East Dunbartonshire Health & Social Care Partnership

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**Chief Officer
Derrick Pearce**

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East Dunbartonshire HSCP

Performance Audit & Risk Committee Meeting

10.00am Friday 13th March 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: L McDonald, J Robertson, C Carthy	**Verbal**	**Noting**
3.	C Smith	Draft Minutes of Last Meeting – 9th February 2026	**Paper**	**Approval**
4.	A McCready	Performance Audit and Risk Committee – Terms of Reference Review	**Verbal**	**Noting**
5.	T Reid	2024/25 Audit Progress Report - External Audit (Mazars)	**Paper**	**Approval**
6.	A Craig	Performance Management Update Qtr3 25/26	**Paper**	**Noting**
7.	A Blair	Specialist Children Services – Skye House, Inspection Report	**Paper**	**Noting**
8.	A Blair	Specialist Children Services – Ward 4, Inspection Report	**Paper**	**Noting**
9.	D Aitken	Care at Home Service Inspectorate Report	**Paper**	**Noting**
10.	A McCready	HSCP Corporate Risk Register Update	**Paper**	**Approval**
11.	A McCready	HSCP PAR Agenda Planner	**Paper**	**Noting**

Item	Lead	Description	Update	For Noting/ Approval
12.	C Smith	AOCB	**Verbal**	**Noting**
13.	C Smith	Date of next meeting – 17/18/19 June 2026 TBC	**Verbal**	**Noting**

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

Date: Monday 9th February 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
	Pamela Marshall	EDC Councillor	PM
	Alison McCready	HSCP Chief Finance and Resources Officer	AM
	Jamie Robertson	EDC Chief Finance Officer and Executive Officer	JR
	Kathleen Halpin	HSCP Chief Nurse	KH
	Lesley McDonald	NHS Non-Executive Board Member	LM
	Tom Reid	Audit Director, Mazars External Auditors	TR
	Charles Vincent	NHS Non-Executive Board Member	CV
	Andy Craig	HSCP Planning, Performance & Quality Officer	AC
	Vandrew McLean	HSCP Corporate Business Manager	VM
Minutes:	Lorraine Brown	HSCP Corporate PA	LB

Item No.	Topic	Action by
1.	**Welcome and Introductions**	LC
	Ms Libby Cairns opened the meeting in the absence of Councillor Smith, and welcomed all members. No declarations of interest were proposed at this point. Apologies were submitted by David Aitken and Claire Carthy.	
2.	**Draft Minutes of Last Meeting – 6th November 2025**	LC/All
	LMcD highlighted amendment in the previous minute in relation to the spelling of her forename. She requested that for future meetings she is referred to as Lesley McDonald. Amendment will be made to previous minute. Otherwise, minute was accepted as a true and accurate record of proceedings as proposed by LC and seconded by LMcD. **Item Approved**	
3.	**Performance Audit and Risk Committee – Terms of Reference Review**	AMcC
	AMcC provided an update to the members regarding the Terms of Reference Review for the Performance, Audit and Risk Committee. It was noted that the Standards Officer has yet to review the revised version. As this matter remains unresolved, it was agreed that it will be revisited at a future meeting. **Item Noted/Agreed.**	

4.	**Forvis Mazars Audit Report for Year Ended 31st March 2024**	TR
	Forvis Mazars Annual Audit Plan for Year Ended 31st March 2025	
	TR provided an update regarding the 2023/24 period, noting that the data migration for East Dunbartonshire Council to the financial reporting system is anticipated to be completed today, enabling the financial statements to be signed off without modification.	
	He expressed appreciation to AMcC and FS for their ongoing support during the audit process. LC also extended thanks to TR and his team for successfully concluding this matter. LC requested clarification on status of audit items (pg. 22 of 216) and whether they related to data migration work mentioned by TR, who confirmed this was accurate and that he had received updated information within the last two weeks.	
	Upon joining the meeting, Councillor Smith offered further gratitude to all involved for their contributions. Councillor Smith requested that LC continue chairing meeting.	
	No other questions were raised at this point. **Audit Report for Year Ended 31st March 2024 – Agreed & Approved.**	
	In terms of the Annual Audit plan for Year Ended 31st March 2025 TR summarised the approach contained within the attached report and the audit risks. Timeline is set out within the report and sign off expected at the June 2026 meeting of the Performance Audit and Risk Committee. He further highlighted points of note from the report (Section 4, Section 5 & Section 6) and suggested he was happy to follow up with members if required.	
	No other questions or concerns were raised at this point. **Annual Audit Plan for Year Ended 31st March 2025 – Agreed & Approved.**	
5.	**East Dunbartonshire Integration Joint Board/HSCP Final Audited Annual Accounts 2023/2024**	AMcC
	AMcC reported that the submission has been forwarded for committee approval. The final audited accounts, which relate to the initial report discussed by TR under agenda item 4, are now ready for sign off. Some clarification was sought regarding some specific areas of the accounts which have been resolved and will be reflected in the sign off version. LC expressed appreciation to all participants for their dedication and collaborative effort in completing this task.	
	LC made some observations from the report, noting the task's difficulty and that current committee members who will be signing off the accounts were not present during the original reporting period with exception of DP, who was not in the Chief Officer post at that time. LC conducted her own due diligence and had made specific reference to areas of clarification she had reviewed given she was not a Board Member at the time the accounts cover. LC pointed out that there may be a small typo regarding Specialist Children's Services, which she was content to discuss following the	

	meeting. LC confirmed she had checked the high level risks contained within the accounts were consistent with the risk register relating to June 2024 as cited in accounts. LC also reviewed the Budget paper from March 2023 and Financial Planning Update paper March 2024 to ensure information relating to budget, financial outlook, impact re assessing previously earmarked reserves and financial challenges was consistent, and information is contained predominantly at p148-149 of pack. LC raised the point regarding compliance with the Local Authority Accounts (Scotland) Regulations 2014 referred to at p152, and elsewhere in accounts, with regards to not meeting the prescribed timescales, however acknowledged the extenuating circumstances which Members are aware of relating to the financial system issues, LC referenced the requirement for notice of inspection of accounts to be published and being unable to check the notice on EDC website due to the notice being electronically superseded by the following year however the Principal Finance Manager has confirmed verbally to LC prior to this meeting that the notice was published giving an inspection timeframe to the public of 3rd February to 21st February. LMcD referenced the current Terms of Reference, it was noted that this has within, that Performance, Audit and Risk Committee (PAR) can sign the final audited statements, thereafter presenting to the IJB on 19th March 2026. **Item Noted/Approved.**	
6.	**Performance, Audit & Risk Committee Response to Forvis Mazars Governance Letter on East Dunbartonshire IJBs Financial Statements for the Year Ending 31st March 2025**	AMcC
	The Performance Audit and Risk Committee drafted a response to the Mazars 2024/2025 audit. AMcC informed members that the item would be removed from the agenda and the letter revised for approval as a Performance Audit and Risk Committee response. LC confirmed the draft was accurate but needed a stronger, more consistent tone. LMcD agreed and requested that the revised response be circulated for comment prior to the meeting, and members supported this plan. **Item Noted/Approved.**	
7.	**Audit Planning 2026/27 And Internal Audit Update to December 2025**	JR
	JR noted that work continues on the audit plan, with two outputs completed in the period. This resulted in the cumulative year to date total being five outputs. This represents 55% completion of the nine outputs planned for 2025/26, at 75% through the year and reflects the reduced resources available compared to the assumptions underpinning the audit plan. The Senior Auditor who was acting up to the Audit & Risk Manager role has now left the Council, leaving vacancies at both the Senior Auditor and Audit & Risk Manager positions, whilst the Audit & Risk Manager is on secondment. JR was happy to take any questions in terms of the audit.	

	Questions;	
	LMcD inquired about the audit planning for 2026/2027, specifically whether a risk-based approach had been adopted or if the initial focus was on identifying priority areas. JR responded that the plan is to prioritise high-risk audits within EDC and the HSCP initially, that there is comprehensive audit analysis, and suitable oversight in place. **Item Noted/Agreed.**	
8.	**HSCP Corporate Risk Register Update**	AMcC
	AM updated that all live risks had been reviewed since last Committee meeting in November. There remain 21 live risks, 3 of which are very high, 10 high and 8 medium. The risk register was thoroughly reviewed; risks narrative had been reworded, risks levels reviewed including whether these are Treated or Tolerated, or marked as manageable where appropriate. A simpler format for data capture and tracking is under consideration – risk on a page. LC noted ongoing challenges with tracking and recommended more work. DP said targeted sessions have improved understanding of risk management and acknowledged and thanked members for the detailed discussions at the last Performance Audit and Risk Committee meeting. **Comments/questions** LMcD mentioned two risks HSCP01 and HSCP09, each currently rated at 25 with a goal to reduce them to 16, and asked about the timelines for achieving this. AMcC explained that financial sustainability is being continuously addressed, with a break-even point projected for Month 7 and ongoing efforts to improve efficiency. DP noted that for Item 3.11 – Skye House, that it was anticipated that the risk levels will reduce following the published reports and that an update will be brought back to the next Performance Audit and Risk Committee meeting. AMcC expressed appreciation to the committee for their feedback and confirmed that comments will be documented. **Item Noted/Approved.**	
9.	**HSCP PAR Agenda Planner**	AMcC
	The PAR agenda planner is attached for reference. AMcC has invited members to suggest any items they would like added. DP mentioned that, for the meeting on March 13th, the committee will receive reports concerning the outcomes of the Skye House Inspection and the Ward 4 Inspection report. Additionally, the committee will review the newly published Care Inspectorate report on the in-house Care at Home service at the next meeting. Andrea Blair, General Manager of Specialist Children's Services, will be invited to attend and present information regarding the inspections, with the agreement of the Chair. **Item Noted/Approved.**	

10.	AOCB	LC
	No further business to report at this time. Clarity was given on the date of the next meeting and confirmed as 13th March, with a time change of 1pm to 3pm.	
11.	**Date of next meeting – 13th March 2026**	
	Meeting concluded.	

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

DATE OF MEETING:	**13th MARCH 2026**
REPORT REFERENCE:	**PERF/130326/05**
CONTACT OFFICER:	**ALI MCCREADY, CHIEF FINANCE & RESOURCES OFFICER**
SUBJECT TITLE:	**FORVIS MAZARS – ANNUAL AUDIT PROGRESS 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.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0   BACKGROUND/MAIN ISSUES

3.1   The Annual Audit Plan (AAP) for year ending 31st March 2025 was presented at the last Performance Audit and Risk Committee on the 9th February 2026. The AAP sets out the scope of engagement, planned scope and audit approach timelines, significant risks and key judgements, the wider audit scope and best value, proposed audit fee for the year, a commitment to independence and materiality and misstatements.

3.2   The Annual Audit Report (AAR) provides the Performance Audit and Risk Committee with information about the progress in delivering the external audit responsibilities for East Dunbartonshire Integration Joint Board. The Planning and Risk Assessment phases of the 2024/25 audit have been completed with no identified changes required to the audit approach.

3.3   Forvis Mazars meet regularly with the finance team as the audit progresses, and will continue to do so. All remaining phases of the audit are on track with completion planned for June 2026. The intention remains to present the draft Annual Audit Report to the June Performance Audit and Risk Committee.

3.4   A copy of the Annual Audit Progress Report to 31st March 2025 as at March 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 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 Progress Report for the year ending 31 March 2025 as at March 2026.

Audit Progress Report

East Dunbartonshire Integration Joint Board

March 2026

forvis mazars

Contents

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mazars

Audit progress

01

Audit progress

Purpose of this report

This report provides the Performance Audit and Risk Committee with information about the progress in delivering our external audit responsibilities for East Dunbartonshire Integration Joint Board.

We plan to complete the 2024/25 audit by June 2026 and present our draft Annual Audit Report to the June Performance Audit and Risk Committee. We have completed the planning and risk assessment phases of the 2024/25 audit. We have not identified any changes required to our audit approach, including the significant risks which we presented to you in the Annual Audit Plan.

We have met regularly with the finance team as the audit progresses, and we will continue to do so.

Summary of work for the planning and interim phase:

Areas	Description	Planned timeline	Status
Planning and risk assessment	We have developed our understanding of the entity, performed our risk identification and assessment procedures, and considered the proposed accounting policies and accounting treatments. We have also developed the audit strategies and planned procedures we intend to perform, completed our preliminary analytical reviews, and determined our audit materiality levels	November - December 2025	Completed
Substantive procedures	We have completed our audit testing of income and are in the process of reviewing the supporting documentation for our expenditure samples. A small number of expenditure documents are outstanding from the Finance team to enable us to finalise this area. We have completed our planned testing on all other areas of the financial statements, and the work is being reviewed by the Engagement Manager.	February - March 2026	On track

forvis mazars

Audit progress

Summary of work for the planning and interim phase (continued):

Areas	Description	Planned timeline	Status
Wider scope and Best Value	Our wider scope and Best Value work is ongoing. We are also continuing our follow-up of prior-year audit findings and management's responses.	February - March 2026	On Track
Completion procedures	We will undertake final reviews of the financial statements and the disclosure checklist, perform the final engagement director review, agree the content of the letter of representation, and prepare our auditor's report. We will also perform our subsequent events reviews, report our audit findings and the results of our wider scope and Best Value work to the Performance, Audit and Risk Committee, and proceed to sign our independent auditor's report.	April - June 2026	On Track

02

National publications

National publications

Audit Scotland

1. Integration Joint Boards: Finance bulletin 2024/25

The Accounts Commission's latest report says difficult decisions are urgently needed about how health and social care services are delivered, and where to redesign, reduce or discontinue services. IJBs have reached a critical point, with a significant risk they will become financially unsustainable within the next 12 to 24 months.

Alongside savings and using reserves, IJBs have been relying on substantial additional funding from their partners in the NHS and councils. IJBs need to plan their finances more realistically to reduce this reliance, as health boards and councils face their own significant financial pressures.

Link: [Integration Joint Boards: Finance bulletin 2024/25 | Audit Scotland](#)

Forvis Mazars

2. Navigating cyber risks: How local authorities can build resilience against emerging threats

The recent cyber-attack on local authorities in November 2025 highlights the urgent need for robust resilience strategies. From ransomware to legacy systems, public bodies face growing risks that can disrupt essential services and compromise citizen trust. In this article, Forvis Mazars highlights the increasing importance of cybersecurity for local authorities, outlining the key cyber risks they face and setting out recognised good-practice measures to strengthen resilience and mitigate these threats.

Link: [Navigating cyber risks: How local authorities can build resilience against emerging threats - Forvis Mazars](#)

3. AI in Local Government – Turning potential into practice

From predictive maintenance and smarter waste collection to AI-enabled housing and social services, councils are beginning to translate AI's potential into tangible benefits. This report from Forvis Mazars highlights real-world AI use cases already delivering value for Local Authorities and outlines the governance and data foundations needed to deploy AI safely and confidently.

Link: [Applying AI in Local Government: Turning potential into practice](#)

forvis mazars

National publications

Forvis Mazars (continued)

4. Annual Local Government Risk Report 2026

Local government is operating in one of the most challenging environments in decades. Financial pressures, structural reforms, rising service demands, and technological disruption have converged to create unprecedented complexity.

