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Aberdeen City Health & Social Care Partnership
A caring partnership

To: Members of the Integration Joint Board

Town House,
ABERDEEN 24 June 2025

INTEGRATION JOINT BOARD

The Members of the **INTEGRATION JOINT BOARD** are requested to meet in **Room 4 - Health Village on TUESDAY, 1 JULY 2025 at 10.00 am. This is a hybrid meeting and members may also attend remotely.**

ALAN THOMSON
INTERIM CHIEF OFFICER - GOVERNANCE

B U S I N E S S

1.1 Welcome from the Chair

DECLARATIONS OF INTEREST

2.1 Declarations of Interest and Transparency Statements

Members are requested to intimate any Declarations of Interest or Transparency Statements

DETERMINATION OF EXEMPT BUSINESS

3.1 Exempt Business

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

STANDING ITEMS

4.1 Video Presentation

4.2 Minute of Board Meeting of 13 May 2025 (Pages 5 - 12)

4.3 Minute of Risk, Audit and Performance Committee of 30 April 2025 (Pages 13 - 16)

4.4 Business Planner (Pages 17 - 20)

4.5 IJB Insights Planner (Pages 21 - 22)

4.6 Chief Officer's Report - HSCP.25.051 (Pages 23 - 32)

RISK

5.1 Strategic Risk Register and Risk Appetite Statement - HSCP.25.061 (Pages 33 - 48)

GOVERNANCE

6.1 IJB Scheme of Governance Annual Review - HSCP.25.056 (Pages 49 - 146)

PERFORMANCE AND FINANCE

7.1 Medium Term Financial Forecast - HSCP.25.053 (Pages 147 - 158)

7.2 Alcohol & Drug Partnership Annual Report 2025 - HSCP.25.060 (Pages 159 - 210)

STRATEGY

8.1 Final Strategic Plan - HSCP.25.058 (Pages 211 - 330)

8.2 Housing Contribution Statement - HSCP.25.059 (Pages 331 - 342)

TRANSFORMATION

9.1 Shifting the Balance of Care - A Community-Focused Approach to Delivery of Frailty and Specialist Rehabilitation Services within ACHSCP - HSCP.25.054 (Pages 343 - 394)

9.2 Supplementary Procurement Workplan 2025/26 - Discharge to Assess - HSCP.25.062 - to follow

Please note that there are exempt appendices in respect of this report.

ITEMS THE BOARD MAY WISH TO CONSIDER IN PRIVATE

10.1 Supplementary Procurement Workplan 2025/26 - Discharge to Assess - Exempt Appendices - HSCP.25.062 - to follow

DATE OF NEXT MEETING

11.1 IJB Insights Session - 9 September 2025

- Culture
- Horizon Scanning
- Justice Social Work
- Annual Performance Report
- GMEDS Update

11.2 Integration Joint Board - 30 September 2025

Website Address: https://www.aberdeencityhscp.scot/

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

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Aberdeen City Health & Social Care Partnership
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ABERDEEN, 13 May 2025. Minute of Meeting of the INTEGRATION JOINT BOARD.

Present:-	Hussein Patwa, Chair; Councillor Cooke, Vice Chair; and Mark Burrell, Councillor Lee Fairfull, Councillor Martin Greig, Ritchie Johnson, Councillor M. Tauqeer Malik, Jim Currie, Jamie Donaldson, Amanda Foster, Dr Stephen Friar, Maggie Hepburn, Dr Caroline Howarth, Amy McDonald, Shona McFarlane, Fiona Mitchelhill and Graeme Simpson.
Also in attendance:-	Martin Allan, Jess Anderson, Kay Diack, Nicola Edwards, John Forsyth, Sarah Gibbon, Jane Gibson, Stuart Lamberton, Graham Lawther, Alison MacLeod, Judith McLenan, Grace Milne, Shona Omand-Smith, Alison Paterson, Sandy Reid and Angela Scott.
Apologies:-	David Blackbourn, Jenny Gibb, Phil Mackie, Kenneth McAlpine and Dr Joy Miller.

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

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WELCOME FROM THE CHAIR

1. The Chair extended a warm welcome to everyone meeting in the Health Village.

The Board resolved:-
to note the Chair's remarks.

DECLARATIONS OF INTEREST AND TRANSPARENCY STATEMENTS

2. Members were requested to intimate any declarations of interest or transparency statements in respect of items on the agenda.

The Board resolved:-
to note that the Chair advised that he had a connection in relation to all items on the agenda by virtue of (1) being a Member of the Diverse Experiences Advisory Panel, a named partner in the Scottish Government's Mental Health and Wellbeing Strategy Delivery Plan; (2) the Depute Representative of said Group to the Scottish Government Mental Health and Wellbeing Leadership Board; (3) being an unpaid carer; and (4) his participation in a project with Dundee University investigating aspects of coding for

chronic pain, however having applied the objective test, he did not consider that he had an interest and would not be withdrawing from the meeting.

EXEMPT BUSINESS

3. Members were requested to determine that any exempt business be considered with the press and public excluded.

The Board resolved:-
there was no exempt business.

APPOINTMENT OF CHAIR - HSCP.25.029

4. The Board had before it a report advising of recent changes of appointments to the Chair and Vice Chair roles.

The report recommended:-
that the Board:
(a) note the appointment, by NHS Grampian, of Hussein Patwa as Chair of the Integration Joint Board; and
(b) note the appointment, by Aberdeen City Council, of Councillor John Cooke as Vice Chair of the Integration Joint Board.

The Board resolved:-
to agree the recommendations.

Following the decision at article 4 of this minute, the Chair officially thanked Councillor Cooke for his service as Chair, particularly through recent challenging times. He thanked members for the opportunity to serve as Chair.

He noted the ongoing innovation and gave thanks to officers, partners and others involved. The Chair also thanked Shona Omand-Smith for her service as she would be leaving the partnership mid-June.

Referencing his personal circumstances the Chair observed that in 2025, disability need no longer be a barrier to achieving potential, and living with chronic pain and long term conditions should not necessarily be a barrier to achieving ambition.

In terms of practicalities, the Chair encouraged everyone to participate stating that there was no monopoly on good ideas and no silly questions. Finally, he advised that he may

need to slightly tweak his chairing going forward but that he would keep everyone up to date where appropriate.

VIDEO PRESENTATION: DENNIS CLOSE

5. The Board received a video presentation entitled Dennis Close - Independent and Supported.

Members heard that it was the first young person service developed in Aberdeen for people with Learning Disabilities and this was due to awareness of a service gap for independent and supported living. Some of the service provision had been redesigned to enable creation of the space that was part of the transformation journey for modernising services.

The Board resolved:-
to note the video.

MINUTE OF BOARD MEETING OF 4 FEBRUARY 2025 AND ATTENDANCE RECORD

6. The Board had before it the minute of its meeting of 4 February 2025 and the 2025 attendance record.

The Board resolved:-
(i) to note the Attendance Record;
(ii) to instruct the Lead for People and Organisation to bring an update on abortion care to the next meeting of the IJB on 1 July 2025; and
(iii) to approve the minute as a correct record.

MINUTE OF SPECIAL BOARD MEETING OF 28 FEBRUARY 2025

7. The Board had before it the minute of its Special Meeting of 28 February 2025.

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

MINUTE OF IJB BUDGET MEETING OF 18 MARCH 2025

8. The Board had before it the minute of its Budget meeting of 18 March 2025.

INTEGRATION JOINT BOARD
13 May 2025

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

MINUTE OF RISK, AUDIT AND PERFORMANCE COMMITTEE OF 25 FEBRUARY 2025

9. The Board had before it the minute of the Risk, Audit and Performance Committee meeting of 25 February 2025.

The Board resolved:-
to note the minute.

DRAFT MINUTE OF CLINICAL AND CARE GOVERNANCE COMMITTEE OF 11 MARCH 2025

10. The Board had before it the draft minute of the Clinical and Care Governance Committee meeting of 11 March 2025.

The Board resolved:-
to note the minute.

BUSINESS PLANNER

11. The Board had before it the Business Planner, which was presented by the Chief Officer who advised Members of the updates to reporting intentions and that further items would be added to future reporting cycles.

The Board resolved:
(i) to note the reason for the removal of lines 14, 15, 16 and 17 (Progress on EOMF and Review of Equality Outcomes, Biennial Progress report on delivery of our Equality Outcomes and Mainstreaming Framework, GIRFE Toolkit - Update on Work and Review of Hosted Services including Abortion Care respectively) and their modification to Service Updates;
(ii) to note the reasons for the transfer of lines 13, 18 and 30 (Out of Hours Primary Care (GMED) Service, Improving Transitions and Locality Planning Annual Performance Reports respectively); and
(iii) to otherwise agree the Planner.

INTEGRATION JOINT BOARD
13 May 2025

IJB INSIGHTS PLANNER

12. The Board had before it the IJB Insights Sessions and Topic Specific Seminars Planners prepared by the Strategy and Transformation Manager.

The Board resolved:-
(i) to agree to add the topic of Adult Social Care to the IJB Insights Planner; and
(ii) to otherwise note the Planner.

CHIEF OFFICER'S REPORT - HSCP.25.028

13. The Board had before it the report from the Chief Officer, ACHSCP. The Chief Officer presented the update on highlighted topics and responded to questions from members.

The report recommended:-
that the Board note the detail contained within the report.

The Board resolved:-
(i) to note that the Chief Officer would provide an update on eMAR; and
(ii) to otherwise note the detail contained within the report.

FINANCIAL POSITION UPDATE - YEAR END REPORT - HSCP.25.030

14. The Board had before it the 2024/25 revenue budget draft outcome, prior to audit, for the delivery of the IJB responsibilities; and an update on the 2025/26 year budget savings, prepared by the Chief Finance Officer.

The Chief Finance Officer presented the report and responded to questions from Members.

The report recommended:-
that the Board:
(a) note the 2024/25 IJB draft outturn position before partner contribution of an overspend of £10.490m;
(b) note additional in year funding of £10.490m had been provided by the partners, with Aberdeen City Council providing £4.043m and NHS Grampian providing £6.447m, in order to allow the IJB to balance the 2024/25 budget;
(c) note the progress on the 2025/26 budget savings work;
(d) note NHS Grampian Health Board considered the NHS Grampian 2025/26 budget on 10 April 2025 which included provision for IJB overspends; and

(e) approve the transfer of £5.931m from the 2025/26 Prescribing budget to the Adult Social Care budget. The overall budget of the IJB is unchanged**.**

The Board had before it an amendment from Councillor Malik:-
that the Board –
(1) Notes the recommendations contained within the report;
(2) Notes that the Scottish Government has bailed out NHS Grampian with a £67m loan to tackle one of the largest overspends of any NHS Board in Scotland;
(3) Notes that Aberdeen City Council received no loan from the Scottish Government;
(4) Notes the membership of this Board is made up of NHS Grampian Board members and Elected City Councillors;
(5) Agrees that given the financial position of NHS Grampian and the Financial incompetence of the IJB which has recorded an overspend of £17.035m it really is time for this Board to reflect on the year end 2024/25; and
(6) Agrees that the public want to see scrutiny and debate and for this Board to test ideas therefore the end of year report should recognise that bringing forward amendments to recommendations is designed to challenge the status quo which has resulted in the IJB having no reserves and being in a challenging financial position as set out within the report.

Councillor Malik's amendment failed to attract a seconder and was therefore not put to the vote, in accordance with Standing Order 23.9.

The Board resolved:-
to agree the recommendations.

At this juncture, Councillor Malik intimated that he did not agree with the recommendations and would not support them, and asked for this to be recorded in the minute.

ANNUAL REVIEW OF FINANCIAL REGULATIONS AND RESERVES POLICY - HSCP.25.035

15. The Board had before it the revised IJB Financial Regulations and an updated Reserves Policy prepared by the Chief Finance Officer.

The report recommended:-
that the Board:
(a) approve the revised Financial Regulations, as at appendix A of the report; and
(b) approve the revised Reserves Policy, as at appendix B of the report.

The Chair moved, seconded by the Vice Chair:-

that the Board approve the recommendations.

Councillor Malik, seconded by Mark Burrell, moved as an amendment:-
that the Board –
(1) Notes and agree the recommendations;
(2) Notes that 4.5 of the report, states that the IJB has no remaining reserves and therefore there will be no risk reserve for use in 2025/26 and also 2026/27 financial years based on the current financial forecasts; and
(3) Agree this is unacceptable, therefore agree that the IJB must work towards having a minimum reserve of £5m by the end of 2025/26 therefore instruct the Chief Finance Officer to report within her next financial update, how the IJB will start to work towards having a minimum reserve of £5m by the end of 2025/26.

On a division, there voted:- for the motion (6) – the Chair, Vice Chair, Mark Burrell, Councillor Fairfull, Councillor Greig and Ritchie Johnson; for the amendment (1) – Councillor Malik.

The Board resolved:-
(i) to instruct the Chief Finance Officer to include sensitivity analysis for all future budget forecasting; and
(ii) to otherwise adopt the motion.

RECRUITMENT AND SELECTION PROCESS FOR CHIEF FINANCE OFFICER - HSCP.25.038

16. The Board had before it a report prepared by the Interim Talent Lead, Aberdeen City Council, setting out the proposed approach to recruiting a Chief Finance Officer of the IJB (ACHSCP).

The report recommended:-
that the Board:
(a) note the job profile attached at Appendix 1 of the report;
(b) establish a temporary Committee of the IJB, to be called an Appointment Panel, constituting the Chair and Vice Chair of the IJB and the Chief Officer (who will act as Chair of the Appointment Panel), to interview candidates and make an appointment;
(c) agree that in the absence of the Chair or Vice Chair of the IJB, that the IJB agree that a voting member of the IJB from the relevant constituent body, substitutes for the Chair or Vice Chair of the IJB at the Appointment Panel;
(d) agree that the appointment of the Chief Finance Officer shall be determined by the Appointment Panel, on behalf of the IJB; and
(e) agree that the Chief Officer makes arrangements for an Interim Chief Finance Officer should they consider it necessary to do so.

The Board resolved:-
to agree the recommendations.

ANNUAL RESILIENCE REPORT - INCLUSION OF INTEGRATION JOINT BOARDS AS CATEGORY 1 RESPONDERS UNDER CIVIL CONTINGENCY ACT 2004 - HSCP.25.031

17. The Board had before it a report prepared by the Business, Resilience and Communications Lead providing assurance on the IJB's resilience arrangements in fulfilment of its duties as a Category 1 responder under the Civil Contingencies Act 2004.

The report recommended:-
that the Board indicate they were assured that the duties of the IJB as a Category 1 responder under the Civil Contingencies Act 2004 were being met (as detailed in the report).

The Board resolved:-
to agree they were assured that their duties were being met.

IJB INSIGHTS - 10 JUNE 2025

18. The Board had before it the date of the next IJB Insights Session as 10 June 2025.

The Board resolved:-
to note the date of the IJB Insights Session.

INTEGRATION JOINT BOARD - 1 JULY 2025

19. The Board had before it the date of the next IJB meeting as 1 July 2025.

The Board resolved:-
to note the date of the next meeting.
- HUSSEIN PATWA, Chair.

Aberdeen City Health & Social Care Partnership
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Risk, Audit and Performance Committee

Minute of Meeting

Wednesday, 30 April 2025
10.00 am Virtual - Remote Meeting

ABERDEEN, 30 April 2025. Minute of Meeting of the RISK, AUDIT AND PERFORMANCE COMMITTEE. Present: Councillor Martin Greig Chair; and Councillor John Cooke and Ritchie Johnson.

Also in attendance: Calum Leask, Anne MacDonald (Audit Scotland), Vicki Johnstone, Alison MacLeod and Amy McDonald.

Apologies: Hussein Patwa and Jamie Dale.

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

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DECLARATIONS OF INTEREST OR TRANSPARENCY STATEMENTS

1. There were no Declarations of Interest or Transparency Statements.

DETERMINATION OF EXEMPT BUSINESS

2. There was no exempt business.

MINUTE OF PREVIOUS MEETING OF 25 FEBRUARY 2025

3. The Committee had before it the minute of its previous meeting of 25 February 2025, 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 for the transfer to the IJB of the report at line 8 (Strategic Risk Register and Risk Appetite Statement), the removal of the reports at lines 9, 19, 22, 26 and 28 (Financial Position Update) and the deferral of line 20 (Board Assurance and Escalation Framework); and
(ii) to otherwise agree the Planner.

EXTERNAL AUDIT - ANNUAL AUDIT PLAN 2024/25 - HSCP.25.027

5. The Committee had before it a report prepared by the Engagement Manager, External Audit (Audit Scotland) presenting the audit plan for 2024/25. The Engagement Officer introduced the report and responded to questions from members.

The report recommended:-
that the Committee note the contents of the report.

The Committee resolved:-
to agree the recommendation.

QUARTERLY PERFORMANCE REPORTS AGAINST THE DELIVERY PLAN - Q4 UPDATE - HSCP.25.026

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

The Transformation Programme Manager introduced the report and responded to questions from members.

The report recommended:
that the Committee note the Delivery Plan Quarter 4 Summary, the Tracker and Dashboard as appended to the report.

The Committee resolved:-
to agree the recommendation.

DATE OF NEXT MEETING - 17 JUNE 2025

7. The Committee had before it the date of the next meeting: Tuesday 17 June 2025 at 2pm.
The Committee resolved:-

to note the date of the next meeting.

- **COUNCILLOR MARTIN GREIG, Chair.**

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	A	B	C	D	E	F	G	H	I	J
2	INTEGRATION JOINT BOARD BUSINESS PLANNER - The Business Planner details the reports which have been instructed by the Board 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**	**ORGANISATION ACHSCP/ACC/NHSG**	**Update/Status**	**Delayed/ Deferred or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
4	**2025/26 Meetings**									
5	**1 July 2025**									
6	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations					On the agenda		
7	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer	HSCP.25.051	Graham Lawther	Fiona Mitchelhill	ACHSCP	On the agenda		
8	04.11.2022	IJB Scheme of Governance Review 2025	To present the revised Scheme of Governance to the IJB for consideration and approval	HSCP.25.056	Jess Anderson/John Forsyth/Vicki Johnstone	Jenni Lawson	ACHSCP	On the agenda		
9	18-Mar-25	Medium Term Financial Forecast	On 18 March 2025: to instruct the IJB Chief Finance Officer to refresh the Medium Term Financial Forecast following approval of the IJB Strategic Plan (2025-2029). This is the estimated 4 year Medium Term Financial Forecast, the model considers the category expenditure of the IJB and the changes which need to be actioned within the cost base to work towards bringing financial balance.	HSCP.25.053	Amy McDonald	Fiona Mitchelhill	ACHSCP	On the agenda		
10	14 April 2025	Alcohol & Drug Partnership Annual Report 2025	To provide information in relation to overall progress on the Alcohol & Drug Partnership Delivery Framework since 2019 and a specific update in relation to highlights from 2024 – 2025. Appendix A is a copy of a survey required by the Scottish Government in relation to Alcohol & Drug Partnership activity..	HSCP.25.060	Simon Rayner	Fiona Mitchelhill	ACHSCP	On the agenda		
11	07.05.2024	Strategic Plan 2025-2029	To present the final Strategic Plan 2025-2029 for approval.	HSCP.25.058	Alison MacLeod	Alison MacLeod	ACHSCP	On the agenda		
12	06 March 2025	Housing Contribution Statement	To present the Housing Contribution Statement which is required as part of the Strategic Plan.	HSCP.25.059	Alison MacLeod	Fiona Mitchelhill	ACHSCP	On the agenda		
13	Standing Item	Risk Appetite Statement and Strategic Risk Register	To present revised versions of the Risk Appetite Statement and Strategic Risk Register.	HSCP.25.061	Martin Allan	Martin Allan	ACHSCP	On the agenda		
14	22.08.23	Shifting the Balance of Care – A Community-Focused Approach to Delivery of Frailty and Specialist Rehabilitation Services within Aberdeen City Health & Social Care Partnership	To provide an overview of interrelated projects relating to the 'Discharge Without Delay' national programme, highlighting the implications for rebalancing the provision of care from inpatient settings to support within the patients home where possible.	HSCP.25.054	Sarah Gibbon / Julie Warrender/ Fiona Mitchelhill	Alison MacLeod and Fiona Mitchelhill	ACHSCP	On the agenda		
15	13 June 2025	Supplementary Procurement Workplan 2025/26 - Discharge to Assess	To present a Supplementary Procurement Work Plan for 2025/26 for expenditure on social care services, together with the associated procurement Business Case, for approval - tender for a period of up to five years and subsequent award of contract for Discharge to Assess Service.	HSCP.25.062	Neil Stephenson/ Catherine King	Fiona Mitchelhill	ACHSCP	Late circulation		
16	19 November 2024	Financial Position Update	On 19 November 2024 at the IJB, Members agreed that a finance update would be presented to every IJB and RAPC meeting going forward.	HSCP.25.052	Amy McDonald	Fiona Mitchelhill	ACHSCP		R	Quarter 1 IJB monitoring report is not available until later in July therefore there is no finance report being taken to this meeting.
17	09 July 2024	Creating Hope Together: Scotland's Suicide Prevention Strategy and Action Plan	To note the published national Suicide Prevention Strategy and Action Plan and to provide assurance on activities locally. This was presented to the IJB on 25 April 2023, when Members instructed the Chief Officer to provide an update on progress annually. Last update was 9 July 2024.	HSCP.25.055	Kevin Dawson / Jennifer Campbell	Alison MacLeod and Kevin Dawson	ACHSCP		R	Proposed removal and circulated as a Service Update instead as no decision required by the IJB (noting report).
18	24 September 2024	Digital Innovation Programme: Technology Enabled Care	On 24/09/24 HSCP.24.071: to instruct the Chief Operating Officer to report back within 9 months with a Full Business Case in respect of Technology Enabled Care and to seek external funding opportunities, including with the Scottish Government, to support the delivery of a Full Business Case.	HSCP.25.057	James Maitland	Claire Wilson	ACHSCP		D	Request from Claire Wilson to defer to 30 September 2025 as Scottish Government funding has been secured - Fuller detailed plan to be submitted in September taking account of this.
19	**30 September 2025**									
20	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer		Graham Lawther	Fiona Mitchelhill	ACHSCP			
21	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations							
22	19 November 2024	Financial Position Update	On 19 November 2024 at the IJB, Members agreed that a finance update would be presented to every IJB and RAPC meeting going forward.		CFO	Fiona Mitchelhill	ACHSCP			
23	04 November 2024	Audited Final Accounts 2024/25 including the External Auditor's Annual Audit Report	To consider and approve the audited final accounts for 2024/25.		CFO/ Anne MacDonald	Amy McDonald/ Audit Scotland	Audit Scotland			
24	29.11.22	Climate Change Project and Reporting	To seek approval for the submission of the climate change report to the Scottish Government. Report HSCP.24.080 presented on 19 November 2024.		Calum Leask/ Sophie Beier	Phil Mackie	ACHSCP			

	A	B	C	D	E	F	G	H	I	J
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25	Standing Item	ACHSCP Annual Performance Report	To seek approval to publish the the ACHSCP Annual Report for 2024/25 and to instruct the Chief Officer to present this to ACC and NHSG (last presented 24/09/24).		Alison MacLeod / Calum Leask	Alison MacLeod	ACHSCP			
26	10.10.23	Strategic Review of Neuro Rehabilitation Pathway - Phase 1 Evaluation	On 10 October 2023 IJB agreed to instruct the Chief Officer to report an evaluation of Phase 1 to the Integration Joint Board in **autumn 2025** before Phase 2 commences.		Sarah Gibbon	Julie Warrender	ACHSCP	Deferred from September 2024 as implementation was delayed.		
27	**2 December 2025**									
28	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer		Graham Lawther	Fiona Mitchelhill	ACHSCP			
29	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations							
30	19 November 2024	Financial Position Update	On 19 November 2024 at the IJB, Members agreed that a finance update would be presented to every IJB and RAPC meeting going forward.		CFO	Fiona Mitchelhill	ACHSCP			
31		Health and Social Care Partnership Meeting Dates 2026-27	To seek approval of the Integration Joint Board (IJB), Risk Audit and Performance Committee (RAPC) and Clinical and Care Governance Committee (CCGC) meeting dates for 2026-27.		Emma Robertson	Alan Thomson	ACC	02 December 2025		
32	23.09.21	Primary Care Improvement Plan Update	Annual update report. HSCP.24.078 reported to IJB on 19 November 2024.		Emma King / Alison Penman	Emma King	ACHSCP	02 December 2025		
33	01.11.2023	Chief Social Work Officer's Annual Report	To inform Members of the role and responsibilities exercised by the Chief Social Work Officer; to provide information on the delivery of statutory social work services and decision making in the period; and to give a progress report on key areas of social work provision within Aberdeen City. Last presented to IJB on 19 November 2024		Graeme Simpson	Eleanor Sheppard	ACC	02 December 2025		
34	27.05.2024	North East Population Alliance Strategic Partnership Agreement	To provide an annual progress report on the strategic partnership agreement (Memorandum of Understanding with Public Health Scotland). On 19 November 2024: agrees to instruct the Chief Officer to provide a progress report to the IJB on the second year of the operation of the Strategic Partnership Agreement.		Martin Murchie	Data Insights	ACC Corporate Services			
35	18 March 2025	Grant Funding for Voluntary Organisations	On 18 March 2025: to instruct the Chief Officer to bring back a report on the future funding of grant funded services beyond 31 March 2026 to the meeting of the IJB on 2 December 2025; and to instruct the Commissioning Lead to include qualitative feedback from service users as part of participant reviews in the Service Review at Appendix D of report HSCP.25.021 and to bring this back to the meeting of the IJB on 2 December 2025.		Shona Omand-Smith	Fiona Mitchelhill	ACHSCP			
36	**3 February 2026**									
37	Standing Item	Chief Officer Report	To provide a regular update from the Chief Officer		Graham Lawther	Fiona Mitchelhill	ACHSCP			
38	Standing Item	Video Presentation	To note the regular video presentation from a choice of partner organisations							
39	04.02.2025	Grampian Vaccination and Immunisation Annual Report 2025	Annual paper on Vaccine Uptake across all programmes and particularly the Childhood Immunisations Improvement Action Plan. Last approved on 4 Febraury 2025.		Clare-Louise Walker/ Jo Hall	Sandy Reid	ACHSCP/ ACVC			
40	16.08.22	Fast Track Cities	To provide an annual update on the actions against the action plan submitted to the Integration Joint Board (IJB) on 21 January 2020. This is an annual report. Last presented to IJB on 4 February 2025.		Daniela Brawley / Lisa Allerton	Sandy Reid	ACHSCP			
41	31.01.2023	Carers' Strategy	To provide an update and annual review of the strategy approved by IJB on 31 January 2023. Members agreed on 31.01.23 to instruct the Chief Officer of the IJB to report back on progress with the Carer Strategy and Action Plan annually. Reported to IJB on 6 February 2024.		Stuart Lamberton/ Grace Milne	Alison MacLeod	ACHSCP			
42	**17 March 2026 - Budget**									
43	Standing Item	IJB Budget	To approve the Budget.		CFO	Amy McDonald	ACHSCP			
44	Standing Item	Medium Term Financial Forecast	The estimated 4 year Medium Term Financial Forecast		CFO	Amy McDonald	ACHSCP			
45	**2026 and dates TBC**									
46	24 September 2024	National Care Service	are seeking to postpone start of Stage 2 process and we'll get new dates in due course. Therefore date for IJB is TBC.		Fiona Mitchelhill	Fiona Mitchelhill	ACHSCP	TBC		

	A	B	C	D	E	F	G	H	I	J
2	INTEGRATION JOINT BOARD BUSINESS PLANNER - The Business Planner details the reports which have been instructed by the Board 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**	**ORGANISATION ACHSCP/ACC/NHSG**	**Update/Status**	**Delayed/ Deferred or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
47	22 March 2024	Outcome of IJB Culture Research Project	Presented to the IJB on 7 May 2024 - suggestion to recommission in 12-18 months.		Alison McLeod	Alison MacLeod	ACHSCP	TBC late 2026		
48	30.08.24	Health and Care Experience Report 2025-2026	To present findings from the Health and Care Experience survey for 2025/26. Due in September 2026, last presented 24/09/24.		Calum Leask	Alison MacLeod	ACHSCP	September 2026		
49	27.08.2024	Review of Whistleblowing Policy	Due in 2026		Martin Allan	Fraser Bell	ACHSCP	2026		
50	07.05.2024	Morse Community Electronic Patient Record Evaluation and Contract Renewal	On 7 May 2024, Members agreed :(i) to note the Morse Evaluation appended at Appendix B of the report; and (ii) to approve a further three year contract with Cambric, running from October 2024, to supply Morse as an Electronic Patient Record for Community Nursing, Hospital at Home, Macmillan Nursing, Health Visiting and School Nursing Services		Michelle Grant	Alison MacLeod, Strategy and Transformation	ACHSCP	TBC May 2027		
51	09 July 2024	Evaluation of Aberdeen City Vaccination and Wellbeing Hub	To provide an evaluation of the Aberdeen City Vaccination and Wellbeing Hub. See report HSCP.24.047 on 9 July 2024.		Caroline Anderson	Fiona Mitchelhill	ACHSCP	Early 2028		
52	04.02.2025	GP Vision Update	On 4 February 2025, the IJB resolved to instruct the Chief Officer to report back to the Integration Joint Board by spring 2026 with a progress update on the implementation of the vision and objectives.		Alison Chapman/ Emma King	Fiona Mitchelhill	ACHSCP	Spring 2026		
53	06 March 2025	Draft Debt Recovery (Mental Health Moratorium) (Scotland) Regulations	To update members on the impact to the IJB of any Regulations approved by the Scottish Parliament which apply a mental health moratorium to debt.		Fiona Mitchelhill	Fiona Mitchelhill	ACHSCP	TBC		
54	Standing Item	Annual Review of Financial Regulations and Reserves Policy	To present the findings of a financial governance review, a revised version of the IJB's Financial Regulations and an updated Reserves Policy for approval - RAPC noted on 25 February 2025, approved on 13 May 2025 by IJB.		Amy McDonald	Amy McDonald	ACHSCP			
55	Standing Item	Annual Resilience report - Inclusion of Integration Joint Boards as Category 1 Responders under Civil Contingency Act 2004	To provide information of the inclusion of IJB's as Category 1 Responders, in terms of the Civil Contingencies Act 2004 and an outline of the requirements that this inclusion involves. Annual report, last considered at IJB on 13 May 2025.		Martin Allan	Martin Allan	ACHSCP			
56	04.11.2022	IJB Scheme of Governance Annual Review	To present the revised Scheme of Governance and seek approval of the revised Standing Orders and Terms of Reference. This is an annual review, previously presented on 7 June 2022, 25 April 2023, 9 July 2024 and 1 July 2025.		Jess Anderson/John Forsyth/Vicki Johnstone	Jenni Lawson	ACHSCP	On the agenda		
57	**Service Updates**									
58	18 March 2025	Grant Funding - Counselling Services	On 18 March 2025 - instruct the Commissioning Lead to issue a Service Update no later than **31 July 2025** in respect of provision of all Counselling Services.		Shona Omand-Smith	Fiona Mitchelhill	ACHSCP			
59	Standing Item	Progress on EOMF and Review of Equality Outcomes}	This year the report will be incorporated into the biennial review (below) so only one report will come this year.		Alison Macleod	Alison MacLeod	ACHSCP	Circulated to IJB Members on 14 May 2025 - ER		On 13 May 2025, the IJB agreed removal as a report from the Planner and issue as a Service Update instead as no decision required by the IJB (noting report).
60	30.11.22	Biennial Progress report on delivery of our Equality Outcomes and Mainstreaming Framework }	To approve publication and submission of the report to the Equality and Human Rights Commission This is a statutory obligation to report on progress every two years after approval; reported in May 2021 and April 2023 (HSCP.23.024). Incorporated with line above.		Alison Macleod	Alison MacLeod	ACHSCP	Circulated to IJB Members on 14 May 2025 - ER		On 13 May 2025, the IJB agreed removal as a report from the Planner and issue as a Service Update instead as no decision required by the IJB (noting report).
61	19 November 2024	GIRFE Toolkit - Update on Work	At the IJB meeting on 19 November 2024, the IJB agreed to have a further update for members on the progress towards the implementation of the Getting it Right for Everyone (GIRFE) Toolkit across Aberdeen City.		Shona Omand-Smith			Circulated to IJB Members on 14 May 2025 - ER		On 13 May 2025, the IJB agreed removal as a report from the Planner and issue as a Service Update instead as no decision required by the IJB (noting report).
62	04 February 2025	Review of Hosted Services including Abortion Care	On 4 February 2025, Members agreed to instruct the Strategy and Transformation Lead to report back to the IJB in May 2025 on the proposed actions following the recommendations of the review of hosted services.		Alison MacLeod	Strategy and Transformation	ACHSCP	Circulated to IJB Members on 14 May 2025 - ER		On 13 May 2025, the IJB agreed removal as a report from the Planner and issue as a Service Update instead as no decision required by the IJB (noting report).

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IJB Insights January 2025 - March 2026

(NB: all 1000-1200, hybrid)

Date	Agenda	Presenter
9th September 2025	1. Culture	Alison
	2. Horizon Scanning	Alison
	3. Justice Social Work	Claire Wilson/ Val Vertigans
	4. Annual Performance Report	Alison
	5. GMEDS Update	Magdalena Polcik-Miniach
11th November	1. Culture	Alison
	2. Horizon Scanning	Alison
	3 Care Reform Act	TBC
	4. Public Dental Service	Emma King
	5. Third Sector in Aberdeen City	Maggie Hepburn
13th January 2026	1. Culture	Alison
	2. Horizon Scanning	Alison
	3. TBC	
	4. TBC	
17th February 2026	1. Culture	Alison
	2. Horizon Scanning	Alison
	3. Budget and MTFF	Amy McDonald
	4. Year 2 Delivery Plan	Alison

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	1 July 2025
Report Title	Chief Officer's Report
Report Number	HSCP.25.051
Lead Officer	Fiona Mitchelhill, Chief Officer
Report Author Details	Graham Lawther Communications Business Partner glawther@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	None
Terms of Reference	5

1. Purpose of the Report

1.1. The purpose of the report is to provide the Integration Joint Board with an update from the Chief Officer on recent and upcoming activities.

2. Recommendations

It is recommended that the Integration Joint Board:

a) Notes the detail contained within the report.

3. Strategic Plan Context

3.1. The Chief Officer's report highlights areas of Aberdeen Citty Health and Social Care Partnership (ACHSCP) activity which are relevant to the delivery of the Strategic Plan.

4. Summary of Key Information

Local updates

1. World Diversity Day celebration

On 31 May 2025, staff from Jesmond, Torry, and Fairview care homes in Aberdeen celebrated World Diversity Day at Aberdeen's Town House. They shared food, wore traditional costumes, and demonstrated local dancing. The event showcased 12 countries and was organised by care home managers with the Care Home Lead Nurse. Residents also participated in the celebrations.

A survey was sent to care home staff who have relocated to Aberdeen from other countries to assess their experiences. This will help the collaborative care home group and individual homes to welcome new staff and ease their transition.

Torry and Persley Castle care home managers contributed to the day's programme, which included presentations on equality, diversity, inclusion, and future steps.

2. Chronic Obstructive Pulmonary Disease (COPD) Community Appointment Day (CAD)

On 21 May 2025, the NHS Grampian Planning & Innovation Team, in collaboration with three GP practices (Elmbank, Woodside, and Torry), held a CAD for COPD. Patients diagnosed with COPD and their carers were invited to attend. The event included a

"What Matters to Me" conversation, a talk on living well with COPD by Dr Kris Mclaughlin and colleagues, and information stalls from various services and voluntary organisations.

Practice nurses from Elmbank and Woodside were available to speak with patients, and attendees could connect with others for peer support at the cafe.

A total of 109 people attended the CAD (83 patients and 26 carers), and 46 people completed a feedback form. Initial impacts recorded include:

- 83.4% felt the CAD improved their ability to self-manage their symptoms
- 85.1% felt the CAD increased their knowledge about services and support to help them live well
- 93.8% felt positive about accessing multiple services in one day
- The overall experience of the day was rated 4.46 stars out of 5.

Feedback from attendees included positive remarks about the event's regularity, the opportunity to meet nurses and other people with COPD, and the informative nature of the day

3. Strategic Change Board

During its May meeting, the Strategic Change Board (SCB) discussed recalibrating its approach to transformation due to current pressures on the health and care system. The board highlighted the importance of long-term, system-wide change over short-term responses.

Key themes included developing a shared model of change, clarifying system priorities, and enhancing engagement with staff and partners. This initiative was bolstered by a cross-system workshop on 16 May, co-led with Healthcare Improvement Scotland (HIS), to co-design a vision, principles, and cultural shifts for transformation.

The consensus was on moving from intent to impact through practical steps, shared ownership, and transparent discussions about the implications of change. A consolidated update will be presented to the Integration Joint Boards to support further discussion and alignment.

4. Social work practitioner application funding

ACHSCP has secured a grant of £1.239million from the Scottish Government for its 'Invest to Save' initiative, aiming to develop a Social Work Practitioner Application within the current financial year.

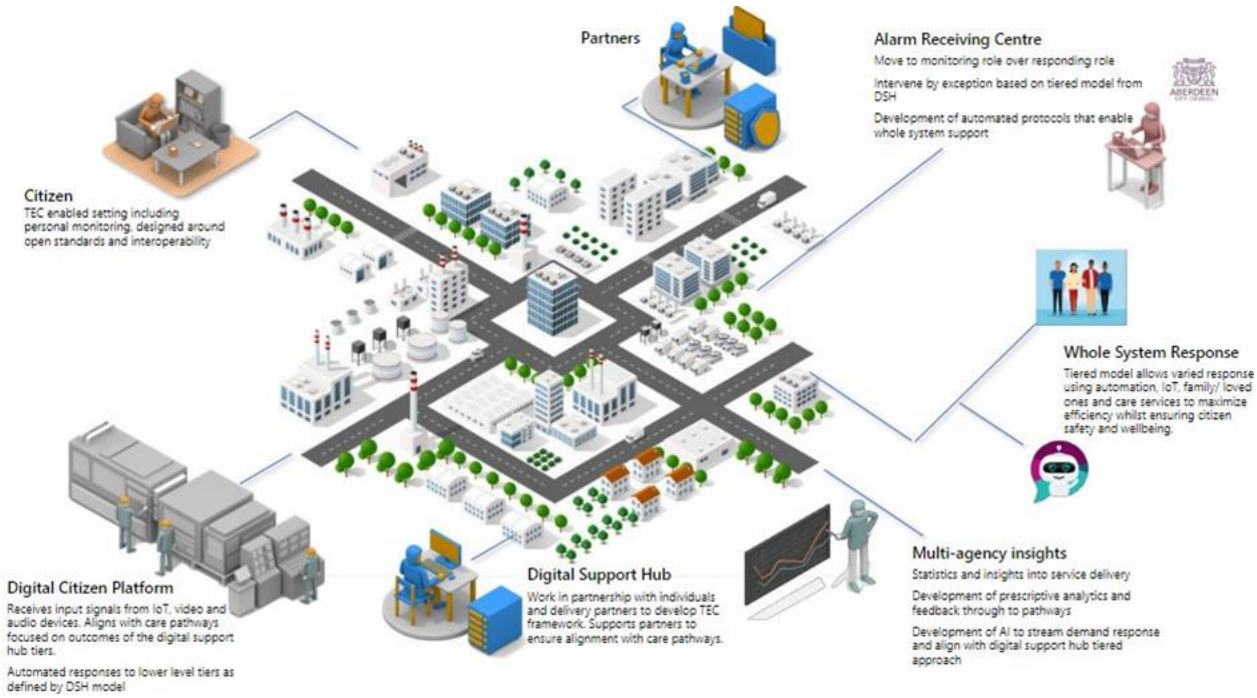
This new application leverages existing technology, enabling practitioners to document conversations directly into the Dynamics 365 platform. Dynamics 365 is currently utilised for social work applications encompassing Social Work and Citizen Services.

Populating the relevant data within the Dynamics platform ensures the creation of a Care Commissioning Plan for individuals through the Home Care Commissioning Portal.

The introduction of this application will support the maintenance and real-time updates of care plans, enhancing care delivery efficiency by at least 15%.

These applications collectively advance the Aberdeen City Council's Smart City Vision, promoting technology reuse, platform interoperability, and data sharing to provide services better tailored to current and future needs, thereby proactively addressing health and wellbeing requirements.

Furthermore, the integration with Technology Enabled Care and the new digital alarm receiving centre introduces the potential for technology-supported care prescriptions, tailored to individual needs. This innovation aims to reduce hospital admissions and improve discharge support, minimising delays.



5. eMAR evaluation

The electronic Medication Administration Record (eMAR) system replaces traditional paper-based records. This digital solution aligns with ACHSCP strategic objective to implement innovative technologies in care settings. Initial training and go-live were completed in January 2025, and the system has been operational since then.

Evaluation of eMAR at the Back Hilton Road facility, which provides a care home service for 11 people with learning disabilities, has shown improvements across medication

processes and procedures, including monitoring, management, administration, safety, and tracking of medication usage.

There are health and wellbeing advantages for service-users due to fewer medication errors and additional time savings from reduced error responses. Staff feedback on eMAR has indicated the system is simple, user-friendly, and efficient. The manager has seen an increase in staff confidence and a reduction in anxiety regarding administering medication.

The ACHSCP Strategic Plan aim is to increase the adoption of eMAR by care homes. Engagement with providers and sharing experiences from Back Hilton Road has encouraged another of Aberdeen's care home providers to proceed with implementing eMAR.

6. National care-at-home and housing support awards

Specialist Resource Solutions (SRS), which provides care in Aberdeen and Aberdeenshire, has been honoured with two national awards at the 2025 Scottish Care National Care at Home and Housing Support Awards.

SRS was named Provider of the Year and was the winner of the Technology & People Award.

This recognition reflects the commitment, innovation and compassion that drives SRS's work across Aberdeen and Aberdeenshire, with the support and collaboration of ACHSCP and other partners.

SRS is part of the Granite Care Consortium, which is made up of local third sector and independent providers in Aberdeen. The consortium was set up to create market stability, improve outcomes and build a consistently trained and skilled workforce.

Another winner at the awards, which were held in Glasgow in May, was Shaun Duthie who works for Community Integrated Care (CIC) in Aberdeen.

He took home the Emerging Talent accolade on the evening and was recently promoted to the role of Service Leader. His exceptional leadership skills were proven during a recent independent inspection in Aberdeen, where all the CIC services he leads received excellent Care Inspectorate ratings.

Regional updates

1. Grampian Wellbeing Festival

The second Grampian Wellbeing Festival was held across the region in May to support mental health and wellbeing and to raise awareness of community support, activities and events.

The festival was a huge success with over 200 events held in Aberdeen alone. These included concerts, wellbeing walks, aerobics, boogie-in the-bar and mindfulness.

The festival also included the Grampian Meaningful Engagement Network (GMEN) Festival on Friday 30 May 2025 at the Town House in Aberdeen

GMEN is a Grampian-wide partnership with representation from Aberdeen City, Aberdeenshire and Moray, and is for anyone involved in developing, supporting and delivering meaningful activity with older adults.

The theme of the day was Keep Learning and featured a range of speakers and stalls.

Formal evaluation of the impact of the festival will be undertaken and shared in due course.

2. Stroke conference

As the Executive Lead for Grampian, ACHSCP's Chief Officer attended the Grampian Stroke Multidisciplinary Conference in partnership with Chest, Heart & Stroke Scotland (CHSS) on 21 May 2025.

The conference featured a full agenda, covering all stroke services, including rehabilitation and community services.

CHSS showcased their services across Grampian and introduced the new Health Defence programme, set to launch in September 2025 at the Aberdeen Vaccination & Wellbeing Hub, Bon Accord Centre.

The event also included insights from other health boards and recent research findings. An Occupational Therapy Advanced Practitioner from University Hospital Wishaw shared their experiences with Technology Enabled Rehabilitation, highlighting valuable learning and opportunities for Aberdeen.

3. NHSG escalation to Stage 4 of NHS Scotland support and intervention framework

The Scottish Government announced on 12 May 2025 that NHS Grampian had been escalated to Stage 4 of the NHS Scotland Support and Intervention Framework. The escalation reflects concerns about NHSG's financial position, leadership and governance.

NHSG has welcomed the additional support and continues to work collaboratively with the Scottish Government as it oversees the development and delivery of the Improvement Plan to address the concerns.

More information is at https://www.gov.scot/groups/nhs-grampian-assurance-board/

National updates

1. **New cardiovascular disease Directed Enhanced Service (DES)**

The Scottish Government introduced a new cardiovascular disease (CVD) Directed Enhanced Service in May 2025 to improve early identification and prevention across Scotland.

A DES is a nationally commissioned service that health boards can offer to GP practices, distinct from Local Enhanced Services (LES) which are tailored to specific local needs.

This initiative enables practices to proactively screen a percentage of patients aged 35-60 by assessing five key risk factors – blood pressure, body mass index, smoking and alcohol status, and cholesterol and glucose risks – and prioritise patients from deprived areas, where CVD mortality rates are significantly higher.

Each practice has been given a capped number of patients who can be supported via the DES. This number varies across each practice, dependant on practice size and deprivation levels. The Scottish Government uses the term 'missingness' to describe patients who are deemed at risk on all five measurements. Patients can then be offered screening and given a CVD risk score, which then allows practices to give appropriate primary prevention measures and with all those screened receiving lifestyle advice.

The initiative, which is optional for GP practices, aligns with Scotland's broader preventative health agenda, aiming to reduce avoidable deaths from CVD by 20% over the next 20 years.

2. **Review of Social Work Governance report**

The Care Inspectorate's Review of Social Work Governance and Assurance across Scotland was published on 5 May 2025.

The publication highlights both strengths and areas for improvement and examines how social work leaders are supported to ensure statutory duties are met, how staff are effective and uphold core values, and how risks are managed.

The review found that while social work governance structures were mostly effective and values were upheld, challenges exist in ensuring social work has equal influence within

health and social care partnerships and in managing significant staffing and financial pressures.

The review also included a staff survey and whilst the key findings of this report are Scotland wide, we have received a bespoke report on the findings of the staff survey for Aberdeen which was very positive.

A paper summarising key points and next steps will be presented in due course to the Clinical Care & Governance Committee.

The full publication is at:
https://www.careinspectorate.com/images/documents/8101/Review%20of%20social%20work%20governance%20and%20assurance%20across%20Scotland.pdf

3. Publication of Population Health Framework

The Scottish Government and the Convention for Scottish Local Authorities (COSLA) have jointly published the Population Health Framework and the Health and Social Care Service Renewal Framework https://www.gov.scot/publications/scotlands-population-health-framework/ https://www.gov.scot/publications/health-social-care-service-renewal-framework/

Both frameworks represent a significant milestone in the ambition to improve the health of the population. They focus on key activities to tackle the root causes of poor health, reduce inequalities and build a more sustainable, person-led and community-focused health and social care system for Scotland.

4. Care Reform Bill passes Stage 3

Plans to transform social care across Scotland will now be progressed after the Scottish Parliament approved the Care Reform (Scotland) Bill on 10 June 2025 https://www.gov.scot/publications/care-reform-scotland-bill-stage-3-debate-social-care-ministers-opening-speech-10-june-2025/.

The bill will bring forward a number of enhancements to social care including:

- enshrining “Anne’s law” in legislation to uphold the rights of people living in adult care homes to see loved-ones and identify an essential care supporter
- strengthening support for unpaid carers by establishing a legal right to breaks, following the additional £13 million already allocated for up to 40,000 carers to take voluntary sector short breaks
- empowering people to access information on their care and improving the flow of information across care settings
- improving access to independent advocacy to guarantee people are involved in decisions about their care

- creating a national chief social work adviser role to provide professional leadership, as part of plans for a new National Social Work Agency.

Alongside the bill, an advisory board will be established to drive progress and scrutinise reform, replacing an interim board that met for the first time in May.

5. Implications for IJB

5.1 Equalities, Fairer Scotland and Health Inequality

There are no direct equalities implications arising from the recommendations of this report as it is a noting report.

