Public Document Pack

Aberdeen City Health & Social Care Partnership
A caring partnership

To: Members of the Risk, Audit and Performance Committee

Town House,
ABERDEEN 26 March 2024

RISK, AUDIT AND PERFORMANCE COMMITTEE

The Members of the **RISK, AUDIT AND PERFORMANCE COMMITTEE** are requested to meet in **Virtual - Remote Meeting on TUESDAY, 2 APRIL 2024 at 10.00 am.**

JENNI LAWSON
INTERIM CHIEF OFFICER - GOVERNANCE

B U S I N E S S

DECLARATION OF INTERESTS AND TRANSPARENCY STATEMENTS

1.1 Members are requested to intimate any declarations of interest or transparency statements

DETERMINATION OF EXEMPT BUSINESS

2.1 Members are requested to determine that any exempt business be considered with the press and public excluded

STANDING ITEMS

3.1 Minute of Previous Meeting of 28 November 2023 (Pages 3 - 8)

3.2 Business Planner (Pages 9 - 12)

GOVERNANCE

4.1 Board Assurance and Escalation Framework - HSCP.24.017 (Pages 13 - 54)

RISK

5.1 Strategic Risk Register - HSCP.24.015 (Pages 55 - 84)

AUDIT

6.1 External Audit Strategy 2023/24 - HSCP.24.014 (Pages 85 - 104)

6.2 Internal Audit Plan 2024-27 - HSCP.24.018 (Pages 105 - 116)

6.3 Internal Audit Update Reports - HSCP.24.019 (Pages 117 - 126)

6.4 Internal Audit Report - IJB Hosted Services - HSCP.24.020 (Pages 127 - 132)

PERFORMANCE

7.1 Quarterly Performance Reports against the Delivery Plan - HSCP.24.013 (Pages 133 - 160)

EXEMPT / CONFIDENTIAL BUSINESS

8.1 There is no exempt business

COMMITTEE DATES

9.1 Date of Next Meeting - 4 June 2024

Should you require any further information about this agenda, please contact Emma Robertson, emmrobertson@aberdeencity.gov.uk

Aberdeen City Health & Social Care Partnership
A caring partnership

Risk, Audit and Performance Committee

Minute of Meeting

Tuesday, 28 November 2023
10.00 am Virtual - Remote Meeting

ABERDEEN, 28 November 2023. Minute of Meeting of the RISK, AUDIT AND PERFORMANCE COMMITTEE. Present:- Councillor Martin Greig Chairperson; and Mark Burrell, Councillor John Cooke, Martin Allan, Jamie Dale, Alison MacLeod, Paul Mitchell, Michael Oliphant (Audit Scotland) and Sandy Reid.

Also in attendance: Elizabeth Cameron, Barbara Dunbar, John Forsyth, Stuart Lamberton, Graham Lawther, Calum Leask, Grace Milne and Alison Penman.

Apologies: June Brown, Hussein Patwa, Shona Omand-Smith and Claire Wilson.

The agenda and reports associated with this minute can be found here.

Please note that if any changes are made to this minute at the point of approval, these will be outlined in the subsequent minute and this document will not be retrospectively altered.

DECLARATIONS OF INTEREST OR TRANSPARENCY STATEMENTS

1. Members were requested to intimate any declarations of interest or connections in respect of items on the agenda.

The Committee resolved:-
to note that there were no Declarations of Interest or Transparency Statements.

EXEMPT BUSINESS

2. There was no exempt business.

MINUTE OF PREVIOUS MEETING OF 19 SEPTEMBER 2023

3. The Committee had before it the minute of its previous meeting of 19 September 2023, for approval.

The Committee resolved:-
to approve the minute as a correct record.

BUSINESS PLANNER

4. The Committee had before it the planner of committee business, as prepared by the Chief Finance Officer.

The Committee resolved:-
(i) to note the reasons outlined by the Chief Finance Officer for the deferral of item 15 (Financial Regulations Review) to RAPC in June 2024; and
(ii) to otherwise note the Planner.

DIRECTIONS TRACKER - HSCP.23.086

5. The Committee had before it an update prepared by the Strategy and Transformation Lead, in respect of the status of Directions made by the Integration Joint Board to Aberdeen City Council and NHS Grampian.

The report recommended:-
that the Committee note the detail and updates in Appendix A of the report.

The Committee resolved:-
to agree the recommendation.

STRATEGIC RISK REGISTER - HSCP.23.083

6. The Committee had before it a report prepared by the Business and Resilience Manager, presenting an updated version of the Integration Joint Board's Strategic Risk register, following the deep dive undertaken on 13 October 2023 in respect of Risks 1 and 7.

The report recommended:-
that the Committee:
(a) note the revised Strategic Risk Register (SRR) as detailed in the Appendix to the report; and
(b) agree the proposal that the risk ratings of the 2 Very High risks (Risks 1 and 7) be reduced to High, as outlined in the report.

The Committee resolved:-
to agree the recommendations.

RISK, AUDIT AND PERFORMANCE COMMITTEE
28 November 2023

INTERNAL AUDIT UPDATE REPORT - HSCP.23.081

7. The Committee had before it a report prepared by the Chief Internal Auditor providing an update on Internal Audit's work since the last update. Details were provided of the progress against the approved Internal Audit plans, audit recommendations follow up, and other relevant matters for the RAPC to be aware of.

The report recommended:-
that the Committee:
(a) note the contents of the RAPC - Internal Audit Update Report November 2023 as appended at Appendix A of the report, and the work of Internal Audit since the last update;
(b) note the progress against the approved 2023/24 Internal Audit Plan as detailed in the Internal Audit Update Report; and
(c) note the progress that had been made with implementing recommendations agreed in the Internal Audit reports as outlined in the Internal Audit Update Report.

The Committee resolved:-
to agree the recommendations.

INTERNAL AUDIT REPORT – CARE MANAGEMENT SYSTEM - HSCP.23.082

8. The Committee had before it a report prepared by the Chief Internal Auditor presenting the outcome of the planned audit of the Care Management System that had been included in the Internal Audit Plan.

The report recommended:-
that the Committee review, discuss and comment on the issues raised in the report.

The Committee resolved:-
to note the information provided.

INTERNAL AUDIT REPORT - IJB COMPLAINTS HANDLING - HSCP.23.093

9. The Committee had before it a report prepared by the Chief Internal Auditor presenting the outcome from the planned audit of the IJB Complaints Handling that had been included in the Internal Audit Plan.

The report recommended:-
that the Committee review, discuss and comment on the issues raised in the report.

The Committee resolved:-
to note the information provided.

QUARTER 2 DELIVERY PLAN UPDATE - HSCP.23.084

10. The Committee had before it a report prepared by the Transformation Programme Manager providing assurance in respect of the progress of the Delivery Plan as set out within the Aberdeen City Health and Social Care Partnership Strategy Plan 2022-2025.

The report recommended:-
that the Committee note the Delivery Plan Quarter 2 Summary, the Tracker and Dashboard as appended to the report.

The Committee resolved:-
(i) to note the information provided on the 'deeper dive' regarding Infrastructure; and
(ii) to otherwise agree the recommendation.

WORKFORCE PLAN ANNUAL UPDATE REPORT - HSCP.23.080

11. The Committee had before it the 2022/23 Annual Report for Aberdeen City Health and Social Care Partnership Workforce Plan prepared by the Senior Project Manager. This report gave an overview of the current workforce and the progress made against the Workforce Plan Priorities.

The Senior Project Manager and Transformation Programme Manager presented the Workforce Plan and a 'deep dive' in respect of ACHSCP / NHS Grampian sickness absence and responded to questions from Members who noted the good progress made recently in respect of the recruitment fair.

The report recommended:-
that the Committee note the progress of the Workforce Plan to date.

The Committee resolved:-
(i) to note that the Senior Project Manager would include further information on the uptake of initiatives and analysis of successful Healthy Working Lives projects in the next annual Workforce Plan update;
(ii) to note the information provided on the 'deeper dive' regarding staff sickness and absence rates; and
(iii) to otherwise note the progress.

RISK, AUDIT AND PERFORMANCE COMMITTEE
28 November 2023

PRIMARY CARE IMPROVEMENT PLAN UPDATE REPORT - HSCP.23.079

12. The Committee had before it a report prepared by the PCIP Programme Manager providing an update on progress implementing the Primary Care Improvement Plan.

The report recommended:-
that the Committee:
(a) note the update presented on the PCIP, as outlined in the report; and
(b) note that the annual PCIP Update report was presented to the meeting of the Integration Joint Board at its meeting on 10 October 2023.

The Committee resolved:-
to agree the recommendations.

JUSTICE SOCIAL WORK PERFORMANCE REPORT - HSCP.23.085

13. The Committee had before it a report prepared by the Service Manager providing the updated Justice Social Work Annual Performance Report for 2022/23 and the Community Payback Order Annual Report for 2021/22.

The report recommended:-
that the Committee note the Justice Social Work Annual Performance Report 2022-23 as included at Appendix 1.

The Committee resolved:-
to note the information provided.

DATE OF NEXT MEETING - 24 JANUARY 2024 AT 2PM

14. The Committee had before it the date of the next meeting: Wednesday 24 January 2024 at 2pm.

The Committee resolved:-
to note the date of the next meeting.
- COUNCILLOR MARTIN GREIG, Chair.

This page is intentionally left blank

	A	B	C	D	E	F	G	H	I	J
1	**RISK and AUDIT PERFORMANCE COMMITTEE BUSINESS PLANNER**									
2	**The Business Planner details the reports which have been instructed by the Committee as well as reports which the Functions expect to be submitting for the calendar year.**									
3	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Report Number**	**Report Author**	**Lead Officer / Business Area**	**Directorate**	**Update/Status**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
4	**2 April 2024**									
5	Standing Item	Board Assurance and Escalation Framework (BAEF)	To note the Framework (reviewed by the Committee on an annual basis as per resolution on 26.08.2020)	HSCP24.017	Martin Allan	Business Manager	ACHSCP	Transferred from 24 January 2024		
6	07.09.23	Strategic Risk Register	To present an updated version of the Integrated Joint Board's (IJB) Strategic Risk register.	HSCP24.015	Martin Allan	Business and Resilience Manager	ACHSCP			
7	Standing Item	External Audit Strategy 2023/24	To provide a summary of the work plan for Audit Scotland's 2022/23 external audit of Aberdeen City Integration Joint Board (IJB).	HSCP24.014	Anne MacDonald	Audit Scotland	Audit Scotland	2022/23 Strategy last considered at April 2023 RAPC.		
8		Internal Audit Plan 2024-27	To seek approval of the Internal Audit Plan for the Aberdeen City Integration Joint Board for 2023-26	HSCP24.018	Jamie Dale	Chief Internal Auditor	Governance			
9		Internal Audit Update Reports	To provide an update on the work of Internal Audit.	HSCP24.019	Jamie Dale	Chief Internal Auditor	Governance			
10		Internal Audit Report - IJB Hosted Services	To present the outcome from the planned audit of Hosted Services that was included in the Internal Audit Plan.	HSCP.24.020	Jamie Dale	Chief Internal Auditor	Governance			
11	30.11.22	Quarterly Performance Reports against the Delivery Plan	To note the position.	HSCP24.013	Alison Macleod	Strategy and Transformation Team				
12	Standing Item	Whistleblowing Updates	Quarterly update		Martin Allan	Business Manager	ACHSCP		R	There are no updates this quarter
13	24.08.21	Navigator project evaluation	IJB 24.08.21 - NAVIGATOR REPORT - HSCP.21.086 - to instruct the Chief Officer, ACHSCP to present an evaluation and update report to the RAPC prior to conclusion of Year 2 funding. (First two years October 21 to October 23)	HSCP24.016	Simon Rayner	ADP Strategic Lead	ACHSCP	Simon Rayner advised: The Navigator service only went live in August 2022 due to the service getting set up and recruitment etc. We have 6 months of initial data but not the qualitative work yet or feedback from service users or HSCP staff. This will be issued as a Service Update. Members agreed on 13 June 2023 to defer report to November 2023, then further to April 2024.	R	Simon Rayner advises that discussions are taking place in respect of the future of the project.
14	**4 June 2024**									
15	Standing Item	Internal Audit Reports - Annual Report & IJB Performance Management Reporting	Assurance that services are operating effectively		Jamie Dale	Chief Internal Auditor	Governance	Reports presented to RAPC on 13 June 2023 - this is an annual requirement so a date in June 2024 shoud be identified.		
16	13.06.2023	Local update on the full Mental Welfare Commission report.	Members agreed on 13 June 2023 to instruct the Lead for Mental Health and Learning Disability Inpatient Services, Specialist Services and CAMHS to bring a report back to Committee in 12 months' time in order to provide a local update on the full Mental Welfare Commission report.		Judith McLenan / Amanda Farquharson	CAMHS	NHSG	Expected June 2024		

	A	B	C	D	E	F	G	H	I	J
3	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Report Number**	**Report Author**	**Lead Officer / Business Area**	**Directorate**	**Update/Status**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
17	30.11.22	Quarterly Performance Reports against the Delivery Plan	To note the position.		Alison Macleod	Strategy and Transformation Team		May or June 2024		
18	Standing Item	Directions Tracker	To present the six-monthly update on the status of Directions made by the Integration Joint Board (IJB) to Aberdeen City Council (ACC) and NHS Grampian (NHSG).		Alison MacLeod	Strategy and Transformation Team				
19	02.05.23	Primary Care Improvement Plan (Update)	Six monthly update regarding progress implementing the Primary Care Improvement Plan . Last reported 28 November 2023.		Alison Penman	Susie Downie	ACHSCP			
20	Standing Item	Review of Financial Governance	To provide assurance on Governance Environment - annual report. Last RAPC was 13 June 2023.		Paul Mitchell	Chief Finance Officer	ACHSCP			
21		Review of Duties and Year End Report - Annual Review of RAPC	To present a review of reporting for 2023/24 and an early draft intended schedule of reporting for 2024/25 to provide assurance that the Committee is fulfilling all the duties as set out in its terms of reference.		Paul Mitchell Alison MacLeod/ Amy Richert	Chief Finance Officer	ACHSCP			
22		Approval of Unaudited Accounts			Paul Mitchell	Chief Finance Officer	ACHSCP			
23		Quarter 4 (2023/24) Financial Monitoring Update	To summarise the 2023/2024 revenue budget performance for the services within the remit of the IJB for quarter 4 ; To advise on any areas of risk and management action relating to the revenue budget performance of the IJB services; and approve the budget virements.		Paul Mitchell	Chief Finance Officer	ACHSCP			
24	**10 September 2024**									
25										
26	**3 December 2024**									
27	07.09.23	Strategic Risk Register	To present an updated version of the Integrated Joint Board's (IJB) Strategic Risk register.		Martin Allan	Business Manager	ACHSCP	as agreed at Risk Workshop in Jan 24, the report will also present the IJB's Risk Appetite Statement for mid year review.		
28		Workforce Plan Annual Update Report	To provide an overview of the current workforce and the progress made against the Workforce Plan Priorities - Members agreed at IJB in November 2022 to instruct the Chief Officer to report progress annually to the Risk, Audit, and Performance Committee. Last reported on 28 November 2023.		Stuart Lamberton / Grace Milne	Chief Officer	ACHSCP			

	A	B	C	D	E	F	G	H	I	J
3	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Report Number**	**Report Author**	**Lead Officer / Business Area**	**Directorate**	**Update/Status**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
29	19.09.2023	Justice Social Work Delivery Plan update 2023-24 and Performance Report	On 22.06.21, from Justice Social Work Performance Management Framework - HSCP.21.053; (i)to approve the Justice Social Work Performance Management Framework as a first iteration of work in progress and agree to its implementation by the justice service; and (ii)to instruct the Chief Officer (ACHSCP) to use this framework as the basis for a report outlining the performance of the justice service and present this report to RAPC no later than the end of Q1 2022-2023 and then similarly on an annual basis thereafter. Plan reported on 19.09.2023, Performance Report on 28.11.2023.		Kevin Toshney/ Claire Wilson / Lesley Simpson / Liz Cameron	Chief Social Work Officer	ACHSCP			
30	**TBC**									
31	19.09.2023	Locality Planning Annual Reports	To note the update - At IJB on 19 September 2023, members instructed the Lead Officer to submit the 2023-24 Locality Planning Annual Reports to the Committee in September 2024.		Alison Macleod / Iain Robertson	Lead Strategy and Performance Manager	ACHSCP	May/June 2025 - as the refreshed LOIP and Locality Plans come into effect on 29 April 2024 , the Locality Planning Team representing both Community Planning and ACHSCP requested to move the annual reporting from August/September 2024 to June 2025 as the three annual performance reports on the new plans would have only been in place for a couple of months if taken in June 2024.		

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	2 April 2024
Report Title	Review of Board Assurance and Escalation Framework
Report Number	HSCP24.017
Lead Officer	Martin Allan
Report Author Details	*Name:* Martin Allan *Job Title:* Business and Resilience Manager *Email Address:* martin.allan3@nhs.scot
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	*No*
Appendices	a. Board Assurance and Escalation Framework Revised 2024
Terms of Reference	9. Monitor the risk appetite and/or tolerance established by the Board Assurance Framework to ensure effective oversight and governance of the partnership's activities. 10. Ensure the existence of, and compliance, with an appropriate risk management strategy including: reviewing risk management arrangements; receiving biannual Strategic Risk Management updates and undertaking in-depth review of a set of risks and annually review the IJB's risk appetite document with recommendations being brought to the IJB

RISK, AUDIT AND PERFORMANCE COMMITTEE

1. Purpose of the Report

1.1. To present the annual review of the Integration Joint Board's (IJB) Board Assurance and Escalation Framework (BAEF) as part of the Risk, Audit and Performance Committee's (RAPC) annual review of the Framework.

2. Recommendations

2.1. It is recommended that the Risk, Audit and Performance Committee:

(a) Approve the revised Board Assurance and Escalation Framework (BAEF) as attached at Appendix A; and

(b) Agree that the Framework continue to be reviewed annually by RAPC.

3. Strategic Plan Context

3.1. Risk management is referenced in the Strategic Plan, specifically in relation to the management of risk to enablers to the Plan eg workforce, technology, finances, as well as in the Strategic Aims of the Plan.

4. Summary of Key Information

4.1. In order to fulfil its remit, the IJB must demonstrate an effective governance process whereby it can be assured that key risks to the achievement of integration objectives are appropriately identified, communicated and addressed.

4.2. The BAEF describes the regulatory framework of the IJB to support its vision, values and principles, within which the RAPC will work. Fundamental to the framework are the IJB's strategic priorities and the appetite for risk that exists across these priorities.

4.3. The BAEF presents and populates a model where individuals, groups and committees, plans, reports, and reporting processes are mapped at different

organisational levels, against two broad assurance requirements - compliance and transformation.

4.4. A key element of the assurance framework is the risk management system, whose outputs (i.e. strategic and corporate risk registers, and other reports) contribute significantly to assurance on key risks to objectives. The appendices illustrate the landscape in which the IJB operate:
The committee structure and terms of reference
The risk assessment system
The risk escalation process
The clinical and care governance framework
The IJB's cycle of business.

4.5. The RAPC performs the key role of reviewing and reporting on the effectiveness of the governance structures in place and on the quality of the assurances the Board receives.

4.6. The BAEF was formally approved by the IJB in 2016 and was last reviewed by RAPC on 28 February 2023. The 2024 review has been undertaken and the revised version is attached as Appendix A to this report.

4.7. The main changes to the framework are in relation to minor housekeeping updates relating to changes to names of posts in the Senior Leadership Team.

4.8. It is proposed that the BAEF continue to be reviewed on an annual basis.

5. Implications for Committee

5.1. Equalities, Fairer Scotland and Health Inequality
There are no direct equalities, Fairer Scotland and Health Inequalities implications arising from this report, however the BAEF outlines the regulatory framework of the IJB, supporting its vision, values and principles in terms of equalities, the principles within the Fairer Scotland Duty and tackling health inequalities.

5.2. Financial
There are no direct financial implications arising from this report.

5.3. Workforce

There are no direct workforce implications arising from this report.

5.4. Legal
There are no direct legal implications arising from this report.

5.5. Unpaid Carers
There are no direct implications relating to Unpaid Carers arising from this report.

5.6. Information Governance
There are no direct information governance implications arising from this report.

5.7. Environmental Impacts
There are no direct environmental implications arising from this report.

5.8. Sustainability
There are no direct sustainability implications arising from this report.

5.9. Other
There are no other implications arising from this report.

6. Management of Risk
The IJB's Board Assurance and Escalation Framework outlines the governance processes for the consideration and escalation of risks through the Partnership.

6.1. Identified risks(s)

Reputational Damage.

6.2. Link to risks on strategic or operational risk register:

The development and revision of the BAEF will help to mitigate all of the risks on the IJB's Strategic Risk Register, however the main risk that it will help mitigate is "There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care" This report helps to mitigate the risks as it commits to an annual review of the BAEF to ensure it is updated appropriately. Further, the information provided in the BAEF

helps to mitigate the impact of a number of risks in the strategic risk register, by providing the necessary assurance and escalation processes.

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership

A caring partnership

Board Assurance and Escalation Framework

Approved February 2023. Next Review April 2024.

Content

Part 1: Introduction

1.1 Background

The partner organisations of Aberdeen City Health and Social Care Partnership (ACHSCP), Aberdeen City Council and NHS Grampian (the "Parties"), are committed to successfully integrating health and social care services, to achieve the partnership's vision of:

"A caring partnership, working together with our communities to enable people to achieve healthier, fulfilling lives and wellbeing."

ACHSCP has established an Integration Joint Board (IJB) through the Public Bodies (Joint Working) (Scotland) Act 2014. The remit of the IJB is to prepare and implement a Strategic Plan in relation to the provision of health and social care services to adults in its area in accordance with sections 29-39 of the Public Bodies Act. The arrangements for governance of the IJB itself, including rules of membership, are set out in the Scheme of Governance.

While the Parties are responsible for implementing governance arrangements of services the IJB instructs them to deliver, and for the assurance of quality and safety of services commissioned from the third and independent sectors, the Parties and the IJB are accountable for ensuring appropriate clinical and professional governance arrangements for their duties under the Act. The IJB therefore needs to have clear structures and systems in place to assure itself that services are planned and delivered in line with the principles of good governance and in alignment with its strategic priorities.

The IJB must have in place a robust framework to support appropriate and transparent management and decision-making processes. This framework will enable the board to be assured of the quality of its services, the probity of its operations and of the effectiveness with which the board is alerted to risks to the achievement of its overall purpose and priorities.

1.2 Regulatory framework

The Aberdeen City Health and Social Care Integration Scheme describes the regulatory framework governing the IJB, its members and duties. In particular, the IJB is organised in line with the guidance set out in the Roles, Responsibilities and Membership of the Integration Joint Board - governments advice to supplement the @Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014. The principles of and codes of conduct for corporate governance in Scotland are set out in @ "On Board: A Guide for Members of Public Bodies in Scotland", published by the Scottish Government in July 2006. Detailed arrangements for the board's operation are set out in @ "Roles, Responsibilities and Membership of the Integration Joint Board" Guidance and advice to supplement the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014. The IJB also has its own Scheme of Governance.

The IJB will make recommendations, or give directions where appropriate (e.g. where funding for the delivery of services is required) to the decision-making arms of Aberdeen City Council and NHS Grampian as required.

1.3 Purpose of the framework

This governance framework describes the means by which the board secures assurance on its activities. It sets out the governance structure, systems and performance and outcome indicators through which the IJB receives assurance. It also describes the process for the escalation of concerns or risks which could threaten delivery of the IJB's priorities, including risks to the quality and safety of services to service users.

It is underpinned by the principles of good governance[1] [2] [3] and by awareness that ACHSCP is committed to being a leading edge organisation in the business of transforming health and social care.

This commitment requires governance systems which will encourage and enable innovation, community engagement and participation, and joint working. Systems for assurance and escalation of concerns are based on an understanding of the nature of

[1] Good Governance Institute (GGI) and Healthcare Quality Improvement Partnership (HQIP), *Good Governance Handbook,* January 2015,. http://www.good-governance.org.uk/good-governance-handbook-publication/

[2] The Scottish Government, Risk Management – public sector guidance, 2009. http://www.gov.scot/Topics/Government/Finance/spfm/risk

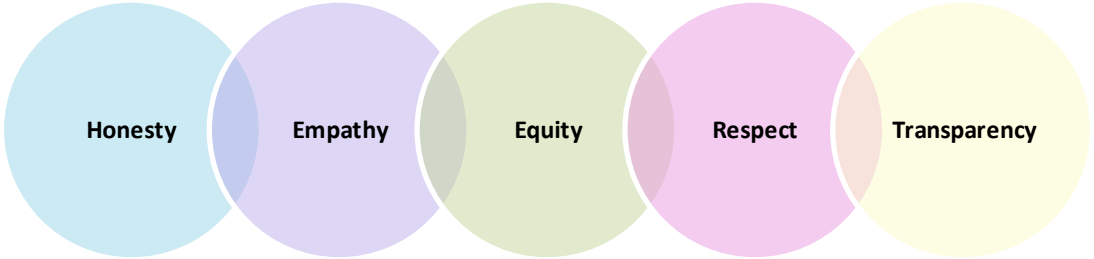
[3] Chartered Institute of Public Finance and Accountancy (CIPFA) and the International Federation of Accountants® (IFAC®). *International Framework: Good Governance in the Public Sector*, (2014) - http://www.cipfa.org/policy-and-guidance/standards/international-framework-good-governance-in-the-public-sector

risk to an organisation's goals, and to the appetite for risk-taking. The development of a mature understanding of risk is thus fundamental to the development of governance systems. The innovative nature of Health and Social Care Integration Schemes also requires governance systems which support complex arrangements, such as hosting of services on behalf of other IJBs, planning only of services delivered by other entities, accountability for assurance without delivery responsibility, and other models of care delivery and planning. This framework has been constructed in the light of these complexities and the likelihood that it may be important to amend and revise the systems as our understanding of the integration environment develops.

The structures and systems described are those in place from January 2023. In order to ensure that the framework can best support the IJB in its ambitions going forward, it will be reviewed annually.

1.4 An integrated approach to governance for health and social care

In working towards the vision stated above, the IJB has agreed the following values in its Strategic Plan 2022-2025:



The integration principles identified by The Scottish Government [4] also underpin decision-making within the IJB.

In 2013, the principles of good governance for both healthcare quality and for quality social care in Scotland are described.[5] These stressed the importance of:

- Embedding continuous improvement
- Providing robust assurance of high quality, effective and safe clinical and care services

[4] Integration Planning and Delivery Principles, The Scottish Government. http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Principles

[5] Governance for Quality Healthcare, The Scottish Government, 2013. http://www.gov.scot/Topics/Health/Policy/Quality-Strategy/GovernanceQualityHealthcareAgreement

- The identification and management of risks to and failure in services and systems
- Involvement of service users/carers and the wider public in the development of services
- Ensuring appropriate staff support and training
- Ensuring clear accountability

The rest of this document and its appendices sets out the structures and systems currently in place to support both assurance of compliance and of transformation of services within the scope of ACHSCP business. This framework can be represented graphically as follows in Table 1:

Table 1: Assurance and Compliance Framework

<table>
<tr><th></th><th>ASSURANCE of COMPLIANCE</th><th>ASSURANCE of IMPROVEMENT, INNOVATION and TRANSFORMATION</th></tr>
<tr><td>FOCUS</td><td>Compliance with standards and regulation, communication and escalation of concerns and risks</td><td>Improving services, measuring and sustaining improvement
Challenging work patterns, innovation, redesign and transformation</td></tr>
<tr><td>KEY COMPONENTS</td><td colspan="2">People and Groups: partners; roles; committee structures
Plans and Activities: engagement plan; risk management policy and system; audit system
Feedback and Reporting processes: concerns and escalation process</td></tr>
<tr><td rowspan="4"></td><td colspan="2">Board Level</td></tr>
<tr><td colspan="2">Corporate Level</td></tr>
<tr><td colspan="2">Service Level</td></tr>
<tr><td colspan="2">Individual Level</td></tr>
<tr><td>OUTCOMES</td><td>IJB measures of success for stakeholders and assurances from internal and external sources</td><td>IJB measures of success for stakeholders and assurances from internal and external sources</td></tr>
</table>

Part 2: The Framework

2.1 Strategic priorities

In its revised Strategic Plan[6] approved by IJB in June 2022, ACHSCP has articulated four broad strategic aims, and five enablers with a number of priorities identified under each.

Strategic Aims			
Caring Together	**Keeping People safe at home**	**Preventing Ill Health**	**Achieve fulfilling, healthy lives**
Strategic Priorities			
❖ Undertake whole pathway reviews ensuring services are more accessible and coordinated ❖ Empower our communities to be involved in planning and leading services locally ❖ Create capacity for General Practice improving patient experience ❖ Deliver better support to unpaid carers	❖ Maximise independence through rehabilitation ❖ Reduce the impact of unscheduled care on the hospital ❖ Expand the choice of housing options for people requiring care ❖ Deliver intensive family support to keep children with their families	❖ Tackle the top preventable risk factors for poor mental and physical health including: - obesity, smoking, and use of alcohol and drugs ❖ Enable people to look after their own health in a way which is manageable for them	❖ Help people access support to overcome the impact of the wider determinants of health ❖ Ensure services do not stigmatise people ❖ Improve public mental health and wellbeing ❖ Improve opportunities for those requiring complex care ❖ Remobilise services and develop plans to work towards addressing the consequences of deferred care

Strategic Enablers				
Workforce	**Technology**	**Finance**	**Relationships**	**Infrastructure**
❖ Develop a Workforce Plan ❖ Develop and implement a volunteer protocol and pathway ❖ Continue to support initiatives supporting staff health and wellbeing ❖ Train our workforce to be Trauma informed	❖ Support the implementation of appropriate technology-based improvements – digital records, SPOC, D365, EMAR, Morse expansion ❖ Expand the use of Technology Enabled Care throughout Aberdeen. ❖ Explore ways to assist access to digital systems ❖ Develop and deliver Analogue to Digital Implementation Plan	❖ Refresh our Medium-Term Financial Framework annually ❖ Report on financial performance on a regular basis to IJB and the Audit Risk and Performance Committee. ❖ Monitor costings and benefits of Delivery Plan projects ❖ Continually seek to achieve best value in our service delivery	❖ Transform our commissioning approach focusing on social care market stability ❖ Design, deliver and improve services with people around their needs ❖ Develop proactive communications to keep communities informed	❖ Develop an interim and longer-term solution for Countesswells ❖ Review and update the Primary Care Premises Plan

[6] Aberdeen City Health and Social Care Partnership Strategic Plan 2022-2025

A Delivery Plan has been developed detailing specific projects which ensure delivery against these priorities. The projects are managed using recognised project and programme management techniques with a member of the Senior Leadership Team (SLT) identified as Senior Responsible Officer (SRO). Progress is monitored regularly by the SLT, quarterly by the Risk Audit and Performance Committee and annually by the IJB via the Annual Performance Report (APR).

2.2 Risk Management Policy

a) Risk appetite

Risk appetite can be defined as:

The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time'.
(HM Treasury - 'Orange Book' 2006)

The ACHSCP recognises that achievement of its priorities may involve balancing different types of risk and that there may be a complex relationship between different risks and opportunities. The IJB has debated its appetite for risk in pursuit of the goals of integration so that its decision-making process protects against unacceptable risk and enables those opportunities which will benefit the communities it serves.

b) Risk Appetite Statement

The IJB has consequently agreed a statement of its risk appetite. The IJB will review and agree the risk appetite statement on an annual basis. The IJB last reviewed its Risk Appetite Statement in October 2022.

This statement is intended to be helpful to the board in decision-making and to enable members to consider the risks to organisational goals of not taking decisions as well as of taking them. The ACHSCP's appetite for risk will likely change over time, to reflect the needs of the residents, the changing environment in which the ACHSCP operates and a desire to develop innovation in local service provision.

c) Risk Management Approach

The Risk Appetite statement, risk management system, strategic and operational risk registers together form the risk management approach as outlined in this Framework..

The framework sets out the arrangements for the management and reporting of risks to IJB strategic priorities, across services, corporate departments and IJB partners. In line with the principles set out in the Australia/New Zealand Risk Management Standard 4360 [7], it describes how risk is contextualised, identified, analysed for likelihood and impact, prioritised, and managed. This process is framed by the requirement for consultation and communication, and for monitoring and review.

Identified risks are measured according to the IJB risk assessment methodology described below and recorded onto risk registers. The detailed methodology for assessment of risk appears at Appendix 6. They are escalated according to the flowchart shown at Appendix 7.

d) Risk Assessment methodology

Risks are measured against two variables: the likelihood (or probability) of any particular risk occurring and the consequence or severity (impact) of that risk should it occur.

For example, there may be a risk of fire in a particular office building. If it happens, this would cause harm or damage to people, property, resources and reputation.

The ***likelihood*** of this occurring will be affected by the strength of fire safety precautions (prevention). The ***consequence*** or ***severity*** of the incident if it does occur will be affected by contingency management (containment, firefighting, evacuation procedures, emergency help, communications etc. by fire safety response and by effective Business Continuity Planning (BCP) to ensure that essential services continue to be delivered, even if at a reduced level for a period). BCP serves to reduce consequence of risk events mostly in major structural or physical risks such as fire, flood, terrorism or natural disaster.

It is important to note that in most areas of risk identified and managed by ACHSCP, the aim is to manage down the likelihood of a risk event and that in most cases, the consequence or severity of a risk event will remain the same throughout the lifetime of the

[7] Standards New Zealand, AS/NZS ISO 31000:2009 Risk Management – Principles and guidelines is a joint Australia/New Zealand adoption of ISO 31000:2009

risk. For example, if there is a shortage of key clinical specialists one month, the consequence for service users could be a poorer health or wellbeing outcome. If vacancies are filled in a subsequent month, the likelihood of that consequence is reduced but if the risk event nevertheless occurs, the consequence for patients or clients may still be 'major' depending on the nature of the service involved.

