvement plan.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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		Treat	Head of Adult Services

Control Measures

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

Risk Management Actions

Risk to quality of intervention and statutory structured intervention and support for adults at risk of harm if provision of adult support and protection training is compromised. This may additionally reduce the pool of trained 'Council Officers' required to undertake statutory Adult Support and Protection work. This could also impact adversely upon the outcomes of our Adult Support and Protection Inspection Improvement Plan. Agreement on 6th May 2026, Risk Management review session, that mitigations including implementation of Improvement Plans, Governance Framework and Training Plans have reduced the risk from High to Medium. Risk now closed.

Original				Previous				Current				Target			
Original Date:				Last Update:			09/12/25	Latest Update:			02/03/26	Target Date:			08/06/26
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
3	4	12	2 - HIGH	3	4	12	2 - HIGH	2	4	8	3 - MEDIUM	2	4	8	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP03	Failure to comply with General Data Protection Regulations (GDPR) resulting in loss, inappropriate sharing or unlawful processing of sensitive personal data, including risks arising from emerging technologies (e.g. AI/LLMs)	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
Structural changes require new and more sophisticated forms of data management. Lack of understanding and awareness of Data Protection legislation and the common law duty of confidentiality. Increasing demand and competing priorities may reduce staff vigilance and adherence to Information Governance requirements. Large volumes of sensitive and special category data (health and social care information) are routinely accessed for legitimate purposes, increasing the risk of inappropriate handling or disclosure. Inadequate or inconsistent training in Information Governance and data protection requirements, alongside variable application of established procedures. Reliance on a range of digital systems and technologies, with ongoing system changes and increased use of electronic records. Insufficient technical controls or monitoring (e.g. data loss prevention, audit of access and data movement) may limit the ability to prevent or detect inappropriate data sharing or access. Emerging technologies, including Artificial Intelligence (AI) and Large Language Models (LLMs), introduce additional risks where: Staff may access or use non-approved tools ("shadow IT"), including personal devices or accounts. Time pressures may lead to copying, exporting, or inputting sensitive data into external systems. Organisational guidance on safe AI use may be unclear or inconsistently applied. Data entered into external systems may be processed, stored, or retained outside organisational control	Breach of Information Governance legislation including GDPR and the common law duty of confidentiality. Harm or distress to individuals whose personal or sensitive data is lost, accessed, or shared inappropriately, including potential safeguarding implications. Financial penalties and regulatory enforcement action, including requirement to notify the Information Commissioner's Office (ICO) and affected individuals. Reputational damage to NHS Greater Glasgow & Clyde, East Dunbartonshire Council and the HSCP, leading to loss of public trust and confidence. Operational disruption arising from incident response, investigation, containment, and remediation activity, including potential legal and disciplinary processes. Unauthorised processing or disclosure of data via external platforms (including AI tools), including potential transfer outside the UK/EU without appropriate safeguards. Risk that data shared externally may be retained, reused, or re-identified by third parties, increasing the likelihood of future exposure.	Data Protection	29/04/26	Treat	Information Governance Lead / Data Protection Officer

Control Measures

A comprehensive Information Governance framework is in place across the HSCP, supported by professional codes of practice, policies and procedures governing the use and sharing of data. Monitoring of Information Governance standards, agency security policies, and Caldicott Guardian responsibilities, supported by NHSGGC-wide governance structures. Information Sharing Protocol (endorsed by the Information Commissioner) in place for the HSCP. Mandatory Information Governance and GDPR training for all staff, with ongoing awareness programmes. Policies updated to reflect GDPR requirements, including secure email standards and appropriate handling of sensitive information. All laptops (including partner organisation equipment) are encrypted.
Role-based access controls to electronic systems, authorised by senior clinicians and the Caldicott Guardian.

Audit processes in place for monitoring access to electronic records and identifying inappropriate access. Approved corporate digital tools (including NHS-secure AI solutions where available) supported by guidance on appropriate use. Clear policy position that personal or sensitive data must not be entered into non-approved or public AI tools.

Use of anonymised, aggregated or redacted data where possible to support analysis, reporting and service improvement.

Defined incident management and reporting procedures for data breaches, including escalation and investigation processes.