Link: [Annual Local Government Risk Report 2026](#)

03

Public sector resilience and readiness forum

Public sector resilience and readiness forum

We are delighted to invite you to our public sector resilience and readiness forum, bringing together senior leaders and finance professionals from across Scotland's public sector.

This half day session will provide a focused update on key financial reporting changes, explore practical lessons from a major local government transformation programme, and conclude with a panel discussion on cyber security, featuring expert and client perspectives on incident response and organisational resilience.

Event details – Tuesday 24 March, Forvis Mazars Glasgow Office

- **09:00** - Registration and breakfast
- **09:30** - Welcome and introduction
- **09:40** - Financial reporting workshop
- **10:40** - Break
- **10:50** - Transformation: Delivering value in the public sector
- **11:20** - Break
- **11:30** - Cyber resilience panel: How to respond to growing cyber threats
- **12:00** - Lunch and networking

Please register at https://pages.mazars.co.uk/scottish-public-sector-forum-registration.

**Event:
Scottish public sector resilience and readiness forum**

Tuesday 24 March
Glasgow

Get in touch to register

forvis mazars

Contact

Forvis Mazars

Tom Reid
Director
Tom.Reid@mazars.co.uk

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

DATE OF MEETING:	**13th MARCH 2026**
REPORT REFERENCE:	**PERF/130326/06**
CONTACT OFFICER:	**ALISON WILLACY, PLANNING PERFORMANCE & QUALITY MANAGER**
SUBJECT TITLE:	**HSCP ANNUAL DELIVERY PLAN UPDATE 2025/26 Q3**

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 third 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 Integration Joint Board (IJB) 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 22 are on track for delivery. Four projects are at risk and there is no update available for one project.

3.5 The four projects which are at risk are:

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

4.0 IMPLICATIONS

The implications for the Committee are as undernoted.

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

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

4.1 Frontline Service to Customers – None

4.2 Workforce (including any significant resource implications) – None

4.3 Legal Implications – None

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

4.5 Procurement – None

4.6 ICT - None

4.7 Economic Impact – None

4.8 Sustainability – None

4.9 Equalities Implications – None

4.10 Other – None

5.0 MANAGEMENT OF RISK

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

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

6.0 IMPACT

6.1 STATUTORY DUTY – None

6.2 EAST DUNBARTONSHIRE COUNCIL - None

6.3 NHS GREATER GLASGOW & CLYDE - None

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

7.0 POLICY CHECKLIST

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

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

HSCP TRANSFORMATION 25

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HSCP TRANSFORMATION PROGRAMME 2025/26			
Programme overview	**Summary of RAG Status**		
Projects	On Track	At Risk	In Exception
27	**22**	**4**	**0**

Project Name	Previous Status	Current status	Progress	Original Project End Date	Forecast Project End Date
Improve quality and relevance of information on HSCP website and maximise the potential of HSCP website to enable people to manage their own health and care needs	▶	▶	75%	31–Mar–2026	31–Mar–2026
Implement year one of the East Dunbartonshire Public Health Framework	▶	▶	75%	31–Mar–2026	31–Mar–2026
Review Care at Home services to focus on reablement expansion to mitigate demand growth	▶	TBC	TBC	31–Mar–2026	31–Mar–2026
Service Review Social Work Community Occupational Therapy Service	▶	▶	75%	31–Mar–2026	31–Mar–2026
Complete review of Respite (Commissioned)	▶	▶	80%	31–Mar–2026	31–Mar–2026
Commence the Review of the Supported accommodation estate	▶	▶	55%	31–Mar–2026	31–Mar–2026
(Commissioned) Review and implement recommendations to reduce high–cost care packages (LD)	▶	▶	40%	31–Mar–2026	31–Mar–2026
Explore potential of developing an all–age learning disability function	▶	▶	70%	31–Mar–2026	31–Mar–2026
Strategic Review of Mental Health and Alcohol and Drugs Services	▶	▶	80%	31–Mar–2026	31–Mar–2026
Service Review Community Mental Health Team (CMHT) and Older Peoples Community Mental Health Team (OPCMHT)	▶	▶	70%	31–Mar–2026	31–Mar–2026
Resolution of North Lanarkshire Corridor Service Level Agreement (NHS GGC/NHS Lanarkshire)	▶	▶	75%	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	⚠	⚠	75%	31-Mar-2026	31-Mar-2026
Review summary business cases for Woodlands and Milngavie Clinic	⚠	⚠	60%	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	▶	▶	75%	31-Mar-2026	31-Mar-2026
Review and refresh the HSCP Medium-Term Financial Strategy (MTFS)	▶	▶	15%	31-Mar-2026	31-Mar-2026
Implement focussed programme of de-prescribing and realistic medicine	▶	▶	75%	31-Mar-2026	31-Mar-2026
Review of Business Support Function	▶	▶	75%	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	▶	▶	75%	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	▶	▶	70%	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	▶	▶	75%		Green – Project on track

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

Project Description					

Project Sponsor	Project Manager				
Alison McCready	Andy Craig; Jane Jeffrey				

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Review of HSCP website content commenced.	• Ongoing review of website content through short life working group.

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

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

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

PROJECT RAG STATUS UPDATE

Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-02 Implement year one of the East Dunbartonshire Public Health Framework		▶	▶	75%	Green – Project on track

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

Project Description

Project Sponsor	Project Manager
Alison McCready	Sarah McChristie; Connie Williamson

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Identified and progressed opportunities to strengthen collaboration across HSCP, health improvement and third sector partners, ensuring alignment with the National Population Health Framework. • Started delivery of key prevention and early intervention actions and embedded public health objectives within locality plans and service redesign work streams. • Explored current data sharing processes, identified gaps, and initiated work with colleagues and partners to improve access, alignment and use of population health data.	• Target prevention and early intervention work in communities experiencing the greatest health inequality, supporting ED PH Framework's focus on reducing inequalities. • Embed poverty awareness approaches across services and partners to align local practice with national policy and the PH Framework's ambition for equitable access and improved health outcomes. • Re-establish a whole systems approach to healthy weight by commence early development work that supports the PH Framework's commitment to addressing wider determinants of health and alignment to the national population health framework. • Review and synthesise 2025/26 activity to demonstrate contribution to year 1 PH Framework priorities and inform next year planning and improvement actions.

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

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

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

PROJECT RAG STATUS UPDATE

Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-03 Review Care at Home services to focus on reablement expansion to mitigate demand growth		▶	No update available	No update available	No update available

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
• No update available	• No update available

Reason for RAG Status

There are no significant risks or issues at this time.

Benefits

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

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
	✅		✅		

PROJECT RAG STATUS UPDATE

Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP–25–04 Service Review Social Work Community Occupational Therapy Service		▶	▶	75%	Green – Project on track

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

Project Description

Project Sponsor	Project Manager
David Aitken	Richard Murphy

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• OT Review as part of Adult SW Service Review is now being finalised for presentation to SMT/IJB.	• Final options appraisal paper and template to be completed for SMT/IJB review.

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

Benefits	

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	Other Intended Benefits		
£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)		▶	▶	80%	Green – Project on track

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

Project Description

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

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Cap agreed internally although not yet communicated due to request to extend consultation beyond LD at mid point; • Further benchmarking on costs complete; • Workshop arranged to finalise Model / Spec for building based respite complete; • Stage 2 Consultation document complete pending decision to extend beyond LD; • Draft Service Specs Complete for new contract and sent to Legal; • Contract Novation from TMF to Enable for existing model complete; • New model approved pending wider consultation.	• Complete Integrated Impact Assessment; • Complete Consultation Stage 2 LD Only; • Finalise Service Specs for new contract; • IJB Paper – March 26; • Hold staff workshop with survey; • Commence separate Respite consultation for other care groups; • EQIA for other care groups respite review.

Reason for RAG Status

There are no significant risks or issues at this time.

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

PROJECT RAG STATUS UPDATE

Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-07 Commence the Review of the Supported accommodation estate		▶	▶	55%	Green – Project on track

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

Project Description

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

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Workshop held to develop mid to long term plan in relation to ongoing projected need; • Report to IJB on resource demand – held; • SBAR re TRFS approved at IJB; • Overnight template returns analysed; • Alton Holdings Steering Group meetings scheduled; • Uncommissioned spend action plan developed.	• Report to IJB on resource demand; • Pen Profiles for hard to place individuals; • Baseline reviews for priority overnight arrangements ragged as low risk, Quarriers Fire Safety low risk and uncommissioned supported accommodation; • Supp Acc / Alton Holdings PID; • Supp Acc / Alton Holdings EQIA; • Supp Acc / Alton Comms and Engagement Plan; • Supp Acc / Alton Integrated Impact Assessment (IIA); • Restructure of DSR meetings.

Reason for RAG Status

There are no significant risks or issues at this time.

Benefits

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

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

PROJECT RAG STATUS UPDATE

Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-08 (Commissioned) Review and implement recommendations to reduce high-cost care packages (LD)		▶	▶	40%	Green – Project on track

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

Project Description

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

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• 2 new posts approved to progress objective still not in place, impacting progress; • Progressing a mid to long term plan in relation to ongoing projected need and alternative core and cluster care models – see supported accommodation actions.	• Programme of individual community care reviews. • Start date for 2 new social workers to undertake the care assessments. • Revise assesment templates • Priority review scheduling

Reason for RAG Status

There are no significant risks or issues at this time.

Benefits

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

Drivers for Change

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

PROJECT RAG STATUS UPDATE

Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-09 Explore potential of developing an all-age learning disability function		▶	▶	70%	Green – Project on track

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

Project Description

Project Sponsor	Project Manager
David Aitken; Claire Carthy	Karen Lamb

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• SWOT complete; • Stage 4–7 of 10 step review process complete; • EQIA complete • Consultation and Engagement Plan complete; • Staff survey complete; • Option Appraisal complete; • Benchmarking complete	• Impact Assessment to be completed; • IJB Paper – Mar 26; • Health Team Questionnaire to be issued.

Reason for RAG Status

There are no significant risks or issues at this time.

Benefits

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

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✅	✅	✅	✅	❌	❌

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP–25–10 Strategic Review of Mental Health and Alcohol and Drugs Services		▶	▶	80%	Green – Project on track
Original Project End Date	Forecast Project End Date	Date of last project board			
31–Mar–2026	31–Mar–2026				
Project Description					
Project Sponsor		Project Manager			
David Aitken		Gillian Healey; Simon Reilly			

HIGHLIGHT REPORT	
Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Council approved Direct Awards. • Engagement with providers to update on implementation plans and direct awards completed. • Contract implementation process commenced.	• Next and final stage of the review includes development and implementation of contractual arrangements.

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

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

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

PROJECT RAG STATUS UPDATE

Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-11 Service Review Community Mental Health Team (CMHT) and Older Peoples Community Mental Health Team (OPCMHT)		▷	▷	70%	Green – Project on track

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

Project Description

Project Sponsor	Project Manager
David Aitken	Lorriane Currie

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Service Review has now worked through stages up to options appraisal. • Options are being prepared and worked up for presentation to Review Steering Group before being considered by SMT/IJB.	• Preparation of initial Options Appraisal paper for Review Steering Group. • Submission to SMT/IJB

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

Benefits	

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	Other Intended Benefits			
£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)		▶	▶	75%	Green – Project on track

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

Project Description

Project Sponsor	Project Manager
David Aitken	Lorraine Currie

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Confirmation of NHS Lanarkshire position now received and final actions required to establish if there has been further amendment of local arrangements and financial framework as part of wider NHS GGC & Lanarkshire Service Level Agreement.	• Written confirmation from NHS Lanarkshire has now been received and further confirmation of boundary issues and financial framework to be finalised.

Reason for RAG Status

Nothing additional which requires escalation at this time.

Benefits

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

Drivers for Change

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

PROJECT RAG STATUS UPDATE

Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-13 Conclude the planning and operationalisation of the West of Scotland Adolescent Intensive Psychiatric Care Unit (IPCU)		⚠️	⚠️	40%	Amber – Project at risk

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

Project Description

Project Sponsor	Project Manager
Andrea Blair	Jackie Hardie

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• There are several ongoing reviews concerning adolescent inpatient care. The 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. • 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. The allocated IPCU budget for 2025/26 is primarily directed towards 15.2 WTE Band 5 nurses, who will be recruited to develop their skills and competencies and will be placed in Skye House at present; to date, 11 WTE have been successfully recruited.	• In Quarter 4, we expect the tri-regional review of adolescent inpatient units to report by year-end, and its findings will inform future delivery models in line with the Mental Health Strategy and the Service Renewal Framework. Recruitment will continue using the IPCU budget for 15.2 WTE Band 5 nurses, currently placed in Skye House. To date, 11 WTE have been recruited, with efforts ongoing to complete the staffing plan.

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

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-14 Conclude the planning and operationalisation of a West of Scotland (WoS) Regional Planning Regional Forensic and Secure Care CAMH services	▶	▶	70%	Green – Project on track

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

Project Description

Project Sponsor	Project Manager
Andrea Blair	Jackie Hardie

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• A standard reporting template for Regional FCAMHS 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. • Requests were submitted to the Vacancy Group to extend current fixed-term posts by a further six months while longer-term funding is confirmed. • A Band 8A FCAMHS Co-ordinator Job Description developed and shared with Regional Planning Team. • Unable to fully recruit remaining team members until funding confirmed. • Secure Care Pathway service delivery continued throughout Quarter 3. A reporting template was developed with reporting to the Regional Alliance via the Regional Planning Team. Draft pathway standards were developed and will be shared with the Regional Alliance for approval.	• Further develop training with 3 x 2 sessions for 3 training workshops Jan/Feb/March. Total training is 10 sessions per spoke in total. Then 10 extra sessions for development support / developing local links and pathways.

Reason for RAG Status

There are no significant risks or issues at this time.

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

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

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP–25–18 Bishopbriggs Premises – progress approved property redesigns in 2025/26	⚠️	✅	100%	Project 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
• Following a further delay, Site Handover/practical completion date of 07.11.25 • Operational Opening and clinical appointments for patients on Monday 01.12.25	• Site operationally opened • Some residual snagging remains, ongoing following works of 17.01.26, but does not impact operational use

Reason for RAG Status
• Update Report to IJB on 22.01.26

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	⚠️	⚠️	75%	Amber – Project at risk

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 been instructed to visit site and inspect premises and value site. • East Dunbartonshire has also been proposed a site for a possible Health and Care Facility via Infrastructure investment through Scottish Government pipeline. Await update via NHS Capital Planning and Property Team.	• Valuation from District Valuer, as well as Feasibility Costs review to see if a viable project. • Update from NHS Capital and Property Team on possible investment into an East Dunbartonshire Health and Care Facility.