Risk measurement tables are widely used by organisations and set out levels of both likelihood and consequence, in order to reach an overall risk assessment score. It is rare in the type of services the IJB is concerned with that this is a scientific process but it provides a practical way of comparing different types of risk issues and helping organisations to prioritise between issues so that they can be managed and the risk reduced. This measurement system is also used to decide when to escalate issues that cannot be managed locally or that are of such significance that the members of the senior team or the IJB need to be aware of them.

A key point to remember when assessing a risk for the first time is what controls are currently in place to prevent a risk event. The ACHSCP risk assessment procedure requires the identification of an **initial,** or **gross,** level of risk. This is the risk assessment where it is assumed no controls are in place. This is useful in order to determine and absolute severity of a risk but in practice, the second assessment, or current risk level, is particularly important in risk management terms. This identifies the level of risk taking into account any controls (and gaps in controls) which currently exist. The third level of risk assessment comprises the stage aspired to where the level of risk may be tolerated within the terms of the Risk Appetite, once all effective actions have been completed and the controls are at optimal strength. This is the **target** level of risk.

The IJB's risk measurement table is shown below:

DESCRIPTOR	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	Can't believe this event would happen - will only happen in exceptional circumstances.	Not expected to happen, but definite potential exists - unlikely to occur.	May occur occasionally, has happened before on occasions - reasonable chance of occuring.	Strong possibility that this could occure - likely to occur.	This is expected to occur frequently / in most circumstances - more likely to occur than not.

Risk Matrix

Impact / Likelihood	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	Very High	Very High
Likely	Medium	Medium	High	High	Very High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

The outputs from risk assessment are as follows:

IJB board level: The Board Strategic Risk Register (SRR)

The fundamental purpose of the SRR is to provide the organisation's Governing Body - i.e. the IJB - with assurance that it is able to deliver the organisation's ***strategic objectives and goals.*** This involves setting out those issues or risks which may threaten delivery of objectives and assure the IJB that they are being managed effectively and that opportunity to achieve goals can be taken: it is the lens through which the IJB examines the assurances it requires to discharge its duties. The IJB uses this document to monitor its progress, demonstrate its attention to key accountability issues, ensure that it debates the right issue, and that it takes remedial actions to reduce risk to integration. Importantly, it identifies the assurances and assurance routes against each risk and the associated mitigating actions.

The IJB's SRR format is included in the document (Appendix 1). While many of the issues may be termed strategic, the key thing to remember is that these are issues which may affect the ability to deliver on strategy. It is quite possible that significant operational issues will also be incorporated, therefore. The Senior Leadership Team consider risks classified as 'very high' for inclusion in the SRR (see Appendix 7 – risk escalation process). The Senior Leadership Team reviews the SRR in light of their experiences and insight into key issues, including commissioning risk, and recommends the updated version to the Risk, Audit and Performance Committee (RAPC) for formal review (twice a year) and an annual review by the IJB.

The issues identified are measured according to the IJB risk appetite and risk assessment methodology.

The risks are identified by:

- Discussions at Senior Leadership Team
- Review of Performance data and dashboards
- Review of Flash Reports escalated to SLT by Project Teams (based on project risk logs)
- Review of the Operational Risk Register (see below) including 'deep dives' on areas of operational risk aligned to strategic risk
- Review of Chief Officer reports and reports from IJB sub committees

The Senior Leadership Team agrees issues for inclusion on (and removal from) the SRR, and submits to the RAPC for formal review (twice a year) and an annual review by the IJB.

Risk, Audit & Performance Committee reviews the SRR for the effectiveness of the process annually.

The SRR is shared with the NHS Grampian and Aberdeen City Council through the report consultation process. In addition to this, the SRR is submitted to ACC's Risk Board for information and scrutiny twice a year.

Corporate Level: Operational Risk Register

While the SRR is a *top-down* record of risks to objectives, the Operational Risk Register (ORR) is a *bottom-up* operational document which reflects the top risks that are escalated through the IJB's delegated services and gives detail on how they are being managed.

It may well contain risks that have a strategic angle, as well as those which are operational in nature, and will definitely contain risks that affect strategic objectives.

Risks from service risk registers are escalated to the ORR according to their risk assessment scores. New risks and risks proposed for escalation, will be discussed at the Clinical and Care Risk Meetings. New risks proposed for escalation can also be discussed at the Operational Leadership Team daily huddles as well as at quarterly Meetings of the Senior Leadership Team (when risk management is a standing item on the agenda).

The IJB has a standardised risk register format which is used for the ORR and all other risk registers as detailed below.

The Operational Risk Register comprises high scoring risks or those which cannot be managed locally from a range of sources. This document is reviewed by the Clinical Care and Governance committee (from a clinical and care governance perspective) to ensure:

- the right risks are being reported and escalated
- actions are being taken to mitigate risk and improve the strength of controls
- these actions have been effective in reducing the risk level
- the IJB is aware of high-level risks affecting services and of those where actions are not being taken in a timely manner or have not been successful in reducing the risk

The issues identified are measured according to the risk assessment methodology. They are recorded using the following format:

Table 2: Risk Recording Format

ID	Strategic Priority	Description of Risk	Context/Impact	Date Last Assessed	Controls	Gaps in controls	Likelihood	Consequences	Risk Assessment	Assurances	Risk Owner/Handler	Comments

The risks are identified, using the risk assessment matrix for high scoring risks, from:

- Review of Portfolio Management dashboards
- Operational department risk registers
- Service and locality risk registers and review of reports from service governance groups
- Review of reports from IJB sub committees
- ACHSCP Occupational Health, Safety and Wellbeing committee reports

The Chief Officer owns the Operational Risk Register, and the Clinical and Care Governance Group moderate risks escalated to ensure consistency and appropriateness of issues identified for inclusion and removal. The Clinical Care and Governance Group will meet every 2nd month and will identify any new risks. New or escalated risks are reported to the Clinical and Care Governance Committee so that the Committee are aware of the evolving profile of operational risks.

New operational risks proposed for escalation can also be discussed at the Operational Leadership Team daily huddles as well as at quarterly Meetings of the Senior Leadership Team (when risk management is a standing item on the agenda).

Occupational health and safety risks will be reported to the Partnership's Health, Safety and Wellbeing Committee. Some risks may be reported to both the Clinical Care and Governance Group and the Health, Safety and Wellbeing Committee. Governance arrangements are in place to capture these risks at source and share with the other forum.

Service and locality level: Risk registers and reports from governance groups

Service and locality risk registers will use the same format as the ORR and are compiled at local level and discussed at local management and governance meetings.

Where risks cannot be satisfactorily managed locally, or where they are above scores as set out in the escalation flowchart, they will be escalated for possible entry onto the ORR. New risks and those identified for escalation will be considered at the regular Clinical Care Risk Meetings and recommendations made for the attention of the Clinical and Care Governance Group. The Operational Leadership Team will also receive regular feedback from the Clinical Care Risk Meetings. It is critical to emphasise that the risk management system cannot rely on escalation through the risk register process alone. The Senior Leadership Team, through the operational group management structure, has a key role in helping to manage and find solutions to risk issues at all levels of the organisation.

Operational risks managed at the service and department level are monitored by the Chief Officer and Senior Leadership Team. The Clinical and Care Governance Group (see Appendix 3) has a key role in identifying risk across services which may affect the safety and quality of services to users. The Group also has responsibility for reminding risk owners to ensure operational risks are reviewed regularly and for reporting new and escalated risks to the Group. The aims in developing risk communication between services and the IJB will be to achieve consistency in reporting the nature and scale of risks and to clarify how these are reported, escalated and actions monitored. The risk escalation flowchart at Appendix 7 shows the basis for this process.

2.3 Roles and Responsibilities for governance

a) Committee structure

This section describes the key committees and groups in relation to the IJB governance framework..

The board has established two committees, as follows: **Risk, Audit and Performance**, and **Clinical and Care Governance**. These committees have powers delegated to them by the IJB as set out in the Terms of Reference document.

In relation to governance and assurance, the **Risk, Audit and Performance Committee (RAPC)** performs the key role of reviewing and reporting on the relevance and rigour of the governance structures in place and the assurances the Board receives.

These will include a risk management system and a performance management system underpinned by an Assurance Framework.

The **Clinical and Care Governance Committee (CCGC)** performs the role of providing assurance to the IJB on the systems for delivery of safe, effective, person-centred care in line with the IJB's statutory duty for the quality of health and care services To

support this role, the CCGC is informed by the clinical and care governance arrangements in place across NHS Grampian and Aberdeen City Council (see Appendix 4 - Clinical and care governance diagram).

The IJB's **Senior Leadership Team (SLT)** is an executive group with oversight of the implementation of IJB decisions. The SLT will take collective responsibility and accountability for the delivery of Aberdeen City Health and Social Care Partnership's (ACHSCP) Delivery Plan 2022-2025. It will work together to identify any emerging risks and issues and to address those together. It will work to identify and embrace opportunities for accelerating the delivery of the Delivery Plan. It will provide a forum to 'join the dots' between local, regional and national initiatives ensuring that the HSCP operates as efficiently and effectively as possible

A diagram illustrating the structure appears at Appendix 2. A summary of the purpose, membership and reporting arrangements for these groups appears at Appendix 3.

b) Individual responsibilities

1. Board and corporate level:

The Chief Officer provides a single point of accountability for integrated health and social care services.

The Board and all its members must as a corporate body ensure good governance through the structures and systems described in this document. To provide assurance that the Board has the capability and competence required, an annual self-assessment and periodic (minimum 3 yearly) independent assessment will be undertaken.

2. Professional level:

There are existing clinical and professional leadership structures in place to support clinical and care governance. These are:

- Chief Nurse & Frailty Lead
- Chief Officer Social Work (Adults)
- Allied Health Professional and Grampian Specialist Rehabilitation Lead
- Primary Care Lead
- Public Health Lead
- Medical Lead

3. Locality level:

The Board Assurance and Escalation Framework is aligned with the locality structure. This will require that there is a direct line of sight to the appropriate clinical and professional lead roles and must take into account the location of services: some are locality based and others not.

2.4 Reporting of information to provide assurance and escalate concerns (internal & external)

The framework shown in Table 1 in section 1.4 can be populated as shown in Table 3 below. Leads and Service Managers will work with their partners in local services to develop systems for reporting from their various governance forums through to the IJB, as indicated in Table 3 below. In addressing the nature of assurance, it is important to note that the IJB, the RAPC and the CCGC operate assurance mechanisms to review *process* as well as *performance*, and in this regard the work of the RAPC is the key governance mechanism for auditing *process*.

Table 3: Reporting of information to provide assurance and escalate concerns

FOCUS	**Assurance of compliance, performance, improvement and transformation**						
	Individuals	**Plans / activities**	**Groups / Partners**	**Reporting and feedback processes**			
				Compliance with standards	**Risk escalation and review**	**Performance monitoring**	**Improvement and Transformation reporting**
Board level	Chair Chief Officer Board members Chairs / CEOs of the Partners	Strategic plan Strategic Risk Register Operational Risk register Performance framework Budget Monitoring	Board Senior Leadership Team Risk, Audit and Performance Committee	Review of BAEF Review of risk scoring Review of Performance dashboard Transformation Performance Report Audit reports to Board Exception and action plan review Bi-annual review of integration scheme Bi-annual review of strategic plan			

		Audit plan Standing Orders Integration Scheme	Clinical and Care Governance Committee Other IJBs Scrutiny / governance arms of Parties	
Corporate level	Chief Officer /Chief Operating Officer/Chief Finance Officer Senior Leadership Team Members	Strategic and Operational risk registers Performance dashboard Business planning Budget monitoring Joint Complaints Procedure	Senior Leadership Team Senior Management Teams Strategic Planning Group Clinical and Care Governance Group Portfolio Programme Boards	Financial monitoring Strategic and Operational risk register review Risk moderation and review
Service level	Clinical leads and Professional leads Service managers	Engagement, Participation and Empowerment Strategy Clinical and care governance policies Risk registers and assessments	Community partners Service governance forums 'Deep Dive' activity	Risk register system Governance reports Real time feedback Response to complaints Learning from Duty of Candour events Service level dashboards
Individual level	Staff members Service users Carers	Engagement, Participation and Empowerment Strategy Complaints policy	Staff forums IJB engagement activity	Objective setting and review Supervision and line management Staff surveys Feedback mechanisms (see assurance source section) Community engagement feedback

		Safeguarding alerts Risk assessment Incident reporting	Locality Empowerment Groups	

Table 4: Reporting of information to provide assurance and escalate concerns with partner organisations

FOCUS	**Assurance of compliance, performance, improvement and transformation**						
	Individuals	**Activities**	**Groups / Partners**	**Reporting and feedback processes**			
				Compliance with standards	**Risk escalation and review**	**Performance monitoring**	**Improvement and Transformation reporting**
NHSG Board	NHSG Board Chair ACHSCP Chief Officer	Regular Report	NHS Board Chief Executive Team	Oversight of IJB activity & minutes			
ACC Full Council	ACC Chief Executive	Regular Report	ACC Full Council ACC Chief Executive Corporate Management Team	Oversight of IJB activity & minutes Information on financial governance, risk management, clinical & care governance etc			
Pan-Grampian IJBs	Chairs of Aberdeen City, Aberdeenshire and Moray IJB's and Chief Officers of Aberdeen City, Aberdeenshire and Moray Health and	Regular meetings	North East Partnership Steering Group	Established regionally			

	Social Care Partnerships			
ACC & NHSG CEs	Chief Executives of NHSG and ACC and Chief Officer of ACHSCP	Quarterly Performance Review Meetings Bi-monthly 2-1 meetings	ACC NHSG ACHSCP	Performance Finance Risk Governance Directions Transformation Programme

2.5 Sources of assurance

a) Quality of services

Current providers have a range of clinical and care governance arrangements in place. Through these, the IJB has access to assurances which support the delivery of high-quality care and ensure good governance. These assurances include:

- Quality Strategies
- Policies on raising concerns
- HR Policies
- Performance Frameworks
- Safeguarding Policy (Vulnerable Adults)
- Incident reporting and investigation policies and procedures
- Information Governance policies and processes
- Board member visits to service areas ('Deep Dive' activity)
- Staff Surveys
- Joint Staff Forum
- Staff Induction Programmes
- Leadership Programmes
- Performance and Appraisal Development Process
- Compliance reports – health and social care
- Learning lessons systems

b) Engagement

The IJB regards the engagement of its partners and stakeholders in the planning and delivery of services as essential to achieving the goals of integration. The nature and level of engagement varies from group to group and the range of stakeholders with whom the IJB engages is broad. In August 2021, the IJB approved guidance for public engagement which described the vision, scope, commitments and responsibilities with the aim of improving the range, quality and consistency of engagement practice. The guidance is based not only on the IJB's vision and values but also on relevant national and local policy including the Charter for Involvement, the National Standards for Community Engagement, Planning with People and Community Planning Aberdeen's Community Empowerment Strategy. Within the Strategy and Transformation Team there is a dedicated Engagement Officer whose role is to promote engagement in all its forms as an ongoing and integral activity ensuring it is constructive and a positive experience.

c) Other internal and external sources of assurance

In addition to the assurances emanating from the IJB's clinical and care governance framework, and its engagement with partners and stakeholders, there are numerous internal and external sources which relate to the delegated services. These include:

- Internal Audit
- External Audit
- External inspection agencies (Care Inspectorate and Healthcare Improvement Scotland)
- Health and Safety Executive
- Mental Welfare Commission
- Externally commissioned independent investigations e.g. Ombudsman and homicide investigations
- Clinical Audit
- Scottish Council for Voluntary Organisations (SCVO)
- Royal College reviews
- Accreditation
- Information Services Division (ISD) Scotland
- Benchmarking with other health and social care providers
- Involvement in and learning from case reviews
- Voluntary Health Scotland
- Crown Office / Procurator Fiscal Reports

- The IJB will also commission external reviews of specific services where the need for additional independent assessments and assurance are identified.

Appendices

1 Strategic Risk Register format

2 Committee diagram

3 Transformation Programme Structure and Senior Management Structure

4 Role of the Committees

5 Clinical and care governance diagram

6 Risk assessment tables

7 Risk escalation process

8 Ownership and Version Control for the Board Assurance and Escalation Framework

Appendix 1 – Strategic risk register format

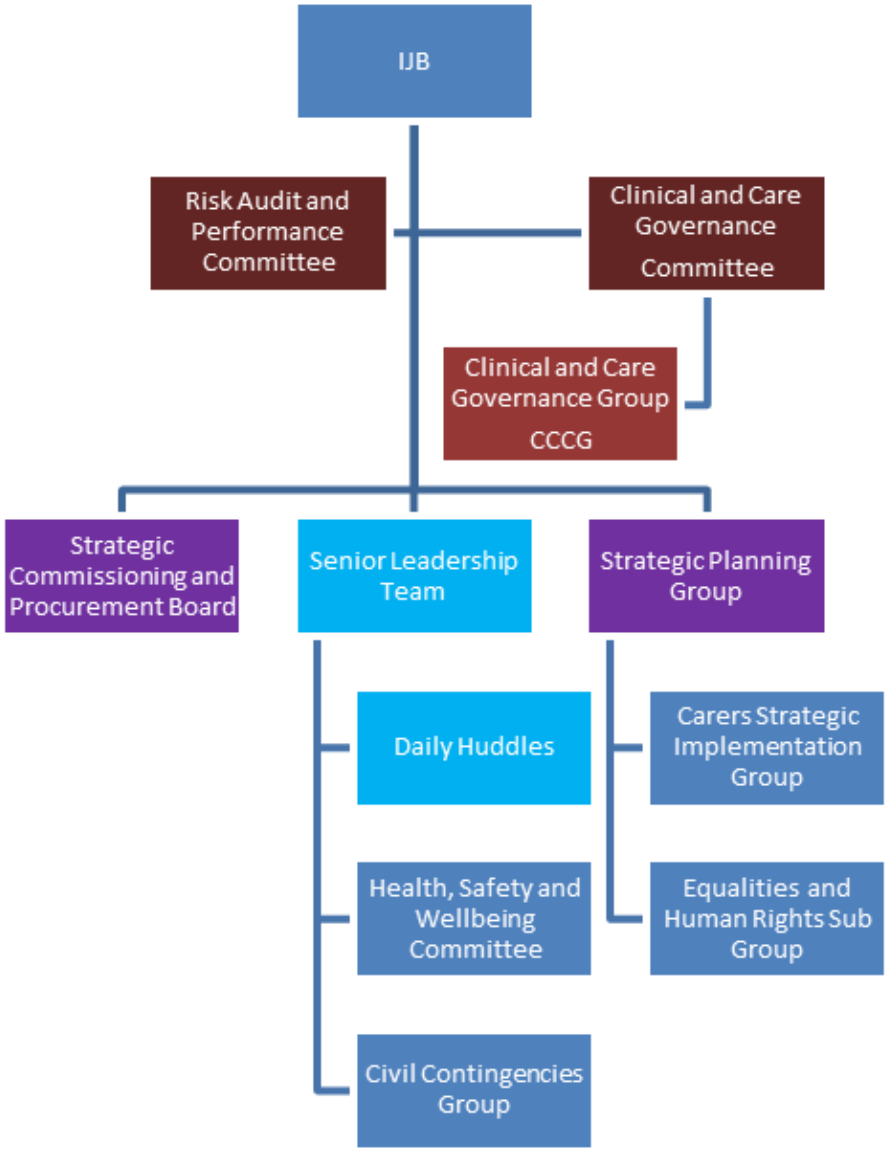
<table>
<tr><th colspan="3">- 1 -</th></tr>
<tr><td colspan="3">Description of Risk:</td></tr>
<tr><td colspan="2">Strategic Priority:</td><td>Lead Director:</td></tr>
<tr><td>Risk Rating: low/medium/high/very high

Medium</td><td rowspan="2">Rationale for Risk Rating:

Rationale for Risk Appetite:</td><td rowspan="2"></td></tr>
<tr><td>Risk Movement: increase/decrease/no change

NO CHANGE</td></tr>
<tr><td colspan="2">Controls:</td><td>Mitigating Actions:</td></tr>
<tr><td colspan="2">Assurances:</td><td>Gaps in assurance:</td></tr>
<tr><td colspan="2">Current performance:</td><td>Comments:</td></tr>
<tr><td colspan="2"></td><td></td></tr>
</table>

Appendix 2 - Board Committee diagram



Appendix 3 – Roles of the Governance Groups

Principal function/s	Membership	Reports to	Reports received / reviewed
Senior Leadership Team			
• Monitoring the delivery of the Delivery Plan 2022-25. • Monitor Key Performance Indicators across services. • Provide oversight of political enquiries and complaints. • Monitor the ACHSCP's Strategic Risk Register and identify emerging risks and issues. • Monitor the ACHSCP's financial position. • Oversee the IJB and committees' business planners. • Approve regular initiatives including, annual contract workplan, annual audit plan, annual governance statement	The core membership is as follows: • Chief Officer • Chief Operating Officer-Chair • Chief Finance Officer • Medical Lead • Strategy & Transformation Lead • Business Support, Communications & Contingency Lead • People and Organisation Lead • Allied Health Professional and Grampian Specialist Rehabilitation Lead • Chief Nurse & Frailty Lead • Chief Officer Social Work (Adults) • Mental Health & Learning Disabilities Lead (Community) • Mental Health & Learning Disabilities Lead (Specialist/In-Patient) • Commissioning Lead • Strategic Home Pathways Lead	IJB	The following will report as required to the Senior Leadership Team : • Senior Leadership team members • Service Managers • Transformation Programme Managers • Chief Officers – Moray and Aberdeenshire in relation to performance of 'hosted services' • Designated service health and safety leads • Partnership representatives /

Principal function/s	Membership	Reports to	Reports received / reviewed
and the Risk Appetite Statement. • Approval of ACHSCP strategies and policies prior to consideration by the IJB. • Provide a forum for escalation of matters arising from other relevant executive groups within the ACHSCP as set out in the Executive Governance Structures.	• Primary Care Lead • Public Health Lead		trade union representatives • Service Improvement and Quality • Chief Social Work Officer • Health Intelligence
Strategic Planning Group			
Establishing a Strategic Planning Group (SPG) is a requirement under the Public Bodies (Joint Working) (Scotland) Act 2014. Key partners in delivering health and social care integration are represented on the group. The SPG is the essence of the collaborative and co-productive approach of Aberdeen City Health and Social Care Partnership. It ensures that key strategic, policy, performance and improvement decisions relating to integration functions are informed and co-developed by partners and the organisations and communities they represent.	• Strategy and Transformation Lead (Chair)* • Primary Care Lead • Chief Nurse & Frailty Lead • Allied Health Professional and Grampian Specialist Rehabilitation Lead • Chief Officer Social Work (Adults) • Commissioning Lead • NHSG Planning Innovation and Programmes • Sexual Health Services • Mental Health and Learning Disability • Community Planning • ACC Housing Strategy • ACC Integrated Children's Services • ACVO • Scottish Care • Bon Accord Care • Active Aberdeen Partnership • Alcohol and Drugs Partnership	IJB	Locality Empowerment Groups Annual Performance Report Strategic Plan Carers Strategy Workforce Plan Equality and Human Rights Subgroup Climate Change Subgroup

Principal function/s	Membership	Reports to	Reports received / reviewed
	• Community Justice • Locality Empowerment Group Representatives • Civic Forum • Community Council Forum • Carer Representatives • Service User Representatives • ACC Business Intelligence • Health Intelligence		
Risk Audit and Performance Committee			
To review and report on the relevance and rigour of the governance structures in place and the assurances the Board receives. These will include a risk management system and a performance management system underpinned by an Assurance Framework.	The Committee will be chaired by a non-office bearing voting member of the IJB and will rotate between NHS and ACC. The Committee will consist of not less than 4 members of the IJB, excluding Professional Advisors. The Committee will include at least two voting members, one from Health and one from the Council. The Board Chair, Chief Officer, Chief Finance Officer, Chief Internal Auditor and other Professional Advisors and senior officers as required as a matter of course, external audit or other persons shall attend meetings at the invitation of the Committee. The Chief Internal Auditor should normally attend meetings and the external auditor will attend at least one meeting per annum.	IJB	Annual audit plan
Clinical & Care Governance Committee			
To provide assurance to the IJB on the systems for delivery of safe, effective, person-centred care in line with the	The Committee shall be established by the IJB and will be chaired by a voting member of the IJB. The Committee shall comprise of:	IJB	CCG Group report Feedback/Incidents Reporting

Principal function/s	Membership	Reports to	Reports received / reviewed
IJB's statutory duty for the quality of health and care services.	• 4 voting members of the IJB • Chief Officer • Chief Social Work Officer • Medical Lead • Chair of the Clinical and Care Governance Group • Chair of the Joint Staff Forum • Professional Lead – Nurse/AHP • Public Representative • Third sector Sector representatives		Escalations from CCG Group
Clinical & Care Governance Group			

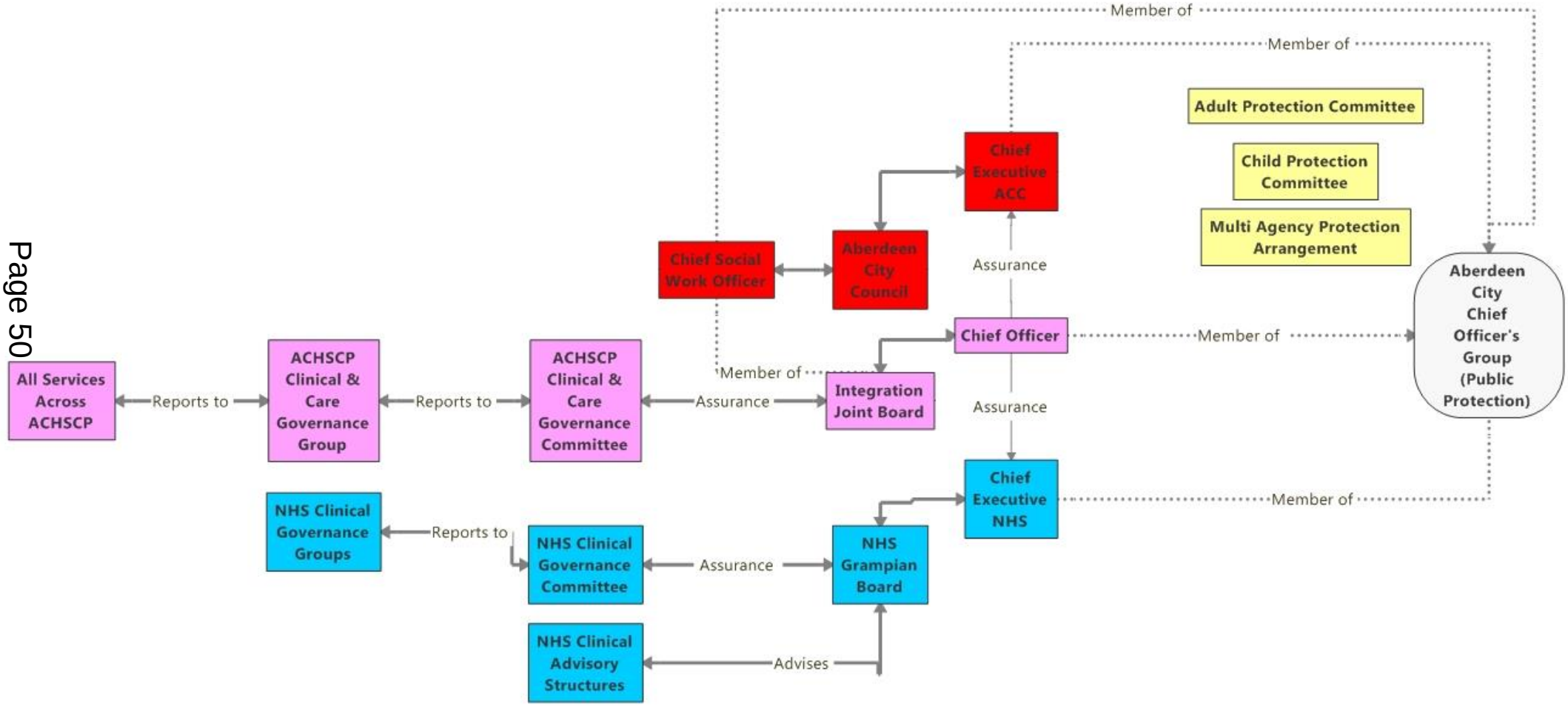
To oversee and provide a coordinated approach to clinical and care governance issues and risks within the Aberdeen City Health and Social Care Partnership.	• Medical Lead
	  • Chief Officer Social Work (Adults)
	  • Chief Nurse & Frailty Lead
	• Public Health Lead
	• Patient/Public Representative
	  • Allied Health Professional and Grampian Specialist Rehabilitation Lead
	• GP Representative
	• Dental Clinical Lead or Dental Service Representative
	• Lead Optometrist
	• Representative from Sexual Health Service
	• General Practice Patient Safety Lead
	• Woodend Hospital and Link@ Woodend Representative
	• Representative from Commissioned Service
	• Partnership Representative
		Senior Leadership Team
		Clinical and Care Governance Committee
		NHSG Clinical Quality & Safety Group
		ACC Public Protection Committee
			Reports from services:
			AHP
			Dentistry
			Optometry
			Pharmacy
			Nursing
			General Practice
			Social Work/Care
			Woodend Hospital and Links @ Woodend
			Biannual Reports
			Falls
			Pharmacy/medication
			Patient Safety in Primary Care
			New and escalated risks

Principal function/s	Membership	Reports to	Reports received / reviewed
	• Representative from Community Mental Health and Learning Disability Services • Representative from Acute Sector • Public Partner		
Locality Empowerment Groups			
To deliver the locality planning requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, in respect of the Aberdeen City Health and Social Care Partnership. The Locality Empowerment Groups play a key role in ensuring the delivery of the Aberdeen City Health and Social Care Strategic Plan, including contributing to the delivery of its associated strategic outcomes. The role of the Locality Empowerment Groups include developing and ensuring appropriate connections and partnerships across the Locality to help to improve the health and wellbeing of the locality population and reduce the health inequalities that we know impact poorly on people's lives. The locality leadership group will influence, and be influenced by, the city's Strategic Planning Group and ultimately the Integration Joint Board.	Community Members Public Health Coordinators	Strategic Planning Group	Locality Plans Health Improvement Fund report

Principal function/s	Membership	Reports to	Reports received / reviewed
The locality leadership group will also influence and be influenced by the Aberdeen City Community Planning Partnership.			
Strategic Commissioning and Procurement Board			
The purpose of the Strategic Commissioning and Procurement Board is to ensure effective and forward strategic planning of commissioning activity. It provides a central function drawing together representatives from ACC Procurement services and ACHSCP commissioners to ensure the smooth and efficient commissioning and procurement of social care services across the City.	• Lead Commissioner ACHSCP • Finance Officer ACC • Chief Officer Social Work (Adults) • Lead for Mental Health and Learning disability ACHSCP • NHS Grampian Health Intelligence • Head of Commercial and Procurement Services ACC • Category Managers, Commercial and Procurement Services • Scottish Care Representative • ACVO Representative • NHS Grampian acute services • NHS Grampian Procurement representative	IJB	Workstreams and project groups Business Case Programme Management documentation

Appendix 5 – Clinical and care governance diagram

The diagram on the following page provides an overview of the clinical & care governance processes within ACHSCP. The processes draw upon the existing clinical & care governance within Aberdeen City Council and the NHS. Clinical & care governance matters relating to the ACHSCP are considered by its Clinical & Care Governance Group. The Clinical & Care Governance group has representation from all services across ACHSCP and report to the ACHSCP Leadership Team, Clinical & Care Governance Committee and provide assurance to ACC and NHS clinical and safety structures.


Member of
Member of
Adult Protection Committee
Child Protection Committee
Multi Agency Protection Arrangement
Chief Executive ACC
Chief Social Work Officer
Aberdeen City Council
Assurance
Aberdeen City Chief Officer's Group (Public Protection)
Chief Officer
Member of
All Services Across ACHSCP
Reports to
ACHSCP Clinical & Care Governance Group
Reports to
ACHSCP Clinical & Care Governance Committee
Assurance
Member of
Integration Joint Board
Assurance
Chief Executive NHS
Member of
NHS Clinical Governance Groups
Reports to
NHS Clinical Governance Committee
Assurance
NHS Grampian Board
NHS Clinical Advisory Structures
Advises

NHS Scotland Core Risk Assessment Matrices

Table 1 - Impact/Consequence Definitions

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience/ clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable.	Unsatisfactory patient experience/clinical outcome, short term effects – expect recovery <1wk.	Unsatisfactory patient experience/ clinical outcome long term effects –expect recovery >1wk.	Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects.
Objectives/ Projects	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significant project over-run.	Inability to meet project objectives; reputation of the organisation seriously damaged.
Injury (physical and psychological) to patient/ visitor/staff	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints/ Claims	Locally resolved verbal complaint.	Justifiable written complaint peripheral to clinical care.	Below excess claim. Justifiable complaint involving lack of appropriate care.	Claim above excess level. Multiple justifiable complaints.	Multiple claims or single major claim. Complex justifiable complaint.
Service/ Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to a significant "knock on" effect.
Staffing and Competence	Short term low staffing level temporarily reduces service quality (< 1 day). Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality. **Minor error** due to ineffective training/ implementation of training. Ongoing problems with staffing levels.	Late delivery of key objective/ service due to lack of staff. **Moderate error** due to ineffective training/ implementation of training.	Uncertain delivery of key objective /service due to lack of staff. **Major error** due to ineffective training/implementation of training.	Non-delivery of key objective/ service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training/ implementation of training.
Financial (including damage/loss/ fraud)	Negligible organisational/ personal financial loss (£<1k).	Minor organisational/ personal financial loss (£1-10k).	Significant organisational/ personal financial loss (£10-100k).	Major organisational/personal financial loss (£100k-1m).	Severe organisational/ personal financial loss (£>1m).
Inspection/Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity/ Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media/adverse publicity, less than 3 days. Public confidence in the organisation undermined. Use of services affected.	National/International media adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Enquiry/FAI.