5.2 Financial

There are no direct financial implications arising from the recommendations of this report as it is a noting report.

5.3 Workforce

There are no direct workforce implications arising from the recommendations of this report . as it is a noting report

5.4 Legal

There are no direct legal implications arising from the recommendations of this report as it is a noting report.

5.5 Unpaid Carers

There are no direct implications relating to unpaid carers arising from the recommendations of this report ads it is for noting.

5.6 Information Governance

There are no direct information governance implications arising from the recommendations of this report as it is for noting only.

5.7 Environmental Impacts

There are no direct environmental implications arising from the recommendations of this report as it is a noting report.

5.8 Sustainability

There are no direct sustainability implications arising from the recommendations of this report as it is a noting report.

5.9 Other Implications

There are no other direct implications arising from the recommendations of this report as it is for noting only.

6. Management of Risk

There are no direct risk management issues.

Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	1 July 2025
Report Title	Risk Appetite Statement and Strategic Risk Register
Report Number	HSCP.25.061
Lead Officer	Martin Allan
Report Author Details	Name: Martin Allan Job Title: Business, Resilience and Communications Lead Email Address: martin.allan3@nhs.scot
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	A Risk Appetite Statement B Strategic Risk Register Summary
Terms of Reference	1 (c) Any other matter that the Chief Officer determines appropriate to report to the IJB

1. Purpose of the Report

1.1. To present to the Integration Joint Board (IJB) revised versions of the Risk Appetite Statement (RAS) and Strategic Risk Register (SRR).

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approve the Integration Joint Board (IJB) revised Risk Appetite Statement as detailed at Appendix A;

b) Agree that the Risk Appetite Statement be added to the agendas of the IJB, the Clinical Care and Governance Committee and to the Risk, Audit and Performance Committee to further support the Board and committee decision making process; and

c) Approve the revised summary of the IJB Strategic Risk Register as detailed at Appendix B.

3. Strategic Plan Context

3.1. The draft Strategic Plan 2025-2029 and the Medium-Term Financial Framework are on the agenda for today's IJB meeting. Work has been undertaken to align the activities within the Strategic Plan and the Medium-Term Financial Framework to the 8 risks in the Strategic Risk Register. The Strategic Plan outlines the 8 strategic risks, along with narrative which explains how the Strategic Plan will help mitigate each of the risks.

4. Summary of Key Information

4.1. The IJB's RAS 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'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 Risk, Audit and Performance 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.

4.3. At the Risk, Audit and Performance Committee on 3 December 2024, it was agreed that the IJB Insights and Topic Specific Seminars be used to gather the thoughts of IJB members around the review of the Statement.

4.4. As a result, the Insights Session on 14 January 2025 considered the Statement. The Session heard from the Business, Resilience and Communications Lead who explained that Aberdeen City Health and Social Care Partnership (ACHSCP) was drafting a refreshed Strategic Plan which would be taken through the IJB in July 2025.

4.5. At the Insights Session, members considered the risk dimensions and how changing one dimension could have a knock-on effect to other dimensions. The thoughts and comments of the IJB Members were collated. These included raising the dimension about Financial Risk to a high appetite, specifically in relation to risks that could help the IJB achieve financial sustainability. Similarly, in relation to the Quality and Innovation and Reputation Dimensions, these were raised to high appetite. The Dimensions relating to Regulatory and Compliance and Safety remain at either no appetite or low appetite. These changes reflected the conversations and discussions of the IJB and Senior Leadership Team (SLT) members.

4.6. ACHSCP's SLT considered the Statement at a session on 22 January 2025 and the Statement was then considered by the IJB at its Topic Specific Seminar on 18 February 2025.

4.7. As a result, the Statement has been amended to take account of the suggested changes from IJB members and SLT and a revised version forms Appendix A to this report.

4.8. One of the proposals arising from the consultation on the RAS was the suggestion that the Statement be included in the agendas of the IJB and its committees to allow members to refer to the Statement when considering Board/Committee matters.

4.9. 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.

4.10. The IJB's Board Assurance and Escalation Framework (BAEF) describes the regulatory framework of the IJB to support its vision, values and principles. Fundamental to the framework are the IJB's strategic priorities and the appetite for risk that exists across these priorities.

4.11. The BAEF was formally approved by the IJB in 2016 and was last reviewed by Risk Audit and Performance Committee (RAPC) in 2024. The 2025 review of the BAEF will be reported to the RAPC in August 2025 and will include alignment to the Strategic Plan 2025-2029.

4.12. 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.

4.13. The SLT reviews the SRR in light of their experiences and insight into key issues 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 RAS and the Strategic Risks.

4.14. As referenced in the Medium-Term Financial Framework, there are risks associated with the estimates in the Framework and the report has outlined 3 risk profiles (100% delivery of savings, 75% delivery of savings and 50% delivery of savings).

4.15. In relation to the 100% delivery of savings, there is a significant amount of work underway to deliver the 2025/26 savings required. The level of risk is high now but will fall as plans are developed. The 2026/27 year also requires a considerable amount of work to drive out the savings. The IJB look to present and deliver a balanced budget each year and therefore savings at this level will require to be delivered.

4.16. In relation to the 75% delivery of savings, this level of savings delivery at £9.6m represents a lower level of risk for ACHSCP but higher risk for the IJB partners as at this level the IJB will have a budget deficit of £3.216m at the end of the financial year. ACHSCP will present a balanced budget for 2026/27 but recognise there is a level of risk in doing so. Given there are 9 months before the start of the new financial year there is time to fully mitigate this risk. In this profile, the overall risk profile is lower as less is being delivered.

4.17. In relation to the 50% delivery of savings, this level of savings delivery at £6.4m highlights an issue with the Strategic Plan and failing to deliver this plan. It could also result from changes in the external environment also with respect to excessive demands being placed on services.

4.18. To mitigate this risk the following actions will be taken: addressing issues identified with project plans as they arise through the Budget Savings

Oversight Group and Senior Leadership Team; ensuring adequate project document and resource is put in place to deliver plans; and working closely with teams going through change to maintain their engagement.

4.19. Given the above risk profile context outlined in the Medium-Term Financial Framework, changes have been made to Strategic Risks 1 and 7 as detailed in Appendix B to this report as well as in the Strategic Plan.

4.20. In relation to risk 1, it is proposed that the Event of the risk would be revised to the potential failure of commissioned services to deliver on their contract within available budget. The projects and activities in the Delivery Plan around the delivery of care will help to mitigate the risk.

4.21. In relation to risk 7, it is proposed that the Cause, Event and Consequence of the risk be reworded to reflect the details in the Strategic Plan and Medium-Term Financial Framework. The Cause would be lack of continued integration of staff and use of technology, to assist the restructuring and redesign of roles to meet strategic priorities, with the Event being the failure to manage staffing budgets within forecasted predictions and the Consequence being unmet health and social care needs with clinical risks and reputational damage. Again, the projects and activities in the Delivery Plan around greater integration of health and social care staff will help mitigate the risk.

4.22. The current SRR template has been used since the start of the IJB and has been updated as per the governance requirements. The current template has grown in size over the last 10 years and following discussion at SLT it is proposed that a revised template be developed to help SLT members and specific risk owners to have a more focussed SRR that will allow them to see more clearly the current performance of the mitigations of the risks. The proposed template also links to the risk appetite statement and its risk dimensions in a more co-ordinated way. This template is currently being worked on and will be presented to future meetings of RAPC and the IJB, as well as being used by risk owners in SLT. It is also proposed that the more detailed template be used for the annual review of the strategic risks and risk appetite.

4.23. The new template was discussed at the IJB Insights Session on 10 June, 2025, whereat members noted the planned revision to the template.

4.24. Attached as Appendix B to this report is a revised summary of the SRR which is replicated in the Strategic Plan and referenced to in the Medium-Term Financial Framework, demonstrating alignment between these key

strategic documents. The summary outlines the 8 strategic risks, along with narrative which explains how the Strategic Plan will help mitigate each of the risks (as mentioned at 3.1 to this report).

5. Implications for IJB

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

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. 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.

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Appendix A
IJB Risk Appetite Statement –2025

Introduction

The Integration Joint Board (the IJB) recognises that it is operating in, and directly shaping, a collaborative health and social care partnership. It exists 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. This reflects its 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.

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 IJB and officers in decision-making and to enable them 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) against each dimension. Higher levels of all risk types may be accepted if specific and effective controls are demonstrably in place and there are clear advantages for the delivery of strategic objectives.

There may be occasions when there are competing risks for which the IJB has conflicting appetites. In such instances, the decision maker and/or the officer making a recommendation, will be expected to consider and manage those competing risks and appetites and exercise careful judgement

From time to time, the IJB may decide to deviate from its agreed risk appetite. When this is case, it will be important to exercise judgement whilst assessing the potential impacts across the organisation.

Risk Appetite

The dimensions of risk and corresponding risk appetite are:

Dimension of Risk	Corresponding Risk Appetite
Finance	The IJB has a low appetite for risks which may impair financial stewardship, internal controls and financial sustainability. The IJB has a high appetite for risks that could help the IJB achieve financial sustainability such as transformational activity. The IJB acknowledges the substantial challenges regarding financial certainty and will seek to maximise the use of resources available.
Regulation & Compliance	The IJB has no appetite for risks that will result in breaches to regulatory and statutory compliance.
Quality & Innovation	The IJB has a high appetite for risks which will deliver the quality outcomes prescribed by professional bodies. The IJB has a high appetite for risks associated with the development and delivery of innovative practices for realising the IJB's strategic objectives.

Dimension of Risk	Corresponding Risk Appetite
Safety	The IJB has a low appetite for risks which could cause harm to patients/clients or to staff. By low appetite, 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. Otherwise, the IJB has no appetite for such risks.
Reputation	The IJB has a high appetite for risks associated with the IJB's reputation where the action being proposed has significant benefits for the organisation's strategic priorities. 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.
Commissioned & Hosted Services	The IJB recognises the complexity of planning and delivery of commissioned and hosted services. The IJB has a low appetite for risks relating to patient/client safety. The IJB has a high appetite for risks which relate to service redesign or improvement where as much risk as possible has been mitigated.

Review

This risk appetite statement will ordinarily be reviewed annually, and when the IJB's strategic plan is reviewed.

APPENDIX B

Risk	Event	Strategic Plan Mitigation
Commissioned Services (including General Practice)	Potential failure of commissioned services to deliver on their contract within available budget.	The General Practice (GP) Vision work and the transformation projects focused on commissioned social care services will both help to achieve sustainable service delivery in these areas.
Financial Sustainability	A risk that the IJB exceeds its allocated funding.	Current and future transformation and budget savings projects along with enhanced monitoring arrangements will help to achieve financial balance.
Delivery of Hosted Services	A risk that these do not deliver expected outcomes.	There isn't a specific activity in the Strategic or Delivery Plans but an ongoing business as usual activity is the delivery of the recommendations from the Internal Audit on Hosted Services.
Performance	A risk that services fail to meet national, regulatory, and local standards.	Prevention and Early Intervention activity to manage demand. Service modernisation and transformation to maximise performance. Improved datasets and data sharing to enhance performance monitoring

		and continuous improvement.
Transformation	A risk that people do not receive the best health and social care outcomes.	Service modernisation and transformation to maximise the potential to improve outcomes.
Involvement of lived experience	A risk that services are not tailored to meet individual needs.	Inclusion of a 'strategic approach' of communicating and engaging with our stakeholders and communities, ensuring they are well informed and involved in decisions.
Workforce	Failure to manage staffing budgets within forecasted predictions.	Commitment to refresh the Workforce Plan.
Premises	A risk that buildings across the city, operated by, or overseen by, the IJB/ACHSCP are not being used to maximum efficiency and are not in line with statutory/regulatory requirements.	Current Premises Review. Commitment to develop an Infrastructure Plan.

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	1 July 2025
Report Title	Scheme of Governance Review 2025
Report Number	HSCP.25.056
Lead Officer	Fiona Mitchelhill, Chief Officer
Report Author Details	Name: Jess Anderson Job Title: Team Leader, Regulatory and Compliance Team, Legal Services, Aberdeen City Council. Email Address: JeAnderson@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	a. Standing Orders b. Proposed Standing Orders c. Roles and Responsibilities Protocol d. Terms of Reference for the Appointments Panel Committee e. Table of change to the Scheme of Governance f. IIA- Proportionality and Relevance Assessment.
Terms of Reference	5) The approval or amendment of the Scheme of Governance.

1. Purpose of the Report

1. The purpose of this report is to present the revised Scheme of Governance to the IJB for consideration and approval.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Considers and approves the revised Roles and Responsibilities Protocol (as attached at Appendix C);
b) Notes that there are no changes to the IJB Carers and Service User Representatives Expenses Policy;
c) Notes there are no changes to the Code of Conduct;
d) Agrees to the establishment of the Appointment Panel Committee and notes that it will only meet when there is business to determine,
e) Agrees the Terms of Reference for the Appointments Panel attached at Appendix C;
f) Considers and approves the revised Standing Orders for the IJB (as attached at Appendix A);
g) Agrees that the Chief Officer shall, where necessary, make arrangements to secure interim cover for the Chief Finance Officer role;
h) Instructs the Chief Officer to upload the revised documents, as approved, to the Aberdeen City Health and Social Care Partnership's (ACHSCP) website.

3. Strategic Plan Context

3.1. This report links to the Strategic Plan by setting out the governance framework in place for the IJB and its committees to monitor the implementation and progress of the Strategic Plan.

4. Summary of Key Information

The 'Scheme of Governance' is the name given to the suite of documents which set out how the IJB will operate and do business. The Scheme of Governance is comprised of the Standing Orders, Terms of Reference, Roles and Responsibilities Protocol, Carers Expenses Policy, and Code of Conduct. The Scheme of Governance is reviewed on an annual basis, with any changes being presented to the IJB for approval. The IJB last approved changes to the Scheme of Governance in July 2024.

The proposed changes made to the Scheme of Governance have been as a consultative review with the Chair and Vice Chair of the IJB, the Chief Officer and

Clerk to the IJB. The rationale for these changes are set out in more detail below. For ease of reference there is also a summary document attached at Appendix D which lists the changes in an easy-to-read format.

Members should be aware that the Terms of Reference for the Clinical and Care Governance and Risk Audit and Performance Committees will be reviewed after the Aberdeen City Health and Social Care Partnership (ACHSCP) have completed a large scale review of the governance and assurance structures for all services delegated to the IJB. The aim of this review is to identity the reporting lines both operationally and strategically with a view to streamlining what is reported, why and to which forum. It is likely that this will result in more focussed reporting to the IJB and its committees on matters which are the remit of the IJB. Further, the review will incorporate any actions deemed appropriate as a result of the Care Inspectorate's Review of Social Work Governance and assurance across Scotland. The IJB review is underway with most first returns being submitted for each ACSHCP Senior Leadership Team area. The aim is to bring the revised Terms of Reference to the IJB before the end of the year.

Integration Scheme

The Integration Scheme (IS) is the legal document through which Aberdeen City Council and NHS Grampian (the Partner organisations) delegate functions to the IJB. The Public Bodies (Joint Working) (Scotland) Act 2014 makes it clear that the Integration Scheme is a document prepared and approved by the partner organisations, rather than by the IJB itself.

The IS was last reviewed by the Partner organisations in 2023 and approved by the Scottish Ministers in September 2024. No further changes have been made.

Standing Orders

The IJB's Standing Orders regulate the manner in which meetings of the IJB and its committees are managed. This includes the manner in which meetings are called, speaking at meetings and voting.

The IJB's Standing Orders have been amended to improve the clarity of the Standing Orders. Members will see that content of the Standing Orders are largely statutory in nature and where this is the case the relevant Standing Order has been marked with a "(s)". All other Standing Orders are designated as non-statutory. This means the IJB has scope to amend or alter these Standing Orders as it deems appropriate.

These suggested changes are highlighted in the revised version at Appendix A. The most significant changes are:

- Simplifying the process in the event of an equality of votes. Members should note that whilst the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 requires the IJB to vote by a majority and have a mechanism for dispute resolution, the process of how to vote and manage disputes is a matter for the IJB to determine.
- Clarification of timescales for submission of formal proposals to the IJB.
- Additional wording at Standing Order 18.9 to formally note a members' dissention.
-

Due to the need to re-write (and simplify) the section on equality of votes, a clean version of the proposed Standing Orders is attached at Appendix B.

Roles and responsibilities Protocol

The Roles and Responsibilities Protocol sets out the high-level duties and responsibilities of senior IJB officers – the Chief Officer, Chief Finance Officer and Medical Lead.

The document has been reviewed and there has been a minor change to the section for the Chief Operating Officer. Otherwise, the Roles and Responsibilities Protocol remains unchanged.

Code of Conduct

The IJB's Code of Conduct sets out the standards of conduct and behaviour expected from all IJB Members. The Code of Conduct was produced by the IJB and subsequently approved by the Scottish Ministers. It is based on the Model Code of Conduct issued by the Scottish Ministers.

The IJB's Code of Conduct has been reviewed by officers and no changes have been identified. The IJB's Code of Conduct remains appropriate and in line with Scottish Government guidance and the Model Code of Conduct. The Code of Conduct was sent out to members in February 2025.

Expenses policy

The review of the IJB Carers and Service User Reps Expenses Policy will be carried out once all the new members are in post in order to meaningfully engage with carer/service user reps and get their feedback for the review. A report on the review of the IJB Carers and Service User Reps Expenses Policy will be brought to the IJB once the review has been completed.

Appointments Panel

The Aberdeen City Integration Scheme states that the IJB shall appoint its Chief Officer and Chief Finance Officer. In order to discharge this responsibility, the IJB appoints a temporary recruitment committee as and when there is a need to recruit to either of these posts. This requires a report to come to the IJB each time there's a recruitment, whilst ensuring that coincides with the timescales set by the recruitment process. In order to ensure this is more streamlined, the IJB is being asked to formally establish the Appointments Panel Committee, (rather than do this each time a vacancy arises). The Committee will only meet where there is a recruitment and selection process ongoing and will be subject to the Terms of Reference attached at Appendix D to this report and the IJB Standing Orders, where relevant.

In line with previous decisions and due to the seniority and statutory requirements for the Chief Finance Officer role, the IJB is being asked to agree the position that where the post becomes vacant, the Chief Officer shall make arrangements for an Interim Chief Finance Officer should they consider it necessary to do so.

For clarity, the Integration Scheme provides that the Chief Executives of the Council and NHS Grampian may make arrangements for an Interim Chief Officer should they consider it necessary to do so.

Any appointment to the position of Chief Officer/ Chief Finance Officer, whether interim or permanent, shall be reported to the IJB at the next available meeting.

5. Implications for IJB

5.1. Equalities, Fairer Scotland and Health Inequality

The outcome of the test of proportionality and relevance is that the Scheme of Governance has a neutral to indirect positive impact on equalities. Please see the assessment attached at Appendix E for information. The Scheme of Governance is not setting policy, having an impact on service change or delivery but instead provides a framework

against how the IJB operates and its decisions are made. As such a full impact assessment as it is not required.

5.2. Financial

There are no financial implications arising from the recommendations of this report.

5.3. Workforce

There are no direct workforce implications arising from the recommendations of this report.

5.4. Legal

The Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014 sets out the requirements on the IJB in respect of its' Standing Orders. The existing (and revised) Scheme of Governance complies with this Order.

5.5. Unpaid Carers

There are no direct impacts on Unpaid Carers arising from this report. As noted above, the Carers Expenses Policy shall be brought before the IJB at a later date, once all Service User and Carers Representatives have been recruited to the IJB, to allow for those representatives to be part of that review.

5.6. Information Governance

There are no direct information governance implications arising from the recommendations within this report.

5.7 Environmental Impacts

There are no direct environmental implications arising from the recommendations of this report.

5.8 Sustainability

There are no impacts on sustainable development arising from this report.

6. Management of Risk

Risk Appetite Statement

6.1. Identified risks(s)

Regulatory Compliance Risk. The IJB has agreed that it will accept no, or low risk in relation to breaches of regulatory and statutory compliance;

- *The likelihood of occurrence of this type of risk is low.*
- *This is because the Scheme of Governance provides clarity around the governance of the IJB and how it conducts its business and makes decisions. Compliance with the Scheme is monitored by Aberdeen City Council's Legal Services, which in turn mitigates and reduces the risk around IJB governance specifically.*

To this end, the risk score provided against this risk is consistent with the Risk Appetite Statement.

Link to risks on strategic or operational risk register:

Risk Summary 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.

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Aberdeen City Health & Social Care Partnership
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SCHEME OF GOVERNANCE

Approved by the Aberdeen City Integrationed Joint Board, ~~9~~ 1 July 2025~~4~~

ABERDEEN CITY INTEGRATIONED JOINT BOARD,

SCHEME OF GOVERNANCE

1. Purpose and Interpretation

1.1 The Aberdeen City Integration Joint Board ("the IJB") is the Integration Authority for Aberdeen City. It was delegated functions from NHS Grampian (NHSG) and Aberdeen City Council ("the Council") in 2016 and is a separate legal entity. The delegated functions are set out in the IJB's Integration Scheme. The IJB is responsible for the strategic planning of functions which have been delegated to it, and as such, issues Directions to both NHSG and the Council to deliver health and social care services to the people of Aberdeen.

1.2 This Scheme of Governance contains key governance documents which facilitate the way in which the IJB operates. It is one of the primary sources of assurance required to demonstrate the effectiveness of the IJB's internal controls. It governs how the IJB makes decisions, business will be determined, meetings are conducted, the membership of the IJB, behaviours and conduct of IJB members and sets out the roles and responsibilities of key personnel around the IJB.

1.4 The Scheme of Governance comprises the following:

Document	Purpose
Aberdeen City Integration Scheme	Sets out the arrangements between the Council and the NHSG to delegate functions to the IJB in respect of adult social care and health care services.
Aberdeen City Integrated Joint Board Standing Orders	Rules of procedure for meetings of the IJB and its committees.
Aberdeen City Integrated Joint Board- Roles and Responsibilities	Explanation of the key roles within the Aberdeen City Health and Social Care Partnership (ACHSCP).
Aberdeen City Integrated Joint Board- Code of Conduct	Rules governing conduct of IJB members.
Aberdeen City Integrated Joint Board- Combined Terms of Reference for the IJB and its Committees	Powers reserved to the IJB and the decision making authority delegated by the IJB to its committees.

Aberdeen City Health & Social Care Partnership
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Aberdeen City Integrat~~ed~~ioned Joint Board Standing Orders

Date Created:	November 2022	
Version:	V ~~4~~3.0	
Location:	Governance	
Author (s) of Document:	Jessica Anderson, ACC Legal Services	
Approval Authority	IJB	
Scheduled Review:	July 202~~6~~5	
Effective Date:	~~1~~02 July 2025~~4~~	
Changes:	March 2023 July 2025	July 2025~~024~~

Table of Contents

S = Standing Orders which are required by statute

NS = Standing Orders which are non-statutory

1. Introduction

1.1 The Aberdeen City Integration Joint Board ("the IJB") comprises voting representatives of Aberdeen City Council ("the Council") and the Grampian NHS Board ("the NHS Board") ("the constituent authorities") and non-voting advisory representatives[1].

1.2 These Standing Orders are made under t~~T~~he Public Bodies (Joint Working) (Scotland) Act 2014 ("the Act") and the subordinate legislation[2] and any provision, regulation or direction issued by Scottish Ministers shall have precedence over anything written here in the event of any conflict.

1.3 These Standing Orders regulate the conduct and proceedings of the IJB and its committees.

1.4 All meetings of the IJB and its committees shall be regulated by these Standing Orders, which the IJB may amend as it so determines, except that all requirements of t~~T~~he Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 in relation to Standing Orders shall be met.

1.5 Any amendments to these Standing Orders shall be effective from the day following the day on which the changes were agreed.

1.6 Except where prohibited by statute, it shall be competent for any member at any time during a meeting to move the suspension of the whole or any specified part of these Standing Orders. Such a motion shall, if seconded, be put to the vote immediately without discussion.

1.7 A two thirds majority of voting members in attendance shall be required to suspend Standing Orders. For the avoidance of doubt, if the figure is not a whole number it shall be rounded up.

1.8 Standing Orders shall be reviewed by the IJB on an annual basis.

1.9 Non-material amendments can be made to Standing Orders by the Chief Officer, following consultation with the Chair and Vice Chair of the IJB, without the requirement to report to the IJB. Members shall be notified once such amendments have been completed.

2. Membership[3]

2.1 The IJB shall include the following voting members:-

a. Four councillors nominated by the Council; and

[1] As set out in Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Order 2015

[2] Article 18 of t~~T~~he Public Bodies (Joint Working) (Integration Joint Boards) Scotland Order 2014/285 (the 2014 Order)

[3] Article 3 of the 2014 Order

b. Four members nominated by the NHS Board, of whom three shall be non-executive directors and one an executive director.

2.2 The IJB shall include the following non-voting members, with those at (d), (e) and (f) to be appointed by the NHS Board:-

a. The Council's Chief Social Work Officer;
b. The IJB Chief Officer;
c. The IJB Chief Finance Officer appointed under section ~~S~~95 of the Local Government (Scotland) Act 1973;
d. A registered medical practitioner on the list of primary medical services performers prepared by the NHS Board;
e. A registered nurse employed by the NHS Board or by a person or body with which the NHS Board has a contract; and
f. A registered medical practitioner employed by the NHS Board and not providing primary medical services;

2.3 The IJB must appoint, in addition, at least one member, whom shall be non-voting, from each of the following groups:-

a. Staff of the constituent authorities providing services under integration functions, of whom one shall be a trade union representative and one a partnership representative;
b. Third sector bodies carrying out activities related to health or social care in the Council area;
c. Service users living in the Council area; and
d. People providing unpaid care in the Council area.

2.4 The IJB shall appoint a Public Health Consultant employed by the NHS Board who shall be a non-voting member.

2.5 The IJB may appoint such additional (non-voting) members as it sees fit, but such members shall not be councillors or non-executive NHS Board members.

3. Appointment of the Chair and Vice Chair of the IJB[4]

3.1 The Chair shall be appointed by one of the constituent authorities for an appointing period not exceeding two years.

3.2 The constituent authority which does not appoint the Chair must appoint the Vice Chair for that appointing period.

3.3 The Chair and the Vice Chair appointments referred to in 3.1 and 3.2 shall alternate automatically in each successive appointing period.

3.4 A constituent authority may change the person appointed by that authority as Chair or Vice Chair during the appointing period for the remaining period.

[4] Article 4 of the 2014 Order

3.5 The constituent authorities may only appoint a Chair and Vice-Chair from their membership set out under Standing Order 2 (2.1) above.

4. Term of Office[5]

4.1 The term of office of an IJB member shall be such period as the IJB shall determine which shall not exceed three years.

4.2 A member appointed under Standing Order 2 (2.2) (a) - (c) above shall remain a member for as long as they hold the office in respect of which they are appointed.

4.3 At the end of a term of office set out under Standing Order 4.1 ~~(1)~~ above, a member may be reappointed for a further term of office.

4.4 This paragraph is subject to Standing Order 6 (resignation of members) and 7 (removal of members) below.

4.5 In the event that a voting member ceases to become an IJB member in the circumstances set out in Standing Orders 5, 6 or 7, the constituent body will require to appoint an IJB member in accordance with Standing Order 2.1 and where necessary, Standing Order 3.

5. Disqualification[6]

5.1 A person is disqualified from being a member of the IJB where:

a. a~~A~~ person who has within the period of five (5) years immediately preceding the date of appointment been convicted of any criminal offence in respect of which the person has received a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine);
b. a person who has been removed or dismissed for disciplinary reasons from any paid employment or office with a Health Board or local authority;
c. a person who is insolvent;
d. a person who has been removed from a register maintained by a regulatory body, other than where the removal was voluntary; and
e. a person who has been subject to a sanction under section 19(1)(b) to (e) of the Ethical Standards in Public Life etc. (Scotland) Act 2000.

[5] Article 7 of the 2014 Order
[6] Article 8 of the 2014 Order

6. Resignation of Members[7]

6.1 A member may resign their membership of the IJB at any time by giving the IJB notice in writing (e.g. by giving the IJB's Chief Officer notice in writing).

6.2 Where a voting member of the IJB resigns, the IJB must inform the constituent authority which nominated them.

6.3 This section does not apply to the non-voting members listed in Standing Order 2 (2.2) (a) to (f).

6.4 Other non-voting members of the IJB shall hold office during each three-year period until they are replaced by the appropriate nominating body.

7. Removal of Members (Voting and Non- Voting)[8]

7.1 If a member has not attended three consecutive meetings of the IJB and/or its committees, and such absence is not due to illness or other reasonable cause as the IJB may determine, the IJB may remove that member from office by providing them with one month's notice in writing.

7.2 If a member acts in a way which brings the IJB into disrepute or in a way which is inconsistent with the proper performance of the IJB's functions or its Code of Conduct for Members, that conduct will be addressed in line with the IJB's Code of Conduct for Members.

7.3 If a member is disqualified during a term of office for a reason referred to in Standing Order 5 (5.1) above, they are to be removed from office immediately.

7.4 Where a Council or NHS Board member ceases for any reason to be a Councillor or an NHS Board member during the term of office, they are to be removed from office with effect from the day on which they cease to be a Councillor or an NHS Board member.

7.5 Subject to the above paragraphs, a constituent authority may remove a member which it nominated by providing one month's notice in writing to the member and to the IJB.

8. Substitutes[9]

8.1 A voting member who is unable to attend a meeting of the IJB or its committees shall, insofar as possible, arrange for a suitably experienced substitute, who is

[7] Article 9 of the 2014 Order
[8] Article 10 of the 2014 Order
[9] Article 12 of the 2014 Order

a member of the appropriate constituent authority, to attend in their place with voting rights.

8.2 A non-voting member who is unable to attend a meeting of the IJB may arrange for a suitable substitute to attend the meeting in their place.

8.3 Where the Chair or Vice Chair is unable to attend a meeting of the IJB, any substitute attending in their place shall not preside over the meeting.

9. Temporary Vacancies in Voting Membership[10]

9.1 Where there is a temporary vacancy in the voting membership of the IJB, the vote which would otherwise have been cast by the member appointed to that vacancy may be cast by the other members nominated by the appropriate constituent authority.

9.2 Where, because of temporary vacancies, the number of members nominated by a constituent authority is one or zero and that constituent authority is to appoint the Chair, the Chair must be appointed temporarily by the other constituent authority.

9.3 Where a temporary vacancy, or the temporary appointment of the Chair in the circumstances set out in the paragraph above, persists for more than six months, the Chair of the IJB must notify the Scottish Ministers in writing of the reasons why the vacancy remains unfilled.

9.4 The Chief Officer shall determine an item of urgent business in consultation with the Chair/Vice Chair of the IJB and the Chief Executives of the Council and NHS Board during the period between the date of a Local Government Election and the appointment of voting members by the Council only in the situation where the IJB does not have a quorum of members - on the basis that any such action shall be reported to the next meeting of the IJB as an item on the agenda.

10. Effect of Vacancy in Membership[11]

10.1 A vacancy in the membership of the IJB will not invalidate anything done by or any decision of the IJB.

11. Calling meetings[12]

11.1 The Chair may call a meeting of the IJB at such times as they see fit.

[10] Article 13 of the 2014 Order
[11] Article 15 of the 2014 Order
[12] Schedule 1(1) of the 2014 Order

11.2 A request for a special meeting of the IJB to be called may be made by a requisition signed by at least five of the voting members, which shall specify the business proposed to be transacted and which shall be presented to the Chair. Email confirmation of the request for a special meeting will discharge the requirement for the notice to be signed.

11.3 If the Chair refuses to call a meeting requisitioned under the above paragraph or does not call a meeting within seven days after the making of the request, the members who signed the requisition may call the meeting.

11.4 The business to be transacted at any requisitioned meeting shall be limited to the business specified in the requisition.

11.5 The IJB's annual calendar of meetings shall run from 1 April to 31 March of the following calendar year. A schedule of meetings shall be approved by the IJB prior to 1 April of the new meeting year.

12. Notice of Meetings[13]

12.1 Prior to each meeting of the IJB or one of its committees, a notice of the meeting specifying the time, place and business to be transacted shall be sent electronically to every member or sent to the usual place of residence of every member, so as to be available to them at least 7 calendar days before the meeting. Email confirmation of the notice of the meeting by the Chair, or a member authorised to act on the Chair's behalf, will discharge the requirement for the notice to be signed by the Chair.

12.2 A failure to serve notice of a meeting on a member in accordance with the paragraph above shall not affect the validity of anything done at the meeting.

12.3 In the case of a meeting of the IJB called by members in accordance with Standing Order 11, email confirmation from those members requisitioning the meeting shall discharge the requirement in Standing Order 12.1 for the notice to be signed by the members who requisitioned the meeting.

12.5 In the event that an item of business has to be considered on an urgent basis, a meeting of the Board may be called at 48 hours' notice by the Chair following consultation with the Vice Chair and Chief Officer. The Urgent Business meeting would retain all the IJB's functions and powers, and these Standing Orders would apply.

12.6 If the office of Chair is vacant or the Chair is unable to act for any reason, the Vice Chair may at any time call an Urgent Business meeting in terms of Standing Order 12.5 following consultation with the Chief Officer.

[13] Schedule 1(2) of the 2014 Order

13. Access to meetings[14]

13.1 Members of the public and representatives of the media shall be admitted to meetings of the IJB to observe the proceedings, unless IJB adopt a resolution to exclude the public and media on grounds that publicity for any item under discussion would be prejudicial to the public interest due to the confidential nature of the business to be transacted or for other reason specified in Appendix B. However, members of the public and representatives of the media shall not be admitted to meetings of the IJB committees.

13.2 Other than the live webcasting or recording of IJB meetings, any video or sound recordings or broadcasting of meetings by any other means, or the taking of any photographs/use of cameras, will be at the Chair's discretion.

13.3 Members of the public may, at the Chair's sole discretion, be permitted to address the IJB for an agreed period but shall not generally be permitted to participate in discussion at a meeting.

13.4 Nothing in these Standing Orders shall preclude the Chair from requiring the removal from a meeting of any person or persons who persistently disrupts the meeting.

14. Remote attendance[15]

14.1 ~~A member who is unable to be present for a meeting of the IJB or any of its committees at the venue identified in the notice calling the meeting shall notify the Clerk and the Chair at least 3 days (or, if this is not possible, as soon as practicable) in advance of the meeting.~~ Any member unable to be present at a meeting shall be able to take part remotely in any way which reasonably allows the Members participation. For the avoidance of any doubt, such participation includes voting. A member remotely participating in this way is referred to in this Standing Order as a "Remote Member". A Remote Member is encouraged to activate their video camera (if possible) for the duration of the meeting.

14.2 Where the Chair is participating remotely, the Vice Chair will take the Chair, except in respect of Standing Order 14.7 where the Chair will take the Chair.

a. The Member chairing the meeting must be physically present at the meeting venue, therefore where both the Chair and Vice Chair are participating remotely or have sent apologies, Members present at the meeting venue will appoint a Chair to chair the meeting from amongst their number.

[14] Non statutory, but adopted as good practice
[15] The 2014 Order makes no provision for how meetings are to be held, leaving it up to individual IJB's.

b. In the event that no agreement is reached between those Members present, the decision will be taken by means of a procedural motion.

14.3 Remote Members will be counted for the purposes of determining whether there is a quorum.

14.4 A Remote Member will cast their vote as if participating in a roll call vote.

14.5 Any Remote Member who has declared an interest in an item and withdrawn must ~~pause/exit the video/communication link whilst the item is being considere~~ leave the meeting~~d~~. The Clerk will inform/re-invite the Remote Member (whether by email or otherwise) when to ~~re-start the link and~~ resume their participation.

14.6 Any Remote Member must confirm that they are in a secure private location, and that no-one else is able to hear or view the proceedings from the device being used by that Remote Member, before they can participate in the Committee's consideration of any confidential and/or exempt item of business.

14.7 The Chair (whom failing, the Vice Chair) may direct that a meeting shall be conducted solely by means of the participation of Remote Members. Such a direction may be made during a meeting or otherwise.

14.8 The Guidance for attending remote meetings via Microsoft Teams is found in Appendix A below.

15. Business[16]

15.1 The notice of a meeting shall include an agenda of items of business which shall be considered in the order in which they are listed except where the Chair, at his or her discretion, may determine otherwise.

15.2 Acceptance of late items of business is at the Chair's discretion having regard to any special circumstances which requires it to be considered as a matter of emergency.

16. Reports by Officers[17]

[16] Schedule 1(2) of the 2014 Order
[17] Non-statutory, but adopted as good practice

16.1 Reports must be produced in draft and sent to the following officers for consultation in accordance with the published timetable prior to being accepted onto the IJB final agenda:-

a. Chair of the IJB;
b. Vice Chair of the IJB;
c. Chief Officer, ACHSCP;
d. Chief Finance Officer, ACHSCP;
e. Chief Social Work Officer, the Council
~~f. Chief Operating Officer, ACHSCP;~~
~~g.~~f. Chief Executive, the Council;
~~h.~~g. Chief Executive, NHSG;
~~i.~~h. Chief Officer – Finance, the Council;
~~j.~~i. Director of Finance, NHSG;
~~k.~~j. Chief Officer – Governance, the Council
~~l.~~k. IJB Data Protection Officer, NHSG;~~;~~
~~m.~~l. Nursing and Medical Directors;
~~n.~~m. Public Health Consultant; and
~~o.~~n. Clerk to the IJB.
~~p.~~o. Director of Corporate Services, the Council
~~q.~~p. Director of Families and Communities, the Council
~~r.~~g. Director of City Regeneration and Environment, the Council

16.2 The Council's Leader(s) and Convener of the Finance and Resources Committee shall be consulted on draft reports relating to the IJB Budget in line with the requirements of the IJB Budget Protocol.

16.3 Where the report is for an IJB Committee, with the exception of the Appointments Panel Committee, the draft reports must be sent to the following officers for consultation;

a) ~~-~~the Chair of that Committee
b) Executive Lead ~~Officer~~ for the Committee
c) Chief Officer, ACHSCP
d) Chief Finance Officer, ACHSCP
~~Chief Operating Officer, ACHSCP~~
e) Chief Executive, the Council
f) Chief Executive, NHSG
g) Chief Social Work Officer, the Council
h) Chief Officer- Finance, the Council
i) Director of Finance, NHSG,
Chief Officer-Governance, the Council
j) Director of City Regeneration and Environment, the Council

~~a. Director of Commissioning, the Council~~
~~b.~~ IJB Data Protection Officer, NHSG;
~~c.~~ Nursing and Medical Directors;
~~d.~~ Public Health Consultant;
~~e.~~ Clerk to the IJB, the Council

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17. Quorum[18]

17.1 No business is to be transacted at a meeting of the IJB, ~~or its committees~~the Clinical and Care Governance Committee and Risk Audit and Performance Committees unless at least one half of the voting members is present. For meetings of the IJB, this shall mean that two voting members of each constituent authority shall be present and for a meeting of an IJB Committee, one voting member of each constituent authority shall be present.

18. Conduct of Meetings[19]

18.1 At each meeting of the IJB, ~~or~~ the Clinical and Care Governance Committee and Risk Audit and Performance Committee~~one of its committees~~, the Chair of the IJB or Committee, if present, shall preside.

18.2 If the Chair is absent from a meeting of the IJB, the Vice Chair shall preside.

18.3 If the Chair and Vice Chair are both absent from a meeting of the IJB, a voting member chosen at the meeting by the other voting members attending the meeting, shall preside at the meeting. For the avoidance of doubt, this shall not be the substitute for the Chair or Vice Chair as is specified in Standing Order 8.3.

18.4 No Vice Chairs shall be appointed to the Clinical and Care ~~and~~ Governance Committee and Risk Audit and Performance Committee~~ IJB committees~~. In the event that the Chair of ~~a~~ either committee is absent, a voting member chosen at the meeting by other voting members attending the meeting shall preside.

18.5 If it is necessary or expedient to do so, the Chair or, whom failing the Vice Chair, may adjourn a meeting of the IJB, or a committee to another date, time or place.

18.6 Following the introduction of an item of business by the Chair, all members shall be entitled to ask questions of the Report Author, through the Chair, and discuss the item as openly as possible.

18.7 When, in the opinion of the Chair, members have had a reasonable opportunity to consider the item of business, the Chair shall move to a determination of the matter.

18.8 Every effort shall be made by members to ensure that as many decisions as possible are made by consensus. Where the IJB or an IJB Committee has been unable to reach a decision by consensus following the procedure in this paragraph, the Chair shall invite the IJB to move to a vote. The process followed at ~~paragraph~~ Standing Order 23 shall apply.

[18] Schedule 1(3) of the 2014 Order
[19] Schedule 1(4) of the 2014 Order

18.9 Where a voting member does not agree with, or support the recommendation, and wishes to record their dissent, the Clerk shall~~can~~ record that member's dissent~~ion~~ ~~, at their request,~~ in the minute of the meeting.

18.1~~0~~9 The IJB shall schedule a dedicated budget meeting to consider and agree the IJB budget and adhere to the provisions set out in the IJB Budget Protocol.

18.1~~1~~0 Clerking support to the IJB and its committees shall be provided by the Council.

19. Power and Duties of Chair[20]

19.1 It shall be the duty of the Chair:-

a. To preserve order and ensure that any member wishing to speak is given due opportunity to do so and to a fair hearing;
b. To call members to speak ~~according to the order in which they caught the Chair's eye~~;
c. To decide on all matters of order, competency and relevancy;
d. To ensure that the sense of the meeting is duly determined; and,
e. If requested by any member, to ask the mover of a recommendation ~~(motion)~~ or proposal~~amendment~~ to state its terms.

19.2 The Chair shall have authority to determine all procedural matters during IJB meetings following consultation with the Clerk, excepting the suspension of Standing Orders as outlined in ~~paragraph~~ Standing Order 1.6.

19.3 The ruling of the Chair on all matters in these Standing Orders shall be final.

19.4 Deference shall, at all times, be paid to the authority of the Chair. The Chair shall be heard without interruption and all members shall address the Chair when speaking.

20. Declarations of Interest and Transparency Statements[21] -

20.1 Members must adopt the 3- stage approach (Connection – Interest-Participation) set out in section 5 of the (Declarations of Interests) of the IJB Code of Conduct.

20.2 A member will declare their interest as early as possible in meetings. Where they have declared an interest, they must withdraw from the meeting room

[20] Common law powers of a Chairperson
[21] This is derived from the IJB Code of Conduct, which is required by the Ethical Standards in Public Life etc. (Scotland) Act 2000.

(including from any public gallery). They must not participate in any way in those parts of meetings where they have declared an interest. If the meeting is being held online, or the member is participating remotely, the member must retire to a separate breakout room or leave and re-join after the discussion on the matter has concluded. It is not sufficient for them to turn off their camera and/or microphone for the duration of the matter.

20.3 When making a declaration, a member should provide enough information for those at the meeting to understand why they are making a declaration.

20.4 Members should consider whether it is appropriate for transparency reasons for them to state publicly in the meeting where they have a connection, which they do not consider amounts to an interest. Such a statement is referred to in these Standing Orders as a "Transparency Statement".

21. Minutes[22]

21.1 A record must be kept of the names of the members attending every meeting of the IJB or of one of its committees.

21.2 Minutes of the proceedings of each meeting of the IJB, ~~or~~ the Clinical Care and Governance and Risk Audit and Performance Committees, ~~its committee~~, including any decision made at that meeting, are to be drawn up and submitted to the subsequent meeting of the IJB or the committee for agreement after which they must be agreed by the IJB as an accurate record of the meeting.

21.3 Draft Minutes from the Clinical Care and Governance and Risk Audit and Performance Committees ~~IJB's committees~~ will be presented to the IJB for noting.

22. Alteration or Revocation of Previous Decision[23]

22.1 No decision of the IJB shall be altered or revoked within six months of it having been taken unless a report recommendation to that effect is approved by the IJB.

23. Voting[24]

[22] Schedule 1(5) of the Order
[23] This is non-statutory, but adopted to ensure stability of IJB decision making.
[24] Article 11 of the 2014 Order requires that votes be by majority of voting members present

23.1 In the event that the IJB has been unable to reach a decision after following the procedure outlined in Standing Order 18, and a vote is required, the provisions of this Standing Order shall apply.

23.2 Any member may ~~wish to~~ make a proposal for agreement by the IJB. The proposal must relevant to the business on the agenda. A proposal can be raised at the meeting for consideration and discussion by the IJB.

23.3 Where a member wishes to formally make recommendations or proposals relating to an item of business on the agenda, it must differ subtantialy from the recommendation. Such a proposal must be submitted to the Clerk~~,~~ by 10 am ~~noonpm~~, on the second working day[25] prior to the meeting of the IJB, and thereafter moved at the meeting.

23.4 The recommendation or proposal shall be circulated to members by the Clerk once finalised and determined to be competent or, as soon as is reasonably practicable thereafter.

23.5 Such a proposal requires to be seconded by a~~A~~ voting member, who may reserve his/her speech for a later period of the debate.

23.6 A~~cceptance of an urgent~~ recommendation or proposal that was not submitted timeously ~~does not meet the time period~~ in terms of Standing Order 23.3 above~~,~~ can only be accepted onto the agenda at the discretion of ~~is a matter for~~ the Chair ~~to determine at the meeting~~.

~~Where the recommendation (motion) or amendments are proposed prior to a meeting, members should provide a copy of the proposed wording to the Clerk as soon as is reasonably practicable and, if possible, before the meeting commences~~.

23.7 A proposal, after being seconded, shall not be amended or withdrawn without the agreement of the IJB.

23.~~8~~3 Each recommendation ~~(motion)~~ or proposal put to a meeting of the IJB shall be decided by a majority of the votes of those members attending and entitled to vote. For the avoidance of doubt, each such recommendation or proposal may be approved in whole or in part and proposals to that effect may be made at any time.

23.~~9~~4 The Chair will have the prior right to the recommendation in the report ~~(the motion)~~, except where the Chair waives that right.

23.10~~5~~ A recommendation and any ~~amendments~~ proposals~~thereto~~, shall be moved and seconded. Movers shall be entitled to speak for ten minutes and all other members, including movers when summing up at the conclusion of debate, shall be entitled to speak for five minutes. No member shall speak in support of a recommendation ~~(motion)~~ or proposal until it has been seconded. ~~Any member who has moved or seconded a recommendation (motion) shall not~~

[25]For example, a proposal must be submitted to the Clerk by 10 am the preceding Friday, in the case of a meeting of the IJB on a Tuesday.

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~~be entitled to enter the debate.~~ A member shall not be entitled to speak more than once in debate, except the mover when summing up. A member shall be entitled, however, to ask ~~a~~ questions of an officer on the recommendation or any proposals put forward, and members are permitted to ask questions of other members where it relates to business on the agenda. ~~.~~

23.11~~6~~ All recommendations ~~(motions)~~ and proposals~~d amendments~~ must relate to the item of business on the agenda and all ~~amendments~~ proposals must differ from the recommendation substantially.

23.12~~7~~ The Chair shall determine whether a recommendation ~~(motion)~~ or a proposal~~n amendment~~ is competent and relevant and may seek advice from officers in this regard.

23.13~~8~~ A recommendation ~~(motion~~) or proposal~~amendment~~ is incompetent it if would require the incurring of expenditure and the source of the funding is not identified.

23.14~~9~~ A recommendation ~~(motion)~~ or proposal~~amendment~~ moved, but not seconded, or which is ruled incompetent by the Chair, will not be put to the vote but will be recorded in the minute.

23.15~~0~~ If a recommendation ~~(motion)~~ or a proposal~~n amendment~~ is withdrawn, the mover or seconder can move or second, and speak in support of, a further recommendation ~~(motion)~~ or ~~amendment~~proposal~~.~~

23.16 ~~23.11~~ A member can make minor alterations to their recommendation or proposal, once seconded ~~(motion)~~ or ~~amendment~~ with consent of the Chair.

23.17~~2~~ Votes shall be taken by roll call except where an electronic voting system is available, in which case it shall be used in preference to any other method.