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

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

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

PROJECT RAG STATUS UPDATE

Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-20 Review summary business cases for Woodlands and Milngavie Clinic		⚠	⚠	60%	Amber – Project at risk

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 held for both sites pending progress of investigations into a Milngavie site and discussions with Capital Planning/Property re East Dun being proposed as a site for a Health and Care Facility. • Woodlands Feasibility paused pending discussions re East Locality accommodation requirements.	• 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					
There are no significant risks or issues at this time.					
Benefits					
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	Other Intended Benefits			
Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-21 Refresh Digital Strategy in line with the new Strategic Plan 2025-30	▷	✅	100%	Project Complete
Original Project End Date	Forecast Project End Date		Date of last project board	
31-Mar-2026	31-Mar-2026		21-Jul-2025	
Project Description				
Project Sponsor		Project Manager		
Alison McCready		Andy Craig; Alison Willacy		
HIGHLIGHT REPORT				
Actions completed within the last reporting period		Actions planned in the Next Reporting Period		
• HSCP Digital Strategy approved by IJB on 13th November.		• Digital Health & Care Strategy Board to develop workplan.		
Reason for RAG Status				
There are no significant risks or issues at this time.				

Benefits			
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	Other Intended Benefits	
Drivers for Change			

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✅	✅	✅	✅	❌	✅

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-22 Continued delivery of East Dunbartonshire components of the GGC Unscheduled Care Joint Commissioning Plan		⚠️	⚠️	0%	Amber – Project at risk
Original Project End Date	Forecast Project End Date		Date of last project board		
31-Mar-2026	31-Mar-2026				
Project Description					
Project Sponsor			Project Manager		
Kathleen Halpin			Fiona Munro; Alison Willacy		
HIGHLIGHT REPORT					
Actions completed within the last reporting period			Actions planned in the Next Reporting Period		
• GGC Unscheduled Care delivery plan has not been ratified due to the emerging transformation agenda.					

• Actions that had been included within the Unscheduled Care delivery plan aligned with the HSCP frailty workstream and has continued to align. • HSCP are working closely with GGC on the local contribution to urgent and unscheduled care planning.	

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

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

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

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-23 Complete the Review of the Care Home Support Team	▷	✅	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					
There are no significant risks or issues at this time.					
Benefits					
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	Other Intended Benefits			
Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
	✔		✔		

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-24 Undertake a test of change in relation to enhanced multi-disciplinary working in health and community care		▷	▷	75%	Green – Project on track
Original Project End Date	Forecast Project End Date	Date of last project board			
31-Mar-2026	31-Mar-2026				
Project Description					
Project Sponsor			Project Manager		
Kathleen Halpin			Fiona Munro		
HIGHLIGHT REPORT					
Actions completed within the last reporting period			Actions planned in the Next Reporting Period		

• Pathways are embedded in practice for MDT teams to access geriatricians for complex frailty.	• Analysis of data to be undertaken with QEUH geriatricians to measure outcomes in relation to prevention of hospital admission

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

Benefits		

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

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

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-25 Review and refresh the HSCP Medium-Term Financial Strategy (MTFS)		▶	▶	15%	Green – Project on track
Original Project End Date	Forecast Project End Date		Date of last project board		
31-Mar-2026	31-Mar-2026				
Project Description					
Project Sponsor			Project Manager		
Alison McCready			Anne Getty; Fiona Shields		
HIGHLIGHT REPORT					
Actions completed within the last reporting period			Actions planned in the Next Reporting Period		

• Refreshing the MTFS is contingent on finalising the budget for 26/27 which is well underway and should conclude next month. • Once the budget is finalised and approved, that will form the basis of the MTFS.	• Continue negotiations with funding organisations re budget settlements • Develop 2026/27 savings programme with assigned owners • Conclude 2026/27 budget and obtain IJB sign-off informing the MTFS.

Reason for RAG Status

There are no significant risks or issues at this time.

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

Drivers for Change

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

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-26 Implement focussed programme of de-prescribing and realistic medicine	▶	▶	75%	Green – Project on track

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

Project Description

Project Sponsor	Project Manager
	Carolyn Fitzpatrick

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period

• Deprescribing training now complete. • Practices are now implementing actions of repeat prescribing LES. • Deadline for Practice task completion end of March 2026.	• Continue to support practices whilst they work towards completion of actions required for repeat prescribing LES (deadline March 2026).

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

Benefits	
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	Other Intended Benefits
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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	▶	▶	75%	Green – Project on track
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
• Project Board session held to analyse outputs from Working Groups. 1-2 groups pending, which will be future implementation actions for the review. • Options Appraisal underway via Project Board members.	• Options completed for review, by Project Board • Options Appraisal and Impact Assessment taken to Governance Forums, SMT, FSPG, Staff Partnership and with Business Support/Service Leads

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

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

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

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-28 Review of HSCP Management Structure	▶	✅	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	
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 reported to the IJB on 19th December 2025. • IJB approved the operating model and the new leadership structure. • An implementation group is being convened and recruitment/matching will commence to populate the new structure, in partnership.	• Recruitment/matching will commence to populate the new structure, in partnership.

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

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

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

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**RAG Status**
HSCP-25-29 Service Review of Adult Social Work Services	▶	▶	75%	Green – Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**		
31-Mar-2026	31-Mar-2026			
Project Description				
Project Sponsor		**Project Manager**		

David Aitken	Stephen McDonald

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Ten Stage review process has been followed and final work to prepare Options Appraisal Report and Template is now being completed for SMT and IJB consideration.	• Option appraisal to be completed • Presentation to SMT and IJB for approvals

Reason for RAG Status

There are no significant risks or issues at this time.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	Other Intended Benefits	
£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 completed an submitted to IJB in January.	

Reason for RAG Status

There are no significant risks or issues at this time.

Benefits

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

Drivers for Change

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

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	RAG Status
HSCP-25-31 Review supervision policies and practises, and develop standards aligned with values such as empowering people, self-management, shared decision-making, and co-production within Specialist Children's Services	▶	▶	70%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board	

31-Mar-2026	31-Mar-2026	

Project Description

Project Sponsor	**Project Manager**
Andrea Blair	Andrea Blair

HIGHLIGHT REPORT

Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• The monitoring strategy is currently being agreed upon. • Staff survey and guideline audit have been completed, documented, and feedback has been provided.	• Implement monitoring strategy.

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

Benefits	

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

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
	✅		✅		

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**13th MARCH 2026**
REPORT REFERENCE:	**PERF/130326/07**
CONTACT OFFICER:	**ANDREA BLAIR, GENERAL MANAGER SPECIALIST CHILDREN'S SERVICES**
SUBJECT TITLE:	**JOINT UNANNOUNCED INSPECTION TO SKYE HOUSE IN AUGUST 2025**

1.0 PURPOSE

1.1 The purpose of this report is to provide an update on a joint unannounced inspection of Skye House in August 2025, carried out by the Mental Welfare Commission for Scotland and Healthcare Improvement Scotland.

2.0 RECOMMENDATIONS

2.1 It is recommended that the Performance Audit and Risk (PAR) Committee;
- notes the report on the joint unannounced visit / safe delivery of care inspection to Skye House in August.
- notes the findings relating to areas of good practice, areas for improvement, and the requirements that NHS Greater Glasgow and Clyde must prioritise to meet national standards.
- notes the accompanying Improvement Action Plan, outlining the planned actions to be taken forward in response to the inspection.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0   BACKGROUND/MAIN ISSUES

3.1   The Minister for Social Care, Mental Wellbeing and Sport committed to addressing the serious concerns raised in the BBC documentary aired in February 2025 about young people's experiences in Skye House. In response, the Minister commissioned the Mental Welfare Commission for Scotland (the Commission) and Healthcare Improvement Scotland (HIS) to conduct inspections across all three young people's units in Scotland, as well as the children's inpatient psychiatric unit in Glasgow.

3.2   The commission and HIS conducted a six-day joint unannounced inspection of Skye House in August 2025. Skye House, located on the Stobhill Campus in Glasgow, is a 24-bed Tier 4 specialist Child and Adolescent Mental Health Inpatient Unit. Skye House is the regional unit for the West of Scotland, occassionally admitting young people from other regions when beds are unavailable locally.

3.3   Although the Commission and HIS employ different yet complementary approaches, HIS's scrutiny of systems, leadership, and governance at the macro level directly influences the care and treatment experienced at the microlevel, which is the statutory focus of the Commission. This collaboration aimed to provide enhanced, independent assurance of the unit.

SUMMARY OF JOINT FINDINGS AND NEXT STEPS

3.4   The report (Appendix 1) identifies eleven areas of good practice, including the introduction of a care manager role to coordinate young people's care and be key point of contact for young people's carers and families, availability of indoor and outdoor recreational facilities, and additional investment to significantly increase the nursing establishment and also review and increase the multidisciplinary team. The report also highlights increased senior nursing support, regular reflective practice for staff, and short-life working groups that have helped drive targeted improvement activity.

3.5   Alongside these positive findings, the report outlines nine areas for improvement. These include concerns around aspects of staff culture, longstanding staffing gaps, and the need for clearer compliance with the Mental Health (Care and Treatment) (Scotland) Act 2003. Further improvements are required in mandatory training, the consistency of restraint recording, the filling of the social work vacancy, and the quality and audit of care plans and risk assessments. Additional areas identified include the development of a seclusion policy and routine offering of advance statements as part of discharge planning.

3.6   The report also sets out sixteen priority requirements that NHS Greater Glasgow and Clyde must address to meet national standards. These focus on ensuring compliance with child and adult protection responsibilities, strengthening fire safety, and implementing a robust multidisciplinary workforce model. Other key requirements include protected leadership time for appraisals, improved access to clinical supervision, timely learning from adverse events, stronger governance of policies, and improvements to meaningful activity, mealtime support, dietetic provision, care documentation and infection-control standards. Ongoing maintenance of the ward

environment—including signage, heating, privacy and dignity within Skye House—is also required.

3.7 The Commission and HIS expect NHS Greater Glasgow and Clyde to address all of the requirements and areas for improvement. The NHS board must prioritise the requirements to meet national standards. An Improvement Action Plan (Appendix 2) has been developed by the NHS board.

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 – 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 The improvement plan requirement is to be completed within 18 weeks and requires concentrated focus from the whole team. There is a risk that the time frame is

challenging to complete whilst delivering day to day operations. This will be monitored and tracked weekly to ensure progress is on schedule and drift identified timeously.

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 – Report on the joint unannounced visit / safe delivery of care inspection Skye House August 2025

Joint report Skye House, August 2025.pdf

8.2   Appendix 2 – Improvement Action Plan Skye House August 2025

Improvement Action Plan

Healthcare Improvement Scotland and Mental Welfare Commission:
Unannounced Safe Delivery of Care Inspection and Visit to
Child and Adolescent Mental Health Service Inpatient Units.

Skye House, NHS Greater Glasgow and Clyde, August 2025

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature:

Full Name: Dr Lesley Thomson KC

NHS board Chief Executive

Signature:

Full Name: Professor Jann Gardner

Date: **12th February 2026**

Date: 12th February 2026

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
Improvement 1	**Culture: significant concerns were raised in relation to the attitudes of some staff, both permanent and supplementary. While this was reported to Skye House managers at the time of our visit and action taken, this is an issue that requires ongoing investment in culture change. This includes supporting colleagues who witness and hear such attitudes to not tolerate but to address this behaviour directly with their peers** Senior team members will attend active bystander training to support development of whole staff team in relation to peer challenge Civility saves lives champions will be embedded within Skye House	June 2026 May 2026 February 2026	Inpatient Service Manager/ Professional leads		

	Skye House has developed for bank staff a more specific Skye House induction including what the expectations of working within Skye House are in terms of values and attitudes.	December 2026			
	Neurodevelopmental sponsorship group commenced to support neuroaffirming practice across the team focusing on young person journey, adult talk with young people, family involvement, care decisions and build environment	February 2026			
	Meetings in Skye House have now a built in point for reflection and multiple perspective to enable perspectives to be heard, understood, explored and challenged.	February 2026			
	Safety Climate survey scheduled to take place in February for young people and staff benchmarking current position	May 2026			
	SCS focus on culture will be part of staff development days in May 2026.	June 2026			

	Supervision focus across team and monitoring of frequency in line with NHSGGC policy				
Improvement 2	**There are long standing gaps in staffing at Skye House. Whilst the recent reported commitment to increase nurse staffing levels at Skye House is welcome, implementation and impact underpinned by a robust workforce model is required.** Additional staffing has been agreed across professional groups within Skye House. 11 wte additional nurses are in post with 6 wte at advertisement. Additional MDT posts have been advertised: Dietetics, Psychology, SLT, Art therapy and occupational therapy posts have been interviewed for in January 2026 and appointed to. Additional activity coordinator commences at the beginning of February 2026. A tri-regional review has been commissioned by the Chief Executives	August 2026 May 2026 February 2026 May 2026	Inpatient Service Manager / SCS General Manager/ Chief Officer		

			Inpatient Service Manager/ Clinical Director		
Improvement 3	**Authority to treat young people should be in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003. Lawful practice and understanding of roles and responsibilities has yet to be embedded at Skye House. There is a need to implement a robust system of audit involving the multidisciplinary team.**		Inpatient Service Manager/ Clinical Director		
	There is an established weekly meeting to review all medication paperwork. There is a formal annual audit of medication paperwork. There is weekly monitoring of legal documentation. A review of all these processes with the MDT will be undertaken to ensure adherence to legal authority to treat.	April 2026.			
	The service are seeking ongoing dialogue regarding Authority to treat	February 2026			

	and roles with the Mental Welfare Commission to understand the differences highlighted and agree a way forward.				
Improvement 4	**NHS Greater Glasgow and Clyde should consider adding self-harm and suicide prevention training to mandatory training for Skye House staff.** NHSGGC offer an annual half day's training which is an update on the literature and best practise around suicide and self-harm across Specialist Children's Services. It utilises resources provided by NHS Education Scotland and any updated literature / practise that have occurred throughout the year. This is recorded and available to staff via a Teams channel. Skye House will build this into all staff pdp and ensure time is released to attend in person or via digital access.	June 2026	Inpatient Service Manager and professional leads		
Improvement 5	**Restraint recording requires to be consistent in terms of numbers and detail. Multiple restraints need to be**		Inpatient Service Manager		

	recorded as such to avoid under-reporting. Datix (which is the incident management system) has been a focus of development within Skye House in January 2026 to ensure accuracy and detail of completion. Over the next 8 weeks focus will be on reporting incidents separately rather than within one incident and reviewed in incident reporting group to ensure change in recording to single incidents.	March 2026.			
Improvement 6	**Social work vacancy: this vacancy requires to be filled and there needs to be understanding of the value of the social work contribution. This will also enhance understanding of child and adult support and protection practice and reporting**. Rather than there being a vacancy within Skye House a new role has been created as part of workforce development which is a social work role. This was not present previously. Currently the job description is being agreed and will then be advertised in	June 2026	Inpatient Service Manager		

	Spring 2026. It would be anticipated the postholder will commence by June 2026.				
Improvement 7	**The quality of care plans and risk assessments/risk management plans need to improve and be subject to regular audit. (linked to requirement noted below)**				
	There is a short life working group on care planning focused on nursing standards in relation to 72 hour assessment, named nurse and assessment.	April 26			
	There is an audit of nursing care plans every 3 months using MCAAT and at present a monthly audit of care plans against specific standards including young person voice in care plans, family involvement, MDT voice and that the young person has a copy of plan.	March 26			
	A young person friendly care plan has been developed and implementation plan in development	March 26			