Risk Management Actions

Strengthen and clarify organisational guidance on the use of emerging technologies, including AI/LLMs, with clear "dos and don'ts" and decision support for staff.
Enhance Information Governance training to include practical scenarios relating to AI use and handling of sensitive data, with targeted input for higher-risk roles (e.g. analytical and reporting teams).
Increase communication and awareness activity to reinforce good Information Governance practice and highlight risks associated with non-approved tools.
Review and enhance technical controls, including:
- Data Loss Prevention (DLP) measures
- Web filtering and access controls
- Monitoring of large data exports and unusual system activity
Further develop audit and monitoring arrangements for access to sensitive datasets, including routine review of anomalies and escalation where required.
Undertake periodic compliance and assurance activity across services, with targeted review of high-risk areas.
Test and strengthen incident response arrangements through regular exercises, including scenarios involving emerging technologies and data breaches.

Original				Previous				Current				Target			
Original Date:			Unknown	Last Update:			Unknown	Latest Update:			13/05/26	Target Date:			28/04/27
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
3	3	9	3 - MEDIUM	3	3	9	3 - MEDIUM	4	4	16	2 - HIGH	3	4	12	2 - HIGH

Risk Reference	Risk Name	Risk Owner (Role)
HSCP04	Failure to comply with General Data Protection Regulations - failure to destroy records in line with schedule of destruction dates	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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.	Breach of Information management legislation. Financial penalty Increased external scrutiny Reputational damage to NHS GG&C, ED Council or the HSCP Litigation	Data Protection		Treat	HSCP Corporate Business Manager

Control Measures

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. Record Management Plan in place for HSCP with actions for continuous improvement.

Risk Management Actions

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 progressed to address review of records. HSCP Records post NHSGG&C (business support) health post 12 months fixed term readvertised June 2025 with appointment made August 2025. Start date 05.01.26. Discussion underway with NHSGGC Health Records as to next steps with regards to destruction schedules for records held off site with records management company (May 2026).

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			06/11/26
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
4	2	8	3 - MEDIUM	4	2	8	3 - MEDIUM	4	2	8	3 - MEDIUM	2	2	4	4 - LOW

Risk Reference	Risk Name	Risk Owner (Role)
HSCP05	Failure in service delivery through failure of business continuity arrangements in the event of a civil contingency level event.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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		Treat	Planning, Performance & Quality Management Manager

Control Measures

Regular testing and updating of emergency plans (multi-agency response) and Business Continuity Plans; Comprehensive plans for a Pandemic outbreak, IT failure/cyber attack and updated PARD / Critical Persons List. Business Continuity Event undertaken 01.12.25 and wider Civil Contingencies Event for First Responders held 12.12.25

Risk Management Actions

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 continuity planning to ensure alignment across partner agencies. (ongoing). Progression of crisis management founding principles training for members of HSCP with Scottish Government Civil Contingencies team.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			Achieved
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
2	5	10	3 - MEDIUM	2	5	10	3 - MEDIUM	2	5	10	3 - MEDIUM	2	5	10	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP06	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.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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. Delayed availability of key financial information due to Oracle Fusion migration issues within EDC. Progress made in year however improvements in current timelines still required in order to ensure the availability of real time data. 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 ongoing 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; reduced confidence in interim reporting figures; inability to deliver Commissioning Strategy; inability to progress service reviews / redesign to meet budget requirements for savings	Service Delivery		Treat	Chief Finance & Resources Officer

Control Measures

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.

Risk Management Actions

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). Digital enablers are being explored particularly within the business support service review. Weekly integrated finance update meetings to discuss key deadlines and information requirements.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			Achieved
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
3	3	9	3 - MEDIUM	3	3	9	3 - MEDIUM	3	3	9	3 - MEDIUM	3	3	9	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP07	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	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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		Treat	Heads of Service

Control Measures

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.

Risk Management Actions

Workforce plan development commenced 2025 in line with HSCP Strategic Plan and concluded 2026 with regular reviews planned. 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.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			Achieved
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
4	3	12	2 - HIGH	4	3	12	2 - HIGH	3	3	9	3 - MEDIUM	3	3	9	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP08	Failure of external care providers to maintain delivery of services.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
Uncontrollable market forces (recruitment /retention, impact of immigration status limitations, 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		Treat	Head of Health & Community Care

Control Measures

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

Risk Management Actions

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)

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			31/03/27
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
3	4	12	2 - HIGH	3	4	12	2 - HIGH	3	4	12	2 - HIGH	2	4	8	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP09	Risk of failure to achieving transformational change and service redesign plans within necessary timescales and at the pace required.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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		Treat	Chief Finance & Resources Officer

Control Measures

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 NHSGG&C re support requirements. Continual monitoring of emerging macro financial pressures (August 2025). Mitigations continue to be explored with identification of non-recurring savings particularly through positive management decision making in the interim pending service review outcomes.