23.18~~3~~ Where there is an equality of votes ~~a tied vote~~, there shall be no casting vote afforded to the Chair or to any other member or group of members and in that event:-

Stage 1

(i) The Chair shall~~,~~ call on the Chief Officer to outline the consequences of each potential ~~-~~outcome, to provide such clarification as~~that~~ may be appropriate or requested and to set out the ramifications to the IJB of withdrawing the matter and maintaining the status quo and, thereafter, to make a recommendation.

(ii) The Chair shall then immediately without further discussion call for a ~~roll call~~vote on the recommendation ~~(motion)~~ that is before the meeting.

(iii) If there is still an equality of votes ~~result remains a tie~~, the Chair may:

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a. call a recess of the meeting for such period as the Chair thinks fit to allow members to further consider matters and, once the meeting is reconvened, returndefer to step (ii) above; or,

b. suspend further discussion on the issue of contention and defer the matter to the next meeting of the IJB; and/ or

c. where the Chair is of the view that a special meeting of the IJB requires to be convened in accordance with Standing Order 11.2, suspend further discussion on the issue of contention and defer the matter to that special meetinginstruct the Chief Officer to review the matter with the aims of addressing any concerns raised by the IJB and developing a proposal which the IJB can reach a decision on and bringing that proposal to a meeting of the IJB-.

(iv) Where, in the event that following the recess in terms of Standing Order 23.13 (iii) (a) there is still a tied vote, the Chair shall, at the Chair's discretion, either; call a further recess in terms of the said Standing Order 23.13 (iii) or chose to proceed with either option in terms of Standing Order 23.13(iii) (b) or Standing Order 23.13 (iii) (c).

Stage 2

-(v) At the next meeting of the IJB, after consideration of either; a further report, or an outline from the Chief Officer of the consequences -of the issue being consideredfrom the Chief Officer, the Chair shall call for a vote. Where there remains an equality of votes, the Chair shall;

a) invite members to speak in support of and against the recommendation and call a further vote.

(vi) If there remains an equality of votes, the Chair shall;

a) defer the matter to another meeting of the IJB; or

b) invite members to agree to reject the recommendation and agree that the status quo be maintained; -or;

c) in the event of a decision having to be made due to a legal or regulatory requirement, a decision will be made by the casting of lots, the method of which shall be determined by the Clerk.

(v) Once the meeting is reconvened in accordance with (iv) above and the matter has been discussed in terms of Standing Order 18, the Chair shall call for a roll call in terms of Standing Order 23.13(ii). In the event of a tied vote the Chair shall determine whether the matters should be deferred in terms of Standing Order 23.13(iii) (b) or Standing Order (iii) (c). Where this is the case, the Chair shall direct the Chief Officer to provide such clarification that may be appropriate or requested and to set out the ramifications to the IJB of withdrawing the matter and maintaining the status quo and bring that back to a future meeting.

Once the meeting is reconvened in accordance with (iv) above and the matter has been discussed in terms of Standing Order 18, the Chair

~~shall call for a roll call in terms of Standing Order 23.13(ii). In the event of a tied vote the Chair shall determine whether the matters should be deferred in terms of Standing Order 23.13(iii) (b) or Standing Order (iii) (c). Where this is the case, the Chair shall direct the Chief Officer to provide such clarification that may be appropriate or requested and to set out the ramifications to the IJB of withdrawing the matter and maintaining the status quo and bring that back to a future meeting.~~

(vi) ~~At a future meeting of the IJB in accordance with Standing Order 23.13(iii)(b) and (c), the matter shall be discussed in terms of the procedure set out in Standing Order 18 and the Chair shall invite members to vote in accordance with 23.13 (ii) above.~~

~~If there remains a tied vote the Chair shall direct the Chief Officer to provide such clarification that may be appropriate or requested together with the options available to the IJB, including an outline of the ramifications of remaining with the status quo and invoking the dispute procedure under the Integration Scheme.~~

~~The Chair shall invite members to consider and discuss these options in terms of Standing Order 18 and vote in accordance with Standing Order 23.13 above on the issue.~~

~~a. In the event of a further tied vote, a vote will be put to members on whether to withdraw the matter or have the status quo apply.~~

24. Expenses[26]

24.1 The IJB may pay the reasonable travel and other expenses of ~~unpaid carer~~ representatives ~~and other unpaid representatives who are appointed as members~~ of ~~the IJB~~ in accordance with the policy at Appendix C[27].

25. Committees[28]

25.1 The IJB ~~may~~ has established ~~such~~ three committees ~~as it may determine~~ for the undertaking of its functions. These are;

- The Clinical and Care Governance Committee
- The Risk Audit and Performance Committee, and
- The Appointments Panel Committee.

25.2 The IJB must appoint the Chairs of ~~each~~ the Clinical and Care Governance Committee and the Risk Audit and Performance Committee ~~committee it establishes~~ for an appointing period not exceeding three years.

[26] Article 16 of the 2014 Order
[27] Approved by the IJB on 11 August 2020
[28] Article 17 of the 2014 Order. Precise procedure is left up to each IJB.

~~25.3~~

25.3 The IJB may change the persons appointed as Chairs of the Clinical and Care Governance Committee and the Risk Audit and Performance Committee during the appointing period for the remainder of that period.

~~25.4~~ 25.4 The IJB Chair/Vice Chair shall not chair the Clinical and Care Governance Committee or the Risk Audit and Performance Committee ~~an IJB Committee.~~

~~25.5~~

~~25.6~~ 25.5 The IJB shall appoint two voting members from each constituent authority to serve on the Clinical and Care Governance Committee and two voting members from each constituent authority to serve on the Risk Audit and Performance Committee ~~each committee~~ to ensure equal representation.

~~25.7~~ 25.6 Any decision of the Clinical and Care Governance Committee or the ~~and~~ Risk Audit and Performance Committee ~~a committee~~ must be agreed by a majority of the votes cast by the voting members of that committee.

~~25.8~~ 25.7 The Clinical and Care Governance Committee and the Risk Audit and Performance Committee ~~Committee~~ shall each meet four times each financial year. The Appointments Panel Committee shall meet as and when there is business to determine. The Chair may, at any time, convene additional meetings of the Committee.

~~25.9~~ 25.8 The IJB will review and alter the Terms of Reference of any of its committees annually, as part of its annual review of the Scheme of Governance. Before the annual review date of the Scheme of Governance, the IJB may alter the Terms of Reference at any time where it considers it necessary to do so.

~~25.10~~ 25.9 All IJB members shall be entitled to receive ~~committee~~ papers for the Clinical and Care Governance Committee and Risk Audit and Performance Committee and an open invitation shall be extended to members to attend those Committee meetings.

~~25.11~~ 25.10 The level of participation for non-committee members in these proceedings shall be at the discretion of the committee Chair, though non-committee members may not propose or second a recommendation ~~(motion)~~ or ~~amendment~~proposal, or vote.

~~25.12~~ 25.11 Committee meetings shall be conducted in accordance with these Standing Orders.

~~25.13~~ 25.12 ~~A~~The Clinical and Care Governance Committee and Risk, Audit and Performance Committee will formally provide a copy of its minutes to the IJB for inclusion on the agenda of subsequent meeting.

~~25.14~~ 25.13 Following agreement from a majority of members, a committee may refer or escalate an item of business to the next IJB meeting for consideration. The Clerk of the committee shall make the necessary arrangements.

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26. General Powers of IJB[29]

26.1 The IJB may enter into a contract with any other person for the provision of goods and services for the purpose of undertaking the functions conferred on it by the Act, including but not limited to administrative support, accounting or legal services.

27. Register of Interests and Code of Conduct[30]

27.1 The IJB Standards Officer shall keep and maintain a Register of Interests, which shall be published on the Internet, in which all members shall record their interests and hospitality offered by virtue of their membership of the IJB. The Standards Officer shall be the officer so designated by the Standards Commission, following a nomination by the IJB. All members are required to complete a register of interests in a standard format to comply with their obligations under the IJB Code of Conduct, within a month of appointment and when any changes occur. A form to register interests will be sent to all members on appointment and members must submit an updated form when there are any changes.

27.2 All members shall be bound by the terms of the Code of Conduct for members of Aberdeen City ~~Health and Social Care Partnership~~ Integrated Joint Board ~~Public Bodies~~, provided for under the Ethical Standards in Public Life etc. (Scotland) Act 2000.

28. Deputations[31]

28.1 The competency of a deputation (in respect of Standing Orders 28.6 a. - d.)) will be determined by the Chair. If the Chair deems a deputation to be incompetent it will not be heard at the meeting.

28.2 Every request for a deputation must be in writing and submitted to the Clerk of the IJB at least two working days before the meeting to which it relates.

a. For example, for a meeting on a Thursday, requests must be received by the end of the Monday; and for a meeting on a Tuesday, requests must be received by the end of the previous Thursday.

28.3 In the event that a report has not been published to enable a deputation request to comply with the deadline set out in Standing Order 12, deputation requests may still be submitted and put on to the agenda. In such instances, Standing

[29] Article 19 of the 2014 Order
[30] This is derived from the IJB Code of Conduct, which is required by the Ethical Standards in Public Life etc. (Scotland) Act 2000.
[31] Non - statutory

Order 12 would require to be suspended at the meeting for the deputation to be heard.

28.4 The request must state the report on the agenda which the deputation wants to be heard and the action (if any) the deputation would like the IJB to take in relation to the report.

28.5 A competent deputation request will be placed on the agenda for the relevant meeting of the IJB.

28.6 The following deputation requests are not competent:

a. Deputations which fail to comply with Standing Order 28.2;
b. Deputations which relate to reports containing confidential information;
c. Deputations which relate to the annual budget; and
d. Deputations which do not relate to a report on an agenda.

28.7 Deputations cannot consist of more than three people.

28.8 The Chair shall determine the duration of a d~~D~~eputation.~~s should not last for more than ten10 minutes, irrespective of the number of speakers~~.

28.9 No individual may form part of more than one deputation on the same matter.

28.10 Following the conclusion of the deputation, IJB members will be given the opportunity to ask questions of the deputation for a maximum of ten minutes.

Appendix A –Remote Attendance Guidance

This short guide is intended to assist you to participate in a remote meeting and is not a replacement for fuller Teams instruction provided by your constituent authorities.

You will have received an invitation from the Clerk in either Outlook (email) or Teams to participate in a Teams Meeting. You can join the meeting via your laptop/tablet or from a standard telephone.

In advance of the meeting

Members should:-

- Ensure that they have downloaded the agenda papers and saved these on their desktop for easy access.
- Inform the Clerk if they are unable to attend or may be late.
- Inform the Clerk if they have any query, or potential amendment to the minute to allow this to be considered and investigated in advance. (This should then be raised in the normal manner during the meeting).

On the day of the meeting

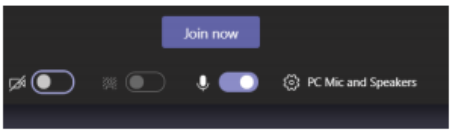
Members should:-

- Ensure they are located as close to their broadband router as possible or connect their computer direct to the router by cable.
- Join the Teams meeting 5 minutes before the start time.
- Ensure that their microphone remains at mute unless they have been invited to speak by the Chair.
- Activate their video camera (if possible).
- Ensure that any personal items on display in the background cannot be picked up on video camera.

Access the meeting remotely

Laptop/Tablet Device

Open your agenda for the meeting. Then open your invitation within Outlook email or Teams. Select *'Join Now'* and you have remotely joined the meeting.



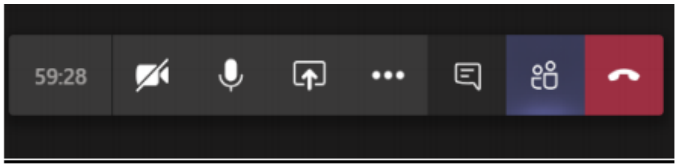
Telephone - Joining a Meeting

Call the telephone number in the Outlook appointment which has been sent to you and use the conference code provided in that invitation as set out below. You will be guided by the voice message.

Join Microsoft Teams Meeting
+44 20 3443 9692 United Kingdom, London (Toll)
Conference ID: *******#

Joined the Meeting

If you have joined the meeting via Teams you will then see the *Options Bar* as per the image below (shows 8 options) – this should appear at the centre of the Teams screen. Thereafter you will see the *Options Bar*



From the right

- Hang Up / Terminate – Participants can terminate the call via the red handset which allows them to leave the meeting and re-join if they select the "join" button from the invitation.
- Show Participants (2nd from right) – Displays a list of all remote participant.
- Show Conversation (3rd from right) – This allows you to 'chat' with all other participants in the meeting. NB - this is NOT Private Chat but Meeting Chat. Private chat remains available via the Chat icon on the top left of the side.
- Ellipsis (more options) button (4th from right) provides a further 8 options as advised.
- Share (5th from right) provides sharing options.
- Microphone (6th from right), you can mute/unmute the microphone.
- Camera (7th from right), you can select camera on/ off.
- Timer (furthest left) shows the duration of the meeting.

How to participate
You should use the 'hands' facility or Teams Chat facility (3rd from right on the options bar) to alert the Chair if you wish to participate. The Clerk will alert the Chair and the Chair will call your name.

Viewing Agenda whilst in Remote Meeting
You should already have your agenda open and can access this from Teams via the toolbar at the bottom of your screen. This will allow you to switch between Teams and your agenda.

Declaring an Interest
If you have declared an interest in a report and intend to leave the meeting during discussion at the appropriate time, you should hang up (using the telephone symbol on the Options Bar) in order to remove yourself from the meeting and the Clerk will reinvite you when that business is concluded.

You should NOT re-join the meeting until you receive an invitation from the Clerk. This invitation will pop up on your screen, and you should select 'video call' from the two options given.

Appendix B- Exempt and Confidential Information

In accordance with Standing Order 13, the IJB may pass a resolution to meet in private in order to consider certain items of business, and may decide to do so for the following reasons;

a) The IJB is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation.
b) The business relates to the commercial interests, contractual terms (whether proposed or to be proposed), financial or business affairs of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
c) The business necessarily involves reference to personal information and requires to be discussed in private in order to uphold the Data Protection Principles.
d) The business relates to a particular office holder, or member of the IJB.
e) The business relates to any particular applicant or recipient or former recipient of any financial assistance provided by the IJB.
f) The business relates to legal advice given or received or information obtained or action to be taken (whether or not in connection with any proceedings).

Appendix C – IJB Carers and Service User Representatives Expenses Policy

Why does this expenses policy exist?

This policy ensures that any unpaid carer or other representatives who are members of the IJB and associated groups or committees **are not out of pocket** as a result of carrying out their duties (as defined in the Public Bodies (Joint Working) (Scotland) Act 2014).

Who is the expenses policy for?

This policy is for unpaid carer and service users representatives who are appointed as a member of the Aberdeen City Health and Social Care Partnership (ACHSCP) Integration Joint Board (IJB) as per the Standing Orders 2.3 c) and d) and any associated groups or committees.

When does this expenses policy apply?

This expenses policy applies to enable unpaid carer and service user representatives to undertake the work required in their capacity as IJB members. This includes preparatory work for, and attendance at:

- IJB meetings (including Development Sessions and Seminars)
- Strategic Planning Groups
- Locality Groups
- Other associated groups or committees
- IJB related duties and events (e.g. meeting a community group to explain the Strategic Commissioning Plan)

What are the principles of the policy?

Recognising diversity and minimising barriers to full participation

We recognise there is a diversity of needs and will work with each carer and service user representative individually to provide any reasonable adjustments/extra support they may require to fully participate in the IJB.

Good stewardship and management of public funds

We promote consideration of cost effectiveness, value for money, and respect for the environment. It may be more cost effective for travel and accommodation to be booked through the IJB as opposed to booking this personally and being reimbursed. The cost of the use of eBikes would fall within the scope of this policy. We encourage IJB members to be paper free as far as possible, but will support the cost of printing when required. Where possible, dated, official receipts will be required for any reimbursement in line with Aberdeen City Council (ACC)Travel and Subsistence Allowance Guidance (see Appendix A).

Collaboration and continuous improvement

Our IJB Carers and Service Users have a nominated point of contact within ACHSCP who is the main link in relation to this policy. Regular meetings take place and a Standing Agenda item at these will be a review of expenses claims, how the process is working, and what improvements could be fed into the annual review of the policy. It is a shared responsibility between the representatives and the nominated point of contact to enable the smooth implementation of this policy allowing the representatives to fulfil their role whilst not being out of pocket.

What expenses are included in this policy?

The following are examples of costs which can be reimbursed under this policy. The list is not exhaustive and the overarching aim of the policy i.e. that representatives should not be out of pocket, has primacy.

- **Travel costs**
  - public transport (excludes first class travel)
  - mileage (45p/mile)
  - parking
  - taxi costs - where public transport arrangements are not suitable
  - ferries and other forms of transport as required in island communities

- **Subsistence (where no meals or refreshments are provided)**
  - Reimbursement of reasonable lunch expenses as per current Local Council guidelines
  - Reimbursement of reasonable dinner expenses as per current Local Council guidelines
  - Overnight accommodation and reimbursement of reasonable expenses for overnight stays, if and when required, as per current Local Council guidelines

  See Appendix A for current Local Council guidelines and rates.

- **Preparatory work and administration to carry out duties**
  - Printing and paper costs.
  - IT / communication costs (e.g. phone / iPad / laptop) although a Council owned laptop will normally be loaned for the period of tenure NB: there will be a requirement to agree to abide by the relevant policies in relation to use of IT equipment, data protection etc.

- **Replacement care / care cover**
  - for attendance at IJB meetings
  - for attendance at other meetings/events relating to role
  - for travel times to meetings

- for preparation time

- **Loss of income to attend meetings**
  - Where appropriate, loss of earnings income to attend IJB meetings will be considered (to be discussed and agreed in advance – NIHR Guidelines for public involvement in health and social care research could help inform these discussions).
  - Any potential impact on social security benefits to be considered and discussed.

What is the process for claiming expenses?

- Smaller items of expenditure (e.g. mileage within Aberdeen, parking and administrative expenses for local meetings) will be reimbursed on receipt of a correctly completed claim form and appropriate, dated receipts. Replacement care, reimbursement of lost income, and travel and subsistence for meetings out with Aberdeen, must be agreed in advance with the IJB's Chief Finance Officer.
- The nominated point of contact is the Senior Project Manager (Strategy), who will support communication with the representatives and will assist with completion and submission of expenses claims.
- A copy of the Travel and subsistence claim form is attached at Appendix B and representatives will be provided with a template for their own use.
- In line with ACC policy, claims should be made within 3 months of the date the expense was incurred however claims received out with this timescale will still be processed but must be accompanied by a note of explanation from the Chief Finance Officer.
- Claim Forms should be completed nd submitted via the nominated point of contact along with relevant receipts and/or confirmation of approval by Chief Finance officer if appropriate.
- All expenses will be paid within 30 days of the receipt of a properly completed, valid, expenses claim form, however, to ensure equity of involvement and engagement, if required, immediate payments may be made.
- Payments will be made via BACS transfer where possible. Bank details will require to be provided to enable payment. Representative will be set up on the BACS system in advance of claims being made. Where BACS payment is unsuitable alternative payment arrangements (such as cheque/cash) can be arranged.

Reviewing this policy

This policy will be reviewed annually with relevant stakeholders and by the Integration joint Board as part of its Scheme of Governance review. The Appendices will be updated appropriately in line with any changes made by ACC. Any proposed changes to this policy will be discussed with those covered by the policy before implementation.

Appendix A

Aberdeen City Council Travel and Subsistence Allowance (June 2023)

Car and Motor Cycle Allowances

Essential Users

You are an Essential Car User if you are in a post whose duties are of such a nature that it is essential for you to have a car at your disposal whenever required.

Where a post is designated as requiring an Essential Car User Allowance the following annual allowance will be paid, Business Mileage is based on the previous financial year.

Actual Annual Business Mileage	**Annual ECU Allowance**
Under 1200 miles	£120
1200 – 5000 miles	£250
5001 – 7,500 miles	£500
Over 7,501 miles	£800

A lump sum is payable in 12 monthly instalments to all essential users.

In addition, a payment in respect of miles run on official business, within the City, is made as undernoted:

Essential mileage

0 – 10,000 miles	0.45p
Over 10,000 miles	0.25p

Those carrying a fellow employee as a passenger will receive an additional 5 pence per passenger per mile.

Casual Users

You are a Casual User if you are in a post for where it is merely desirable that a car should be available when required. No lump sum is payable, but a payment in respect of miles run on official business in any financial year within the City of Aberdeen is made as undernoted:

Casual mileage rate

0 – 10,000 miles	0.45p
Over 10,000 miles	0.25p

In addition those carrying a fellow employee as a passenger will receive an additional 5 pence per passenger per mile.

Motor Cycle Allowances

Officers using a motor cycle are entitled to the following rates:

0 – 10,000 miles	0.24p
Over 10,000 Miles	0.24p

Push Bike Allowances

The current rate is 20p per mile in respect of miles run on official business.

Travel Outwith the City of Aberdeen

All mileage will be reimbursed at casual/ essential rates of 45p per mile with passenger allowance if applicable.

Workplace Change Allowance

Mileage paid at the Essential/ Casual Allowances Rate up to a maximum value of a First Bus monthly pass.

Bus Passes/ Fares are reimbursed on receipted expenditure up to a maximum of a First Bus monthly pass.

Subsistence Allowances

Subsistence allowances will be payable to officers who are prevented by their official duties from taking a meal at their home, administrative centre or establishment where they normally take their meals, and thereby incur additional expenditure. The allowance shall not be paid where a suitable meal is provided or the officer has been previously reimbursed.

The maximum allowances are as follows:

- Breakfast: £8.00
- Lunch: £12.00
- Evening Meal: £25.00

Services should request receipts to verify that expenditure has been incurred.

Appendix B

ABERDEEN CITY COUNCIL TRAVEL AND SUBSISTENCE CLAIM MONTH 20

ALL RELEVANT DETAILS MUST BE COMPLETED: INCOMPLETE FORMS WILL BE RETURNED.

Name ..... Payroll No. (7 digit per payslip) ..... Job Title .....

Service ..... Normal Place of Work .....

Registration Number..... Car exact cc.....

User Type: Essential /Casual /Motor Bike /Bicycle (delete as appropriate)

Date	Details of each journey with locations, purpose and where passenger miles are claimed; include the passenger name(s) (the form will be returned if passenger name(s) are not completed).	Participant in ACC Tusker Leased Car Scheme (Y/N)	Mileage	Passenger Miles	Workplace Change Allowance / ACC Leased Car Mileage		Hours of Absence (only complete if subs. claimed)		Other Expenses/ Subsistence		Cost Centre
					Mileage	Bus Fares	From	To	£	p	
	The total column must be completed:										

GUIDANCE NOTES AVAILABLE ON PeopleAnytime

Once completed and approved this form should please be sent to: BusinessSupportTeam4@aberdeencity.gov.uk

Page 91

Declaration by Claimant

I declare that all claims entered by me on this form, including mileage, result from expenses actually and necessarily incurred by me in the course of my duties and that any subsistence payments claimed in consequence of such expenses do not exceed the allowances approved by the City Council. **I declare that the above vehicle is roadworthy and is insured for business purposes.**

Signature..... Date.....

(AUTHORISER TO BE COMPLETED IN BLOCK LETTERS)

Signature..... Date.....

Authoriser.....

Job title.....

Who is the expenses policy for?
This policy is for unpaid carer representatives who are appointed as a member of the Aberdeen City Health and Social Care Partnership Integration Joint Board (IJB) as per the Standing Orders 3b), c) and d) and any associated groups or committees. It can also be used for other unpaid representatives on IJBs, such as service users.

Why does this expenses policy exist?
This policy ensures that any unpaid carer or other representatives who are members of the IJB and associated groups or committees are not out of pocket as a result of carrying out their duties (as defined in the Public Bodies (Joint Working) (Scotland) Act 2014).

When does this expenses policy apply?
This expenses policy applies to enable unpaid carer and other representatives to undertake the work required in their capacity as IJB members. This includes preparatory work for, and attendance at:

- IJB meetings (including Workshop and Development Sessions)
- Strategic Planning Groups
- Locality Groups
- Other associated groups or committees
- IJB related duties and events (e.g. meeting a community group to explain the Strategic Commissioning Plan)

What expenses are included in this policy?

The following are included but prior approval must be sought before any expense is incurred

- **Travel costs**
  - public transport (excludes first class travel - receipts to be provided)
  - mileage (45p/mile)
  - parking (receipts to be provided)
  - taxi costs - where public transport arrangements are not suitable (receipts to be provided)
- **Subsistence (where no meals or refreshments are provided)**
  - Reimbursement of reasonable lunch expenses as per current Local Council guidelines (receipts to be provided)
  - Reimbursement of reasonable dinner expenses as per current Local Council guidelines (receipts to be provided)
  - Overnight accommodation and reimbursement of reasonable expenses for overnight stays, if and when required, as per current

Local Council guidelines (receipts to be provided)

- **Preparatory work and administration to carry out duties**
  - IT / communication costs (e.g. phone / iPad / laptop) although a Council owned laptop will normally be loaned for the period of tenure NB: there will be a requirement to agree to abide by the relevant policies in relation to use of IT equipment, data protection etc.

- **Replacement care / care cover**
  - for attendance at IJB meetings
  - for attendance at other meetings/events relating to role
  - for travel times to meetings
  - for preparation time (if and when required – to be discussed and agreed in advance)

- **Loss of income to attend meetings**
  - Where appropriate, loss of earnings income to attend IJB meetings will be considered (to be discussed and agreed in advance – NIHR Guidelines for public involvement in health and social care research could help inform these discussions).
  - Any potential impact on social security benefits to be considered and discussed.

  Example: one HSCP has allocated resources to their local carers centre to enable carers to support other carers around strategic planning. This allows carers to be recompensed on a sessional basis to support engagement.

What is the process for claiming expenses?

- A named contact person will be identified to support communication, completion and agreement of all expenses claims.
- Expenses forms will be provided in electronic or paper format before or at each meeting / event to claim travel and subsistence expenses (receipts to be provided).
- For preparatory and administrative costs, reimbursement of costs as spent.
- For replacement care and loss of income reimbursement, discussion and agreement with named contact person in advance.
- All expenses will be paid in accordance with normal expenses processing deadlines following receipt of a properly completed expenses claim form. However, to ensure equity of involvement and engagement, if required immediate payments may be made. A payment schedule with dates of reimbursement will be provided.
- Payments will be made via BACS transfer where possible. Bank details will require to be provided to enable payment. Where BACS payment is unsuitable alternative payment arrangements (such as cheque/cash) can only be agreed by the Chief Finance Officer.

Reviewing this policy

This policy will be reviewed annually with the relevant recipients. Any proposed changes to this policy will be discussed with those covered by the policy before implementation.

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Aberdeen City Health & Social Care Partnership
A caring partnership

SCHEME OF GOVERNANCE

Approved by the Aberdeen City Integration Joint Board,

1 July 2025

ABERDEEN CITY INTEGRATION JOINT BOARD,

SCHEME OF GOVERNANCE

1. Purpose and Interpretation

1.1 The Aberdeen City Integration Joint Board ("the IJB") is the Integration Authority for Aberdeen City. It was delegated functions from NHS Grampian ("NHSG") and Aberdeen City Council ("the Council") in 2016 and is a separate legal entity. The delegated functions are set out in the IJB's Integration Scheme. The IJB is responsible for the strategic planning of functions which have been delegated to it, and as such, issues Directions to both NHSG and the Council to deliver health and social care services to the people of Aberdeen.

1.2 This Scheme of Governance contains key governance documents which facilitate the way in which the IJB operates. It is one of the primary sources of assurance required to demonstrate the effectiveness of the IJB's internal controls. It governs how the IJB makes decisions, business will be determined, meetings are conducted, the membership of the IJB, behaviours and conduct of IJB members and sets out the roles and responsibilities of key personnel around the IJB.

1.4 The Scheme of Governance comprises the following:

Document	Purpose
Aberdeen City Integration Scheme	Sets out the arrangements between the Council and the NHSG to delegate functions to the IJB in respect of adult social care and health care services.
Aberdeen City Integration Joint Board Standing Orders	Rules of procedure for meetings of the IJB and its committees.
Aberdeen City Integration Joint Board- Roles and Responsibilities	Explanation of the key roles within the Aberdeen City Health and Social Care Partnership (ACHSCP).
Aberdeen City Integration Joint Board- Code of Conduct	Rules governing conduct of IJB members.
Aberdeen City Integration Joint Board- Combined Terms of Reference for the IJB and its Committees	Powers reserved to the IJB and the decision making authority delegated by the IJB to its committees.

Aberdeen City Health & Social Care Partnership
A caring partnership

Aberdeen City Integration Joint Board

Standing Orders

Date Created:	November 2022	
Version:	V 4.0	
Location:	Governance	
Author (s) of Document:	Jessica Anderson, ACC Legal Services	
Approval Authority	IJB	
Scheduled Review:	July 2026	
Effective Date:	2 July 2025	
Changes:	March 2023 July 2025	July 2025

Table of Contents

S = Standing Orders which are required by statute

NS = Standing Orders which are non-statutory

1. Introduction

1.1 The Aberdeen City Integration Joint Board ("the IJB") comprises voting representatives of Aberdeen City Council ("the Council") and the Grampian NHS Board ("the NHS Board") ("the constituent authorities") and non-voting advisory representatives[1].

1.2 These Standing Orders are made under the Public Bodies (Joint Working) (Scotland) Act 2014 ("the Act") and the subordinate legislation[2] and any provision, regulation or direction issued by Scottish Ministers shall have precedence over anything written here in the event of any conflict.

1.3 These Standing Orders regulate the conduct and proceedings of the IJB and its committees.

1.4 All meetings of the IJB and its committees shall be regulated by these Standing Orders, which the IJB may amend as it so determines, except that all requirements of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 in relation to Standing Orders shall be met.

1.5 Any amendments to these Standing Orders shall be effective from the day following the day on which the changes were agreed.

1.6 Except where prohibited by statute, it shall be competent for any member at any time during a meeting to move the suspension of the whole or any specified part of these Standing Orders. Such a motion shall, if seconded, be put to the vote immediately without discussion.

1.7 A two thirds majority of voting members in attendance shall be required to suspend Standing Orders. For the avoidance of doubt, if the figure is not a whole number it shall be rounded up.

1.8 Standing Orders shall be reviewed by the IJB on an annual basis.

1.9 Non-material amendments can be made to Standing Orders by the Chief Officer, following consultation with the Chair and Vice Chair of the IJB, without the requirement to report to the IJB. Members shall be notified once such amendments have been completed.

2. Membership[3]

2.1 The IJB shall include the following voting members:-

a. Four councillors nominated by the Council; and

[1] As set out in Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Order 2015

[2] Article 18 of the Public Bodies (Joint Working) (Integration Joint Boards) Scotland Order 2014/285 (the 2014 Order)

[3] Article 3 of the 2014 Order

b. Four members nominated by the NHS Board, of whom three shall be non-executive directors and one an executive director.

2.2 The IJB shall include the following non-voting members, with those at (d), (e) and (f) to be appointed by the NHS Board:-

a. The Council's Chief Social Work Officer;
b. The IJB Chief Officer;
c. The IJB Chief Finance Officer appointed under section 95 of the Local Government (Scotland) Act 1973;
d. A registered medical practitioner on the list of primary medical services performers prepared by the NHS Board;
e. A registered nurse employed by the NHS Board or by a person or body with which the NHS Board has a contract; and
f. A registered medical practitioner employed by the NHS Board and not providing primary medical services;

2.3 The IJB must appoint, in addition, at least one member, whom shall be non-voting, from each of the following groups:-

a. Staff of the constituent authorities providing services under integration functions, of whom one shall be a trade union representative and one a partnership representative;
b. Third sector bodies carrying out activities related to health or social care in the Council area;
c. Service users living in the Council area; and
d. People providing unpaid care in the Council area.

2.4 The IJB shall appoint a Public Health Consultant employed by the NHS Board who shall be a non-voting member.

2.5 The IJB may appoint such additional (non-voting) members as it sees fit, but such members shall not be councillors or non-executive NHS Board members.

3. Appointment of the Chair and Vice Chair of the IJB[4]

3.1 The Chair shall be appointed by one of the constituent authorities for an appointing period not exceeding two years.

3.2 The constituent authority which does not appoint the Chair must appoint the Vice Chair for that appointing period.

3.3 The Chair and the Vice Chair appointments referred to in 3.1 and 3.2 shall alternate automatically in each successive appointing period.

3.4 A constituent authority may change the person appointed by that authority as Chair or Vice Chair during the appointing period for the remaining period.

[4] Article 4 of the 2014 Order

3.5 The constituent authorities may only appoint a Chair and Vice-Chair from their membership set out under Standing Order 2 (2.1) above.

4. Term of Office[5]

4.1 The term of office of an IJB member shall be such period as the IJB shall determine which shall not exceed three years.

4.2 A member appointed under Standing Order 2 (2.2) (a) - (c) above shall remain a member for as long as they hold the office in respect of which they are appointed.

4.3 At the end of a term of office set out under Standing Order 4.1 above, a member may be reappointed for a further term of office.

4.4 This paragraph is subject to Standing Order 6 (resignation of members) and 7 (removal of members) below.

4.5 In the event that a voting member ceases to become an IJB member in the circumstances set out in Standing Orders 5, 6 or 7, the constituent body will require to appoint an IJB member in accordance with Standing Order 2.1 and where necessary, Standing Order 3.

5. Disqualification[6]

5.1 A person is disqualified from being a member of the IJB where:

a. a person who has within the period of five (5) years immediately preceding the date of appointment been convicted of any criminal offence in respect of which the person has received a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine);
b. a person who has been removed or dismissed for disciplinary reasons from any paid employment or office with a Health Board or local authority;
c. a person who is insolvent;
d. a person who has been removed from a register maintained by a regulatory body, other than where the removal was voluntary; and
e. a person who has been subject to a sanction under section 19(1)(b) to (e) of the Ethical Standards in Public Life etc. (Scotland) Act 2000.

[5] Article 7 of the 2014 Order
[6] Article 8 of the 2014 Order

6. Resignation of Members[7]

6.1 A member may resign their membership of the IJB at any time by giving the IJB notice in writing (e.g. by giving the IJB's Chief Officer notice in writing).

6.2 Where a voting member of the IJB resigns, the IJB must inform the constituent authority which nominated them.

6.3 This section does not apply to the non-voting members listed in Standing Order 2 (2.2) (a) to (f).

6.4 Other non-voting members of the IJB shall hold office during each three-year period until they are replaced by the appropriate nominating body.

7. Removal of Members (Voting and Non- Voting)[8]

7.1 If a member has not attended three consecutive meetings of the IJB and/or its committees, and such absence is not due to illness or other reasonable cause as the IJB may determine, the IJB may remove that member from office by providing them with one month's notice in writing.

7.2 If a member acts in a way which brings the IJB into disrepute or in a way which is inconsistent with the proper performance of the IJB's functions or its Code of Conduct for Members, that conduct will be addressed in line with the IJB's Code of Conduct for Members.

7.3 If a member is disqualified during a term of office for a reason referred to in Standing Order 5 (5.1) above, they are to be removed from office immediately.

7.4 Where a Council or NHS Board member ceases for any reason to be a Councillor or an NHS Board member during the term of office, they are to be removed from office with effect from the day on which they cease to be a Councillor or an NHS Board member.

7.5 Subject to the above paragraphs, a constituent authority may remove a member which it nominated by providing one month's notice in writing to the member and to the IJB.

8. Substitutes[9]

[7] Article 9 of the 2014 Order
[8] Article 10 of the 2014 Order
[9] Article 12 of the 2014 Order

8.1 A voting member who is unable to attend a meeting of the IJB or its committees shall, insofar as possible, arrange for a suitably experienced substitute, who is a member of the appropriate constituent authority, to attend in their place with voting rights.

8.2 A non-voting member who is unable to attend a meeting of the IJB may arrange for a suitable substitute to attend the meeting in their place.

8.3 Where the Chair or Vice Chair is unable to attend a meeting of the IJB, any substitute attending in their place shall not preside over the meeting.

9. Temporary Vacancies in Voting Membership[10]

9.1 Where there is a temporary vacancy in the voting membership of the IJB, the vote which would otherwise have been cast by the member appointed to that vacancy may be cast by the other members nominated by the appropriate constituent authority.

9.2 Where, because of temporary vacancies, the number of members nominated by a constituent authority is one or zero and that constituent authority is to appoint the Chair, the Chair must be appointed temporarily by the other constituent authority.

9.3 Where a temporary vacancy, or the temporary appointment of the Chair in the circumstances set out in the paragraph above, persists for more than six months, the Chair of the IJB must notify the Scottish Ministers in writing of the reasons why the vacancy remains unfilled.

9.4 The Chief Officer shall determine an item of urgent business in consultation with the Chair/Vice Chair of the IJB and the Chief Executives of the Council and NHS Board during the period between the date of a Local Government Election and the appointment of voting members by the Council only in the situation where the IJB does not have a quorum of members - on the basis that any such action shall be reported to the next meeting of the IJB as an item on the agenda.

10. Effect of Vacancy in Membership[11]

10.1 A vacancy in the membership of the IJB will not invalidate anything done by or any decision of the IJB.

[10] Article 13 of the 2014 Order
[11] Article 15 of the 2014 Order

11. Calling meetings[12]

11.1 The Chair may call a meeting of the IJB at such times as they see fit.

11.2 A request for a special meeting of the IJB to be called may be made by a requisition signed by at least five of the voting members, which shall specify the business proposed to be transacted and which shall be presented to the Chair. Email confirmation of the request for a special meeting will discharge the requirement for the notice to be signed.

11.3 If the Chair refuses to call a meeting requisitioned under the above Standing Order or does not call a meeting within seven days after the making of the request, the members who signed the requisition may call the meeting.

11.4 The business to be transacted at any requisitioned meeting shall be limited to the business specified in the requisition.

11.5 The IJB's annual calendar of meetings shall run from 1 April to 31 March of the following calendar year. A schedule of meetings shall be approved by the IJB prior to 1 April of the new meeting year.

12. Notice of Meetings[13]

12.1 Prior to each meeting of the IJB or one of its committees, a notice of the meeting specifying the time, place and business to be transacted shall be sent electronically to every member or sent to the usual place of residence of every member, so as to be available to them at least 7 calendar days before the meeting. Email confirmation of the notice of the meeting by the Chair, or a member authorised to act on the Chair's behalf, will discharge the requirement for the notice to be signed by the Chair.

12.2 A failure to serve notice of a meeting on a member in accordance with the paragraph above shall not affect the validity of anything done at the meeting.

12.3 In the case of a meeting of the IJB called by members in accordance with Standing Order 11, email confirmation from those members requisitioning the meeting shall discharge the requirement in Standing Order 12.1 for the notice to be signed by the members who requisitioned the meeting.

12.5 In the event that an item of business has to be considered on an urgent basis, a meeting of the Board may be called at 48 hours' notice by the Chair following consultation with the Vice Chair and Chief Officer. The Urgent Business meeting would retain all the IJB's functions and powers, and these Standing Orders would apply.

[12] Schedule 1(1) of the 2014 Order
[13] Schedule 1(2) of the 2014 Order

12.6 If the office of Chair is vacant or the Chair is unable to act for any reason, the Vice Chair may at any time call an Urgent Business meeting in terms of Standing Order 12.5 following consultation with the Chief Officer.

13. Access to meetings[14]

13.1 Members of the public and representatives of the media shall be admitted to meetings of the IJB to observe the proceedings, unless IJB adopt a resolution to exclude the public and media on grounds that publicity for any item under discussion would be prejudicial to the public interest due to the confidential nature of the business to be transacted or for other reason specified in Appendix B. However, members of the public and representatives of the media shall not be admitted to meetings of the IJB committees.

13.2 Other than the live webcasting or recording of IJB meetings, any video or sound recordings or broadcasting of meetings by any other means, or the taking of any photographs/use of cameras, will be at the Chair's discretion.

13.3 Members of the public may, at the Chair's sole discretion, be permitted to address the IJB for an agreed period but shall not generally be permitted to participate in discussion at a meeting.

13.4 Nothing in these Standing Orders shall preclude the Chair from requiring the removal from a meeting of any person or persons who persistently disrupts the meeting.

14. Remote attendance[15]

14.1 Any member unable to be present at a meeting shall be able to take part remotely in any way which reasonably allows the Members participation. For the avoidance of any doubt, such participation includes voting. A member remotely participating in this way is referred to in this Standing Order as a "Remote Member". A Remote Member is encouraged to activate their video camera (if possible) for the duration of the meeting.

14.2 Where the Chair is participating remotely, the Vice Chair will take the Chair, except in respect of Standing Order 14.7 where the Chair will take the Chair.

a. The Member chairing the meeting must be physically present at the meeting venue, therefore where both the Chair and Vice Chair are participating remotely or have sent apologies, Members present at the meeting venue will appoint a Chair to chair the meeting from amongst their number.

[14] Non statutory, but adopted as good practice

[15] The 2014 Order makes no provision for how meetings are to be held, leaving it up to individual IJB's.

b. In the event that no agreement is reached between those Members present, the decision will be taken by means of a procedural motion.

14.3 Remote Members will be counted for the purposes of determining whether there is a quorum.

14.4 A Remote Member will cast their vote as if participating in a roll call vote.

14.5 Any Remote Member who has declared an interest in an item and withdrawn must leave the meeting. The Clerk will inform/re-invite the Remote Member (whether by email or otherwise) when to resume their participation.

14.6 Any Remote Member must confirm that they are in a secure private location, and that no-one else is able to hear or view the proceedings from the device being used by that Remote Member, before they can participate in the Committee's consideration of any confidential and/or exempt item of business.

14.7 The Chair (whom failing, the Vice Chair) may direct that a meeting shall be conducted solely by means of the participation of Remote Members. Such a direction may be made during a meeting or otherwise.

14.8 The Guidance for attending remote meetings via Microsoft Teams is found in Appendix A below.

15. Business[16]

15.1 The notice of a meeting shall include an agenda of items of business which shall be considered in the order in which they are listed except where the Chair, at his or her discretion, may determine otherwise.

15.2 Acceptance of late items of business is at the Chair's discretion having regard to any special circumstances which requires it to be considered as a matter of emergency.

16. Reports by Officers[17]

16.1 Reports must be produced in draft and sent to the following officers for consultation in accordance with the published timetable prior to being accepted onto the IJB final agenda:-

[16] Schedule 1(2) of the 2014 Order

[17] Non-statutory, but adopted as good practice

a. Chair of the IJB;
b. Vice Chair of the IJB;
c. Chief Officer, ACHSCP;
d. Chief Finance Officer, ACHSCP;
e. Chief Social Work Officer, the Council
f. Chief Executive, the Council;
g. Chief Executive, NHSG;
h. Chief Officer – Finance, the Council;
i. Director of Finance, NHSG;
j. Chief Officer – Governance, the Council
k. IJB Data Protection Officer, NHSG;
l. Nursing and Medical Directors;
m. Public Health Consultant; and
n. Clerk to the IJB.
o. Director of Corporate Services, the Council
p. Director of Families and Communities, the Council
q. Director of City Regeneration and Environment, the Council

16.2 The Council's Leader(s) and Convener of the Finance and Resources Committee shall be consulted on draft reports relating to the IJB Budget in line with the requirements of the IJB Budget Protocol.

16.3 Where the report is for an IJB Committee, with the exception of the Appointments Panel Committee, the draft reports must be sent to the following officers for consultation;

a) the Chair of that Committee
b) Executive Lead for the Committee
c) Chief Officer, ACHSCP
d) Chief Finance Officer, ACHSCP
e) Chief Executive, the Council
f) Chief Executive, NHSG
g) Chief Social Work Officer, the Council
h) Chief Officer- Finance, the Council
i) Director of Finance, NHSG,
j) Chief Officer-Governance, the Council
k) Director of City Regeneration and Environment, the Council
l) IJB Data Protection Officer, NHSG;
m) Nursing and Medical Directors;
n) Public Health Consultant;
o) Clerk to the IJB, the Council

17. Quorum[18]

17.1 No business is to be transacted at a meeting of the IJB, the Clinical and Care Governance Committee and Risk Audit and Performance Committees unless at least one half of the voting members is present. For meetings of the IJB, this shall mean that two voting members of each constituent authority shall be

[18] Schedule 1(3) of the 2014 Order

present and for a meeting of an IJB Committee, one voting member of each constituent authority shall be present.

18. Conduct of Meetings[19]

18.1 At each meeting of the IJB, the Clinical and Care Governance Committee and Risk Audit and Performance Committee, the Chair of the IJB or Committee, if present, shall preside.

18.2 If the Chair is absent from a meeting of the IJB, the Vice Chair shall preside.

18.3 If the Chair and Vice Chair are both absent from a meeting of the IJB, a voting member chosen at the meeting by the other voting members attending the meeting, shall preside at the meeting. For the avoidance of doubt, this shall not be the substitute for the Chair or Vice Chair as is specified in Standing Order 8.3.

18.4 No Vice Chairs shall be appointed to the Clinical and Care Governance Committee and Risk Audit and Performance Committee. In the event that the Chair of either committee is absent, a voting member chosen at the meeting by other voting members attending the meeting shall preside.

18.5 If it is necessary or expedient to do so, the Chair or, whom failing the Vice Chair, may adjourn a meeting of the IJB, or a committee to another date, time or place.

18.6 Following the introduction of an item of business by the Chair, all members shall be entitled to ask questions of the Report Author, through the Chair, and discuss the item as openly as possible.

18.7 When, in the opinion of the Chair, members have had a reasonable opportunity to consider the item of business, the Chair shall move to a determination of the matter.

18.8 Every effort shall be made by members to ensure that as many decisions as possible are made by consensus. Where the IJB or an IJB Committee has been unable to reach a decision by consensus following the procedure in this paragraph, the Chair shall invite the IJB to move to a vote. The process followed at Standing Order 23 shall apply.

18.9 Where a voting member does not agree with, or support the recommendation, and wishes to record their dissent, the Clerk shall record that member's dissent in the minute of the meeting.

18.10 The IJB shall schedule a dedicated budget meeting to consider and agree the IJB budget and adhere to the provisions set out in the IJB Budget Protocol.

18.11 Clerking support to the IJB and its committees shall be provided by the Council.

[19] Schedule 1(4) of the 2014 Order

19. Power and Duties of Chair[20]

19.1 It shall be the duty of the Chair:-

a. To preserve order and ensure that any member wishing to speak is given due opportunity to do so and to a fair hearing;
b. To call members to speak;
c. To decide on all matters of order, competency and relevancy;
d. To ensure that the sense of the meeting is duly determined; and,
e. If requested by any member, to ask the mover of a recommendation or proposal to state its terms.

19.2 The Chair shall have authority to determine all procedural matters during IJB meetings following consultation with the Clerk, excepting the suspension of Standing Orders as outlined in Standing Order 1.6.

19.3 The ruling of the Chair on all matters in these Standing Orders shall be final.

19.4 Deference shall, at all times, be paid to the authority of the Chair. The Chair shall be heard without interruption and all members shall address the Chair when speaking.

20. Declarations of Interest and Transparency Statements[21] -

20.1 Members must adopt the 3- stage approach (Connection – Interest-Participation) set out in section 5 of the (Declarations of Interests) of the IJB Code of Conduct.

20.2 A member will declare their interest as early as possible in meetings. Where they have declared an interest, they must withdraw from the meeting room (including from any public gallery). They must not participate in any way in those parts of meetings where they have declared an interest. If the meeting is being held online, or the member is participating remotely, the member must retire to a separate breakout room or leave and re-join after the discussion on the matter has concluded. It is not sufficient for them to turn off their camera and/or microphone for the duration of the matter.

20.3 When making a declaration, a member should provide enough information for those at the meeting to understand why they are making a declaration.

20.4 Members should consider whether it is appropriate for transparency reasons for them to state publicly in the meeting where they have a connection, which

[20] Common law powers of a Chairperson

[21] This is derived from the IJB Code of Conduct, which is required by the Ethical Standards in Public Life etc. (Scotland) Act 2000.

they do not consider amounts to an interest. Such a statement is referred to in these Standing Orders as a "Transparency Statement".

21. Minutes[22]

21.1 A record must be kept of the names of the members attending every meeting of the IJB or of one of its committees.

21.2 Minutes of the proceedings of each meeting of the IJB, the Clinical Care and Governance and Risk Audit and Performance Committees, including any decision made at that meeting, are to be drawn up and submitted to the subsequent meeting of the IJB or the committee for agreement after which they must be agreed by the IJB as an accurate record of the meeting.