	Risk assessment training included in induction of new staff in October 25 and for all new staff to future.	Complete			
	Nursing improvement project – to support case note standards, Datix and risk management plan within face caras a short life working group has commenced with implementation in May 2026 with audit process built in.	May 2026			
	MDT Fortnightly review of risk assessments. Open ward is reviewed weekly and risk profile updated standard dependent on change in risk profile.	March 2026			
	Risk management plans – a review will be undertaken in terms of risk management across the unit and improvement plan developed	May 2026			

Improvement 8	**An NHS Greater Glasgow and Clyde seclusion policy needs to be in place to underpin the use of seclusion at Skye House.** A review of any policy gaps in relation to restrictive practice has commenced with a commitment to least restrictive practice at all times. Any gaps will then result in policy development and seclusion will be considered in this.	June 2026	Mental Health Policy Manager		
Improvement 9	**Anyone has a right to make an advance statement, and we recommend that Skye House build the offer of an advance statement into practice when the person is well, as part of discharge planning** Skye House will within the care pathway process ensure and demonstrate advanced statements are considered with the young person, carer and community team supported by advocacy services.	April 2026	Inpatient Service Manager		
Requirement 1	**NHS Greater Glasgow and Clyde must ensure that all staff are aware of their responsibilities in relation to child protection and adult support and**				

	protection and, safeguarding policy and legislation is followed when there is evidence of harm and/or immediate risk. All staff will have completed the mandatory training module on public protection All registered staff should complete Public Protection level 3 roles and responsibilities training	March 2026 September 2026			
Requirement 2	**NHS Greater Glasgow and Clyde must ensure all improvement actions within fire risk assessments are completed, fire safety equipment is tested and maintained within required timeframes and staff are trained in fire evacuation procedures (see page 31).** The fire door survey has been completed as per the recommendation of the fire risk assessment. The Estates department is reviewing the survey and will action accordingly. The fire extinguishers have also been assessed and replaced.	March 2026	Estates Manager		

			Inpatient Service Manager		
	Fire evacuation planned twice per year to ensure staff have experience of evacuation	March 2026/ August 2026			
Requirement 3	**NHS Greater Glasgow and Clyde must ensure that a robust multidisciplinary workforce model is implemented to promote patient and staff safety (see pages 25 and 34).**	August 2026	Inpatient Service Manager / Head of Tier 4 Services/ SCS General Manager/ Chief Officer		
	Additional staffing has been agreed across professional groups within Skye House. 11 wte additional nurses are in post with 6 wte at advertisement. Additional MDT posts have been advertised: Dietetics, Psychology, SLT, Art therapy and occupational therapy post have been interviewed for in January 2026 and appointed to.	May 2026			
	Additional activity coordinator commences at the beginning of February 2026.	February 2026			
	A tri-regional review has been commissioned by the Chief Executives responsible for the regional units and	May 2026			

	led by Scotland West. This will report in Early 2026 and inform the model for regional units going forward which will then direct sustainable safe workforce requirements.				
Requirement 4	**NHS Greater Glasgow and Clyde must ensure clinical leaders are provided with adequate time to lead and ensure the timely completion of staff appraisals (see page 34).** Within the workforce development a number of posts identified and being recruited to are to provide leadership across professional groups to ensure compliance with Health and Care (Staffing) (Scotland) Act 2019 in relation to duty of Time to lead. Turas completion rates are monitored monthly and all staff at work will have Turas in place by May 26. Bed reduction to 16 beds have occurred to enable duties within Health and Care (Staffing) (Scotland) Act 2019 to be met including time to lead.	April 2026 May 2026 Complete August 2026	Inpatient Service Manager/ Professional leads		

	Senior nursing staff will attend ready to lead programme				
Requirement 5	**NHS Greater Glasgow and Clyde must enable staff to be supported to attend clinical supervision and reflective practice (see page 37).** For nursing additional supervisors have been allocated. The Health care support workers are offered group supervision. All new staff will attend the NES supervision training to develop their knowledge in supervision, supervision structure and be supported to develop as supervisors. For nurse line management there is an agreed template to record this and allocated staff and will be carried out in line with NHSGGC policy and audited through monitoring process. A monitoring process has been developed and will be implemented to ensure regular monitoring of attendance in line with NHSGGC policy on supervision and reflective practice across professional groups.	June 2026 March 2026 April 2026	Inpatient Service Manager and Professional Leads		

Requirement 6	**NHS Greater Glasgow and Clyde must ensure timely review and implementation of lessons learned from reported incidents including significant adverse events (see page 39).**		Lead for Governance, Clinical Director and Inpatient Service Manager		
	NHSGGC have put in place a robust process of all overdue SAERs to ensure completion of SAERS and learning from events is integrated in a timely way.	February 2026			
	There is a weekly decision making process for all adverse events to be reviewed in line with NHS GGC policy for managing adverse events and review progress of Adverse Event reviews ongoing.	Complete and in place			
	There is a monthly review of all Datix themes within the Incident review group , learning would be shared in team meeting.	Complete and in place			
	Learning from SAERS related to Skye House are fedback to the staff team through team meetings and action plan	May 2026			

	developed which is monitored through the SCS SAER group.				
Requirement 7	**NHS Greater Glasgow and Clyde must ensure effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use (see page 40).** NHSGGC is currently undertaking a review of the Policy Development Framework which provides the framework for all policy development and revision in NHSGGC to ensure a robust framework for the development, approval and management of policies and other associated documents in line with the approach to Active Governance.	April 2026. April 2026	Corporate Services Manager/ Lead for Governance in SCS		
	Specific clinical guidance documents are the responsibility of each service and a review of all documents will be undertaken to ensure these are in date.				

Requirement 8	**NHS Greater Glasgow and Clyde must ensure meaningful activity is consistently provided, including evenings and weekends (see pages 20 and 43).**	February 2026	Inpatient Service Manager		
	NHSGGC recognises the importance of meaningful occupation and activity in relation to recovery. As part of workforce development two activity coordinators will work over a 7 day period including evenings and weekends commencing in February 2026. Activities offered will be personalised to young people's interest and preference enabling young people to have positive experiences building on their strengths and interests.				
Requirement 9	**NHS Greater Glasgow and Clyde must ensure adequate provision of mealtime support, therapeutic environment during mealtimes and a full range of dietary options (see page 49).**	June 2026	Dietetic Professional Lead, Occupational Therapy Professional Lead, Professional Nurse Lead and Inpatient Service Manager		
	NHSGGC has undertaken a review of dietary options and provision based on feedback received. There is a clear				

	developed plan in place to ensure appropriate provision of meals which will be monitored by the Lead dietician in liaison with facilities team. There are a range of spaces available to young people to support mealtimes which will be utilised dependent on personalised needs. Mealtime support training is currently being reviewed by clinical leaders across professional groups to ensure training and development is standardised and competency based				
Requirement 10	**NHS Greater Glasgow and Clyde must ensure robust processes are in place to provide adequate dietetic cover (see page 49).** There is a weekly timetable of dietetic availability developed to ensure dietetic cover for the ward NHSGGC as part of workforce development put in place two further dietician roles with one being interviewed in January and a further post anticipated to be interviewed in February. This is in recognition of the	Complete April 2026.	Dietetic Professional Lead and Inpatient Service Manager		

	increase in use of beds to support young people who ae experiencing an eating disorder and the necessary role of dietetics in care planning and intervention to support recovery.			
Requirement 11	**NHS Greater Glasgow and Clyde must ensure that:** ***all young person's care documentation is accurately and consistently completed and reviewed appropriately** ***young people and their families are involved in planning their care, and that this is clearly documented** ***there is a system in place to identify young people if they are unable to confirm their name and date of birth themselves during medication administration (see pages 5 and 55).**		Inpatient manager/ professional leads	
	There is an established cycle of case note audit across all professional groups with improvement plans developed following audit.	Annual audit as minimum		
	Nursing improvement project – to support case note standards, Datix and	May 2026		

	risk management plan within face caras a short life working group has commenced with implementation in May 2026 with audit process built in.				
	There is a Short life working group on care planning focused on nursing standards in relation to 72 hour assessment, named nurse and assessment.	April 2026			
	There is an audit of nursing care plans every 3 months using MCAAT and at present a monthly audit of care plans against specific standards including young person voice in care plans	February 2026			
	A young person friendly care plan has been developed	March 2026			
	Risk management – Datix training has been the focus in January as part of assurance of Datix.	March 2026			
	Hepma – if a young person does not consent to a photograph being stored on HEPMA then a description has been	Completed			

	added – this has now occurred for all young people.				
Requirement 12	**NHS Greater Glasgow and Clyde must ensure all staff are compliant with the safe management of linen and appropriate wearing of jewellery (see page 56).**		Senior Charge Nurse		
	All nursing staff will complete Learn pro module GGC:178 Segregation of Waste and Linen. This will also be included in induction of all new nursing staff. 80% of staff in scope and at work will have completed by May 2026.	May 2026			
	The Standard Infection Control Precautions Audit includes linen management and will be completed in March 2026, results will be reviewed and action plan developed accordingly	March 2026			
	Hand hygiene is a monthly audit to ensure compliance with standard. These will be monitored monthly.	Monthly			
	Uniform policy is a monthly audit at Skye House and daily leadership on each shift in relation to uniform	Monthly			

	compliance which includes jewellery occurs. There is a wider external audit throughout Mental health with non-planned audits occurring.				
Requirement 13	**NHS Greater Glasgow and Clyde must ensure adequate oversight and cleaning schedules for windows including window mesh (see page 56).** The Estates department has agreed annual contract with an identified a supplier and actioned that this is put in place for all windows in Skye House where mesh is present.	June 2026	Estates Manager		
Requirement 14	**NHS Greater Glasgow and Clyde must ensure measures are put in place to ensure regular maintenance and timely repair of heating systems (see pages 22 and 57).** Estates are procuring a specialist underflooring heating provider to service the heating based on feedback to date. Estates will link with the Energy team within NHSGGC for regular and routine monitoring through remote monitoring.	April 2026	Estates Manager		

Requirement 15	**NHS Greater Glasgow and Clyde must ensure there is clear signage in place when entry and exits to wards are locked as per NHS Greater Glasgow and Clyde policy (see page 60).** NHSGGC have a Policy on Locked doors. Implementation of that policy will be refreshed with the team to ensure all elements of policy are adhered to including clear signage when in use. This will occur through team meetings, handovers and nursing meetings. When the locked door policy is in place an audit of compliance with policy will occur.	March 2026 – June 2026.	Inpatient Service Manager/ Senior charge nurse		
Requirement 16	**NHS Greater Glasgow and Clyde must ensure the Skye House building environment, including visiting areas, is monitored and maintained including to promote privacy and dignity (see page 60).** As part of the workforce development a post has been developed to support the management of the build environment. The postholder is in post and a	June 2026	Inpatient Service Manager/ Estates Manage		

	programme of areas to be addressed has been developed. Introduction of a monthly walk arounds with estates team have been developed to ensure all building issues are identified and addressed in a timely manner. In relation to specific toilet doors this work has been undertaken based on feedback given.	April 2026 Complete			

	Chief Officer **Derrick Pearce** **AGENDA ITEM NO: 08.**

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**13th MARCH 2026**
REPORT REFERENCE:	**PERF/130326/08**
CONTACT OFFICER:	**ANDREA BLAIR, GENERAL MANAGER SPECIALIST CHILDREN'S SERVICES**
SUBJECT TITLE:	**JOINT UNANNOUNCED INSPECTION OF NATIONAL CHILD PSYCHIATRY INPATIENT UNIT – WARD 4, IN AUGUST 2025**

1.0   PURPOSE

1.1   The purpose of this report is to provide an update on a joint unannounced inspection of the National Child Psychiatry inpatient Unit (Ward 4) at the Glasgow Royal Hospital for Children on two days in August 2025, carried out by the Mental Welfare Commission for Scotland and Healthcare Improvement Scotland.

2.0   RECOMMENDATIONS

2.1   It is recommended that the Performance Audit and Risk (PAR) Committee;
- notes the report on the joint unannounced visit / safe delivery of care inspection to National Child Psychiatry inpatient unit in August 2025.
- notes findings relating to areas of good practice, areas for improvement, and the requirements that NHS Greater Glasgow and Clyde must prioritise to meet national standards.
- notes the accompanying Improvement Action Plan, outlining the planned actions to be taken forward in response to the inspection.

DERRICK PEARCE
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0   BACKGROUND/MAIN ISSUES

3.1   The Minister for Social Care, Mental Wellbeing and Sport committed to addressing the serious concerns raised in the BBC documentary aired in February 2025 about young people's experiences in Skye House. In response, the Minister commissioned the Mental Welfare Commission for Scotland (the Commission) and Healthcare Improvement Scotland (HIS) to conduct inspections across all three young people's units in Scotland, as well as the children's inpatient psychiatric unit – Ward 4, in Glasgow's Royal Children's Hospital.

3.2   The Commission and HIS conducted a two-day joint unannounced visit / inspection of the National Child Psychiatric Inpatient Unit (hereafter referred to as Ward 4) in August 2025.

3.3   The unit, based in Ward 4 of the Royal Hospital for Children in Glasgow, provides flexible inpatient psychiatric care for children aged 5–11 with severe and complex mental health needs, including those with neurodevelopmental conditions, physical health issues and complex psychosocial factors. Although primarily for children under 12, those over 11 may be admitted when clinically appropriate, such as in cases of developmental delay. As a national service, referrals are accepted from all Scottish Health Boards.

3.4   Although the Commission and HIS employ different yet complementary approaches, HIS's scrutiny of systems, leadership, and governance at the macro level directly influences the care and treatment experienced at the microlevel, which is the statutory focus of the Commission. This collaboration aimed to provide enhanced, independent assurance of Ward 4.

SUMMARY OF JOINT FINDINGS AND NEXT STEPS

3.5   The report (Appendix 1) highlights strong practice within Ward 4, noting that previous recommendations made by the Commission have been addressed and that the multidisciplinary team feels valued, supported and able to deliver high-quality, individualised care. Importantly, young people and families reported positive, person-centred experiences, reflected in respectful interactions, tailored information and lawful, well-planned care. A range of quality-improvement initiatives, such as talking mats, weekly community meetings, digital information resources and a Skills Sharing Network, are now embedded in practice, supported by recent expansion in psychology, occupational therapy, speech and language therapy, family therapy and nursing. The implementation of continuous intervention guidance and a trauma-informed debriefing approach further strengthens the therapeutic environment.

3.6   Alongside these strengths, the report identifies two areas for improvement: an NHS GGC seclusion policy needs to be in place to underpin the use of the seclusion room on Ward 4, and Ward 4 to build the offer of an advance statement into practice when the person is well, as part of discharge planning.

3.7   The report sets out five requirements that NHS Greater Glasgow and Clyde must prioritise to meet national standards. These include ensuring all improvement actions

within fire-risk assessment are completed, ensuring effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up-to-date guidance is in use, and ensuring all staff who administer rapid tranquillisation have completed immediate life-support training or equivalent. NHS Greater Glasgow and Clyde must also ensure that rooms used for seclusion meet the Quality Network for Inpatient CAMHS standards, and that all documentation, such as nutritional and fluid charts, care-plan reviews and risk assessments, is completed consistently.