Table 2 - Likelihood Definitions

Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	• Can't believe this event would happen • Will only happen in exceptional circumstances	• Not expected to happen, but definite potential exists • Unlikely to occur.	• May occur occasionally • Has happened before on occasions • Reasonable chance of occurring.	• Strong possibility that this could occur • Likely to occur.	This is expected to occur frequently/in most circumstances more likely to occur than not.

Table 3 - Risk Matrix

Likelihood	Consequences/Impact				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	Medium	High	High	V. High	V. High
Likely	Medium	Medium	High	High	V. High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

References: AS/NZS 4360:2004 'Making It Work' (2004)

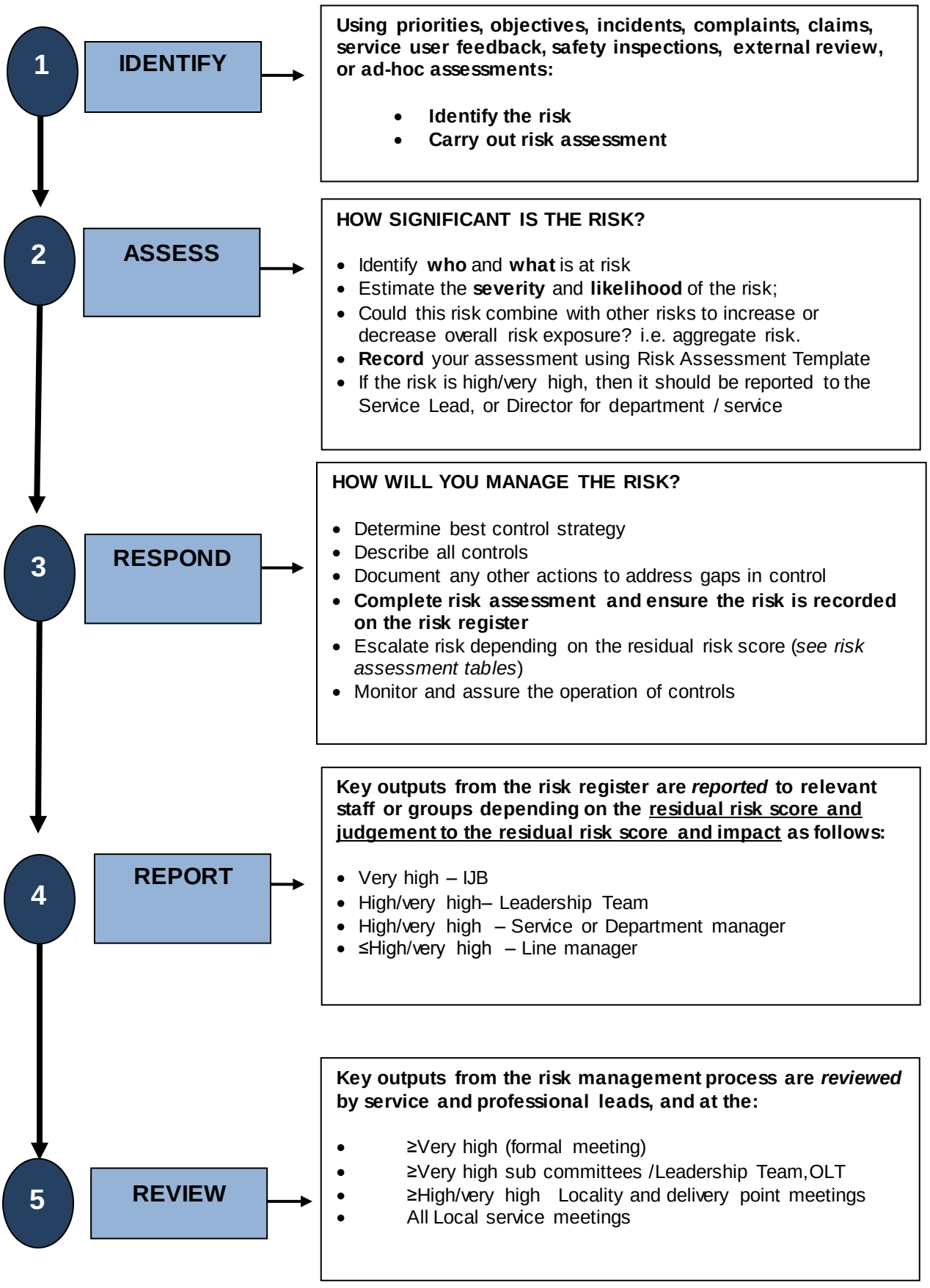
Table 4 - NHSG Response to Risk

Describes what NHSG considers each level of risk to represent and spells out the extent of response expected for each.

Level of Risk	Response to Risk
Low	Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.
Medium	Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective.
High	Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significant resources. Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these controls to be effective and that it is not reasonably practicable to do more. The Board may wish to seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information systems or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.
Very High	Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The Board will seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information systems or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.

Version March 2013

Appendix 7 – Risk escalation process



Appendix 8: Ownership & Version Control

Ownership:

The BAEF Framework is owned by the Senior Leadership Team and is regularly reviewed by the team.

Version Control

1. Version Control/Document Revision History (begun 24.11.2017)			
Version	Reason	By	Date
1.	Revisions to the BAEF requested by the Audit & Performance Committee at its meeting on the 21st of November 2017	Sarah Gibbon, Executive Assistant	24.11.2017
2.	Additional revisions to BAEF pending submission to IJB	Sarah Gibbon, Executive Assistant	22.01.2018
3.	Acceptance of changes	Sarah Gibbon, Executive Assistant	31.01.2018
4.	Annual Review	Sarah Gibbon Executive Assistant	18.01.2019
5.	Annual Review	Neil Buck Support Manager	22.04.2020
6.	Annual Review	Martin Allan Business Manager	August 2021
7.	Annual Review	Martin Allan Business and Resilience Manager	February 2023

8.	Annual Review	Martin Allan, Business and Resilience Manager	February 2024

Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	2 April 2024
Report Title	Strategic Risk Register
Report Number	HSCP24.015
Lead Officer	Martin Allan
Report Author Details	*Name:* Martin Allan *Job Title:* Business and Resilience Manager *Email Address:* martin.allan3@nhs.scot
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	*No*
Appendices	a. Risk Appetite Statement b. Strategic Risk Register
Terms of Reference	10. Ensure the existence of, and compliance, with an appropriate risk management strategy including: reviewing risk management arrangements; receiving biannual Strategic Risk Management updates and undertaking in-depth review of a set of risks and annually review the IJB's risk appetite document with recommendations being brought to the IJB

1. Purpose of the Report

1.1. To present to the Risk, Audit and Performance Committee (RAPC) its Risk Appetite Statement and an updated version of the Strategic Risk Register (SRR).

2. Recommendations

2.1. It is recommended that the Risk, Audit and Performance Committee:

a) Note the Integrated Joint Board (IJB) revised Risk Appetite Statement at Appendix A;
b) Agree that the Committee reviews the Statement at its meeting in September 2024; and
c) Approve the IJB revised Strategic Risk Register at Appendix B;

3. Strategic Plan Context

3.1. Risk management is referenced in the Strategic Plan, specifically in relation to the management of risk to enablers to the Plan eg workforce, technology, finances, as well as in the Strategic Aims of the Plan.

4. Summary of Key Information

Revised Risk Appetite Statement

4.1. The IJB's Risk Appetite Statement is intended to be helpful to the Board in decision-making and to enable members to consider the risks to organisational goals of not taking decisions as well as of taking them. The ACHSCP's appetite for risk will change over time, reflecting a longer-term aspiration to develop innovation in local service provision. The IJB regularly debates its appetite for risks and opportunities in the pursuit of its objectives and will ensure that the statement on risk appetite reflects these discussions.

4.2. The IJB Members, at a workshop on 16 January, 2024, considered the Board's Risk Appetite Statement and agreed that the Committee review the Statement at the mid-point of financial year 2024/25 to sense check the Board's appetite to risk at that point. The Risk Appetite Statement is attached as Appendix A to this report.

Updates on Strategic Risk Register

4.3. The fundamental purpose of the SRR is to provide the IJB with assurance that it is able to deliver the organisation's strategic objectives and goals. This involves setting out those issues or risks which may threaten delivery of objectives and assure the IJB that they are being managed effectively and that opportunity to achieve goals can be taken: it is the lens through which the IJB examines the assurances it requires to discharge its duties. The IJB uses this document to monitor its progress, demonstrate its attention to key accountability issues, ensure that it debates the right issue, and that it takes remedial actions to reduce risk to integration. Importantly, it identifies the assurances and assurance routes against each risk and the associated mitigating actions

4.4. The Senior Leadership Team (SLT) reviews the SRR in light of their experiences and insight into key issues, including commissioning risk, and recommends the updated version to the RAPC for formal review (twice a year) and an annual review by the IJB. The IJB also hold an annual risk workshop whereat the Board review the Risk Appetite Statement and the Strategic Risks.

4.5. At its last meeting in November,2023, the Committee noted the outcomes of the deeper dive undertaken in October 2023 on the 2 very high risks on the SRR, these are Risk 1 (Commissioning) and Risk 7 (Workforce). As a result the Committee agreed to lower the risk ratings for these 2 risks from Very High to High.

4.6. At the IJB Workshop in January 2024, the members present discussed the seven strategic risks. During the discussion the members requested that reference be made to the public consultation undertaken on the Primary Care Vision work as this was not currently reflected in the strategic risks. The Register has been amended with additions to risks 1 and 6. The members also noted that an internal audit on hosted services was planned in 2024/25 and that the outcomes of the audit would allow the risk on hosted services (Risk 3) to be updated.

4.7. The Business and Resilience Manager has met with all Risk Owners to review the risks and to take into account the discussions held at the IJB Workshop in January 2024.

4.8. The updated version of the SRR forms Appendix B to this report.

4.9. As mentioned, the SRR is also considered by SLT on a quarterly basis. Through this process, no new risks have been recommended to be added to the SRR and no risks have been recommended for de-escalation.

5. Implications for Committee

5.1. Equalities, Fairer Scotland and Health Inequality
There are no direct equalities, Fairer Scotland and Health Inequalities implications arising from this report.

5.2. Financial
There are no direct financial implications arising from this report.

5.3. Workforce
The deeper dive on 13 of October,2023 discussed the Workforce Risk (Risk 7) in detail. The updated version of the Risk is outlined in Appendix B to this report.

5.4. Legal
There are no direct legal implications arising from this report.

5.5. Unpaid Carers
There are no direct implications relating to Unpaid Carers arising from this report.

5.6. Information Governance
There are no direct information governance implications arising from this report.

5.7. Environmental Impacts
There are no direct environmental implications arising from this report.

5.8. Sustainability
There are no direct sustainability implications arising from this report.

5.9. Other
There are no other implications arising from this report.

6. Management of Risk

The IJB's Board Assurance and Escalation Framework outlines the governance processes for the consideration and escalation of risks through the Partnership. The SRR is part of the governance arrangements.

6.1. Identified risks(s)

All known strategic risks.

6.2. Link to risks on strategic or operational risk register:

The report has the full SRR appended.

This page is intentionally left blank

Appendix A

IJB Risk Appetite Statement (as at February 2024)

Aberdeen City Health and Social Care Integration Joint Board (the IJB) recognises that it is both operating in, and directly shaping, a collaborative health and social care partnership, existing in a mixed economy where safety, quality and sustainability of services are of mutual benefit to local citizens and to all stakeholders. It also recognises that its appetite for risk will change over time, reflecting a longer-term aspiration to develop innovation in local service provision based on evidence of benefits and on a culture of continuing, planned engagement with the public and other stakeholders, including those involved in service delivery. As a result, the IJB risk appetite will evolve and change over time.

The IJB recognises that achievement of its priorities will involve balancing different types of risk and that there will be a complex relationship between different risks and opportunities. The risk appetite approach is intended to be helpful to the board in decision-making and to enable members to consider the risks to organisational goals of *not* taking decisions as well as of taking them.

The IJB has identified several broad dimensions of risk which will affect the achievement of its strategic priorities. The IJB will set a level of appetite ranging from "none" up to "very high (none, low, medium, high, very high)" for these different dimensions. Higher levels of all risk types may be accepted if specific and effective controls are demonstrably in place and there are clear advantages for integration objectives. The dimensions of risk and corresponding risk appetite are:

Dimension of Risk	**Corresponding Risk Appetite**
Financial risk	Low to medium. It will have zero tolerance of instances of fraud. The Board must make maximum use of resources available and also acknowledge the challenges regarding financial certainty.
Regulatory compliance risk	It will accept no or low risk in relation to breaches of regulatory and statutory compliance.
Risks to quality and innovation outcomes	Low to medium (quality and innovation outcomes which predict clearly identifiable benefits and can be managed within statutory safeguards)

Risk of harm to patients/clients and staff	Similarly, it will accept low risks of harm to patients/clients or to staff. By low risks, the IJB means it will only accept low risk to patients/clients or staff when the comparative risk of doing nothing is higher than the risk of intervention
Reputational risk	It will accept medium to high risks to reputation where the decision being proposed has significant benefits for the organisation's strategic priorities. Such decisions will be explained clearly and transparently to the public.
Risks relating to commissioned and hosted services	The IJB recognises the complexity of planning and delivery of commissioned and hosted services. The IJB has no or low tolerance for risks relating to patient/client safety and service quality. It has medium to high tolerance for risks relating to service redesign or improvement where as much risk as possible has been mitigated.

The IJB has an appetite to take decisions which may expose the organisation to additional scrutiny and interest. Wherever possible, decisions will be taken following consultation/co-production with the public and other key stakeholders. Concerted efforts will be made to explain reasons for decisions taken to the public transparently in a way which is accessible and easy to understand. This risk appetite statement will be reviewed annually, and when the IJB's strategic plan is reviewed and more often when required.

Aberdeen City Health & Social Care Partnership
A caring partnership

Strategic Risk Register

Revision	Date
1.	March 2018
2.	September 2018
3.	October 2018 (IJB & APS)
4.	February 2019 (APS)
5.	March 2019 (IJB)
6.	August 2019 (APS)
7.	October 2019 (LT)
8.	November 2019 (IJB workshop)
9.	January 2020 (ahead of IJB)
10	March 2020 (RAPC)
11	July 2020 (IJB)
12	October 2020 (IJB Workshop)
13	November 2020 (IJB)
14	January 2021 (RAPC)
15	May 2021 (IJB)
16	June 2021 (RAPC)
17	September 2021 (RAPC)
18	November 2021 (Following IJB Workshop and ahead of IJB meeting in Dec)
19	February 2022 (RAPC)
20	August 2022 (ahead of IJB Workshop)
21	Review reflecting workshop-IJB Oct 22
22	November 2022 (RAPC)
23	January 2023 (SLT)
24	May 2023 (RAPC and IJB)
25	September 2023 (ahead of deep dive in October 2023)
26	November 2023 for RAPC
27	December 2023 for annual IJB Workshop (held in January 2024)

Aberdeen City Health & Social Care Partnership

A caring partnership

28	February 2024 for RAPC

Introduction & Background

This document is made publicly available on our website, in order to help stakeholders (including members of the public) understand the challenges currently facing health and social care in Aberdeen.

This is the strategic risk register for the Aberdeen City Integration Joint Board, which lays the foundation for the development of work to prevent, mitigate, respond to and recover from the recorded risks against the delivery of its strategic plan.

Just because a risk is included in the Strategic Risk Register does not mean that it will happen, or that the impact would necessarily be as serious as the description provided.

More information can be found in the Board Assurance and Escalation Framework and the Risk Appetite Statement.

Appendices

- Risk Tolerances
- Risk Assessment Tables

Colour – Key

Risk Rating	Low	Medium	High	Very High
Risk Movement		Decrease	No Change	Increase

Risk Summary:

1	Description of Risk: Cause: The commissioning of services from third sector and independent providers (eg General Practice and other primary care services) requires all stakeholders to work collaboratively to meet the needs of local people. Event: Potential failure of commissioned services to deliver on their contract Consequence: There is a gap between what is required to meet the needs of local people, and services that are available. Consequences: to the individual include not having the right level of care delivered locally, by suitably trained staff. Consequences: ability of other commissioned services to cope with the unexpected increased in demand. Consequences to the partnership includes an inability to meet peoples needs for health and care and the additional financial burden of seeking that care in an alternative setting	**High**
2	Cause: IJB financial failure and projection of overspend Event: Demand outstrips available budget Consequence: IJB can't deliver on its strategic plan priorities, statutory work, and projects.	**High**
3	Cause: Under Integration arrangements, Aberdeen IJB hosts services on behalf of Moray and Aberdeenshire, who also hosts services on behalf of Aberdeen City. Event: hosted services do not deliver the expected outcomes, fail to deliver transformation of services, or face service failure. Consequence: Failure to meet health outcomes for Aberdeen City, resources not being maximised and reputational damage.	**High**
4	Cause: Performance standards/outcomes are set by national and regulatory bodies and those locally-determined performance standards are set by the board itself. Event: There is a risk that the IJB, and the services that it directs and has operational oversight of, fails to meet the national, regulatory and local standards. Consequence: This may result in harm or risk of harm to people.	**High**
5	Cause: Demographic & financial pressures requiring IJB to deliver transformational system change which helps to meet its strategic priorities. Event: Failure to deliver transformation and sustainable systems change. Consequence: people not receiving the best health and social care outcomes	**High**
6	Cause: Need to involve lived experience in service delivery and design as per Integration Principles Event: IJB fails to maximise the opportunities created for engaging with our communities	**Medium**

	Consequences: Services are not tailored to individual needs; reputational damage; and IJB does not meet strategic aims	
7	Cause- The ongoing recruitment and retention of staff. Event: Insufficient staff to provide patients/clients with services required. Consequence: Potential loss of life and unmet health and social care needs, leading to severe reputational damage.	**High**

<table>
<tr><th colspan="7">-1-</th></tr>
<tr><td colspan="7">Description of Risk: Cause: The commissioning of services from third sector and independent providers (eg General Practice and other primary care services) requires all stakeholders to work collaboratively to meet the needs of local people.
Event: Potential failure of commissioned services to continue to deliver on their contract
Consequence: There is a gap between what is required to meet the needs of local people, and services that are available.
Consequences: to the individual include not having the right level of care delivered locally, by suitably trained staff.
Consequences: ability of other commissioned services to cope with the unexpected increased in demand.
Consequences to the partnership includes an inability to meet peoples needs for health and care and the additional financial burden of seeking that care in an alternative setting</td></tr>
<tr><td colspan="4">Strategic Aims: Caring Together
Strategic Enablers: Relationships and Infrastructure</td><td colspan="3">Leadership Team Owner: Lead Commissioner and Primary Care Lead</td></tr>
<tr><td colspan="4">Risk Rating: low/medium/high/very high
HIGH</td><td colspan="3" rowspan="7">Rationale for Risk Rating:

Primary Care
• Increased demand in primary care and widespread recruitment difficulties continues to impact on practices, which has led to practices prioritising the core GMS contract over any non-essential work eg Care Home SLA’s.
• Increased demand in primary care and widespread recruitment difficulties continues to impact on practices, which has increased the risk and frequency of handing back their contracts or closing their lists.
• Increase in unexpected/unplanned and planned demand is a risk to patients and the ACHSCP
• Increased risk of reduction in General Dental Practitioners capacity as a result of patient deregistration activity seen in some regions
• Delayed implementation of Primary Care Improvement Plan (PCIP) due to staff redeployment due to Covid and lack of available workforce for recruitment.
Social Care
• Recruitment difficulties in residential and non-residential businesses.
• Uncertainly regarding the National Care Home Contract percentage uplift for 24/25
• Interim provision in care homes will reduce as of March 2024 due to unsustainable funding streams and lack of capacity of medical cover.

Rationale for Risk Appetite:
As 3rd and independent sectors are key strategic partners in delivering transformation and improved care experience, we have a low tolerance of this risk. It is suggested that this risk tolerance should be shared right throughout the organisation, which may encourage staff and all providers of primary health and care services to escalate valid concerns at an earlier opportunity.</td></tr>
<tr><td colspan="4">IMPACT</td></tr>
<tr><td>Almost Certain</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Likely</td><td></td><td></td><td></td><td>✓</td><td></td></tr>
<tr><td>Possible</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Unlikely</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Rare</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>LIKELIHOOD</td><td>Negligible</td><td>Minor</td><td>Moderate</td><td>Major</td><td>Extreme</td></tr>
<tr><td colspan="4">Risk Movement: increase/decrease/no change
NO CHANGE 22.02.24</td></tr>
<tr><td colspan="4">Controls:

General
• Grampian Data Gathering Group
• Quarterly Budget Monitoring Reports</td><td colspan="3">Mitigating Actions:
Social Care
• All opportunities to work in a collaborative manner to commission services are advertised on Public Contract Scotland, as well as individual invitations made to CEOs / owners of social care services.
• Additional offers are made to encourage dialogue where the provider is unavailable to attend collaborative commissioning workshops etc.
• Agreed strategic commissioning approach for ACHSCP.</td></tr>
</table>

Social Care

- Conscious cultural shift to change relationships, with all strategic commissioning activity proceeding in a collaborative manner.
- Examples of collaborative commissioning models used as exemplar models within the City. Care at Home, Mental Health / Learning disability accommodation review.
- Strategic Commissioning Programme Board (includes representatives from third and independent sectors)
- Residential and Non-Residential Oversight Groups-meet depend on the needs of the sector
- Providers Huddle (meets weekly)
- Daily meetings with Care at Home Providers over Winter period 2023/24
- Stood up Care at Home Strategic Group (meets monthly)
- Winter Planning and coordination workshop to be held in December 2023
- Care at Home clients have a personal RAG status identifying vulnerability and this will be linked to the Persons at Risk Database
- Care at home clients are being reviewed in regard to how their outcomes are supported using a tech first approach
- In process of setting up Commissioning Academy (City, Moray and Shire)
- Technology First approach is being used to support people achieve the best outcome.

Primary Care

- Local Medical Council
- GP Sub Group
- Clinical Director and Clinical Leads
- Primary Care Contracts Team
- Primary Care Integrated Management Group
- GP Contract Oversight Group
- ACHSCP PCIP Project Group
- Grampian Sustainability Group
- Senior Leadership Team
- Review of Closed List process
- Health Assessment Team (for asylum and refugees)
- Grampian Data Gathering Group
- Quarterly Budget Monitoring Reports
- Deeper Dive on Risks 1 and 7 held on 13th October, 2023.This will likely be repeated in 2024.
- A Patient Stakeholder Group has been established around the Primary Care Visioning Exercise.

- Strategic commissioning programme board (SCPB members) established to provide governance framework for commissioning activity.
- Continue to liaise with the care home sector through the collaborative approach detailed in the controls to explore agreement at a local level until a national agreement is in place with Scotland Excel
- Continue to support the flow from acute into interim beds at Woodlands.
- 1 SLA now in place for all interim/emergency beds
- Winter Planning and coordination workshop held in December 2023
  - Workshop with providers in Feb and March 2024 to inform them of commissioning opportunities a help to shape the content and process of the tender.
  - Interim provision in alternative housing including care homes, Very sheltered and Sheltered housing will be further developed during 2024-25
  - All people using care at home Self Directed Support Options 1, 2 & 3 will be reviewed through a Technology first Lens.
  - Mental Health and Wellbeing Festival during May 2024 will help to promote and support the sector to be more mindful of their own and service users Wellbeing.

Primary Care

- Sustainability meetings with all Practices in Aberdeen City
- Working in collaboration with the Scottish Government, Local Medical Council (LMC) and Clinical Leads with practices to agree a sustainable way forward using individualised action plans and group discussions.
- Strategic Change Lead is establishing a task and finish group to review medical cover across care settings in the City with a view to establishing an alternative model for medical cover.
- Collaborative approach with the integration of the Health Assessment Team into Aberdeen City Council's Settlement Team to manage demand and risk of becoming a Dispersal City
- General Practice Vision and future provision workshops looking at SMART objectives to meet the unscheduled care demands
- Comms and engagement to raise public awareness on general practice pressures and wider Multi-Disciplinary Team roles
- Weekly RAG status on general practices to understand pressures
- An engagement plan has been developed to ensure that a co-production approach is being used for the Visioning Exercise, and patients from across the Grampian area are involved in the development of the vision and strategic objectives.

Assurances:

Social Care

- Progress against our strategic commissioning workplan
- Market facilitation opportunities and wide distribution of our market position statements
- Oversight of both residential and non-residential social care services
- Inspection reports from the Care Inspectorate
- Daily meetings and monthly strategic meetings with Care at Home help to build relationships and better communication.

Gaps in assurance:

Social Care

- Difference between National Care Home Contract rate (last reviewed in 2013) and providing a 24 hour residential service
- Inability to benchmark accurately due to variation of service models
- Contract Monitoring visits (enhanced services)
- Having 1 SLA for all interim/emergency beds is a single point of failure

• We are currently undertaking service mapping which will help to identify any potential gaps in market provision • Working collaboratively with sector to shape commissioning and procurement processes. **Primary Care** • Monitoring of Primary Care Improvement Plan • Daily report monitoring • Good relationships with GP practices, ensuring communication through agreed governance routes • Links to Dental Practice Advisor who works with independent dentists • Director of Dentistry co-ordinating Grampian contingency planning to • • horizon scan for regional deregistration activity • • proactively work with practices that wish to deregister patients • • plan suitable contingency arrangements in the event patients are deregister • Part of the Eye Health Network and Clinical Leads for Optometry in Shire & Moray and the overall Grampian Clinical Lead • Roles of Clinical Director and Clinical Leads, including fortnightly Grampian wide Clinical Lead Meetings, including meetings with Office Bearers from LMC and GP Sub Committee • Peer Support	**Primary Care** • Market or provider failure can happen quickly despite good assurances being in place. For example, even with the best monitoring system, the closure of a practice can happen very quickly, with (in some cases) one partner retiring or becoming ill being the catalyst. • Market forces and individual business decisions regarding community optometry, general practice and general dental practitioners cannot be influenced by the Partnership and lack of demand information • Public Dental Services staffing capacity to flexibly increase service provision in short term
Current performance: **Social Care** • We now have established a care at home strategic providers group, with agreed terms of reference. Their strategic ambition is to ensure the safe and effective delivery of care at home across Aberdeen. • We are in the process of drafting a Market Position Statement which details all Accommodation needs across Aberdeen City, this will come to IJB in May 2024. • We are currently looking at what and how to use a 20 bedded unit within the city to best serve the needs of the population. • A financial risk rating of each residential care home/setting is part of an on-going process, to give intelligence on the commercial viability and financial risks within these businesses. • We are co-designing services with staff, managers and people with lived experience to ensure the services are fit for the future. This is being carried out in line with Ethical Commissioning Principles and Getting it Right for Everyone (GIRFE principles. **Primary Care** • The process for closed lists was reviewed and agreed in line with GMS regulations, a meeting was held with all practices to give an overview of this and the paperwork subsequently circulated with an FAQs document.	**Comments:** **Social Care** Cost of living continues to impact on the provision of the service and the staff ability to get to work due to fuel prices. Currently working with the market to find the best option which will be reduced and will affect the unmet need/ delayed discharges and delayed transfer of care figures. **Primary Care** Lack of space for MDT working. Sustainability report has a limited predictability due to the ever changing nature of primary care. GP practices are expressing an increasing challenge in meeting the needs of practice populations and therefore many are prioritising the delivery of the core GMS contract. The impact of this means that any additional non-core/statutory work is being reviewed by practices and in some instances, stopped. This varies across the City and the Partnership continues to work with Practices to find collaborative and financially sustainable solutions for both parties. This main amendments made to this risk since the last time the Committee considered it are: 1. additional Controls and mitigations added to the social care commissioning risk

-2-

Description of Risk: Cause-IJB financial failure and projection of overspend

Event-Demand outstrips available budget

Consequence-IJB can't deliver on its strategic plan priorities, statutory work, and projects.

Strategic Aims: All
Strategic Enablers: Finance

Leadership Team Owner: Chief Finance Officer

Risk Rating: low/medium/high/very high

HIGH

IMPACT					
Almost Certain					
Likely				✓	
Possible					
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: increase/decrease/no change*:*

NO CHANGE 22.02.2024

Rationale for Risk Rating:

- If the partnership does not have sufficient funding to cover all expenditure, then in order to achieve a sustainable balanced financial position, decisions will be required to be taken which may include reducing/stopping services
- If the levels of funding identified in the Medium Term Financial Framework are not made available to the IJB in future years, then tough choices would need to be made about what the IJB wants to deliver. It will be extremely difficult for the IJB to continue to generate the level of savings year on year to balance its budget. The MTFF will be reported to the IJB in March 2024.
- The major risk in terms of funding to the Integration Joint Board is the level of funding delegated from the Council and NHS and whether this is sufficient to sustain future service delivery. There is also a risk of additional funding being ring-fenced for specific priorities and policies, which means introducing new projects and initiatives at a time when financial pressure is being faced on mainstream budgets.

Rationale for Risk Appetite:

The IJB has a low-moderate risk appetite to financial loss and understands its requirement to achieve a balanced budget. The IJB recognises the impacts of failing to achieve a balanced budget on Aberdeen City Council & its bond – an unmanaged overspend may have an impact on funding levels.

However, the IJB also recognises the significant range of statutory services it is required to meet within that finite budget and has a lower appetite for risk of harm to people (low or minimal).

Controls:

- Financial information is reported regularly to the Risk, Audit and Performance Committee, the Integration Joint Board and the Senior Leadership Team
- Risk, Audit & Performance receives regular updates on transformation programme & spend.
- Approved reserves strategy, including risk fund
- Robust financial monitoring and budget setting procedures including regular budget monitoring & budget meeting with budget holders.
- Budgets delegated to cost centre level and being managed by budget holders.

Mitigating Actions:

- The Senior Leadership Team are committed to driving out efficiencies, encouraging self-management and moving forward the prevention agenda to help manage future demand for services.
- The Senior Leadership Team have formalised arrangements to receive monthly financial monitoring statements.
- Senior Leadership Team will be scrutinising Year 3 of the ACHSCP Delivery Plan to identify projects that will generate financial savings or prevent and reduce future budget pressures.

• Medium-Term Financial Strategy. • Medium Term Financial Strategy review, including a members workshop ahead of the budget meeting (5th March, 2024) • SLT have a revised vacancy management process that has been operating since end of November, 2023, which prioritises vacancy approval to help support a balanced budget position in 2023/24, and this is continuing in 2024.	
Assurances: • IJB and the Risk, Audit and Performance Committee oversight and scrutiny of budget under the Chief Finance Officer. • Board Assurance and Escalation Framework. • Quarterly budget monitoring reports. • Regular budget monitoring meetings between finance and budget holders. • Monthly financial monitoring to SLT	**Gaps in assurance:** • The financial environment is challenging and requires regular monitoring. The scale of the challenge to make the IJB financially sustainable should not be underestimated. • There is a gap in terms of the impact of transformation on our budgets. Many of the benefits of our projects relate to early intervention and reducing hospital admissions, neither of which provide cashable savings
Current performance: Quarter 2 position is showing a £5.4m overspend. This is being reviewed at weekly meetings of the Senior Leadership Team.	**Comments:** • The financial position in future years will be challenging. Discussions are continuing with ACC and NHSG regarding level of funding for future years. • The current financial pressures have the potential to impact on our ability to deliver on our strategic plan priorities and projects and the level of transformation and service change originally agreed. A consequence of this would be reduced patient flow and poorer outcomes for people if the best destination for their care is not available.

- 3 -

Description of Risk: Cause: Under Integration arrangements, Aberdeen IJB hosts services on behalf of Moray and Aberdeenshire, and who also hosts services on behalf of Aberdeen City.

Event: hosted services do not deliver the expected outcomes, fail to deliver transformation of services, or face service failure.

Consequence: Failure to meet health outcomes for Aberdeen City, resources not being maximised and reputational damage.

Strategic Aims: All
Strategic Enablers: Relationships

Leadership Team Owner: Chief Officer

Risk Rating: low/medium/high/very high

HIGH

IMPACT					
Almost Certain					
Likely				✓	
Possible					
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (increase/decrease/no change):

NO CHANGE 22.02.2024

Rationale for Risk Rating:

- Considered high risk due to the projected overspend in hosted services
- Hosted services are a risk of the set-up of Integration Joint Boards.

Rationale for Risk Appetite:

- The IJB has some tolerance of risk in relation to testing change.

Controls:

- Integration scheme agreement on cross-reporting
- North East Partnership Steering Group
- Aberdeen City Strategic Planning Group (ACSPG)
- North East System Wide Transformation Group

Mitigating Actions:

- Intention to develop Service Level Agreements for 9 of the hosted services considered through budget setting process
- In depth review of the other 3 hosted services.
- Quarterly reporting to ACSPG and annual reporting on budget setting to IJB (once developed).

Assurances:

- These largely come from the systems, process and procedures put in place by NHS Grampian, which are still being operated, along with any new processes which are put in place by the lead IJB.
- North East System Wide Transformation Group (Officers only) led by the 4 pan-Grampian chief executives. The aim of the group is to develop real top-level leadership to drive forward the change agenda, especially relating to the delegated hospital-based services.
- Both the CEO group and the Chairs & Vice Chairs group meet quarterly. The meetings are evenly staggered between groups, giving some six weeks between them, allowing progressive work / iterative work to be timely between the forums.
- The Portfolio approach and wider system approach demonstrates closer joint working across the 3 Health and Social Care Partnerships and the Acute Sector.