21.3 Draft Minutes from the Clinical Care and Governance and Risk Audit and Performance Committees will be presented to the IJB for noting.

22. Alteration or Revocation of Previous Decision[23]

22.1 No decision of the IJB shall be altered or revoked within six months of it having been taken unless a report recommendation to that effect is approved by the IJB.

23. Voting[24]

23.1 In the event that the IJB has been unable to reach a decision after following the procedure outlined in Standing Order 18, and a vote is required, the provisions of this Standing Order shall apply.

23.2 Any member may make a proposal for agreement by the IJB. The proposal must relevant to the business on the agenda. A proposal can be raised at the meeting for consideration and discussion by the IJB.

23.3 Where a member wishes to formally make recommendation or proposals, relating to an item of business on the agenda, it must differ substantially from the recommendation. Such a proposal must be submitted to the Clerk by 10

[22] Schedule 1(5) of the Order

[23] This is non-statutory, but adopted to ensure stability of IJB decision making.

[24] Article 11 of the 2014 Order requires that votes be by majority of voting members present

am on the second working day[25] prior to the meeting of the IJB, and thereafter moved at the meeting.

23.4 The recommendation or proposal shall be circulated to members by the Clerk once finalised and determined to be competent or, as soon as is reasonably practicable thereafter.

23.5 Such a proposal requires to be seconded by a voting member, who may reserve his/her speech for a later period of the debate.

23.6 A recommendation or proposal that was not submitted timeously in terms of Standing Order 23.3 above can only be accepted onto the agenda at the discretion of the Chair.

23.7 A proposal, after being seconded, shall not be amended or withdrawn without the agreement of the IJB.

23.8 Each recommendation or proposal put to a meeting of the IJB shall be decided by a majority of the votes of those members attending and entitled to vote. For the avoidance of doubt, each such recommendation or proposal may be approved in whole or in part and proposals to that effect may be made at any time.

23.9 The Chair will have the prior right to the recommendation in the report, except where the Chair waives that right.

23.10 A recommendation and any proposals, shall be moved and seconded. Movers shall be entitled to speak for ten minutes and all other members, including movers when summing up at the conclusion of debate, shall be entitled to speak for five minutes. No member shall speak in support of a recommendation or proposal until it has been seconded. A member shall not be entitled to speak more than once in debate, except the mover when summing up. A member shall be entitled, however, to ask questions of an officer on the recommendation or any proposals put forward, and members are permitted to ask questions of other members where it relates to business on the agenda.

23.11 All recommendations and proposals must relate to the item of business on the agenda and all proposals must differ from the recommendation substantially.

23.12 The Chair shall determine whether a recommendation or a proposal is competent and relevant and may seek advice from officers in this regard.

23.13 A recommendation or proposal is incompetent it if would require the incurring of expenditure and the source of the funding is not identified.

23.14 A recommendation or proposal moved, but not seconded, or which is ruled incompetent by the Chair, will not be put to the vote but will be recorded in the minute.

[25] For example, a proposal must be submitted to the Clerk by 10 am the preceding Friday, in the case of a meeting of the IJB on a Tuesday.

23.15 If a recommendation or a proposal is withdrawn, the mover or seconder can move or second, and speak in support of, a further recommendation or proposal.

23.16 A member can make minor alterations to their recommendation or proposal, once seconded or with consent of the Chair.

23.17 Votes shall be taken by roll call except where an electronic voting system is available, in which case it shall be used in preference to any other method.

23.18 Where there is an equality of votes, there shall be no casting vote afforded to the Chair or to any other member or group of members and in that event:-

Stage 1

(i) The Chair shall call on the Chief Officer to outline the consequences of each potential outcome, to provide such clarification as may be appropriate or requested and to set out the ramifications to the IJB of withdrawing the matter and maintaining the status quo and, thereafter, to make a recommendation.

(ii) The Chair shall then immediately without further discussion call for a vote on the recommendation that is before the meeting.

(iii) If there is still an equality of votes, the Chair may:

a. call a recess of the meeting for such period as the Chair thinks fit to allow members to further consider matters and, once the meeting is reconvened, return to step (ii) above; or,

b. defer the matter to the next meeting of the IJB; and/ or

c. instruct the Chief Officer to review the matter with the aims of addressing any concerns raised by the IJB and developing a proposal which the IJB can reach a decision on and bringing that proposal to a meeting of the IJB.

Stage 2

(iv) At the next meeting of the IJB, after consideration of either a further report or an outline from the Chief Officer of the consequences of the issue being considered, the Chair shall call for a vote. Where there remains an equality of votes, the Chair shall;

a) invite members to speak in support of and against the recommendation and call a further vote.

(v) If there remains an equality of votes, the Chair shall;

a) defer the matter to another meeting of the IJB;

b) invite members to agree to reject the recommendation and agree that the status quo be maintained; or

c) in the event of a decision having to be made due to a legal or regulatory requirement, a decision will be made by the casting of lots, the method of which shall be determined by the Clerk.

24. Expenses[26]

24.1 The IJB may pay the reasonable travel and other expenses of representatives in accordance with the policy at Appendix C[27].

25. Committees[28]

25.1 The IJB has established three committees for the undertaking of its functions. These are;

- The Clinical and Care Governance Committee
- The Risk Audit and Performance Committee, and
- The Appointments Panel Committee.

25.2 The IJB must appoint the Chairs of the Clinical and Care Governance Committee and the Risk Audit and Performance Committee for an appointing period not exceeding three years.

25.3 The IJB may change the persons appointed as Chairs of the Clinical and Care Governance Committee and the Risk Audit and Performance Committee during the appointing period for the remainder of that period.

25.4 The IJB Chair/Vice Chair shall not chair the Clinical and Care Governance or the Risk Audit and Performance Committee.

25.5 The IJB shall appoint two voting members from each constituent authority to serve on the Clinical and Care Governance Committee and two voting members from each constituent authority to serve on the Risk Audit and Performance Committee to ensure equal representation.

25.6 Any decision of the Clinical and Care Governance Committee or the Risk Audit and Performance Committee must be agreed by a majority of the votes cast by the voting members of that committee.

25.7 The Clinical and Care Governance Committee and the Risk Audit and Performance Committee shall each meet four times each financial year. The Appointments Panel Committee shall meet as and when there is business to determine. The Chair may, at any time, convene additional meetings of the Committees.

[26] Article 16 of the 2014 Order

[27] Approved by the IJB on 11 August 2020

[28] Article 17 of the 2014 Order. Precise procedure is left up to each IJB.

25.8 The IJB will review and alter the Terms of Reference of any of its committees annually, as part of its annual review of the Scheme of Governance. Before the annual review date of the Scheme of Governance, the IJB may alter the Terms of Reference at any time where it considers it necessary to do so.

25.9 All IJB members shall be entitled to receive papers for the Clinical and Care Governance Committee and Risk Audit and Performance Committee and an open invitation shall be extended to members to attend those Committee meetings.

25.10 The level of participation for non-committee members in these proceedings be at the discretion of the committee Chair, though non-committee members may not propose or second a recommendation or proposal, or vote.

25.11 Committee meetings shall be conducted in accordance with these Standing Orders.

25.12 The Clinical and Care Governance Committee and Risk, Audit and Performance Committee will formally provide a copy of its minutes to the IJB for inclusion on the agenda of subsequent meeting.

25.13 Following agreement from a majority of members, a committee may refer or an item of business to the next IJB meeting for consideration. The Clerk of the committee shall make the necessary arrangements.

26. General Powers of IJB[29]

26.1 The IJB may enter into a contract with any other person for the provision of goods and services for the purpose of undertaking the functions conferred on it by the Act, including but not limited to administrative support, accounting or legal services.

27. Register of Interests and Code of Conduct[30]

27.1 The IJB Standards Officer shall keep and maintain a Register of Interests, which shall be published on the Internet, in which all members shall record their interests and hospitality offered by virtue of their membership of the IJB. The Standards Officer shall be the officer so designated by the Standards Commission, following a nomination by the IJB. All members are required to complete a register of interests in a standard format to comply with their obligations under the IJB Code of Conduct, within a month of appointment and when any changes occur. A form to register interests will be sent to all members

[29] Article 19 of the 2014 Order

[30] This is derived from the IJB Code of Conduct, which is required by the Ethical Standards in Public Life etc. (Scotland) Act 2000.

on appointment and members must submit an updated form when there are any changes.

27.2 All members shall be bound by the terms of the Code of Conduct for members of Aberdeen City Integrated Joint Board, provided for under the Ethical Standards in Public Life etc. (Scotland) Act 2000.

28. Deputations[31]

28.1 The competency of a deputation (in respect of Standing Orders 28.6 a. - d.)) will be determined by the Chair. If the Chair deems a deputation to be incompetent it will not be heard at the meeting.

28.2 Every request for a deputation must be in writing and submitted to the Clerk of the IJB at least two working days before the meeting to which it relates.

a. For example, for a meeting on a Tuesday, requests must be received by the end of the previous Thursday.

28.3 In the event that a report has not been published to enable a deputation request to comply with the deadline set out in Standing Order 12, deputation requests may still be submitted and put on to the agenda. In such instances, Standing Order 12 would require to be suspended at the meeting for the deputation to be heard.

28.4 The request must state the report on the agenda which the deputation wants to be heard and the action (if any) the deputation would like the IJB to take in relation to the report.

28.5 A competent deputation request will be placed on the agenda for the relevant meeting of the IJB.

28.6 The following deputation requests are not competent:

a. Deputations which fail to comply with Standing Order 28.2;
b. Deputations which relate to reports containing confidential information;
c. Deputations which relate to the annual budget; and
d. Deputations which do not relate to a report on an agenda.

28.7 Deputations cannot consist of more than three people.

28.8 The Chair shall determine the duration of a deputation..

28.9 No individual may form part of more than one deputation on the same matter.

28.10 Following the conclusion of the deputation, IJB members will be given the opportunity to ask questions of the deputation for a maximum of ten minutes.

[31] Non - statutory

Appendix A –Remote Attendance Guidance

This short guide is intended to assist you to participate in a remote meeting and is not a replacement for fuller Teams instruction provided by your constituent authorities.

You will have received an invitation from the Clerk in either Outlook (email) or Teams to participate in a Teams Meeting. You can join the meeting via your laptop/tablet or from a standard telephone.

In advance of the meeting

Members should:-

- Ensure that they have downloaded the agenda papers and saved these on their desktop for easy access.
- Inform the Clerk if they are unable to attend or may be late.
- Inform the Clerk if they have any query, or potential amendment to the minute to allow this to be considered and investigated in advance. (This should then be raised in the normal manner during the meeting).

On the day of the meeting

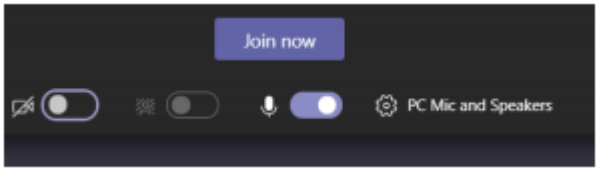
Members should:-

- Ensure they are located as close to their broadband router as possible or connect their computer direct to the router by cable.
- Join the Teams meeting 5 minutes before the start time.
- Ensure that their microphone remains at mute unless they have been invited to speak by the Chair.
- Activate their video camera (if possible).
- Ensure that any personal items on display in the background cannot be picked up on video camera.

Access the meeting remotely

Laptop/Tablet Device

Open your agenda for the meeting. Then open your invitation within Outlook email or Teams. Select *'Join Now'* and you have remotely joined the meeting.



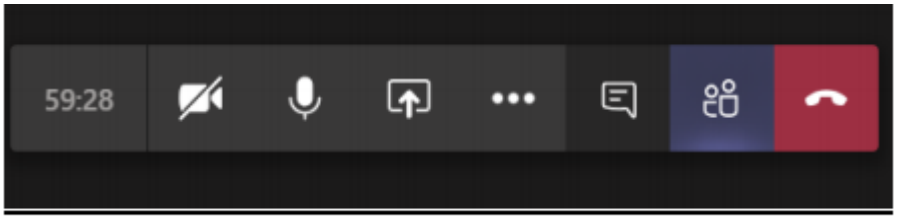
Telephone - Joining a Meeting

Call the telephone number in the Outlook appointment which has been sent to you and use the conference code provided in that invitation as set out below. You will be guided by the voice message.

Join Microsoft Teams Meeting
+44 20 3443 9692 United Kingdom, London (Toll)
Conference ID: *******#

Joined the Meeting

If you have joined the meeting via Teams you will then see the *Options Bar* as per the image below (shows 8 options) – this should appear at the centre of the Teams screen. Thereafter you will see the *Options Bar*



From the right

- Hang Up / Terminate – Participants can terminate the call via the red handset which allows them to leave the meeting and re-join if they select the "join" button from the invitation.
- Show Participants (2nd from right) – Displays a list of all remote participant.
- Show Conversation (3rd from right) – This allows you to 'chat' with all other participants in the meeting. NB - this is NOT Private Chat but Meeting Chat. Private chat remains available via the Chat icon on the top left of the side.
- Ellipsis (more options) button (4th from right) provides a further 8 options as advised.
- Share (5th from right) provides sharing options.
- Microphone (6th from right), you can mute/unmute the microphone.
- Camera (7th from right), you can select camera on/ off.
- Timer (furthest left) shows the duration of the meeting.

How to participate

You should use the 'hands' facility or Teams Chat facility (3rd from right on the options bar) to alert the Chair if you wish to participate. The Clerk will alert the Chair and the Chair will call your name.

Viewing Agenda whilst in Remote Meeting

You should already have your agenda open and can access this from Teams via the toolbar at the bottom of your screen. This will allow you to switch between Teams and your agenda.

Declaring an Interest

If you have declared an interest in a report and intend to leave the meeting during discussion at the appropriate time, you should hang up (using the telephone symbol on the Options Bar) in order to remove yourself from the meeting and the Clerk will reinvite you when that business is concluded.

You should NOT re-join the meeting until you receive an invitation from the Clerk. This invitation will pop up on your screen, and you should select 'video call' from the two options given.

Appendix B- Exempt and Confidential Information

In accordance with Standing Order 13, the IJB may pass a resolution to meet in private in order to consider certain items of business, and may decide to do so for the following reasons;

a) The IJB is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation.
b) The business relates to the commercial interests, contractual terms (whether proposed or to be proposed), financial or business affairs of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
c) The business necessarily involves reference to personal information and requires to be discussed in private in order to uphold the Data Protection Principles.
d) The business relates to a particular office holder, or member of the IJB.
e) The business relates to any particular applicant or recipient or former recipient of any financial assistance provided by the IJB.
f) The business relates to legal advice given or received or information obtained or action to be taken (whether or not in connection with any proceedings).

Appendix C – IJB Carers and Service User Representatives Expenses Policy

Why does this expenses policy exist?

This policy ensures that any unpaid carer or other representatives who are members of the IJB and associated groups or committees **are not out of pocket** as a result of carrying out their duties (as defined in the Public Bodies (Joint Working) (Scotland) Act 2014).

Who is the expenses policy for?

This policy is for unpaid carer and service users representatives who are appointed as a member of the Aberdeen City Health and Social Care Partnership (ACHSCP) Integration Joint Board (IJB) as per the Standing Orders 2.3 c) and d) and any associated groups or committees.

When does this expenses policy apply?

This expenses policy applies to enable unpaid carer and service user representatives to undertake the work required in their capacity as IJB members. This includes preparatory work for, and attendance at:

- IJB meetings (including Development Sessions and Seminars)
- Strategic Planning Groups
- Locality Groups
- Other associated groups or committees
- IJB related duties and events (e.g. meeting a community group to explain the Strategic Commissioning Plan)

What are the principles of the policy?

Recognising diversity and minimising barriers to full participation

We recognise there is a diversity of needs and will work with each carer and service user representative individually to provide any reasonable adjustments/extra support they may require to fully participate in the IJB.

Good stewardship and management of public funds

We promote consideration of cost effectiveness, value for money, and respect for the environment. It may be more cost effective for travel and accommodation to be booked through the IJB as opposed to booking this personally and being reimbursed. The cost of the use of eBikes would fall within the scope of this policy. We encourage IJB members to be paper free as far as possible, but will support the cost of printing when required. Where possible, dated, official receipts will be required for any reimbursement in line with Aberdeen City Council (ACC)Travel and Subsistence Allowance Guidance (see Appendix A).

Collaboration and continuous improvement

Our IJB Carers and Service Users have a nominated point of contact within ACHSCP who is the main link in relation to this policy. Regular meetings take place and a Standing Agenda item at these will be a review of expenses claims, how the process is working, and what improvements could be fed into the annual review of the policy. It is a shared responsibility between the representatives and the nominated point of contact to enable the smooth implementation of this policy allowing the representatives to fulfil their role whilst not being out of pocket.

What expenses are included in this policy?

The following are examples of costs which can be reimbursed under this policy. The list is not exhaustive and the overarching aim of the policy i.e. that representatives should not be out of pocket, has primacy.

- **Travel costs**
  - public transport (excludes first class travel)
  - mileage (45p/mile)
  - parking
  - taxi costs - where public transport arrangements are not suitable
  - ferries and other forms of transport as required in island communities

- **Subsistence (where no meals or refreshments are provided)**
  - Reimbursement of reasonable lunch expenses as per current Local Council guidelines
  - Reimbursement of reasonable dinner expenses as per current Local Council guidelines
  - Overnight accommodation and reimbursement of reasonable expenses for overnight stays, if and when required, as per current Local Council guidelines

See Appendix A for current Local Council guidelines and rates.

- **Preparatory work and administration to carry out duties**
  - Printing and paper costs.
  - IT / communication costs (e.g. phone / iPad / laptop) although a Council owned laptop will normally be loaned for the period of tenure NB: there will be a requirement to agree to abide by the relevant policies in relation to use of IT equipment, data protection etc.

- **Replacement care / care cover**
  - for attendance at IJB meetings
  - for attendance at other meetings/events relating to role
  - for travel times to meetings

- for preparation time

- **Loss of income to attend meetings**
  - Where appropriate, loss of earnings income to attend IJB meetings will be considered (to be discussed and agreed in advance – NIHR Guidelines for public involvement in health and social care research could help inform these discussions).
  - Any potential impact on social security benefits to be considered and discussed.

What is the process for claiming expenses?

- Smaller items of expenditure (e.g. mileage within Aberdeen, parking and administrative expenses for local meetings) will be reimbursed on receipt of a correctly completed claim form and appropriate, dated receipts. Replacement care, reimbursement of lost income, and travel and subsistence for meetings out with Aberdeen, must be agreed in advance with the IJB's Chief Finance Officer.
- The nominated point of contact is the Senior Project Manager (Strategy), who will support communication with the representatives and will assist with completion and submission of expenses claims.
- A copy of the Travel and subsistence claim form is attached at Appendix B and representatives will be provided with a template for their own use.
- In line with ACC policy, claims should be made within 3 months of the date the expense was incurred however claims received out with this timescale will still be processed but must be accompanied by a note of explanation from the Chief Finance Officer.
- Claim Forms should be completed nd submitted via the nominated point of contact along with relevant receipts and/or confirmation of approval by Chief Finance officer if appropriate.
- All expenses will be paid within 30 days of the receipt of a properly completed, valid, expenses claim form, however, to ensure equity of involvement and engagement, if required, immediate payments may be made.
- Payments will be made via BACS transfer where possible. Bank details will require to be provided to enable payment. Representative will be set up on the BACS system in advance of claims being made. Where BACS payment is unsuitable alternative payment arrangements (such as cheque/cash) can be arranged.

Reviewing this policy

This policy will be reviewed annually with relevant stakeholders and by the Integration joint Board as part of its Scheme of Governance review. The Appendices will be updated appropriately in line with any changes made by ACC. Any proposed changes to this policy will be discussed with those covered by the policy before implementation.

Appendix A

Aberdeen City Council Travel and Subsistence Allowance (June 2023)

Car and Motor Cycle Allowances

Essential Users

You are an Essential Car User if you are in a post whose duties are of such a nature that it is essential for you to have a car at your disposal whenever required.

Where a post is designated as requiring an Essential Car User Allowance the following annual allowance will be paid, Business Mileage is based on the previous financial year.

Actual Annual Business Mileage	Annual ECU Allowance
Under 1200 miles	£120
1200 – 5000 miles	£250
5001 – 7,500 miles	£500
Over 7,501 miles	£800

A lump sum is payable in 12 monthly instalments to all essential users.

In addition, a payment in respect of miles run on official business, within the City, is made as undernoted:

Essential mileage

0 – 10,000 miles	0.45p
Over 10,000 miles	0.25p

Those carrying a fellow employee as a passenger will receive an additional 5 pence per passenger per mile.

Casual Users

You are a Casual User if you are in a post for where it is merely desirable that a car should be available when required. No lump sum is payable, but a payment in respect of miles run on official business in any financial year within the City of Aberdeen is made as undernoted:

Casual mileage rate

0 – 10,000 miles	0.45p
Over 10,000 miles	0.25p

In addition those carrying a fellow employee as a passenger will receive an additional 5 pence per passenger per mile.

Motor Cycle Allowances

Officers using a motor cycle are entitled to the following rates:

0 – 10,000 miles	0.24p
Over 10,000 Miles	0.24p

Push Bike Allowances

The current rate is 20p per mile in respect of miles run on official business.

Travel Outwith the City of Aberdeen

All mileage will be reimbursed at casual/ essential rates of 45p per mile with passenger allowance if applicable.

Workplace Change Allowance

Mileage paid at the Essential/ Casual Allowances Rate up to a maximum value of a First Bus monthly pass.

Bus Passes/ Fares are reimbursed on receipted expenditure up to a maximum of a First Bus monthly pass.

Subsistence Allowances

Subsistence allowances will be payable to officers who are prevented by their official duties from taking a meal at their home, administrative centre or establishment where they normally take their meals, and thereby incur additional expenditure. The allowance shall not be paid where a suitable meal is provided or the officer has been previously reimbursed.

The maximum allowances are as follows:

- Breakfast: £8.00
- Lunch: £12.00
- Evening Meal: £25.00

Services should request receipts to verify that expenditure has been incurred.

ABERDEEN CITY COUNCIL TRAVEL AND SUBSISTENCE CLAIM MONTH 20

ALL RELEVANT DETAILS MUST BE COMPLETED: INCOMPLETE FORMS WILL BE RETURNED.

Name …….. Payroll No. (7 digit per payslip) …….. Job Title……..

Service ……..

Normal Place of Work……

GUIDANCE NOTES AVAILABLE ON PeopleAnytime

Once completed and approved this form should please be sent to: BusinessSupportTeam4@aberdeencity.gov.uk

Registration Number…… Car exact cc……

User Type: Essential /Casual /Motor Bike /Bicycle (delete as appropriate)

Date	Details of each journey with locations, purpose and where passenger miles are claimed, include the passenger name(s) (the form will be returned if passenger name(s) are not completed).	Participant in ACC Tusker Leased Car Scheme (Y/N)	Mileage	Passenger Miles	Workplace Change Allowance / ACC Leased Car Mileage		Hours of Absence (only complete if subs. claimed)		Other Expenses/ Subsistence		Cost Centre
					Mileage	Bus Fares	From	To	£	p	
	The total column must be completed:										

Declaration by Claimant

I declare that all claims entered by me on this form, including mileage, result from expenses actually and necessarily incurred by me in the course of my duties and that any subsistence payments claimed in consequence of such expenses do not exceed the allowances approved by the City Council. **I declare that the above vehicle is roadworthy and is insured for business purposes.**

Signature……
Date……

(AUTHORISER TO BE COMPLETED IN BLOCK LETTERS)

Signature…… Date……

Authoriser……

Job title……

Who is the expenses policy for?
This policy is for unpaid carer representatives who are appointed as a member of the Aberdeen City Health and Social Care Partnership Integration Joint Board (IJB) as per the Standing Orders 3b), c) and d) and any associated groups or committees. It can also be used for other unpaid representatives on IJBs, such as service users.

Why does this expenses policy exist?
This policy ensures that any unpaid carer or other representatives who are members of the IJB and associated groups or committees are not out of pocket as a result of carrying out their duties (as defined in the Public Bodies (Joint Working) (Scotland) Act 2014).

When does this expenses policy apply?
This expenses policy applies to enable unpaid carer and other representatives to undertake the work required in their capacity as IJB members. This includes preparatory work for, and attendance at:

- IJB meetings (including Workshop and Development Sessions)
- Strategic Planning Groups
- Locality Groups
- Other associated groups or committees
- IJB related duties and events (e.g. meeting a community group to explain the Strategic Commissioning Plan)

What expenses are included in this policy?

The following are included but prior approval must be sought before any expense is incurred

- **Travel costs**
  - public transport (excludes first class travel - receipts to be provided)
  - mileage (45p/mile)
  - parking (receipts to be provided)
  - taxi costs - where public transport arrangements are not suitable (receipts to be provided)
- **Subsistence (where no meals or refreshments are provided)**
  - Reimbursement of reasonable lunch expenses as per current Local Council guidelines (receipts to be provided)
  - Reimbursement of reasonable dinner expenses as per current Local Council guidelines (receipts to be provided)
  - Overnight accommodation and reimbursement of reasonable expenses for overnight stays, if and when required, as per current

Local Council guidelines (receipts to be provided)

- **Preparatory work and administration to carry out duties**
  - IT / communication costs (e.g. phone / iPad / laptop) although a Council owned laptop will normally be loaned for the period of tenure NB: there will be a requirement to agree to abide by the relevant policies in relation to use of IT equipment, data protection etc.

- **Replacement care / care cover**
  - for attendance at IJB meetings
  - for attendance at other meetings/events relating to role
  - for travel times to meetings
  - for preparation time (if and when required – to be discussed and agreed in advance)

- **Loss of income to attend meetings**
  - Where appropriate, loss of earnings income to attend IJB meetings will be considered (to be discussed and agreed in advance – NIHR Guidelines for public involvement in health and social care research could help inform these discussions).
  - Any potential impact on social security benefits to be considered and discussed.

  Example: one HSCP has allocated resources to their local carers centre to enable carers to support other carers around strategic planning. This allows carers to be recompensed on a sessional basis to support engagement.

What is the process for claiming expenses?

- A named contact person will be identified to support communication, completion and agreement of all expenses claims.
- Expenses forms will be provided in electronic or paper format before or at each meeting / event to claim travel and subsistence expenses (receipts to be provided).
- For preparatory and administrative costs, reimbursement of costs as spent.
- For replacement care and loss of income reimbursement, discussion and agreement with named contact person in advance.
- All expenses will be paid in accordance with normal expenses processing deadlines following receipt of a properly completed expenses claim form. However, to ensure equity of involvement and engagement, if required immediate payments may be made. A payment schedule with dates of reimbursement will be provided.
- Payments will be made via BACS transfer where possible. Bank details will require to be provided to enable payment. Where BACS payment is unsuitable alternative payment arrangements (such as cheque/cash) can only be agreed by the Chief Finance Officer.

Reviewing this policy

This policy will be reviewed annually with the relevant recipients. Any proposed changes to this policy will be discussed with those covered by the policy before implementation.

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Aberdeen City Health & Social Care Partnership
A caring partnership

Aberdeen City Integration Joint Board

Roles and Responsibilities

Date Created:	November 2022	
Version:	V 2.0	
Location:	Governance	
Author (s) of Document:	Jessica Anderson, ACC Legal Services	
Approval Authority	IJB	
Scheduled Review:	April 2026	
Effective Date:	2 July 2025	
Changes:	March 2023 July 2024 July 2025	

Title	Roles and Responsibilities of Aberdeen City Integration Joint Board		
Date	July 2025	**Version**	4

1 INTRODUCTION

1.1 The Roles and Responsibilities of the Aberdeen City Integration Joint Board (hereinafter referred to as the "Protocol") was approved by Aberdeen City Integration Joint Board (hereinafter referred to as the "IJB") on 27 March 2018. Its purpose is to explain the remit of the statutory officers within the IJB, namely, the Chief Officer and the Chief Finance Officer and other key personnel within the Aberdeen City Health and Social Care Partnership (ACHSCP).

2 OPERATIONAL PROTOCOL

2.1 Chief Officer

2.1.1 Aberdeen City Council and NHS Grampian (hereinafter referred to as "the Partners") have delegated functions to the IJB under the Integration Scheme. The IJB is responsible for setting strategic direction and setting appropriate policies. Applying the delegated authority provided to them by the Partners, the Chief Officer is responsible for implementing approved strategy and policy and for the operational management of the workforce. The IJB is required by law to appoint a Chief Officer[1]. The Chief Officer is responsible for ensuring compliance with all relevant statutory provisions in respect of the delegated functions; shall direct and ensure that coordinated and appropriate arrangements are in place to discharge the requirements and duties of the IJB as a Category 1 Responder under the Civil Contingencies Act 2004 and other relevant legislation; and shall comply with the roles and responsibilities of the Chief Officer as detailed in the IJB's Financial Regulations. The Chief Officer is responsible for making arrangements for an Interim Chief Finance Officer should they consider it necessary to do so.

2.2 Chief Finance Officer

2.2.1 The Chief Finance Officer has overall responsibility for Finance including Audit and Financial Management. The IJB is required to appoint the Chief Finance Officer[2] who shall discharge their duties (as set out in the job description applying at the time) in accordance with the powers as delegated to them by the Partners under their respective approved Schemes of Delegation. In discharging their duties and in making any recommendation to the IJB, the Chief Finance Officer will account for the policies and procedures of the Partners as appropriate.

[1] Section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014

[2] Under section 3 of the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014/285

2.2.2 The Chief Finance Officer shall:-

a) act as the Proper Officer responsible for the administration of the financial affairs of the IJB in terms of section 95 of the Local Government (Scotland) Act 1973;

b) adhere to IJB and the Partners Financial Regulations and relevant Codes of Practice of the Board for the control of all expenditure and income;

c) comply with the roles and responsibilities of the Chief Finance Officer as detailed in the IJB's Financial Regulations;

d) monitor the IJB's revenue budget during the course of each financial year and report thereon to the IJB;

e) determine all accounting procedures and financial record keeping of the IJB, to ensure the IJB is fully compliant with the CIPFA Statement of Recommended Practice;

f) have financial oversight of any procurement for the engagement of consultants, external advisors for specialist advice entered into directly by the IJB (but not procurement carried out on behalf of the IJB);

g) be the primary point of contact with both internal and external audit and provide information as appropriate; and

h) develop the IJB's Medium Term Financial Framework.

2.3 Medical Lead

2.3.1 The Medical Lead shall be the Clinical Lead of the IJB and the Clinical and Care Governance Committee and a member of the Senior Leadership Team within ACHSCP. The roles and responsibilities of the Medical Director may be shared between more than one person.

2.3.2 The Medical Lead will be expected to provide leadership, advice, and support to:

a) the ACHSCP Senior Leadership Team;
b) staff working within ACHSCP services, and particularly medical practitioners and those working across primary and community care and within services hosted by or on behalf of the ACHSCP; NHS Grampian Medical Director and Medical Directorate colleagues and clinicians; in relation to clinical and care safety;

c) GPs and other NHS external contractors working within Aberdeen City and in partnership with those across all 3 Grampian Health and Social Care Partnerships as required; and
d) the IJB as a formal advisor to the IJB on clinical and care matters.

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ABERDEEN CITY INTEGTRATION JOINT BOARD (IJB)

Title	Appointments Panel Committee Terms of Reference		
Lead	Chief Officer		
Date	1st July 2025	**Version**	1.0

Quorum
Two Voting members, one from each constituent authority

Composition of the Committee

The Committee shall comprise;

The Chair of the IJB
Vice Chair of the IJB
Chair of Clinical Care and Governance Committee**
Chair of Risk Audit and Performance Committee**

Advisers to the Committee;

Chief Officer of the IJB*
Chief Executives of Aberdeen City Council and NHS Grampian**
HR advisers from Aberdeen City Council and NHS Grampian
Chief Finance Officer, Aberdeen City Council or NHS Grampian*

**for the recruitment of the Chief Finance Officer*
***for the recruitment of the Chief Officer*

In the absence of the Chair or Vice Chair of the IJB, a voting member of the IJB from the relevant constituent body, shall substitute for the Chair or Vice Chair of the IJB at the Appointments Panel Committee.

A HR Adviser shall act as Chair of the Committee.

Matters reserved to the Committee

The Appointments Panel Committee shall;

1) Approve the job profile of the Chief Officer and/ or Chief Finance Officer
2) Approve the selection process for any recruitment;
3) Agree the timeline for the recruitment and selection process;
4) Consider the outcomes of any assessment centre process;
5) Participate in and undertake, final selection interviews of candidates;
6) Agree the appointments of the Chief Officer and/or Chief Finance Officer, on behalf of the IJB; and
7) Be consulted on any interim appointments.

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Document	Page	Proposed Change	Rationale
Standing Orders	4	Additional wording	Addition of key to denote what Standing Orders are statutory or not.
	14 (Standing Order 16)	Updating and amending wording to reflect removal of Chief Operating Officer and other posts	Minor updating to remove references to Chief Operating Officer and ensuring designations are accurate Removal of requirement to notify Clerk in advance. Accepted that meetings are hybrid.
	16 (Standing Order 17)	Insertion of additional wording	To reflect the fact that the Standing Orders are applicable to CGG and RAP Committees.
	16 (Standing Order 18.4)	Insertion of additional wording	To reflect the fact that the Standing Orders are applicable to CGG and RAP Committees
	17 (Standing Order 18.9)	Insertion of additional wording	To include formal recognition of dissention from a decision
	14 (Standing Orders 6.1 and 16.3)	Insertion of Directors at the Council who have been added to the circulation list for receiving draft reports for the IJB and IJB Committees	To reflect that the Council's Director of Corporate Services, Director of Children, Families and Communities and Director of City Regeneration and Environment have all been added to the circulation list of reports for the IJB and IJB Committees.
	17 (Standing Order 19.1)	Deletion of "motion" and "amendment" and addition of "proposal"	To support collaboration, encourage challenge and improve the discursive culture at IJB meetings by referring to recommendations (reports tabled at meetings) and proposals for agreement from any IJB member which differ to that recommendation.
	18 (Standing Order 21)	Amended wording	Clarifying which committees the Standing Order relates to
	19 (Standing Order 23.2), 23.3, 23.4, 23.5, 23.6, 23.7, 23.8,	Amended wording	Additional wording to include a timescale for alternative recommendations and

	23.9, 23.10, 23.11, 23.12, 23.13, 23.14,		proposals to be submitted by. This allows officers reasonable time to consider the proposals made and make a determination on competency and relevancy. For openness, circulation of proposals to all members as soon as practicable after competency determined to allow all members time to consider it. Revised wording around process for equality of votes, trying to make the process simpler to follow.
22	25	Amended wording	Clarity around which SO's relate to which committee, having regard to the establishment of the Appointment Panel Committee.
Roles and Responsibilities	1 & 2	Amended wording	Minor changes from 'Integrated Joint Board' to 'Integration Joint Board' Amended wording to include duties in Job description of CFO also relevant.
	4 (Chief Operating Officer)	Removal of wording	To reflect that the post is no longer established.

ACHSCP Impact Assessment – Stage 1 – Proportionality and Relevance

Name of Policy or Practice being developed	IJB Scheme of Governance
Name of Officer completing Proportionality and Relevance Questionnaire	Jess Anderson
Date of Completion	06/06/25
What is the aim to be achieved by the policy or practice and is it legitimate?	The Scheme of Governance sets out the mechanisms by which the IJB makes decisions, conducts its meetings and its remit and that of its committees.
What are the means to be used to achieve the aim and are they appropriate and necessary?	It is a legal requirement that the IJB has standing orders governing its decision making. Further, the suite of documents within the Scheme of Governance demonstrate openness and transparency of the roles and responsibilities of the IJB and its members. As such, it is necessary to have Standing |Orders and proportionate to ensure that the remaining suite of documents which form the Scheme are available to the public and are transparent.
If the policy or practice has a neutral or positive impact please describe it here.	The Scheme has a is positive to neutral impact because the Scheme of Governance by ensuring that decisions taken at IJB (the business) are taken in accordance with the law. Also, the Standing Orders provide that meetings of the IJB are open to the public and these are available to access via Aberdeen City Council's website or in person at the venue of the IJB meeting.
Is an Integrated Impact Assessment required for this policy or decision (Yes/No)	No

Rationale for Decision **NB: consider: -** • **How many people is the proposal likely to affect?** • **Have any obvious negative impacts been identified?** • **How significant are these impacts?** • **Do they relate to an area where there are known inequalities?** • **Why are a person's rights being restricted?** • **What is the problem being addressed and will the restriction lead to a reduction in the problem?** • **Does the restriction involve a blanket policy, or does it allow for different cases to be treated differently?** • **Are there existing safeguards that mitigate the restriction?**	The Scheme applies to the IJB and its committees. It is there to ensure that the meetings of the IJB are conducted in a manner that is compliant with the law. The Scheme itself does not impact individuals necessarily, rather the decisions coming from the IJB may do- particularly if they relate to policy or strategic plans. There's very much an indirect impact in that correct and appropriate decision making means that the IJB is complying with the duties it is bound by, such as the Equality Duty, Fairer Scotland Duty, when reports are being consulted on and thereafter decided upon.
Decision of Reviewer	Agreed that no IIA is required for this paper for the reasons provided above.
Name of Reviewer	John Forsyth
Date	18 June 2025

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	1 July 2025
Report Title	Medium Term Financial Forecast
Report Number	HSCP.25.053
Lead Officer	Chief Officer, Fiona Mitchelhill
Report Author Details	Amy McDonald, Chief Finance Officer Email Address: amymcdonald@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	No
Terms of Reference	*4) The approval of the Medium-Term Financial Framework.*

INTEGRATION JOINT BOARD

1. Purpose of the Report

This report provides;

1.1 The estimated 4 year Medium Term Financial Forecast (MTFF). This model considers the category expenditure of the IJB and the changes which need to be actioned within the cost base to work towards bringing financial balance. Scenario planning is used to highlight how financial sustainability is impacted if varying levels of savings are achieved.

2. Recommendations

It is recommended that the Integration Joint Board:

2.1. Notes the further development of the Medium Term Financial Forecast as the new IJB Strategy is brought forward. The MTFF sets out anticipated cost pressures and future funding projections based on planning assumptions to allow the IJB to work towards financial balance under the new Strategic Plan (2025-29).

3. Strategic Plan Context

3.1. The Strategic Plan (2025-29) is underpinned by the MTFF. Being able to look beyond the current year is crucial to support the IJB's future longer term financial sustainability.

3.2. The Strategic Plan is considerate of the financial challenges over the next 4 years. The work ongoing to balance the budget in 2025/26 and the savings required in 2026/27 to deliver a more sustainable future financial position for the IJB. Failing to deliver the required £14.354m of savings in 2025/26 will impact the future sustainability of the IJB and the MTFF models presented.

3.3. The Strategic Plan considers the growing demand for health and social care services where resources available to meet that demand are not increasing at the same rate. The IJB Strategic Plan relies on the growing level of prevention and early intervention projects which will help to reduce but not eliminate future demand. This programme of prevention and early intervention includes improvement in adult healthy weight, public mental health and active ageing, increasing the uptake of immunisations and cancer screening, the work of the Alcohol and Drugs Partnership in reducing the

harm caused by alcohol and drug use, and implementing the action plans for the Suicide and Self Harm Prevention strategies.

3.4. As well as managing demand the cost of service delivery must be reduced. The Strategic Plan sets out the intention to transform service delivery to ensure demand can be met within resources allocated to the partnership. Transformation activities focus on reimaging how care is delivered, further embedding technology enabled care, delivering a more efficient infrastructure to reduce property running costs, restructuring and integrating the health and care provision to meet user needs. The Medium Term Financial Forecast seeks to focus transformation activity which will be taken forward under the 2025-2029 Strategy document.

3.5. ACHSCP recognises that NHS Grampian were escalated to stage four of the NHS Scotland National Performance Framework on the 12th of May 2025. At the NHS Grampian Board meeting of 12th June 2025 it was noted there was a requirement to save £45m in 2025/26 year and develop a three year Financial Recovery Plan necessary to support the Board returning to financial balance. The IJB receive approximately 61% of required annual funding from NHS Grampian. The MTFF assumes funding from NHS Grampian is maintained at the same level as in 2025/26 however this may change - the Chief Officer will continue to work closely with NHS Grampian to work through the uncertainties which may come with this process.

4. The Medium Term Financial Forecast

4.1. The Medium Term Financial Forecast is an estimation of future events. The future of Health and Social Care is marked by considerable financial uncertainty, driven by rising demand, inflationary pressures and the need for systematic reform. The 2025 spending review has highlighted a critical funding gap for all IJB's in Scotland, all IJB's required to make savings, Aberdeen City is no different. The forecast assumes the current funding settlement is consistent over the 4 years of the 2025-29 Strategy however there is a lack of long-term funding certainty beyond 2026, combined with the cumulative impact of Brexit, COVID-19 and energy price shocks adds to this volatility. These challenges raise concerns about the sustainability of services and the ability to deliver on reform ambitions without further financial support. The forecast has assessed a four year profile based on current

assumptions, below shows the estimated future financial pressures for the IJB over the next four years.

Estimated Budget Pressures	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000
Pay	4,122	4,127	4,233	4,360
Non pay inflation	606	646	666	686
Primary Care Prescribing	2,524	2,000	2,000	2,000
Commissioned Services	9,344	3,847	3,962	4,081
Additional service demand	1,485	1,997	2,082	2,169
Recurring deficit	16,786			
eNIC pressure	2,050			
	36,918	**12,617**	**12,943**	**13,296**

Assumptions embedded within Budget Pressures:

Pay – 3%, each year for Aberdeen City Council and NHS Grampian staffing – based on the latest Scottish Government Public Sector Pay Policy. Pay funding pressures have been provided for health staff by NHS Grampian with the assumption this will continue, while a share of additional funding for Local Government will be assumed, should the agreed pay award exceed 3%. Costs are taken from the current payroll, this is expected to fall as restructuring work changes the level of partnership staffing.

Non pay inflation – 3%, in every year for non-pay covering external purchasing includes one off expenditure in 2025/26.

Primary Care Prescribing – 4.5%, in 2025/26. Inflation is reduced in future years to allow the output from the NHS Grampian prescribing group to feed through, with actions taken to reduce the continued growth of prescriptions.

Commissioned Services – 3% in each future years, 2025/26 contains a higher pressure from key commissioned service provider. Inflation is largely covered by Real Living wage increase from Scottish Government.

Additional Service Demand – 1% across all areas excluding pay, primary care and set aside budgets. This additional demand recognition reflects the wider pressures being placed on the IJB. The 1% pressures is the difference between the growth in service demand in and the impact of preventative measures reducing this. This figure is an estimation in 2026/27, 2027/28 and

2028/29 to pick up the costs of additional demand while Public Health Scotland develop a more measurable framework on how this should be assessed. This ongoing work to model the future impacts which includes the growth in the population of people aged over 65 years and 75 years, that the Scottish Burden of Disease Study highlights there will be more people with health needs to support, for Aberdeen City this will mean additional service demand. The IJB will require to manage the pressure of service demand as well as normal inflationary pressures.

4.2. The two funding sources for the Partnership are NHS Grampian and Aberdeen City Council. Any future funding will be impacted by the respective financial planning processes of both organisations and the funding settlements they receive. The MTFF makes assumptions regarding future funding contributions from both Partners based on current available information. Outlined below is the potential funding that will be provided over the term of this plan:

Estimated Funding Forecast	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000
NHS Grampian	233,755	239,358	245,129	251,073
NHS set aside	55,500	55,500	55,500	55,500
Aberdeen City Council	137,729	142,809	148,052	153,819
eNIC	1,201			
Additional Partner funding	10,909			
Total funding	439,094	437,667	448,681	460,392

The funding increase from NHS Grampian represents a 3% budget increase with the exception of Primary Care General Medical Services inflation which is directly covered by Scottish Government. This is consistent with the 2025/26 funding provided.

Aberdeen City Council increase of 3.6% represents the estimated increase in the Real Living Wage increase for commissioned service providers and uplift in Free Personal and Nursing Care costs provided by Scottish Government.

INTEGRATION JOINT BOARD

Estimated Summary position	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000
Estimated budget requirement	439,094	451,712	464,655	477,950
Total Funding	439,094	437,667	448,681	460,392
Surplus/ (deficit) before savings	(0)	(14,045)	(15,974)	(17,558)
Budget Gap		(14,045)	(15,974)	(17,558)

The summary position above highlights that the IJB will require to make significant savings of what could be around £14.045m, dependent on service demand, in 2026/27 – reflecting full delivery of the £14.354m savings in 2025/26. The work in the next two financial years, 2025/26 and 2026/27, is required in the main to remove the structural deficit the IJB has been carrying.

Savings will continue to be required in subsequent years although at a lower level if the previous years required savings are made in full:

Estimated Summary position	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000
Estimated in year savings required		(14,045)	(1,929)	(1,585)

Savings in 2027/28 and 2028/29 will be driven through the implementation of the Strategy which reflects the improvements to the financial position - restructuring efficiencies and greater use of digital technology will be key.

The IJB will require to deliver all savings before reserves can start to be accumulated. Reserve balances will help to manage against in year pressures and also potentially can be used for reinvestment.

The Strategic Plan is therefore critical to support the delivery of financial sustainability and the necessary actions to achieve this - particularly the preventative projects supporting a reduction in some of the system demand. It is acknowledged that during the period of this Strategic Plan (2025-29) that the prevention activity will not be great enough to curtail the growing demands in health and care. The IJB will look to incorporate the further work

of Public Health Scotland when this becomes available to understand better what this differential will be. Translating the impact of current projects to strengthen preventative actions will be necessary – the Strategic Plan Dashboard, being developed, will include finance, demographic and workforce data to support this analysis.

Transformational redesign and restructuring is be taken forward with the intention to start the delivery of this work in 2026/27 providing more affordable and sustainable services within the resources available.

This financial forecast will therefore require review and refresh as part of the annual finance cycle - updating with the most current information to ensure the required focus to deliver a balanced budget each year.

4.3. Medium Term Financial Forecast – **Risk**

The IJB recognises the need for both financial planning and monitoring as the remaining reserve balances which helped manage against financial risk were used in the 2024/25 year. The financial position has become more fragile as a result and therefore understanding of financial risk and how to mitigate this is crucial.

The Medium Term Financial Forecast is a model based on current planning assumptions. Given that assumptions are liable to change there are likely to be a number of potential future scenarios that may arise, particularly when there is the potential for changing levels of demand. There will not just be one scenario but better and worse scenarios. The MTFF presented represents a base scenario based on current planning assumptions.

Savings are driven by the Strategy and cover:

- Restructuring of teams to achieve greater integrated services;
- Greater emphasis on enablement – fewer residential care beds will be required;
- Embedding of digital technology to reduce infrastructure costs and staff required to support service delivery;

- Greater use of Technology Enabled Care to reduce the costs of delivering care;
- Changing the model of care to improve outcomes and lower costs; and
- Making sure the charges for care are fair and reasonable.

The ability to deliver savings has been assessed under 3 risk profiles and the ability to realise savings:

100% Delivery of Savings

There is a significant amount of work underway to deliver the 2025/26 savings required of £14.354m, the MTFF assumes these savings will be made in full. The 2026/27 year also requires a considerable amount of work to drive out what could be a further £14.045m of savings. The IJB look to present and deliver a balanced budget each year and therefore savings at this level will require to be delivered.

The IJB partners recognise the need for the IJB to deliver savings in full and not overspend in 2025/26. If the 100% savings target is missed there are implications not just in understanding how the 2025/26 year will be balanced by partners but any savings which are not delivered will add to the savings target in 2026/27.

75% Delivery of Savings

This level of savings delivery represents a lower level of risk for the Partnership in 2026/27 but higher risk for the IJB partners. If savings of 75% were delivered the IJB would have a budget deficit of £3.511m at the end of the financial year 2026/27.

ACHSCP will present a balanced budget for 2026/27 but recognise there is a level of risk in doing so. Given there are 9 months before the start of the new financial year there is time to fully mitigate this risk.