3.8 The Commission and HIS expect NHS Greater Glasgow and Clyde to address all of the requirements and areas for improvement. The NHS board must prioritise the requirements to meet national standards. An Improvement Action Plan (Appendix 2) has been developed by the NHS board to be implemented in response to the inspection.

4.0   <u>IMPLICATIONS</u>

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 – 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   The improvement plan may not be completed in 18 weeks where there is dependent actions from wider services. Improvement actions are being tracked weekly and escalation built in to highlight any drift in timescales.

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** – Report on the joint unannounced visit / safe delivery of care inspection National Child Psychiatry Inpatient Unit – Ward 4 August 2025

Joint report NCPIU Ward 4, August 2025.pdf

8.2   **Appendix 2** – Improvement Action Plan Royal Hospital for Children, NHS GGC August 2025

Improvement Action Plan

Healthcare Improvement Scotland and Mental Welfare Commission: Unannounced Safe Delivery of Care Inspection and Visit to Child and Adolescent Mental Health Service Inpatient Units.

Royal Hospital for Children, NHS Greater Glasgow and Clyde - 18-19 August 2025

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature:

Full Name: Dr Lesley Thomson KC

NHS board Chief Executive

Signature:

Full Name: Professor Jann Gardner

Date: **15th January 2026**

Date: **15th January 2026**

File Name: 2025-12-16 NCPIU Ward 4 Improvement Action Plan v.01	Version: 0.1	Date: 21/01/2026
Produced by: HIS/NHS GGC	Page: Page 1 of 6	Review Date: -
Circulation type (internal/external): Internal and external		

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
Improvement 1	**An NHS Greater Glasgow and Clyde seclusion policy needs to be in place to underpin the use of the seclusion room on Ward 4.** A review of any policy gaps in relation to restrictive practice has commenced with a commitment to least restrictive practice at all times. Any gaps will then result in policy development and seclusion will be considered in this.	December 2026	Mental Health Policy Manager		
Improvement 2	**Anyone has a right to make an advance statement, and we recommend that Ward 4 build the offer of an advance statement into practice when the person is well, as part of discharge planning.** Ward 4 will within the discharge planning process ensure advanced statements are considered with the child, carer and community team.	March 2026	Senior Charge Nurse and Responsible Medical Officer within NCIPU		

Requirement 1	**NHS Greater Glasgow and Clyde must ensure all improvement actions within fire risk assessments are completed to include but not limited to repair and replacement of defective fire doors (see page 22).** There is a programme of work across QEUH/ RHC site to address identified areas in line with Fire risk assessments which includes but is not exclusive to fire doors. The specific fire door project is programmed to run until June 2028. All existing fire doors are subject to inspection and repaired as necessary to maintain the fire integrity of the hospital. As per the draft report, Senior managers have advised that Ward 4 does not have any current outstanding actions from the fire risk assessment.	June 2028	Site Manager Estates		
	NHS Greater Glasgow and Clyde must ensure effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use (see page 34).	April 2026	Corporate Risk Manager/ Lead for Governance SCS		

	NHSGGC is currently undertaking a review of the Policy Development Framework which provides the framework for all policy development and revision in NHSGGC to ensure a robust framework for the development, approval and management of policies and other associated documents in line with the approach to Active Governance. Specific clinical guidance documents are the responsibility of each service and a review of all documents will be undertaken to ensure these are in date.			
	NHS Greater Glasgow and Clyde must ensure all staff who administer rapid tranquillisation have completed immediate life support training or equivalent (see page 35). All ward 4 trained nursing staff will be trained in immediate life support training. This has already commenced.	March 2026	Senior Charge Nurse	
	NHS Greater Glasgow and Clyde must ensure that rooms used for seclusion	June 2026	Senior Charge Nurse and Responsible Medical	

	meet QNIC requirements (see page 14 and page 41). A scoping exercise benchmarking against QNIC standards will occur within ward 4 to identify suitable room(s). Practice guidance in relation to least restrictive practice will be developed in the context of seclusion being used only when all other means of behavioural support have been utilised and in line with the Mental Health Act.		Officer and Service Manager within NCIPU	
	NHS Greater Glasgow and Clyde must ensure that all documentation is completed consistently, including nutritional fluid charts, care plan reviews and risk assessments (see page 42). There is a standardised audit twice a year which will continue to monitor compliance in line with professional standards. In addition, a local weekly audit led by the Senior Charge Nurse will be put in place to support improvement over the next 8 weeks	April 2026.	Senior Charge Nurse with NCIPU	

	targeting areas highlighted. CPD on documentation and record keeping focused on completion of areas highlighted will occur.			

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**13 MARCH 2026**
REPORT REFERENCE:	**PERF/130326/09**
CONTACT OFFICER:	**DAVID AITKEN, HEAD OF ADULT SERVICES/CHIEF SOCIAL WORK OFFICER TELEPHONE NUMBER: 0141 232 8237**
SUBJECT TITLE:	**CARE INSPECTORATE INSPECTION REPORT EAST DUNBARTONSHIRE CARE AT HOME SERVICE**

1.0 PURPOSE

1.1 The purpose of this report is to provide the Committee with the outcome of the most recent unannounced inspection of the East Dunbartonshire Care at Home Service, which was published by the Care Inspectorate in January 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 unannounced inspection of the East Dunbartonshire Care at Home Service, which was published by the Care Inspectorate in January 2026.

3.2 The service provides support to people with a range of needs including physical and mental health conditions, dementia and palliative care, and at the time of inspection was providing a service to 403 people.

3.3 The inspection took place in November 2025 and evaluated the quality of our Care at Home Service using a six-point scale where 1 is unsatisfactory and 6 is excellent.

3.4 The Care Inspectorate undertook their inspection over four days and reached their evaluation decisions following the completion of interviews and surveys with adults who used our Care at Home service and their families/carers, interviews with staff and leadership team, direct practice observations, document review and evaluation from external professionals.

3.5 The inspection focussed upon the following four areas with the grades awarded indicated below (bold);

- 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**

3.6 The grades awarded represent an improvement on the previous inspection evaluation outcomes

3.7 Particular strengths were identified within the report and the key messages which were highlighted within the Care Inspectorate report are set out below;

- Carers were kind, respectful, and delivered person-centred care that reflected people's individual needs and preferences
- People and their families consistently spoke positively about the care they received, with high satisfaction reflected in survey responses
- Staff worked well together and supported each other to cover shifts, though scheduling for evenings and weekends remained a challenge
- Managers were approachable and responsive, using feedback and audits to drive improvements across the service
- Care plans and medication procedures had improved through regular reviews, training, and quality checks, helping to keep people safe.

3.8 From the previous inspection there were three Requirements and areas for improvement all of which had been met in full within timescales.

3.9 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.

3.10 The Committee are asked to note the contents of the report and the Inspection 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 <u>POLICY CHECKLIST</u>

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 <u>APPENDICES</u>

8.1 Appendix 1 – Care Inspectorate Report - Home Care Services - Mainstream Team January 2026

Home Care Services – Mainstream Team Housing Support Service

Kirkintilloch Health Care Centre
10 Saramago Street
Kirkintilloch
G66 3BF

Telephone: 01415 782 101

Type of inspection:
Unannounced

Completed on:
10 November 2025

Service provided by:
East Dunbartonshire Council

Service provider number:
SP2003003380

Service no:
CS2004082079

HAPPY TO **TRANSLATE**

About the service

Home Care Services - Mainstream Team provides care at home services to people living in the East Dunbartonshire local authority area. The service provides support to people with a range of needs including physical and mental health conditions, dementia and palliative care. It also has a small reablement team providing short term support, mainly to people discharged from hospital to maximise their independence. At time of inspection, they were providing a service to 403 people.

Their aims and objectives state that they will work alongside people, their family, and friends to work out what people want and need and develop a support plan which details how the carers will achieve the outcomes identified and support independence.

About the inspection

This was an unannounced inspection which took place on 4,5, 6 and 7 November. The inspection was carried out by three inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service.

 This included previous inspection findings, registration and complaints information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with 19 people using the service and sixteen of their family members. We evaluated survey results from 49 people and family members.
- spoke with 17 staff and management
- observed practice and daily life
- reviewed documents
- evaluated information from fifteen external professionals who had contact with the service.

Key messages

- Carers were kind, respectful, and delivered person-centred care that reflected people's individual needs and preferences.
- People and their families consistently spoke positively about the care they received, with high satisfaction reflected in survey responses.
- Staff worked well together and supported each other to cover shifts, though scheduling for evenings and weekends remained a challenge.
- Managers were approachable and responsive, using feedback and audits to drive improvements across the service.
- Care plans and medication procedures had improved through regular reviews, training, and quality checks, helping to keep people safe.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

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

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing?   5 - Very Good

This key question was evaluated as very good, because we saw important strengths in how the service supported people's health and wellbeing.

Carers were kind, respectful and paid close attention to people's individual needs. For example, one person living with dementia was supported gently and at their own pace. Staff checked their care plan and offered extra help, and their family member told us they were very happy with the care. Everyone we spoke to, including family members, had positive things to say about the carers. People receiving care described staff as caring, reliable, and attentive. One person said 'Staff are just really nice people, friendly. Nothing they could do better. what they do is good.' Many said they felt listened to and supported in a way that respected their choices and routines. One person said, 'They do it in a way I like, make me feel at ease'. Another person said 'They know my routine. The minute I get out of bed they know what to do next.' These comments echoed what we saw in practice and confirmed the positive impact of the care provided. This was also reflected in the survey results, which showed high levels of satisfaction. This means people were treated with dignity and felt safe and supported.

The service has introduced scheduled time slots for people receiving care, following a suggestion from the previous inspection. One person told us, 'We ask for a Sunday at nine and we always get that so we can go to church.' This approach was working well and helped improve clarity and consistency in how support was delivered.

Care plans were clear and personal, with good instructions for things like personal care, medication, and moving safely. Carers followed these plans and adapted their support to suit each person's preferences. For example, carers adapted shower routines to make people feel comfortable. Medication procedures had previously been inconsistent, but the service had made improvements. Staff now followed clearer guidance, audits were carried out regularly, and training had been updated. This means people were now supported more safely and reliably with their medication.

How good is our leadership?   5 - Very Good

This key question was evaluated as very good, because managers showed strong leadership and a clear commitment to continuous improvement of the service.

Managers were described as approachable and supportive. They knew their staff well and created a positive team culture. New carers were mentored by experienced staff, which helped build confidence and consistency. Regular team meetings were held to share information and get feedback from staff. Managers responded quickly to issues raised by staff, such as confusion around medication procedures, by organising meetings, updating training, and creating helpful guidance. One carer said 'Team meetings happen fairly often, we get to ask things and things get actioned. Really good if we raise concerns, very prompt to action and seniors update the care plan.' This meant staff felt listened to and supported.

The service had systems in place to check the quality of care, including audits of care plans and medication records. However, some serious incidents, such as medication errors, accidents, or adult protection concerns,

had not always been reported to the Care Inspectorate as required. Although these incidents had been evaluated by the service and action taken to keep people safe, it is the responsibility of leaders to make sure these are reported to the Care Inspectorate. Strengthening this process will help ensure the service is open and accountable.

(See area for improvement one).

Areas for improvement

1.

When staff report medication errors, accidents, incidents, or adult protection concerns to their supervisor, it is then the responsibility of leaders to notify the Care Inspectorate when required. This ensures the service is open and accountable.

This is in keeping with the Care Inspectorate's notification guidance as outlined in 'Adult Care Services: Guidance on records you must keep and notifications you must make' (March 2025)

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'I use a service and organisation that are well led and managed.'(HSCS 4.23)

How good is our staff team?   **4 – Good**

This key question was evaluated as good, because there were a number of strengths in staffing which outweighed areas needing improvement.

Staff were observed to be caring, confident, and professional in their work. They supported each other well and were observed to work well together in practice. One carer told us 'We all get on. Good place to work.' Daily meetings helped manage staffing and make sure care was delivered safely. However, scheduling carers for evenings and weekends was sometimes challenging, particularly when covering annual leave, sickness or training. One carer said, 'We cover too many shifts.' Managers had tried different shift patterns, but these hadn't solved the issue. The team continued to explore ways to make schedules more manageable for carers whilst ensuring people receive consistent support.

Training was a clear priority for the service, and the majority of staff had completed key courses such as dementia care and adult protection training. A training tracker was in place to monitor progress and expiry dates. However, some staff still needed refresher training, especially around medication. Staff were expected to report any medication errors, even if they happened during a previous visit, and to raise concerns with supervisors. Improving accountability in these areas will help make sure care is safe and that learning is shared across the team.

How well is our care and support planned?   4 - Good

This key question was evaluated as good as we found strengths in care planning which outweighed areas for improvement.

Many care plans were well written and included personal details, routines, and preferences. These helped carers understand how best to support each person. Plans were generally in line with national standards and showed that people's views had been considered. This meant people received care that was tailored to their needs.

However, standards were inconsistent. Some care plans were missing key information or had outdated information. For example, some lacked next of kin details or had incomplete personal profiles. Risk assessment documents were not always completed, however, care plans did contain detailed information about how people should be supported to keep them safe. Risk assessment recording was discussed with leaders, who agreed to review the process to ensure these were carried out consistently and documented, when they were required.

When risk assessments were completed, they were detailed and included input from professionals, but most did not have review dates or clear triggers for reassessment. Improving consistency in risk reviews and linking risk reduction to outcomes like dignity and independence would help ensure people continue to receive the right support as their needs change.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 12 August 2025 the provider must demonstrate that personal plans records accurately reflect needs.

In order to do this the provider must:

1. Each person has a person-centred plan that records in sufficient detail, their risks and assessed needs and how staff are to support them with that.
2. Evidence involvement of the person or their representatives to clearly identify goals and preferences.
3. Review and update the plan recording progress towards goals and any changes.
4. Have quality assurance systems that record staff demonstration of competency in revising support in accordance with the person's plan. Any deficits identified have a clear associated action plan.

This is in order to comply with: Regulation 5(1) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services)Regulations 2011(SSI 2011/210).

This is to ensure care and support is consistent with the Health and Social Care Standard 1.15:

'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices'.

This requirement was made on 26 June 2025.

Action taken on previous requirement

The service has taken effective action to meet this requirement. Personal plans were found to be person-centred and detailed, with clear documentation of assessed needs, associated risks, and support instructions. Risk assessment documentation was not always completed however the appropriate information was found in other sections of the plan. Plans showed evidence of involvement from people and/or their representatives, and reviews were carried out either six-monthly or in response to changes in need. This ensured that plans remained current and reflective of people's goals and preferences.

Quality assurance systems were in place to monitor care planning and staff competency. Audits identified areas for improvement, such as incomplete or outdated information and these were followed up with clear action plans. Staff observations were carried out by leaders, who observed staff referring to support plans during visits and delivering care in line with documented guidance. Supervision records confirmed that training, performance, and concerns were discussed and tracked. These systems provided assurance that care planning is responsive, and supports positive outcomes for people.