Risk Management Actions

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 (August 2025). Ongoing weekly Budget savings meeting cycle in HoS and Service Manager diaries to generate 26/27 savings proposals (Jan'26). Management and monitoring of implementation (ongoing).

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			31/03/27
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
5	5	25	1 - VERY HIGH	5	5	25	1 - VERY HIGH	3	4	12	2 - HIGH	3	3	9	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP10	Failure to deliver actions to drive performance on unscheduled care with adverse impact on whole system flow.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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		Treat	Head of Health & Community Care

Control Measures

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. Additional Scottish Government funding secured as part of NHS GGC award to target AWI delays.

Risk Management Actions

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.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			31/03/27
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
4	4	16	2 - HIGH	4	4	16	2 - HIGH	4	4	16	2 - HIGH	3	4	12	2 - HIGH

Risk Reference	Risk Name	Risk Owner (Role)
HSCP11	Failure of some or all of General Practice to deliver core services.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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		Tolerate	Head of Health & Community Care

Control Measures

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.

Risk Management Actions

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.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
2	4	8	3 - MEDIUM	2	4	8	3 - MEDIUM	2	4	8	3 - MEDIUM	2	4	8	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP12	Failure to deliver the MOU commitments within the Primary Care Improvement Plan	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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		Tolerate	Head of health & Community Care

Control Measures

Prioritisation of MOU commitments, maximising use of reserves to meet commitments where appropriate and non recurring, accommodation strategy to expand space capacity.

Risk Management Actions

Representation to SG for funding to support full extent of MOU commitments, prioritisation of current funding allocation to core contractual commitments where appropriate. Clinical Director leading on maintaining and/or improving relationships between GP practices and HSCP.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:				Target Date:			
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
2	4	8	3 - MEDIUM	2	4	8	3 - MEDIUM	2	4	8	3 - MEDIUM	2	4	8	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP13	Inability to secure sufficient accommodation in the West Locality to deliver effective integrated health and social work services in that area.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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. There remains some pressure in the West Locality with options being explored and investigated with NHSGG&C and other partners with further discussions ongoing re one site in the West Locality (December 2025) for which an independent valuation is being progressed. SG 26/27 budget announcement included reference to East Dunbartonshire's inclusion in the first tranche of a primary and community care infrastructure investment programme - details to be confirmed.	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 e.g. 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 has relieved pressures in this locality area. Pressures in West Locality remain. It is anticipated that there will be accommodation pressures arising from GP funding streams which will require practices to maximise use of their own accommodation which will have implications for PCIP programmes.	Service Delivery		Treat	Chief Finance & Resources Officer

Control Measures

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 will take place in 2026 which will help inform a refresh of the ED HSCP Property Strategy which will include hosted services, Oral Health and Specialist Children Services working with NHSGG&C board colleagues.

Risk Management Actions

Progression of actions within ED HSCP Property Strategy have included the opening planned CTAC premises in Bishopbriggs in Dec'25. 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 CTAC clinic opened 1st December 2025. Continue to explore alternative solutions to address remaining capacity within HSCP accommodation. Continue to explore additional accommodation options within the West locality. (October 2025). Alignment with EDC Property Strategy through ongoing discussions. SG 26/27 budget announcement included reference to East Dunbartonshire inclusion in the first tranche of a primary and community care infrastructure investment programme - details to be confirmed and progressed with NHSGGC Property team.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
4	4	16	2 - HIGH	4	4	16	2 - HIGH	4	4	16	2 - HIGH	3	4	12	2 - HIGH

Risk Reference	Risk Name	Risk Owner (Role)
HSCP14	Failure to secure an alternative system to Carefirst for Social Work case management and provider financial payments.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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		Treat	Chief Finance & Resources Officer

Control Measures

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.