If any projects do not deliver the savings when required there is a risk the future year budget will not be balanced. There will be constraints on the

realisation of staff savings owing to the Scottish Government Public Sector Pay Policy and the differing terms and conditions of employment across NHS Grampian and Aberdeen City Council.

50% Delivery of Savings

This level of savings delivery at £7.023m in 2026/27 highlights an issue with the Strategic Plan and failing to deliver this plan. It could also result from changes in the external environment with respect to excessive demands being placed on services.

To mitigate this risk the following actions will be taken:

- Budget savings options are developed in consultation with stakeholders using a structured evidence-based approach that balances the need for financial sustainability with the delivery of essential services.
- Base line financial assessments include a clear understanding of current expenditure patterns, cost drivers and service pressures including reviewing trends and identifying areas of inefficiency or duplication will be considered.
- Prioritisation of planning will be focused on high impact areas where savings can be achieved without compromising outcomes. This may involve moving resources towards preventative care models and early intervention services which have been shown to reduce long term costs.
- Stakeholder engagement involving clinicians, care professionals, service users and communities through direct engagement and consultation. This will ensure changes are realistic, acceptable and more likely to succeed.
- Performance monitoring and evaluation – establishing a clear timelines and targets to track the impact of savings initiatives.
- Governance and risk management to ensure savings plans are embedded with risk registers updated to reflect potential impacts on service delivery and workforce morale as appropriate.
- Integrated care and commissioning ensuring alignment of strategies across health and social care to avoid duplication and secure better

value. Audit Scotland highlights the importance of joint commissioning to streamline services and reduce overheads[1]

- Savings plans will be developed to ensure they are deliverable, that there is appropriate oversight and support of delivery and teams are enable to achieve the objectives which have been set out.
- Addressing issues identified with project plans as they arise through the Budget Savings Oversight Group and Senior Leadership Team.
- Ensuring adequate project document and resource is put in place to deliver plans.
- Working closely with teams going through change to maintain their engagement.

The risk sensitivity analysis highlights;

- The challenge in driving change;
- The assumptions around the requirements in reducing expenditure; and
- The need to assess the potential outcome of scenarios so these can be managed.

The IJB also have awareness of the risks associated with the MTFF being:

- Partner funding availability, including conditions placed on the Local Government and NHS financial settlements.
- The impact of the NHS Grampian Financial Recovery Plan being developed;
- Future cost pressures which will arise during the year;
- Underestimation of existing cost pressures; and
- Changes/new local and national requirements;

These risks reinforce the need to keep this plan under review with actions to address aligned to the IJB risk appetite and documented in the risk register.

5. Implications for IJB

5.1. Equalities, Fairer Scotland and Health Inequality

[1] Commissioning social care impact report – audit-scotland.gov.uk

There are no direct equalities implications from this report however there will be an equality impact assessment completed as required for all budget savings and future projects as these are brought forward.

5.2. **Financial**

Financial implications are noted in the report. The IJB will move towards financial stability over the next 4 years but only in the context of requiring to deliver excess £28m of savings over the next 2 years.

In the scenario of being unable to deliver the savings on a recurring basis the IJB, in the absence of reserves, would have to seek further funding from the Partners.

5.3. **Workforce**

There are no direct implications as a result of this report.

5.4. **Legal**

The Public Bodies (Joint Working) (Scotland) Act 2014 requires the IJB to publish an annual financial statement which relates to the amount it intends to spend in furtherance of its Strategic Plan. Statutory Guidance on Strategic Planning mandates that the IJBs Strategic Plan should incorporate a medium term financial plan for the resources. This report sets out the MTFF for consideration in respect of that requirement,

5.5. **Unpaid Carers**

There are no direct implications as a result of this report.

5.6. **Information Governance**

There are no direct implications as a result of this report

5.7. **Environmental Impacts**

There are no direct implications as a result of this report

5.8. **Sustainability**

There are no direct implications as a result of this report.

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	1 July 2025
Report Title	Alcohol & Drug Partnership Annual Report 2025
Report Number	HSCP.25.060
Lead Officer	Fiona Mitchelhill
Report Author Details	Simon Rayner Alcohol & Drug Partnership Lead Simon.rayner@nhs.scot
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	A Scottish Government Survey of ADPs
Terms of Reference	2). Any function or remit delegated under the Aberdeen City Integration Scheme, which is bound to be undertaken by the IJB itself

1. Purpose of the Report

This report provides information in relation to overall progress on the Alcohol & Drug Partnership Delivery Framework since 2019 and a specific update in relation to highlights from 2024 – 2025. Appendix A is a copy of a survey required by the Scottish Government in relation to Alcohol & Drug Partnership activity.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Notes the detail contained within the report
b) Notes the completed Scottish Government Survey at Appendix A

3. Strategic Plan Context

3.1. This report supports the work of the Aberdeen Health and Social Care Partnership (ACHSCP) Delivery Plan and specifically "Preventing Ill Health: Tackle the top preventable risk factors for poor mental and physical health including: - obesity, smoking, and use of alcohol and drugs". It supports the work of the Alcohol and Drug Partnership and it supports the work within Community Planning Local Outcome Improvement Plan to reduce drug related deaths by 10% by 2026.

4. Summary of Key Information

4.1. The Aberdeen Alcohol and Drugs Partnership (ADP) is currently refreshing its current delivery framework. This work is taking place concurrently with Community Planning Aberdeen who are refreshing the Local Outcome Improvement Plan (LOIP), the ACHSCP are refreshing their Strategic Plan and the Scottish Government are planning to refresh their National Mission for post 2026.

4.2. This report provides information in relation to overall progress on the Delivery Framework since 2019 and a specific update in relation to highlights from 2024 – 2025.

4.3. The Aberdeen City Alcohol and Drug Partnership (ADP) continues to play a pivotal role in delivering the National Mission to reduce drug-related deaths and improve lives. This report outlines the ADP's activities, achievements, and challenges during the 2024/25 financial year, reflecting a strong commitment to data-informed decision-making, workforce resilience, lived experience inclusion, stigma reduction, and holistic family support.

4.4. The Delivery Framework presents a comprehensive strategy structured around five strategic themes aimed at addressing substance use and its associated harms. Each theme includes detailed descriptions, key actions,

and improvement aims aligned with the Local Outcome Improvement Plan (LOIP).

4.5. Theme 1: Whole-Family Approach: This theme recognises that substance use affects not just individuals, but entire families. It aims to provide holistic, wraparound support that includes children, parents, carers, and extended family members. The approach is proactive and preventative, focusing on:

- Early identification of risk in children and young people.
- Strengthening family resilience and protective factors.
- Embedding substance use workers in family and children's services.
- Supporting families through psychological wellbeing services.
- Promoting rights-based approaches and trauma-informed care.
- Enhancing communication and education in schools and communities.

4.6. Specific actions include:

Universal Prevention

- Identified lead in education for substance education
- All schools delivering the same curriculum in relation to drug and alcohol harm as part of a wider context of personal and social education
- All schools stocking naloxone in First Aid kits and staff trained
- All schools offering pupils First Aid qualification including naloxone awareness

Selective Prevention

- Establishment of Fit Like Hubs with drug and alcohol workers embedded

Indicated Prevention

- Identified lead for substance use and vulnerable young people
- Commissioned Family Psychological Wellbeing Service

4.7. In addition to the above there is a joint thematic group between the ADP and the Child Protection Committee being formed. Shared work to date has included awareness sessions on Foetal Alcohol Spectrum Disorder, Sudden Unexpected Infant Deaths, Birth Parents Project and Hard Edges: Women with Multiple Complex Needs

Specific Improvement work has included

- LOIP Charter #1 100% of schools have a progressive, cohesive and relevant substance misuse curriculum by 2021
- LOIP Charter #2 Increase the % of care experienced children and young people receiving educational support and input on alcohol and drugs issues by 2021
- LOIP Charter #3 Reduce the number of births affected by drugs by 0.6 %, by 2022
- LOIP Charter #4 Reduce the average age from 14 to 12 at which children are identified as requiring preventative support to mitigate the risk of future harm in relation to drug and alcohol use by 2026
- LOIP Charter #5 Reduce the % of 13-15 year olds reported as using each subgroup of drug by 50% and cannabis by 20% by 2026
- LOIP Charter #6 Decrease the number of women who are drinking in pregnancy in the 40% most deprived SIMD areas by 5% by 2026
- LOIP Charter #7 Reduce by 5% the no. of children aged 0-4 who are referred to Children's Social Work because of neglect arising from parental mental health, addiction and domestic abuse 2026

4.8. 2024–2025 Highlights

- The ADP is working towards full implementation of the Whole Family Approach Framework, with activities including a commissioned Family Psychological Wellbeing Service and joint work with the Child Protection Committee. Plans are in place to conduct a needs assessment in 2025/26. Family-inclusive practices are embedded in commissioning and care planning.
- Information on treatment and support services is disseminated through online platforms and materials tailored for minority ethnic groups and people with learning difficulties. Prevention activities span all age groups and include harm reduction, mental wellbeing, pregnancy and parenting support.

- We welcome that all secondary schools have staff members trained to administer naloxone and that from the 2024/25 school session all S4 pupils have been trained in administering naloxone, in addition to the Level 6 first aid course. This provides them with a qualification, as well as the ability to save someone's life. In addition, 88 staff were trained in naloxone in 2024.
- Through our 13-15 year old substance projects we have tested a range of mechanisms which are prevention focused and aim to both raise awareness of the harm from substance use and vaping but also provide support to stop using. A key area has been empowering young people to develop the material to ensure it has greatest chance of success.
- Pupils from Lochside Academy have started to develop a substance use social media awareness campaign focussing awareness, informed choice, harm reduction and support.
- The Aberdeen City Health and Wellbeing Survey undertaken across all schools in November 2024, data shows that compared to November 2023, shows signs of positive impact, with a 34.5% decrease from 136 to 89 in the number of 13-15 year olds reporting that they have used cannabis. There has also been a 20.8% decrease in the number reporting they have used ketamine from 24 to 19.

4.9. Theme 2: Reducing Harm, Morbidity and Mortality: This theme is focused on saving lives and reducing the immediate and long-term health impacts of substance use. It prioritises:

- Harm reduction strategies such as naloxone distribution and overdose prevention
- Increasing access to testing and treatment for Blood Borne Viruses (BBVs).
- Promoting responsible alcohol use and increasing alcohol brief interventions.
- Ensuring timely access to treatment and support for those at risk.
- Targeting interventions in communities with the highest levels of harm.

4.10. Specific actions include:

- Established Assertive Outreach Service.

- Created dedicated Criminal Justice / ADP and Violence Against Women / ADP posts.
- Expanded naloxone distribution; Aberdeen City Council and North East College became corporate distributors.
- Developed the Aberdeen Protects Naloxone App.
- Ran three media campaigns on overdose and naloxone.
- Launched Sharp Response outreach harm reduction service (via Alcohol & Drugs Action / CORRA Foundation funding).

- Tested the Navigator Service and supported Drug & Alcohol Care Team at Aberdeen Royal Infirmary.
  - Piloted the Here 4U Scotland Digital Lifelines project.
  - Established Dry Blood Spot Testing (DBST) and mobile BBV testing.
- Developed rights-based work and led the National Charter of Rights.
  - Created emergency planning and local alert processes.
  - Commissioned the Try Dry app.
  - Recommissioned Tier 1 & 2 Direct Access Drug and Alcohol Harm Reduction Service and Injecting Equipment Provision.
  - Reviewing the Alcohol Brief Interventions offer.

4.11. Specific Improvement work has included

- Increase the number of BBV testing and treatment opportunities by 2021.
- Increase the % of the population informed about responsible alcohol use by 2021.
- Reduce fatal drug overdoses by increasing naloxone distribution by 10% annually by 2021.
- Increase alcohol screening and support in priority neighborhoods by 10% annually by 2026.
- 80% of people closed from Assertive Outreach to be no longer at risk by 2026.
- Reduce drug-related deaths in priority neighborhoods by 20% by increasing naloxone distribution by 25% annually by 2026.

4.12. 2024–2025 Highlights

- Aberdeen City ADP supports vulnerable groups through strategic partnerships, trauma-informed practices, and independent advocacy. Formal protocols support individuals with co-occurring mental health and substance use issues, and referral pathways are in place for undiagnosed mental health concerns.

- Harm reduction services are widely available across various settings, including community pharmacies, hospitals, justice services, and outreach programs. There is growing demand for services such as drug checking, and psychological support for young people affected by ketamine use

- Our partnership continues to prioritise reducing Drug Related Deaths (DRDs) through innovation and targeted intervention. Key achievements include:
    - 23% reduction in suspected DRDs from 2023/24 (73) to 2024/25 (56), though still 12% higher than 2022/23 (49) and an overall increasing trend
    - 45% of DRDs in 2024/25 occurred in priority neighbourhoods—a decrease from previous years.
    - A new data system now tracks overdoses, ambulance callouts, and outreach referrals by location and time, enabling more responsive, locality-based interventions.

- Expansion of Naloxone Access and Awareness
    - Public awareness and access to naloxone have been expanded through:
    - Aberdeen Protects app (launched Dec 2024) with 533 downloads to date.
    - Features include overdose response guidance, naloxone ordering, and real-time alerts.
    - Public access naloxone boxes to be installed at four strategic sites to be confirmed.
    - Community learning events and outreach, including International Overdose Awareness Day activities
- Alcohol Harm Reduction and Support Access
    - Despite efforts, alcohol-related support engagement has declined:
    - 36% drop in referrals to Alcohol and Drugs Action from 2023 to 2024.

- 21% decrease in people starting alcohol treatment (337 in 2024/25 vs. 427 in 2023/24).
- 14% drop in treatment referrals overall, with a slight decline in priority area engagement.

- Targeted Interventions
  - A promotional campaign increased engagement with the 'Alcohol Aberdeen' online screening quiz (167 completions; 41% during Alcohol Awareness Week).
  - New self-referral pathway from the quiz led to 4 direct helpline contacts.
  - Alcohol Brief Interventions (ABIs) rose by 12% from 2022/23 to 2023/24, with 40% delivered in wider settings.
- Public Awareness Gaps
  - Survey data revealed that only 48.6% of City Voice respondents correctly identified the recommended alcohol limits, with nearly a third unclear on drink content—highlighting the need for continued education

4.13. Theme 3: Service Quality Improvement: This theme ensures that all services are accessible, high-quality, and person-centred. It is underpinned by the full implementation of the Medication-Assisted Treatment (MAT) Standards, which include:

- Same-day access to treatment.
- Informed choice and personalised care.
- Trauma-informed and psychologically informed practice.
- Integration with mental health, housing, and welfare support.
- Shared care with primary care providers.

4.14. Specific actions include:

- Fully implemented Medication-Assisted Treatment (MAT) standards:
  - Same-day access to MAT.
  - Informed choice on medication and dosage.
  - Proactive identification of high-risk individuals.
  - Harm reduction at point of MAT delivery.
  - Support to remain in treatment.

  - Psychologically informed system with low-intensity psychosocial interventions.
  - MAT shared with Primary Care.
  - Access to independent advocacy and support for housing, welfare, and income.
  - Mental health care at point of MAT delivery.
  - Trauma-informed care.
- Introduced long-acting Buvidal as a treatment option.
- Increased treatment service capacity.
- Established Occupational and Psychological Therapies within integrated services.
- Created Intensive Housing Support Service.
- Funded an independent Advocacy Service.
- Merged Marywell Medical Practice, Community Nursing Outreach, and Timmermarket.
- Made Health Needs Assessment a routine part of drug treatment intake.
- Developed a new Target Operating Model for Timmermarket.

4.15. Specific Improvement work has included

- Increase uptake of drug treatment, especially in Locality Areas, by 10% annually by 2021.
- Ensure 80% of individuals in the justice system with substance use concerns are offered or accessing support by 2026.

4.16. Spotlight for 2024 – 2025

- There are many barriers to people engaging with drug services and we know that a range of interventions and approaches based in the heart of our communities are required to ensure people, particularly in our priority neighbourhoods, have access to the support they need and that any potential harm is reduced. Through a range of outreach interventions, we aim to support individuals in accessing the services they need.
- Assertive Outreach (AO) is a crucial approach for engaging individuals who are at high risk of substance use harm. The approach provides targeted support to those most at risk, helping

to reduce harm by enhancing their existing support or accessing appropriate drug and alcohol services to meet their needs. Through our Assertive Outreach project, we have focused on the outcomes of people engaged with service and aiming to increasing the number of people closed who are no longer classed at risk. We have seen a 15% increase in the percentage of people closed from Assertive Outreach no longer considered at risk, with 71% (404) of people closed no longer considered at risk, compared to 56% (291) in 2023/24.

- The project has introduced:
  - Individualised Approach/ Shared Safety and Care Plans
  - Tailored multi-agency interventions and outreach efforts, and
  - Process for responding to patterns and risk factors associated with fatal overdoses to enable individuals referred to be supported in their community
- As well as positive outcomes for people referred, we've also seen a 10% increase in the number of referrals to Assertive Outreach from 523 in 2023/24 to 573 in 2024/25. This is the highest they've been since April 2021 and shows that the referral pathways and awareness across our partners is impactful. In 2024/25, 54% of Assertive Outreach referrals were from priority neighbourhoods, this is an 8% increase from 46 % in 2023/24.

- Barriers to residential rehabilitation include limited detox and stabilisation services, funding challenges, and transportation issues. Pathways have been revised following the opening of Rae House in Aberdeenshire. Certain groups, including women, people on OST, and those with co-occurring mental health issues, face unmet needs.

- Challenges in implementing MAT standards include insufficient staffing, funding, and psychological support. These issues have been escalated through national monitoring channels

4.17. Theme 4: Supporting Recovery This theme promotes visible, inclusive, and sustainable recovery pathways. It values lived experience and community-based support, and includes:

- Funding and supporting recovery communities like Aberdeen In Recovery.

- Reducing stigma through public campaigns and awareness events.
- Expanding peer support, fellowships, and recovery groups.
- Creating pathways from recovery into employment and housing.
- Establishing residential rehabilitation options in the North East.

4.18. Specific actions include:

- Continued funding for Aberdeen In Recovery.
- Secured permanent premises for Aberdeen In Recovery.
- Embedded lived experience in ADP governance, service management, and design.
- Led International Overdose Awareness Day.
- Delivered a 2023 anti-stigma campaign focused on substance use.
- Hosted lived experience engagement events.
- Employed four additional recovery workers.
- Supported the establishment of North East residential rehab.
- Developed a Recovery to Employment Pathway with ABZ Works.

4.19. Specific Improvement work has included

- Increase by 10% the number of people in active recovery from drugs and alcohol by 2025.

4.20. Spotlight for 2024 – 2025

- Efforts to reduce stigma include workshops and the development of a local charter of rights aligned with the national charter. Stigma reduction is embedded in strategic documents such as the ADP strategy, MAT standards delivery plan, and harm prevention action plans.

- Over the past 18 months Public Health and Alcohol and Drug Partnership colleagues have been facilitating a Grampian-wide Working Group to support the implementation of the National Charter of Rights with a Grampian voice. The work has focussed on the lived experiences of those people coming into service and

opening a dialogue with senior decision makers to make improvements.

- In addition, the Working Group co-designed a reporting tool to provide evidence on the implementation of the Charter of Rights to Scottish Government and supplementary data in line with Medically Assisted Treatment Standards. It resulted in Grampian being heralded as an example of good practice by leading national policy makers with aspirations to embed the practice across the rest of Scotland. Grampian colleagues have had the opportunity to challenge current reporting procedures to apply in future a Rights-based approach. This enables a holistic submission on the Substance Use landscape across an Alcohol and Drug Partnership and its community.
- Promotional materials have been developed locally in Grampian to promote the local voice alongside the National Charter of Rights.
- Recovery from drug and alcohol-related harm is crucial for creating healthier communities. We know that each person's recovery journey is unique, and that providing a range of supportive opportunities helps sustain their recovery, reduce stigma, and increase resilience. Through our recovery project we are committed to building on the treatment, support and community peer led initiatives available and providing recovery support at the individual, family, and community levels to help people live free from the potential harm of alcohol and drugs.
- One of the initiatives we have piloted is the co-design of an employability pathway with ABZ Works which aims to support people in recovery into employment through support provided by employability keyworker. When people are work-ready, a paid work experience placement with ongoing employability keyworker is provided. Weekly employability drop-ins at Waterloo Quay started on 6 June 2024, and as at 30 March 2025, 22 individuals (12 males and 10 females) have been referred and 45% (10) have either moved into employment or training/work placement/volunteering.
- **Aberdeen In Recovery** (AiR) are now running sessions on Sundays and Alcohol and Drugs Action open on Saturdays and Sundays, to ensure that when people need support, they can access it. There were 144 members of Aberdeen In Recovery during 2024/25. Of which 41% were from the Central locality, 19% South and 18% North locality. On average Aberdeen In Recovery are running 14 different groups per week with the aim of providing a variety of options to meet the individual's interest

and needs. Through **Aberdeen In Recovery** activities, there were 18,229.5 SAFE (Stable Addiction-Free Engagement) hours which equates to 2430.6 days.

4.21. Theme 5: Intelligence-Led Delivery: This theme ensures that all actions are informed by data, evidence, and lived experience. It includes:

- Learning reviews for every drug- and alcohol-related death.
- Mapping service engagement to identify missed opportunities.
- Developing performance dashboards and risk matrices.
- Embedding a Human Learning System approach to service design.
- Using data to drive continuous improvement and innovation.

4.22. Specific actions include:

- Established a learning review process for all drug and alcohol-related deaths.
- Developed a Risk Matrix to support proactive intervention.
- Funded a dedicated data analyst.
- Mapped service engagement of 251 individuals in the 12 months prior to drug-related death.
- Created performance dashboards.
- Implemented the Human Learning System.
- Piloted Community Appointment Days, GIRFE, and the Liberated Method to improve engagement and service delivery.

4.23. Specific Improvement work has included

- Reduce the rate of both alcohol-related and drug-related deaths by 10% by 2026.

4.24. Spotlight for 2024 – 2025

- Aberdeen City ADP has robust structures in place for monitoring alcohol and drug harms, including an independently chaired Substance Death Review Group, and mechanisms to monitor drug trends. This information feeds into a wider emergency

resilience plan that includes benchmark thresholds for emerging threats such as novel synthetics.

- In response to emerging threats, protocols are being revised to address issues related to nitazines, ketamine, crack cocaine, and safe sleep practices.

- We know that local data suggests that people in our most deprived communities are 7.66 times more likely to die from substance use than those living in least deprived areas. Over the 18 months, work has been done to understand opportunities to reduce harm. This has included the use of data and learning from 251 drug related deaths, resulting in a profile of risk factors and the testing of a different approach with 'liberated' teams who wraparound high-risk individuals. Developments in operational practice include the introduction of outreach services operating in priority neighbourhoods and routine health needs assessments which has highlighted a high incidence of underdiagnosed and under treated comorbidities. As reported in the Daily Brief about the community appointment day approach that is being trialled with people in Torry where the risk is known to be higher. The focus on high risk, high need individuals is at the heart of these developments and in doing so, working with people to address what matters to them, not just dealing with substance use.

4.25. **Next Steps:** A detailed refresh of the ADP Delivery Framework is being developed and will include the following elements:

- **Elevate Primary Prevention**
    - **Why:** While the current plan includes universal and selective prevention efforts, a more explicit and structured focus on primary prevention can help reduce the overall incidence of substance use in the long term.
    - **Recommendations:**
    - **Develop a City-Wide Primary Prevention Strategy** that aligns with the LOIP and includes clear, measurable outcomes.

- **Use data to identify emerging trends** (e.g., vaping, online drug markets) and proactively design prevention campaigns.

- **Deepen the Whole-Family Approach with Intergenerational Support**
    - **Why:** Strong progress has been made embedding substance use workers in family services and schools. However, long-term resilience requires sustained, intergenerational support.
    - **Recommendations:**
    - Expand trauma-informed family therapy and parenting programmes.
    - Introduce intergenerational mentoring schemes involving people in recovery.
    - Evaluate long-term outcomes of Fit Like Hubs and scale successful models.

- **Strengthen Alcohol Harm Reduction Strategies**
    - **Why:** Despite progress in drug-related harm reduction, alcohol-related support engagement has declined significantly.
    - **Recommendations:**
    - Reassess and redesign alcohol referral pathways and outreach strategies.
    - Launch a targeted alcohol harm awareness campaign, especially in priority areas.
    - Expand Alcohol Brief Interventions (ABIs) into non-traditional settings (e.g., workplaces, sports clubs).

- **Expand Assertive Outreach and Community-Based Interventions**
    - **Why:** Assertive Outreach has shown strong results, especially in priority neighbourhoods.
    - **Recommendations:**
    - Scale Assertive Outreach to cover more localities and include weekend/evening services.

- Integrate mental health and housing support more deeply into outreach teams.
- Use real-time data from the new overdose tracking system to dynamically deploy outreach resources.

- **Advance Data-Driven, Rights-Based Service Design**
  - **Why:** The Human Learning System and Charter of Rights work has positioned Aberdeen as a national leader.
  - **Recommendations:**
  - Institutionalise the Charter of Rights reporting tool across all services.
  - Expand the use of predictive analytics to identify at-risk individuals earlier.
  - Continue to pilot and scale innovative models like Community Appointment Days.

- **Address Health Inequalities and Comorbidities**
  - **Why:** Data shows a stark disparity in substance-related deaths in deprived areas.
  - **Recommendations:**
  - Embed routine health needs assessments in all frontline services.
  - Develop integrated care pathways for individuals with comorbid physical and mental health conditions.
  - Target health literacy and access campaigns in the most deprived SIMD areas

5. Implications for IJB

5.1. Equalities, Fairer Scotland and Health Inequality

There are no direct implications arising from the recommendations set out in the report.

5.2. Financial

There are no direct implications arising from the recommendations set out in the report.

5.3. Workforce

There are no direct implications arising from the recommendations set out in the report.

5.4. Legal

There are no direct implications arising from the recommendations set out in the report.

5.5. Unpaid Carers

There are no direct implications arising from the recommendations set out in the report.

5.6. Information Governance

There are no direct implications arising from the recommendations set out in the report.

5.7. Environmental Impacts

There are no direct implications arising from the recommendations set out in the report.

5.8. Sustainability

There are no direct implications arising from the recommendations set out in the report.

5.9. Other

There are no direct implications arising from the recommendations set out in the report.

6. Management of Risk

The ADP will monitor progress towards mitigating the areas of risk closely and will provide further detail to the IJB should this be necessary.

6.1. Identified risks(s)

There are no identified risks arising from the recommendation at this stage

Scottish Government
Riaghaltas na h-Alba

Alcohol and Drug Partnership (ADP) Annual Reporting Survey: 2024/25

This survey is designed to collect information from all ADPs across Scotland on a range of aspects relating to the delivery of the National Mission to reduce drug deaths and improve lives, as well as activities relating to alcohol **during the financial year 2024/25**. This will not reflect the totality of your work but will cover areas where you do not already report progress nationally through other means.

The survey is composed of single option and multiple-choice questions with a limited number of open text questions. We want to emphasise that the multiple-choice options provided are for ease of completion and it is not expected that every ADP will have all of these in place.

This survey includes questions from across drug and alcohol policy areas. It has been designed to collate as many asks as possible from Scottish Government to minimise requests throughout the year. There is a combination of established questions which enable comparison year on year and new questions that reflect current and anticipated future data needs.

We do not expect you to go out to services to respond to questions relating to activities undertaken by them in your area. Where questions refer to service level activities, we are interested in the extent to which you are aware of these as ADP.

The data collected will be used to better understand progress at a local level and will inform:

- National monitoring of the National Mission to reduce drug deaths and improve lives;
- The work of the ongoing evaluation of the Nation Mission, including the economic evaluation;
- The work of advisory groups including those supporting the programmes around Whole Family Approach, surveillance, and residential rehabilitation among others;
- The work of national organisations which support local delivery; and
- Future policy planning around drugs and alcohol.

Findings will be published as Official Statistics in the autumn. The publication reporting on the 2023/24 ADP survey is available on the Scottish Government website. We plan to publish data from closed answer (quantitative) questions at an ADP level to enable best use of the survey data and ensure transparency. Data from closed answer (qualitative) questions will be shared with Public Health Scotland and their commissioned research teams to inform drug and alcohol policy monitoring and evaluation, where excerpts and/or summary data may be used in published reports, and will be subject to FOI requests. You may still wish to publish your return, as in previous years.

The deadline for returns is Friday 13th June 2025. Your submission should be signed off by the ADP and the IJB. We are aware that there is variation in the timings of IJB meetings, so if sign off is not possible by the date of submission, please indicate this when you provide your return and advise an expected sign off date if possible.

If you require clarification on any areas of the survey or would like any more information, please do not hesitate to get in touch by email at substanceuseanalyticalteam@gov.scot.

Cross-cutting priority: Surveillance and Data Informed

Question 1

Which Alcohol and Drug Partnership (ADP) do you represent? Mark with an 'x'. [single option]

X Aberdeen City ADP

Aberdeenshire ADP

Angus ADP

Argyll & Bute ADP

Borders ADP

City of Edinburgh ADP

Clackmannanshire & Stirling ADP

Dumfries & Galloway ADP

Dundee City ADP

East Ayrshire ADP

East Dunbartonshire ADP

East Renfrewshire ADP

Falkirk ADP

Fife ADP

Glasgow City ADP

Highland ADP

Inverclyde ADP

Lothian MELDAP ADP

Moray ADP

North Ayrshire ADP

North Lanarkshire ADP

Orkney ADP

Perth & Kinross ADP

Renfrewshire ADP

Shetland ADP

South Ayrshire ADP

South Lanarkshire ADP

West Dunbartonshire ADP

West Lothian ADP

Western Isles ADP

Question 2

Which groups or structures were in place at an ADP level to inform surveillance and monitoring of alcohol and drug harms or deaths? Mark all that apply with an 'x' – if drug and alcohol deaths are reviewed at a combined group, please select both 'Alcohol death review group' and 'Drug death review group'.
[multiple choice]

X Alcohol death review group

Alcohol harms group

X Drug death review group

X Drug trend monitoring group/Early Warning System

None

Other (please specify):

Question 3

3a. Do Chief Officers for Public Protection receive feedback from drug death reviews? Mark with an 'x'.
[single option]

X Yes

No

Don't know

3b. If no, please provide details on why this is not the case.
[open text – maximum 500 characters]

Question 4

Please list what local and national structures are in place in your ADP area for the monitoring and surveillance of alcohol and drug harms and deaths. Please describe how these have been used to inform local decision making in response to emerging threats (e.g. novel synthetics) in the past year. [open text – maximum 2,000 characters]

Aberdeen has a prepared emergency resilience plan with benchmark thresholds for monitoring substance use harm and emergeing threats

Question 5

5a. Have you made specific revisions to any protocols in the past year in response to emerging threats (e.g. novel synthetics, trends in cocaine, new street benzos, etc.) ? Mark with an 'x'.
[single option]

X Yes

No

5b. Please provide details of any revisions
[open text – maximum 500 characters]

Policy and practice have been updated in relation to nitazines and local harm; in relation to safe sleep and substance use; guidance in relation to ketamine use; seizures and crack use

Question 6

Please describe ways in which you routinely engage with commissioned services in your ADP area (e.g. through online surveys, reporting databases, email or phone communication, ADP representation on governance or advisory structures, events etc.).
[open text – maximum 1000 characters]

;Aberdeen ACVO is represented on the ADP along with other key 3rd sector commissioned providers.We run an integrated service management strucutre which specialist 3rd sector comissioned services are part of. All events etc are open invitation by default unless secifically established for a particualr sector

Cross-cutting priority: Resilient and Skilled Workforce

Question 7

7a. What is the whole-time equivalent[1] staffing resource routinely dedicated to your ADP Support Team as of 31 March 2025?
[numeric, decimal]

Total current staff (whole-time equivalent including fixed-term and temporary staff, and those shared with other business areas)	1.30
Total vacancies (whole-time equivalent)	0.00

7b. Please list the job title for each vacancy in your ADP Support Team on the 31 March 2025 (if applicable).
[open text – maximum 500 characters]

Question 8

Please select any initiatives you have undertaken as an ADP that are aimed at improving employee wellbeing (volunteers as well as paid staff). Mark all that apply with an 'x'
[multiple choice]

Training and awareness

X Promotion of information and support initiatives

X Provision of training on issues including trauma awareness and crisis management

Other (please specify):

Workplace support

X Flexible working

[1] Note: whole-time equivalent (WTE) is a unit of measurement that indicates the total working hours of employees in relation to a full-time position. It helps to standardise and compare staffing resource across different teams or organisations. A full-time employee is equal to one whole-time equivalent. For part-time employees, divide their hours by the whole-time equivalent. For example, if a part-time employee is required to work 7.5 hours per week and a 'full-time' position is considered to be 37.5 hours, the WTE would be 0.2 (7.5 hours / 37.5 hours).

Implementation of risk assessment for work at home and in the workplace

X Inclusive workplace initiatives (including staff networks and wellbeing champions)

X Provision of occupation health services

Staff recognition schemes

Use of disability passports

Workload management

Other (please specify):

Institution-provided support

X Provision of coaching and supervision for staff and volunteers

Provision of counselling for staff and volunteers

Other (please specify):

Wellbeing activities

X Drug and/or alcohol death reflective sessions

Peer support groups

Provision of mindfulness courses/learning materials

Social and physical activities

Other (please specify):

Engagement

X Participation in local Clinical Care Governance Meetings

X Undertaking of staff needs assessments and engagement to understand wellbeing needs

X Regular meetings about staff pressures with senior and junior staff

Other (please specify):

Other initiatives which don't fit in these categories (please specify):

Cross cutting priorities: Lived and Living Experience

Question 9

9a. Do you have a formal mechanism at an ADP level for gathering feedback from people with lived/living experience who are using services you fund? Mark all that apply with an 'x'.
[multiple choice]

X Engagement with recovery communities

X Experiential data collected as part of the Medication Assisted Treatment (MAT) programme

X Feedback / complaints process

X Lived / living experience panel, forum and / or focus group

X Questionnaire / survey

No formal mechanism in place

X Other (please specify): Lived experience representatives are part fo the ADP and service Managemnt strucutres

9b. In the past year, have members of any of the following groups with lived and/or living experience participated in any of the above engagement mechanisms? Mark all that apply with an 'x'.
[multiple choice]

X People who are current or former employees or volunteers at the ADP or drug and/or alcohol services

X People who are not employed at the ADP or at drug and/or alcohol services

X People who are currently accessing treatment or support for problem **drug** use (may include treatment for problem alcohol use)

X People who are currently accessing treatment or support for problem **alcohol** use

X People with living experience of drug and/or alcohol use who are not currently receiving treatment or support

X People who are experiencing homelessness

X Women

X Young people

Other (please specify):

Question 10

10a. In what ways are **people with lived and living experience** able to participate in ADP decision-making? Mark all that apply with an 'x'.
[multiple choice]

X Through ADP board membership

X Through a group or network that is independent of the ADP

Through an existing ADP group/panel/reference group

X Through membership in other areas of ADP governance (e.g. steering group)

Not currently able to participate

Other (please specify):

10b. In what ways are **family members** able to participate in ADP decision-making? Mark all that apply with an 'x'.
[multiple choice]

X Through ADP board membership

X Through a group or network that is independent of the ADP

Through an existing ADP group/panel/reference group

Through membership in other areas of ADP governance (e.g. steering group)

Not currently able to participate

Other (please specify):

Question 11

What mechanisms are in place within your ADP to ensure that services you fund involve people with lived/living experience and/or family members in their decision-making (e.g. the delivery of the service)? Mark all that apply with an 'x'.
[multiple choice]

Asked about in reporting

X Stipulated in our contracts

None

Other (please specify):

Cross cutting priorities: Stigma Reduction

Question 12

Within which written strategies or policies does your ADP consider stigma reduction for people who use substances and/or their families? Mark all that apply with an 'x'.
[multiple choice]

X ADP strategy, delivery and/or action plan

X Alcohol deaths and harms prevention action plan

Communication strategy

Community action plan

X Drug deaths and harms prevention action plan

X MAT standards delivery plan

x Service development, improvement and/or delivery plan

None

Other (please specify):

Question 13

Please describe what work is underway in your ADP area to reduce stigma for people who use substances and/or their families.
[open text – maximum 2,000 characters]

Grampian has held a number of workshops and workstream meetings to reduce stigma. This has resulted in the development of a local charter of rights and an implementation plan for the national charter of rights.

Fewer people develop problem substance use

Question 14

How is information on local treatment and support services made available to different audiences at an ADP level (not at a service level)? Mark all that apply with an 'x'. [multiple choice]

	In person (e.g. at events, workshops, etc)	Leaflets / posters	Online (e.g. websites, social media, apps, etc.)
Non-native English speakers (English Second Language)		X	X
People from minority ethnic groups		X	X
People from religious groups			
People who are experiencing homelessness			
People who are LGBTQI+			
People who are pregnant or peri-natal			
People who engage in transactional sex			
People who have been involved in the justice system			
People with hearing impairments and/or visual impairments			X
People with learning disabilities and literacy difficulties			X
Veterans			
Women			
None of the above			
Other (please specify			

Question 15

Which of the following education or prevention activities were funded or supported[2] by the ADP?[3] Mark all that apply with an 'x'.
[multiple choice]

	0-15 years (children)	16-24 years (young people)	25 years+ (adults)
Campaigns / information		X	X
Harm reduction services	X	X	X
Learning materials	X	X	
Mental wellbeing		X	X
Peer-led interventions			
Physical health		X	X
Planet Youth			
Pregnancy & parenting	X	X	X
Youth activities			
Other (please specify)			
None			

[2] Note: 'supported' refers to where the ADP provides resources of some kind (separate from financial, which is covered by "funded"). This could take the form of knowledge exchange, staffing, the supply of materials (e.g. learning templates, lending them a physical location), etc.
[3] Note: activities which are not relevant for older age groups have been shaded out to avoid confusion on completion of this question.

Risk is reduced for people who use substances

Question 16

16a. Please select in which settings each of the following harm reduction initiatives are delivered in your ADP area. Mark all that apply with an 'x'.
[multiple choice]

	Supply of naloxone	Hepatitis C testing	Injecting equipment provision	Wound care
Community pharmacies	X	X	X	
Drug services (NHS, third sector, council)	X	X	X	X
Family support services	X			
General practices	X	X	X	X
Homelessness services	X	X	X	x
Hospitals (incl. A&E, inpatient departments)	X			
Justice services	X			
Mental health services	X			
Mobile/outreach services	X	X	X	X
Peer-led initiatives	X	X		
Prison				
Sexual health services		X		
Women support services	X	X		
Young people's service	X			
None				
Other (please specify)				

16b. Please provide details about any changes to settings in which harm reduction initiatives have been delivered in the past year. Please describe the changes and any reasons for these changes.
[Open text- maximum 2,000 characters]

Everyone entering drug treatment has a health needs assessment by Specialist GP / Community Nurse at point of entry and higehr risk people followed

Question 17

17a. Which of the following harm reduction interventions are there currently a demand for in your ADP area? (Either where the intervention is not currently provided or where demand exceeds current supply). Mark all that apply with an 'x'.
[multiple choice]

X Drug checking

Drug testing strips

X Harm reduction advice and support in relation to psychostimulants

Heroin Assisted Treatment

X Naloxone availability in public facilities (e.g. pre-stationed naloxone, naloxone box etc.)

X Provision of foil

X Safe supply of substances

X Safer drug consumption facility

X Safer inhalation pipe provision

X Other (please specify): There is significant demand for resources for ketamine harm reduction and psychologial support for traumatised yong people being harmed by ketamine use

17b. Please provide any details (e.g. scale of demand, source of requests, whether current demand exceeds supply etc.).
[open text – maximum 500 characters]

Question 18

18a. Do you have an adequate supply of naloxone in your ADP area to meet general needs? Mark with an 'x'.
[single option]

X Yes

No

Unsure

18b. Within the context of a more toxic and unpredictable drug supply which may require higher doses of naloxone to be administered, do you have adequate supply of naloxone in your ADP area to meet demand if a significant incident were to occur? Mark with an 'x'.
[single option]

Yes

No

X Unsure

People most at risk have access to treatment and recovery

Question 19

Which partners within your ADP area have documented pathways in place, or in development, to ensure people who experience a near-fatal overdose (NFO) are identified and offered support? Mark all that apply with an 'x'.
[multiple choice]

	NFO pathway in place	NFO pathway in development
Community recovery providers	X	
Homeless services	X	
Hospitals (including emergency departments)		X
Housing services	X	
Mental health services	X	
Police Scotland	X	
Primary care	X	
Prison	X	
Scottish Ambulance Service	X	
Scottish Fire & Rescue Service		
Specialist substance use treatment services	X	
Third sector substance use services	X	
Other (please specify)		

Question 20

Which, if any, of the following barriers to implementing NFO pathways exist in your ADP area? Mark all that apply with an 'x'.
[multiple choice]

Further workforce training required

High staff turnover

X Insufficient funds

Issues around information sharing

Lack of leadership

Lack of ownership

Lack of physical infrastructure

X Lack of staff to support out of hours or extended core business hours

X Workforce capacity

None

Other (please specify):

Question 21

In what ways have you worked with justice partners[4]? Mark all that apply with an 'x'. [multiple choice]

Strategic level

X ADP representation on local Community Justice Partnership

X Contributed to strategic planning

X Coordinated activities between justice, health or social care partners

Data sharing

X Justice organisations represented on the ADP (e.g. COPFS, Police Scotland, local Community Justice Partnership, local Justice Social Work department, prison)

Provided advice and guidance

Other (please specify):

Operational level

X Provided funding or staff for a specialist court (Drug, Alcohol, Problem Solving)

X Raised awareness about community-based treatment options (partners involved in diversion from prosecution or treatment-based community orders)

X Supported staff training on drug or alcohol related issues

Activities to support implementation of MAT standards

Other (please specify):

Service level

Funded or supported:

Navigators for people in the justice system who use drugs

X Services for people transitioning out of custody

X Services in police custody suites

Services in prisons or young offenders' institutions

Services specifically for Drug Treatment and Testing Orders (DTTOs)

Services specifically for people serving Community Payback Orders with a Drug or Alcohol Treatment Requirement

Other (please specify):

[4] Note: 'justice partners' includes Community Justice Partnerships (CJPs), Justice Social Work departments, Prisons and Young Offender Institutes, Police, Crown Office and Procurator Fiscal Service (COPFS), Scottish Courts and Tribunals Service (SCTS), Sacro, and third sector organisations that specifically serve people involved with the criminal justice system.

Question 22

Which activities did your ADP support at each stage of the criminal justice system? Mark all that apply with an 'x'.
[multiple choice]

	Pre-arrest[5]	In police custody[6]	In courts[7]	In prison[8]	Upon release[9]
Advocacy or navigators					
Alcohol interventions		X	X		
Drug and alcohol use and treatment needs screening		X	X		
Harm reduction inc. naloxone		X	X		
Health education & life skills					
Medically supervised detoxification					
Opioid Substitution Therapy		X		X	
Psychosocial and mental health based interventions		X		X	
Psychological and mental health screening					
Recovery (e.g. café, community)					
Referrals to drug and alcohol treatment services		X		X	X
Staff training					
None					
Other (please specify)					

[5] Pre-arrest: Services for police to refer people into without making an arrest.
[6] In police custody: Services available in police custody suites to people who have been arrested.
[7] In courts: Services delivered in collaboration with the courts (e.g. services only available through a specialist drug court, services only available to people on a DTTO).
[8] In prison: Services available to people in prisons or young offenders' institutions in your area (if applicable).
[9] Upon release: Services aimed specifically at supporting people transitioning out of custody.

Question 23

What barriers to accessing support, if any, are there in your area for people who are involved in the justice system? Mark all that apply with an 'x'.
[multiple choice]

Lack of accessibility to mainstream alcohol and drug services and support services (such as lack of transport options)

X Lack of services tailored specifically to people who are on Community Payback Orders, Drug Treatment and Testing Orders, Supervised Release Orders and other community orders

Lack of specific pathways for people who are involved in the justice system

Lack of support for people who are involved in the justice system after receiving treatment

Services with entry requirements which exclude people convicted of specific offences (such as arson)

Services with entry requirements which exclude people on Community Payback Orders, Drug Treatment and Testing Orders, Supervised Release Orders and other community orders

None

Other (please specify):

Question 24

What types of residential services are available in your area which can be accessed by people who are subject to Community Payback Orders, Drug Treatment and Testing Orders, Supervised Release Orders and other community orders to access support? Mark all that apply with an 'x'.
[multiple choice]

X Mainstream residential rehabilitation services (i.e. those who are open to anyone)

Mainstream residential services other than rehabilitation (e.g. recovery housing)

Residential services specifically targeted to people involved in the justice system, such as Turnaround or other service (please specify which services):

Mainstream stabilisation/crisis services

Other (please specify):

Question 25

25a. Do you have drugs and alcohol testing services in your ADP area for people going through the justice system on an order or licence? Mark all that apply with an 'x'.
[multiple choice]

Yes, for alcohol

Yes, for drugs

X No

Unsure

25b. Who provides testing services for drugs and/or alcohol? Mark all that apply with an 'x'.
[multiple choice]

	Alcohol testing	**Drugs testing**
Private provider		
NHS addiction services		
Other local provider (please specify)		
Other arrangement (please specify)		
Not applicable	X	X

25c. What methods are used for drugs and/or alcohol testing? Mark all that apply with an 'x'. [multiple choice]

	Alcohol testing	**Drugs testing**
Handheld devices		
Spit tests		
Urine tests		
Electronic monitoring		
Patches		
Other (please specify)		
Not applicable	X	X

People receive high quality treatment and recovery services

Question 26

What **screening options** are in place to address alcohol harms? Mark all that apply with an 'x'.
[multiple choice]

- [ ] Alcohol hospital liaison
- [x] Arrangements for the delivery of alcohol brief interventions in all priority settings
- [ ] Arrangement of the delivery of alcohol brief interventions in non-priority settings
- [ ] Fibro scanning
- [ ] Pathways for early detection of alcohol-related liver disease
- [ ] None
- [ ] Other (please specify):

Question 27

What **treatment options** are in place to address alcohol harms? Mark all that apply with an 'x'.
[multiple choice]

- [x] Access to alcohol medication (e.g. Antabuse, Acamprase, etc.)
- [ ] Alcohol hospital liaison
- [ ] Alcohol-related cognitive testing (e.g. for alcohol related brain damage)
- [x] Community-based alcohol detox (including at-home)
- [ ] In-patient alcohol detox
- [x] Pathways into mental health treatment
- [x] Psychosocial counselling
- [x] Residential rehabilitation
- [ ] None
- [ ] Other (please specify):

Question 28

28a. Which, if any, of the following barriers to residential rehabilitation exist in your ADP area? Mark all that apply with an 'x'.
[multiple choice]

- Availability of aftercare
- X Availability of detox services
- X Availability of stabilisation/crisis services
- X Challenges accessing additional sources of funding
- Current models are not working
- Difficulty identifying all those who will benefit
- Further workforce training required
- Geographic distance
- X Insufficient base funding
- X Insufficient staff
- Lack of awareness of residential rehabilitation among potential clients
- Lack of awareness of residential rehabilitation amongst referrers
- Lack of bed capacity within ADP area
- Lack of specialist providers
- X Lack of transportation to travel to available capacity
- Scope to further improve/refine your own pathways
- X Variation in prices from different providers
- Waiting times
- None
- Other (please specify): A barrier to accessing residential support is the requirment from some providers that people come off their medication either prior or during their stay. This contradicts the provision of MAT Standards where people have rights, choice and the option to stay on MAT as long as they wish.