Gaps in assurance:

- Ongoing review of hosted services through development of SLAs has stalled due to focus on Annual Delivery Plan for NHS Grampian's Plan for the Future

Current performance: • Once the SLA's are reported to the Risk, Audit and Performance Committee, the IJB will be informed on current performance on an ongoing basis. • The scope of an audit on hosted services is being drafted and will be reported at some point in 2024.	**Comments:** Review of budget has highlighted that this work is crucial to maintain transparent accountability of service delivery and use of resources. The Lead for Strategy and Transformation will raise this with Grampian Planner colleagues to align to 2024/25 budget setting.

Aberdeen City Health & Social Care Partnership
A caring partnership

- 4 -

Description of Risk:

Cause: Performance standards/outcomes are set by national and regulatory bodies and those locally-determined performance standards are set by the board itself.

Event: There is a risk that the IJB, and the services that it directs and has operational oversight of, fails to meet the national, regulatory and local standards.

Consequence: This may result in harm or risk of harm to people.

Strategic Aims: All
Strategic Enablers: Technology

Leadership Team Owner: Strategy and Transformation Lead

Risk Rating: low/medium/high/very high

HIGH

IMPACT					
Almost Certain					
Likely				✓	
Possible					
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (*increase/decrease/no change)*

NO CHANGE 22.02.2024

Rationale for Risk Rating: Service delivery is broad ranging and undertaken by both in-house and external providers. There are a variety of performance standards set both by national and regulatory bodies as well as those determined locally and there are a range of factors which may impact on service performance against these. Poor performance will in turn impact both on the outcomes for service users and on the reputation of the IJB/partnership. Given current situation with increased demand and staffing pressures there might be times that the likelihood of services not meeting standards is possible.

Rationale for Risk Appetite:
The IJB has no to minimal tolerance of harm happening to people as a result of its actions, recognising that in some cases there may be a balance between the risk of doing nothing and the risk of action or intervention.

Controls:

- Clinical and Care Governance Committee and Group
- Risk, Audit and Performance Committee
- Data and Evaluation Group
- Performance Framework
- Linkage with ACC and NHSG performance reporting
- Annual Performance Report
- Chief Social Work Officer's Report
- Ministerial Steering Group (MSG) Scrutiny
- External and Internal Audit Reports
- Links to outcomes of Inspections, Complaints etc.
- Contract Management Framework
- Weekly Senior Leadership Team Meetings

Mitigating Actions:

- Continual review of key performance indicators
- Review of and where and how often performance information is reported and how learning is fed back into processes and procedures.
- On-going work developing a culture of performance management and evaluation throughout the partnership
- Refinement of Performance Dashboard, presented to a number of groups, raising profile of performance and encouraging discussion leading to further review and development
- Recruitment of additional resource to drive performance management process development
- Risk-assessed plans with actions, responsible owners, timescales and performance measures monitored by dedicated teams
- Restructure of Strategy and Transformation Team which includes an increase in the number of Programme and Project Managers will help mitigate the risk of services not meeting required standards.

• Daily Operational Leadership Team Huddles • Urgent and Unscheduled Care Programme Board	• Use of Grampian Operational Pressure Escalation System (G-OPES) and Daily and Weekly System Connect Meetings help to mitigate the risk of services not meeting standards through system wide support. • Four focus areas of the system wide critical response to ongoing system pressures • All recommendations from the Internal Audit report on Performance Management have been implemented.
Assurances: • Joint meeting of IJB Chief Officer with two Partner Body Chief Executives. • Performance Dashboard reported quarterly to Risk, Audit & Performance Committee. • Bespoke report developed for Clinical and Care Governance Committee and considered at every meeting. • Annual report on IJB activity developed and reported to ACC and NHSG • Care Inspectorate Inspection reports considered by services with action plans developed and monitored • Capture of outcomes from contract review meetings. • External reviews of performance. • Benchmarking with other IJBs	**Gaps in assurance:** • Community Planning Aberdeen (CPA) currently refreshing the LOIP. Attempt is being made to link current ACHSCP reporting to that however the final outcome of this will not be confirmed until the CPA Board in February 2024. • Locality Plans are also being reviewed as part of the LOIP refresh. The intention is to streamline these and make them more focused making it easier to monitor performance and report on performance. Current community engagement closed 3rd November 2023. Again outcome will not be confirmed until CPA Board in February 2024.
Current performance: • Performance reports submitted to IJB, Risk, Audit and Performance and Clinical and Care Governance Committees. • Various Steering Groups for strategy implementation established. • Close links with social care commissioning, procurement and contracts team have been established via the Strategic commissioning and Procurement Board • IJB Dashboard has been shared widely. • SLT workshops held to develop a Partnership dashboard	**Comments:**

-5-

Description of Risk:

Cause: Demographic & financial pressures requiring IJB to deliver transformational system change which helps to meet its strategic priorities.

Event: Failure to deliver transformation and sustainable systems change.

Consequence: people not receiving the best health and social care outcomes

Strategic Aims: All
Strategic Enablers: Technology and Infrastructure

Leadership Team Owner: Strategy and Transformation Lead

Risk Rating: low/medium/high/very high

HIGH

IMPACT					
Almost Certain					
Likely					
Possible				✓	
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (*increase/decrease/no change)*

NO CHANGE 22.02.2024

Rationale for Risk Rating:

- Recognition of the known demographic curve & financial challenges, including cost of living, which mean existing capacity may struggle
- This is the overall risk – each of our transformation programme work streams are also risk assessed with some programmes being a higher risk than others.
- Given current situation with increased demand and staffing pressures there might be times when it is likely that transformational projects delivery may be delayed.
- System Wide demand on Information Governance Services for data sharing agreements

Rationale for Risk Appetite:

- The IJB has some appetite for risk relating to testing change and being innovative.
- The IJB has no to minimal appetite for harm happening to people – however this is balanced with a recognition of the risk of harm happening to people in the future if no action or transformation is taken.

Controls:

- Governance Structure and Process (Senior Leadership Team meetings, Operational Team Daily Huddles and IJB and its Committees)
- Quarterly Reporting of Delivery Plan progress to Risk, Audit & Performance Committee
- Annual Performance Report
- External and Internal Audit

Mitigating Actions:

- Programme management approach being taken across whole of the Partnership
- Regular reporting of progress on programmes and projects to Senior Leadership Team
- Increased frequency of governance processes, Senior Leadership Team now meeting weekly
- A number of plans and frameworks have been developed to underpin our transformation activity across our wider system including: Primary Care Improvement Plan and Action 15 Plan.
- All Programme and Project Managers have been trained in the appropriate level of Managing Successful Programmes methodology and Prince2, where appropriate.

Assurances:

- Risk, Audit and Performance Committee Reporting
- Robust Programme Management approach supported by an evaluation framework

Gaps in assurance:

• IJB oversight • Board Assurance and Escalation Framework process • Internal Audit has undertaken a detailed audit of our transformation programme. All recommendations from this audit have now been actioned. • The Medium-Term Financial Framework prioritises transformation activity that could deliver cashable savings • Separation in Year 2 Delivery Plan of transformational projects from business as usual projects • The Medium-Term Financial Framework, Portfolio Management Approach aims and principles, and Programme of Transformation have been mapped to demonstrate overall alignment to strategic plan.	• Our ability to evidence the impact of our transformation: documenting results from evaluations and reviewing results from evaluations conducted elsewhere allows us to determine what works when seeking to embed new models. • Changes to funding have meant that temporary recruitment to certain posts is in place for 2023/24, with further work to be done to identify funding beyond that.
Current performance: • The Strategic/Delivery Plan has been approved and Strategy and Transformation resource has been allocated to deliver on the projects within the Plan.	**Comments:** The current financial pressures have the potential to impact on our ability to deliver on our strategic plan priorities and projects and the level of transformation and service change originally agreed. A consequence of this would be reduced patient flow and poorer outcomes for people if the best destination for their care is not available.

- 6 -

Description of Risk

Cause: Need to involve lived experience in service delivery and design as per Integration Principles

Event: IJB fails to maximise the opportunities created for engaging with our communities

Consequences: Services are not tailored to individual needs; reputational damage; and IJB does not meet strategic aims.

Strategic Aims: All
Strategic Enablers: Relationships

Leadership Owner: Chief Officer

Risk Rating: low/medium/high/very high

MEDIUM

IMPACT					
Almost Certain					
Likely					
Possible			✓		
Unlikely					
Rare					
LIKELIHOOD	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (*increase/decrease/no change)*

NO CHANGE 22.02.2024

Rationale for Risk Rating:

- Now that localities governance and working arrangements are established the impact of not maximising the opportunities is moderate but at the moment, in the early stages of the arrangements, the likelihood remains a possibility.
- Cost of living and digital exclusion are potential barriers for community engagement

Rationale for Risk Appetite:
The IJB has some appetite to risk in relation to testing innovation and change. There is zero risk of financial failure or working out with statutory requirements of a public body.

Controls:

- Locality Empowerment Groups (LEGs)
- Senior Leadership Team Meetings and Operational Leadership Huddles
- CPP Community Engagement Group
- Equalities and Human Rights Sub-Group
- A Patient Stakeholder Group has been established around the Primary Care Visioning Exercise

Mitigating Actions:

- Strategic Planning Group (SPG) Pre-Meeting Group set up to support locality empowerment group members on the SPG.
- Continued joint working with Community Planning colleagues to oversee the ongoing development of locality planning
- An engagement plan has been developed to ensure that a co-production approach is being used for the Visioning Exercise, and patients from across the Grampian area are involved in the development of the vision and strategic objectives.

Assurances:

- Strategic Planning Group (LEGs have representation on this group)
- IJB/Risk, Audit and Performance Committee
- CPA Board

Gaps in assurance

- Locality Empowerment Groups are recovering post Covid and this is a slow process. They are meeting regularly again and there is the ongoing challenge in relation to membership and diversity. The Public Health Team are working hard to build these up but resistance is always experience from certain groups within the city's population. We are working with relevant groups to understand the best way to engage and recognise that one approach does not suit all.

Current performance:

Comments:

• LEGs representatives attend the SPG on a regular basis and participate in the meetings. • Review of joint locality planning arrangements is underway • Locality Plans are being streamlined and revised along-side the revision of the Local Outcome Improvement Plan (LOIP)	

- 7 -

Description of Risk: Cause-The ongoing recruitment and retention of staff

Event: Insufficient staff to provide patients/clients with services required.

Consequence: Potential loss of life and unmet health and social care needs, leading to severe reputational damage.

Strategic Aims: All

Strategic Enablers: Workforce

Leadership Team Owner: People & Organisation Lead

Risk Rating: low/medium/high/very high

HIGH

IMPACT					
Almost Certain					
Likely				✓	
Possible					
Unlikely					
Rare					
LIKELIHOOD -	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**

Risk Movement: (*increase/decrease/no change*)

NO CHANGE 22.02.2024

Controls:

- Clinical & Care Governance Committee reviews tactical level of risk around staffing numbers
- Clinical & Care Governance Group review the operational level of risk
- Oversight of daily Operational Leadership Team meetings to maximise the use of daily staffing availability
- Revised contract monitoring arrangements with providers to determine recruitment / retention trends in the wider care sector-*replicate wording in risk 1 and include pc risk*
- Establishment of daily staffing situational reports (considered by the Leadership Team)
- NHSG and ACC workforce policies and planning groups
- Daily Grampian System Connect Meetings and governance structure
- Daily sitreps from all services (includes staffing absences)
- ACHSCP Workforce Plan Oversight Group has met twice. There are 3 workstream groups established under the Plan.
- Deeper Dive on Risks 1 and 7 held on 13th October, 2023. This will likely be repeated in 2024.

Rationale for Risk Rating:

- The current staffing complement profile changes on an incremental basis over time.
- However the proportion of over 50s employed within the partnership (by NHSG and ACC) is increasing rapidly (i.e. 1 in 3 nurses are over 50).
- Totally exhausted work force with higher turnover of staff (particularly over 50)
- Current very high vacancy levels and long delays in recruitment across ACHSCP services.
- Economic upturn in North East post covid, which means there is direct competition with non-clinical posts and negatively impacting on the calibre of candidates for a number of posts, there are national Scottish shortages in all of the professions within the Partnership and we are competing with the Central Belt for people's choice for employment.
- Post Covid 19 landscape, where many staff have reflected on their personal situation, which has led to increased numbers of early retirement applications, requests for reduced hours and staff leaving the service
- Staff experienced a challenging winter in 2022/23 and the likelihood that this will be just as challenging in 2023/24.

Rationale for Risk Appetite:

- Will accept minimal risks of harm to service users or to staff. By minimal risks, the IJB means it will only accept minimal risk to services users or staff when the comparative risk of doing nothing is higher than the risk of intervention.

• The Partnership's Workforce Plan Annual Report was submitted to the Risk, Audit and Performance Committee on 28th November, 2023. The report received positive feedback from the Members of the Committee.	
Assurances: ACHSCP Workforce Plan and Oversight Group Agreed governance arrangements Formal performance reporting against the Strategic/Delivery Plan has continued to be developed in consultation with the SLT. Staff side and union representation on daily Operational Leadership Team meetings	**Mitigating Actions**: • Significantly increased emphasis on health/wellbeing of staff and positive feedback regularly received, over 900 staff attended these type of initiatives in the last year. • All staff strongly encouraged to use their annual leave throughout the year, take regular breaks and this to be positively modelled by SLT • establishment of ACHSCP recruitment programme, with significantly increased Social Media presence • promotion and support of the 'We Care' and 'Grow of own' approaches • embrace the use of new/improved digital technologies to develop and support the ACHSCP infrastructure & develop a road map with a focus on enablement for staff. Working with Microsoft to increase online appointment bookings and significantly reduce pressure on staff, as well as looking at resolving current IT issues regarding different systems. • flexible/hybrid working options to become 'normal' working practice that benefit staff time & supports their wellbeing as well as helps staff retention • Increased emphasis on communication with staff • increased collaboration across the Senior Leadership Team (SLT) and integration between professional disciplines, third sector, independent sector and communities through Localities to help diversity of the workforce • Increased monitoring of staff statistics (sickness, turnover, CPD, complaints etc) through Senior Leadership Team and daily Operational Leadership Team meetings, identifying trends. • Awareness of new Scottish Government, NHSG and ACC workforce policies and guidelines • Partnership to reintroduce staff recognition events to encourage retention • Staff Wellbeing budget in 2023/24 of £25,000 • Production of recruitment video(s) for a range of posts within the Partnership and shared at the IJB meeting in December, 2023. • Partnership Jobs Fair-November 2023-In conjunction with ABZ Works ((18 Partnership Services presenting stalls and over 200 attendees) • Holding regular job showcase sessions with clients seeking work in Aberdeen City. • Successful 4 week internship of 4 Career ready students in July 2023. Ongoing support from the Partnership to continue the mentoring of Career Ready students in 2024. • Foundation Apprentice started with Business Support in September 2023, and subject to feedback will continue in 2024. • Currently working with 3 City and 1 Aberdeenshire Academies around a variety of different subjects to match school curriculum with future workforce opportunities. • Partnership Staff Conference convened for 29th February, 2024. • Establishment of Social Media Comms Group to help promote workforce opportunities and raise the profile of the organisation.
Current performance:	**Gaps in assurance**

• Partnership sickness absence rate at end of September 2023 was 5.3% (compared to NHSG 5.28%) • Partnership ACC staff sickness days absent per staff member was lower than the ACC average • Managing workforce challenges through daily Operational Leadership Team meetings and Daily Connect Meetings and structures • Managing very high level vacancies in comparison to neighbouring Health Boards • Ongoing development of governance dashboard for SLT, which will include data on staff absences, turnover etc. To be considered by SLT quarterly. • Once the 3 Workstream Groups have met then the mitigations will be added to the register with SMART measures.	• The deeper dive on the 13th of October and the production of the Partnership's Workforce Annual Plan asked the question around gaps in assurance. • Development of governance dashboard is ongoing, including updates on Workforce Plan data.
	Comments: • Ongoing consultation on National Care Service. Any updates arising from the progress of the Service that has a bearing on the risk will be updated in due course. • Workforce is an enduring risk across Scotland. Eg Aberdeen City Health and Social Care Partnership vacancies in NHSG are 11.6% compared to Scottish average of 7.1%.

Appendix 1 – Risk Tolerance

Level of Risk	*Risk Tolerance*
Low	Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. Chief Officers/Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.
Medium	Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective. Chief Officers/Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Chief Officers/Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective.
High	Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significant resources. Chief Officers/Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Chief Officers/Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these continue to be effective and confirm that it is not reasonably practicable to do more. The IJB's may wish to seek assurance that risks of this level are being effectively managed. However the IJB's may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public
Very High	Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Chief Officer/Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The IJB's will seek assurance that risks of this level are being effectively managed. However the IJB's may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public

Appendix 2 – Risk Assessment Matrices (from Board Assurance & Escalation Framework)

Table 1 - Impact/Consequence Definitions

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience/ clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable.	Unsatisfactory patient experience/clinical outcome, short term effects – expect recovery <1wk.	Unsatisfactory patient experience/ clinical outcome; long term effects –expect recovery >1wk.	Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects.
Objectives/ Project	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significnt project over-run.	Inability to meet project objectives; reputation of the organisation seriously damaged.
Injury (physical and psychological) to patient/ visitor/staff.	Adverse event leading to minor injury not requiring first aid	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significnt injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints/ Claims	Locally resolved verbal complaint	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim. Complex justified complaint.
Service/ Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to facility leading to significant "knock on" effect.
Staffing and Competence	Short term low staffing level temporarily reduces service quality (< 1 day). Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality **Minor error** due to ineffective training/implementation of training.	Late delivery of key objective/ service due to lack of staff. **Moderate error** due to ineffective training/ implementation of training. Ongoing problems with staffing levels	Uncertain delivery of key objective /service due to lack of staff. **Major error** due to ineffective training/implementation of training.	Non-delivery of key objective/ service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training / implementation of training.
Financial (including damage/loss/ fraud)	Negligible organisational/ personal financial loss (£<1k).	Minor organisational/ personal financial loss (£1-10k).	Significnt organisational / personal financial loss (£10-100k).	Major organisational/personal financial loss (£100k-1m).	Severe organisational/ personal financial loss (£>1m).
Inspection/Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity/ Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale/ public attitudes.	Local media – long-term adverse publicity. Significnt effect on staff morale and public perception of the organisation.	National media/adverse publicity, less than 3 days. Public confidnce in the organisation undermined. Use of services affected.	National/International media/ adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Enquiry/FAI.

Table 2 - Likelihood Definitions

Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	• Can't believe this event would happen • Will only happen in exceptional circumstances.	• Not expected to happen, but definite potential exists • Unlikely to occur.	• May occur occasionally • Has happened before on occasions • Reasonable chance of occurring.	• Strong possibility that this could occur • Likely to occur.	This is expected to occur frequently/in most circumstances more likely to occur than not.

Table 3 - Risk Matrix

Likelihood	Consequences/Impact				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

References: AS/NZS 4360:2004 'Making It Work' (2004)

Table 4 - NHSG Response to Risk

Describes what NHSG considers each level of risk to represent and spells out the extent of response expected for each.

Level of Risk	Response to Risk
Low	Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.
Medium	Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective.
High	Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significnt resources. Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these continue to be effective and confirm that it is not reasonably practicable to do more. The Board may wish to seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significnt incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.
Very High	Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The Board will seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significnt incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

Risk, Audit and Performance Committee

Date of Meeting	2.04.2024
Report Title	External Audit – Annual Audit Plan 2023/24
Report Number	HSCP24.014
Lead Officer	Anne MacDonald, Engagement Manager, External Audit (Audit Scotland)
Report Author Details	Anne MacDonald, Engagement Manager, External Audit (Audit Scotland) Email: amacdonald@audit-scotland.gov.uk
Consultation Checklist Completed	No
Appendices	Appendix A – External Audit: Annual Audit Plan 2023/24

1. Purpose of the Report

1.1. This is the external auditor's audit plan for the 2023/24 financial year and is provided for discussion and noting by the Risk, Audit and Performance Committee (RAPC). The report sets out the auditor's plan in respect of the 2023/24 audit and covers both the audit of the board's financial statements and the auditor's wider scope responsibilities.

2. Recommendations

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

a) Note the contents of the report.

3. Summary of Key Information

3.1. The Accounts Commission has appointed Michael Oliphant, Audit Director, Audit Scotland as auditor of the Aberdeen City Integration Joint Board (IJB) for the five-year period covering financial years 2022/23 to 2026/27.

3.2. This report to those charged with governance summarises the external auditor's view of the risks for the audit and the approach to be undertaken to gain sufficient assurance over the risks, to allow the auditor to provide an opinion on the IJB's financial statements for the financial year ended 31 March 2024.

3.3. The programme of work within the plan is set in accordance with Audit Scotland's Code of Audit Practice which applies to all public sector audits in Scotland. The plan also sets out the audit fees and the wider scope audit responsibilities.

4. Implications for IJB

4.1. **Equalities –** there are no direct implications arising from this report.

4.2. **Fairer Scotland Duty –** there are no direct implications arising from this report.

4.3. **Financial –** there are no direct implications arising from this report.

4.4. **Workforce -** there are no direct implications arising from this report.

4.5. **Legal** – there are no direct implications arising from this report.

4.6. **Other -** NA

5. Links to ACHSCP Strategic Plan

5.1. The work of external audit is relevant to all of the IJB's strategic aims but there are no expected implications arising from this report.

Risk, Audit and Performance Committee

6. Management of Risk

6.1. **Identified risks(s):** The External Audit process considers risks involved in the areas subject to review. Any risk implications identified through the External Audit process are as detailed in the attached report.

6.2. **Link to risks on strategic risk register:** The risk is for the external auditor not being able to give an opinion on the financial statements before the statutory deadline.

6.3. **How might the content of this report impact or mitigate these risks:** Where risks have been identified by the external auditor, discussions are ongoing with management to mitigate these risks, the sources of management assurance as set out in the plan will be reviewed and relevant audit procedures will be conducted.

This page is intentionally left blank

Aberdeen City Integration Joint Board

Annual Audit Plan 2023/24

AUDIT SCOTLAND

Prepared for Aberdeen City Integration Joint Board
March 2024

Contents

Introduction

Summary of planned audit work

1. This document summarises the work plan for our 2023/24 external audit of Aberdeen City Integration Joint Board (IJB). The main elements of our work include:

- an audit of the annual accounts leading to an independent audit opinion
- independent audit opinions on other statutory information published within the annual accounts including the Management Commentary, the Annual Governance Statement and the Remuneration Report
- consideration of Best Value arrangements and wider scope areas: financial management; financial sustainability; vision, leadership and governance; and use of resources to improve outcomes.

Audit Appointment

2. We have been appointed as the external auditor of Aberdeen City IJB for the period 2022/23 to 2026/27 inclusive. The 2023/24 financial year is therefore the second of our five-year audit appointment. You can find details of your audit team at Appendix 1.

Adding value

3. We aim to add value to the IJB through our external audit work by being constructive and forward looking, identifying and encouraging good practice and by making recommendations. In so doing, we will help the IJB promote improved standards of governance, better management and decision making and more effective use of resources.

Respective responsibilities of the auditor and Integration Joint Board

4. The Code of Audit Practice 2021 sets out in detail the respective responsibilities of the auditor and the Aberdeen City IJB. Key responsibilities are summarised below.

Auditor responsibilities

5. Our responsibilities as independent auditors are established by the Local Government (Scotland) Act 1973 and the Code of Audit Practice (including supplementary guidance) and guided by the Financial Reporting Council's Ethical Standard.

6. Auditors in the public sector give an independent opinion on the financial statements and other information within the annual accounts. We also review and report on the wider scope arrangements in place at the IJB. In doing this, we aim to support improvement and accountability.

Aberdeen City Integration Joint Board responsibilities

7. The IJB is responsible for maintaining accounting records and preparing financial statements that give a true and fair view.

8. The IJB has the primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity that enable them to deliver their objectives.

Financial statements audit planning

Introduction

9. The annual accounts are an essential part of demonstrating the IJB's stewardship of resources and its performance in the use of those resources.

10. We focus our work on the areas of highest risk. As part of our planning process, we prepare a risk assessment highlighting the audit risks relating to production of the financial statements.

Materiality

11. The concept of materiality is applied by auditors in planning and performing the audit, and in evaluating the effect of any uncorrected misstatements on the financial statements. We are required to plan our audit to determine with reasonable confidence whether the financial statements are free from material misstatement. The assessment of what is material is a matter of professional judgement over both the amount and the nature of the misstatement.

Materiality levels for the 2023/24 audit

12. We assess materiality at different levels as described in Exhibit 1. The materiality values for the IJB are set out in Exhibit 1.

Exhibit 1

2023/24 Materiality levels for Aberdeen City IJB

Materiality	Amount
Planning materiality – This is the figure we calculate to assess the overall impact of audit adjustments on the financial statements. Materiality has been set based on our assessment of the needs of the users of the financial statements and the nature of the Aberdeen City IJB's operations. For the year ended 31 March 2024 we have set our materiality at 2% of gross expenditure based on the latest projected outturn for 2023/24.	£8.4 million
Performance materiality – This acts as a trigger point. If the aggregate of errors identified during the financial statements audit exceeds performance materiality, this could indicate that further audit procedures should be considered. Using our professional judgement, we have assessed performance materiality at 75% of planning materiality.	£6.3 million

Materiality	Amount
Reporting threshold – We are required to report to those charged with governance on all unadjusted misstatements more than the 'reporting threshold' amount. This has been set at 3% of planning materiality.	£250,000

Source: Audit Scotland

Significant risks of material misstatement to the financial statements

13. Our risk assessment draws on our knowledge of the IJB, its major transaction streams, key systems of internal control and risk management processes. It is informed by our discussions with management, consideration of the work of internal audit and a review of supporting information.

14. Audit risk assessment is an iterative and dynamic process. Our assessment of risks set out in this plan may change as more information and evidence becomes available during the progress of the audit. Where such changes occur, we will advise management and where relevant, report them to those charged with governance.

15. Based on our risk assessment process, we identified the following significant risks of material misstatement to the financial statements. These are risks which have the greatest impact on our planned audit procedures. Exhibit 2 summarises the nature of the risk, the sources of assurance from management arrangements and the further audit procedures we plan to perform to gain assurance over the risk.

Exhibit 2

2023/24 Significant risk of material misstatement to the financial statements

Significant risk of material misstatement	Sources of assurance	Planned audit response
1. Risk of material misstatement due to fraud caused by management override of controls As stated in International Standard on Auditing (UK) 240, management is in a unique position to perpetrate fraud because of management's ability to override controls that otherwise appear to be operating effectively.	Owing to the nature of this risk, assurances from management are not applicable in this instance.	• Evaluate assurances from the external auditors of partner bodies, i.e., Aberdeen City Council and NHS Grampian, which will include: ○ Assessing the design and implementation of controls over journal entry processing ○ Making inquiries of individuals involved in the financial reporting process about inappropriate or unusual activity relating to the processing of journal entries and other adjustments

Significant risk of material misstatement	Sources of assurance	Planned audit response
		○ Testing journals around the year-end and focusing on areas of risk ○ Evaluating significant transactions outside the normal course of business ○ Reviewing accounting estimates ○ Substantive testing of income and expenditure transactions around the year-end to confirm they are accounted for in the correct financial year ○ Focused testing of accounting accruals and prepayments. • Assess the adequacy of controls in place for identifying and disclosing related party relationships and transactions in the financial statements.

Source: Audit Scotland

16. As set out in International Standard on Auditing (UK) 240*: The auditor's responsibilities relating to fraud in an audit of financial statements*, there is a presumed risk of fraud over the recognition of revenue. There is a risk that revenue may be misstated resulting in a material misstatement in the financial statements.

17. We have rebutted this risk because funding is provided by way of budget allocations from the IJB's partners and can be readily agreed to third party confirmations. Any changes require approval from each partner in line with the IJB's integration scheme. There is no estimation or judgement in recognising this stream of income and we do not regard the risk of fraud to be significant.

18. In line with Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom*, as most public-sector bodies are net spending bodies, the risk of material misstatement due to fraud related to expenditure recognition may in some cases be greater than the risk relating to revenue recognition.

19. We have also rebutted the risk of material misstatement caused by fraud because the IJB does not incur expenditure directly and does not operate a bank account. The IJB commissions services from its partner bodies with all IJB expenditure being processed through the financial systems of the partner bodies.

20. As a result, we have not incorporated specific work into our audit plan in these areas over and above our standard audit procedures.

Other areas of audit focus

21. As part of our assessment of audit risks, we have identified other areas where we consider there are also risks of material misstatement to the financial statements. Based on our assessment of the likelihood and magnitude of the risk, we do not consider these to represent significant risks. We will keep these areas under review as our audit progresses.

22. The areas of specific audit focus are:

- On conclusion of the 2022/23 audit of the annual accounts, we made recommendations for improvement in the working paper package provided for audit and the management commentary included in the unaudited accounts. If the expected improvements are not delivered, there is a risk the audit will be delayed. In addition, the chief finance officer is due to retire in July 2024 which may have further implications for the audit of the annual accounts.
- Transactions for the IJB are recorded through the partners' financial ledgers. If robust processes are not in place, there is a risk that expenditure and income is miscoded and IJB accounts are misstated.

Wider Scope and Best Value

Introduction

23. The Code of Audit Practice sets out the four areas that frame the wider scope of public sector audit. The Code of Audit Practice requires auditors to consider the adequacy of the arrangements in place for the wider scope areas in audited bodies.

24. In summary, the four wider scope areas cover the following:

- **Financial management** means having sound budgetary processes. We will consider the arrangements to secure sound financial management including the strength of the financial management culture, accountability and arrangements to prevent and detect fraud, error and other irregularities.
- **Financial sustainability** – as auditors, we consider the appropriateness of the use of the going concern basis of accounting as part of the annual audit. We will also comment on financial sustainability in the longer term. We define this as medium term (two to five years) and longer term (longer than five years).
- **Vision, leadership and governance** – we conclude on the IJB's arrangements to deliver its vision, strategy and priorities. We also consider the effectiveness of the governance arrangements to support delivery.
- **Use of resources to improve outcomes** – we will consider how the IJB demonstrates economy, efficiency and effectiveness through the use of financial and other resources.

Wider scope risks

25. We have identified wider scope audit risks in the areas set out in Exhibit 3. This exhibit sets out the risks, sources of assurance from management arrangements and the further audit procedures we plan to perform to gain assurances over the risks.

Exhibit 3
2023/24 wider scope risks

Description of risk	Sources of assurance	Planned audit response
1. Financial sustainability The board acknowledges that while demand for services is increasing, financial resources are not keeping pace. There is a need to explore areas where savings can be made, for	• Regular budget monitoring • Medium term financial planning arrangements.	• Discussion with officers. • Monitor the financial position throughout the year and provide an update in our 2023/24 Annual Audit Report.

Description of risk	Sources of assurance	Planned audit response
example, through robust financial management, service redesign and innovation.		• Consider the long-term affordability of budget decisions.
2. Workforce challenges The recruitment and retention of staff is challenging across all health and social care services, particularly in the areas of trauma informed care, complex care and self-directed support. There is a shortage of clinical staff which is a significant risk for sustainable service delivery.	• Workforce planning arrangements.	• Discussion with officers. • Review of workforce plan.

Source: Audit Scotland

Best Value

26. Auditors have a duty to be satisfied that bodies that fall within section 106 of the 1973 Act have made proper arrangements to secure Best Value. We will consider how the IJB demonstrates that it is meeting its Best Value responsibilities and we will report our findings as part of our Annual Audit Report.

Reporting arrangements, timetable, and audit fee

Reporting arrangements

27. Matters arising from our audit will be reported on a timely basis and will include agreed action plans. Draft management reports will be issued to the relevant officers to confirm factual accuracy.

28. We will provide an independent auditor's report to Aberdeen City IJB and the Accounts Commission setting out our opinions on the annual accounts. We will provide the IJB and the Controller of Audit with an annual report on the audit containing observations and recommendations on significant matters which have arisen during the audit.

29. Exhibit 4 outlines the target dates for our audit outputs, and we aim to issue the independent auditor's report by the statutory deadline of 30 September 2023.

Exhibit 4
2023/24 Audit outputs

Audit Output	Target date outlined in Audit Scotland Planning Guidance	Date of nearest scheduled Risk, Audit and Performance Committee
Annual Audit Plan	By 31 March 2024	2 April 2024
Independent Auditor's Report	By 30 September 2024	24 September 2024
Annual Audit Report	By 30 September 2024	24 September 2024

Source: Audit Scotland

30. All Annual Audit Plans and reports, as detailed in Exhibit 4, and any other outputs on matters of public interest will be published on our website: www.audit-scotland.gov.uk.

Timetable

31. To support an efficient audit, it is critical that the timetable for producing the annual report and accounts for audit is achieved. We have included a proposed timetable for the audit at Exhibit 5.

32. We will continue to work closely with management to identify the most efficient approach as appropriate and will keep timeframes and logistics for the completion of the audit under review. Progress will be discussed with management and finance officers over the course of the audit.

Exhibit 5
Proposed annual report and accounts timetable

Key stage	Provisional Date
Consideration of the unaudited annual accounts by those charged with governance	4 June 2024
Latest submission date for the receipt of the unaudited annual accounts with complete working papers package	30 June 2024
Latest date for final clearance meeting with the Chief Finance Officer	30 August 2024
Issue of draft Letter of Representation and proposed Independent Auditor's Report	13 September 2024
Agreement of audited and unsigned annual accounts	13 September 2024
Issue of Annual Audit Report to those charged with governance.	16 September 2024
Signed Independent Auditor's Report	24 September 2024

Source: Audit Scotland

Audit fee

33. In determining the audit fee, we have taken account of the risk exposure of the IJB and the planned management assurances in place. The proposed audit fee for 2023/24 is £33,360 (2022/23 £34,970).