Risk Management Actions

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). Discussions are ongoing with EDC DoF with regards re-prioritisation of digital project funding. 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). Discussions are ongoing with EDC DoF with regards re-prioritisation of digital project funding. HSCP Digital Group received notification that Carefirst will reach end of life on 31st August 2028, with support ending at that time. The contract is being extended to March 2028, whilst a replacement is sought.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			31/08/27
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
4	3	12	2 - HIGH	4	3	12	2 - HIGH	4	3	12	2 - HIGH	3	3	9	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP16	Failure to deliver Prison Based SW in line with the Memorandum of Understanding	Chief Social Work Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
The current funding received from SPS is insufficient to provide PBSW services to the prison population in Low Moss. Demand has increased 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 and there is one vacancy in a team of 4 FTE.	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		Treat	Head of Children's Services & Criminal Justice

Control Measures
Regular meetings with PBSW. Submission of Business Case to SPS to request increased funding. Regular meetings with the Governor. Situation now escalated to SWS and SG. Temporary additional funding agreed,however, difficulty in procuring short term Prison trained SW staff.

Risk Management Actions

Escalation of business case to ensure prioritised for progression, identification and planning of resource requirements through SPS and SG. In the short term a further £40,000 has been agreed by SPS to employ an additional SW. Further £100,000 agreed until September 2026

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			30/09/26
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
4	4	16	2 - HIGH	4	4	16	2 - HIGH	4	4	16	2 - HIGH	3	3	9	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP17	Current /future service levels reduce or cease following increase in employers national insurance contributions (eNIC's) - effective 6th April 25.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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		Treat	Chief Finance & Resouces Officer

Control Measures

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.

Risk Management Actions

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. HSCP position is maintained in confirming a lack of funding to support supplier increase requests especially as negotiated/managed via Scotland Excel. Scope for local frameworks will be explored in order to manage risk of price increases now being prioritised.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			31/03/27
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
3	4	12	2 - HIGH	3	4	12	2 - HIGH	3	4	12	2 - HIGH	3	3	9	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP18	Senior Management Team Vacancies/Capacity	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
Due to promotions and planned absence key HSCP posts including Heads of Service is vacant. Management Structure review Phase 1 has now concluded and confirmation of NHSGGC banding of Interface HoS post is being progressed in order to commence recruitment. EDC grading has been verified and is in line with expectations.	Failure to meet all roles and responsibilities for key posts, within the HSCP.	Service Delivery		Treat	Heads of Service

Control Measures

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 recruitment of Head of Interface Health and Care Services concludes as identified as required as part of the management structure service review and as approved at IJB. Head of Interface Health and Care Services post to SMT on 04.03.26 for approval.

Risk Management Actions

Interim Management cover arrangements in place, with support from NHSGG&C and EDC. Consider other mechanisms for delivery of services. Continue to develop and regularly review cover arrangements until recruitment concludes as part of the management structure service review for which phase 1 has now completed. Phase 2 to follow. All Senior Management recruitment has now concluded with appointments made (May 2026)

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			Achieved
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
3	3	9	3 - MEDIUM	3	3	9	3 - MEDIUM	3	3	9	3 - MEDIUM	3	3	9	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP19	Impact of further reductions to 36hrs working week for NHSGG&C "Agenda for Change " staff on 1 April 2026	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
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		Treat	Heads of Service

Control Measures

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 worked on plans to implement this reduction by August 2025 and any associated financial impact as a result. NHSGGC CMT approved proposal to fund 75% of the funding requirement submitted by areas - prioritisation review in progress to identify HSCP and hosted service teams who require to cover clinic/appointment times and those that can cover the reduction in hours with minimal/no impact on patients/service users.

Risk Management Actions

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)
Approximate costs of this reduction identified with a further review required now that potential funding has been identified as 75% of requirement.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			06/05/26	Target Date:			Achieved
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
3	3	9	3 - MEDIUM	3	3	9	3 - MEDIUM	3	3	9	3 - MEDIUM	3	3	9	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP20	Skye House there is a risk that the demands of the team mean that they cannot meet all expectations whilst delivering a front line service.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
Since Feb 25 the service has been actively participating in a number of reviews and scrutiny processes alongside the increase in acuity of need.	There is notable impact on staff wellbeing, and a requirement to have continual oversight at all levels	Service Delivery		Treat	General Manager - SCS

Control Measures

Staffing shortfall and safe staffing escalation occurring with temporary monies being available to support some additional staffing. Issues highlighted and escalated via CO to wider system. All routes of escalation being used.
EOG oversight and operational oversight group for improvement plans. Time for reflection for every meeting for team members and a meeting structure to respond to improvement requirements.