28b. What actions are your ADP taking to overcome these barriers to residential rehabilitation?
[open text – maximum 500 characters]

Most of the barriers encountered are not in direct control of the ADP and would need substantial investment from central governement and national level resolution

Question 29

29a. Have you made any revisions in your pathway to residential rehabilitation in the last year? Mark with an 'x'.
[single option]

- No revisions or updates made in 2024/25
- Yes - Revised or updated in 2024/25 and this has been published

X Yes - Revised or updated in 2024/25 but not currently published

29b. If yes, please provide brief details of the changes made and the rationale for the changes.
[open text – maximum 500 characters]

The opneing of Rae House locally has required the modification of pathways. In the final stages of agreeing and publishing

Question 30
Are there any specific groups in your ADP area who do not have their needs met by the current residential rehabilitation provision (for reasons such as lack of appropriate models of care, inadequate capacity, the location of services or any other factors)? Mark all that apply with an 'x'.
[multiple choice]

Lesbian, gay or bisexual people

People from minority religions

X People on OST

X People who are experiencing homelessness

X People who are involved in the justice system

X People who are pregnant or perinatal

X People with child dependents

X People with co-occurring mental health problems

People with council tenancies

People with specific physical health condition, including long term illness and disability

Trans people

X Women

None

Other (please specify):

Question 31

31a. Which, if any, of the following barriers to implementing the Medication Assisted Treatment (MAT) standards exist in your area? Mark all that apply with an 'x'.
[multiple choice]

- Accommodation challenges (e.g. appropriate physical spaces, premises, etc.)
- X Availability of stabilisation/crisis services
- X Burden of data collection and reporting
- Challenges engaging with GPs
- Difficulty identifying all those who will benefit
- Further workforce training is needed
- Geographical challenges (e.g. remote, rural, etc.)
- X Insufficient funds
- X Insufficient staff
- Lack of awareness among potential clients
- X Lack of capacity
- X Scope to further improve/refine your own pathways
- Waiting times
- None
- X Other (please specify): Investment and capcity for psychological staff and training

31b. What actions is your ADP taking to overcome these barriers to implementing MAT in your ADP area?
[open text – maximum 500 characters]

Has been highlighted in SG Quarterly monitoring report

Question 32

Other than opioids, which substances are currently the highest priority in your ADP area for treatment and support? Please rank the substances of concern in your area in order of priority – add a number to all that apply, with 1 being highest priority.
[ranking]

- 1 Alcohol
- 4 Cannabis/cannabinoids
- 2 Cocaine, and other stimulants
- 1 Ketamine
- 2 Pregabalin/gabapentin
- 3 Street benzos
- 3 Polydrug use (please specify any most common combinations of drugs): Crack
- Other (please specify):

Question 33

Which of the following treatment and support services are in place specifically for **children and young people using alcohol and/or drugs**? Mark all that apply with an 'x'.[10]
[multiple choice]

	Up to 12 years (early years and primary)	13-15 years (secondary S1-4)	16-24 years (young people)
Alcohol-related medication (e.g. acamprosate, disulfiram, naltrexone, nalmefene)			X
Diversionary activities			
Employability support			X
Family support services	X	X	X
Information services	X	X	X
Justice services			X
Mental health services (including wellbeing)	X	X	X
Opioid Substitution Therapy			X
Outreach/mobile (including school outreach)			X
Recovery communities			X
School outreach			
Support/discussion groups (including 1:1)			
Other (please specify)	In the context of children and young people we fund a Prevention and early intertvention service located within Family Wellbeing Hubs (Fit Like Hubs), which are comprised of a range of family support services. These services work	In the context of children and young people we fund a Prevention and early intertvention service located within Family Wellbeing Hubs (Fit Like Hubs), which are comprised of a range of family support services. These services work	In the context of children and young people we fund a Prevention and early intertvention service located within Family Wellbeing Hubs (Fit Like Hubs), which are comprised of a range of family support services.

[10] Note that treatment and support services which are inappropriate for younger age groups have been shaded out to avoid confusion on completion of this question.

	collaboratively along side our commissioned service. Additionally through our Prevention & Early Intevention lead we are linked with children's social work services and work here	collaboratively along side our commissioned service. Additionally through our Prevention & Early Intevention lead we are linked with children's social work services and work here	These services work collaboratively along side our commissioned service. Additionally through our Prevention & Early Intevention lead we are linked with children's social work services and work here

Quality of life is improved by addressing multiple disadvantages

Question 34

Do you have specific treatment and support services in place for the following groups? Mark all that apply with an 'x'.
[multiple choice]

	Yes	No
Non-native English speakers (English Second Language)		X
People from minority ethnic groups		X
People from religious groups		X
People who are experiencing homelessness	X	
People who are involved in the justice system	X	
People who are LGBTQI+	X	
People who are neurodivergent		X
People who are pregnant or peri-natal	X	
People who engage in transactional sex	X	
People with hearing impairments and/or visual impairments		x
People with learning disabilities and literacy difficulties		
Veterans		X
Women	X	
Other (please specify)		

Question 35

35a. Are there formal joint working protocols in place to support people with co-occurring substance use and mental health diagnoses to receive mental health care? Mark with an 'x'.
[single choice]

X Yes

No

35b. Please provide details.
[open text – maximum 500 characters]

Being delivered as part of MAT 9 improvement work

Question 36

What arrangements are in place within your ADP area for people who present at substance use services with mental health problems **for which they do not have a diagnosis**? Mark all that apply with an 'x'.
[multiple choice]

Dual diagnosis teams

Formal joint working protocols between mental health and substance use services specifically for people with mental health problems for which they do not have a diagnosis

X Pathways for referral to mental health services or other multi-disciplinary teams

X Pathways for referral to third sector services for mental health support

X Professional mental health staff within services (e.g. psychiatrists, community mental health nurses, etc)

Provision of joint appointments for those with co-occurring mental health problems and problem substance use

X Provision of mental health assessments for people who are presenting with mental health problems

None

Other (please specify):

Question 37

How do you as an ADP work with support services **not directly linked to substance use** (e.g. welfare advice, housing support, etc.) to address multiple disadvantages? Mark all that apply with an 'x'.
[multiple choice]

X By representation on strategic groups or topic-specific sub-groups

X By representation on the ADP board

X Through partnership working

Via provision of funding

Not applicable

Other (please specify):

Question 38

Which of the following activities are you aware of having been undertaken in ADP funded or supported[11] services to implement a trauma-informed approach? Mark all that apply with an 'x'.
[multiple choice]

X Engaging with people with lived/living experience

X Engaging with third sector/community partners

X Provision of trauma-informed spaces/accommodation

Presence of a working group

Recruiting staff

X Training existing workforce

None

Other (please specify):

Question 39

39a. Does your ADP area have specific referral pathways for people to access independent advocacy? Mark with an 'x'.
[single option]

X Yes

No

Don't know

39b. If yes, are these commissioned directly by the ADP? Mark with an 'x'.
[single option]

X Yes

No

Don't know

[11] Note: 'supported' refers to where the ADP provides resources of some kind (separate from financial, which is covered by "funded"). This could take the form of knowledge exchange, staffing, the supply of materials (e.g. learning templates, lending them a physical location), etc.

Children, families and communities affected by substance use are supported

Question 40

Which of the following treatment and support services are in place for **children and young people affected by a parent's or carer's substance use**? Mark all that apply with an 'x'.[12]
[multiple choice]

	Up to 12 years (early years and primary)	13-15 years (secondary S1-4)	16-24 years (young people)
Advocacy		X	X
Carer support			
Diversionary activities			
Employability support			
Family support services	X	X	X
First aid training		X	X
Information services			
Mental health services	X	X	X
Outreach/mobile services			
School outreach			
Social work services	X	X	X
Support/discussion groups			
Other (please specify)			

Question 41

Which of the following support services are in place **for adults** affected by **another person's substance use**? Mark all that apply with an 'x'.
[multiple choice]

X Advocacy

Commissioned services

Counselling

One to one support

Mental health support

X Naloxone training

X Support groups

Training

None

Other (please specify):

[12] Note support services which are likely to be inappropriate for younger age groups have been shaded out to avoid confusion on completion of this question.

Question 42

42a. Do you have an agreed set of activities and priorities with local partners to implement the Holistic Whole Family Approach Framework in your ADP area? Mark with an 'x'.
[single option]

X Yes

No

Don't know

42b. Please provide details of these activities and priorities for 2024/25.
[open text – maximum 500 characters]

- Identified lead for substance use and vulnerable young people
- Commissioned Family Psychological Wellbeing Service

In addition to the above there is a joint thematic group between the ADP and the Child Protection Committee being formed. Shared work to date has included awareness sessions on Fetal Alcohol Spectrum Disorder, Sudden Unexpected Infant Deaths, Birth Parents Project and Hard Edges: Women with Multiple Complex Needs
Specific Improvement work has included in the LOIP

Question 43

When did your ADP most recently conduct an audit or needs assessment of the support currently available in your area for children, young people and adults affected by a family member's substance use? Mark with an 'x'. [single option]

2020/21

2021/22

2022/23

2023/24

2024/25

None undertaken in the past 5 years

X There are plans to undertake one in 2025/26

Unsure

Question 44

Which of the following services supporting a Family Inclusive Practice[13] or a Whole Family Approach are in place in your ADP area (for people with family members both in and not in treatment)? Mark all that apply with an 'x'.
[multiple choice]

- Advice
- X Advocacy
- Benefits and debt advice
- Mentoring
- X Peer support
- Personal development
- Social activities
- Support for self care activities
- Support for victims of gender based violence and their families
- Youth services
- None
- Other (please specify):

Question 45
What support would be helpful to facilitate the implementation of a Family Inclusive Practice or a Whole Family Approach? Mark all that apply with an 'x'.
[multiple choice]

- X Additional funding
- X Additional resources
- Advice to support setting up of lived and living experience forums/co-production methods
- X Guidance at a national level
- Information shared from other services
- Sharing of participation tools
- X Workforce training
- Analytical support (please specify any details):
- Other (please specify):

Question 46
What mechanisms are in place within your ADP area to ensure that services adopt a family inclusive practice? Mark all that apply with an 'x'.
[multiple choice]

- X Asked about in their reporting

[13] Family Inclusive Practice is a collaborative approach where professionals actively involve a person's family and social networks in care, proactively ask about the needs of the whole family, to ensure all family members are supported.

X Prerequisite for our commissioning

Regular training provided to services

None

X Other (please specify): Its factored into assessment and careplanning work

Question 47

In what ways do you work with the Children's Service's Planning Partnership (CSPP) in your area? Mark all that apply with an 'x'.
[multiple choice]

ADP representation on CSPP

Co-location of services

X Co-management of projects

Coordinated activities

Coordinated living and lived experience co-production approaches

Co-ordination around staff training

X CSPP representation on ADP

Data sharing

X Integrated planning

X Joint interpretation of data and evidence at a strategic level

X Joint referrals to relevant services

Knowledge sharing

Pooled funding

Shared and joint outcomes

X Shared assessment of local needs

None

Other (please specify):

Finances

Question 48

How much funding does the ADP receive from the following sources? Please mark all which apply with an 'x' and provide details on the amount of funding which is received.
[multiple choice, numeric]

Health board: £ 700k

Local authorities: £ 700k

Funding from other grant funder(s) (such as Corra and Inspiring Scotland Foundation): £ x

Other (please specify source and how much funding) x: £ x

Question 49

49a. How often do you provide financial reports for you ADP area? Mark all that apply with an 'x'.
[multiple choice]

X Monthly

Quarterly

Six monthly

Annually

X Other (please specify): Finance planning is monthly and would be escalated if need on the basis of any issues being encountered

49b. Who is financial reporting provided to? Mark all that apply with an 'x'.
[multiple choice]

x IJB/IA Chief Financial Officer

IJB/IA Chief Officer

ADP Chair

Other (please specify):

49c. Do you have a dedicated finance officer or team within the ADP? Mark with an 'x'.
[single option]

X Yes

No, the ADP coordinator undertakes this as part of their role

No, finances are managed externally to the ADP

Other (please specify):

Question 50

50. Please describe what financial system(s) are used to manage finances in your area (i.e. Oracle, Efin, Excel spreadsheets).
[open text – maximum 500 characters]

Confirmation of sign-off

Question 51

Has your response been signed off at the following levels? Mark all that apply with an 'x'. [multiple choice]

ADP

IJB

Not signed off by IJB (please specify date of the next meeting in dd/mm/yyyy format):

Thank you

Thank you for taking the time to complete this survey, your response is highly valued. The results will be published in the 2024/25 ADP Annual Survey Official Statistics report, scheduled for publication in autumn 2025.

Please do not hesitate to get in touch via email at substanceuseanalyticalteam@gov.scot should you have any questions.

[End of survey]

Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	01 July 2025
Report Title	Strategic Plan 2025-2029
Report Number	HSCP25.058
Lead Officer	Fiona Mitchelhill, Chief Officer
Report Author Details	Alison MacLeod Strategy and Transformation Lead ACHSCP AliMacleod@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	A - Strategic Plan 2025-2029 B - Changes from Draft to Final C –Strategic Plan 2025-2029 Evidence Document D - Strategic Plan 2025-2029 Consultation Plan E – Integrated Impact Assessment Strategic Plan 2025-2029
Terms of Reference	8 - The approval or amendment of the Strategic Plan and on-going monitoring of its delivery through the Annual Performance Report

1. Purpose of the Report

1.1. The purpose of this report is to present to the Integration Joint Board (IJB) the final Strategic Plan 2025-2029 for approval.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approves the Strategic Plan 2025-2029, and
b) Instructs the Chief Officer to publish the Strategic Plan and instigate the formal launch and promotion activities.

3. Strategic Plan Context

3.1. Section 29 of the Public Bodies (Joint Working) (Scotland) Act 2014 requires the IJB to prepare a Strategic Plan and section 35 requires the IJB to publish this plan. Our previous Strategic Plans have had a lifespan of a period of three years, however it is proposed that the lifespan of this Strategic Plan will be for a period of four years although it will be reviewed annually to take account of changing circumstances and these will be reflected in an annual Delivery Plan which will be submitted to IJB for approval alongside the Medium Term financial Framework in March every year. The 4 year lifespan is to enable us to align with the proposed refresh periods of our partner plans, particularly the Local Outcome Improvement Plan (LOIP) and the Children's Services Plan.

4. Summary of Key Information

4.1. An initial draft of the Strategic Plan 2025-2029 was presented to the IJB on 18th March 2025 along with an Evidence Document and Consultation Plan. The IJB approved the draft to go out for public consultation and instructed the Chief Officer to bring a final version incorporating the feedback to the IJB meeting on 1st July 2025.

4.2. The Strategic Plan attached at Appendix A has not only been updated from the consultation feedback but it has also undergone significant re formatting. The IJB is aware that external support had been involved in reviewing the Strategic Plan and the reformatting is largely as a result of feedback from them. Appendix B contains a high level summary of the changes from the draft to the final report. Of particular note is the strengthening of the alignment between the Strategic Plan with finance and risk with more emphasis and detail being provided in relation to each.

4.3. The implementation of this four year Strategic Plan will be achieved through the successful delivery of four Annual Delivery Plans. These will contain details of the projects and activities we plan to undertake along with timelines and measures. Appended to the Strategic Plan is our Routemap

for delivery which gives a high level overview of the activity we plan to undertake over the four year lifespan of the Strategic Plan although it should be noted that this is our intention at this time. Every year a review of progress and emerging priorities will be undertaken and the subsequent year's Delivery Plan will be developed which will continue to be aligned to both the Medium Term Financial Framework and the Strategic Risk Register. The section entitled Implementation and Governance on page 22 of the Strategic Plan confirms how we will measure progress and delivery.

4.4. In developing the Strategic Plan the IJB were advised in March 2025 that an Evidence Document had been developed. Part of that contained references to the Population Needs Assessment (PNA) 2023. The PNA has recently been updated and was presented to the Community Planning Aberdeen Management Group at their meeting on 21st May 2025. The Evidence Document contained in Appendix C has been updated to reflect the updated PNA. The key changes from the 2023 to the 2025 PNA are: -

- The impact of deprivation is even more stark – data for the most deprived areas is worsening and that for the least deprived is improving.
- In terms of demographics although we were aware that the 75+ age group is due to increase by 16.2% overall, the increase for males in this age group is predicted at 26.2%.
- Over half of single occupancy households are associated with people over the age of 50.
- There is an increase in adult use of e-cigarettes
- The estimate of people in the city who are considered obese has risen from 23% in 2019 to 32% in 2023.

These changes have been considered when finalising the Strategic Plan and either incorporated into the detail or will be fed into current and future service planning.

4.5. The report to IJB in March covered the consultation undertaken to date and the feedback from that. As described in that report the public consultation was a joint one with other Community Planning Aberdeen partners. The aim of this was to reduce the burden on communities and streamline the process. The plans and strategies included the Local Housing Strategy, Health and Social Care Partnership Strategic Plan, Community Learning and Development (CLD) Plan, the Local Development Plan (LDP), the Visitor Levy Proposal, the Children's Services Plan, and the Local Outcome Improvement Plan and Locality Plans. The consultation ran from 24th March to 18th May 2025 and comprised of two online surveys, one for adults and one for children and young people, an outreach programme involving 98 groups/school locations across Aberdeen and 6 locality events

with specific activities designed by the Aberdeen Youth Movement and Aberdeen Ambassadors for children and young people. People were also able to complete a paper copy of the online surveys. The feedback has been incorporated into the final version of the Strategic Plan and the Consultation Plan contained at Appendix D has been updated to reflect this.

5. Implications for IJB

5.1. Equalities, Fairer Scotland and Health Inequality

A Proportionality and Relevance assessment has been undertaken on the Strategic Plan. This has determined that full impact assessments may be required for some of the specific projects or activities in the Delivery Plan and some of these have already been submitted to IJB in March as part of the Medium Term Finance Framework in relation to the Budget Savings projects. Others will be developed as required as the work is undertaken on transformation projects.

5.2. Financial

The ACHSCP Strategic Plan 2025-2029 will be delivered within the existing IJB budget as approved within the Medium-Term Financial Framework. Additional funding has been received for the technology project.

5.3. Workforce

The ACHSCP Strategic Plan 2025-2029 will be delivered by the existing workforce. 'Workforce' is an enabler within the Strategic Plan. The current Workforce Plan is due to be refreshed in 2025 to take cognisance of the new Strategic Plan. As well as continuing to focus on the current workforce priorities - recruitment and retention, mental health and wellbeing, growth and development opportunities – the revised Workforce Plan will seek to map out how the shape and cost of our workforce is predicted to change over the four year lifespan of the Strategic Plan and identify what support staff require to build skills and confidence in new ways of working.

5.4. Legal

Sections 29 and 35 of the Public Bodies (Joint Working) (Scotland) Act 2014 require the IJB to prepare and publish a Strategic Plan. This report details the actions we are taking to ensure these obligations are met.

5.5. Unpaid Carers

The development and delivery of our Carers Strategy is focused on improving experiences of unpaid carers. The Carers Strategy action plan and annual reporting provided to the IJB represents our progress and commitments moving forward. The Carers Strategy 2023-2026 supports delivery of the Strategic Plan 2025-2029 recognising the contribution that unpaid carers make to the wider health and care system.

5.6. Information Governance

There are no direct information governance implications arising from the recommendations of this report

5.7. Environmental Impacts

There are no direct environmental implications arising from the recommendations of this report.

5.8. Sustainability

There are no direct sustainability implications arising from the recommendations of this report.

5.9. Other

There are no other direct implications arising from the recommendations of this report.

6. Management of Risk

6.1. Identified risks(s)

Sections 29 and 35 of the Public Bodies (Joint Working) (Scotland) Act 2014 require the IJB to prepare and publish a Strategic Plan. There is a risk that if we do not make progress in developing a Strategic Plan for 2025-2029, we will not meet these obligations.

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

The development and delivery of the ACHSCP Strategic Plan 2025-2029 is linked to and impacted by all the risks currently on the Strategic Risk Register as referenced in the Strategic Plan.

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

By developing and publishing the ACHSCP Strategic Plan 2025-2029 in July 2025 we are meeting our legal obligation and providing a strategic basis for the collaborative work of the IJB over the four years from July 2025 to March 2029.

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STRATEGIC PLAN

2025 - 2029

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CONTENTS

FOREWORD

I am delighted to present Aberdeen City Integration Joint Board's (IJB) Strategic Plan which covers the four-year period from 2025 to 2029. This is our fourth Strategic Plan since integration and the delivery of it will be our most challenging yet. Demand for health and social care services continues to grow yet the resources available to meet that demand are not increasing at a corresponding rate. Our plan therefore sets out our intention first and foremost to transform our service delivery to help ensure we can protect essential frontline services. We remain committed to our prevention and early intervention agenda which will help manage future demand and we will increase our focus on that once we have achieved the balance between demand and resource. We will work with our partners and the people of Aberdeen to improve the overall health and wellbeing of the population.

Achieving good health is impacted by many factors, for example, education and income, housing and living environment, social and community support. These are commonly known as the wider determinants of health. Inequality in these wider determinants has a direct impact on health and a key feature of this Strategic Plan is for the IJB to work with partners in Aberdeen City to try to close the inequality gap.

This plan relates to services delegated to and hosted by the IJB. The content has been informed by a detailed analysis of current and emerging local, regional, and national factors affecting health and social care delivery. This includes factors such as statutory responsibilities; current performance towards delivering better outcomes; and feedback from engagement with stakeholders including staff, citizens, and our partner organisations. The outcome of this analysis has been collated into an Evidence Document which is published alongside this Strategic Plan.

Whilst we would like to be able to have a response to every challenge highlighted in our Evidence Document our Medium-Term Financial Framework indicates that we will not have the resources to do this so in developing this Strategic Plan and more importantly the Delivery Plans that underpin the implementation of it, we have tried to be realistic in terms of what we can achieve. We are therefore prioritising our activity against two aims: -

- Modernising our approach to service delivery, which will involve making the best use of resources and implementing transformation, and
- Increasing our focus on prevention and early intervention, which will include prioritising activities that improve both physical and mental health and reduce harm

We hope that by doing this we will achieve sustainable service delivery that will mean community health and social care services will meet the care and support needs of the people of Aberdeen now and in the years to come.

Hussein Patwa
Chair – Aberdeen City Integration Joint Board

Current Service Delivery

The Aberdeen City IJB via its delivery organisation the Aberdeen City Health and Social Care Partnership (ACHSCP) provide community health and social care services including Primary Care, Adult Social Work, Adult Social Care, Community Nursing, Immunisations, and Public Health and Health Improvement which are delegated from our parent organisations NHS Grampian and Aberdeen City Council. The IJB is also responsible for the Grampian wide provision of some services including Frailty and Older People's Services, Rehabilitation, Sexual Health Services and Mental Health and Learning Disabilities Services. Aberdeen City IJB 'hosts' these services on behalf of both Aberdeenshire and Moray IJBs.

In 2023/24 8,790 people in Aberdeen City were receiving social care services/support, 58% of whom were frail/elderly.

6,000 people were supported by a Social Worker, with **5,305 receiving care at home** and 2,055 resident were in a care home

3,365 people had long term needs and **510 people required high levels of care at home** (10 hours or more).

In 2024/25 there were 1,265 patient admissions to Hospital at Home, 1,694 referrals to the Community Link Worker Service, and the City Visits Team undertook 6,216 visits

170,489 vaccinations were administered, and 170,000 appointments were available at our Community Treatment and Assessment Centres throughout the City

Our Stay Well Stay connected activities and events reached **1,777 people a massive 169% increase** on the previous year.

90% of healthcare episodes take place in Primary Care, which includes general practice, dentistry, community pharmacy and aspects of community urgent care.

There are however currently several challenges for our service delivery

- It is estimated there is a shortfall in General Practice funding of 22.8 % yet new housing development projections indicate that there will be an increase of approximately 41,964 people in Aberdeen City. Currently the maximum our practices list sizes could accommodate is 4,881
- Increasing demand and cost of care delivery in adult social care which has led to budget overspend and a need to review the way care is delivered and ensure there is a robust approach to the application of the Eligibility Criteria.
- Adult Social Care services are at capacity causing longer waits for assessment and lowering performance on Delayed Discharges. This adds pressure on Aberdeen Royal Infirmary which is also experiencing higher demand. We need to transform our service delivery to increase capacity within existing resources.
- The rising demand and need for inpatient care in Mental Health and Learning Disability services along with prolonged lengths of stay is challenging patient flow.
- Increasing instances of spikes in substance use requiring a community response.
- Pressure on Abortion Care Services requiring a review of the way the service is delivered
- Increase in prescribing costs and high volume of wastage – continued engagement with the group who are reviewing this across Grampian.

Our Vision and Values

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Our Vision is to **'empower communities to achieve fulfilling and healthy lives'**.

Our values represent what is important to us as we go about delivering their Vision.
Our values are:

Transparency	- We will be open and transparent enabling scrutiny of our decision making and activity.
Honesty	- We will be honest in our communications and interactions.
Empathy	- We will understand citizens' needs, listen to their views, and involve them in decision making.
Respect	- We will respect the views and the rights of Aberdeen's citizens.
Equity	- We will provide services that have equity of access for all and address negative impacts of inequality

We are **there** for the people of Aberdeen.

Our Key principles to Service Delivery

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Integrated Care

Integrated health and social care, delivered by multidisciplinary teams, supported by shared information.

Improving system flow

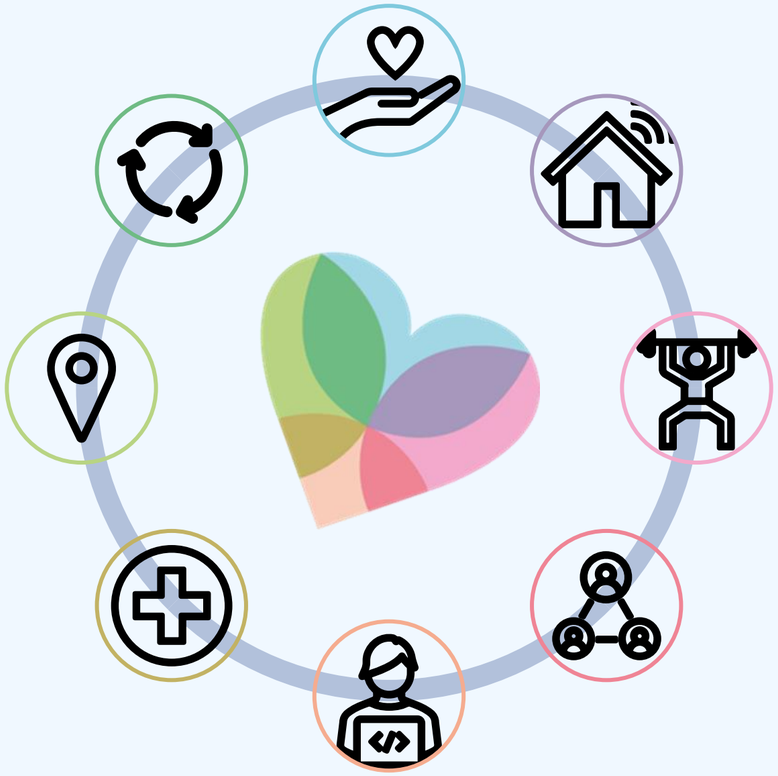
Separation of planned and unplanned care, including within primary care, front door diversion from acute services and effective discharge planning.

Single point of access

To health and care services, both step up and step down, with a focus on rapid provision of community support and easy access/ referral to all services.

Focus on prevention

Professionals and the local community working in partnership to achieve a clear focus on prevention of exacerbation of ill health.



Care closer to home

Provision of care in or near to usual place of residence, supported by skilled, empowered community teams.

Strengths based approach

Taking a strengths-based approach when assessing care needs, with the aim of maximising independence.

Assessment and Review

Regular assessment and review of care plans, completed by a skilled professional working in partnership with services users and carers.

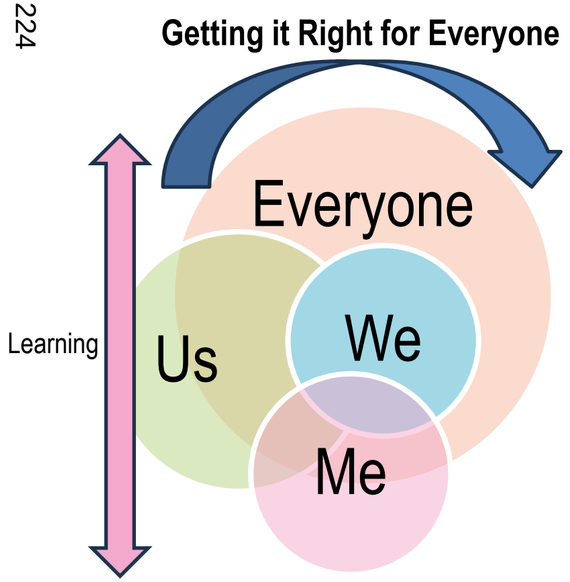
Technology based care

To support independence and improve quality of like, for example telehealth together with smart use of data and predictive case management to identify health and care needs as early as possible.

Strategic Approaches

In addition to our key principles to service delivery shown above we are also committed to the following strategic approaches to everything we do: -

- Considering the **whole system** and the impact of our activities on others
- Changing **public expectations and behaviours** towards acceptance of alternative care and support and where possible taking responsibility for their health
- **Collaborating** with our partners which may include co-location, combined pathway design, and sharing data,
- **Communicating and engaging** with our stakeholders and communities, ensuring we keep them informed and that they are involved in decisions regarding service planning and delivery
- Adopting the **Grampian Hope** which unifies GIRFE, Putting People First, Trauma Informed, Human Learning System, Self Directed Support and Realistic Medicine to consistently provide support to help people live their best lives.



The Grampian Hope Approach – unifying GIRFE, Putting People First, Trauma Informed, Human Learning System, Self Directed Support and Realistic Medicine to consistently provide support to help people live their best lives

Me (and mine)

I am part of a wider community (family, friends, community.

I will gain the information I need to make decisions about my life.

I am the expert in my own life, and I will know what is right for me.

I know that I can be clear about what matters to me.

I am supported to make the choices.

I am trusted to know what is right for me.

I understand that I will be treated with kindness, respect and dignity.

We (People who support me)

The people who support me take the time to listen and understand me, considering my while life when making decisions.

We focus on strengths, not problems, to do what's right for each person and their unique situation.

We actively listen understand a person's needs and what resources are available.

We will discuss options and agree together what would support me best.

We will work together to empower you to take charge of your own life.

We will build trust through meaningful conversations in a place that feels safe to you.

Being heard is a powerful support that can lead to positive changes in thinking and behaviours.

Us (Community)

My family, friends and community play the biggest role in helping me live well.

Building relationships within my family and community helps support me, keep me well, and makes me feel part of the community.

How do all the services/local groups who support me work together to ensure I am getting the support I need.

Everyone (How we work)

Each person should have a chance to feedback to improve services and systems.

Services, community support, and peer groups are connected to help people find the best resources to achieve their goals.

The people I would with share information in an accessible way to support my wellbeing.

Strategic Plan Development

The development of this strategic plan began with an assessment of current situation which involved consideration of the national context in which we work, our statutory responsibilities, our local context and local priorities, our performance against national indicators and information provided in the Population Needs Assessment (PNA). This resulted in the production of an Evidence Document which is published alongside this Strategic Plan and available for review.

The first stage of this assessment was a review of the latest data in relation to population health in Aberdeen City (from PNA): -

Physical Health

- Life Expectancy had been increasing since the early 1980s but has now remained virtually unchanged since 2012-14.
- The latest figures for Healthy Life Expectancy indicate that males can expect to have a period of 16.7 years and females a period of 19.6 years with health problems.

- In 2023, cancer and circulatory diseases (such as coronary heart disease and stroke) together accounted for half (50.4%) of all causes of death.
- In 2023, the most prevalent disease overall was hypertension, at an incidence of 11.1 patients per 100 population.

- The incidence of Chronic Obstructive Pulmonary Disease (COPD) at 200 (3-year average number) has increased.
- Data from the Scottish Health Survey estimates that in 2019-23, 18% of people had doctor-diagnosed asthma, up from 16% in 2018-22

Mental Health

- In 2023, Dementia and Alzheimer's disease were the leading cause of death for females (13.4% of all female deaths) and the second most common cause of death for males (7% of all male deaths).
- In 2023 there were 29 probable suicides (24 male and 5 female).

- In 2019-2023, an estimated 18% of people were deemed to have a potential psychiatric disorder.
- Depression was reported as the second most prevalent condition at 7.3 patients per 100 population.

Health Behaviours

- In 2019-2023 23%of adults were drinking alcohol above the guideline recommendations which is an increase on the previous period.
- In 2023 there were 54 drug related deaths an increase from 42 in 2022.
- Over half of the deaths in Aberdeen City in 2023 were associated with cancers and circulatory diseases, for which smoking, obesity, and physical inactivity are risks.

- Smoking during pregnancy can have significant consequences for mother and baby, and increases the risk of stillbirth, miscarriage and preterm birth. Around 9% of pregnancies booked are current smokers.
- In 2022 and 2023, 5.6% of 13–18-year-olds reported that they were vaping regularly which could lead to smoking in later life.

- Obesity rates in 2023 were 32%, a significant increase from 23% in 2016-19.
- In the latest 2020-2022 reporting period, bowel cancer screening uptake were 67.8%.
- The latest data for the three-year rolling period 2020-2023 indicates an uptake rate of 80.3% for breast cancer screening.
- The NHS Grampian cervical cancer screening uptake rate for females aged 25-49 in 2021/22 was 67.3%

- During 2022-23, 56,564 Influenza vaccines were administered to eligible groups which equates to and uptake rate of 50.8%.

Strategic Plan Development

There are obvious challenges in relation to the physical and mental health of the population of Aberdeen as well as to influencing health related behaviours in order to improve population health and help reduce the harm and negative impacts of some of the health behaviours.

Health Indicator	Least Deprived	Most Deprived
Life Expectancy Males	81.1	71.7
Life Expectancy Females	84.8	76.4
Healthy Life Expectancy (Scotland)		26 years lower
Alcohol related hospital admissions (per 100,000)	300.7	1,044.2
Alcohol related deaths (per 100,000)	10.5	40.4
Drug related hospital admissions (per 100,000)	39.9	532
Drug related deaths (per 100,000)	5.2	57.3
Psychiatric patient hospital admissions (per 100,000)	144	343
Prescriptions for anxiety, depression and psychosis	12.5%	23.8%
Cancer registrations (per 100,000)	571.2	768.9
Early deaths from cancer (per 100,000)	98	249
Hospitalisations for coronary heart disease (per 100,000)	256.2	443.1
Early death from coronary heart disease (per 100,000)	25	95.9
Hospitalisations for COPD (per 100,000)	65.4	402.9
Incidences of smoking in pregnancy	2.8%	25%
Disposable income required to be spent on healthy diet	11%	50%

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Impact of Deprivation

There is a strong association between deprivation and health outcomes as indicated by the table below. According to an analysis of the Scottish Index of Multiple Deprivation (SIMD) in 2020,19.3% of Aberdeen City's population are in the three most health deprived data zones. This is higher than Edinburgh (16.2%) but considerably lower than both Dundee (48.4%) and Glasgow (54.4%). The neighbourhoods in the 20% most deprived data zones (Quintile 1) include Torry, Woodside, Seaton, Northfield, Middlefield, Tillydrone, Mastrick, Sheddocksley and George Street.

Reducing the impact of inequality and influencing the wider determinants of health will be a focus of the IJB.

Demographics and Burden of Disease

By 2028 the number of 65–74-year-olds will increase by 14.4% and the number of 75+ will increase by 16.1% - that represents an additional 4,000 people who will potentially require health and social care. Interestingly in the 75+ age category the increase in the male population is expected to be 26.2%. In addition, 28% of people report they are living with limiting, long term conditions whilst 11% report living with non-limiting conditions.

The Scottish Burden of Disease study forecasts a 21% increase in the annual disease burden in Scotland over the next 20 years. Applied to the local context this would mean potentially an additional 6% reporting limiting, long term conditions.

Over half of single occupancy households are associated with people over 50 which increases the risk of limited access to informal carers should the need arise.

All of the above have the potential to increase future demand for health and social care services.

Strategic Plan Development

Budget

A report to the IJB on 18th March 2025 confirmed that the final outturn position for 2024/25 indicated that there is a recurring overspend of £16.786m. This was resolved using a combination of funding from partners and available reserves however there are no remaining uncommitted reserves with which to balance financial risks for 2025/26 onwards. The City IJB position reflects the common position across Scotland.
The future of Health and Social Care is marked by considerable financial uncertainty, driven by rising demand, inflationary pressures and the need for systematic reform. The 2025 spending review highlighted a critical funding gap for all IJB's in Scotland with all required to make savings, Aberdeen City is no different.
The revised Medium Term Financial Framework reports the following in terms of areas of budget pressure over the four years of this Strategic Plan.

Estimated Budget Pressures	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000
Pay	4,122	4,127	4,233	4,360
Non pay inflation	606	646	666	686
Primary Care Prescribing	2,524	2,000	2,000	2,000
Commissioned Services	9,344	3,847	3,962	4,081
Additional service demand	1,485	1,997	2,082	2,169
Recurring deficit	16,786			
eNIC pressure	2,050			
	36,918	**12,617**	**12,943**	**13,296**

It is crucial that budget savings are achieved on a recurring basis for the IJB to remain in financial balance and enable the continued provision of health and social care. This will require the IJB to take action to offset these pressures, either by reducing forecasted demand, reducing costs, or both, in order to achieve a balanced budget in future years. The Routemap contained at Appendix A of this plan gives an indication of the tough decisions that need to be made.

The main area of forecasted budget pressure is Commissioned Services. The reason for this is a combination of increasing demand for social care caused by an ageing population and the anticipated increase in the burden of disease along with the increasing cost of delivery of services. A recent Audit Scotland report confirmed that there has been a 19% rise in the hourly cost of providing care at home between 2016/17 and 2022/23. The actions the IJB need to take must cover both reducing the forecasted demand and reducing the cost of delivering services.

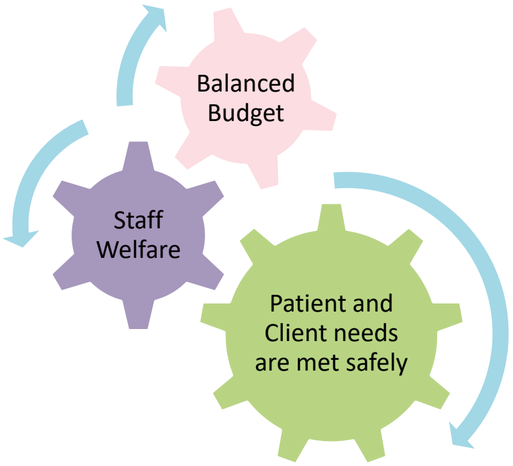
The other main cost pressure comes from payroll costs. The IJB are currently looking to manage these costs by robust vacancy management which includes a process for considering alternative ways that the service could be delivered. We need to maximise the opportunities that integration and technology bring in order to ensure efficiency and value for money.

There is a Grampian Group looking at reducing prescribing costs through reviewing what is being prescribed where and also seeking to reduce the level of waste and it is hoped that work will at least mitigate some of the cost pressures on prescribing.

In terms of non-pay costs the IJB will continue to implement our policy of 'essential spend only' in relation to non-pay spend, certainly in the first two years of this Strategic Plan. The IJB do not own assets, and asset costs are only 1% of the IJB budget, however we will continue to seek ways to consolidate our use of premises including collaborating with our partners to maximise the use of resources across the city of Aberdeen and to identify other non-pay costs where savings could be made.

Assuming savings can be achieved over the short-term, 2025/26 and 2026/27, there still remains a small deficit in future years that will require to be addressed. Whilst the IJB need to deliver within budget they are committed to protecting service delivery to the most vulnerable citizens of Aberdeen and to achieving balance between available budget, meeting client and patient needs safely, and staff welfare.

Achieving Balance



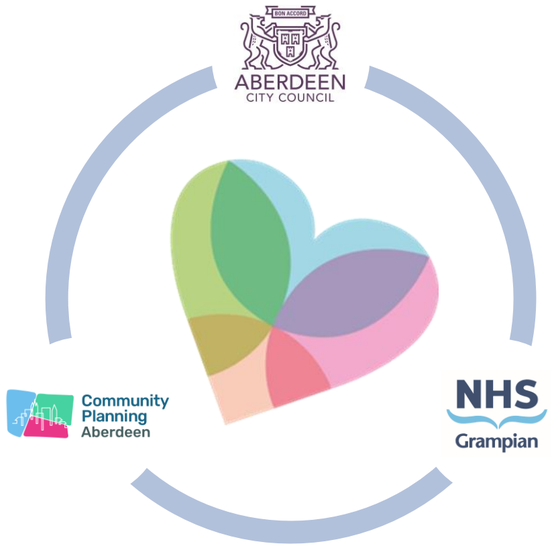
Alignment with partners

The next stage of assessment took a whole system approach and considered what Community Planning Aberdeen (CPA); Aberdeen City Council (ACC) and NHS Grampian (NHSG) were doing with their planning.

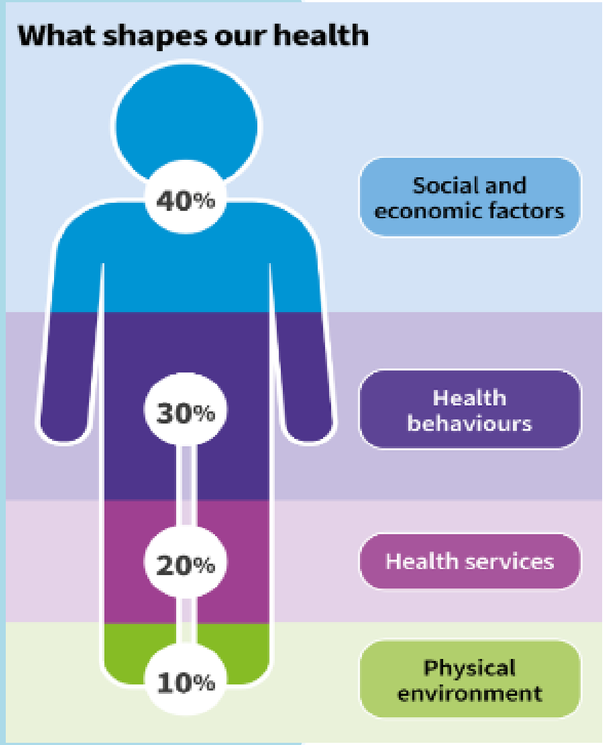
This led to the inclusion of some of the Local Outcome Improvement Plan activities in our Delivery Plan, a joint approach with ACC on consideration of the wider determinants of health and the use of case studies based on real life service users to bring our response to their needs alive.

It also led to the joint public consultation exercise undertaken using the 14 themes of the Scottish Place Standard Tool the outcome of which informed development of both the Strategic and the Delivery Plan.

Finally, it prompted the use of a Logic Model tool to inform our theory of change (see figure on page18).



Wider Social Determinants of Health



Health outcomes in Aberdeen are shaped by social and economic factors, health behaviours, access to health services and the physical environment.

In terms of **children and young people**, challenges exist during the period from before birth to the start of school, including maternal drug and alcohol use, and smoking at the beginning of pregnancy. Inequities in education, particularly in early life contribute to long term health disparities impacting things like the development of early speech and language skills, the uptake of childhood immunisations, and the mental health and wellbeing of children and young people.

The transition from children's to adult social care services particularly for children with a learning disability is often challenging and there is a need to ensure this is more effective and does not adversely impact outcomes for these children.

Aberdeen City Council have developed the Family Support Model which is a new approach to support families with complex and multi-faceted challenges to shift the focus from reactive and risk-based services to upstream and preventative approaches and this will help address inequality in these areas. ACHSCP services will work as part of that model to provide relevant health and care to those families.

A healthy **economy** is inextricably linked to the health and wellbeing of a population. People who experience economic inequality can experience poorer health and wellbeing. ACHSCP can help people maintain or improve their health and wellbeing in order that they can fulfil their role in the workplace, maintain their income, provide a sense of purpose and contribute to a healthy economy.

Having **housing** which is affordable, warm, and secure is an essential part of wellbeing. The availability, location, type, and quality of housing is also important. Some households experience fuel poverty and some residents require specialist provision housing as a result of ill-health or disability. For a range of reasons, others are without a secure place to live. The Aberdeen City IJB is responsible for disabled adaptations, and we will work with housing providers and other partners across the city to support the provision of adaptations enabling people to live independently in their own homes for as long as possible. We will share information on predicted need to enable housing colleagues to plan for future housing requirements. We will also continue to provide bespoke health and care services to the homeless population.

The **natural environment** and access to green (land) and blue (water) space is vital to health and wellbeing. Climate change poses risks to physical health associated with excess heat or cold, and the impact of air pollution. It also poses risks to mental health in relation to the impact of loss or damage from extreme weather events.

Case Studies & Lived Experience

As part of the joint approach a number of case studies have been prepared. Below are a sample of these along with a description of how the IJB Strategic plan could support each.
NB: whilst the case studies are an amalgamation of scenarios relating to real people the names are fictional, and the photos are stock images.

Name: Amara
Frail Person

About Amara
- Amara, 83 is a retired widow who lives in sheltered housing and relies on her state pension and benefits for income.
- Her three children and two grandchildren live nearby and help with transport and shopping now that she is too frail to use public transport.
- She lives independently within sheltered housing, socialising with neighbours, and has no need of any social care. She has a tablet and smartphone but relies on her family to help with these technologies.
- She would like to be able to use them independently to find out what other benefits she may be entitled to and to interact with services, but she is under-confident.

What does Amara need?
- Support to use and understand digital technology.
- Access to groups of likeminded people with similar aspirations
- Proactive communication from authorities on what support is available to her.

What is Amara feeling?
- Like a burden to her family because she relies on their help.
- Under-confident about her abilities to navigate digital services.
- Concern about being a victim of online fraud
- Hopeful of being able to enhance her skills and to live as independently as she can for as long as possible.

To support Amara…
Our Stay Well Stay Connected programme (working alongside the Aberdeen City Council Future Libraries Model) helps to address the social isolation Amara feels and also has programmes to support those who are digitally excluded. We know we need to improve information about the health and social care services and community groups available and how to access them so people like Amara can be more proactive and self-sufficient in meeting their own needs.

Name: Frank
Complex Mental Health

About Frank
- Frank, 35, has lived in a residential facility to support him with his long-term complex mental health problems, having previous spent time as a hospital inpatient.
- The shared housing, living with other with mental health problems is causing Frank difficulties. He finds the home noisy and is unhappy at sharing his living space with people he doesn't like.
- His parents have seen a deterioration in his presentation and wellbeing as a result of his living conditions.
- The staff at the facility have also expressed concerns and, although they provide support for his health and independence, this support is not consistently applied due to frequent changes in staff.
- His parents fear he will be admitted to hospital again if his living conditions do not change.

What does Frank need?
- A living space that is quieter and feels like home, where he can choose his housemates and be closer to his family.
- Access to support within the community rather than hospital-based care.
- Consistency of support from healthcare team.
- Opportunities to make more friends to enhance his social life.
- Access to hobbies and interest that support his mental health.
- An effective and clear recovery plan is essential for Frank to manage his condition.

What is Frank feeling?
- Frustration and anger due to the lack of suitable accommodation and services that meet his needs locally and the long wait time for a more suitable environment.
- Anxiety and worry about the possibility of being detained in the hospital if his situation reaches a crisis point.
- Unhappiness with his current noisy living environment and sharing space with people he wouldn't choose to live with.
- Fear that the frequent staff changes, and inconsistent support may lead to his behaviour deteriorating making the placement unsustainable, potentially resulting in another hospital admission.
- Desire for independence and connection to live independently in a quieter, homely environment close to his family, where he can access community support and engage in hobbies that support his mental health.

For Frank…

Our principle of 'care closer to home' will help meet Frank's needs and our strategic approach of Grampian Hope should ensure he has wrap around care from a consistent and known team. Support from community based commissioned substance use services should help Frank on his road to recovery.

Case Studies & Lived Experience

Name: Sarah
Unpaid Carer

About Sarah

- Sarah, 41 is a single parent working 30 hours per week as a supervisor in a supermarket.
- She has a 16-year-old daughter with a learning disability who needs support with communications, mobility, personal care and eating. Sarah receives help from paid carers and her sister and mother.
- Her sister's availability will soon decrease, and her mother is being assessed for dementia, meaning she may no longer be able to support Sarah, and may need support herself at some point in the future.
- Sarah relies on her smartphone for communication. She has a driving licence but relies on public transport to get around the city.

What does Sarah need?