Met – within timescales

Requirement 2

By 12 August 2025, the provider must ensure that people are supported safely with their mobility and transfers, including where equipment is used.

To do this, the provider must, at a minimum:

a) every person who receives support with moving and handling has a clear record of the outcome of their assessment by a suitably qualified person determining the support they require.
b) review that record to reflect any changing need or level of risk.
c) ensure the moving and handling practice of staff is observed and evaluated regularly with records kept to evidence this.

This is in order to comply with: Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirement for Care Services) Regulation 2011(SSI 2011/210).

This is to ensure care and support is consistent with Health and Social Care Standard 3.14:

'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes'.

This requirement was made on 26 June 2025.

Action taken on previous requirement

All individuals receiving moving and handling support had detailed, person-centred assessments completed by a suitably qualified assessor. These assessments included environmental context, equipment needs, and agreement from the person and/or their representative. Risk ratings were clearly recorded and used to guide support.

A review process was in place, with carers reporting changes to seniors who arranged reassessments. Updated assessments were shared with staff to ensure they had the most up-to-date information.

Staff were observed using equipment safely, checking for damage, and offering reassurance during transfers. Competency observations confirmed that practice aligned with care plan guidance and supported both physical safety and emotional wellbeing. While most risk assessments lacked a specified review date or documented triggers for reassessment, the overall system ensured that people were supported safely and responsively.

Met – within timescales

Requirement 3

By 12 August 2025, the provider must ensure medication is managed in line with the organisational medication protocol so as to protect the health and wellbeing of people experiencing care. To do this the provider must:

1. Each individual has an accurate record of their assessed level of support they need to safely take their medication.
2. All staff supporting people with medication have clear recorded instructions about the needs of that person and can demonstrate in their practice competency in supporting them in accordance with their needs, policy and best practice in medication administration and associated recording.
3. Quality assurance systems record checks that the medication policy is being implemented safely, and for any deficits noted identify actions including staff training.

This is in order to comply with: Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services)Regulations 2011(SSI 2011/210)

This is to ensure care and support is consistent with Health and Social Care Standard 1.24:

'Any treatment or intervention that I experience is safe and effective'.

This requirement was made on 26 June 2025.

Action taken on previous requirement

Care plans now included accurate records of each person's assessed level of support with medication. Staff were observed delivering support in line with these assessments. Staff demonstrated respectful, person-centred care, used PPE appropriately, and referred to support plans before administering or prompting medication.

Medication protocols had been clarified and reinforced through updated training, cluster meetings, and accessible guidance for staff. A structured audit process with escalation procedures had been introduced. This included daily checks by carers and reviewing completed medication administration records (MAR). While some MAR records showed omissions, these were being addressed through targeted staff discussions. The overall approach demonstrated that staff were supported to follow best practice and that quality assurance systems were effective in identifying and responding to areas for improvement.

Met – within timescales

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

The service should ensure that staff training is refreshed or repeated as necessary. This should include, but not limited to, adult support and protection training.

This is to ensure care and support is consistent with the Health and Social Care Standards which state:

'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14).

This area for improvement was made on 24 May 2024.

Action taken since then

Most staff had completed key training, including adult support and protection, and a tracker was in place to monitor progress and expiry dates. However, some staff still needed medication refresher training. The service agreed to bring medication refresher training in-house, as relying on pharmacist availability had caused delays. This will help ensure staff stay confident and skilled in their roles.

This area for improvement has been met.

Previous area for improvement 2

To ensure positive outcomes for people the provider should ensure people experience stability in who provides their care and are supported by people who knows them and understands their needs, choices and wishes.

This is to ensure care and support is consistent with Health and Social Care Standard 4.16:

'I am supported and cared for by people I know so that I experience consistency and continuity'.

This area for improvement was made on 26 June 2025.

Action taken since then

The service provided continuity of care by matching carers to individuals and responding to people's preferences wherever possible.

Care plans include detailed instructions that support consistent, person-centred care. While staffing pressures continue to affect scheduling, many people we spoke to said that they had regular carers who supported them. Leaders are actively working to reduce overload and further improve stability for both carers and the people they support.

This area for improvement has been met.

Previous area for improvement 3

To promote positive outcomes for people the provider should respond to all expressions of dissatisfaction and complaints in accordance with the organisational complaints handling procedure.

This is to ensure care and support is consistent with Health and Social Care Standard 4.19:

'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes'.

This area for improvement was made on 26 June 2025.

Action taken since then

Complaint records showed that concerns were logged, and included details of the complaint and any actions taken to resolve them. Complaints were responded to in line with local authority guidelines, showing that the service followed its procedures and took concerns seriously.

This area for improvement has been met.

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Detailed evaluations

How well do we support people's wellbeing?	5 - Very Good
1.3 People's health and wellbeing benefits from their care and support	5 - Very Good

How good is our leadership?	5 - Very Good
2.2 Quality assurance and improvement is led well	5 - Very Good

How good is our staff team?	4 - Good
3.3 Staffing arrangements are right and staff work well together	4 - Good

How well is our care and support planned?	4 - Good
5.1 Assessment and personal planning reflects people's outcomes and wishes	4 - Good

To find out more

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Tha am foillseachadh seo ri fhaighinn ann an cruthannan is cànain eile ma nithear iarrtas.

অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

هذه الوثيقة متوفرة بلغات ونماذج أخرى عند الطلب

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EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**13th MARCH 2026**
REPORT REFERENCE:	**PERF/130326/10**
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**.

2.2 Consider and approve the risk on a page reporting template as **Appendix 2.**

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 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 progressing.

3.4 The Chief Finance and Resource Officer and Corporate Business Manager met with the NHSGGC Chief Risk Officer in early February 2025 to discuss the HSCP approach to Corporate and Service Risk management and review and the proposal to move corporate risks to a risk on a page format.

3.5 The risk on a page reporting format **(Appendix 2)** was presented to the Senior Management Team on 4th March 2026.

3.6 The risk on a page template details the risk cause, effect, risk category, risk strategy, control measures and risk management actions. The template records the date the risk was raised, and the changes to risk score from the original risk score, to last reported risk score (previous), the current risk score and target risk score with the dates of changing risk likelihood, impact and priority rating. The proposed format presents the information in a more accessible format for officers to use.

3.7 Senior Management Team Officers were in support of the revised format pending review by the Performance, Audit and Risk Committee (PAR).

3.8 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.

CORPORATE RISK REGISTER – March 2026

3.9 The Corporate Risk Register captures the high level risks across the HSCP and the hosted services.

Risk Appetite Category	Number of Risks	Number of Risks Reviewed
Clinical	0	0
Financial	2	2
General Data Protection	2	0 *2 Not due for review in this period – Priority 3
Financial and Service Delivery	1	1
Service Delivery	15	14 *1 Not due for review in this period – Priority 3
Business Continuity	1	1
TOTAL	**21**	**21**

3.10 There are a total of 23 risks (21 live risks) included within the HSCP Corporate Risk Register which remains as previously reported to the PAR Committee on 9th February 2026.

3.11 Of the 21 live risks identified within the Corporate Risk Register, 3 are considered to be very high risk (priority 1), 10 are considered to be high risk (priority 2) and 8 are considered to be a medium risk (priority 3).

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

3.12 There are 3 Very High Risk, Priority 1 risks.

3.13 HSCP01 and HSCP09 relate to the ability to deliver a balanced budget and the failure to achieve transformational change and completion of transformational service redesign plans within necessary timescales and at the pace required. Both risks have been reviewed and remain at a score of 25, Priority 1 which is the highest possible risk score and further risk management actions have been detailed. Transformational change and service reviews have commenced and will run through 2025/2026. 2026/2027 budget planning is underway and further efficiencies are required and are in development. Ongoing weekly budget meetings have been established with Heads of Service and Service Managers to generate 2026/2027 savings proposals.

3.14 HSCP20 relates to Skye House where the risk event, cause and effect has been reviewed and updated to detail the high demand Skye House team are experiencing in relation to patient acuity and scrutiny. There is an enhanced level of monitoring and support in place. A review of all inspection feedback will determine future plans, these actions should close the gap between current and target risk score to 4 and Priority 4.

High Risk - Priority 2, Risk Score 12-16

3.15 There has been a review of high risks scores, which have remained at 10 high risks in this period. Following ongoing review of the reported risk scores and actions to mitigate the risks there has been minimal impact for HSCP02, HSCP07, HSCP08, HSCP13, HSCP14, HSCP17, HSCP21, HSCP22 although there has been some update to control measures for HSCP10 and HSCP16.

3.15.1 HSCP10 – Additional Scottish Government funding has been secured as part of NHSGGC award to target Adults with Incapacity (AWI) delays.

3.15.2 HSCP16 – Relates to the failure to deliver Prison Based Social Work in line with the Memorandum of Understanding (MOU) at HMP Low Moss. In addition to the 1 x FTE maternity leave, there is one vacancy in a team of 4 FTE. As an update to the control measures, an update has been given to Social Work Scotland and Scottish Government.

**Medium Risk - Priority 3, Risk Score 6-10**

3.15.3 There are 8 medium risks included in the Corporate Risk Register. There has been minimal change or movement in HSCP06, HSCP11, HSCP12 and HSCP19.

3.15.4 HSCP03 and HSCP04 – Failure to comply with General Data Regulations are under review and the intention is to combine to a single over-arching Data Protection Risk scored at a Medium Risk Priority 3, and continue to be included in Service Risk Registers with regular review.

3.15.5 HSCP05 – Progression of crisis management founding principles training for members of the HSCP with Scottish Government Civil Contingencies Team.

3.15.6 HSCP18 – The Head of Interface Health and Care services post has been approved for recruitment , following delays to job evaluation, by Senior Management Team vacancy group on 04.03.26. The implementation process for the management structure service implementation has commenced.

3.16 Following the risk management actions set out, this reduces to target risk score of;- 0 Very High Risk, 4 as High risk, and the remaining 17 risks reducing to 14 medium and 3 low risks.
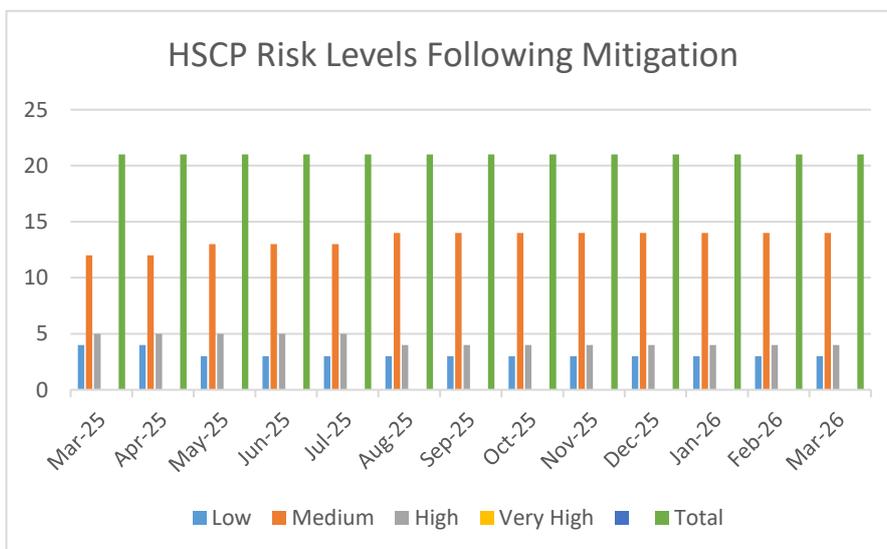
3.17 The majority of risks on the Corporate Risk Register can be categorised as risk to Service Delivery, followed by Finance and Data Protection.

Figure: Risk Appetite Types - Corporate Categories
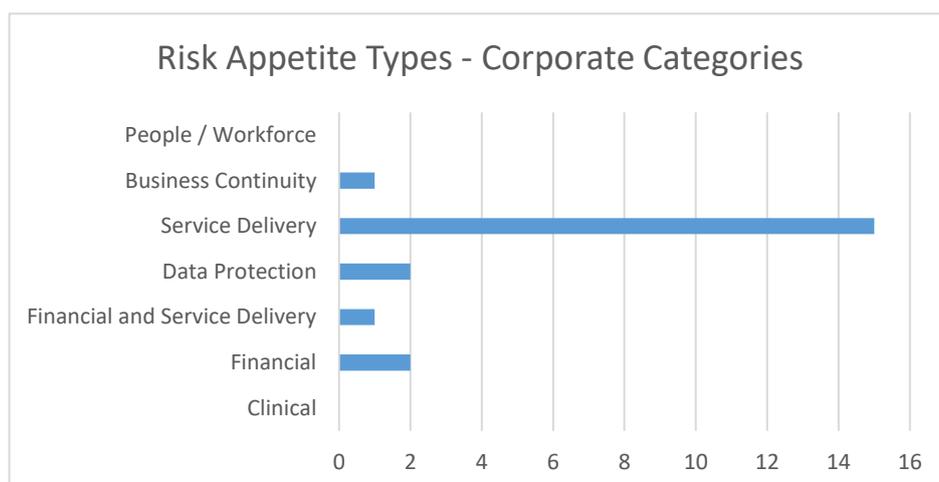
Service Risk Registers – March 2026

3.18 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.

3.19 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.

3.20 There are a total of 21 service risk registers with 134 live/active risks associated with these registers. 4 are Very High risks, 25 are High level risks, 58 are Medium level risks and 47 are Low level risks.

3.21 This is a variance of 10 live/active risks last reported, relating to an error in figures of +10 risks from one service area.

3.22 In this period, there has been a decrease of 5 Very High level risks, and a decrease of 4 High level risks. Medium risks have reduced by 2 and there has been an increase of 1 Low Level risk last reported to the PAR Committee.