Risk Management Actions

Enhanced level of monitoring and support at present. Review of all feedback within system and review feedback to determine future action plans.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:			09/06/26	Target Date:			Achieved
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
5	4	20	1 - VERY HIGH	5	4	20	1 - VERY HIGH	2	4	8	3 - MEDIUM	2	4	8	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP21	Inability to meet the demand for neurodevelopment disorder assessment and treatment.	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
Demand for ND assessments is in excess of limited resource available for ND assessments, this is a pattern nationally with limited additional funding	For children and young people services there is a separate ND waiting list, the impact is therefore that the volume of referral does not enable prioritisation of those most at risk of harm in relation to ND where diagnosis would support risk management. There is an impact on staff wellbeing where demand is higher than capacity and staff frequently report feeling overwhelmed, dealing with public dissatisfaction and distress.	Service Delivery		Treat	General Manager - SCS

Control Measures

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. Funded waiting list team to target waiting list young people who will time out of services. Application of access policy to ND pathway being tested in line with Planning iwth People to inform decision making through governance.

Risk Management Actions

Waiting list additionality. Strategic planning re Planning with People being developed. Task and finish groups internally for efficiencies

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:				Target Date:			
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
4	4	16	2 - HIGH	4	4	16	2 - HIGH	4	4	16	2 - HIGH	3	3	9	3 - MEDIUM

Risk Reference	Risk Name	Risk Owner (Role)
HSCP22	Inability to deliver an intensivised CAMHS pathway for Scotland West	Chief Officer

Cause	Effect	Risk Category	Date Raised	Risk Strategy	Risk Lead (role)
Expectation of Scottish Government and sub national partners to develop and deliver a intensivised model of CAMHS for Scotland West.	There will be challenge to sustaining the improved quality and delivery in the regional inpatient adolescent unit and to the system ability to accomodate demand in arising from a reduced number of CAMHS beds.	Service Delivery		Treat	General Manager - SCS

Control Measures

National adoption of national inpatient specification. Agreed subnational implementation plan for delivery in Scotland West. Agreed workforce plan and financial framework and funding.

Risk Management Actions

Develop a implementation group. Escalation through GGC CMT and subnational structures.

Original				Previous				Current				Target			
Original Date:				Last Update:				Latest Update:				Target Date:			
Original Residual Likelihood	Original Residual Impact	Original Risk Score (Likelihood x Impact)	Original Priority	Previous Residual Likelihood	Previous Residual Impact	Previous Risk Score (Likelihood x Impact)	Previous Priority	Current Residual Likelihood	Current Residual Impact	Current Risk Score (Likelihood x Impact)	Current Priority	Acceptable Residual Likelihood	Acceptable Residual Impact	Target Risk Score (Likelihood x Impact)	Target Priority
4	4	16	2 - HIGH	4	4	16	2 - HIGH	4	4	16	2 - HIGH	3	3	9	3 - MEDIUM

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce
AGENDA ITEM NO: 14.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**17 JUNE 2026**
REPORT REFERENCE:	**PERF/170626/14**
CONTACT OFFICER:	**DAVID AITKEN, HEAD OF ADULT SERVICES/CHIEF SOCIAL WORK OFFICER TELEPHONE NUMBER: 0141 232 8237**
SUBJECT TITLE:	**CARE INSPECTORATE INSPECTION – PINEVIEW HOUSING SUPPORT SERVICE**

1.0 PURPOSE

1.1 The purpose of this report is to provide the Committee with the outcome of the recent unannounced inspection of the Pineview Housing Support Service in East Dunbartonshire which was completed in May 2026

2.0 RECOMMENDATIONS

It is recommended that the Committee:

2.1 Note the contents of the report.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 This report provides the Committee with a summary of the report and outcome from the most recent unannounced inspection undertaken by the Care Inspectorate into the Pine Housing Support service which took place on the 6th May 2026.

3.2 Pineview is a registered service for adults with complex learning disabilities living in a shared home. The service is provided by East Dunbarton HSCP/Council and is located in Bearsden, with the capacity to support three people.