- To maintain her flexible working hours and income.
- To ensure her daughter's health and wellbeing and development support her independent living skills.
- To undertake the guardianship process for her daughter and make decision on her behalf as she transition in adulthood.
- To find supportive groups for her daughter and improve her daughter's community abilities.
- To secure alternative care for her daughter and develop a contingency plan for emergencies.
- To increase her savings for a suitable vehicle.

What is Sarah feeling?

- Concern that the support network provided by her mother and sister will be reduced.
- Concern that she may now be required to support her mother should she be diagnosed with dementia.
- Frustration at the lack of support for single parents whose children have additional support needs.
- Frustration at the lack of continuity in the people providing paid-for care.
- Frustration at the complex nature of health and guardianship processes
- Anxiety about everything she must having in place for the care of her daughter.

Supporting Sarah…

Sarah can be supported by the Aberdeen City Adult Carers Support Service who will help her to develop and Adult Carers Support Plan which will detail her specific needs in relation to maintaining her caring role and having a life alongside caring. They can also signpost her to groups and services that can help her navigate the care system for her daughter and help access to transport.

Public Consultation

There was strong support for the priorities we specifically mentioned in the Place Standard Tool - refreshing our Primary Care Improvement Plan (93.6%), a focus on community and home-based services allowing people to live independently (93.4%), deliver and promote a range of opportunities to increase social interaction and improve physical and mental health and wellbeing (93.1%) and continue our inclusive approach when designing and delivering services (91.9%). In addition, the following comments were made: -

Feedback	What we have done
Access to healthcare services, particularly GPs and dental services is a concern	Included commitment to implementing and reviewing our Primary Care Improvement Plan in our Delivery Plan
There is a lack of support for those with mental health issues and substance abuse.	Included specific actions in our Delivery Plan around support for people with complex needs and substance use as well as specifically reducing the harm from drugs and alcohol use.
More community involvement and better transparency, communication and collaboration	Included commitment to this in the 'Our Strategic Approach' section
Use different methods to reach out involving disabled and visually impaired individuals in consultations	Included commitment to this in the 'Our Strategic Approach' section although note that we will include all sensory impairments.
Information Dissemination and Community Engagement need to improve	Included commitment to this in the 'Our Strategic Approach' section
Listen to our concerns and act on them, keep us informed on what is happening and how our feedback is being used	Included commitment to this in the 'Our Strategic Approach' section
Identify areas of health inequality and focus, increase resources to those	Augmented the section on inequality to increase focus however at this point we cannot increase resources although that will remain an ambition for the future.
People need to take responsibility for their health, with the recognition that some people need support and education to do this.	Included commitment to this in the 'Our Strategic Approach' section
Keen on lifestyle prescribing (e.g. nature walks)	Included reference to alternative care in the 'Our Strategic Approach' section
Be realistic in relation to funding (i.e. only commit to actions in the Strategic plan that can be delivered within reducing budgets)	Considered as part of Strategic Plan development and added as part of Chair of IJB Foreword

Our Challenge and Response

The assessment of our current performance in relation to both service delivery and financial performance and the current and predicted health of the population in Aberdeen and the predicted growth of the older population and burden of disease has led to the creation of the following key challenge and response statements.

Our Key Challenge

"Our demand is predicted to increase through a combination of an ageing population and a higher burden of disease. The resource we have available to us is not enough to continue to deliver the current level of service. There is evidence of a growing divergence in outcomes between those citizens who live in more affluent areas of the city to those who live in areas of deprivation."

Our Response

We need to take action to reduce the predicted demand. We must transform the way we deliver some services so we can maximise the resources we have. We will need to stop some services and reduce the level of service we provide. We need to take steps to improve equity of access to care and support to ensure better outcomes for people living in areas of greater deprivation.

Strategic Aims and Priorities

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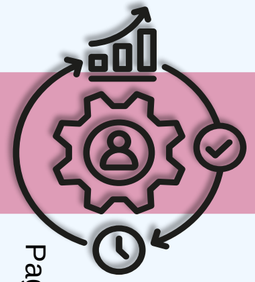
This in turn has led to the creation of the following aims and priorities – more detail on the activities we will undertake to deliver these is contained in our Delivery Plan.

Aims	Priority	Outcome	Measure
 MODERNISE OUR APPROACH TO SERVICE DELIVERY	Make Best use of Resources	Financial Balance	Budget Performance
	Implementing Transformation	Sustainable service provision that can meet future demand.	Service measures around numbers of patients and clients supported, waiting times, unmet need etc. System measures around Delayed Discharges, Emergency Department Attendance, Performance and Admission.
 SHIFT OUR FOCUS TOWARDS PREVENTION AND EARLY INTERVENTION	Improve Physical and Mental Health	Improved population health	National Health and Wellbeing indicators
	Reduce Harm	Reduction in health care need	Level of service demand.

Note that we can't address everything at once and must prioritise/be realistic about what we can do in relation to funding.

Logic Model

Situation

Delivery of community health and social care service to the people of Aberdeen at time of increasing demand and restricted resources

Inputs

Financial Budget
£439 Millon

2,164
Staff Workforce

Activities
What we do

Primary Care Services

Community Nursing

Adult Social Work/ Social Care

Frailty and Older People's Services

Rehabilitation

Public Health/ Health Improvement

Mental Health and Learning Disabilities Services

Sexual Health Services

Substance Use Services

Immunisations

Who we reach

All people in Aberdeen City who require care and support and meet the Eligibility Criteria.

Outcomes

Short

Continuing to meet population need whilst implementing efficiencies and innovations and delivering a balanced budget.

Identifying future transformation and modernisation opportunities and laying the groundwork for these.

Medium

Continuing to meet population need in a slightly different way using more technology and maximising multi agency person led approaches.

Undertaking transformation and modernisation to improve patient and client experience and outcomes

Collaborating more with partners providing more joined up services

Long

Meeting patient and client need in very different ways.

Services are more integrated, accessible, sustainable and person led

Budget is balanced and reserves are being built up for future investment.

Assumptions and Influences

- Demand will continue to grow
- Resources will continue to be constrained

Measures

- Number of patients and clients being supported
- Activity, Waiting Times, and Unmet Need
- ED Attendance, ED Admission and Delayed Discharge

Enablers to Delivery

Finance

Each year we update our Medium-Term Financial Framework (MTFF). This sets out the projected budget available to us over the medium term to support the delivery of our strategic priorities. We anticipate significant financial challenges over the next four years of our Strategy and anticipate a need to stop services or reduce service levels to balance our budget.

To support the development and delivery of our MTFF, we follow a Budget Protocol. This makes provision for consultation with the public on our proposed budget options to address anticipated budget deficits in future years. We will continue to refine and monitor our approach to budget setting to help ensure we evidence an even greater shift to preventative and early intervention activities.

Data

Data is vital to having the relevant information both to plan service delivery in the future (population growth, demographics, burden of disease, impact of deprivation etc.) and to monitor our performance in relation to current activity. Unfortunately, not all of the data that is available is easily accessed or real time and we have only recently clarified our data needs. Data sharing is an issue with information governance arrangements improved data sets and sharing

Infrastructure

Although more and more service delivery will be provided in people's homes many of our services will continue to be buildings based. It is vital that the buildings we use are accessible and fit for purpose. The IJB does not own buildings itself but operates from buildings owned by partners or rented from private landlords. We are currently reviewing our use of premises with a view to maximising space usage and minimising costs. We are also preparing an Infrastructure Plan that dovetails with those of our partners.

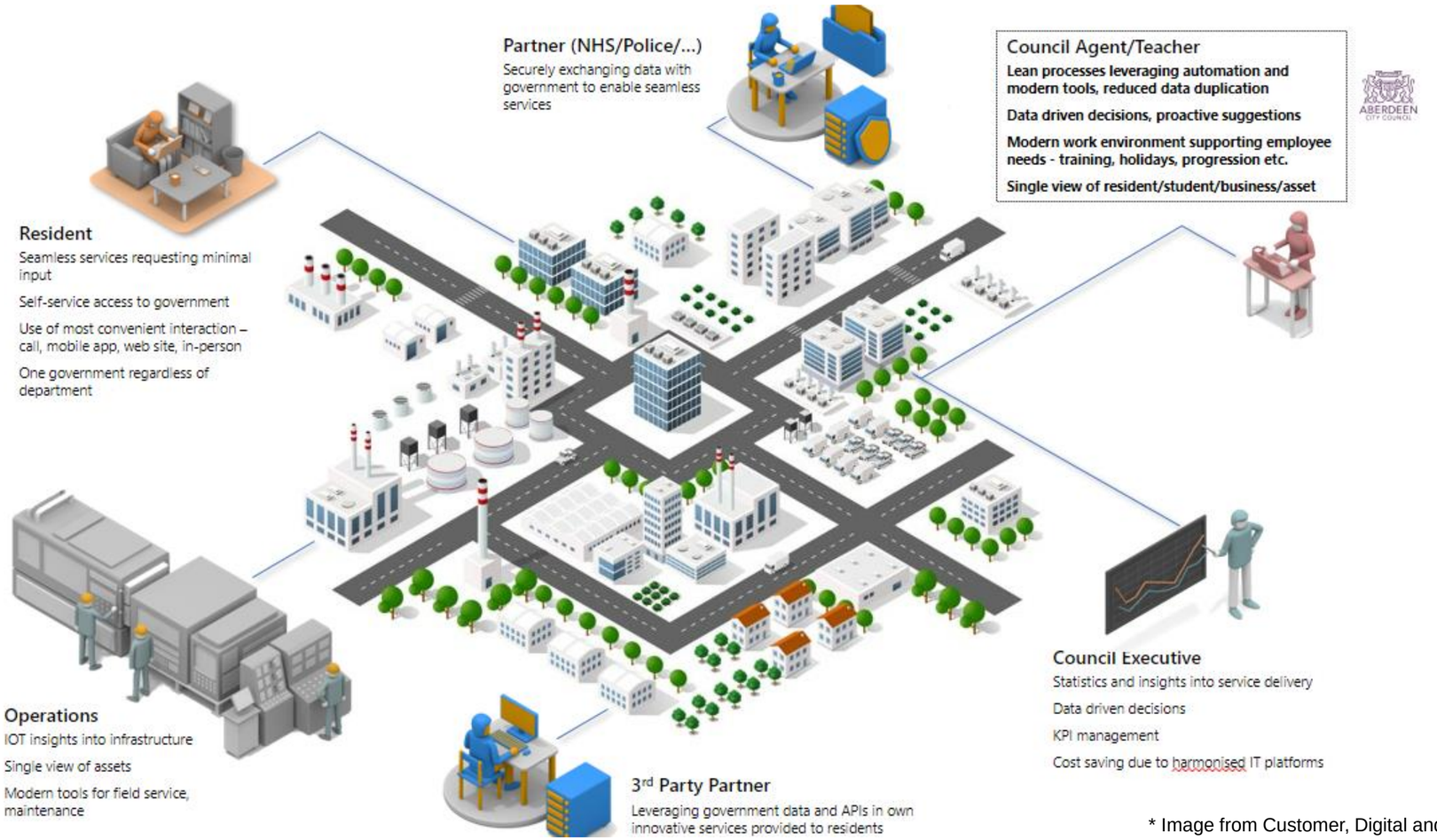
Workforce

It is essential we have the right capability and capacity to meet the future needs of Aberdeen. We will update our Workforce Plan to support the delivery of this Strategy. The challenge of recruitment and retention of staff continues, particularly within clinical and social care settings. However, it is also unlikely that we will be able to afford the same level of staffing in future years. We will look to increase the integration of community teams and maximise the use of digital service delivery whilst ensuring that staff are supported to adapt their skills to this new way of working.

Enablers to Delivery

Technology

This enabler covers both the use of Technology Enabled Care for service users and to digital applications and solutions for staff to modernise service delivery. Undoubtably the introduction of technology will deliver efficiencies in the medium to long term, but it requires investment in the short to medium term. The IJB has been fortunate to secure some initial pump priming external funding to deliver a couple of bespoke initiatives and we will continue to maximise any further similar opportunities. We are aware that not everyone will be able to access and use some of the technology we are seeking to introduce, and we will develop a Digital Inclusion Plan as part of the implementation plan.



* Image from Customer, Digital and Data Strategy (ACC)

Strategic Risks

Our Strategic Risk Register (SRR) contains eight risks. These are listed below along with a narrative of how this strategic plan is designed to mitigate each.

Risk	Event	Strategic Plan Mitigation
Commissioned Services (including General Practice)	Potential failure of commissioned services to deliver on their contract within available budget	The GP Vision work and the transformation projects focused on commissioned social care services will both help to achieve sustainable service delivery in these areas.
Financial Sustainability	A risk that the IJB exceeds its allocated funding	Current and future transformation and budget savings projects along with enhanced monitoring arrangements will help to achieve financial balance.
Delivery of Hosted Services	A risk that these do not deliver expected outcomes	There isn't a specific activity in the Strategic or Delivery Plans but an ongoing business as usual activity is the delivery of the recommendations from the Internal Audit on Hosted Services
Performance	A risk that services fail to meet national, regulatory, and local standards	Prevention and Early Intervention activity to manage demand Service modernisation and transformation to maximise performance Improved datasets and data sharing to enhance performance monitoring and continuous improvement
Transformation	A risk that people do not receive the best health and social care outcomes	Service modernisation and transformation to maximise the potential to improve outcomes
Involvement of lived experience	A risk that services are not tailored to meet individual needs	Inclusion of a 'strategic approach' of communicating and engaging with our stakeholders and communities, ensuring they are well informed and involved in decisions
Workforce	Failure to manage staffing budgets within forecasted predictions	Commitment to refresh the Workforce Plan
Premises	A risk that buildings across the city, operated by, or overseen by, the IJB/ACHSCP are not being used to maximum efficiency and are not in line with statutory/regulatory requirements.	Current Premises Review Commitment to develop an Infrastructure Plan

Implementation and Governance

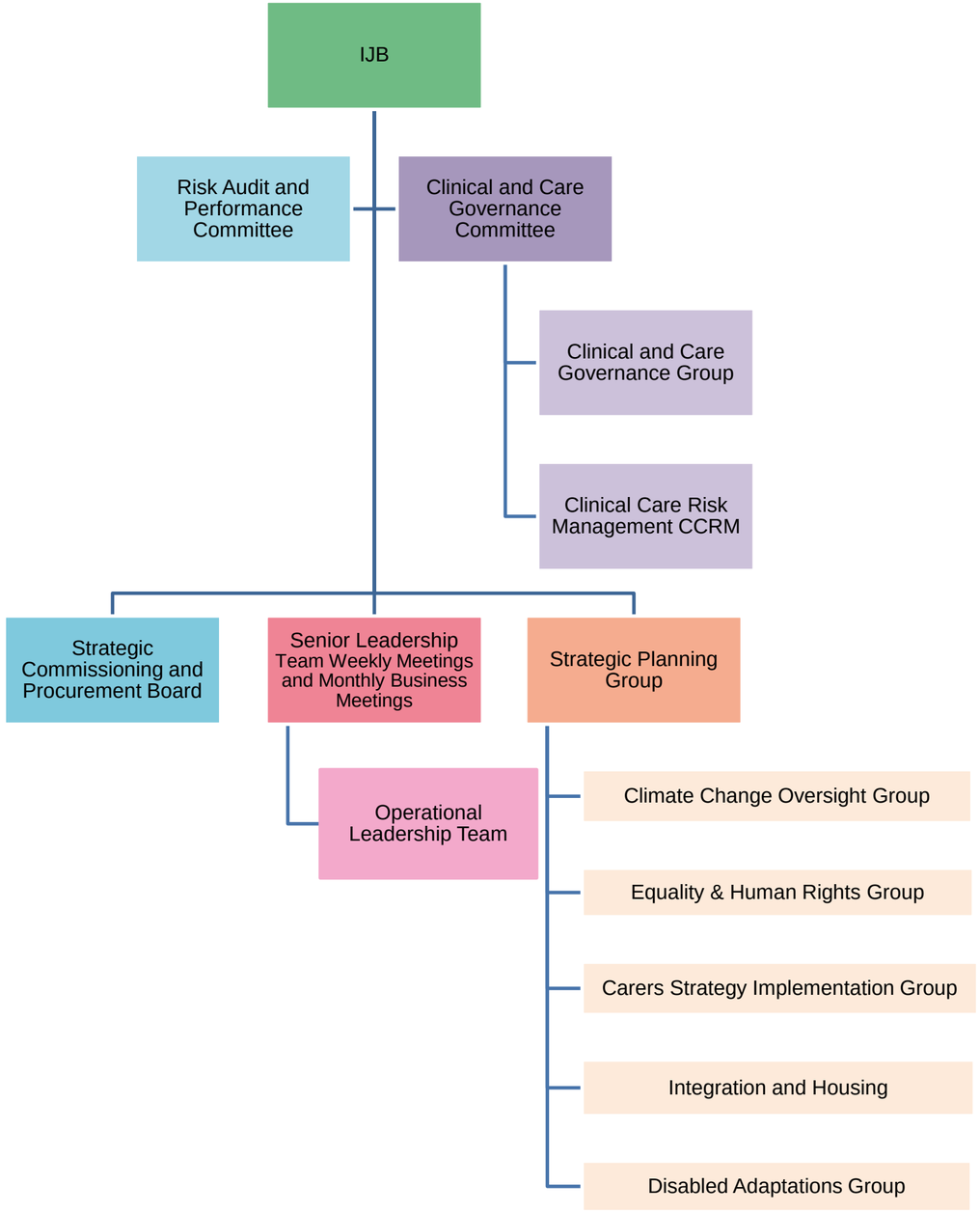
The implementation of this four-year Strategic Plan will be achieved through the successful delivery of four Annual Delivery Plans. These will contain details of the projects and activities we plan to undertake along with timelines and measures. The Routemap attached as Appendix A gives a high-level overview of the activity, we plan to undertake over the four-year lifespan of the Strategic Plan although it should be noted that this is our intention at this time. Every year a review of progress and emerging priorities will be undertaken, and the subsequent year's Delivery Plan will be developed which will continue to be aligned to both the Medium-Term Financial Framework and the Strategic Risk Register.

We will continue to use a programme and project management approach to delivering our Strategic and Delivery Plans. Each project or activity is allocated a member of the Senior Leadership Team to lead on its delivery and a timescale within which it will be started and delivered. A project team will undertake agreed tasks to contribute to the overall successful delivery and milestones and performance measures will be agreed. The availability of resource to deliver will form part of the consideration process when determining what we can commit to in the Delivery Plans. The projects or activities vary in size and complexity. Some of the more complex transformational projects will be subject to formal evaluation, the outcome of which will inform future transformational activity.

As part of our normal approach to service change, we will co-design and coproduce solutions through engagement and consultation with our communities. Each significant service change will be impact assessed using our 'Assessing our Impact' process, details of which can be found on the Aberdeen City Health and Social Care website here.

Progress on the Delivery Plan will be reported monthly to our Senior Leadership Team, and quarterly to both the Risk Audit and Performance Committee (RAPC) and the Chief Executives of Aberdeen City Council and NHS Grampian. Progress will be determined using both project/activity update narrative referring to performance against the project plan and relevant milestones, and data collated in relation to Key Performance Indicators as agreed for each.

Progress against our Strategic Plan including data in relation to National and Ministerial Strategic Group (MSG) Performance Indicators will be reported annually to the IJB, the Scottish Government, and other stakeholders including the public, through the publication of our Annual Performance Report (APR) final-achscp-annual-performance-report-2023-2024-5.pdf).



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Translation and Interpretation available
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ABERDEEN CITY COUNCIL

NHS Grampian

Routemap to Delivery of the Strategic Plan 2025-29

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Appendix A

The IJB's Strategic Plan 2025-29 will be delivered over four years. As the environment we are currently operating in is uncertain and constantly changing, we have only developed a detailed Delivery Plan for 2025-26. This is already in progress and is underpinned by project implementation plans which will be monitored via the governance process detailed in the Strategic Plan. Detailed Delivery Plans will be developed for subsequent years, and these will be informed by the progress made during the previous year and by any emerging priorities or risks. The actions or projects in these plans may continue or build on work that was started in 2025/26 and/or they may contain new actions as a result of annual review or appropriate timing or readiness.

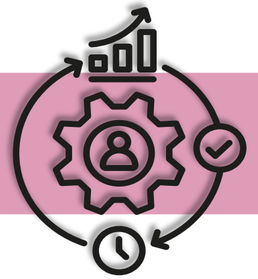
Consideration has been given to longer term planning and this Appendix contains what we have called our Routemap to Delivery over the four financial years 2025-26 through to 2028-29. The actions or projects listed under 2025-26 are all currently in progress as part of the 2025-26 Delivery Plan. These will deliver the £14.3 million target savings for 2025-26 required to achieve a balanced budget. For subsequent years the Routemap lists actions which, at this moment in time we would intend to take in these years. Confirmation or what our future intentions are for each year will come at the point the Medium-Term Financial Framework is finalised each year when we will also develop the corresponding detailed annual Delivery Plan

Work has already begun on developing implementation plans for the actions and projects currently listed under 2026-27 and we know that our budget pressures for 2026-27 are £4.1 million from pay, £1.4 million from non-pay, £3.8 million from commissioned services and £2m from additional demand. Whilst it is difficult to quantify the level of savings that can be achieved in future years, as savings are currently being achieved or planned in these areas, we have a degree of confidence that the actions and projects we are proposing for future years will balance the budget. The robust vacancy management process which has been implemented is already reducing pay costs and there are further opportunities in the integration and restructuring of teams and the introduction of digital technology to achieve efficiencies in some processes which should lead to the achievement of the saving required. The premises review has indicated a level of under-utilisation, and we are confident when we have been able to work out the logistics and identify mitigations to minimise the consequential impacts on patients and staff, that we will be able to achieve savings. Opportunities for further efficiencies in commissioned services contracts are already being identified and again should lead to the achievement of the savings required.

Research undertaken by UK national organisations further enhance the confidence we have in the actions we are proposing. The National Association of Primary Care found that the implementation of integrated neighbourhood teams resulted in a 7% reduction in the cost of care for high intensity patients whilst also reducing demand on GPs and on outpatient departments by 6% each, Emergency Department attendance by 12% and bed days used by 14%.. The Social Care Institute for Excellence found that community based reablement led to 62% of clients no longer needing a service after 6-12 weeks, compared with 5% in the control group, and that 26% had a reduced requirement for homecare hours, compared with 13% of the control group. The NHS Confederation/NHS Providers found that implementing Discharge to Assess/Discharge Without Delay led to a 37% reduction in average length of stay in community hospitals with 83% of patients being discharged with no immediate support requirements. It should be noted that these reductions and savings are not net of the cost of investment, but they do give an indication of the difference that can be achieved.

As well as reducing costs our Strategic Plan confirms that we need to reduce future demand for services. This is where our prevention and early intervention aim will have an impact however it is very difficult to predict the level of this will have as we are reliant on changing individual behaviours. Data from Public Health Scotland states that primary prevention is 3-4 times more cost effective than treatment. The return on investment for immunisations is £34 for every £1 spent and a study by the University of Wales indicated that there is an average return of £14 for every £1 invested in prevention initiatives so we have confidence that successful interventions will yield results.

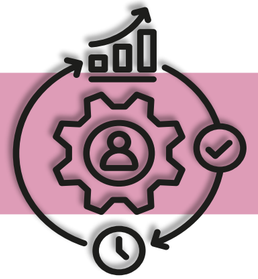
Whilst a level of confidence currently exists the process of developing detailed Delivery Plans in future years based on knowledge and experience gained and evidenced by robust implementation plans will increase confidence levels as we progress through the implementation of the Strategic Plan.



MODERNISE OUR APPROACH TO SERVICE DELIVERY

Strategic Priority – Make best use of resources

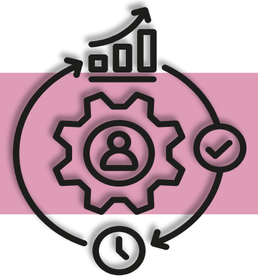
2025/26	2026/27	2027/28	2028/29
Actions to reduce non pay costs			
Undertake review of premises utilisation and make recommendations for future consolidated use	Implement recommendations of review seeking to consolidate/vacate a minimum of two premises whilst also maximising the utilisation of remaining premises. Continue to review other options for consolidated use widening the scope of the review to partner premises and making recommendations.	Implement recommendations of review seeking to consolidate/vacate a minimum of two premises whilst also maximising the utilisation of remaining premises..	Implement recommendations of review seeking to consolidate/vacate a minimum of two premises whilst also maximising the utilisation of remaining premises..
Deliver savings in Utility Costs	Deliver further savings in Utility Costs and identify other building related costs where efficiencies could be made utilising digitised processes where relevant.	Maximise use of digital tools to further reduce building related costs.	Maximise use of digital tools to further reduce building related costs.
Actions to reduce pay costs			
Deliver efficiencies from the robust management of vacancies	Continue robust management of vacancies	Continue robust management of vacancies	Continue robust management of vacancies
Reduce the number of posts in ACHSCP establishment through use of VSER and implement team restructuring through increased integration and use of technology	Continue the utilisation of VSER, integration and technology to streamline and implement team restructuring through increased integration and use of technology	Continue the utilisation of VSER, integration and technology to streamline and implement team restructuring through increased integration and use of technology	Review ACHSCP establishment in light of changes and confirm any further reduction required.



MODERNISE OUR APPROACH TO SERVICE DELIVERY

Strategic Priority – Make best use of resources

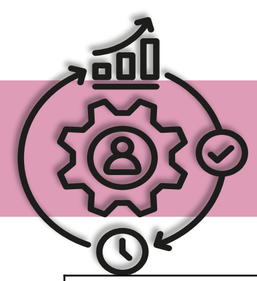
2025/26	2026/27	2027/28	2028/29
Actions to reduce cost of service delivery and/or achieve greater efficiency			
Modernise Care Delivery for Older People	Review consistent application of new guidance in relation to annual review and consideration of Eligibility Criteria	Review consistent application of new guidance in relation to annual review and consideration of Eligibility Criteria	Review consistent application of new guidance in relation to annual review and consideration of Eligibility Criteria
Review Mix of Residential Care	Monitor the mix of residential and non-residential care and ensure it is appropriate for individual needs	Monitor the mix of residential and non-residential care and ensure it is appropriate for individual needs	Monitor the mix of residential and non-residential care and ensure it is appropriate for individual needs
Modernise care delivery models for vulnerable adults including people with Learning Disabilities and Complex Needs.	Ensure implementation of contract reviews and robust application of tiered service delivery	Ensure implementation of contract reviews and robust application of tiered service delivery	Ensure implementation of contract reviews and robust application of tiered service delivery
Implement transitions process to improve service user experience and future financial planning	N/A	Evaluate implementation of Transitions process.	Implement recommendations from evaluation of Transitions process
Redesign Day Care Provision for people with Learning Disabilities	Review impact of day care redesign and seek further redesign at lower cost	Review impact of further redesign	Ensure robust review of all Day Care provision in relation to client needs
Review use and cost of Out of Area care	Identify initiatives to bring people back within area and develop business case to support implementation	Implement at least one initiative to bring people back within area	Implement at least one initiative to bring people back within area
Reduce spend and achieve value for money with key commissioned service provider	Reduce spend and achieve value for money with key commissioned service provider	Reduce spend and achieve value for money with key commissioned service provider	Reduce spend and achieve value for money with key commissioned service provider



MODERNISE OUR APPROACH TO SERVICE DELIVERY

Strategic Priority – Make best use of resources

2025/26	2026/27	2027/28	2028/29
Enabling Actions			
Develop Dashboards to support the planning and delivery of services	Investigate the use of analytics and predictive demand management tools	Review data needs and identify gaps	Refresh Dashboards in light of review
Refresh Workforce Plan focusing on future staffing requirements taking service transformation into account	Ensure robust implementation of Workforce Plan including delivery of support to staff to build skills and confidence in new ways of working.	Ensure robust implementation of Workforce Plan including delivery of support to staff to build skills and confidence in new ways of working.	Ensure robust implementation of Workforce Plan and begin preparations for refresh
Refresh Carers Strategy ensuring unpaid carers in Aberdeen City continue to be supported in their caring roles	Ensure robust implementation of Carers Strategy	Ensure robust implementation of Carers Strategy	Ensure robust implementation of Carers Strategy and begin preparations for refresh
Implement an Individual Budget approach to the charging of social care Ensure charges are increased at least in line with inflation.	Implement the revised Contributing to your Care policy with a view to increasing income Ensure charges are increased at least in line with inflation.	Scope additional opportunities for income across all services Ensure charges are increased at least in line with inflation.	Implement opportunities for additional income. Review the implementation of the Contributing to your Care policy Ensure charges are increased at least in line with inflation.



MODERNISE OUR APPROACH TO SERVICE DELIVERY

Strategic Priority – Implementing Transformation

2025/26	2026/27	2027/28	2028/29
Actions to reduce cost of service delivery and/or achieve greater efficiency			
Deliver city commitments in the GP Vision	Deliver city commitments in the GP Vision	Deliver city commitments in the GP Vision	Deliver city commitments in the GP Vision
Implement and review Primary Care Improvement Plan (PCIP) to identify, successful efficient delivery of services and areas of improvement	Continued implementation of PCIP	Continued implementation of PCIP	Continued implementation of PCIP
Deliver the Discharge Without Delay (DWD) Collaborative commitments	Review impact of DWD implementation and expand concept to other community services where relevant	Review impact and explore other initiatives to improve discharge, maximising additional capacity created through social care transformation	Review discharge data and target the root cause of continuing delays
Redesign model of support to Amputees to community-based provision	Maximise the benefit and efficiency of reablement in community pathways and hospital discharge	Review reablement pathways and identify improvements	Implement improvement initiatives identified in relation to reablement
Codesign alliancing work with Counselling Services	Ensure robust implementation of new contract review process and continue with scheduled review of commissioned services contracts and work with providers to reduce costs	Ensure robust implementation of new contract review process and continue with scheduled review of commissioned services contracts and work with providers to reduce costs	Ensure robust implementation of new contract review process and continue with scheduled review of commissioned services contracts and work with providers to reduce costs
Implement redesign of residential substance use service with a view to delivering a community-based support service model			
Develop an Initial Point of Contact Model (pre assessment offer) for adult social care.	Scope development of a digital front door approach	Implement a digital front door approach	Deliver a Single Point of Access
In conjunction with ACC colleagues, influence the redesign of Sheltered Housing to modernise the model of Housing Support .	Refresh our Market Position Statements to ensure clear articulation of service need	Review Housing support provision and other aspects of Housing for Varying Needs	Refresh our Market Position Statements to ensure clear articulation of service need

SHIFT OUR FOCUS TOWARDS PREVENTION AND EARLY INTERVENTION

Strategic Priority – Improve Physical and Mental Health

2025/26	2026/27	2027/28	2028/29
Actions to reduce future demand for services			
Increase the number of people who accept the invitation of cancer screening on the basis of informed consent.	Review 2025/26 performance in relation to cancer screening uptake and adjust approach to make further improvements as required	Review 2026/27 performance in relation to cancer screening uptake and adjust approach to make further improvements as required	Review 2027/28 performance in relation to cancer screening uptake and adjust approach to make further improvements as required
Improve uptake of immunisations to at least the Grampian average level by March 2027	Improve uptake of immunisations to at least the Grampian average level by March 2027	Review immunisation uptake rates and adjust approach to make further improvements as required	Review immunisation uptake rates and adjust approach to make further improvements as required
Publish an agreed multi-agency Healthy Weight Action Plan for Aberdeen City by December 2025	Implement the multi-agency Healthy Weight Action Plan for Aberdeen City	Review the implementation of the multi-agency Healthy Weight Action Plan for Aberdeen City and agree revised Action Plan	Implement the revised multi-agency Healthy Weight Action Plan for Aberdeen City
Publish an agreed multi-agency Public Mental Health action plan for Aberdeen City by March 26	Implement the multi-agency Public Mental Health Action Plan for Aberdeen City	Review the implementation of the multi-agency Public Mental Health Action Plan for Aberdeen City and agree revised Action Plan	Implement the revised multi-agency Public Mental Health Action Plan for Aberdeen City
Publish an agreed multi-agency Ageing Well action plan for Aberdeen City by April 2026	Implement the multi-agency Ageing Well Action Plan for Aberdeen City	Review the implementation of the multi-agency Ageing Well Action Plan for Aberdeen City and agree revised Action Plan	Implement the revised multi-agency Ageing Well Action Plan for Aberdeen City
N/A	Review the Stay Well Stay Connected Programme in light of the development of the three Public Health Action Plans and look to consolidate activity into a Wellbeing Strategy and Operating Model maximising the collective resources of partners in the City.	In conjunction with partners implement the Wellbeing Strategy and Operating Model	Review and evaluate the Wellbeing Strategy and Operating Model and implement improvements.

SHIFT OUR FOCUS TOWARDS PREVENTION AND EARLY INTERVENTION

Strategic Priority – Improve Physical and Mental Health

2025/26	2026/27	2027/28	2028/29
Actions to reduce future demand for services			
Decrease the number of women who are smoking during pregnancy in the 40% most deprived SIMD	Review 2025/26 performance in relation to women smoking during pregnancy in the 40% most deprived SIMDs and adjust approach to make further improvements as required. Consider other cohorts to target for smoking cessation.	Implement smoking cessation activity for other cohorts identified and review revised Population Needs Assessment to determine relevant cohorts for improvement activity for 2028/29.	Implement smoking cessation activity for other cohorts identified
Reduce the number of 13-18-year-olds in regular use of Vaping products	Increase focus on Vaping avoidance/cessation to both younger and older age groups Review data in relation to use of chewing tobacco and determine whether avoidance/cessation activity is required in this area.	Implement improvement activity as identified and review data in relation to Vaping and chewing tobacco and determine whether further avoidance/cessation activity is required in these areas.	Implement improvement activity as identified and review data in relation to Vaping, chewing tobacco or any other emerging substance and determine whether further avoidance/cessation activity is required in these areas.
Reduce harm caused by the use of drugs and alcohol	Reduce harm caused by the use of drugs and alcohol	Reduce harm caused by the use of drugs and alcohol	Reduce harm caused by the use of drugs and alcohol
Deliver & implement Action plans for Suicide & Self Harm Prevention Strategies	Deliver & implement Action plans for Suicide & Self Harm Prevention Strategies	Deliver & implement Action plans for Suicide & Self Harm Prevention Strategies	Deliver & implement Action plans for Suicide & Self Harm Prevention Strategies

Aberdeen City
Health & Social Care
Partnership

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ABERDEEN CITY COUNCIL

NHS Grampian

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Appendix B

Changes from draft to final Strategic Plan 2025-2029

Section	Changes
Foreword	Minor text changes notably the inclusion of a reference to 'being realistic' about what we can achieve (consultation feedback). Also foreword now attributed to Hussein rather than John
Introduction	The draft had an 'Introduction' section setting the Aberdeen context and containing a lengthy narrative on the Social Determinants of Health. This is a common introduction to be used in all Aberdeen City Council strategies and plans. In the final version, this has been condensed and included as a Wider Social Determinants of Health section (part of the 'Strategic Plan Development Section' below). The change was made due to feedback that there was an imbalance between this section and the rest of the IJB specific text.
The Problems Facing our Citizens	This is the section containing the 'Case Studies'. The draft version contained 10 Case Studies and our response to them was noted at the end of the section. The final version contains only three of the most relevant Case Studies and how the IJB can help support them is noted immediately underneath each – again this was as a result of feedback we received as part of the consultation.
Current Service Delivery	This section did not feature in the draft. The rationale for including it is based partly on feedback from the external support who suggested we needed to make a stronger case for change and partly on the request to align the Strategic Plan with the Medium Term Financial Framework. Most of our budget is allocated to day to day service delivery responding to need and a focus is often on perceived delivery failings – delayed discharges, difficulties in getting GP appointments etc. This section is designed to remind the reader of everything we do and give a flavour of the level of activity we undertake (please note there is no reliable data for GP appointments so we have not been able to include that). It also lists some of the challenges our services are currently facing thus beginning to set the scene as to why we are committing to certain activities..
Our Vision and Values	The value of Transparency has been added back in. In the final draft 'Key Principles for Service Delivery' have been added. These came from work undertaken by the external support we had in developing our Strategic Plan. 'Strategic Approaches' have also been added. This enabled us not only to commit to particular ways of working – whole system, collaboration, and Grampian Hope – but also to respond to some of the feedback from consultation in terms of shifting public expectations and behaviours and communicating and engaging with our stakeholders and communities.
Strategic Plan Development	This is a new section in the final version. It covers the data included in the PNA, the impact of deprivation on health, the challenges of an ageing population, the growing burden of disease, and the financial challenges we are facing currently. It also covers the wider social determinants of health (from the previous Introduction section), how we have tried to align with our partners, the Case Studies, and what

Section	Changes
	we heard from the public consultation including what we did with that feedback (in a You Said/We Did type format). It is designed to strengthen the rationale for why we are committing to the aims and priorities in the Strategic Plan and the activities and projects in our Delivery Plan.
Our Challenge and Response Statements	Unchanged from draft
Strategic Aims and Priorities	Only a high level summary of the aims and priorities is contained in the final version. This is a deliberate attempt to keep the Strategic Plan strategic. The detail will be contained in the Year 1 Delivery Plan which will be considered by the Risk, Audit, and Performance Committee.
Strategic Plan on a Page	This has been removed from the final version of the Strategic Plan. We have retained only the commitments to the Strategic Aims and Priorities but have now included the outcomes we hope to achieve from these and the measures we will use to determine success.
Logic Model	This is new for the draft and is an approach proposed from Aberdeen City Council's review of their strategic framework. It provides an easy read, graphical display of our 'Theory of Change' which is perhaps more relevant for the strategy.
Enablers to Delivery	New for the draft. We had referenced Enablers in previous strategies. It had been suggested that we remove these to keep the strategy concise however the external support advised that the inclusion of these lends weight to the rationale as to our strategic direction and the activities and projects in our Delivery Plan. Finance, technology, infrastructure, workforce and data are all key to us being able to deliver the Strategic and Delivery plans.
Strategic Risks	New from the draft. The inclusion of this arose from the request to ensure the Strategic Plan was more aligned to Risks. The table lists the mitigations in the Strategic Plan relevant to each of the risks in the Strategic Risk Register.
Implementation and Governance	Enhanced from draft which referred only to delivery and measuring impact. Confirmation of continuation of our programme and project management approach and alignment to finance and risks. Included confirmation of measuring our impact and continued monitoring and reporting on delivery. Governance diagram included as a result of feedback
Appendix A – Routemap to Delivery	New from draft. The Routemap has been included to demonstrate our commitment to longer term planning over the four financial years 2025-26 through to 2028-29. It should be noted that this is at a high level and the detail will be contained in the Delivery Plans. There will be a review every year based on progress and emerging priorities. Subsequent Delivery plans will be presented with the MTFF in March 2026, 2027, and 2028

Aberdeen City Health & Social Care Partnership

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Evidence Document

to inform

IJB Strategic Plan 2025-2029

Executive Summary

This Evidence Document contains a detailed analysis of the national and local context for health and social care delivery; our statutory responsibilities; our links with our partners, not only in Aberdeen City but also across Grampian; our current performance; a horizon scan of emerging requirements; and feedback from engagement with staff and the public to date about what they would like to see represented in the strategic plan.

This analysis helped to crystallise what was important to include in the strategic plan. As well as our statutory responsibility to ensure we are delivering on the Integration Principles, are achieving Best Value, and prepare a Housing Contribution Statement we also need to undertake effective community engagement and undertake whole system collaborative working.

The key themes are: -

- We need to take a Population Health approach to improving healthy life expectancy, reducing the impact of inequality, influencing positive changes to the wider determinants of health, and focusing on Early Intervention and Prevention
- We need to address the behavioural risks to health such as smoking and poor diet; access to and use of health care; wider socio-economic determinants such as income, education, housing and employment; geography; and specific characteristics such as sex, ethnicity, disability and social exclusion to improve healthy life expectancy in Aberdeen
- We need to focus on improving Healthy Life Expectancy, reducing alcohol and drug use, reducing smoking rates in pregnancy, improving healthy weight, reducing prescriptions for anxiety and depression, reducing suicide rates, and improving cancer screening as described above needs to be targeted more towards areas of deprivation to achieve the highest impact.
- We need to transform our service delivery by maximising the benefits of digital technology
- We need to continue to work collaboratively with partners to ensure strategic planning is aligned and that the focus is on improving the overall health and wellbeing of the people of Aberdeen city.
- In the short term we need to review service delivery models to reduce spend and achieve savings to balance our budget, thereafter we need to transform service delivery to ensure demand can be met within resources stated within the Medium-Term Financial Forecast.

Some of the evidence relating to operational performance will inform the Annual Delivery Plans as opposed to the Strategic Plan itself. Also, in light of the challenging financial environment it is unlikely the IJB will have the resources it needs to meet all of the challenges highlighted in this document.

Contents

National Context

Below, in no particular order, are the key national strategic developments that shape our strategic planning and direction.

National Public Health Priorities

In June 2018 the Scottish Government and the Convention of Scottish Local Authorities (COSLA) agreed six Public Health Priorities. The intention was that these priorities were shared across the whole of public health and that they facilitated collaborative working. Indeed, these have informed a number of other priorities and policies and are still relevant today.

- A Scotland where we live in vibrant, healthy and safe places and communities.
- A Scotland where we flourish in our early years.
- A Scotland where we have good mental wellbeing.
- A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs.
- A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all.
- A Scotland where we eat well, have a healthy weight and are physically active.

Verity House Agreement

The Verity House Agreement is a partnership agreement between COSLA and the Scottish Government setting out their vision for a more collaborative approach to delivering shared priorities for the people of Scotland. It was published on 30 June 2023 and forms the first part of the new deal between national and local government.

There are three shared priorities under the Verity House Agreement: -
• tackling poverty;
• just transition to net zero; and
• sustainable public services

National Vision

In June 2024, the Cabinet Secretary for Health and Social Care outlined their vision for health and social care - a Scotland where people live longer, healthier and fulfilling lives. This vision is supported by four key areas of work:

- improving population health,
- a focus on prevention and early intervention,
- providing quality services, and
- maximising access.

To deliver this vision the Scottish Government are focusing on four core priorities - eradicating child poverty; growing the economy; tackling the climate emergency; and improving Scotland's public services.

Population Health Framework for Scotland

CoSLA, Scottish Government, NHS and Public Health Scotland have co-designed a Population Health Framework adopting a single-Scotland level aim (with local flexibility in terms of delivery) around healthy/life expectancy to drive the whole system aspirations on prevention.

Two key areas of priority have been identified as initial priorities for focussed action:

- Develop a system that prioritises addressing inequalities and improving prevention within planning, budgets and accountability.
- Develop a whole system approach to improve food environments and ensure a healthy, balanced diet is accessible and affordable to all and improve population levels of healthy weight

Further, the Framework identifies 5 themes and 30 actions. They look like this:

Themes	**Action**
Social & Economic Factors	Community Wealth Building Economic Inactivity Income Maximisation Early Years and Development Economic Development Education
Place & Communities	Community and Voluntary Sector Social Prescribing Spatial Planning Community Planning Housing Licensing Climate Change
Enabling Healthy Living	Food Environment and Nutrition Physical Activity Tobacco Free Generation Drugs and Alcohol Gambling Harm Healthy Digital Use
Equitable Health and Care	Healthcare Inequalities Vaccination and Immunisation: Screening Health Protection
A Prevention Focussed System	Preventative Investment Accountability Health in All Policies: Marmot Places - Collaboration for Health Equity in Scotland Research & Innovation Evaluation & Learning Digital Population Health

National Performance Framework

The Scottish Government's National Performance Framework (NPF) sets out a vision for collective wellbeing. The majority of the National Outcomes that underpin this are directly affected by the health of the population. Given current and forecasted population challenges, tacking action to improve population health is vital to achieving the National Outcomes. It should be noted that the National Outcomes are currently being reviewed. New outcomes in relation to Care, Climate Change, Wellbeing and Fairer Work, Equality and Human Rights, and Housing are being proposed along with the proposal to amend the 'Poverty' outcome to 'Reduce Poverty'. It is anticipated that the National Performance Indicators will also be reviewed once the new outcomes are agreed.

Finance and Performance

In July 2024, the Accounts Commission published a report on Integration Joint Boards Finance and Performance. In it they say that Integration Joint Boards (IJBs) face a complex landscape of unprecedented pressures, challenges and uncertainties and that the financial outlook for IJBs continues to weaken with indications of more challenging times ahead. Inflation, pay uplifts and Covid-19 legacy costs are making it difficult to sustain services at their current level. Overall funding to IJBs in 2022/23 decreased by nine per cent in real terms or by one per cent in real terms once Covid-19 funding is excluded. The projected funding gap for 2023/24 almost tripled, in comparison to the previous year, with over a third anticipated to be bridged by non-recurring savings, with a quarter of the gap bridged using reserves. This is not a sustainable approach to balancing budgets. In addition, the report noted that IJBs operate within complex governance systems that can make planning and decision making difficult and that uncertainty around the direction of the plans for a National Care Service and continued instability of leadership in IJBs has further contributed to this. It also noted that the health inequality gap is widening.

Furthermore, the report noted that data quality and availability is insufficient to fully assess the performance of IJBs and inform how to improve outcomes for people who use services with a lack also of joined up data sharing. The available national indicators, however, showed a general decline in performance and outcomes.

In relation to current commissioning and procurement practices the report noted that these are driven largely by budgets, competition, and cost rather than outcomes for people. They are not always delivering improved outcomes and are a risk for the sustainability of services. Improvement to commissioning and procurement arrangements were seen to have been slow to progress but it was noted that this is developing. Some positive examples of where more ethical and collaborative commissioning models are being adopted were cited.

Finally, the report noted that there is variability in how much choice and control people who use services feel they have and that unpaid carers are increasingly relied on as part of the system but are also disproportionately affected by the increased cost-of-living.

The Accounts Commission propose that whole system, collaborative working is needed as part of a clear national strategy for health and social care that will promote improved outcomes across Scotland but reflects the need to respond to local priorities.

Planning with People

In May 2024, the Scottish Government and COSLA updated their planning with People (Community Engagement and Participation) Guidance. The updated guidance takes into consideration the current challenges being faced by the Public Sector and ensures that all parties are clear on respective roles, responsibilities and processes. It also reinforces the statutory duties for engagement regardless of financial pressures. The guidance sets out the responsibilities each organisation has to community engagement when services are being planned, or changes to services are being considered, and supports them to involve people meaningfully.

The Cabinet Secretary for Health and Social Care confirmed that Scotland's national and local governments are committed to involving people and communities in the decision-making that affects them. Listening to the views of people who use services and involving them throughout the process of planning care delivery, is a key improvement recommendation of the Independent Review of Adult Social Care in Scotland. By working together with people and communities, care providers can transform the experience of

people who use services, as well as the experience of those who deliver them. Fundamentally, good engagement is essential to good service planning and there is no doubt that greater participation brings better outcomes for communities all round.

Scotland's Digital Strategy

In March 2021 the Scottish Government published its Digital Strategy entitled A Changing Nation: How Scotland will Thrive in a Digital World. In it they comment that Scotland's future will be forged in a digital world in which data and digital technologies are transforming every element of the nation and of lives. The strategy refers to the Independent Review of Adult Care in Scotland which reinforced the message that transforming services requires the transformation of the organisations that deliver them. This is not simply about adopting new or better technology. It requires a fundamental shift in culture, skills, leadership, service design, process engineering, the use of data, collaboration, and investment planning. It requires leaders with the confidence to move away from the approaches, systems and ways of working that have been successful in the past. In short, it requires, the transformation of Government and the adoption of new digital business models based on greater accountability, networking, agility and a relentless focus on improving the customer experience.

In October 2021 Scotland's Digital Health and Care Strategy was launched. The vision of this strategy is to improve the care and wellbeing of people in Scotland by making best use of digital technologies in the design and delivery of services. There are three aims: -

- Citizens have access to digital information, tools and services they need to help maintain and improve their health and wellbeing.
- Health and care services are built on people centred, safe and secure and ethical digital foundations which allow staff to record, access and share relevant information across the health and care system in order to improve the delivery of care.
- Health and care planners, researchers and innovators have secure access to the data they need in order to increase the efficiency of health and care systems and develop new and improved ways of working.