34. In setting the fee for 2023/24, we have assumed that the IJB has effective governance arrangements and will prepare comprehensive and accurate accounts for audit in line with the agreed timetable for the audit. The audit fee assumes there will be no major change in respect of the scope of the audit during the year and where our audit cannot proceed as planned, a supplementary fee may be levied.

Other matters

Internal audit

35. It is the responsibility of the IJB to establish adequate internal audit arrangements. Services are provided by the chief internal auditor of Aberdeenshire Council under a shared service arrangement.

36. We intend to draw general assurance from internal audit when assessing the IJB's governance arrangements and our wider scope responsibilities. We are not currently planning to use the work of internal audit to provide assurance for our audit procedures on the financial statements

Independence and objectivity

37. Auditors appointed by the Accounts Commission must comply with the Code of Audit Practice and relevant supporting guidance. When auditing the financial statements, auditors must also comply with professional standards issued by the Financial Reporting Council and those of the professional accountancy bodies. These standards impose stringent rules to ensure the independence and objectivity of auditors.

38. Audit Scotland has robust arrangements in place to ensure compliance with these standards including an annual *'fit and proper'* declaration for all members of staff. The arrangements are overseen by the Executive Director of Innovation and Quality, who serves as Audit Scotland's Ethics Partner.

39. The appointed auditor for the IJB is Michael Oliphant, Audit Director. Auditing and ethical standards require the appointed auditor to communicate any relationships that may affect the independence and objectivity of audit staff. We are not aware of any such relationships pertaining to the audit of the IJB.

Audit Quality

40. Audit Scotland is committed to the consistent delivery of high-quality public audit. Audit quality requires ongoing attention and improvement to keep pace with external and internal changes. A document explaining the arrangements for providing assurance on the delivery of high-quality audits is available from the Audit Scotland website.

41. The International Standards on Quality Management (ISQM) applicable to Audit Scotland for 2023/24 audits are:

- ISQM (UK) 1 which deals with an audit organisation's responsibilities to design, implement and operate a system of quality management (SoQM) for audits. Our SoQM consists of a variety of components, such as: our governance arrangements and culture to support audit quality,

compliance with ethical requirements, ensuring we are dedicated to high-quality audit through our engagement performance and resourcing arrangements, and ensuring we have robust quality monitoring arrangements in place. Audit Scotland carries out an annual evaluation of our SoQM and has concluded that we comply with this standard.

- ISQM (UK) 2 which sets out arrangements for conducting engagement quality reviews, which are performed by senior management not involved in the audit to review significant judgements and conclusions reached by the audit team, and the appropriateness of proposed audit opinions of high-risk audit engagements.

42. To monitor quality at an individual audit level, Audit Scotland also carries out internal quality reviews of a sample of audits. Additionally, the Institute of Chartered Accountants of England and Wales (ICAEW) carries out independent quality reviews.

43. Actions to address deficiencies identified by internal and external quality reviews are included in a rolling Quality Improvement Action Plan which is used to support continuous improvement. Progress with implementing planned actions is regularly monitored by Audit Scotland's Quality and Ethics Committee.

44. Audit Scotland may periodically seek your views on the quality of our service provision. The team would also welcome feedback more informally at any time.

Appendix 1. Your audit team

45. The audit team involved in the audit of Aberdeen City IJB have significant experience in public sector audit.

Name	Position
Michael Oliphant moliphant@audit-scotland.gov.uk	Audit Director/Engagement Lead
Anne MacDonald amacdonald@audit-scotland.gov.uk	Senior Audit Manager/Engagement Manager
Arlene Deeming adeeming@audit-scotland.gov.uk	Senior Auditor
Deirdre Sim dsim@audit-scotland.gov.uk	Auditor

46. The local audit team is supported by a specialist technical accounting team, who have significant experience of public bodies and work with accounting regulatory bodies.

Aberdeen City Integration Joint Board

Annual Audit Plan 2023/24

Audit Scotland's published material is available for download on the website in a number of formats. For information on our accessibility principles, please visit:
www.audit-scotland.gov.uk/accessibility

For the latest news follow us on social media or **subscribe to our email alerts.**

AUDIT SCOTLAND

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
Phone: 0131 625 1500 Email: **info@audit-scotland.gov.uk**

AS.4.0

Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	2 April 2024
Report Title	Internal Audit Annual Plan 2024-27
Report Number	HSCP24.018
Lead Officer	Jamie Dale Chief Internal Auditor
Report Author Details	Jamie Dale Chief Internal Auditor Jamie.Dale@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	Appendix A – Aberdeen City IJB – Internal Audit Plan 2024-27
Terms of Reference	2. Review and approve the annual audit plans (internal and external) on behalf of the IJB, receiving reports, overseeing and reviewing actions taken on audit recommendations and escalating to the IJB as appropriate.

1. Purpose of the Report

1.1. The purpose of this report is to seek approval of the Internal Audit Plan for the Aberdeen City Integration Joint Board for 2023-26.

2. Recommendations

2.1. It is recommended that the Committee review, discuss, comment on, and thereafter approve the Internal Audit Plan for 2024-27 as attached at Appendix A.

3. Strategic Plan Context

RISK, AUDIT AND PERFORMANCE COMMITTEE

3.1. It is one of the duties of the Integration Joint Board Risk, Audit and Performance Committee to review and approve the Internal Audit Plan on behalf of the Integration Joint Board and, thereafter, receive reports on that planned work.

4. Summary of Key Information

4.1. The Internal Audit Plan, as it relates to the Integration Joint Board, is attached at Appendix A. Assurance will also be taken from the wider work of Internal Audit within Aberdeen City Council, specific work relating to Adult Social Care Services in the Council, and from NHS Grampian Internal Audit reports, amongst other sources.

4.2. All audits included in the attached plan, as well as those in future plans, will help inform Internal Audit's opinion on the adequacy and effectiveness of the IJB's framework of governance, risk management and control. Where opportunities for improvement in controls and their application, or improvements in value for money, are identified these will be reported along with recommendations for management to consider.

5. Implications for IJB

5.1. **Equalities, Fairer Scotland and Health Inequality –** An equality impact assessment is not required because the reason for this report is for the RAPC to discuss, review and comment on the contents of the Internal Audit Plan and there will be no differential impact, as a result of this report, on people with protected characteristics.

5.2. **Financial –** There are no direct implications arising from this report.

5.3. **Workforce** – There are no direct implications arising from this report.

5.4. **Legal** –There are no direct implications arising from this report.

5.5. **Unpaid Carers** – There are no direct implications arising from this report.

5.6. **Information Governance –** There are no direct implications arising from this report.

5.7. **Environmental Impacts –** There are no direct impacts arising from this report.

5.8. **Sustainability** – There are no direct impacts arising from this report.

5.9. **Other** – There are no other impacts arising from this report.

6. Management of Risk

6.1. **Identified risks(s):** The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the resultant report.

6.2. **Link to risks on strategic risk register:** The Internal Audit Plan, and this output report, is developed following consideration of the Aberdeen City Health and Social care Partnership Risk Register and through consultation with management.

6.3. **How might the content of this report impact or mitigate these risks:** Where risks are identified during the Internal Audit process, recommendations are made to management in order to mitigate these risks.

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

Internal Audit

Aberdeen City Integration Joint Board
Internal Audit Plan
2024-27

Contents

1 Executive Summary

1.1 Introduction and background

Internal Audit's primary role is to provide independent and objective assurance on the Board's risk management, control, and governance processes. This requires a continuous rolling review and appraisal of the internal controls of the Board involving the examination and evaluation of the adequacy of systems of risk management, control, and governance.

The purpose of this report is to seek approval of the attached Internal Audit plan for 2024-2027.

All audits included in the attached plan, as well as those in future plans, will help inform Internal Audit's opinion on the adequacy and effectiveness of the Board's framework of governance, risk management and control, which is expressed in an annual report, and provides assurance to the Risk, Audit and Performance Committee. Where opportunities for improvement in controls and their application, or improvements in value for money, are identified these will be reported along with recommendations for Management to consider.

1.2 Management commentary

Officers within the Aberdeen City Health and Social Care Partnership have considered and supported the development of the audit areas for 2024-2027 and are content with the proposed plan.

2 Internal Audit Plan

2.1 Plan development

In previous years a single-year Plan has been set out for the Committee's approval. This provided clarity over planned work during each financial year, as changes in the risk environment were often less pronounced over a shorter period. However, this provided less opportunity for the Committee to gain an understanding of the wider context or 'audit universe'. In addition, the Plan was regularly not concluded in full during the financial year to which it originally referred – due to changes in priority, risks, and resources.

There was therefore scope to develop and extend planning to provide a clearer picture of Internal Audit's work and priorities, and to provide flexibility in timing of elements of that work, over an extended period. Therefore, from 2022, the Committee approved a rolling three year plan, with the recognition that this would still be assessed each year and updates made as required.

In formation of the plan, Internal Audit:

- **Reviewed historic audit outputs** – The initial planning stage involved a review of completed work from across the previous years. This looked to gauge the assurance that had been obtained recently and develop a baseline that could be built upon with the current plan. Where it is hoped that the greatest coverage can be obtained in a single year, this is not always possible, so instead it will be ensured that there has been coverage over a number of years, both previously and forward looking.
- **Reviewed the agreed Plan for 2023-26** – In addition to the review of previous assurance work, the agreed plans for 2024/25 and 2025/26, agreed as part of the 2023-2026 plan overall, were reviewed. This is the starting position for the current plan; however this will change based on developments in year and the changing risk profile of the Board.
- **Reviewed Management's progress in implementing agreed audit recommendations** – A review of the work of Management to implement audit recommendations . This looked to identify any areas where management has struggled to implement agreed actions, and where the risks remain, for these to be factored into the audit plan.
- **Reviewed different sources of information** – A suite of information, primarily Committee reporting and the Board's Risk Register, was reviewed to further develop Internal Audit's understanding of the operations and issues of the Board.
- **Reviewed information from other assurance providers** – Discussions were held and reports reviewed from other assurance providers.
- **Held discussion with key stakeholders** – Discussions were held with key stakeholders across the Board. These discussions focused on three key areas:
    - Key risks within the auditable area.

    - Any recent or upcoming developments.
    - Suggestions for assurance reviews, including value adding pieces of work.
- **Benchmarked against other IJBs** – A review of the Internal Audit plans for other IJBs as per their Committee reporting available online. This looked to gain an understanding of issues being faced by other IJBs and identify any auditable areas for Aberdeen City.

The Internal Audit plan for the period April 2024 to March 2027 is presented in Appendix 1 to this report, including the relevant Adult Social Care Service audits within the Aberdeen City Internal Audit Plan 2024-27; this is where Aberdeen City Council is the lead provider of the service.

The plan details what Internal Audit anticipates being able to review in the year, assuming stability in resources available to the Section. The plan is flexible and can be amended to reflect changes in priority or because of new risks being introduced or identified, although consideration needs to be given to the requirement for Internal Audit to complete sufficient work to provide an evidence based annual opinion. Internal Audit will continue to review the Board's risk registers and update its own risk assessments based on audit findings, throughout the Plan's term.

All audits included in the attached plan are part of a rolling programme of work, each element of which will help inform Internal Audit regarding the adequacy and effectiveness of the Board's framework of governance, risk management and control, allowing assurance to be provided regarding those arrangements. Where opportunities for improvement in controls and their application, or improvements in value for money, are identified these will be reported along with recommendations for management to consider. This is the priority of the work however where there are opportunities to provide value adding work, this has been factored into the plan.

The time allocation for all audits assumes that systems to be reviewed are adequately documented, detailing the controls put in place by management, and that testing identifies that these controls are being complied with. If this is not the case, there will be an impact on the time taken to review planned areas and on the plan's achievability.

The Plan also includes time set aside to assist Management in developing their controls and approach to improving compliance. This reflects continuing development of a more proactive value-added approach by Internal Audit, to supplement the more traditional core compliance-oriented audit work. For these elements of the Plan there will not be a separate Internal Audit report to the Risk, Audit and Performance Committee. Highlights from this work will however be provided as part of the regular Internal Audit progress reports provided to the Committee.

With approval of the plan, we will work with Management to schedule the audit work for the year. This will look to match our internal resourcing but also ensure that it is suitable for those relevant stakeholders across the Board. We will look to ensure that management are not inundated with consecutive audits and that fieldwork, where most input is required, is at a time which does not clash with other priorities or commitments.

2.2 Undertaking planned work

When commencing each planned audit, Internal Audit contacts Management responsible for the area to be reviewed along with any other nominated officer. They are reminded of the objective and scope of the review and of how Internal Audit intends to achieve the level of assurance required. Officers are invited to identify any specific aspects of the area to be reviewed that are of particular concern- and all of this is factored into the agreed scoping document. Once fieldwork has been completed, a draft report is issued to Management responsible for the area reviewed along with any other nominated officer. Prior to issuing the final report, Internal Audit seeks confirmation from the officers involved that they are satisfied with the report and actions agreed to address any identified issues.

Outputs from the IJB Internal Audit plan will be shared with Aberdeen City Council's Audit, Risk and Scrutiny Committee after they have been considered by the Risk, Audit and Performance Committee.

Whilst undertaking planned work, it is possible that Internal Audit may identify governance issues that are not within the stated scope of the review being undertaken. Public Sector Internal Audit Standards require that Internal Audit report such instances to those charged with governance. In this respect, Internal Audit's reports may contain issues that appear to be "outwith scope".

3 Appendix 1 – 2024-27 Internal Audit Plan

The below table sets out the Internal Audit Plan for 2024-27. The Plan should be read with the following considerations:

- Where each audit has been mapped to a risk area some reviews will cut across many different categories. This is to show that consideration has been given to ensuring the Plan addresses the myriad of risks across the IJB's operations; the principal risk has been shown below for ease of review.
- Core assurance audits are the typically traditional compliance based reviews that are the foundation for the annual opinion provided by the Chief Internal Auditor. Wider assurance audits are reviews that will focus more on value adding work. Whilst mapping has been provided to show a split in the Plan for the year, the type of review is not exclusive and Internal Audit will ensure that all work contributes to the annual opinion, whilst also adding value where possible.

The relevant planned work with the Aberdeen City Council is also presented.

Function	Auditable Area	Objective	Principal Risk	Assurance
2024/25				
Integration Joint Board	IJB Budget Setting and Monitoring	To ensure that appropriate arrangements are in place regarding IJB budget setting.	Financial	Core
Integration Joint Board	Counter Fraud[1]	To provide assurance that the IJB's arrangements for the prevention of fraud, bribery and corruption are adequate and proportionate.	Financial	Core
2025/26				
Integration Joint Board	Health and Social Care (staffing) Scotland Act 2019	To consider whether appropriate control is being exercised compliance with statutory guidance on safe staffing levels.	Strategic	Wider
Integration Joint Board	Alcohol and Drugs Partnership	To review the ADP's governance and working arrangements to ensure they are effective and fit for purpose.	Operational	Wider
2026/27				

[1] This will be a joint review with NHS Grampian Internal Audit to provide wider assurance across controls in the region. Results of work from Aberdeenshire and Moray will also be considered and factored into reporting.

Function	Auditable Area	Objective	Principal Risk	Assurance
Integration Joint Board	National Care Service Preparedness[2]	To consider whether appropriate control is being exercised over the anticipated changes to delivery as a result of the roll out of the National Care Service.	Strategic	Wider
Integration Joint Board	IJB Asset Management	To ensure resources are allocated appropriately and efficiently following a suitable asset management plan.	Operational	Wider

Function	Auditable Area	Objective	Principal Risk	Assurance
2024/25				
Council Led HSCP Services	HSCP Commissioning	To review plans and progress with commissioning across the Health and Social Care Partnership.	Operational	Core
2025/26				
Council Led HSCP Services	Income Controls	To review the controls in place regarding income for the provision of Health and Social Care Partnership services.	Financial	Core
2026/27				
Council Led HSCP Services	HSCP Delivery[3]	To obtain assurance that adequate arrangements are in place to facilitate the delivery of Health and Social Care Partnership services.	Strategic	Core

[2] Given the ongoing uncertainty around the introduction of the National Care Service on the IJB, further consideration will be given ahead of planning for 2025/26 and 2026/27 to identify appropriate auditable areas and value adding work.

[3] It is expected for this review to be significantly shaped by the impact of the National Care Service. This will be reassessed over the coming years and scoped appropriately.

Aberdeen City Health & Social Care Partnership
A caring partnership

Risk, Audit and Performance Committee

Date of Meeting	2 April 2024
Report Title	Internal Audit Update Report
Report Number	HSCP24.019
Lead Officer	Jamie Dale Chief Internal Auditor
Report Author Details	Jamie Dale Chief Internal Auditor Jamie.Dale@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	Appendix A – RAPC - Internal Audit Update Report April 2024
Terms of Reference	2. Review and approve the annual audit plans (internal and external) on behalf of the IJB, receiving reports, overseeing and reviewing actions taken on audit recommendations and escalating to the IJB as appropriate.

1. Purpose of the Report

1.1. The purpose of this report is to provide the Risk, Audit and Performance Committee (RAPC) with an update on Internal Audit's work since the last update. Details are provided of the progress against the approved Internal Audit plans, audit recommendations follow up, and other relevant matters for the RAPC to be aware of.

2. Recommendations

2.1. It is recommended that the Committee:

a) Note the contents of the RAPC - Internal Audit Update Report February 2024 ("the Internal Audit Update Report"), as appended at Appendix A, and the work of Internal Audit since the last update;

b) Note the progress against the approved 2023/24 Internal Audit Plan as detailed in the Internal Audit Update Report.

3. Strategic Plan Context

3.1. Internal Audit's role is to provide assurance regarding the adequacy and effectiveness of the Integration Joint Board's framework of governance, risk management and control. Each of these areas helps ensure that the IJB can deliver on all strategic priorities as identified in its strategic plan.

4. Summary of Key Information

4.1. Internal Audit's primary role is to provide independent and objective assurance on the Board's risk management, control and governance processes. This requires a continuous rolling review and appraisal of the internal controls of the Board involving the examination and evaluation of the adequacy of systems of risk management, control and governance, making recommendations for improvement where appropriate. Reports are produced relating to each audit assignment and summaries of these are provided to the RAPC.

5. Implications for IJB

5.1. **Equalities, Fairer Scotland and Health Inequality –** An equality impact assessment is not required because the reason for this report is for the RAPC to discuss, review and comment on the contents of the Internal Audit Update Report and there will be no differential impact, as a result of this report, on people with protected characteristics.

5.2. **Financial –** There are no direct implications arising from this report.

5.3. **Workforce** – There are no direct implications arising from this report.

5.4. **Legal** –There are no direct implications arising from this report.

5.5. **Unpaid Carers** – There are no direct implications arising from this report.

5.6. **Information Governance –** There are no direct implications arising from this report.

5.7. Environmental Impacts – There are no direct impacts arising from this report.

5.8. Sustainability – There are no direct impacts arising from this report.

5.9. Other – there are no other impacts arising from this report.

6. Management of Risk

6.1. Identified risks(s): The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the resultant report.

6.2. Link to risks on strategic risk register: The Internal Audit Plan, and this output report, is developed following consideration of the Aberdeen City Health and Social care Partnership Risk Register and through consultation with management.

6.3. How might the content of this report impact or mitigate these risks: Where risks are identified during the Internal Audit process, recommendations are made to management in order to mitigate these risks.

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

Internal Audit

Risk, Audit and Performance Committee
Internal Audit Update Report
April 2024

Contents

1 Executive Summary

1.1 Introduction and background

Internal Audit's primary role is to provide independent and objective assurance on the Council's risk management, control, and governance processes. This requires a continuous rolling review and appraisal of the internal controls of the Board involving the examination and evaluation of the adequacy of systems of risk management, control, and governance, making recommendations for improvement where appropriate. Reports are produced relating to each audit assignment and these are provided to the Risk, Audit and Performance (RAP) Committee. Along with other evidence, these reports are used in forming an annual opinion on the adequacy of risk management, control, and governance processes.

This report advises the RAP Committee of Internal Audit's work since the last update. Details are provided of the progress against the approved 2023/24 Internal Audit plan, audit recommendations follow up, and other relevant matters for the Committee to be aware of.

1.2 Highlights

Full details are provided in the body of this report however Internal Audit would like to bring to the Committee's attention that since the last update:

- Work is underway with regards to delivery of the 2023/24 Internal Audit Plan.

1.3 Action requested of the RAP Committee

The Committee is requested to note the contents of this report and the work of Internal Audit since the last update.

2 Internal Audit Progress

2.1 2023/24 Audits

Service	Audit Area	Position
Council Led HSCP Services	Social Care Financial Assessments	**Review In Progress**
IJB	IJB Hosted Services	**Final Report Issued**

2.2 Follow up of audit recommendations

Public Sector Internal Audit Standards require that Internal Audit report the results of its activities to the Committee and establishes a follow-up process to monitor and ensure that management actions have been effectively implemented.

As at 31 December 2023 (the baseline for our exercise), no audit recommendations were due.

Appendix 1 – Grading of Recommendations provides the definitions of each of the ratings used.

3 Appendix 1 – Grading of Recommendations

Risk level	Definition
Corporate	This issue / risk level impacts the Council as a whole. Mitigating actions should be taken at the Senior Leadership level.
Function	This issue / risk level has implications at the functional level and the potential to impact across a range of services. They could be mitigated through the redeployment of resources or a change of policy within a given function.
Cluster	This issue / risk level impacts a particular Service or Cluster. Mitigating actions should be implemented by the responsible Chief Officer.
Programme and Project	This issue / risk level impacts the programme or project that has been reviewed. Mitigating actions should be taken at the level of the programme or project concerned.

Net risk rating	Description	Assurance assessment
Minor	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	**Substantial**
Moderate	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified, which may put at risk the achievement of objectives in the area audited.	**Reasonable**
Major	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	**Limited**
Severe	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	**Minimal**

Individual issue / risk	Definitions
Minor	Although the element of internal control is satisfactory there is scope for improvement. Addressing this issue is considered desirable and should result in enhanced control or better value for money. Action should be taken within a 12 month period.
Moderate	An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on the audited area's adequacy and effectiveness. Action should be taken within a six month period.
Major	The absence of, or failure to comply with, an appropriate internal control, such as those described in the Board's Scheme of Governance. This could result in, for example, a material financial loss, a breach of legislative requirements or reputational damage to the Board. Action should be taken within three months.
Severe	This is an issue / risk that is likely to significantly affect the achievement of one or many of the Board's objectives or could impact the effectiveness or efficiency of the Board's activities or processes. Examples include a material recurring breach of legislative requirements or actions that will likely result in a material financial loss or significant reputational damage to the Board. Action is considered imperative to ensure that the Board is not exposed to severe risks and should be taken immediately.

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

Risk, Audit and Performance Committee

Date of Meeting	2 April 2024
Report Title	Internal Audit Report – IJB Hosted Services
Report Number	AC2415
Lead Officer	Jamie Dale Chief Internal Auditor
Report Author Details	Jamie Dale Chief Internal Auditor Jamie.Dale@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	No
Terms of Reference	2. Review and approve the annual audit plans (internal and external) on behalf of the IJB, receiving reports, overseeing and reviewing actions taken on audit recommendations and escalating to the IJB as appropriate.

1. Purpose of the Report

1.1. The purpose of this report is to present the outcome from the planned audit of the Integration Joint Board (IJB) Hosted Services that was included in the Internal Audit Plan.

2. Recommendations

2.1. It is recommended that the Committee:

a) Review, discuss and comment on the issues raised in the report.

3. Strategic Plan Context

3.1. Internal Audit's role is to provide assurance regarding the adequacy and effectiveness of the Integration Joint Board's framework of governance, risk

management and control. Each of these areas helps ensure that the IJB can deliver on all strategic priorities as identified in its strategic plan.

4. Summary of Key Information

Assurance Assessment

4.1. The level of net risk is assessed as **MODERATE**, with the control framework deemed to be providing **REASONABLE** assurance over the arrangements in place to monitor the performance of services hosted on its behalf. Whilst the report identifies a Major risk in respect of under-developed governance arrangements, the relative low level of expenditure in this area compared with the overall budget reduces its significance. However, this still concerns HSCP operations and finances. The risk areas identified impact negatively on the overall level of assurance and raise the requirement for action to strengthen the control framework.

4.2. The IJB's Integration Scheme sets out that the IJB should consider and agree hosting arrangements. With the exception of the transfer of one service to hosting in 2020, there has been no opportunity for the IJB to consider and agree the arrangements. The rationale needs to be reviewed and considered, and a pan-Grampian review of hosted services would be beneficial to demonstrate that hosting arrangements are the most effective method of service delivery to contribute to the integration and transformation of health and social care services.

4.3. There have been no opportunities for Aberdeen City IJB to consider strategy and policy in respect of services hosted by the other integration authorities. Whilst the aims of each IJB have similarities, without strategic coordination at the regional level there is a risk hosted services could diverge from Aberdeen City's objectives and impact other commitments (e.g. the scale and pace of transformation), and this may not be identified and mitigated sufficiently in advance.

4.4. Similar risks have been identified in respect of performance management, and financial planning and monitoring. These require further review to establish consistent and proportionate planning and reporting arrangements to provide assurance over delivery, transformation, and cost management. This will require formal agreement with host IJB's. The nature and detail of agreement necessary may vary depending on the materiality and risk level of the service delivered, however it is important to capture key elements of each arrangement, since control over planning and delivery of each service hosted on behalf of the IJB is limited and therefore risk is increased. Governance arrangements must be proportionate, but also provide the IJB

with assurance that financial, strategic, operational, reputational, and other risks are adequately mitigated so that hosted services perform well and provide value for money.

4.5. A clear Grampian-wide framework for discussing and managing the performance of hosted services is required to ensure the IJB can be confident that services hosted on its behalf help deliver its intended strategic priorities. Overarching principles and improved systematic processes are needed to monitor hosted services' delivery and costs, to ensure service quality is appropriate, and transformation opportunities are identified.

4.6. It is acknowledged that the Aberdeen City Health and Social Care Partnership (ACHSCP) cannot address these matters alone. Collaboration with Aberdeenshire and Moray HSCP's and NHS Grampian will be required to obtain and provide consistent, proportionate, and relevant assurance. As the host IJB for the greatest proportion of hosted service budgets Aberdeen City is in an optimal position to lead on this approach.

Severe of major issues / risks

4.7. Issues and risks identified are categorised according to their impact on the Board. The following are summaries of higher rated issues / risks that have been identified as part of this review:

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating
1.3	**Governance Arrangements** – There are currently no formalised arrangements for cross-IJB reporting on the delivery of hosted services. Whilst Aberdeen City IJB has sought to gather performance information for annual reporting, and is able to comprehensively report on the services it hosts on behalf of others, there are no clear and agreed governance and reporting arrangements across the board. It is recognised data may not be available in every hosted service. There is a risk that in the absence of suitable agreements and reporting lines the HSCP will not be aware if there are issues affecting operational delivery of services hosted on its behalf, and will not have sufficient opportunities to provide input to addressing such issues, resulting in impacts on delivery of its own strategic objectives. The Strategic Risk Register for the Aberdeen City IJB recognises this risk, and sets out mitigating actions including ongoing development of SLA's.	Yes	**Major**

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating
	Until governance arrangements to be applied for hosted services are agreed, there will be less clarity over the expectations, responsibilities, and standards which should be adhered to in each arrangement. This can cause difficulties e.g. the Service noted ACHSCP made an operational change to an element of the SOARS service which it hosts on behalf of the other IJBs, and due to the absence of defined delegations or an agreed change management procedure objections were received, since not all IJBs had approved the change prior to the changes in service delivery. The nature and detail of agreement necessary may vary depending on the significance of the service delivered, however it is important to capture key elements of each arrangement, since control over planning and delivery of each service hosted on behalf of the IJB is limited and therefore risk is increased. Any approach must be proportionate to the risk. Rationalising the number and distribution of hosted services may help in this respect, however there is currently an absence of assurance, and any review should not delay progress with determining a means of addressing this risk. In respect of lower-risk services, if a series of shared principles can be agreed supporting governance, delegations, and transparency, a level of mutual assurance could be provided between each IJB. Such principles could equally apply to higher-risk areas, but these may require further or more specific sources of assurance or risk mitigation to be determined. Governance arrangements must provide the IJB with assurance that financial, strategic, operational, reputational, and other risks are adequately mitigated so that hosted services perform well and provide value for money.		

Management Response

4.8. The absence of clear and agreed governance arrangements was recognised in 2021 and plans were made to address this however lack of capacity due to the ongoing response to the COVID-19 pandemic meant these were not fully progressed. We welcome the renewed focus that this report provides and are committed to delivering improved governance arrangements in respect of hosted services. We will devise a schedule that facilitates this around other priorities.

5. Implications for IJB

5.1. Equalities, Fairer Scotland and Health Inequality – An equality impact assessment is not required because the reason for this report is for the

RAPC to discuss, review and comment on the contents of and Internal Audit Report and there will be no differential impact, as a result of this report, on people with protected characteristics.

5.2. Financial – There are no direct implications arising from this report.

5.3. Workforce – There are no direct implications arising from this report.

5.4. Legal –There are no direct implications arising from this report.

5.5. Unpaid Carers – There are no direct implications arising from this report.

5.6. Information Governance – There are no direct implications arising from this report.

5.7. Environmental Impacts – There are no direct impacts arising from this report.

5.8. Sustainability – There are no direct impacts arising from this report.

5.9. Other – there are no other impacts arising from this report.

6. Management of Risk

6.1. **Identified risks(s):** The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the resultant report.

6.2. **Link to risks on strategic risk register:** The Internal Audit Plan, and this output report, is developed following consideration of the Aberdeen City Health and Social care Partnership Risk Register and through consultation with management.

6.3. **How might the content of this report impact or mitigate these risks:** Where risks are identified during the Internal Audit process, recommendations are made to management in order to mitigate these risks.

This page is intentionally left blank

Aberdeen City Health & Social Care Partnership
A caring partnership

Date of Meeting	02 April 2024
Report Title	Quarter 3 Delivery Plan Update
Report Number	HSCP24.013
Lead Officer	Alison MacLeod
Report Author Details	Calum Leask Transformation Programme Manager CLeask@aberdeencity.gov.uk
Consultation Checklist Completed	*Yes*
Exempt	No
Appendices	*a. Quarter 3 Overview* *b. Delivery Plan Quarter 3 Tracker* *c. ACHSCP Delivery Plan Dashboard*
Terms of Reference	5. Receive and scrutinise performance reports and receive assurance that actions in respect of emerging trends are proportionate to the IJB's Risk Appetite Statement.

1. Purpose of the Report

1.1. This report seeks to provide assurance to the Risk, Audit and Performance Committee (RAPC) and relates to the progress of the Delivery Plan as set out within the Aberdeen City Health and Social Care Partnership (ACHSCP) Strategy Plan 2022-2025.

2. Recommendations

2.1. It is recommended that the Risk, Audit and Performance Committee note the Delivery Plan Quarter 3 Summary, the Tracker and Dashboard as appended to this report.

3. Strategic Plan Context

3.1. This report and its appendices directly link to the ACHSCP Strategic Plan and our performance in achieving the associated Delivery Plan. The Strategic Plan's Reporting Framework outlines our requirement to provide assurance to RAPC on a quarterly basis that progress is being made in achieving the Delivery Plan, and this report ensures that this element of governance is achieved in a robust manner.

4. Summary of Key Information

4.1. This report represents the Quarter 3 update to the Risk, Audit and Performance Committee based upon the Year 2 Delivery Plan as approved by IJB in March 2023.

4.2. As outlined in the revised Performance Framework, the Delivery Plan Progress Tracker will show updates for all entries in the Delivery Plan while a supporting Dashboard will be presented showing the key measures which the progression of the Delivery Plan seeks to impact upon.

4.3. Appendix A aims to give some context to the progress being made over the past quarter while the Delivery Plan Progress Tracker (Appendix B) shows this detail for each entry within the Year 2 delivery Plan. The Delivery Plan Dashboard in Appendix C displays the key measures and updated figures (where possible) related to these.

4.4. The Delivery Plan Progress Tracker is a spreadsheet utilised by our programme and project teams to provide updates to the Senior Leadership Team (SLT). For the purposes of RAPC, an update which spans the full quarter has been submitted to provide an overview of what has been achieved over the period from October to December 2023 and any significant risks or issues encountered during that time. However, noting the review deadline that the Senior Leadership Team were undertaking regarding

development of the Year 3 Delivery Plan, some detail provided may have been updated during January 2024. A BRAG (Blue, Red, Amber, Green) status is also provided giving an overarching indication of the health of the delivery plan entry. It should be noted that the status of a particular project may have progressed since the update in the report was given and therefore should be deemed to be historically accurate.

4.5. For this reporting period, there are no new projects marked as closed.

4.6. Appendix C shows the Delivery Plan Dashboard. This has been sorted by Programme rather than by Strategic Aim as was the case in 2022-2023.

5. Implications for IJB

5.1. Equalities, Fairer Scotland and Health Inequality

There are no direct implications arising from this report.

5.2. Financial

There are no direct implications arising from this report.

5.3. Workforce

There are no direct implications arising from this report.

5.4. Legal

There are no direct implications arising from this report.

5.5. Unpaid Carers

There are no direct implications arising from this report.

5.6. Information Governance

There are no direct implications arising from this report.

5.7. Environmental Impacts

There are no direct implications arising from this report.

5.8. Sustainability

There are no direct implications arising from this report.

5.9. Other

None.

6. Management of Risk

6.1. Identified risks(s)

Risk	Likelihood	Impact	Controls	Evaluation
Assurance over strategic plan not met	Low	Medium	Performance Framework outlines the required reporting to take place through the year in order to create assurance	If the paper was not presented, assurance would not be given to the RAPC and therefore part of the remit and responsibility of the Committee would not be met.