Service Risk Level	Total Number	Variance in Period
Very High	4	-5
High Level	25	-4
Medium	58	-2
Low Level	47	+1
Total	**134**	**-10**

3.23 The 4 Very High level risks on the service risk registers all relate to Specialist Children Services.

3.24 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 <u>**MANAGEMENT OF RISK**</u>

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 <u>**IMPACT**</u>

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 <u>**POLICY CHECKLIST**</u>

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 <u>**APPENDICES**</u>
8.1 **Appendix 1** - HSCP Corporate Risk Register March 2026
8.2 **Appendix 2** – Risk on a Page Example

Risk Appetite/Tolerance matrix					

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

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Completed by	Ali McCready (CFO)updated by Vandrew McLean	Date created/ updated	Updated 04.03.26

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

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

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

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

Risk Reference	Risk Event	Cause	Effect	Category of risk	Control Measures	Residual Likelihood	Residual Impact	Current Risk Score (Equals H*I)	Priority	Strategy for Risk	Risk Management Actions	Acceptable Likelihood	Acceptable Impact	Target Risk Score (Equals N*O)	Priority	Risk Lead	Risk Owner
HSCP01 - Updated 29.10.25. Reviewed 09.12.25. Reviewed and Updated 04.03.26.	Inability to achieve recurring financial balance	Rising demand for services due to demographics, new legislation, new national policy, changing societal profile due to economic downturn, post covid service demand impacts, increasing complexity of demand, increasing public expectations re service provision, public service financial challenges resulting in requirements to make financial efficiencies. Cost of living price increases across in house and commissioned services. SG funding settlements not as expected / non recurring nature of funding, challenging budget settlements from partner organisations. Challenging savings programmes in place with increased reliance on reserves balances to achieve a balanced budget.	Reduced ability to maintain service levels leading to service reductions / cessation ; potential risk of poor service / harm to individuals; inability to offer competitive rates to service providers with potential loss of provider / risk to provider sustainability locally; cuts to staffing numbers in post; reputational risk to the HSCP, negative impact on performance and meeting set targets. Contracts for services being terminated and individuals waiting longer for access to services. A balanced budget can only be delivered through the use of reserves which is not a sustainable position.	Financial	Annual budget setting process undertaken in discussion with finance leads for Council and Health Board. Specific investment from SG to support HSCP strategic and national objectives. Annual Delivery Plan incorporating dis-investment / savings options developed and delivering. Internal Budget controls/Management systems and regular financial meetings with Council and NHS finance leads. Programme of efficiency plans established for coming year. Reserves Strategy in place to ensure minimum prudential levels of contingency reserves based on complexity / scale of budgets delegated to the HSCP. Year to date actuals continue to be monitored and full year projected outturn analysed to ensure the true extent of emerging pressures is incorporated. Identification and development of mitigations and future savings pipeline progresses.	5	5	25	1	Treat	Continued liaison with other Chief Finance Officers network / engagement with SG. (ongoing) Monitoring of delivery of efficiency plans for the coming year through the HSCP Annual Delivery Plan board. (March 2025) Review and update of a medium term financial plan to support longer term sustainability updated annually to reflect current financial landscape. (March 2025) Ongoing review / re designation of earmarked reserves.(March 2025) Budget working group established including staff partnership to review budget savings options through the financial year. (March 2025). Development of a "pipeline" to generate further savings. (August 2025). Ongoing weekly Budget savings meeting cycle in HoS and Service Manager diaries to generate 26/27 savings proposals (Jan'26)	4	4	16	2	Chief Finance & Resource Officer	Chief Officer
HSCP02 - Reviewed July 2025. Reviewed 27.10.25 - no change. Reviewed 09.12.25 - no change. Reviewed 02.03.26 - no change.	Failure to implement adult support and protection improvement plan.'	Quality assurance capacity in professional roles is limited due to focus on other areas of work including provision of ASP training as identified by recent joint ASP Inspection	Some adults at risk may not receive the structured statutory intervention and support that they require. Impact on outcome of inspection action improvement plan delivery.	Service Delivery	Social Work and Multi-agency Adult Support & Protection (ASP) procedures, including quality assurance and audit measures, and an appropriate training programme are in place and up to date. Improvement actions identified through the recent Joint Inspection of Adult Support and Protection Services. Funding identified to support the recruitment to the ASP Training post to create capacity to support wider ASP agenda	3	4	12	2	Treat	Delivery of the improvement action plan arising from the Joint Inspection of Adult Support & Protection Services (October 2026). Recruitment to ASP Training post (April 2025). Plan to review Public Protection Team activity over 2025.	2	4	8	3	Head of Adult Services	Chief Officer
HSCP03 - Update May 2025. Review September 2025. Review 27.10.25. Review 09.12.25	Failure to comply with General Data Protection Regulations - loss of sensitive personal data (this risk and mitigation relates to personal data held which is the data controller responsibility of NHS GG&C or ED Council)	Structural changes require new and more sophisticated forms of data management. Lack of understanding and awareness of Data Protection legislation Increasing demand and competing priorities cause workers to have decreased awareness and lessened regard for Information Security. Inadequate training for staff and use of technologies.	Breach of Information management legislation. Harm or reputational risk to individuals whose data is lost or inappropriately shared. Financial penalty Increased external scrutiny Reputational damage to NHS GG&C, ED Council or the HSCP Litigation	Data Protection	Professional Codes of Practice Procedures are in place on all sites for use/release of data. Monitoring of Information Governance Standards and agencies' Security Policy, Caldicott Guardian responsibilities, NHSGGC-wide Information Governance Steering Group. Information Sharing Protocol (endorsed by the Information Commissioner) in place for HSCP. An on-going programme of awareness and training will continue. Policies updated to reflect GDPR and new e-mail policies in place to meet government's secure email standards. All laptops (now including University equipment) encrypted. Extended use of electronic records. A programme of work re the systematic audit of access to electronic records is being extended beyond the Emergency Care Summary includes the Fair Access process. Access to health records is controlled via a role based access protocol signed off by senior clinicians and the Caldicott Guardian.	3	3	9	3	Treat	SMT implements and reviews governance arrangements to comply with legislative requirements. Action plan in place to manage staff's adherence to GDPR including Information Asset register and Information Management Liaison Officer (IMLO) role. Digital GDPR training now mandatory for staff with network access along with specific training delivered by Information Governance Leads for NHSGG&C. (March 2025) A new Records Management Code of Practice for Health and Social Care 2024 has been released principally for NHS, training expected via NHSGG&C on new Code of Practice. Risk covered in service risk registers	2	3	6	3	HSCP Corporate Business Manager	Chief Officer
HSCP04 - Update 04.09.25. Review and Update 27.10.25. Review and Update 09.12.25	Failure to comply with General Data Protection Regulations - failure to destroy records in line with schedule of destruction dates	Lack of understanding and awareness of Data Protection legislation, increasing demand and competing priorities cause workers to have decreased capacity and lesser regard for record destruction requirements. Volume of information assets / records is significant and duplicated across shared drives. Classification of records is cumbersome and clunky and difficult to understand. New Records Management Code of Practice for health and social care which will change retention periods for digital records, lack of resource capacity in HSCP staffing and EDC to support this agenda. Additional requirements for records related to the Scottish Covid Inquiry records retention.	Breach of Information management legislation. Financial penalty Increased external scrutiny Reputational damage to NHS GG&C, ED Council or the HSCP Litigation	Data Protection	A programme of work to catalogue, assign destruction dates to, and destroy records has been developed but not yet implemented due to staff capacity issues across HSCP records. IMLO reports to SMT on status of work. Delays in delivery due to Covid which has compounded position. Record Management Plan in place for HSCP with actions for continuous improvement.	4	2	8	3	Treat	New retention and destruction protocols for social work records (integrating paper and electronic records) being rolled out which will require capacity to address paper records at site. Review of staffing position to prioritise task. Development of an approach for delivery for 2024-25.Review of file classification and rationalisation of number of information assets continuing. (March 2025). SW post progressed to address review of records - ongoing 2025. HSCP Records post NHSGG&C (business support) health post 12 months fixed term readvertised June 2025 with appointment made August 2025. Start date 05.01.26.	2	2	4	4	HSCP Corporate Business Manager	Chief Officer
HSCP05 - Update 04.09.25. Reviewed and updated 15.10.25. Reviewed 09.12.25. Reviewed and updated 24.02.26	Failure in service delivery through failure of business continuity arrangements in the event of a civil contingency level event.	Poor/ineffective Civil contingencies planning, Lack of suitably trained resource, Disjointed partnership working.	Reputational damage Legislative requirements not being complied with. Disruption to services. Loss of life or injury to public and or staff across the HSCP. We do not fully meet the requirements of the Civil Contingency (Scotland) act 2005.	Business Continuity	Regular testing and updating of emergency plans (multi-agency response) and Business Continuity Plans; Comprehensive plans for a Pandemic outbreak, 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	2	5	10	3	Tolerate	Business Continuity plans. Multi agency working. Compliance with national alerts. Civil contingency. Prevent training. Winter planning. Pandemic specific business continuity approach to be regularly refreshed. (updated annually) Engagement in Council / NHS business 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.	2	5	10	3	Planning, Performance & Quality Management Manager	Chief Officer
HSCP06 - Review and Update 29/10/25. Review 09.12.25 Review 04.03.26	Failure to secure effective and sufficient support services from NHS GG&C and ED Council to plan, monitor, commission, oversee and review services as required including functions delivered by business support services.	Limited resources across NHS GG&C and ED Council to manage increasing demands and competing priorities HSCP reliance on NHS GG&C and EDC IT infrastructure and systems, performance reporting support, finance. HR, information governance etc. Delayed completion 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	Engaged in Board wide process to ensure proportionate allocation of support resources. Chief Officer attends constituent body CMT / SMT meetings to represent HSCP requirements for support. Groups established to develop and progress work plans in collaboration with partners represented on the groups. Regular meetings with Key Managers to review support arrangements in place aligned to strategic priorities and Annual delivery plan actions.	3	3	9	3	Tolerate	Collaborative work and engagement with NHS GG&C and ED Council to share understanding of support requirements and reach agreement as to how this is delivered in the most efficient manner (ongoing) Streamline and prioritise processes where appropriate.(31 March 2025). Digital enablers are being explored particularly within the business support service review. Weekly integrated finance update meetings to discuss key deadlines and information requirements.	3	3	9	3	Chief Finance & Resource Officer	Chief Officer
HSCP07 - Reviewed 30.10.25. Reviewed 09.12.25 Reviewed 02.03.26 - no change.	Inability to recruit and retain the appropriate numbers of trained staff to meet requirements resulting in reduction in service or failure to meet statutory duties. Specific workforce pressure areas are Mental Health Officers, qualified Social Workers, Personal Carers, Health Visitors, Psychologists and General Practitioners (independent contractors)and Business Support staffing	Risk reflects national and local workforce pressures. The reduction in numbers of registered staff in post. Ageing workforce able to retire, limited numbers of staff in training to take up post requiring a secondary qualification, lack of remuneration for specialist qualifications (MHOs) leading to inability to retain staff after training. Local pay and grading comparable to other areas, low rates of pay for care at home staff with year on year increases limited to SLW increases. High caseloads within health visiting service compared to other areas across GG&C. National shortage of social care workforce. National recruitment and retention challenges in relation to GPs.	Failure to accurately assess and respond to risk. Unable to provide/arrange care services Inability to meet statutory requirements/duties Service is reduced or reliance on agency cover at premium cost. Fragmented services, increased complaints, service user detriment, reputational damage. Inability to support the shift in the balance of care between secondary and primary care. Inability to support the transformational change agenda in relation to GMS contract, unscheduled care. Inability to meet statutory requirements & duty service user detriment through lack of services or timely intervention. Poorer patient/service user outcomes. Reduction in the number of steps within the health visiting pathway.	Service Delivery	Local workforce plan in place. Vacancy management process in place. Implementation of MHO Role within Social Work Mental Health Team will mitigate MHO workforce risk and reliance upon agency MHOs. Work with Chief Nurse to raise concerns corporately and nationally re community nursing and health visiting workforce and make ongoing representation for funding allocation to East Dunbartonshire. Progress innovative methods for recruitment of staff across the HSCP but particularly promoting a rolling programme of recruitment for care at home staff. Increase staff supervision, prioritise high risk / complex cases. Support national conversation re GP recruitment and retention.	4	3	12	2	Treat	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.	3	3	9	3	Heads Of Services	Chief Officer
HSCP08 - Reviewed October 2025. Reviewed 09.12.25. Reviewed 02.03.26 - no change.	Failure of external care providers to maintain delivery of services.	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	Contract Management Framework Enhanced Risk Assessment (RAG's) / monitoring & oversight of Care Home sector Regular checks / audits of Business Continuity Plans & alignment to HSCP BC Plan. Assurance Visits. Established Care Home & Care at Home Sector Leads to help support oversight arrangements CI Regulation/Inspection framework SXL team - providing national oversight of providers . SCT prioritise business daily and direct support accordingly SCT structure currently under review	3	4	12	2	Treat	Enhanced support and monitoring across care home services, daily /weekly checks via Turas, RAG rating. Provider Forums, Established Sector Leads, Weekly oversight via ORG, early notification alerts via SXL & Network groups, adequacy of rates for service delivery. (ongoing). Local engagement with providers on sustainable fixed rates for care at home / supported living contracts (25/26)	2	4	8	3	Head of Health & Community Care	Chief Officer
HSCP09 - Review 29.10.25. Reviewed 09.12.25. Reviewed and Updated 04.03.26	Risk of failure to achieving transformational change and service redesign plans within necessary timescales and at the pace required.	Lack of capacity within HSCP services and those supporting transformational change to deliver full change programme. Options for delivering transformation through efficiency / cost reduction diminishing without significant impact on levels of service delivery and performance. Scale of financial challenge is growing.	Significantly negative impact on ability to delivery medium to long term organisational outcomes as per the Strategic Plan. Inability to achieve financial balance. Increased risks to patients / service users who may wait longer for access to services. Negative impact on performance targets with increased waiting lists / times.	Service Delivery	Development and scrutiny of annual delivery plans including actions for investment / dis investment. HSCP Delivery Plan Board oversees progress. Annual Business Plan in place. Performance reporting framework established to support tracking of progress. Support through Council and NHS transformation teams to progress priorities where these are significant organisational change. Early collaborative planning with ED Council and 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.	5	5	25	1	Treat	Work through staff and leadership teams to identify further efficiency and redesign options to bring forward in year. Fundamental shift in how services are delivered with a medium / longer term focus. Review of reserves to support redesign / smooth in any change programme. Budget working group established including staff partnership to review budget savings options through the financial year. (March 2025). Continual monitoring of emerging macro financial pressures (August 2025). Ongoing weekly Budget savings meeting cycle in HoS and Service Manager diaries to generate 26/27 savings proposals (Jan'26)	4	4	16	2	Chief Finance & Resource Officer	Chief Officer