3.3 This was a Core Assurance Inspection. This format of inspection is undertaken where services are seen to be better performing and those which consistently deliver high quality care and support, and as such no new evaluations or grades have been awarded. Current grades are; 'How well do we support people's wellbeing?' – 6 (Excellent) and 'How good is our staff team?' – 5 (Very Good).

3.4 The inspection observed practice and daily life in Pineview, engaged with the individuals who live in Pineview, secured feedback from relatives, staff/management, and visiting professionals, and sampled relevant documents.

3.5 The structure of the Core Assurance inspection is set out as follows.

- Legal assurances
- Wellbeing
- Infection prevention and control
- Medication management
- Leadership
- Staffing
- Planned care/support

3.6 The inspection report confirmed significant positive practice and provides assurance as to the quality of care and compliance with registration requirements.

3.7 The findings highlighted that people experienced a consistently safe, and well supported service where strong systems for adult protection were embedded with positive feedback received from relatives who described staff as communicative, and proactive, which they felt contributed to people feeling protected and reassured. Families described feeling included in decision making and confident that their views influenced change

3.8 Further points of assurance to feature within the inspection report include.

- Mandatory training compliance was high
- Policies were up to date
- Staff demonstrated confidence in recognising and responding to concerns
- Medication practice was safe, person centred, and well governed
- Quality assurance processes were well established and embedded in daily practice
- A strong learning culture was described which supported reflection, development and contributed to improvement

- Strengths in leadership were clearly identified with strong staff support and management oversight

3.9 In summary the Pine View Care Inspectorate Inspection Report reflects very positively on the service, staff and leadership. The report identifies real strengths across the delivery of care and support reflective of a service which is high performing, safe, and well led, with no recommendations or requirements as part of this inspection.

3.10 Committee are asked to note the contents of this report and the Care Inspectorate Report, attached at appendix (1).

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

4.2 Frontline Service to Customers – None.

4.3 Workforce – None.

4.4 Legal Implications – None.

4.5 Financial Implications – None.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None

4.10 Sustainability – None.

4.11 Alignment to Population Health Framework – None.

4.12 Alignment to Health and Social Care Strategic Renewal Framework – None.

4.13 Other – None.

5.0 MANAGEMENT OF RISK

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

5.1 Not applicable

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 – Care Inspectorate Inspection Report Pineview Housing Support Service.

Care Inspectorate Inspection Report Pineview Housing Support Service

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Derrick Pearce

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

Meetings

February 2026 – October 2026

Updated 08/06/2026

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
Commissioned Services Assurance
Relevant Audit Scotland reports as available
HSCP PAR Committee Agenda Items – 9th February 2026
Performance, Audit & Risk Committee Response to Forvis Mazars Governance Letter on East Dunbartonshire IJBs Financial Statements for the Year Ending 31st March 2025
Mazars 2024/25 Annual Audit Plan (TR)
Final Audited Accounts 2023/2024 (CFO)
HSCP PAR Committee Agenda Items – 13th March 2026
Internal Audit Plan 2026/27 (GMcC)
Specialist Children Services Update & Inspection Reports
Performance Management Update Qtr3 2025/26 (AC / AW)
2024/25 audit progress report (TR)
Care at Home Service Inspectorate Report
HSCP PAR Committee Agenda Items – 17 June 2026

Internal Audit Update Report (GMcC)
Annual Internal Audit Report (GMcC)
Commissioned Services Assurance
Whistleblowing/Speak Up Update
CMHT Mental Welfare Commission Report (DA)
HMP Low Moss update (CC)
Audit Progress Report 2024/25 (TR)
Performance Management Update Qtr4 2025/26 (AC / AW)
HSCP Directions Log Progress Update
HSCP PAR Committee Agenda Items – 29th June 2026 (tentative)
Final Audited Accounts 2024/25 (Signoff)
Final Audit Report 2024/25 (TR)
Unaudited Accounts 2025/26
HSCP PAR Committee Agenda Items – 29th September 2026 (tentative)
HSCP Delivery Plan 2026/27 Update Qtr 1
Annual Audit Plan 2025/26 – External Audit (Mazars)
Internal Audit Report
HSCP Delivery Plan 2026/2027 Qtr 2
HSCP Corporate Risk Register Update
Final Audit Report 2025/26 (TR) tbc
Final Audited Accounts 2025/26 tbc (legislative deadline for signing 30th Sept, publishing 31st October)