Full Transformational Projects outlined within the Delivery Plan have their own governance routes and risk management in place. As outlined in section 4.5, where risks are required to be escalated this is made to SLT in the first instance as outlined by the Performance Framework.

6.2. Link to risks on strategic or operational risk register:

This report links to Strategic Risk 4 on the Strategic Risk Register: -

Cause: Performance standards/outcomes are set by national and regulatory bodies and those locally determined performance standards are set by the board itself.

Event: There is a risk that the IJB, and the services that it directs and has operational oversight of, fails to meet the national, regulatory, and local standards.

Consequence: This may result in harm or risk of harm to people.

6.3 How might the content of this report impact or mitigate these risks:

The report and its appendices help to mitigate the risk by providing assurance that progress against the Strategic Plan 2022-2025 and the associated Delivery Plan is being achieved, that this is being monitored by the SLT on a monthly basis who consider and direct remedial action and unblock barriers where relevant.

This page is intentionally left blank

Delivery Plan Progress Report

Below is an overview of the number of projects listed within the Delivery Plan sorted by their BRAG (Blue, Red, Amber, Green) status although it should be noted that additional categories have been added i.e. White for Not Started and Purple for Closed.

Section 1.2 shows the projects sorted by Programme to give a sense of how these are progressing overall.

1.1. Overall Delivery Plan Status, by BRAG.

Status	Description	No. of Projects	% of Total Projects
Blue	Complete	2	3
Green	On track to deliver by deadline	49	75
Amber	At risk of non-delivery/not meeting deadline	8	13
Red	Missed Deadline/Unable to Deliver	0	0
White	Not Started	1	2
Purple	Closed	4	8
	TOTAL	**64**	**100**

1.2 Delivery Plan Status collated by Programme.

Programmes have an overall 'Green' status where the majority of their projects fall within the 'Green' rag status or if a proportion of projects have been completed / closed. Those with an overall Amber colour denotes where the majority of projects fall within an 'Amber' RAG status.

Programme (total no. projects)	Blue	Green	Amber	Red	Purple	White	Achievements	Challenges/Worthy of Comment
Commissioning (3)	33%	33%			33%		• Rubislaw Park Nursing Home End of Life Pathway Test of Change opened referrals from all areas within Aberdeen Royal Infirmary at end of 2023 • Bon Accord Care Contract Review and Service Specification review continuing	• Early conversations underway between Aberdeen City and Aberdeenshire Commissioning and Contracts to develop a Commissioning Academy to support delivery of ethical commissioning
Communities (8)		100%					• Evaluation underway of Get Active Northfield Priority Intervention Hub • Easy read locality plans prepared and circulated to Locality Empowerment Group members for consultation • Joint bid being submitted between Communities Team and NHS Support Services Scotland to PeacePlus funding programme, focusing on	• Aberdeen City's Wellbeing Team currently engage with 83 community groups and services across Aberdeen City

Programme (total no. projects)	Blue	Green	Amber	Red	Purple	White	Achievements	Challenges/Worthy of Comment
							addressing frailty and promoting active ageing	
Digital (8)		75%			25%		• Options appraisal presented to SLT on EMAR implementation, with full business case to be prepared for March 2024 • MEOC training delivered to vaccination centre staff • Digital Support Hub now providing 24 hour service with 41 clients	• Balnagask Court TEC replacement on hold pending outcome of availability of funding • Implementation of Morse at a Grampian level on hold and to be reviewed in new financial year
Flexible Bed Base (2)		50%			50%		• Acute medicine trial commenced December 2023 • Total capacity within service is 42 beds (22 frailty consultant led; 4 frailty ANP led; 5 OPAT; 5 end of life care; 5 respiratory Hospital @ Home beds)	• Recruitment an ongoing challenge
Frailty (1)		100%					• Frailty pathway review complete and governance oversight agreed by all 3 Chief Officers • First Board meeting of new format commenced January 2024	• Ongoing challenges with high occupancy levels across the pathway

Programme (total no. projects)	Blue	Green	Amber	Red	Purple	White	Achievements	Challenges/Worthy of Comment
Home Pathways (1)		100%					• Draft 1 of Housing for Varying Needs Market Position Statement being drafted	• Target date of completion for Housing for Varying Needs Market Position Statement March 2024
Infrastructure (2)		100%					• HAI-Scribe infection control assessment completed for new retail site at Countesswells	• New retail site unit at Countesswells expected to be ready to use by March 2024 • New draft Primary Care Premises Plan expected at Assets Management Group early 2024
MHLD (6)		67%	33%				• Engagement workshops for Community Mental Health Commissioned Service Review ongoing • Working group convened across Grampian to review and develop a model moving forward for Autism and Neurodevelopmental assessment	• Mental Health Triage in Primary Care unlikely to continue due to financial limitations • No further Scottish

Programme (total no. projects)	Blue	Green	Amber	Red	Purple	White	Achievements	Challenges/Worthy of Comment
								Government funding for Adult Autism Assessment Team past July 2024
Prevention (7)		86%	14%				• Formal Health Impact Assessment of the Local Transport Strategy completed to inform strategic development • Child healthy weight tier 1 delivery plan agreed • Planning underway to incorporate a whole systems approach to obesity into the refreshed Local outcome improvement plan.	• 5 year health inequalities plan for Grampian in development • Significant staffing and capacity issues within alcohol and drugs specialist services
Primary Care (3)		67%	33%				• General Practice Vision programme concluded three facilitated stakeholder events • CTAC practice based service fully delivered • Pharmacotherapy roll out almost at full capacity	• General Practice Visioning work and accompanying objectives to be delivered to all 3 IJB's in March 2024
Redesigning Adult Social Work (1)		100%					• SLT approved extension of timelines on redesign work to enable its completion	• New project identified in relation to Charging Policy

Programme (total no. projects)	Blue	Green	Amber	Red	Purple	White	Achievements	Challenges/Worthy of Comment
								– contributing to your care, as mechanism to support budget savings
Review of Rehab (2)		50%	50%				• Programme core team established to drive forward work and oversee 3 projects around recruitment, pathways and evaluation	
Resilience (6)	17%	50%	33%				• Timeline developed and agreed at SLT as part of the 2024/25 MTFF • Comms trustees group established to support promotion of activities through social media streams • SMOC review underway	• Anticipated that Scottish Government will begin to propose amendments to National care Service (Scotland) Bill in Spring 2024
Social Care Pathways (4)		100%					• Unmet need list support to be closed as standalone project with work being incorporated into social care pathways review going forward • Programme implementation plan in place to monitor progress on strategic review of social care	•
Strategy (5)		100%					• The Carers Strategy Implementation Group (CSIG) continues to meet bi monthly and is currently pulling	

Programme (total no. projects)	Blue	Green	Amber	Red	Purple	White	Achievements	Challenges/Worthy of Comment
							together the annual update for 2023-24 on the Carers Strategy which is due at IJB on 6 February 2024 • It was agreed that a risk should be developed, agreed, and integrated into the ACHSCP strategic risk register around Climate Change	
Workforce (5)		60%	20%			20%	• Regular development sessions now taking place for SLT • Continuous work ongoing to deliver health and wellbeing initiatives	• SRO exploring use of volunteers at Aberdeen Health Village

1.3 Delivery plan Dashboard

The following provides comment on the Delivery Plan Dashboard.

Measure	Comment
H@H Admissions	Similar number of admissions compared to previous quarter
H@H Capacity	Average percent occupancy has increased across 3 of 4 H@H wards compared with previous quarter
Ward 102 Admissions	Reducing trend compared to baseline
Ward 102 Boarders	Average daily boarders increasing compared to previous quarters
Rosewell House	Admissions similar to previous quarter. Percent of step up admissions remains low.
Rehabilitation review	Overall occupancy percentage remained high, with admissions increasing compared to previous quarter
Specialist Older Adults Rehab Services-Length of Stay (LOS)	Average length of stay decreased in four of six wards. Largest decrease in Links Unit (-26.42). Morningfield House figures likely skewed by very high max length of stay.
Delayed Discharges Specialist Older Adults-Rehab Services	Distinct counts of delays continue to fall. No harm falls reducing following having peaked, but Near miss and Harm Falls are relatively static.
Social care pathways	Average clients with unmet needs and unmet need carer hours decreasing
Home Pathways	Delayed Discharge graph indicates bed days monthly and distinct count of delay beginning to increase
MHLD Transformation	Complex delayed discharge bed days decreasing. RCH average overnight occupancy remains high.
Prevention	Drugs related admissions showing a decrease. Sexual health attendances remain high compared to previous year. Smoking cessation – both 4 and 12 week quit rates showing a downward trend
Strategy	Large increase in the number of carers supported.
Primary Care	CTAC calls responded to continues to increase. Booked appointments increasing sharply and attendance rate plateauing. Stability levels remain relatively static

NB: Metrics whereby Q3 data are unavailable is due to data collection being on a monthly lag

Delivery Plan Y2 Workplan 2023-24

Blue = complete
Red = missed deadline/unable to deliver
Amber = at risk of non-delivery/not meeting deadline
Green = on track to delivery by deadline
Purple = closed

Programme	Ref	Project Description	Project Name	Category	Start Date	End Date	BRAG Status	Tier	Latest Update
Commissioning	KPS23	Deliver robust arrangements for medical cover for care settings	1. Medical Cover for Care Settings	FTP		May-24	*Closed*	**Tier 1 (Prevention)**	This project has been put on hold by SLT, and will be reviewed for re-starting in Year 3.
Commissioning	SE14	Review availability of the range of independent advocacy and implement any recommendations from the review	2. Review range of independent advocacy	FTP		Jun-24	*Completed*	**Tier 1 (Prevention)**	The new contract for advocacy has been awarded and the service manager for advocacy has advised that the contract has now started as of the 1st October 2023.
Commissioning	SE17	Develop and deliver the Procurement Workplan incorporating our commissioning principles so that our commissioning is ethical, creative and co-designed and co-produced with partners and communities.	3. Transformation of Commissioning Approach	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	The Bon Accord Care Contract Review and Service Specification review has continued with Executive Group meetings and additional ALEO discussions. Working closely with colle Further meetings have taken place to establish the service specifications to be included within the new contract. These have been led by the Partnerships Commissioning Lead, Pr Cares Head of Delivery and Development. The project steering group has regularly met to review the feedback from both the Executive Group meeting and Service Specification F forward. The Rubislaw Park Nursing Home End of Life Pathway Test of Change opened to referrals from all areas within Aberdeen Royal Infirmary at the end of 2023. An SBAR was recen progression and continuation of the Test of Change and it has been decided that this will end at the end of March 2024. The learning that has been gained since the start of the tes going forward. We are planning on linking in and working alongside SAS (Scottish Ambulance Service) and other end of life/palliative care colleagues to support community facing The review of the contract for Care at Home, Support Living and Complex Care has commenced with surveys being sent to providers, social care staff and those currently receiving care Service Managers has been scheduled for 12/10/2023. Discussions with ACVO have taken place regarding moving to a Grant Funding model for counselling services in Aberdeen City. Data on all counselling services in the city has bee this is delivered in other locations will be undertaken and an outline model will considered. Following this discussions with service providers will be undertaken City and Shire Commissioning and Contracts are working in collaboration to develop a Commissioning Academy to support providers with the principles and delivery of ethical com Review of the contract for Care at Home, Supported Living and Complex Care - Workshop held with Social Care Service Managers and the feedback from this, along with results f currently receiving services has been collated and grouped into common themes. These will be analysed to determine which elements are within our "gift" to consider for inclusion colleagues from Moray with a view to further reflecting on the how the contract has worked so far and what is required for the future. Workshop held at the end of November with colleagues from Moray Project Board has been set up for Care at Home Contract Review, colleagues are being identified for the proj Providers Event scheduled for February 15th and Event to co - design contract scheduled for 16th March. Feedback from engagement sessions currently being analysed to deter Further discussions have taken place with ACVO relating to moving to a Grant Funding model for counselling services in Aberdeen. ACVO shared a good example of this in practi Fraser of Iriss to and Shona Omand-Smith is getting in touch with Linda Irvine Fitzpatrick who was involved in the work in Edinburgh to arrange a meeting to discuss how best to ap
Communities	CT03	Confirm the accuracy and accessibility of the map of existing universal and social support and work with partners and the community to develop services to meet any identified gaps	4. Support Mapping	BAU		Oct-24	*Green*	**Tier 1 (Prevention)**	Mapping ongoing with community and statutory partners. AGILE guide is out where individuals, carers, families, and community groups can access support staying independent i.e. Care and Repair service, Bon Accord Care, Community Options. Guidance on avoiding social isolation includes information on lifelong learning, physical fitness, digital skills, and volunteering opportunities. Guidance on staying informed includes information on NHS services, cost of living support to maximise food, energy, and benefit support, advocacy services, social care and berea Our community planning partners GREC have prepared a service directory and we will continue to work closely with them. All services on AGILE have been added to the Scotland sources.
Communities	CT07	Continue to develop and evaluate the Northfield Hub as a test of change for cross-sector, easily accessible, community hubs where a range of services coalesce, all responding to local need, to feed into a wider initiative on Priority Intervention Hubs.	5. Priority Intervention Hubs	FTP		Mar-25	*Green*	**Tier 1 (Prevention)**	Get Active Northfield. Evaluation of the “Get Active Northfield” Priority Intervention Hub commenced at the end of November A paper is currently being drafted for the Senior Lead Joint Board (IJB) update report will be presented in May 2024. Aberdeen City Vaccination & Wellbeing Hub - During Q3, the Team worked with 33 partner organisations to deliver a truly integrated priority intervention hub providing support and Treatment & Care (CTAC) appointment. A new community hub area was created to support people post vaccine, where visitors could sit and chat and find out more information to & Stay Connected. This area is available for anyone to walk into without an appointment. A paper was presented to the Integrated Joint Board (IJB) in December 2023 requesting further year, and to agree that this continues as a Priority Intervention Hub Model. This paper also included a request to change the name from "Aberdeen City Vaccination Centre amount of additional support and services working from this location. This paper was well received and agreement to extend was granted alongside agreement to work to the Prio

Communities	CT08	Develop the membership and diversity of our Locality Empowerment Groups	6. Develop LEGs	BAU	Apr-22	Mar-25	*Green*	**Tier 1 (Prevention)**	Integrated Locality Planning Team set up with a remit to grow and diversify LEG membership. LEGs and integrated locality planning are standing agenda items on Community Empowerment Group and Strategic Planning Group. Community Empowerment Strategy launched in December 2022. Stretch Outcome 16 added, with seven dedicated projects to promote community empowerment. A LOIP Projec diversity at Locality Planning meetings, the Communities TPM is Project Manager of this project group. A dedicated local outcome improvement group has been set up to increase and diversify locality planning membership and participation. Locality Planning Team held a series of community engagement events during October and November 2023 using the Place Standard Tool to inform the refresh of our three local membership of our Locality Empowerment Groups and Priority Neighbourhood Partnerships. Communities Team engaging with Mental Health Foundation and GREC to increase participation of New Scots (asylum seekers and refugees) in Aberdeen through accredited tra Engagement with various community groups and venues is ongoing. The Integrated Locality Planning Team are visiting community members in their localities to raise awareness of locality planning and increase LEG and PNP membership. We have Newhill Community Council, Mastrick Community Council, Bridge of Don Community Council, Danestone Community Council, Dyce Community Council, Culter Community Coun
Communities	CT09	Increase community involvement through existing networks and channels	7. Increase community involvement	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	Communities Team are providing project management support and project team members to plan and deliver the Age Friendly Aberdeen launch event in June 2023 at Kings Chu enable individuals and community groups to make better plans to age and retire well by focusing on health, wellbeing, finance, employment, community networks and volunteering with community groups and organisations and we will provide opportunities to link up people with these groups at the event and afterwards. The Community Team continues to engage with communities across Aberdeen. This includes locality planning, community planning, wellbeing, and public health outreach. The W services across Aberdeen City. The Public Health team continues to deliver training and capacity building for communities such as Health Issues in the Community and PEEP training.
Communities	CT10	Deliver Integrated Locality Plans and report on progress	8. Deliver Integrated Locality Plans	BAU	Apr-22	Mar-25	*Green*	**Tier 1 (Prevention)**	North Locality Empowerment Group will next meet on Wednesday 24 January. South Locality Empowerment Group will next meet on Thursday 25 January Central Locality Empowerment Group will next meet on Wednesday 31 January. Easy Read Locality Plans have been prepared by Integrated Locality Planning Team and circulated to LEG members for consultation. Engagement events held across the city during October-November to get community feedback on priorities for the refreshed locality plans. A data report was prepared by the Heal Empowerment Groups and Priority Neighbourhood Partnerships. A series of Community Planning stakeholder events will be held in January to further inform the development of the refreshed LOIP and locality plans. The draft locality plans will be reviewed by the Locality Empowerment Groups and Priority Neighbourhood Partnerships between 24 -31 January. The locality plans remain on track to be approved by the Community Planning Board on 29 April.
Communities	CT11	Ensure the use of Our Guidance for Public Engagement is embedded	9. Public Engagement	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	"Our Guidance for Public Engagement" has been used as basis, and informed the manner of engagement for (1) development of the Carers' Strategy 2023-2026 (2) work in relati the 'Older People and Frailty' pathway (4) The Transitions pathway (Children with additional support needs moving on from school (5) the meal provision and payment options for a Neuro Rehab Pathway.
Communities	CT12	Promote the use of Care Opinion to encourage patients, clients, carers and service users to share experiences of services, further informing choice.	10. Care Opinion Promotion	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	The Specialist Older Adult Rehabilitation Service (SOARS) reviewed and asked for changes to be made to their 'service tree'. The result of which is (1) it makes it easier for the pul 'responders' see only the stories relevant to their service (previously all 'responders' would have seen stories relevant to all SOARS services. The next step is to produce QR codes Health Village: Dietetics received CO training in September. The list/ email address' of 'responders' for the Sexual Health Clinic have been updated and CO promotional materials Learning Disability Services and Community Nursing teams: errors have been identified for 'administrators' and 'responders' in those service tree's. Updates will be made when the
Communities	PIH08	Co-design Aberdeen as an Age Friendly City which supports and nurtures people to get ready for their best retirement and promotes the development of a social movement to encourage citizens to stay well and stay connected within their communities.	11. Community Intervention	BAU	01/03/2023	Mar-25	*Green*	**Tier 1 (Prevention)**	Granite City Gathering project team are working in partnership with both Moray & Aberdeenshire Social Care Partnership to host a month-long wellbeing festival in May with events celebration event in October to align with international older persons' day. Grampian Meaningful Activity Network will promote activity and good practice in all settings across the cit bidding for funding to support the application of a WHO Age Friendly City principles and promote community participation, engagement and empowerment. The EU/UK Governme will run through to March 2024, the Communities Team will submit a joint bid with our colleagues in NHS Support Services Scotland focussing on addressing frailty and promoting Scottish Older Person Assembly (SOPA) age friendly communities' network to learn more about the process of endorsing the age friendly city application and support the creation Connected is undertaking a locality audit of activities and projects that are age friendly. TPM is engaging in LOIP activity.
Digital	AFHL03	Make Every Opportunity Count by ensuring patients, clients and their carers are signposted to relevant services for help.	12. MEOC	BAU	01/04/2022	Mar-25	*Green*	**Tier 1 (Prevention)**	No formal Grampian meetings just now there has been a Programme leadership change for the Grampian programme so expected meetings to be established in January . Met wi behaviour change process) They wanted to review if any duplication and or how MEOC aligns with this . Passed on MEOC resources and project status. Operationally training has in city.
Digital	SE05	Support the implementation of digital records where possible	13. Digital Records	BAU		Mar-25	*Closed*	**Tier 1 (Prevention)**	Marked as closed due as activity is incorporated into projects SE09 and SE10

Digital	SE06	Support the implementation of Electronic Medication Administration Recording (EMAR) in our care homes.	14. EMAR Implementation	FTP		Dec-23	*Green*	**Tier 1 (Prevention)**	Paper with options appraisal presented to SLT in November 2023. SLT have requested a business case be prepared for end March 2024.
Digital	SE07	Seek to expand the use of Technology Enabled Care (TEC) throughout Aberdeen.	15. Expanded Use TEC	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	Business case for Balnagask Court TEC replacement has been completed. On hold pending outcome of availability of funding. 3 month Proof of Concept launched for Assisted Care Robots project. Kingswood Court is currently identified as one site, BAC senior leadership have requested further informatio DPIA in progress. Digital Support Hub (DSH) now providing 24hr service with 41 clients. The hub are in week 5 of discharge from hospital with TEC project supporting 8 people home as an alternati within the project. Work on potential model for Proactive Telecare service within Aberdeen City continuing.
Digital	SE09	Deliver a Single Point of Contact for individuals and professionals including a repository of information on health and social care services available, eligibility criteria and how to access	16. SPOC for Individuals/Professionals	BAU		Mar-24	*Green*	**Tier 1 (Prevention)**	PID and project scope and timelines have been signed off. There was also an agreement to align with the project Initial project contact to make each other aware of delivery requir will carry through the professionals looking after episodes of care with service users. Option appraisal is being worked on. Next step is provide recommended solution and then ge
Digital	SE10	Review the future use of Morse in Community Nursing and Allied Health Professionals	17. MORSE Review in CN/AHPs	BAU		Mar-24	*Green*	**Tier 1 (Prevention)**	Decision by Grampian Chief Officers in December 2023 to put the implementation of Morse at a Grampian level on hold. This is to be reviewed in the new financial year. IJB Paper due in May 2024 to look at evaluating the impact of Morse and the renewal of the contract which is due to expire in October 2024. RAG status at Green since the review has taken place but not in a position to support at present with regards to the Grampian perspective, but the ACHSCP position is to continue implementing Trakcare which will fulfil some of their scheduling needs.
Digital	SE11	Explore ways we can help people access and use digital systems	18. Access to Digital	BAU		Oct-25	*Closed*	**Tier 1 (Prevention)**	Closed as a standalone project. Work is incorporated in a number of other projects
Digital	SE12	Deliver Analogue to Digital Implementation Plan	19. Analogue 2 Digital	FTP		Mar-25	*Green*	**Tier 1 (Prevention)**	In recognition of the progress, we have made on our analogue to digital telecare transition project, Digital Telecare for Scottish Local Government awarded Aberdeen City Health a Digital Telecare Implementation Award on Thursday the 11th of January 2024. In order to achieve Bronze status through Route 2, a Telecare service provider must have successfully deployed digital-ready alarm devices to at least 50% of its dispersed and gr now replaced 58% of the analogue dispersed alarms estate. The rollout of digital alarms is expected to be completed by the end of the year. We have met with Chubb Skyresposne to discuss commercials and technical requirements. A quote has been received just before Christmas with some costs that are yet to be fin
Flexible Bed Base	KPS11	Build on our intermediate bed-based services to create 20 step-up beds available for our primary care multi-disciplinary teams (MDTs) to access.	20 Step-Up Beds	FTP	01.03.2022	Sep-23	*Closed*	**Tier 2 (Early Intervention)**	Due to progress on the workstreams identified (Rosewell Step-up and Woodlands GP Admission Beds) not moving forward as anticipated an SBAR was produced and taken to SL Agreement made to stop the continuation of this as a separate project on the delivery plan due to the close links with frailty and rehab programmes of work. Step up beds must be
Flexible Bed Base	KPS12	Increase our hospital at home base with an ultimate ambition of 100 beds. These will be for Medical and Respiratory pathways, as well as the current Frailty, End of Life Care and OPAT pathways.	21. H@H Beds 100	FTP		Sep-25	*Green*	**Tier 3 (Response)**	Total capacity within the service is 42 beds (22 frailty consultant led, 5 frailty ANP led, 5 OPAT, 5 End of Life Care 5 Respiratory H@H beds). Capacity for the Respiratory beds remains at 5 and communication hasn't been effective between the ward and H@H. With the Lead ANP in post, the Lead Physio taking lead on t ward to build relationships, communication is improving. The planned increase in 5 OPAT beds by the end of June 23 was delayed due to sourcing of equipment and staff training. The equipment is now in place, with staff training ongoin support around these beds and increasing the number of beds we can have. The acute medicine trial went ahead with one patient in December and a meeting is to be confirmed to review this process and the learning from it. Funding proposal including the wider Virtual Capacity that was approved by Scottish Government in Aug 23, reporting is ongoing. Outcomes from the event of wider stakeholders on the 21st of November were shared and where relevant have been included in the project plan to action. Recruitment an ongoing challenge with various roles still vacant. Band 4 Coordinator vacancies a positive with a number of applications, these roles will aid in efficiency across the Jan/Feb 24, this will complement our medical team proving support to the consultants and nursing team.

Frailty	KPS13	Deliver the second phase of the Frailty pathway and undertake a review of implementation to date to identify further improvements to be incorporated into the programme plan.	22. Frailty Pathway 2nd Phase and Review	FTP		Mar-25	*Green*	**Tier 3 (Response)**	Frailty Pathway review has been completed and new Grampian Frailty Board Terms of reference agreed by all 3 Chief Officers with Governance oversight being provided by the U priorities agreed are; •Developing a sustainable Workforce •Implementation of a Managed Clinical and Care Network / Learning network for Frailty in Grampian •Grampian Frailty Performance Monitoring The first Board in the new format will take place on 15th January 2023 with significant development work needed to establish working groups around the priority areas particularly As the new Grampian Board approach is now only focussed on areas where a more focussed Grampian view is needed local plans for all 3 HSCPs will also be required. These wi focussed on developing a level of shared understanding and consistency across Grampian around the following; •Hospital-based Frailty (patients with acuity of need requiring inpatient care) •Patient pathways (e.g. Aberdeen City & Shire flow through ward 102) •Step-up & Step-down pathways •Alternatives to hospital (e.g. Hospital at Home or equivalent) •Community, Prevention & Primary care approaches to Frailty •A commitment to Quality improvement approaches where appropriate •A commitment to gaining lived experience feedback and involvement For Year 3 it is proposed that the Aberdeen City Frailty plan and the work of the Grampian Board be considered as separate but interlinked elements of the delivery plan.
Home Pathways	AFHL05	Develop and deliver local and sustainable system flow and return to home pathways with partners, supporting reduced hospital admission, delays in hospital discharge and out of area placements	23. Home Pathways	FTP	01/06/2022	Mar-25	*Green*	**Tier 1 (Prevention)**	A) Tenders have been returned for the Stoneywood development. B) Housing for Varying Needs Market Position Statement is currently being developed to inform the Local Housing Strategy with a target date for completion of 20/04/24. Five work experience as well. All workshop have been delivered and live experience engagements in sheltered housing completed. Kay to attend Homecoming event in Glasgow as part of Perth and how that can inform our future plans in Aberdeen. Draft 1 of HVN MPS is being written and a timeline developed in the runup to IJB in May.
Infrastructure	SE20	Develop an interim solution for the provision of health and social care services within the Countesswells housing development and work on the long-term solution	24. Health and Care in Counteswells	BAU	Apr-20	Mar-25	*Green*	**Tier 1 (Prevention)**	A unit at the new retail site at Countesswells has been purchased by NHS Grampian. Initial work has been done to identify suitable services to operate from the unit. The design tea consultancy rooms with supporting space have been approved by the leadership team. Our consultant architects are now producing a full design and costing for the work. A projec will operate from the facility. An HAI-Scribe infection control assessment has been carried out. A paper on the works required to fit out Countesswells went to NHS Grampian's As have been identified as applicable to be used for this interim health solution. This was approved with ACC and then went to AMG where funding was agreed. Provided there are no March 2024
Infrastructure	SE21	Assess future infrastructure needs and engage with partners to ensure these needs are met.	25. Infrastructure Plan	BAU	Mar-22	Mar-25	*Green*	**Tier 1 (Prevention)**	AMG has instructed he Primary Care Premises Group (PCPG) to carry out an overhaul of the plan for the 2023 update. This has been reported to the PCPG and remitted to its pla Premises Plan will be with the Assest Management Group early in 2024.
MHLD	AFHL07	Work with Children's Social Work and health services, to predict and plan for future Complex Care demand including developing and implementing a Transition Plan using the GIRFE multi-agency approach for those transitioning between children and adult social care services, initially for Learning Disabilities	26. Complex Care Future need and Transition	FTP	01/06/2022	Mar-24	*Green*	**Tier 2 (Early Intervention)**	Community Mental Health Commissioned Service Review - Organised three engagement workshops 11/12/23 (completed), 17/01/24 (online due to snow and amber weather war public on how the commissioned Community mental Health service should look like after the end of contract in March 2024. The services up for review are WELL Aberdeen, NOV the Scottish government will be reviewed as not further funds are scheduled to arrive. The service is up for review as well. Due to staff movement within the MHLD Services team, the actions below have only progressed recently. The Parents and Carers transition guide for young people with additional completed and sent to graphics in December, to bring together in a suitable format. The adult Learning Disabilities Social Work team and PM are working to complete these. Serv plan for launch in the new year. Complex Care An update on the progress of this work was provided to the Complex Care Programme Board on 07/12/2023. The working group is focusing on building cost projections coming int
MHLD	AFHL08	Deliver a capability framework for a workforce to support complex behaviour.	27. Complex Care Workforce and Skills Development	FTP	06/04/2023	Sep-23	*Green*	**Tier 3 (Response)**	The Capability Framework will be integrated into the Complex Care framework re-tender due for publication in June 2024 and may be applied, in part, to the Supported Living Fram

MHLD	AFHL09	Progress the Grampian wide MHLD Transformation Programme monitored by the Portfolio Board	28. MHLD Programme	FTP	01/06/2022	Mar-25	*Amber*	**Tier 3 (Response)**	General Adult Mental Health Secondary Care Pathway Review: A new timeline has been proposed to support this project to allow for more time early in the new year to consolidate gathered so far. This would lead the timeline to IJB meetings in May 2024. Process mapping has concluded and all service information forms have been completed. This will infor other key stakeholders, to share more widely, the themes arising from the challenges/issues shared about the AMH secondary care pathway, and as an opportunity to gather ideas these issues. Data gathering will continue against these themes. Engagement with Lived Experience continues through an online survey which is scheduled to conclude mid-Janua Learning Disabilities (LD) Health Checks: Focus on planning the pilot using Vaccination Centres in Shire scheduled to progress with a small group. Meeting with Moray took place health checks to understand how long they will take and cost per patient. The Local Enhanced Service model draft was sent to Moray team to review if this route is being pursued. LD wards, those being referred and those being discharged, this has resulted in onward referral to other services. No confirmed City option for delivering LD health checks confirm Scottish Health Boards takes place 17/1/24. Psychological Therapies (PT): Impressive progress has been made across services, with DCAQ analysis and job planning now in place. The next phases of work involve ensuring planned within CAMHS and LD services to that effect. Work has also progressed to ensure that all Consultant Psychologists and other service leads are able to take full responsibi reporting to health intelligence and PHS. Further details of progress are detailed below but in addition SH has volunteered to be involved with SLWG to develop and pilot a PT spec clear on areas requiring development moving forward. 12 SLWGs remain aligned to the PTIB Improvement Plan which will conclude by March 2025. The status of this work will be Public Empowerment Group (PEG): There has been a wider discussion of the PEGO role and the support it offers to the PEG. A meeting was had with the PEGO to discuss the fu focused on the following: •That funding for the PEGO role will not continue through its current funding stream (MHLDS) beyond June 2024. •That without a sustainable funding stream for the PEGO role; that preparing the PEG to be self-sustaining i.e., without the support of the PEGO, would need to begin. •We need to understand what the likely impact of the PEGO role not continuing, would have on the Chair and Vice Chair's participation. It was agreed to meet early 2023 to continue these discussions. Review & Modernisation of MHLD Workforce: The next project board meeting is on the 18/01/2024. Focus is now shifting to Service Needs Assessments of Advanced Roles/Clinica prescribing scope.
MHLD	AFHL09f	Develop a Mental Health triage approach in Primary Care to improve patient experience and promote self-management	29. Mental Health Triage in Primary Care settings	FTP	01/06/2022	Mar-25	*Green*	**Tier 2 (Early Intervention)**	We continue to gather referral data and liaise with Scottish Government colleagues to inform them of the project and to raise its profile. However, due to funding limitations for this project it is unlikely the project will be able to continue. Focus has now shifted to producing a project close report and evaluating/ preser
MHLD	AFHL09g	Review strategy and arrangements for Autism/Neurodevelopmental including further development of the Autism Assessment service and expansion to include neurodevelopmental assessment	30. Autism and Neurodevelopmental Assessment	FTP	1/04/023	Mar-25	*Amber*	**Tier 3 (Response)**	While the Adult Autism Assessment Team (AAAT) in NHS Grampian is funded until July 2024, there is no further Scottish Government funding past that, alongside a lengthy waitin The new Learning Disability, Autism and Neurodiversity Bill is due and if any associated funding that may be attached to this will be published. Progressing and developing any new Neurodevelopmental services is likely to be contingent on additional funding or agreement to resource transfer. A monthly working group convened across Grampian will review the existing service and to bring a scoping exercise aligning future developments to national recommendations in c
MHLD	AFHL09h	Develop and implement approaches to support Suicide Prevention and alignment to national Suicide Prevention Strategy	31. Suicide Prevention	FTP	01/04/2023	Mar-25	*Green*	**Tier 1 (Prevention)**	Suitable representatives for the following sub-groups have been identified. The 5 sub-groups for SAMH are: •Building Community Capacity •Children and Young People •Lived experience •Bereavement •Data analysis and risk Northeast Suicide Prevention Leadership Group (NESPLG) held on Thursday 27.12.23.
Prevention	PIH01	Reduce the use and harm from alcohol and other drugs including through the Drugs Related Deaths Rapid Response Plan	32. Alcohol & Drugs Reduction	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	We have established a sub-group of the ADP to take forward learning and best practice in preventing drug deaths. The group is chaired by Fraser Bell, COO and is partnership with improvements across the whole system. There is ongoing work with schools and care-experienced young people in relation to primary prevention. There is ongoing work to establis significant staffing / capacity issues with our specialist services.
Prevention	PIH02	Deliver actions to meet the HIS Sexual Health Standards	33. HIS Sexual Health Standards	BAU		Mar-25	*Amber*	**Tier 1 (Prevention)**	Sexual Health and Blood Born Viruses MCN reconvened during the last quarter and met twice over the summer, primarily for gathering updates and exploring what a future plan co that is envisaged to be more action focused. Exploratory conversations held with colleagues regarding hepatitis testing and exploring opportunities to align potential actions with we
Prevention	PIH04	Continue the promotion of active lives initiatives with our partners, for example the Physical Activity Academy, Active Travel etc.	34. Promote Active Lives	BAU	Apr-22	Mar-25	*Green*	**Tier 1 (Prevention)**	1) Facilitating connections and delivery of initiatives between sport providers, Sport Aberdeen, RGU, OT and other health and social care staff for Specialist Referrals for long term level opportunity to re-join or re-start any physical activity ambitions for older adults. 3)Physical Activity Academy – funding applied for to upskill BAC staff in Sheltered Housing in S Connects' to discuss opportunities for active travel health behaviour change opportunities within project. 5) Working in partnership with Sport Aberdeen delivering classes using PA travel to Foresterhill Campus 7) discussing use of the National Physical Activity Pathway with NHSG. Recruitment process ongoing to appoint a Public Health Coordinator to focus on obesity agenda, including the promotion of active lives and active travel. The successful candidate Planning is underway to incorporate a whole system approach to obesity into the refreshed Local Outcome Improvement Plan. This activity is being led by a Public Health Consulta refreshed LOIP is on track to come into effect on 30 April 2024.