Risk Reference	Risk Event	Cause	Effect	Category of risk	Control Measures	Residual Likelihood	Residual Impact	Current Risk Score (Equals H*I)	Priority	Strategy for Risk	Risk Management Actions	Acceptable Likelihood	Acceptable Impact	Target Risk Score (Equals N*O)	Priority	Risk Lead	Risk Owner
HSCP10 - Update March 2025. Reviewed and Updated 30.10.25. Reviewed 09.12.25. Reviewed and Updated 04.03.26	Failure to deliver on actions to support the implementation of the Un-scheduled Care Commissioning Plan and inability to support early, effective discharge from hospital	Lack of recurring funding to deliver on key actions. Increasing number of admissions placing increasing demands on discharge planning, capacity and ability of care homes to take individuals, additional pressure on care at homes services to support individuals to remain safely at home. Budget savings options in relation to care home placement impacting on timeframes for admission to care homes from hospital and community. Demands for complex care at home packages outstrips ability to supply through in house / commissioned providers. AWI legislation impacts ability to move individuals and those exercising choice and awaiting preferred care home.	Adverse impact on achievement of reductions in occupied bed days and delayed discharge performance. May adversely impact on wait times for people in community being admitted to care homes when assessed need identified.	Service Delivery	Identification of non recurring funding streams. Hospital assessment team staffing cohort maintained to ensure sufficient assessment function to meet demand, working closely with care providers to determine real time capacity to support discharge, commission additional care home places to meet demand, monitoring absence and enhancing capacity within care at home services to support discharge home. Additional Scottish Government funding secured as part of NHS GGC award to target AWI delays.	4	4	16	2	Treat	Review further options for increasing capacity within care home provision and care at home through recruitment drive and further re-direction of staff. Prioritise ongoing investment through Adult Winter Planning funding to increase capacity across the HSCP in direct care services to support early and effective discharge. (March 2025) Risk management approach to ensure oversight of people who are awaiting admission to hospital. Robust assurance and reporting processes in place to monitor impact on unscheduled care targets.	3	4	12	2	Head of Health & Community Care	Chief Officer
HSCP11 - Updated 04.09.25. Reviewed 16.10.25. Review and Update 09.12.25	Failure of some or all of General Practice to deliver core services.	Demand rises 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 the acute sector (longer wait times for specialist input leading to increased interactions with primary care services) or intentional collective action by GP practices as part of their dispute with SG (particularly urgent care and pharmacotherapy).	Local population no longer able to access timely, safe and effective medical or nursing care within their usual General Practice setting and a delay in access to specialist assessment and treatment. Potential increase in all cause morbidity and mortality, from physical and psychological causes, and an increased reliance on acute sector at a time when they are already likely to be overwhelmed.	Service Delivery	Escalation protocols have been developed including; deferring non urgent work streams at a practice level prioritising the least urgent and escalating as necessary; encouraging Business Contingency Plans, and clear pathways, within each Practice, with confirmed 'Buddy' arrangements, consolidation of primary care at cluster levels (agreed) and HSCP level 4 planning around potential single point of GP level care.	2	4	8	3	Tolerate	HSCP taking a proactive approach to liaising with local practices to offer early support with redeployment of staff or assisting buddying arrangements including the redeployment of HSCP PCIP staff where possible. Active work to maintain and/or improve relationships between GP practices and HSCP.	2	3	6	3	Head of Health & Community Care	Chief Officer
HSCP12 - Update 04.09.25. Reviewed 16.10.25. Reviewed 09.12.25 - updated to de-escalate risk from High to Medium. Reviewed 02.03.26 - no change.	Failure to deliver the MOU commitments within the Primary Care Improvement Plan	Lack of adequate funding to support full delivery of the core MOU commitments, inability to recruit the required staff, lack of accommodation to support additional staffing. Cost of Vaccination Programme(VTP) greater than funding allocation available. Reliance on goodwill of GPs to support delivery of PCIP services is diminishing and collective action is being considered as part of the GP dispute with SG.	Failure to deliver contractual requirements, financial implications to meet contract defaults in the form of transitionary payments, continued pressure on GPs to deliver non specialist functions identified to be met through other professional staff groups (and GPs may reject this responsibility increasing the burden on acute colleagues).	Service Delivery	Prioritisation of MOU commitments, maximising use of reserves to meet commitments where appropriate and non recurring, accommodation strategy to expand space capacity.	2	4	8	3	Tolerate	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.	2	4	8	3	Head of Health & Community Care	Chief Officer
HSCP13 - Update August 2025. Review and Update 27.10.25 Review and Update 09.12.25 Reviewed 04.03.26	Inability to secure sufficient accommodation in the West Locality to deliver effective integrated health and social work services in that area.	Lack of suitable options and capital funding available to progress development of an integrated solution, competition / prioritisation of need across NHSGGC and other HSCP priorities taking precedence, inability to effectively evidence need in context of NHSGGC priority matrix i.e. deprivation. Options for refurbishment / extension across HSCP and GP premises in the area very limited due to nature and location of current estate. Development of two retail units in Bishopbriggs (operationally opened 1st December 2025) provides further capacity to deliver clinical treatments. There remains some pressure in the West Locality with options being explored and investigated with NHSGG&C and other partners with further discussions ongoing re one site in the West Locality (December 2025) for which an independent evaluation 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.	Service Delivery	NHSGG&C Primary Care Property Strategy has been developed which sets out board priorities for primary care accommodation, ED HSCP Property Strategy in place 2023-2025 and regular engagement with colleagues within the Council / NHS board to scope options for progressing strategic priorities, GG&C HSCP Capital Planning Group established to review board wide HSCP priorities. A Primary Care Property Strategy Refresh 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.	4	4	16	2	Treat	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.	3	4	12	2	Chief Finance & Resource Officer	Chief Officer
HSCP14 - Update 04.09.25. Reviewed 30.10.25. Reviewed and updated 09.12.25 Reviewed 04.03.26	Failure to secure an alternative system to Carefirst for Social Work case management and provider financial payments.	Reliance on Council prioritisation of project in context of competing priorities across other Council services, lack of resources within the HSCP and Council support functions to progress implementation.	Current system not fit for purpose to meet the needs of system users. New cloud based systems in development and industry moving on leaving HSCP with out of date system and no opportunity for any further development beyond legislative requirements only. Lack of support in the event system malfunctions as system becomes obsolete. Limits opportunity for service redesign and efficiencies in working practices. Significant financial risks related to payment on planned service requiring manual processes to support variations. Lack of ability to interface to other key systems.	Service Delivery	Business case developed to support new system solution for SW caseload management and financial payments to care providers. Carefirst updates through HSCP Digital Board in place to support collaborative working across HSCP and Council services and promote importance and requirement for new system. Continued engagement with current system provider to ensure continued support available. Technical upgrades to most up to date version of system to ensure applicable for any system upgrades - legislative and reporting requirements being met only. This remains part of EDC digital strategy with project initiation projected for 26/27 as a result of resource issues within EDC IT team. Status continues to be monitored as part of Digital Board.	4	3	12	2	Treat	Escalation of business case to ensure prioritised for progression, identification and planning of resource requirements through care first steering group. Project Lead to be identified (June 2025). Discussions are ongoing with EDC DoF with regards re-prioritisation of digital project funding.	3	3	9	3	Chief Finance & Resource Officer	Chief Officer
HSCP16 - new 17.10.24. Update 29.09.25. Review 09.12.25. Reviewed and Updated 04.03.26	Failure to deliver Prison Based SW in line with the Memorandum of Understanding (MOU) at HMP Low Moss.	The current funding received from SPS is insufficient to provide PBSW services to the prison population in Low Moss. Demand has 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.	Inability to deliver on the statutory requirements and terms of the MoU. The needs of the prison population may not be met and Public Protection compromised. Staff are under extreme pressure and have approach TU for support. Failure to deliver on contractual arrangements.	Service Delivery	Regular meetings with PBSW. Submission of Business Case to SPS to request increased funding. Regular meetings with the Governor. Situation now escalated to SWS and SG. Temporary additional funding agreed,however, difficulty in procuring short term Prison trained SW staff.	4	4	16	2	Treat	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	3	3	9	3	Head Of Children's Services and Criminal Justice	Chief Social Work Officer
HSCP17 - new 08.01.25. Update on 29.10.25. Review 09.12.25. Reviewed & updated 04.03.26	Current /future service levels reduce or cease following increase in employers national insurance contributions (eNIC's) - effective 6th April 25.	No central /additional funding available to support or offset Employers Ni rate Providers currently absorbing but unable to maintain longer term - concerns escalated via Scot Care/CCPG. HSCP unable to support due to lack of funding & wider budget pressures - resulting in limited direct approaches via providers to date	Current or future service levels reduce and/or cease to offset the increase to eNIC's	Financial	Pending clarification from the Scot Govt re funding, working with providers to support any related sustainability issues, aligning approach with other HSCP's via CFO and Commissioners groups. This will continue to be closely monitored.	4	3	12	2	Treat	Ongoing liaison between the Council and HSCP, Commissioners from other HSCP's, Chief Finance Officers network / engagement with SG and Provider Reps. Limited action pending determination from the Scot Govt. 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.	3	3	9	3	Chief Finance & Resource Officer	Chief Officer
HSCP18 - new 8/01/25. Update 29.10.25. Review and updated 09.12.25 Reviewed 02.03.26 - Updated.	Senior Management Team Vacancies/Capacity	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	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.	3	3	9	3	Treat	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 arrangement until recruitment concludes as part of the management structure service review for which phase 1 has now completed. Phase 2 to follow.	3	3	9	3	Heads Of Services	Chief Officer
HSCP19 - new 8/01/25. Update 20.02.25. Update 29.08.25. Reviewed and Updated 09.12.25. Reviewed 02.03.26	Impact of further reductions to 36hrs working week for NHSGG&C "Agenda for Change " staff on 1 April 2026	Reduction from 37 hours per week to 36 hours per week for f/t staff and pro rata reduction for p/t staff to be in place from April 2026 following Scot Govt Directive.	Reduced ability to maintain service levels leading to service reductions / cessation ; potential risk of poor service / harm to individuals. Increased complaints, service user detriment	Service Delivery	Local workforce plan in place for all services requiring to review impact on reduction across HSCP. Review of priorities within services and impact of reduction in capacity/operating hours which may also impact on other services (internal or external). Services 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 the reduction in hours with minimal/no impact on patients/service users.	3	3	9	3	Treat	Review service workforce plans and capacity for both reductions, investigate skill mix, opportunities for integrating access to services (single points of access) and other mechanisms for delivery of services.(August 25) Approximate costs of this reduction identified with a further review required now that potential funding has been identified as 75% of requirement.	3	3	9	3	Heads Of Services	Chief Officer
HSCP20 SCS - approved SMT 19.03.25. Reviewed 01.09.25. Reviewed 05.10.25. Reviewed and Updated 27.10.25. Reviewed and Updated 04.03.26 Reviewed and updated 20.01.26. Reviewed and Updated 04.03.26	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.	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	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 control group for improvement plans. Time for reflection for every meeting for team members and a meeting structure to respond to improvement requirements.	5	4	20	1	Treat	Enhanced level of monitoring and support at present. Review of all feedback within system and review feedback to determine future action plans.	2	2	4	4	General Manager - SCS	Chief Officer
HSCP21 SCS - new - approved SMT 19.03.25. Updated 01.09.25. Reviewed and Updated 27.10.25. Reviewed and Updated 08.12.25 Reviewed and Updated 04.03.26.	Ability to deliver on the neurodevelopmental service specification due to clinical and service reputational risk associated with a large existing waiting list for diagnosis across all ND profiles and increase in new referrals with low capacity within the workforce. The impact is that it is not possible to identify those most at impact who require the support most given the numbers waiting.	Demand for ND assessments is in excess of limited resource available for ND assessments, this is a pattern nationally with limited additional funding	Comprehensive work plan and oversight now in place but limited/ no reduction in waiting times due to demand. This means those at most risk and who would benefit form specialist support cannot be identified easily.	Service Delivery	ND pathway for school age children and transfer of all children to this so that scale of issue now known. Every area has local teams. Efficient models have been developed and upskilling across professional groups so that system can be as efficient as possible. Application of access policy to ND pathway is now occurring.	4	4	16	2	Treat	Describe demand/ capacity, develop reduced criteria for access to service and consult. This has been discussed at CMT and an agreement to apply Access policy to referrals - this work is progressing and will be in place by end of Dec 25 EQIA has been completed and submitted. Engagement with a range of stakeholders.	2	2	4	4	General Manager - SCS	Chief Officer
HSCP22 SCS - new - approved SMT 19.03.25. Updated 01.09.25. Reviewed and Updated 27.10.25. Reviewed and Updated 08.12.25 Reviewed and Updated 04.03.26	Regional SCS developments - FCAMHS/ Secure and IPCU. A potential ward identified for IPCU is now unavailable. A wider regional approach to regional delivery with a review of pathways, needs assessment and intensifying CAMHS pathway is underway.	NHSGGC has been ask to develop a regional IPCU and a FCAMHS/ Secure model. Discussions with Scottish Government have changed direction to an Intensive CAMHS model (March 2026)	This will place demand on service to support developments and risk to board where recurring funding is not established and decision making challenging to progress. Risk to destabilising current workforce.	Financial and Service Delivery	Requirement for regional agreement about regional priorities. Needs assessment to be undertaken by the region in relation to IPCU and wider CAMHS offer for most unwell young people.	4	4	16	2	Treat	Enhanced level of monitoring and support at present. For FCAMHS/ Secure as funding is non recurring recruitment on fixed term basis.	3	3	9	3	General Manager - SCS	Chief Officer

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	5	5	25	1 - VERY HIGH	4	4	16	2 - HIGH

East Dunbartonshire HSCP Performance, Audit & Risk (PAR) Committee Agenda Planner
Meetings
January 2025 – October 2026

Updated 23/02/2026

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 – January 2025
Internal Audit Update (GMcC)
Internal Audit Follow Up Report (GMcC)
Performance Management Update Qtr2/3 24/25 (AC / AW)
Accounts Commission – Integration Joint Boards Finance and Performance 2024
Unaudited Accounts 2023/2024
Corporate Risk Register Update
HSCP PAR Committee Agenda Items – 13th March 2025 (tentative)
Internal Audit Plan 2025/26 and Audit Update (GMcC)

Final Audited Accounts 2023/2024 (CFO) - tbc
Performance Management Update Qtr3 22/23 (AC / AW)
HSCP Directions Log Progress Update
Corporate Risk Register Update
Commissioning Service Oversight Process
HSCP PAR Committee Agenda Items – 19th June 2025
Internal Audit Plan 2025/26 and Audit Update (PB)
Annual Audit Progress Report – External Audit (Mazars)
Criminal Justice Validation Report (CC)
Community Wellbeing Funding (CC)
Performance Management Update Qtr4 24/25 (AC / AW)
HSCP Directions Log Progress Update
Corporate Risk Register Update
Audit Scotland Report into GP practices and the Primary Care Strategy (FMcJ)
HSCP PAR Committee Agenda Items – 15th September 2025 (to be confirmed)
Mazars Annual Audit Report (TR)
PAR Terms of Reference
Performance Management Update Qtr 1 (AW)
HSCP PAR Committee Agenda Items – 6th November 2025
2023/24 audit progress report and verbal update on 2024/25 (TR/AMcC)
Pineview Inspection
John Street Inspection
Unaudited Accounts 2024/2025 (CFO)
Mazars Progress Report (TR)
Performance Management Update Qtr 2 25/26 (AC / AW)
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 25/26 (AC / AW)
2024/25 audit progress report (TR)
Care at Home Service Inspectorate Report
HSCP PAR Committee Agenda Items – 17/18/19 June 2026 (tentative)
Annual Internal Audit Report (GMcC)
Final Internal Audit Follow Up Report (GMcC)
Commissioned Services Assurance
Final Audited Accounts 2024/2025
Annual Audit Plan 2025/26 – External Audit (Mazars) tbc
Whistleblowing/Speak Update
Unaudited Annual Accounts 2025/26 (CFO)
Final Audit Report 2024/2025 (TR)
Performance Management Update Qtr4 25/26 (AC / AW)
HSCP Directions Log Progress Update
HSCP Board Agenda Items – October 2026 (tentative)
Internal Audit Report
HSCP Delivery Plan 2026-2027 Qtr 2
HSCP Corporate Risk Register Update
2025/26 final audit report (TR) tbc
Final Audited Accounts 2025/26 (legislative deadline for signing 30th Sept, publishing 31st October)