Prevention	PIH05	Reduce smoking prevalence across population and prevent e-cigarette and emerging tobacco produce use among young people.	35. Smoking Prevalence	BAU	Apr-22	Mar-25	*Green*	**Tier 1 (Prevention)**	A LOIP project on Reducing Smoking Prevalence has had the project end report accepted by Community Planning Aberdeen Board which saw smoking prevalence drop by 5%. An improvement project is being developed to look at reducing the number of pregnant women smoking in Aberdeen. This will form part of the refreshed LOIP. Charleston Primary School Pilot on Vaping Prevention being delivered by Youth work and Health Improvement Officers. Sharing of practice event has been held with the Education Public Health Team are still contributing to the development of the Grampian Tobacco Strategy and Plan. Budget has been sourced to fund a part time Health Improvement Office ACHSCP's Public Health Team have worked with colleagues from NHSG Public Health Directorate; Aberdeenshire and Moray HSCPs; NHS Grampian Community Pharmacy; and
Prevention	PIH06	Continue to deliver our Stay Well Stay Connected programme of holistic community health interventions focusing on the prevention agenda.	36. Deliver SWSC Prevention	BAU	Apr-22	Mar-25	*Green*	**Tier 1 (Prevention)**	5 year Health Inequalities Plan for Grampian being developed Mental Health - Grampian wide PH partnership developing strategic framework to improve mapping of mental health & wellbeing services (non-Clinical) in Aberdeen city, with focu Health Improvement fund: Public Health Team facilitated decision making groups. We have received applications from various projects including support for asylum seekers, men A second round of HIF funding will open in the North Locality during January-February to allocate remaining funds. Regular HIF updates are reported to the IJB via the Chief Office Health Issues in the Community tutor training continues to be delivered. PEEP training to support disadvantaged parents and families continues to be delivered by HIOs. We continue to support NHSG public Health Directorate's Healthy Futures Prograr Child Healthy Weight tier 1 delivery plan agreed and Peep plans in place. Food in Focus initiatives ongoing to improve vulnerable people's cooking skills and to support better food choices, this includes food growing and confidence to cook initiatives. Young Carers Integrated Food Programme continues to be delivered.
Prevention	PIH06a	Continue to deliver our Stay Well Stay Connected programme of holistic community health interventions focusing on social isolation.	37. Deliver SWSC Social Isolation	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	Men's Wellbeing Groups –Topic led awareness raising for groups of older men to improve health and wellbeing outcomes. RGU Sport & Exercise Science Partnership – Wellbeing Coordinator and Robert Gordon University lecturers & student placements with an ageing population. Falls Prevention Awareness Events – Information and advice on falls prevention held regularly in communities. Aberdeen Befriending Network - Discussions held with ACVO. Boogie in the Bar – Monthly events - Sunnybank Football Club, The Abbot & Dee Swim Club remain hugely popular. Stay Well, Stay Connected Radio Show – Monthly radio show on SHMU bringing health & wellbeing advice and information directly into people's homes, Wellbeing stalls - Bringing health and wellbeing information and advice into people's communities. Soup & Sannie's - food, company & sign posting events in Seaton, Kincorth & Torry. Sheltered Housing activity programme in Seaton & Torry. Mighty Oaks (menopause), Exercise classes, Health walks and planned conversation cafes for 2024 Dementia/Cognitive decline – Cornhill wellbeing programme, Resource centre wellbeing programme & Compassionate spaces with Bon Accord Care. AGILE - Copies are available at Hub 8 in Marischal college and distributed by care managers support workers, wellbeing coordinators, Vaccination centre, links practitioners, servic community nursing team when they out seeing service users. There have been requests for additional copies of AGILE from OT's at ARI and from Garthdee Medical Practice.
Prevention	PIH07	Continue to contribute to the Health Transport Action Plan (HTAP) and the Aberdeen Local Transport Strategy (ALTS) encouraging sustainable and active travel.	38. Contribute to Transport	BAU	Apr-22	Mar-25	*Green*	**Tier 1 (Prevention)**	A formal Health Impact Assessment of the Local Transport Strategy was completed and will be used to inform strategic developments one the strategy is operational. PH input rela work is being led by the HTAP Programme Manager which is a jointly funded post by Nestrans and NHS Grampian.
Primary Care	CT14	Improve primary care stability by creating capacity for general practice	39. Primary Care Stability	BAU		Mar-24	*Amber*	**Tier 1 (Prevention)**	The primary care team continue to work with GP practices to collaborate and discuss current challenges being faced. The situation in relation to practices closing their patient lists been instructed to open their lists from the 28th of July. However, practices may choose to apply to close their list following a formal process and may also choose to informally ma In light of these current challenges and given the critical role that General Practice plays in the wider health and care system; NHS Grampian with the Integration Joint Boards has objectives for General Practice across Grampian. The output of this will be a delivery plan for a Grampian General Practice Strategy. This will provide an opportunity to deliver Gen A series of four facilitated workshop events begun in September 2023 and are near completion with the final session taking place on the 17th of January 2024. Following this there output and recommendations of this priority work which will be presented to the Scottish Government.
Primary Care	CT15	Deliver the strategic intent for the Primary Care Improvement Plan (PCIP)	40. Deliver PCIP	FTP		Mar-25	*Green*	**Tier 1 (Prevention)**	The PCIP Programme continues to deliver on its 6 workstreams and VTP, CTAC and Pharmacotherapy being the 3 workstream of priority and delivery is against the 2018 PCIP. CTAC - practice-based service fully delivered; clinic-based service now operating from sites (BOD, Inverurie Road, College Street, Northfield, Carden House, Airyhall, Kincorth and been delivered 98% against the 2018 PCIP plan. All staff posts have been recruited to against the plan. Looking to operate a service in Torry 2 day a week and this is work in progr Vaccinations (VTP)- fully delivered. The service has moved into the new location in the Bon Accord Centre and the HSCP have agreed to the lease for the premises to be extended Pharmacotherapy - roll out of the service is almost at full capacity, as outlined in our agreed service model of 1 WTE to 10,000 patients. It is recognised this model is insufficient to in the MoU2, and the service model required to deliver is much higher with estimation closer to 2.5 WTE per 5,000. However currently there is no national agreement on this. The workstream has been delivered 99% against the 2018 PCIP plan. The PCIP will be included in the GP Visioning Programme which is currently being delivered across NHS Grampian in terms of revising the delivery of the plan.

Primary Care	CT18	Develop a vision for Primary Care	41. Deliver PCIP	BAU		Mar-24	*Green*	**Tier 1 (Prevention)**	The General Practice Vision programme has now concluded the three facilitated stakeholder events. Workshops 2 and 3 were held on 8 and 22 November 2023, attendance num Stakeholder engagement targeting the younger generation was undertaken in December 2023. This included focus groups in high schools across the area, and a stall at Aberdeen with Medical Students early 2024. Feedback from these groups will be supplemental to the information and feedback already gathered. A fourth workshop has been arranged for 17th January 2023, this will be a smaller workshop, with attendance from the General Practice Vision Programme Board, as well as othe care, patient stakeholder group and finance. Themes that have been identified and will be included in the vision include: • Keeping the population well • Pathways • Data • Models of contract • Premises • IT & Technology • Multi-Disciplinary Team • Mental health • Education • Continuity The Vision and accompanying objectives to deliver that vision will be presented to the three IJB's on the following dates: 20th March 2024 – Aberdeenshire IJB 26th March 2024 – Aberdeen City IJB 28th March 2024 – Moray IJB
Redesigning Adult Social Work	CT01	Redesigning Adult Social Work enhancing the role of Social Work in playing a guiding role in the promotion of personalised options for care and support.	42. Redesigning Adult Social Work	BAU		Dec-24	*Green*	**Tier 3 (Response)**	All adult social work teams have continued to receive an increased number of referrals. Some areas of redesign have been slowed down or paused due to operational, strategic a way of working to meet the increased demand and also to have in place a system of early identification and prevention to reduce demand into the system in the long term. A Flash report was presented to SLT on 25th January 23 to extend the timeline from Sep 22 to Dec 24 to enable the above to be completed. This was agreed. 06/04/23 - Project listed as Tier 3 due to the statutory nature of Social Work provision as a response service. Where possible they would also be intervening in a manner in line with As part of additional work identified work to achieve budget savings a new project was identified in relation to Charging policy - Contributing to your care . This project will be deliver starting payment for meals and services that were previously charged and moving away from cash systems to direct debits . Within phase two , a refreshed Charging Policy will be third phase will be a change in modelling of finance into individual budgets for all clients within D365 . The changes and developments will incrementally increase finance and grea An update on progress will be delivered to Senior Leadership Team in Early Feb along with draft Charging Policy for consideration
Rehabilitation Review	KPS01	Develop a strategic planning framework for reviewing of rehabilitation services across ACHSCP /SOARS / Portfolio for phased implementation from April 2023. Each review should consider how partners in sports and leisure can assist in delivery of rehabilitation and will consider bed base requirements.	43. Strategic Planning Framework for Review Rehab	FTP	01.08.2022	Mar-25	*Amber*	**Tier 1 (Prevention)**	Direction from SRO and Chief Officer sought re focus and direction of review of City wide rehab services
Rehabilitation Review	KPS07	Undertake and implement a strategic review of the Neuro Rehabilitation Pathway	44. Strategic Review Neuro-Rehab	FTP	01.07.2022	Oct-24	*Green*	**Tier 1 (Prevention)**	Report submitted to City IJB for review on the 10th of October was approved. Review report described a 2 phase approach, implementing additional staffing across three main elements in pathway in the first phase, before evaluating impact and then progres Programme Team attended Shire IJB 6th December to present similar report that was brought to the City and this was approved. Programme Team will be attending Moray IJB on the 25th January, again with a similar report to that of City and Shire. Programme Core Team established to drive work forward and oversee 3 projects around Recruitment, Pathways and Evaluation.
Resilience	SE13	Develop a critical path for future budget setting and ongoing monitoring	45. Financial Monitoring	BAU		Mar-25	*Completed*	**Tier 1 (Prevention)**	Regular reporting of the forecasted budget position to Senior Leadership Team, Risk, Audit and Performance Committee and the IJB Committee continues. The Delivery Plan Rev Senior Leadership Team prior to being formally presented to the IJB in March 2024. As part of the 2024/25 MTFF, a timeline has been developed and agreed at SLT. The timeline details the individual stages in the budget setting process and deadlines for each sta
Resilience	SE15	Develop proactive, repeated and consistent communications to keep communities informed	46. Community Communications	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	Comms Adviser has been trained on social media platforms and has received all the invites for the internal comms meetings to allow for attendance and continuity in terms of inte has been established which allows more ACHSCP staff access to post social media content. The Group have developed a diary of social media post for various ACHSCP events p
Resilience	SE23	Review Care for People arrangements	47. Care for People	BAU		Mar-24	*Amber*	**Tier 1 (Prevention)**	The City Care For People (CFP) Plan has been reviewed in 23/24, however once the Persons at risk Database (PARD) has been finalised the CFP Plan will be further revised. The of the exercise held in December 2023 around when a Grampian CFP Group should be set up in response mode.
Resilience	SE24	Review SMOC arrangements	48. SMOC Review	BAU		Mar-24	*Green*	**Tier 1 (Prevention)**	Using the draft options appraisal on SMOC arrangements (last updated in Jan 2024) and referring to the plans for the future operation of the DSC's to produce a revised option ap Chief Nurse to speak to MUSC colleagues about the DSC plans, and a steer to be sought from Shire and Moray HSCP's around their plans to manage attendance at DSC meeting

Resilience	SE25	Create and adopt a Generic Emergency Plan to reflect Aberdeen city IJB's Cat 1 Responder responsibilities	49. Cat 1 Responder	BAU		Mar-24	*Amber*	**Tier 1 (Prevention)**	Once the SMOC review has been approved, this will help inform the production of the IJB's Generic Emergency Plan. Meeting set up for week of 22nd Jan to discuss (with colleag
Resilience	SE26	Preparing for and managing the transition to a National Care Service (NCS) through the Aberdeen City NCS Programme Board	50. NCS	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	Aberdeen City National Care Service Programme Board has been established since December 2022. It continues to meet on a monthly basis and is working to a Workplan coveri is currently paused with the Scottish Parliament's scrutiny of the Bill likely to resume following the summer of 2023. In the meantime, the Scottish Government has agreed with Co represented on national working groups that are seeking to develop the detail of a shared accountability model. It is anticipated that the Scottish Government will begin to propose 2024.
Social Care Pathways	AFHL10	Explore opportunities for working with those on Social Work unmet need lists to help support them while they wait, or divert them from the list	51. Unmet need list support	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	Agreed at SLT on 10th January 2024 this will be closed as a standalone project with the work being incorporated into the Social Care Pathways Review going forward.
Social Care Pathways	CT02	Undertake a strategic review of specific social care pathways utilising the GIRFE multi-agency approach where relevant and develop an implementation plan for improving accessibility and coordination.	52. Strategic Review Social Care	FTP	Jul-22	Dec-25	*Green*	**Tier 2 (Early Intervention)**	A Programme Implementation Plan is in place to monitor overall progress of this work. Main updates at this point are. SCP4 Hospital Discharge Pathways - Realignment to ward structure implemented. Monitoring of impact will be ongoing during winter period. Initial benchmarking survey indicates p SCP6 - Preventative & Proactive Care - SCP6.5 - IPOC- Workshop has taken place to consider how IPOC will be structured, sense-making to be carried out to then inform a busin SCP6.6 - GIRFE - ongoing work as pathfinder with Scottish Government to develop national model. SCP 9 - TEC plan incorporated within the SCP Board structure due to complimentary nature of projects and leadership responsibility moving to Chief Social Worker. Further work
Social Care Pathways	CT04	Implement the recommendations from the June 22 Adult Support and Protection inspection	53. ASP Recommendations Implementation	BAU	Jan-21	Mar-25	*Green*	**Tier 3 (Response)**	• Improvement to recording by NHS Grampian staff of ASP activity – Complete: training curriculum has been amended and a specific Practice Note issued to patient-facing staff. • Investigations taking too long, and case conferences taking place when needed – COMPLETE Marked improvement seen – investigations being held more timeously, increase in is being progressed to provide assurance about this. • Chronologies & Protection Planning – Working Practice Guidance on most effective use of D365 and Chronologies is being developed (being progressed) • Access to Advocacy – Significant improvement in relation to offer of and take up of advocacy. Being embedded into D365 throughout the process. Data collection around this bei • Multi Agency Evaluation & Involvement of staff in improvement work – Council Officer Support Groups are taking place and effective – including consideration of improvement wo were established). Workshop re our approach to LSIs took place on 9th Oct 2024 – guidance being developed.
Social Care Pathways	CT05	Deliver the Justice Social Work Delivery Plan	54. Deliver JSW Plan	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	• Justice Social Work are utilising the national Level of Service Case Management Inventory (LS/CMI) risk/needs assessment tool now that it has been returned to full use with the processes. • The task of identifying suitable premises for the Unpaid Work team remains unchanged with continued liaison to secure premises. There are 2 particular sites of interest being pu • Progress is being made with the requirement to use the VISOR Police information system, a post for a suitably vetted admin worker is in the process for recruitment in order for JS appropriate. There are complications due to the requirement for resetting passwords etc. which requires a higher level of vetting, this is being explored with the Mappa Co-ordinatio meantime, there are clear and robust information sharing protocols in place for Mappa cases and all information is shared with partner agencies as required as well as the Mappa • The new D365 system is being utilised as a working tool, Scottish Government returns were submitted for 2022/23 appropriately. • The service is almost fully staffed with newly appointed staff undertaking appropriate induction and training.
Strategy	AFHL01	Deliver on our Equality Outcomes and Mainstreaming Framework, report on our progress to both the IJB and the Risk, Audit and Performance Committee and plan to revise the EOMF in advance of the 2025 deadline.	55. Deliver EOM Framework	BAU	01/04/2021	Mar-25	*Green*	**Tier 1 (Prevention)**	EOM Framework is a standing item of EHR group agenda, a number of areas being progressed including the development of the DiversCity Officers Network and review of the par New EOMF and IIA process approved by IJB on 25 April 2023, website updated. Following review of our updated process and paperwork the Equality and Human Rights Commiss document that has been circulated to all HSCPs.
Strategy	AFHL02	Undertake and publish Health Inequality Impact Assessments, where relevant, for major service change, in conjunction with people and communities with the relevant protected characteristics ensuring that the requirements of the UNCRC are incorporated.	56. Publish HIIAs	BAU	01/04/2021	Mar-25	*Green*	**Tier 1 (Prevention)**	New IIA process, including UNCRC, is now in place following approval of this and the new EOMF by the IJB on 25 April 2023. Previous HIIAs now published on our website as requ initially, by the DiversCity Officer Network to help build support and capacity across teams as this develops. DiversCity Officers Network continues to progress with initial discussions Improvement Manager, Public Health Scotland for opportunities to collaborate and share learnings.

Strategy	AFHL04	Embed consideration of the impact of climate change in health and social care planning and in business continuity arrangements aiming to reduce our carbon footprint and deliver on our Net Zero emissions target.	57. Climate Change and NetZero	BAU	Aug-22	Mar-25	*Green*	**Tier 1 (Prevention)**	Various project development has been progressed during this reporting period. It was agreed that a risk should be developed, agreed, and integrated into the ACHSCP strategic ris needs to be developed for the climate change programme (work started).
Strategy	CT17	Monitor and evaluate the impact of the Carers Strategy on an ongoing basis factoring in early preparations for the next revision	58. Monitor and Evaluate Carers Strategy	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	The Carers Strategy Implementation Group (CSIG) continues to meet bi monthly and is currently pulling together the annual update for 2023-24 on the Carers Strategy which is du members on 9 January 2024 and our Annual Carers Survey is now live until the end of January 2024. CSIG are currently awaiting the National Carers Census data for Aberdeen C session to look ahead at Year 2 of the Carers Strategy and the action plan is due to take place on 25 January 2024.
Strategy	KPS19	Help people to ensure their current homes meet their needs including enabling adaptations	59. Suitable Homes	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	The Disabled Adaptations Group (DAG) continues to meet quarterly and sub group established to look at the recently published Adaptations guidance, baseline assessment tool b continues to consider and monitor all major and minor adaptations to meet needs and requirements of people living in their homes.
Workforce	SE01	Deliver the Workforce Plan	60. Develop Workforce Plan	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	The workforce plan is aligned with the ACHSCP strategic plan 2022 – 2025 and focusses on three essential core elements; recruitment & retention, mental health & wellbeing, and core elements of the plan as well as an oversight group made up of senior representation across the partnership to monitor and ensure delivery of the plan. These meetings take p delivered to RAPC on 28 November 2023, where it was approved.
Workforce	SE02	Develop and implement a volunteer protocol and pathway with a view to growing and valuing volunteering within the health and social care system	61. Volunteer Protocol Pathways	BAU		Sep-23	*Not Started*	**Tier 1 (Prevention)**	SRO is exploring use of volunteers at Aberdeen health village, as a test of the various protocols needed
Workforce	SE03	Continue to support initiatives supporting staff health and wellbeing	62. Staff Health & Wellbeing	BAU		Mar-25	*Green*	**Tier 1 (Prevention)**	Continuous work ongoing to deliver health and wellbeing initiatives. Initiatives and opportunities shared daily via OLT updates. Funding being sought from 23/24 budget process to and Wellbeing under the Workforce Plan priority, this group will focus on actions and collation of health and wellbeing initiatives being delivered across the partnership to support o
Workforce	SE04	Ensure our workforce are Trauma Informed	63. Trauma Informed Workforce	BAU		Mar-25	*Amber*	**Tier 1 (Prevention)**	ACC have £50k non-recurring funding to support this work and are trying to appoint a Coordinator SLT have been trying to convene a virtual training session , with shire/moray HSCP colleagues. SLT Trauma Informed Workforce session took place 6.9.23, to support leading by example, delivered by Mental Health Service, Clinical Psychologist.
Workforce	SE22	Create and implement an SLT Team Development Plan	64. SLT Development Plan	BAU		Mar-24	*Green*	**Tier 1 (Prevention)**	Regular Development Sessions are now taking place, with a core Development Group of four members of the SLT taking the lead on planning and facilitating these. Views of the now an embedded feature of the way SLT work. The project will be considered delivered within year 2 and deemed to be business as usual going forward."

This page is intentionally left blank

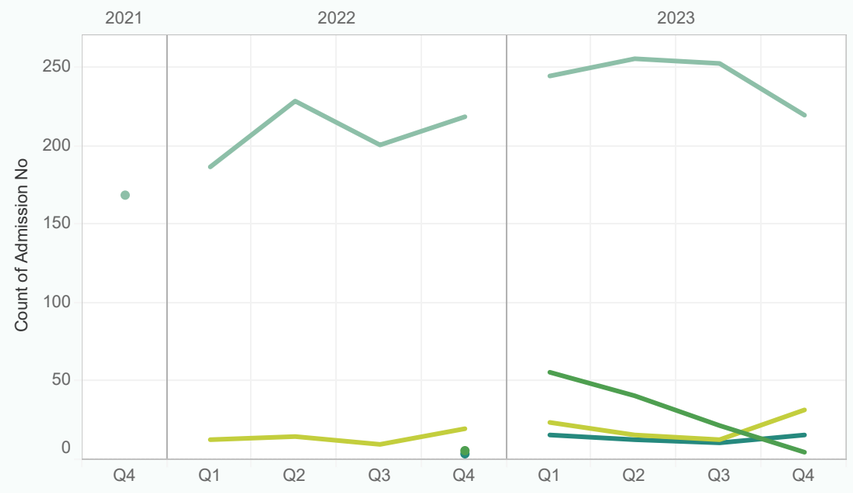
ACHSCP - DELIVERY PLAN YEAR 2 PERFORMANCE REPORTING

DATA SUPPLIED FOR MANAGEMENT INFORMATION PURPOSES ONLY

FLEXIBLE BED BASE

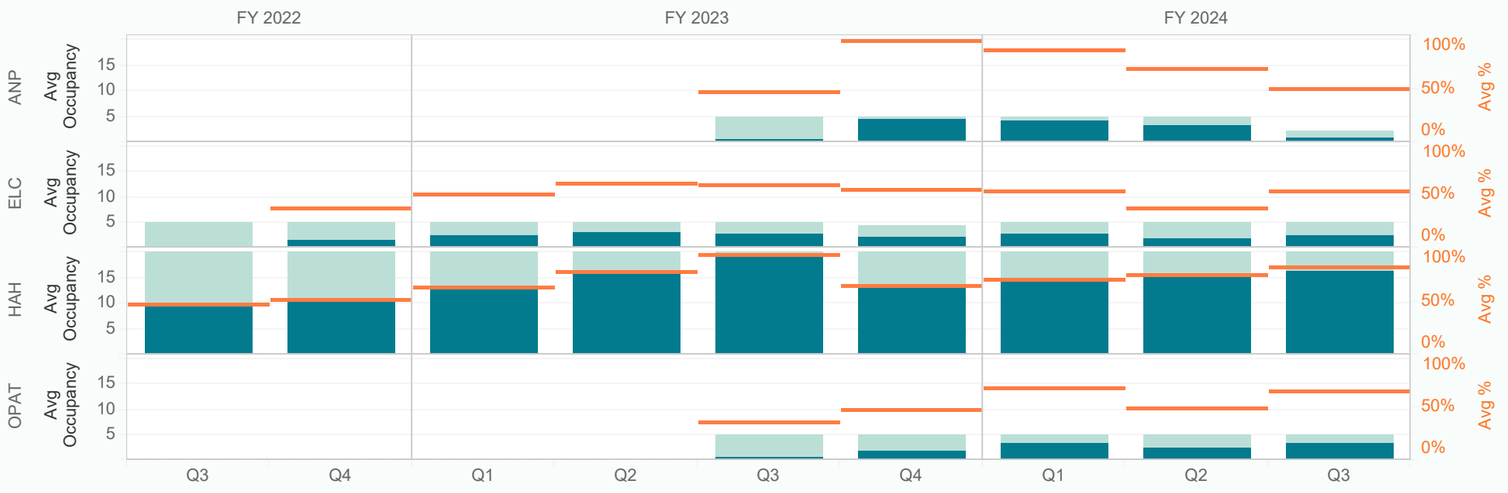
Hospital at Home Admissions (Ward Starts)

	FY 2022 Q4	FY 2024 Q3
Hospital at Home	187	220
		▲ 33
Hospital at Home - ANP		5
		▲ 5
Hospital at Home - ELC	13	32
		▲ 19
Hospital at Home - OPAT		16
		▲ 16



Hospital At Home Capacity and Occupancy - Latest Quarter vs Baseline

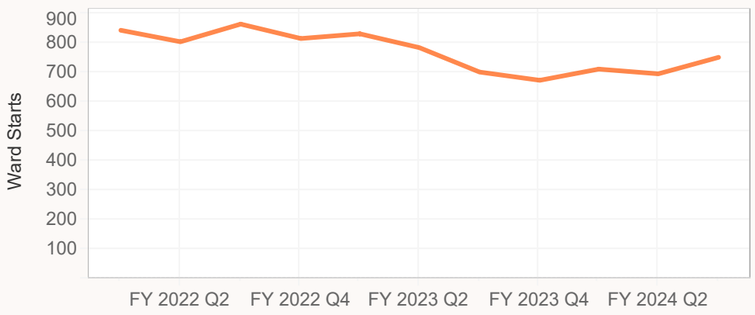
	Average Allocated Beds Available		Average Overnight Occupancy		Average % Occupancy	
	FY 2022 Q4	FY 2024 Q3	FY 2022 Q4	FY 2024 Q3	FY 2022 Q4	FY 2024 Q3
ANP		2.03	0.00	1.02		50.8%
		▲ 2.03		▲ 1.02		▲ 50.8%
ELC	5.00	5.00	1.63	2.62	38.2%	54.8%
		● 0		▲ 0.99		▲ 16.6%
HAH	20.00	20.00	10.51	16.54	52.6%	82.7%
		● 0		▲ 6.03		▲ 30.2%
OPAT		5.00	0.00	3.36		67.2%
		▲ 5.00		▲ 3.36		▲ 67.2%



FRAILTY

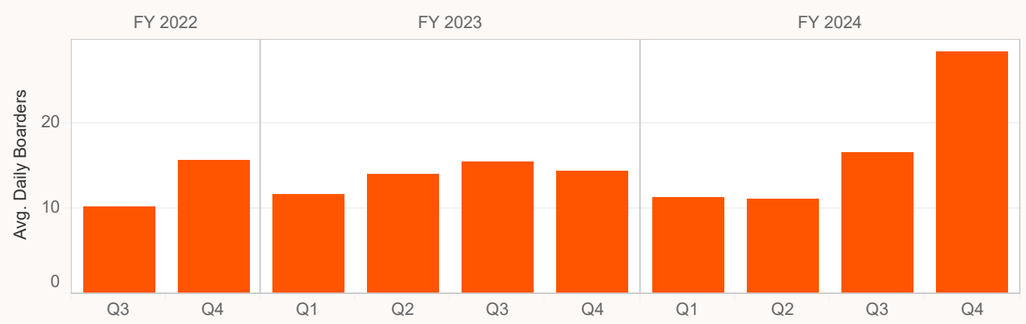
Ward 102 Ward Starts (Admissions)

	FY 2022 Q4	FY 2024 Q3
Ward 102, ARI	816	752
		▼ -64



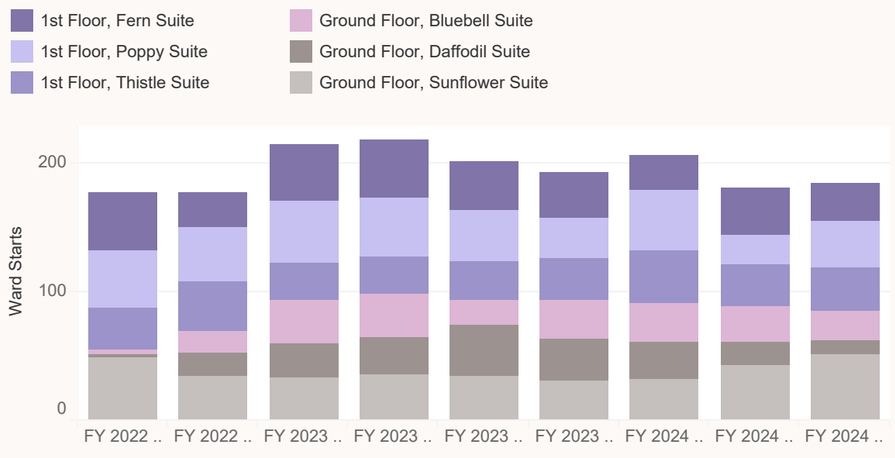
Ward 102 Average Daily Boarders

FY 2022 Q4	FY 2024 Q3
15.7	16.6
	▲ 0.9



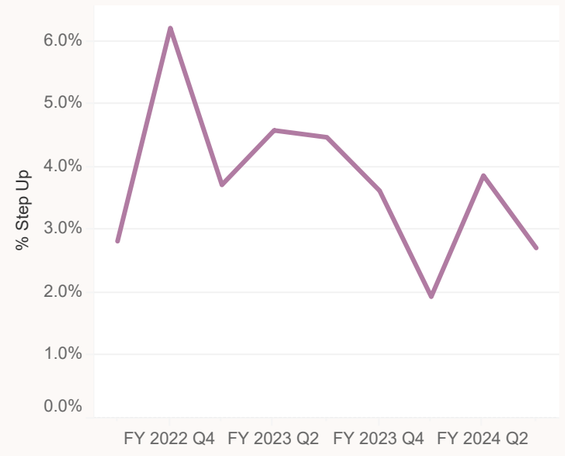
Rosewell House Ward Starts

	FY 2022 Q4	FY 2024 Q3
1st Floor, Fern Suite	26	29
		▲ 3
1st Floor, Poppy Suite	42	36
		▼ -6
1st Floor, Thistle Suite	39	34
		▼ -5
Ground Floor, Bluebell Suite	17	22
		▲ 5
Ground Floor, Daffodil Suite	18	11
		▼ -7
Ground Floor, Sunflower Suite	35	52
		▲ 17



Rosewell House % Step Up (Based on IsFirstWard=1 or Previous Ward Desc-'Hospital at Home' derived from Trakcare for each Admission)

	FY 2022 Q4	FY 2024 Q3
1st Floor, Fern Suite	7.69%	6.90%
		▼ -0.80%
1st Floor, Poppy Suite	7.14%	2.78%
		▼ -4.37%
1st Floor, Thistle Suite	5.13%	2.94%
		▼ -2.19%
Ground Floor, Bluebell Suite	5.88%	0.00%
		▼ -5.88%
Ground Floor, Daffodil Suite	16.67%	0.00%
		▼ -16.67%
Ground Floor, Sunflower Suite	0.00%	1.92%
		▲ 1.92%

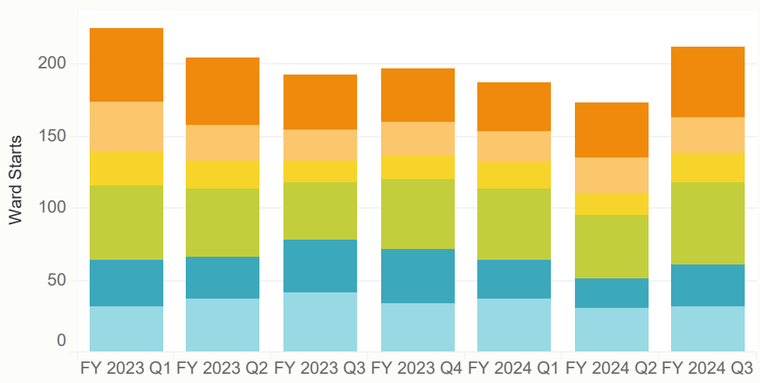


REHABILITATION REVIEW

Links Unit · Morningfield House · Neuro Rehab Unit · Orthopaedic Rehab Unit · Stroke Unit East · Stroke Unit West

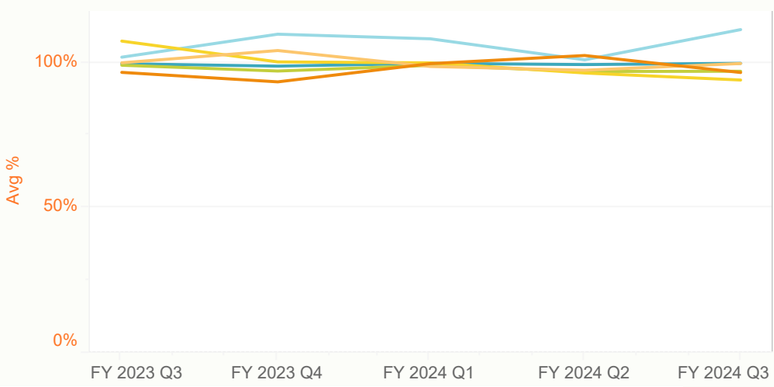
SOARS Ward Starts (Admissions)

	FY 2022 Q4	FY 2024 Q3
Links Unit	53	48
		▼ -5
Morningfield House	41	25
		▼ -16
Neuro Rehab Unit	23	20
		▼ -3
Orthopaedic Rehab Unit	52	58
		▲ 6
Stroke Unit East	34	29
		▼ -5
Stroke Unit West	27	32
		▲ 5



SOARS Average Occupancy

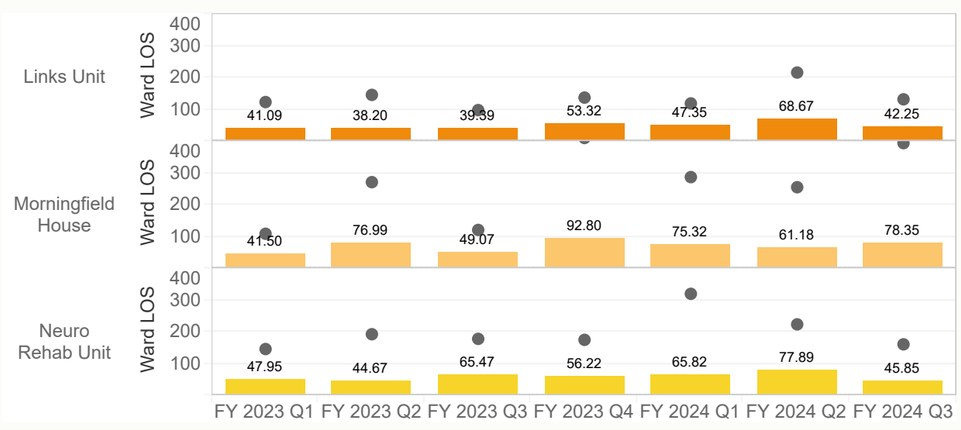
	FY 2022 Q4	FY 2024 Q3
Links Unit	101.3%	96.5%
		▼ -4.8%
Morningfield House	98.3%	99.6%
		▲ 1.3%
Neuro Rehab Unit	107.6%	93.9%
		▼ -13.7%
Orthopaedic Rehab Unit	86.5%	96.9%
		▲ 10.4%
Stroke Unit East	79.1%	99.7%
		▲ 20.5%
Stroke Unit West	99.8%	111.3%
		▲ 11.5%



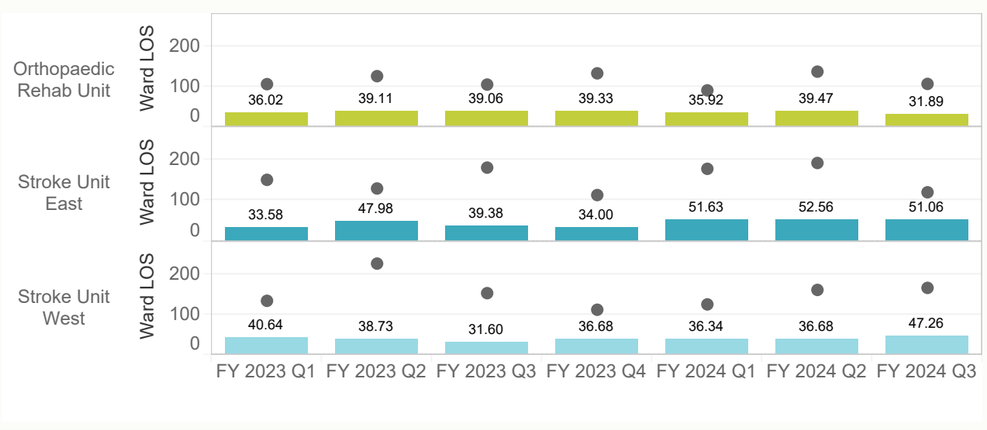
SOARS Average LOS

Denotes Max LOS

	FY 2024 Q3
Links Unit	42.25
Morningfield House	78.35
Neuro Rehab Unit	45.85
Orthopaedic Rehab Unit	31.89
Stroke Unit East	51.06
Stroke Unit West	47.26



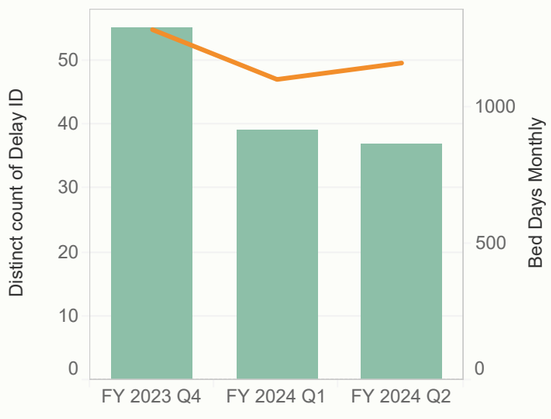
Denotes Max LOS



Delayed Discharges - SOARs Ward Codes at Snapshot (Note Ward102 delays not included)

Bed Days Monthly · Distinct Count of Delay

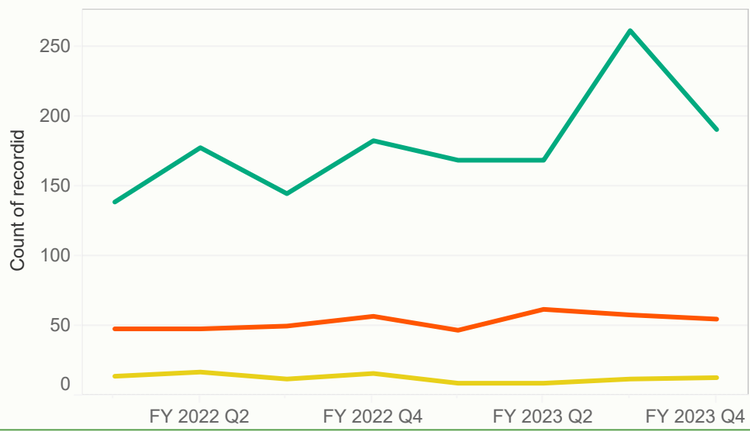
Delays			Bed Days Monthly		
	FY 2022 Q3	FY 2024 Q2	FY 2022 Q3	FY 2024 Q2	
Woodend General Hospital	50	37	928	1,160	
		▼ -13			▲ 232



Datix Falls (All Falls Indcidents Categorised to ABCITY Orgainisation)

HARM · NMISS · NOHARM

	FY 2022 Q4	FY 2024 Q3
HARM	57	48
		▼ -9
NMISS	16	17
		▲ 1
NOHARM	183	199
		▲ 16



ACHSCP - DELIVERY PLAN YEAR 2 PERFORMANCE REPORTING

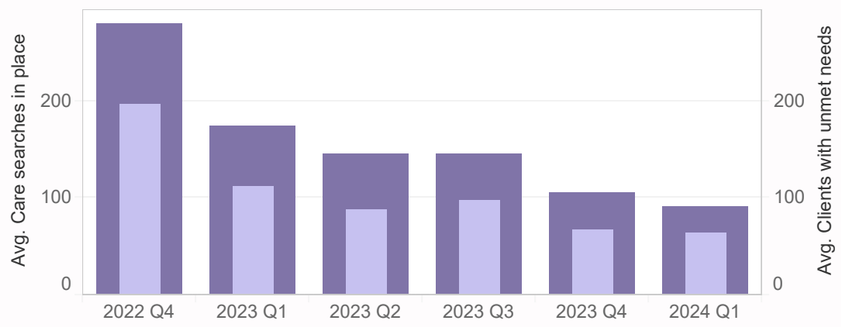
DATA SUPPLIED FOR MANAGEMENT INFORMATION PURPOSES ONLY

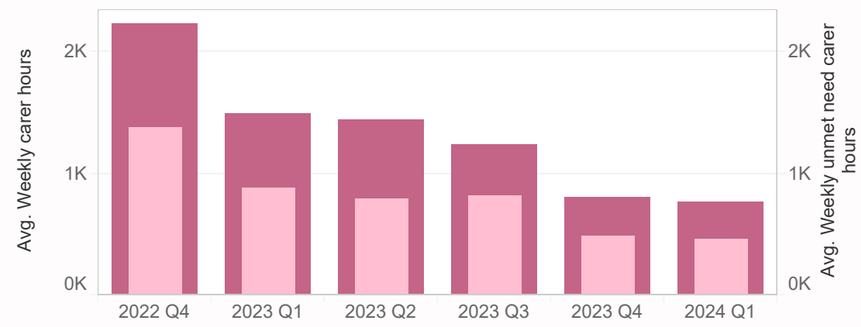
SOCIAL CARE PATHWAYS

OPEN CASES AND UNMET NEED (14+ DAYS OPEN)

	FY 2022 Q4	FY 2024 Q3
Avg. Care searches in place	283.3	105.6
		▼ -178
Avg. Clients with unmet needs	152.5	67.3
		▼ -85.2

	FY 2022 Q4	FY 2024 Q3
Avg. Weekly carer hours	2,756	805
		▼ -1,951.0
Avg. Weekly unmet need carer hours	1,225	482
		▼ -743.1



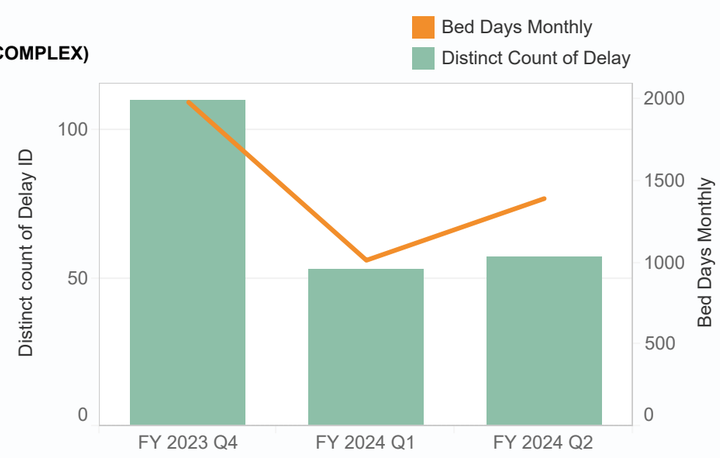


HOME PATHWAYS

DELAYED DISCHARGES (STANDARD AND COMPLEX)

	FY 2022 Q3	FY 2024 Q2
Standard	91	50
		▼ -41
Complex-Code 9	11	7
		▼ -4

	FY 2022 Q3	FY 2024 Q2
Standard	1,258	1,064
		▼ -194
Complex-Code 9	367	328
		▼ -39



MHLD TRANSFORMATION

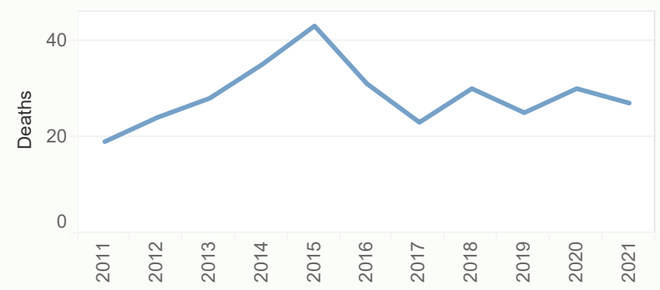
COMPLEX DELAYED DISCHARGE BED DAYS (EXCL WARD AND CARE HOME CLOSURES - ANY LOCATION)

Code 9 reasons

	FY 2022 Q4	FY 2024 Q2
Code 9 reasons	329	328
		▼ -1

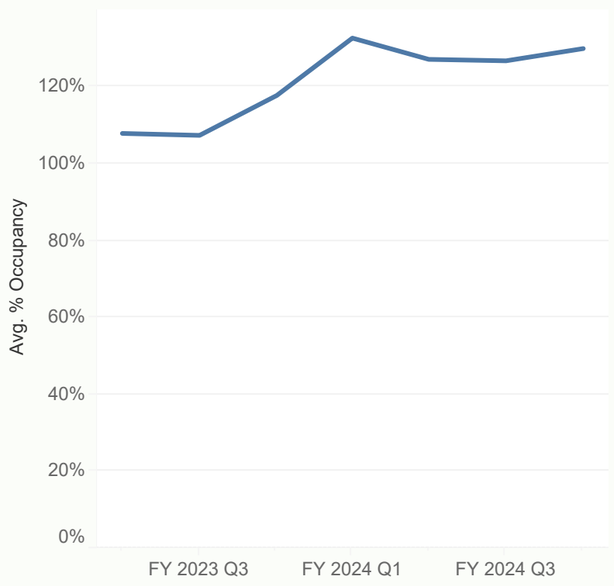
PROBABLE SUIICIDES

2020	2021
30	27
	▼ -3



RCH AVERAGE OVERNIGHT OCCUPANCY (EXCL FORENSIC WARDS)

FY 2022 Q4	FY 2024 Q3
93.2%	126.8%
	▲ 33.6%



	FY 2022 Q4	FY 2024 Q3
Brodie Ward, RCH	87.9%	99.5%
		▲ 11.6%
Corgarff Ward, RCH	78.8%	109.7%
		▲ 30.9%
Davan Ward, RCH		106.7%
		▲ 106.7%
Drum Ward, RCH	98.4%	
		▼ -98.4%
Dunnottar Ward, RCH	99.1%	108.1%
		▲ 9.0%
Eden Ward, RCH	94.6%	141.0%
		▲ 46.5%
Forensic Acute, RCH	111.7%	99.7%
		▼ -11.9%
Forensic Rehab Ward, RCH	99.6%	241.3%
		▲ 141.8%

	FY 2022 Q4	FY 2024 Q3
Fraser Ward, RCH	97.6%	109.8%
		▲ 12.2%
Fyvie Ward, RCH	93.7%	106.9%
		▲ 13.2%
Huntly Ward, RCH	90.1%	110.0%
		▲ 19.9%
IPCU, RCH	74.3%	89.6%
		▲ 15.3%
Loirston Ward, RCH	99.3%	511.8%
		▲ 412.4%
Muick Ward, RCH		108.1%
		▲ 108.1%
Skene Ward, RCH	96.5%	106.5%
		▲ 9.9%
Strathbeg Ward, RCH	83.2%	95.7%
		▲ 12.4%

PROBABLE SUIICIDES

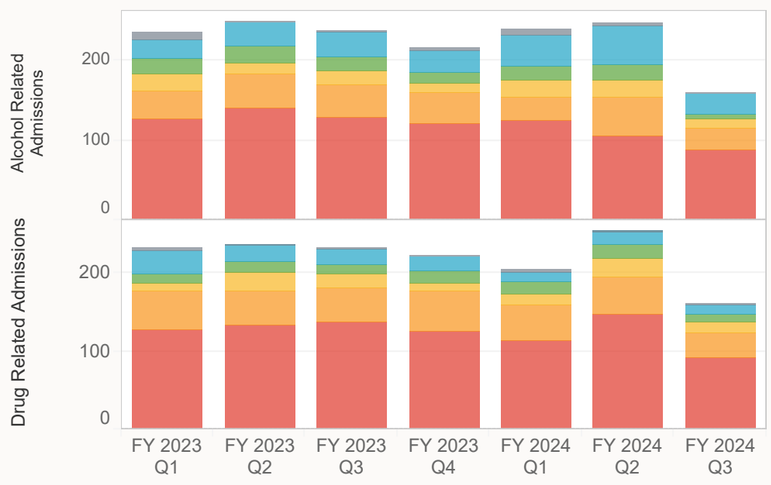
2020	2021
30	27
	▼ -3

PREVENTION

ALCOHOL AND DRUG RELATED ADMISSIONS

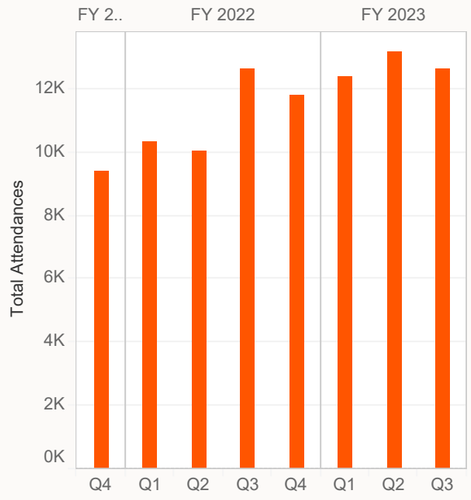
	FY 2022 Q4	FY 2024 Q3
Alcohol Related Admissions	213	159
		▼ -54

	FY 2022 Q4	FY 2024 Q3
Drug Related Admissions	204	160
		▼ -44



SEXUAL HEALTH - TOTAL CLINIC ATTENDANCES (inc Phone, Virtual & F2F)

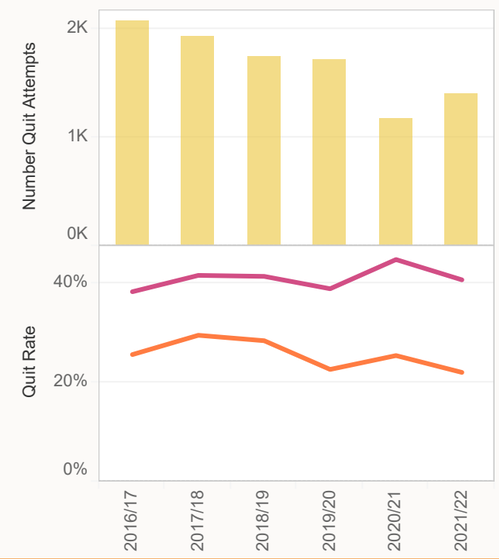
FY 2022 Q4	FY 2023 Q3
11,805	12,606
	▲ 801



SMOKING CESSATION

Four Week Quit Rate Twelve Week Quit Rate

	Number Quit Attempts	Four Week Quit Rate	Twelve Week Quit Rate
2021/22	1,401	40.8%	22.1%
2020/21	1,175	44.9%	25.5%
2019/20	1,712	39.0%	22.7%
2018/19	1,740	41.5%	28.5%
2017/18	1,936	41.7%	29.6%
2016/17	2,072	38.4%	25.7%
2015/16	2,224	32.9%	21.3%
2014/15	2,434	37.8%	27.2%
2013/14	3,781	40.2%	23.4%
2012/13	4,241	47.4%	29.0%
2011/12	4,795	42.5%	23.1%



STRATEGY

SUITABLE HOMES

	Major Adaptations	Minor Adaptations
2019/20	410	654
2020/21	63	295
2021/22	156	610

	Community Alarm	Telecare package	Very Sheltered Housing
2018/19	1,569	1,234	2,382
2019/20	3,105		2,382
2020/21	1,313	1,230	2,382
2021/22	1,365	1,242	2,382
2022/23	1,365	1,242	2,382

CARERS SUPPORTED

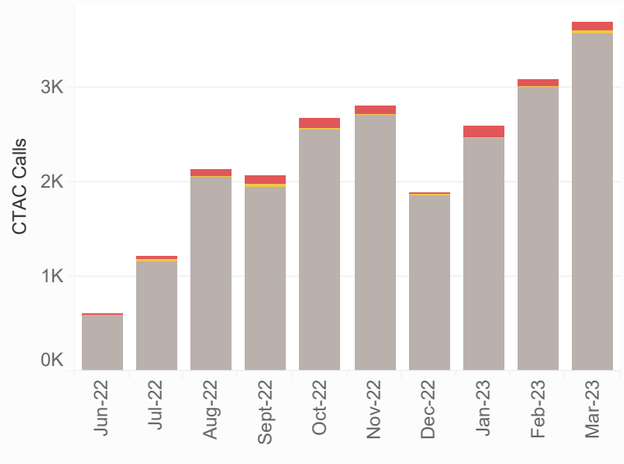
2021/22	2022/23
594	1018
	▲71.3%

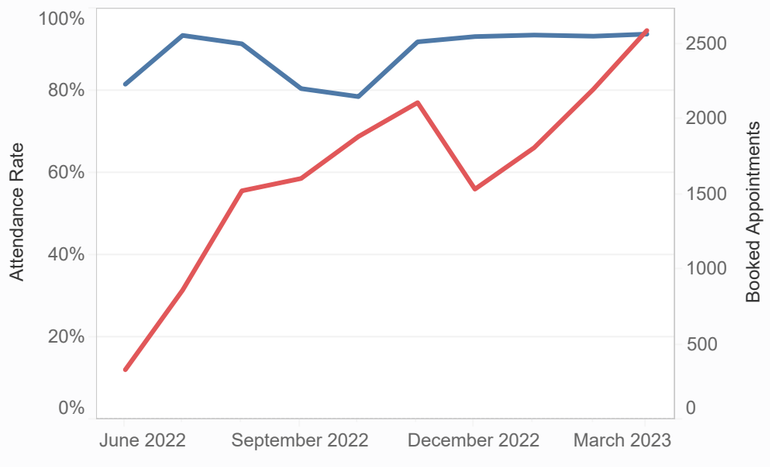
SPACE LEFT INTENTIONALLY BLANK

PRIMARY CARE

COMMUNITY TREATMENT AND CARE- (CTAC)

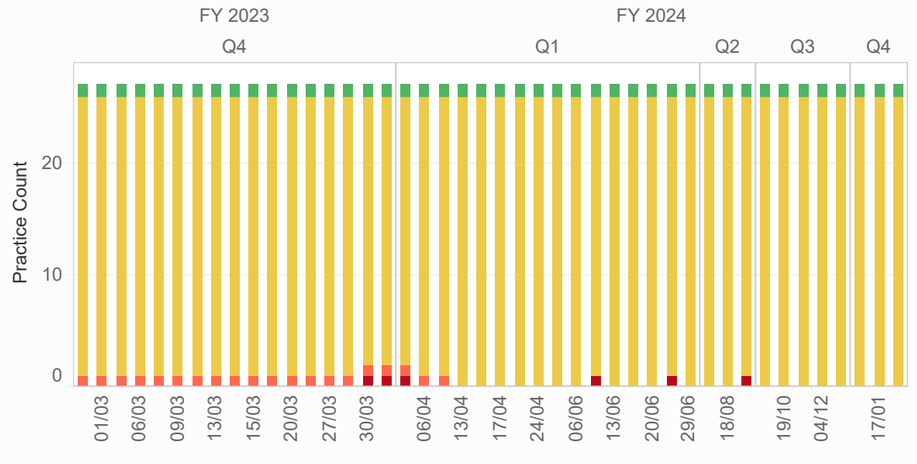
Abandoned Redirected Answered Attendance Rate Booked Appointments





PRIMARY CARE STABILTY LEVELS (Non-standard update frequency)

full service Level 1 - Suspension of Non-Core Activities Level 2 - managed suspension of services Level 3 - full suspension of services



DEFINITIONS

METRICS USED

Datix	**Falls**	This is taken from DATIX as all falls listed under the ABCITY organisation where the incident result is provided as HARM/NO HARM/NEAR MISS.
Delayed Discharges	**Complex and Code 100 Bed Days**	As above however only for complex and Code 100 delays. Code 100 cases are for extremely complex cases and are typically ongoing discharge cases with bespoke requirements. Code 100 cases are not considered delayed discharges in the usual sense and are not published. Complex codes for ward and care home closures have been excluded.
	Complex Delays	A delay meeting the definition for delayed discharge for which the reason for delay is considerd a 'Complex' reason (full delay reason codes available via PHS). These are typically delays where the HSCP has less control (i.e. Adults with Incapacity, Guardianship, Specialist Facility requirements).
	Delayed Discharges	A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge, and who continues to occupy the bed beyond the ready for discharge date and 48 hours after social work has been contacted. It is very important that, while the clinician in charge has ultimate responsibility for the decision to discharge, the decision must be made as part of a multi-disciplinary process and focuses on the needs of the individual patient.
	Monthly Bed Days	The total number of bed days in a month occupied by a delayed discharge. Note this is not the total length of delay.
	Standard Delays	A delay meeting the definition for delayed discharge for which the reason for delay is considerd a 'Standard' reason (full delay reason codes available via PHS).
Hospital at Home	**Allocated Beds Available**	Allocated beds is pulled directly from the applicable field in Trakcare for that ward.
	Average % Occupancy	Calculated using the overnight occupancy for a given ward or group of wards divided by the allocated beds available for the applicable ward(s), given as a percentage.
	Hospital at Home Admissions	Admission to Hospital at Home wards from anywhere in the system at any point during a patients stay, including transfers from any other ward/locations as well as first ward admissions for the given date range. Individuals who have multiple movements into the ward in a date range are counted for both movements.
	Overnight Occupancy	The total number of occupied beds at midnight for The given date.
Mental Health	**Probable Suicides**	'Probable suicides' refers to deaths from intentional self-harm and events of undetermined intent. The latter category includes cases where it is not clear whether the death is a suicide. Data used for this chart is from published data.
	RCH Average Overnight Occupancy	Calculated using the overnight occupancy for a given ward or group of wards divided by the allocated beds available for the applicable ward(s), given as a percentage.
Prevention	**Alcohol and Drug Related Admissions**	These are admissions which have ICD10 codes given below. Note that this figure can vary and lag as diagnosis is determined and amended on Trakcare - this can take a few months to appear within the data. Recent data should be considered as changable. Alcohol Related– F10 codes. Drug Related – F11 – F19 codes.
	Sexual Health Clinic Activity	Provided by ACHSCP for the dashboard and include face to face and phone/virtual visits.
Primary Care	**CTAC calls and attendance**	Provided by ACHSCP. Community Treatment and Care services appointments booked and attended. Call numbers and results also included.
	Primary Care Stability Levels	Supplied by the Primary Care Contracts Team. Practices contact the team with their current 'Level' which can range from full services to full suspension of services.
Rosewell House	**% Step Up (RWH) -**	There are beds which are allocated for people who are presenting as unwell but not requiring an admission to an acute hospital setting. These beds may prevent the person from an avoidable admission to hospital or a crisis driven avoidable admission to a mainstream care home. For the dashboard these are identified using the IsFirstWard flag.
	Ward Starts (RWH) -	Admission to Rosewell House wards from anywhere in the system at any point during a patients stay, including transfers from any other ward/locations as well as first ward admissions for the given date range. Individuals who have multiple movements into the ward in a date range are counted for both movements.
SOARS	**Average LOS**	Calculated as the number of hours between the ward start and the end date divided by 24 to give a decimal day value. This value is expressed as an average for all ward end dates (discharges and transfers) during the given date range.
	Average Occupancy % -	Calculated using the overnight occupancy for a given ward or group of wards divided by the allocated beds available for the applicable ward(s), given as a percentage.
	Max LOS	As above however, only the maximum LOS value for a discharge that has occurred in the given date range.
	Ward Starts -	Admission to SOARS wards from anywhere in the system at any point during a patients stay, including transfers from any other ward/locations as well as first ward admissions for the given date range. Individuals who have multiple movements into the ward in a date range are counted for both movements.
Social Care	**Care Searches in Place**	Provided by ACHSCP. The total number of cases which remain open and awaiting care (a single client can have multiple cases).
	Clients with Unmet Needs	Provided by ACHSCP. The number of clients who have been waiting over 14 days for one or more open cases for social care.
	Weekly Carer Hours	Provided by ACHSCP. The total number of hours required to satisy the care requirements for all open cases.
	Weekly Unmet Needs Carer Hours	Provided by ACHSCP. The total number of hours required to satisy the care requirements for all open cases that have been open for 14+ days.
Strategy	**Adapations**	Provided by ACHSCP. Adaptations completed split by major/minor.
	Telecare	Provided by ACHSCP. Telecare and community alarm clients.
Ward 102	**Daily Boarders -**	A patient who is physically located on a different ward but should have been admitted to the given ward, however no bed was available to admit them. For example a patient who is under the care of Ward 102 may use a bed in another ward.
	Ward 102 Ward Starts	Admission to Ward 102 from anywhere in the system at any point during a patients stay, including transfers from any other ward/locations as well as first ward admissions for a given date range. Individuals who have multiple movements into the ward in a date range are counted for both movements.

GLOSSARY OF ADDITIONAL TERMS

Creative breaks	Creative Breaks is a funding programme of the Short Breaks Fund, operated by Shared Care Scotland on behalf of the Scottish Government. The purpose of the Short Breaks Fund is to increase the range, availability, and choice of short breaks for carers and those they care for across Scotland. The Short Breaks Fund aims to make a lasting positive impact to carers and the people that they care for, to funded organisations, and to wider short breaks policy and practice. The Creative Breaks programme provides grant funding to third sector organisations to develop and deliver short breaks projects and services for carers of adults (aged 21 years), and young carers (caring for children or adults), and the people that they care for.
Criteria led discharge	This term is used to describe a discharge process which is led by certain criteria that will enable the person to be discharged safely. During the persons stay the doctors, nurses and other staff will work with them to observe and record their progress with certain "goals". The term 'goal' refers to what the healthcare team want they person to achieve for their individual health needs. Discharge from hospital happens when they are medically ready to go and their healthcare team have confirmed they have met their goals as an inpatient. Criteria Led Discharge goals may include: • Ability to transfer safely – this doesn't necessarily mean walking, but means they can safely transfer from bed to a chair etc. with any equipment assessed necessary for their needs. • that their blood pressure and temperature are within the required range. • their discharge destination is ready, safe for them to return to and they have any required care packages/equipment in place.
Delayed Discharge	A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge, and who continues to occupy the bed beyond the ready for discharge date. It is very important that, while the clinician in charge has ultimate responsibility for the decision to discharge, the decision must be made as part of a multi-disciplinary process and focuses on the needs of the individual patient
Delayed Transfer of Care	A 'delayed transfer of care' occurs when a patient is ready to leave their current bed but requires some further care in another facility or community hospital but is still occupying an acute bed. Delayed transfers – also referred to as 'DTOCs' or sometimes, often in the media, described as 'bed-blocking' – can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care, as delayed transfers reduce the number of beds available for other patients
Discharge to Assess,	Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person
Emergency discharge beds	This is provision of care in a care home setting for the care of people who are medically fit for discharge however, there is no placement in the current system able to support them with their preferred placement. They may also need a bit more nursing or support to recover completely before moving onto their selected placement. The placement may be required due to a lack of care at home care availability or a place in their preferred care home or Very Sheltered housing scheme not being available. Emergency discharge beds tend to be purchased as a result of increased pressure and demand on the system to support people to move on from the hospital and release bed capacity.
Hospital at home	Is a short-term, targeted intervention that aims to provide a level of acute hospital care in a person's own home or normal place of care that is equivalent to that provided within a hospital.
Hospital Homecoming	A two year volunteer project with nine test sites, at the time of writing, to support people up to 12 weeks after they have been discharged from hospital. Services the volunteers offer include shopping, prescription collections, transport to appointments, befriending and dog walking.
Interim placement	There will be times when a patient in hospital, or the community cannot access the service they require, be that a Care Home, alternative housing with care, or a Care at Home service and therefore a variety of interim options are required. This avoids risk or harm to patients by reducing unnecessary delays for individuals being discharged from hospital but also to avoid where possible unnecessary admissions to hospital.
Reablement	The reablement approach supports people to do things for themselves and helps people to retain or regain their skills and confidence so they can learn to manage again after a period of illness. It is usually provided in the person's own home and aims to assist people to continue to live as they wish and to enable the individual to do ordinary activities like cooking meals, washing, dressing, moving about the home and going out. Reablement may be used to support discharge from hospital, prevent readmission or enable an individual to remain living at home. (from SCIE)
Rehabilitation	Person-centred interventions designed to optimise functioning and reduce disability in individuals with health conditions in interaction with their environment. Rehabilitation may be required following an injury, surgery, disease or illness or because their functioning has declined with age. Rehabilitation can help to reduce, manage or prevent complications associated with many health conditions, such as spinal cord injury, stroke, or a fracture. Rehabilitation is provided by a multidisciplinary workforce including physiotherapists, occupational therapists, speech and language therapists, audiologists, orthotists and prosthetists, clinical psychologists, physical medicine and rehabilitation doctors, and rehabilitation nurses. It addresses underlying conditions such as pain and supports people to overcome difficulties with movement, communication, eating, thinking, seeing, hearing. It helps the person be as independent as possible in everyday activities and enables participation in education, work, recreation and meaningful roles. (WHO)
Respite	An opportunity for carers and those that they care for to have a break from their current circumstances in a residential setting such as a care home or very sheltered housing complex. Respite may be planned in advance, or unplanned where there is a sudden change in someone's situation or as a place of safety, in response to an Adult Protection situation and/or emergency response to risk allowing time to forward plan and make arrangements.
Step down beds	These are rehabilitation beds when people need a bit more time to recover after a period of time when they have been unwell or after surgery. The person is generally well but require a time of support to help them rehabilitate with input from Allied health Professions such as Occupational Therapists and Physiotherapists.
Step up beds	There are beds which are allocated for people who are presenting as unwell but not requiring an admission to an acute hospital setting. This may be in a care home for example which provide 24 hour care and support to a person who may be requiring additional care and support and in some cases nursing input. These beds may prevent the person from an avoidable admission to hospital or a crisis driven avoidable admission to a mainstream care home.

This page is intentionally left blank