Delivery of the aims is focused on six priority areas – digital access, digital skills and leadership, digital services, digital futures, digital foundations and data driven services and insight.

Housing to 2040

The Scottish Government's Housing to 2040 Strategy was published in March 2021. The strategy recognises that good housing and homes lead to reduced poverty and inequality, better health outcomes, improved educational attainment and more cohesive communities. Specifically, the strategy commits to introducing new building standards from 2025/26 to underpin the new Scottish Accessible Homes Standard to future-proof new homes for lifelong accessibility and to improving the adaptations system which will make a critical contribution to supporting people to live independently. The strategy also commits to establishing an inclusive programme of retrofitting social homes which will ensure all planned refurbishment addresses accessibility requirements and that digital connectivity is in place to support technology-enabled care and telehealth.

People at the Centre Approaches

There are a number of initiatives aimed at truly putting people at the centre of decision making in what care and support they get. We will take learning from each of them to improve practice in this area.

The Scottish Government's Getting it right for everyone (GIRFE) initiative is a proposed multi-agency approach to health and social care support and services from young adulthood to end of life care. It is intended that this will form the future practice model of all health and social care professionals and shape the design and delivery of services, ensuring that people's needs are met. GIRFE is about providing a more personalised way to access help and support when it is needed placing the person at the centre of all the decision making that affects them, with a joined-up consistent approach regardless of the support needed at any stage of life.

Human Learning Systems is an alternative approach to public management which embraces the complexity of the real world and enables organisations to work effectively in that complexity. It offers an alternative to the "Markets, Managers and Metrics" approach of New Public Management and outlines a way of making social action and public service more responsive to the bespoke needs of each person that it serves, creating an environment in which performance improvement is driven by continuous learning and adaptation.

The Liberated Method involves a switch of focus from services to people. It advises that we need to stop trying to improve services. If you start with services as your focus for change, you end up with services. People don't necessarily want services they want support, relationships, practical help and they want to be understood. The Liberated Method contests that designing public services around relationships is far more effective. People who have bounced around various public services for years start to positively change how they see themselves, the community, and the world when they're contributing to a relationship and are understood.

What does the National Context mean for ACHSCP Strategic Planning?

- We need to take a Population Health approach to improving healthy life expectancy, reducing the impact of inequality and influencing positive changes to the wider determinants of health
- We need to focus on Early Intervention and Prevention
- We need to engage meaningfully with people and communities involving them in decisions that affect them and adopt a people at the centre approach
- We need to undertake Whole System and collaborative working to
- We need to transform our service delivery by maximising the benefits of digital technology

Statutory Responsibilities

As a Health and Social Care Partnership under the Public Bodies (Joint Working) (Scotland) Act 2014, we must have a **Strategic Plan** (reviewed at least every three years) and publish an Annual Performance Report. Under the Carers Act (Scotland) 2016 we must have a **Carers Strategy**. Aberdeen City have chosen to develop a single Carers Strategy covering both Young and Adult Carers.

The 2014 Act also sets out the **principles** which underpin health and social care and describe how integrated care should be planned and delivered and are intended to work in tandem with the national health and wellbeing outcomes which describe what integrated care is intended to achieve. They set out the expectation of a culture of respect, parity of esteem and genuine engagement in the planning and delivery of person-centred, high quality integrated care and are intended to be the driving force behind the changes in culture and services.

Integration authorities must establish a **Strategic Planning Group** for the purposes of preparing a strategic plan. The views of **localities** must be taken into account with the integration authority required to identify the most appropriate person to represent each locality on the Strategic Planning Group. Integration authorities should provide appropriate levels of support to the people participating in their planning activities.

In terms of the **Public Sector Equality Duty** in Scotland (part of the Equality Act 2010) we must, in the exercise of our functions, have due regard to the need to: -

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The **Fairer Scotland Duty**, set out in Part 1 of the Equality Act 2010, came into force in Scotland from 1 April 2018. It places a legal responsibility on particular public bodies in Scotland to actively consider ('pay due regard' to) how they can reduce inequalities of outcome caused by socio-economic disadvantage, when making strategic decisions.

Under the Civil Contingencies Act 2004, the Aberdeen City IJB is a **Category One Responder** which means they are at the core of the response to most emergencies and are subject to the full set of civil protection duties such as assessing risks, putting emergency plans and business continuity arrangements in place, co-operating and sharing information with other local responders and communicating with communities to warn, inform and advise.

Part 4 of the Climate Change (Scotland) Act 2009 places duties on public bodies relating to **climate change**. The duties require public bodies to contribute to climate change mitigation and to climate change adaptation, and to act sustainably.

The Health and Care (Staffing) (Scotland) Act 2019 provides a statutory basis for the provision of **appropriate staffing** in health and care services, enabling safe and high-quality care and improved outcomes for service users. It builds on existing policies and procedures within both health and care services and effective implementation aims to embed a culture of openness and transparency, ensuring staff are informed about decisions relating to staffing and able to raise concerns.

Under the terms of the Local Government in Scotland Act 2003 or, where applicable, the Public Finance and Accountability (Scotland) Act 2000, the implementation of the duty of **Best Value** applies to integration authorities. That duty is:
• to make arrangements to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost; and in making those arrangements and securing that balance
• to have regard to economy, efficiency, effectiveness, the equal opportunities requirements, and to contribute to the achievement of sustainable development

The **United Nations Convention on the Rights of the Child** (Incorporation) (Scotland) Act 2024 ("the 2024 Act") makes it unlawful for a public authority, including an IJB, to act in a way which is incompatible with the United Nations Convention on the Rights of the Child (UNCRC) requirements. This includes any IJB functions carried out under a contract or other arrangement with another body. Part 3, section 18 of the 2024 Act also places new and enhanced planning and reporting duties.

Integration authorities are key within the collective local leadership of service planning to improve outcomes for babies, children, young people and families, and the development and delivery of each area's Children's Services Plan. A number of duties on IJBs are relevant to safeguarding, supporting and promoting child wellbeing, including upholding rights, and tackling child poverty and other inequalities. Services and professionals within integration authorities are therefore key to effective local partnership approaches to Getting it right for every child; making sure holistic whole family support is available, when it is needed, for as long as it is needed; and driving forward action to help Scotland to #KeepThePromise.
As part of local **children's services planning** arrangements set out in part 3 of the Children and Young People (Scotland) Act 2014, IJBs have duties as designated 'other service providers'. IJBs are required to consider the wellbeing of local children and families in the planning and delivery of services and support. IJBs have responsibility for 'related services', which are those with an impact on child wellbeing, but not provided to children directly, such as services provided to a parent or carer in relation to their own needs, as part of holistic whole family support. In addition, where integrated, some IJBs have responsibility for the delivery of certain 'children's services'. Local planning, resourcing and delivery of services should also ensure that young people experience a smooth transition in the move from receipt of children's services to adult services, as well as considering the needs of care experienced young people, where certain entitlements extend up to age 26.

Introduced under the Social Care (Self-Directed Support) (Scotland) Act 2013, **self-directed support** is the primary delivery mechanism of social care support in Scotland. It puts people at the centre of their support by placing a duty on those who deliver it to involve, collaborate with, and support recipients of care to make informed choices.

Planning with People supports public bodies that plan and deliver health and social care services in Scotland, including integration authorities, to effectively undertake **community engagement and participation**. Effective community engagement and the active participation of people is essential to ensure that Scotland's care services are fit for purpose and lead to better outcomes for people. The guidance, which is co-owned by the Scottish Government and COSLA, outlines statutory requirements for public bodies, presents information on community engagement, and promotes good practice.

A housing advice note was published in 2015, which outlines **the role of housing** in the integration of health and social care and provides guidance on linking strategic plans and local housing strategies. This includes detail on the requirement for a housing contribution statement to form part of the strategic plan.

What do our Statutory Responsibilities mean for Strategic Planning?

When we develop our Strategic Plan we need to: -

- Ensure we are delivering on the Integration Principles
- Consider the impact our Strategic Plan may have and avoid unintentional negative impacts where possible
- Ensure we are achieving Best Value
- Undertake effective community engagement
- Prepare a Housing Contribution Statement
- Carers Strategy and Equality Outcomes

Correlation with Local Priorities

The revised statutory guidance on preparing strategic plans for health and social care integration states that these should ensure correlation with other local priorities, policy direction, service provision and improvement activity and includes a list of these (indicated below by the headings in blue text). Below is a list of the relevant documents for Aberdeen City along with comment in relation to the relevant links for ACHSCP.

Alcohol and Drug Partnership plans

The 2019-2022 ADP Delivery Framework has five broad themes: -

- Whole Family Approach
- Reducing Harm, Morbidity and Mortality
- Service Quality Improvement
- Supporting Recovery
- Intelligence led Delivery

ACHSCP is also aiming to take a **Whole Family Approach** as well as improving quality and ensuring our planning is evidence led. Substance use is a key focus of our Community Mental Health Services and high on the agenda for our prevention programmes.

Carer Strategies

The Aberdeen City Carers Strategy is completely aligned to ACHSCP's Strategic Plan and is identified as one of the key documents that supports delivery. The current Carers Strategy has four priorities: -

- Identifying as a carer and the first steps to support
- Accessing Advice and Support
- Supporting future planning, decision-making and wider carer involvement
- Community Support and services for carers

Our revised Strategic Plan will include a commitment to continue to **support unpaid carers**.

Children's Services Plans

Within the 'what we know' section of the Aberdeen City Children's Services Plan, the statements where ACHSCP can make an impact (with the relevant service in brackets) include: -

- The development of early speech and language skills continues to be a concern (AHP, SALT Service)
- The uptake of immunisations is lower than it should be (Community Nursing and the Aberdeen Wellbeing Hub)
- Closer collaboration and integration by the universal services helps to improve outcomes (all services)
- Schools can access advice and guidance from other professionals (all services)
- There is an increase in the number of children declared disabled (Learning Disability Services with a particular focus on Transitions and predicting demand in adulthood)
- Young Carers need our support (Carers Strategy)
- The mental health and wellbeing of children and young people continues to be a concern (CAMHS)
- Around 22% of children are experiencing child poverty (Reducing the Impact of Inequality/Prevention)
- 50% of households experiencing poverty have dependent children (Reducing the Impact of Inequality/Prevention)
- The groups most likely to be impacted by poverty face different challenges (Reducing the Impact of Inequality/Prevention)
- Food insecurity remains (Reducing the Impact of Inequality/Prevention)

As part of ongoing, routine business we will work closely with our colleagues in Children's Services to ensure there is relevant support where it is needed but the main focus within our Strategic Plan will be a focus on **improving Child Health** .

In terms of the commitments in the Children's Services Plan our main link is in relation to Stretch Outcome 3 of the LOIP '95% of all children will reach their expected developmental milestones by their 27–30-month review by 2026'. ACHSCP's chief Nurse leads the '**Best Start in Life**' Outcome Improvement Group ensuring relevant links are made. An enabler to this work noted in the plan is increasing integration. ACHSCP are committed to closer collaborative working and integration of service to improve outcomes for children.

Community Plans

(NB: for these we have translated as Locality Plans which are referenced within the LOIP section below)

Housing and Homelessness Strategies

ACC Local Housing Strategy

Key links are noted below: -

- There is an adequate supply of housing across all tenures and homes are the right size, type and location that people want to live in with access to suitable services and facilities.
- Homelessness is prevented and alleviated.
- People are supported to live, as far as is reasonably practicable, independently at home or in a homely setting in their community.
- Consumer knowledge, management standards and property condition is improved in the private rented sector.
- Fuel poverty is reduced which contributes to meeting climate change targets.
- The quality of housing of all tenures is improved across the city.

ACHSCP has close links with ACC Housing colleagues through regular meeting of the Housing and Integration meeting and the Disabled Adaptations Group. The Key Links above will be reflected in the **Housing Contribution Statement** which will form part of the Strategic Plan.

Local Development Plan 2023

Relevant Key Policy Areas within the above include: -

- Health and Wellbeing
    - Healthy Developments
    - Air Quality
    - Noise
    - Specialist Care Facilities
    - Changing Place Toilets
- Meeting Housing and Community Needs
    - Residential
    - Mixed Use
    - Density
    - Housing Mix and Need
    - Affordable Housing
- The Vibrant City
    - Tourism and Culture
    - Beach and Leisure

- Delivering Infrastructure, Transport and Accessibility
    - Sustainable Transport
    - Digital infrastructure
    - Telecommunications

ACHSCP is a key consultee in relation to the LDP and will continue to influence those areas that will have a **positive impact on population health**.

Transitional arrangements between children's and adult services

Children and Adult Services meet regularly to consider transition arrangements particularly in the area of Learning Disabilities but we still need to test and embed a **Transitions Plan**. Future demand is captured in our **Market Position Statements for Complex Care and for Independent Living and Specialist Housing Provision**. We will keep these under review as part of Business as Usual.

Local Outcome Improvement Plans (LOIPs)

ACHSCP's main link to the LOIP is through the Resilient, Included and Supported Outcome Improvement Group and Stretch Outcome 10 – Healthy Life Expectancy is 5 years longer by 2026. We do, however have a lead role in other areas of the LOIP and the relevant projects are noted in the table below.

Ref.	Project Aim
3.1	Reduce by 5% the no. of children aged 0-4 who are referred to Children's Social Work as a result of neglect arising from parental mental health, addiction and domestic abuse 2026.
9.4	Increase to 80% the number of community justice clients completing exit questionnaires with 90% of those showing an improvement by 2026.
9.5	80% of individuals in the Justice system that identify to have concerns with their substance use are offered or accessing support by 2026.
10.1	Reduce the 5-year rolling average number of suicides in Aberdeen by at least 5% by 2026.
10.3	Increase by 50% the number of people engaged with Stay Well Stay Connected initiatives by 2025.
10.4	To support 50 low-income families in priority neighbourhoods to improve healthy eating behaviours and adopt good life choices to support healthy weight by 2026.
10.6	Decrease the number of women who are smoking in pregnancy in the 40% most deprived SIMD by 5% by 2026.
11.3	Decrease the number of women who are drinking in pregnancy in the 40% most deprived SIMD areas by 5% by 2026.
11.5	Reduce by 20% the number of drug related deaths in our priority neighbourhoods by increasing the distribution of naloxone by 25% year on year by 2026.

11.6	80% of people closed from Assertive Outreach as no longer considered at risk by 2026.
11.7	Increase by 10% the number of people in active recovery from drug and alcohol by 2025.
16.3	Increase the number and diversity of community members participating in community planning at a meaningful level (Rung 5 and above) by 100% by 2025.

Locality Plans

These are completely aligned to the LOIP and are codesigned with communities through the IJB and ACC joint locality planning arrangements. Delivery will be progressed led by the joint locality planning team. The priorities per locality relevant to adult health and social care are noted below: -

North Locality	Central Locality	South Locality
Improve the physical health and wellbeing of people	**Improve mental health and wellbeing**	**Support children and young people**
Support local volunteering	**Ensure people can access services timely through a person-centred approach**	**Focus on early intervention, prevention, and re-enablement actions**
Early Intervention Approach	Create safe and resilient communities	
Increase the number of people and groups involved in making improvements and decisions in their community	Increase the number of people and groups involved in making improvements and decisions in their community	Increase the number of people and groups involved in making improvements and decisions in their community

These will be reflected in the Strategic Priorities of our Strategic Plan.

NHS health board delivery plans

NHSG's Plan for the Future commits to enabling wellness and includes commitments under the headings of People, Places and Pathways.

People

- **Citizens** (two way engagement, co-production with lived experience, support to access care)
- **Children** (maximise mental health and wellbeing, multi-agency approach to Adverse childhood Events (ACEs), reduce inequalities, voices of young people embedded in decision-making)
- **Colleagues** and Culture (workforce for today and innovate for tomorrow, support health, safety and wellbeing, colleagues included and empowered to make the best contribution)

Places

- **Anchor** (desirable employment destination, treat people equally, a workforce that reflects the community, social responsibility in decision-making, trusted partner who uses influence responsibly and effectively)

- **Communities** (ongoing dialogue leading work, empowerment for community led action, reinforced connection with marginalised and seldom heard communities, integral part of system – leading and participating)
- **Environment** (paperless, maximise technology, Realistic Medicine fully embedded, fit for purpose estate, maximise hybrid working, generate our own energy, resilient to climate conditions)

Pathways

- **Empowering** (self-management, mental and physical wellbeing treated equally, de-medicalised language, make every opportunity count)
- **Access** (pathways centred around individuals and systems joined up, ease of knowing how to get help, high quality and safe care, digital systems and equitable alternatives)
- **Whole System Working** (system leadership, shared actions, recognise value of partners and hold them to account, right care, right place, right purpose, see the whole person, support regional and national colleagues)

In particular, the themes highlighted in bold will be reflected in our revised Strategic Plan.

NHS health board and integration authority workforce plans

The relevant actions for ACHSCP from NHSG's Workforce Plan 2022-25 are noted below along with our response/contribution in brackets: -

- Scaling MDT approach in Primary Care (Primary Care Vision)
- Developing sustainable Primary Care OOH services (Primary Care Vision)
- Increase capacity for in hour's routine and urgent dental care (Review of Dental Services)
- Build capacity to eliminate long waits for Psychological Therapies (PCIP)
- Develop digital skills of the workforce to make maximum use of Office 365 (Strategic Plan Digital Enabler)
- Developing and maintaining digital skills across the whole workforce (Workforce Plan)
- Support implementation and use e-Rostering to its fullest potential (Strategic Plan Digital Enabler)
- Commitment to the implementation of Healthcare Staffing (Scotland) Act (SLT)
- Non-pay reform commitments in Agenda for Change pay deal (SLT)
- Actions from Ministerial Taskforce on Nursing and Midwifery supply, recruitment and retention (SLT)
- Planning and resourcing strategies to ensure required workforce is in place to support recovery of services and increased service demand. (Workforce Plan)
- Succession Planning (Workforce Plan)
- Workforce planning for Allied Health Professionals (Workforce Plan)
- Equality and Diversity (EOMF and IIA process)
- Enhancing local supply pipelines and cement your role as an 'anchor institution', for instance your approach to apprenticeships and community outreach. (Commissioning)
- Making use of new roles, training and development opportunities to support workforce diversification (Workforce Plan)
- Health Care Support Workers (Workforce Plan)
- The use of technology and automation to support increased efficiency, mitigate growth requirements and ease workforce supply pressures. (Digital Enabler)
- Use of national and local workforce policies to maximise recruitment, retention and wellbeing of staffing (Workforce Plan)

- Addressing and reducing barriers to delivering exemplary workforce practice (workforce Plan)

Our local **Workforce Plan,** which supports delivery of our Strategic Plan reflects the elements above that are relevant to Aberdeen City Health and Social Care partnership.

NHS clinical strategies

NHS Grampian Plan for the Future covers this

Other local corporate plans

ACC Delivery Plan

The ACC Delivery plan is completely aligned to LOIP and therefore reference should be made to the section covering this above. Relevant commitments for ACHSCP include: -

- No-one will suffer due to poverty
- 95% of children (0-5 years) will reach their expected developmental milestones by the time of their child health reviews by 2026
- 90% of Children and young people will report that their experiences of mental health and wellbeing have been listened to by 2026. This is reflected in interactions, activities, supports and services
- As corporate parents we will ensure 95% of care experienced children and young people will have the same levels of attainment in education, health and emotional wellbeing, and positive destinations as their peers by 2026
- 30% fewer young people (under 18) charged with an offence by 2026
- Child friendly city where all decisions which impact on children and young people are informed by them as rights holders by 2026

Transformation projects include: -

- **Digital** – NB: ACHSCP are also working with Microsoft and have digital as a key enabler of the Strategic Plan
- Reconfiguration of working arrangements with ALEOs (BAC & Sport Aberdeen are of particular interest to ACHSCP as we work closely with both and will continue to monitor developments in this area)
- **Redesign and reconfiguration of Estates Portfolio** – this is of particular interest to ACHSCP as a number of services are delivered from ACC properties. Our Market Position Statements are designed to articulate our current and future needs in relation to property and our developing Infrastructure Plan will take into account our use of both ACC and NHS Grampian properties.

Public Protection

Child Protection Committee (CPC) Improvement Aims

The Child Protection Programme aims to improve the safety, wellbeing and life chances of vulnerable children and young people. As a partnership we achieve this by: -

- recognising and responding when children and young people need protection
- helping children and young people stay safe, healthy and, for those who have experienced abuse and neglect, to recover from their experiences and
- providing strong and effective collaborative leadership to deliver the Child Protection Programme ensuring the CPC is ready to adapt and adjust as required to both local and national developments
- working across Public Protection workstreams and achieving greater alignment

Adult Protection Committee Strategy

Our Vision for Adult Support and Protection in Aberdeen is:
"Partners in Aberdeen are committed to an inclusive approach to preventing and responding to harm and protecting adults at risk."

- We will develop a robust Data Performance and Quality Assurance Framework
- We commit to continue to develop appropriate mechanisms for effective communication
- We will continuously improve ASP practice, learning and development by reaching all our people, ensuring effective support, preventative measures and protection of adults at risk of harm.
- We commit to learning from situations where there is potential for improvement in practice, and to ensuring related learning is embedded into practice

Both Child and Adult Protection are seen as business as usual for ACHSCP. ACHSCP are represented in relation to public protection by the Lead for Social Work who sits on the committee and actions anything relevant arising from discussions.

In addition to those identified by the Statutory Guidance we have identified the following strategies we feel ACHSCP needs to align to.

Aberdeen Adapts

The IJB are a responsible body in relation to Climate Change and there is currently a Delivery Plan project in relation to this. This links to the Aberdeen Adapts strategy which has the following commitments.

Prevent, Protect, Inform, Collaborate, Innovate

- Minimising risks to people in Aberdeen and their health
- Buildings and Infrastructure
- Flooding and Coastal Change
- Natural Environment
- Society and Economy – reduce impact on health, disruption to services
- Understanding

Regional Economic Strategy

It is estimated that there are 2.8 million people in the UK inactive due to long-term sickness. Using population size as a comparator that could equate to 8,500 people in Aberdeen city. ACHSCP considers that it can contribute to the Regional Economic Strategy by keeping people well and enabling them to participate in the workforce and make a positive contribution to the local economy.

What does Correlation with Local Priorities mean for Strategic Planning?

We need to continue to work collaboratively with partners to ensure strategic planning is aligned and that the focus is on improving the overall health and wellbeing of the people of Aberdeen city.

Workforce Plan

Local Context (Needs Assessment)

Population Health

Life Expectancy and Healthy Life Expectancy

In Aberdeen, Life Expectancy (LE) at birth is higher for females than for males. In 2021-23 in Aberdeen City LE at birth was estimated to be 80.9 years for women and 76.9 years for men. This is similar to the figures for Scotland. LE had been increasing since the early 1980s but has now remained virtually unchanged since 2012-14.

Healthy Life Expectancy (HLE) represents the number of years that an individual can expect to live in good health. The most recent data available relates to 2019-21, when males in Aberdeen City had an estimated healthy life expectancy of 60.2 years, giving an expected period of 'not healthy' health of 16.7 years. In 2019-2021, females in Aberdeen City had an estimated healthy life expectancy of 61.4 years, giving an expected period of 'not healthy' health of 19.6 years. So while on average females have a higher life expectancy than males, they also spend a higher proportion of their lives in 'unhealthy health'.

LE and HLE are affected by many behavioural risks to health such as smoking and poor diet; access to and use of health care; wider socio-economic determinants such as income, education, housing and employment; geography; and specific characteristics such as sex, ethnicity, disability and social exclusion. They are both therefore complex areas in which to achieve positive influence.

Alcohol and Drugs

In the period 2019-23, 23% of adults in Aberdeen City were drinking above the guideline recommendations of 14 units per week. This is slightly higher than the previous rate in 2018-2022 and the 2019-23 rate for Scotland of 22%. Questions relating to alcohol consumption were asked in City Voice 49 (December 2024). When asked if they knew the maximum number of units of alcohol recommended over a week, less than half (48.6%) of respondents correctly choose 14 units. The next most common response was 'don't know' at 25.9%.

In 2023 there were 45 alcohol-specific deaths in Aberdeen City – down from 49 deaths in 2022. As the number of alcohol-specific deaths can fluctuate substantially on a yearly basis, a 5-year rolling average number is also given. For the period 2019-23 this figure was 40.6– lower than the figure of 41.8 in 2018-22. The rate (5-year average age standardised) of alcohol-related deaths in 2019-23 was 19.7 per 100,000 population – slightly lower than the rate for Scotland of 21.5, and lower than the rate for 2018-22 of 20.3 per 100,000 population

In 2020/21-2022/23 there were 411 drug-related hospital admissions (3-year rolling average number) which is equivalent to a rate of 181.3 per 100,000 population, compared to 201.8 per 100,000 population in Scotland. Following a period of increasing drug-related hospital admissions, the rate has decreased slightly in the past three periods – from 200.6 in 2017/18-2019/21.

In 2023 there were 54 drug-related deaths in Aberdeen City – up from 42 deaths in 2022. Of the 54 deaths in 2023, 36 were males and 18 were females. As the number of deaths can fluctuate substantially on a yearly basis, annual rates (age-standardised per 100,000 population) for 5- year periods are also given. In the period 2019-2023, the average annual

rate for drug-related deaths was 23.7 deaths per 100,000 population. This is similar to the equivalent rate for Scotland (23.6 per 100,000 population) and the same as the rate for 2018-2022. In Aberdeen City, drug-related deaths were highest in the 45–54-year-old and 35-44 year old age groups (with 61.5 and 57.1 per 100,000 population respectively in 2019-2023).

Smoking, Vaping and Healthy Weight

Over half of the deaths in Aberdeen City in 2023 were associated with cancers and circulatory diseases, for which smoking, obesity, and physical inactivity are risks.

In the period 2019-2023, an estimated 15% of adults in Aberdeen City were current smokers – the same rate as Scotland. A higher proportion of males (17%) than females (13%) were smokers. The percentage of adults who are current smokers has decreased from 23% in 2014-17. It is estimated that 7% of adults use e-cigarettes (7% males, 7% females) – up from 5% in 2018-2022 . (Note: data for 2019-2023 does not include 2020 data due to COVID-19). Smoking during pregnancy can have significant consequences for mother and baby, and increases the risk of stillbirth, miscarriage and preterm birth. The National Childbirth Trust (2018) emphasises that the impacts of smoking in pregnancy can be longer term as well, putting babies and children at increased risk of asthma, chest and ear infections, as well as psychological problems. Despite the known risks, in Aberdeen, around 9% of pregnancies booked are current smokers.

The issue of vaping in young people has been growing over the past 3 years. Originally designed and loosely accepted as a stop smoking product, vapes were not seen as attractive or accessible for young people. However, the market has changed dramatically over the last 3 years and a new market space has been created which has seen cheap, brightly coloured vapes with sweet flavours which are blatantly targeted towards, and clearly have an appeal with, young people. Whilst most vapes purchased fit with the current legal requirements of having 2ml nicotine or less, this market has also seen illegal vapes appear which are available through various independent businesses which contain more than the legal amount of nicotine, or which are not approved for sale in the UK. In November 2022, 6.7% (473) of pupils in Aberdeen City schools reported that they have tried smoking (either cigarettes or e-cigarettes) – a reduction of 1.3% from March 2022. In 2022 and 2023, 5.6% of 13–18-year-olds reported that they were vaping regularly. Whilst it is documented that vaping is less harmful than smoking, the evidence on the long-term impact of vaping is not yet clear. 99% of e-cigarettes contain Nicotine which is highly addictive and the common link with tobacco smoking products. Anecdotal evidence from partners working with young people in hospitals have indicated vaping has been a major concern around their health conditions.

The Scottish Burden of Disease analysis indicates that of all healthy years lost in Scotland; one in ten are attributable to excess weight, and one in ten attributable to poor diet. The Scottish diet remains too high in calories, fats, sugar and salt, and too low in fibre, fruit and vegetables, and other healthy foods like oil-rich fish. Around two-thirds of all adults in Scotland (67%) are living with overweight (including obesity), with one third (33%) of children starting primary school being at risk of overweight (including obesity). The latest data available in relation to obesity are from 2016-19 when it was estimated that 23% of the City's adult population was obese (classified as a BMI of 30+). This is lower than the rate for Scotland of 29% and a decrease from 25% in 2014-17.

In the period 2019-23, an estimated 71% of adults in Aberdeen City were meeting the recommended guidelines for physical activity (150 minutes of moderate activity or 75 minutes of vigorous activity per week) compared to 66% for Scotland. 21% percent had low or very low levels of physical activity and 8% had some activity. Based on data from the Scottish Household Survey, in 2023 87% of adults in Aberdeen City had taken part in some form of physical activity (including walking) in the previous month. When walking was

excluded, the proportion dropped to 53%. The most common activities were walking (at least 30 minutes) at 79%, multi-gym/weight training at 22%, and running/jogging at 14%

Mental Health

Financial strain and poverty are key drivers of poor mental health. People struggling to pay their rent or mortgage, feed their families, or cover essential bills are at higher risk of developing mental health problems including anxiety and depression. While there is no specific data for Aberdeen City, research carried out for Mental Health Foundation Scotland reported that 33% of survey respondents experienced stress, 40% experienced anxiety, and 13% said they felt hopeless due to their financial situation in the previous month. Recent statistics published by the Scottish Government showed that in March 2023, almost half (49%) of Scottish adults reported that their mental health is being negatively impacted by the cost-of-living crisis, with 13% saying that their mental health was impacted negatively to a large extent. When management of household finances were taken into account, only 3% of those who were 'managing well' reported being negatively impacted to a large extent, compared to 9% for those who were 'getting by ok' and 31% who were 'managing less well'.

Alzheimer Scotland estimate that there are 90,000 people with dementia in Scotland with around 3,000 of these being under the age of 65 years . In 2023, Dementia and Alzheimer's disease were the leading cause of death for females in Aberdeen City (13.4% of all female deaths) and the second most common cause of death for males (7% of all male deaths).

In 2023 there were 29 probable suicides in Aberdeen City (24 male and 5 female). The number of suicides in a single year in the City peaked at 43 deaths in 2015 . As the number of probably suicides can fluctuate on a yearly basis, a 5-year moving average is also given. For the period 2019-2023, the 5-year moving average for Aberdeen City was also 28 (same as the previous period). For the period 2019-2023 the rate (age-standardised per 100,000 population) of 12.3 per 100,000 population was the lower than the rate for Scotland of 14.6 per 100,000 population . Data on rates of probable suicide are no longer available for Aberdeen City at Scottish Index of Multiple Deprivation or Health and Social Care locality level. However, in Scotland, rates of probable suicide varied by Scottish Index of Multiple Deprivation, being highest in quintile 1 (most deprived) at 27.6 per 100,000 population compared to 9.3 in quintile 5 (least deprived).

The General Health Questionnaire (GHQ-12) is a standardised scale which measures mental distress and mental ill-health. A score of 4 or more is indicative of a potential psychiatric disorder. In 2019-2023, an estimated 18% of people in Aberdeen City had a score of 4 or more – lower than the rate for Scotland of 21% and unchanged from 2018-2022. A higher proportion of females (19%) than males (17%) had a score or 4 or more.

Mental wellbeing is measured using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). Possible total scores range from 14 to 70 with higher scores indicating greater wellbeing. In 2019-2023, the average (mean) score for Aberdeen City was 49.5 – slightly higher than the score for Scotland of 48.7. Mean scores were similar for males (49.9) and females (49.1) .

Screening and Vaccinations

There are three main cancer screening programs offered to those residing in Scotland – bowel, breast and cervical screening.

Bowel screening: In the latest 2020-2022 reporting period, bowel screening uptake rates

in Aberdeen City increased to reach 67.8%. This is higher than the Scottish rate for that period (66.2%), however slightly lower than the NHS Grampian health board uptake rate of 71.1%. In terms of localities, Aberdeen South reported the highest uptake rate of 71.1%, followed by Aberdeen North at 69.3% and Aberdeen Central at 61.5%.

Breast cancer screening: The NHS Grampian breast cancer screening uptake rate for females aged between 50-70 has remained stable since 2011.The latest data for the three-year rolling period 2020-2023 indicates an uptake rate of 80.3%. This is higher than the Scottish rate of 75.9%, and places NHS Grampian as the joint third highest rate during the reporting period.

Cervical screening: The NHS Grampian cervical screening uptake rate for females aged 25-49 in 2021/22 was 67.3% (percentage who had a recorded screening test within the last 3.5 years). This rate was marginally higher than the Scottish average rate of 65.7%, but ranks NHS Grampian 12th out of the 14 Scottish Health Boards Between 2018/19 and 2021/22 uptake rates in NHS Grampian and Scotland overall declined year on year.

Influenza vaccines: During 2022-23, 56,564 Influenza vaccines were administered to eligible groups for Aberdeen City (50.8%). This is below the NHS Grampian (54.8%) and Scotland average rates (53.8%), however Aberdeen City (at 37.7%) exceeds the NHS Grampian (36.3%) and Scotland averages (35.2%) for those in the 50-64 years cohort (Adult Flu Vaccine) .

Disease Prevalence

In 2023, the most prevalent disease in Aberdeen City Health and Social Care Partnerships overall was hypertension, at an incidence of 11.1 patients per 100 population. Hypertension was also the most prevalent condition in each of the individual GP Clusters across Aberdeen City Health and Social Care Partnership, ranging from 10.0 to 12.1 per 100 population. The most prevalent disease across Scotland in 2023 was also Hypertension at 13.2 patients per 100 population, above Aberdeen City's rate.

Depression was reported as the second most prevalent condition across Aberdeen City Health and Social Care Partnership at 7.3 patients per 100 population, a marginally lower rate compared to Scotland overall (7.9). Aberdeen City Central cluster's rate was significantly higher than the partnership and overall Scottish rates at 10.5 patients per 100 population, however it should be noted that this data only included 50% of practices in this cluster.

Key Diseases

In 2023, cancer and circulatory diseases (such as coronary heart disease and stroke) together accounted for half (50.4%) of all causes of death in Aberdeen City. In 2023, 26.6% of male deaths and a 24.2 % of female deaths were caused by cancer, and 25.6% of male deaths and 24.5% of female deaths were caused by circulatory diseases.

Leading causes of death are also given for specific disease classifications (e.g. types of cancer and circulatory diseases are listed separately). In 2023, Ischemic heart diseases were the leading cause of death for males (12.6% of a male deaths), followed by Dementia and Alzheimer disease (7%) and Cancer of the trachea, bronchus and lung (6.9%). For females, Dementia and Alzheimer disease was the leading cause of death for (13.4% of all female deaths), followed by Ischaemic heart diseases (78.3%) and cerebrovascular disease (8.1% of all female deaths).

In 2020-2022 there were 1,287 new cancer registrations in Aberdeen (3-year rolling average number). This is equivalent to a rate (age-sex standardised per 100,000 population) of 624.2 – similar to the rate for Scotland of 629.7. In both Aberdeen City and Scotland the rate of cancer registrations decreased from the rates in 2019-2021 (656.6 and 626.9 respectively). The rate of cancer registrations varies by derivation (rate of 768.9 per 100,000 population in Scottish Index of Multiple Deprivation quintile 1 (most deprived) compared to 571.2 in quintile 5 (least deprived)) and by Health and Social Care localities, at 609.5 per 100,000 population in Aberdeen South, 627.4 in Aberdeen North and 656 in Aberdeen Central.

In 2021-23 there were 267 early deaths (<75 years) from cancer (3-year rolling average number). This is equivalent to a rate (age-sex standardised) of 142.9 per 100,000 population – similar to the rate for Scotland of 142.4 per 100,000 population. Overall, the rate of early deaths from cancer has been decreasing in both Aberdeen City and Scotland. The rate of early deaths from cancer is higher is deprived areas at 249 per 100,000 population in Scottish Index of Multiple Deprivation quintile 1 (most deprived) compared to 98 in quintile 5 (least deprived) and varies across the City (Intermediate Zones), from a low of 63 per 100,000 population in Braeside, Mannofield, Broomhill & Seafield South to a high of 315 in Woodside.

In 2021/22-2023/24 there were 663 patient hospitalisations with coronary heart disease (3 year rolling average number). This is equivalent to a rate (age-sex standardised) of 334.2 per 100,000 population – slightly higher than the rate for Scotland of326.8 per 100,000 population. In both Aberdeen City and Scotland, the rate of Coronary Heart Disease patient hospitalisations has decreased over the past 10 years. Coronary Heart Disease hospitalisations are higher in deprived areas at a rate of 443.1 per 100,000 population for Scottish Index of Multiple Deprivation quintile 1 (most deprived) compared to 256.2 in quintile 5 (least deprived). The rate of hospitalisations varies by Intermediate Zone, from a low of 146 per 100,000 population in Ferryhill North to a high of 532.4 in Torry East.

In 2021/2023 the rate (age-sex standardised) of early deaths (<75 years) from Coronary Heart Disease was 43.9 per 100,000 population in Aberdeen City, lower than the rate for Scotland of 54.5. The rate of early deaths from Coronary Heart Disease was higher in more deprived areas (95.9 per 100,000 population in Scottish Index of Multiple Deprivation quintile 1 (most deprived) compared to 25 per 100,000 population in quintile 5 (least deprived) and varied across the city (Intermediate Zones) from a low of 0 in Cults, Bieldside & Milltimber West, Braeside, Mannofield, Broomhill & Seafield South, Cove North and Hanover North to a high of 132 per 100,000 population in Hannover South.

In 2021/22-2023/24, the incidence of Chronic obstructive pulmonary disease in Aberdeen City was 200 (3-year average number). This is equivalent to a rate (age-sex standardised) of 121.5 per 100,000 population which is lower than the rate for Scotland of 136.8 per 100,000 population. After 5 consecutive periods of decreases, incidence increased in both Scotland and Aberdeen City in this last data period (from 104.2 and 119.3 respectively). In 2021-2023 there were 94 deaths (3-year average), which is a rate (age-sex standardised) of 58.1 per 100,000 population – lower than the rate for Scotland of 62 per 100,000 population. Again, the rate of Chronic obstructive pulmonary disease deaths increased in this last period (from 52.2 and 58.7 respectively in 2020-2022). The increase in incidence is reflected in the increase in patient hospitalisations. In 2021/22-2023/24 there were 305 (3-year rolling average number) patient hospitalisations in Aberdeen City (up from 273 in 2020/21-2022/23). This is equivalent to a rate (age-sex standardised) of 184.8 per 100,000 population – lower than the rate for Scotland of 210.1. In Aberdeen City, the rate of patient hospitalisations for Chronic obstructive pulmonary disease is higher for those in deprived areas at a rate of 402.9 per 100,000 population for Scottish Index of Multiple Deprivation quintile 1 (most deprived) compared to 65.4 in quintile 5 (least deprived) and varied across the City (Intermediate Zones) from a low of 22 per 100,000 population in Cults, Bieldside &

Milltimber West to a high of 497 in Mastick.

In 2021/22 to 2023/24 the rate (age-sex standardised per 100,000 population) of asthma hospitalisations was 63.6 in Aberdeen City, lower than the rate for Scotland of 76.2 but higher than the rate for 2020/21 to 2022/23 of 52.8. In Aberdeen City, the rate of patient hospitalisations for Asthma is higher for those in deprived areas at a rate of 102 per 100,000 population for Scottish Index of Multiple Deprivation quintile 1 (most deprived) compared to 40.5 in quintile 5 (least deprived). Rates varied across the city (Intermediate Zones) from a low of 17.3 in Braeside, Mannofield, Broomhill & Seafield North to a high of 162.4 in Northfield.

Data from the Scottish Health Survey estimates that in 2019-23, 18% of people in Aberdeen City had doctor-diagnosed asthma –up from 16% in 2018-22 and slightly higher than the rate for Scotland of 17%. A higher proportion of females (19%) than males (17%) had doctor-diagnosed asthma.

What does this mean for our Strategic Plan?

We need to address the behavioural risks to health such as smoking and poor diet; access to and use of health care; wider socio-economic determinants such as income, education, housing and employment; geography; and specific characteristics such as sex, ethnicity, disability and social exclusion to improve healthy life expectancy in Aberdeen (NB: this is the focus of Stretch Outcome 10 within the LOIP).

We need to reduce alcohol consumption in Aberdeen to a rate that is below the Scottish average.

We need to target drug use in the 35 to 44 year old age group to help reduce the rate of drug related deaths.

We need to reduce the incidence of smoking in pregnant women. NB: this is the focus of a LOIP project.

We need to reduce the incidence of vaping in young people. NB: this is the focus of a LOIP project.

We need to continue the downward trend of obesity in Aberdeen City by improving healthy eating behaviours and encouraging people to adopt healthy life choices. NB: this is the focus of a LOIP project.

We need to be alert to the impact of poverty on mental health and act to reduce the number of prescriptions issued for anxiety and depression by increasing opportunities for alternative social prescribing.

We need to improve cancer screening uptake in Aberdeen city NB: this is a focus of a LOIP project.

Deprivation

According to an analysis of the Scottish Index of Multiple Deprivation (SIMD) in 2020,19.3% of Aberdeen City's population are in the three most health deprived data zones. This is higher than Edinburgh (16.2%) but considerably lower than both Dundee (48.4%) and Glasgow (54.4%). The neighbourhoods in the 20% most deprived data zones (Quintile 1) include Torry, Woodside, Seaton, Northfield, Middlefield, Tillydrone, Mastrick, Sheddocksley and George St.

Estimated Life Expectancy is strongly associated with deprivation. In Aberdeen City in 2019-2023, estimated LE for males in SIMD quintile 1 (most deprived) was 71.7 years compared to 81.1 years for males in SIMD quintile 5 (least deprived) – a difference of 9.5 years. For females, the difference in estimated LE was less marked, at 76.4 years for females in quintile 1 compared to 84.8 years for females in quintile 5 - a difference of 8.4 years. Comparison with data from 2013-2017 shows that the gap in estimated life expectancy between most and least deprived quintiles in Aberdeen City has decreased for males (previously 10 years) and increased for females (previously 8.1 years).

For males, estimated LE at birth ranges from a low of 68.1 years in Old Aberdeen to a high of 84.2 years in Braeside, Mannofield and Broomhill & Seafield North – a difference of 13.7 years. For females it ranges from a low of 74.4 years in Woodside to a high of 88.1 years in West End North – a difference of 13.7 years.

In Scotland, Healthy Life Expectancy (HLE) is strongly associated with deprivation. HLE for males in the most deprived areas of Scotland was 26 years lower than in the least deprived areas. For females the difference was almost 25 years. In the most deprived areas, males and females spend more than a third of their life in 'not good' health compared to around 15% in the least deprived areas.

Alcohol-related hospital admissions were highest for those in the most deprived areas at 1,044.2 per 100,000 population for SIMD quintile 1 (most deprived) compared to 300.7 per 100,000 population for SIMD quintile 5 (least deprived). The rate of alcohol-related hospital admissions ranged from a low of 32.3 in Cults, Bieldside & Milltimber East to a high of 1,432 per 100,000 population in Torry West.

Rates of alcohol-specific deaths are higher for those in deprived areas. In Aberdeen City in 2019-23, the rate (age-sex standardised) for those in SIMD quintile 1 (most deprived) was 40.4 per 100,000 population compared with 10.5 per 100,000 population for SIMD quintile 5 (least deprived). Rates of alcohol-related deaths vary across the city localities, (2019-23 data) from 13.9 per 100,000 population in Aberdeen North, to 14.4 in Aberdeen South and 34.1 in Aberdeen Central.

Rates of drug-related hospital admissions are higher for those in deprived areas at 532 per 100,000 population for those in SIMD quintile 1 (most deprived) compared to 39.9 in SIMD quintile 5 (least deprived). The rate of drug related hospital admissions varies across the localities from 118 per 100,000 population in Aberdeen South, to 163 in Aberdeen North and 248.5 in Aberdeen Central.

The rate of drug-related deaths is higher for those living in deprived areas. In Aberdeen City in 2019-23, the rate (age-sex standardised) of drug related deaths for those in SIMD quintile 1 (most deprived) was 57.3 per 100,000 population compared to 5.2 per 100,000 population in SIMD quintile 5 (least deprived).

In 2021/22, a higher percentage of women were recorded as smoking during pregnancy in more deprived areas: 23.9% in the most deprived SIMD quintile, compared to 2.9% in SIMD 5.

In Scotland's most deprived communities, adult obesity rates persistently exceed those living in the least deprived areas. Children living in our most deprived communities are twice as likely to be at risk of overweight compared to those in our least deprived, with the gap widening in recent years. Those living in the most deprived areas experience the most significant diet and health related inequalities. Affordability can be a barrier to being able to eat a healthy balanced diet. Research has shown that those with the lowest income currently must spend around 50% of their disposable income to eat a healthy diet compared to only 11% for those with the highest income.

A higher proportion of those from SIMD quintile 1 (most deprived) were prescribed drugs for anxiety, depression or psychosis (23.8%) than those in SIMD quintile 5 (least deprived) at 12.5%. The proportion of people prescribed drugs for anxiety, depression or psychosis varied by Locality, at 16.9% in Aberdeen South, 15.9% in Aberdeen Central and 20.5% in Aberdeen North.

Rates of psychiatric patient hospitalisation varied by deprivation, being highest in SIMD quintile 1 (most deprived) at 343 per 100,000 population compared to 144 per 100,000 population in SIMD quintile 5 (least deprived). In Aberdeen City, rates were highest in Aberdeen Central (283 per 100,000 population). Rates were similar in Aberdeen North (185) and Aberdeen South (178).

The rate of cancer registrations varies by derivation (rate of 768.9 per 100,000 population in SIMD quintile 1 (most deprived) compared to 571.2 in SIMD quintile 5 (least deprived)) and by localities, at 609.5 per 100,000 population in Aberdeen South, 627.4 in Aberdeen North and 656 in Aberdeen Central.

The rate of early deaths from cancer is higher is deprived areas at 249 per 100,000 population in SIMD quintile 1 (most deprived) compared to 98 in SIMD quintile 5 (least deprived) and varies across the City (Intermediate Zones), from a low of 63 per 100,000 population in Braeside, Mannofield, Broomhill & Seafield South to a high of 315 in Woodside.

Hospitalisations for coronary heart disease (CHD) are higher in deprived areas at a rate of 443.1 per 100,000 population for SIMD quintile 1 (most deprived) compared to 256.2 in SIMD quintile 5 (least deprived). The rate of CHD hospitalisations varies by Intermediate Zone, from a low of 146 per 100,000 population in Ferryhill North to a high of 532.4 in Torry East. The rate of early deaths from CHD was higher in more deprived areas (95.9 per 100,000 population in SIMD quintiles 1 and 2 compared to 25 per 100,000 population in SIMD quintile 5) and varied across the city (Intermediate Zones) from a low of 0 in Cults, Bieldside & Milltimber West, Braeside, Mannofield, Broomhill & Seafiled South, Cove North and Hanover North to a high of 132 per 100,000 population in Hanover South.

The rate of patient hospitalisations for Chronic, Obstructive Pulmonary Disease (COPD) is higher for those in deprived areas at a rate of 402.9 per 100,000 population for SIMD quintile 1 (most deprived) compared to 65.4 in SIMD quintile 5 (least deprived) and varied across the City (Intermediate Zones) from a low of 22 per 100,000 population in Cult, Bieldside & Milltimber West to a high of 497 per 100,000 population in Mastrick.

What does this mean for our Strategic Plan?

We need to focus on improving Healthy Life Expectancy, reducing alcohol and drug use, reducing smoking rates in pregnancy, improving healthy weight, reducing prescriptions for anxiety and depression, reducing suicide rates, and improving cancer screening as described above needs to be targeted more towards areas of deprivation to achieve the highest impact.

Demand

The Population needs Assessment (PNA) for Aberdeen City confirms that there is an ageing population in the city. By 2028 the number of 65–74-year-olds will increase by 14.4% and the number of 75+ will increase by 16.1% - that represents an additional 4,000 people who will potentially require health and social care. Interestingly in the 75+ age category the increase in the male population is expected to be 26.2%. In addition, 28% of people report they are living with limiting, long term conditions whilst 11% report living with non-limiting conditions.

Mortality does not give a complete picture of the burden of disease borne by individuals in different populations. The overall burden of disease is assessed using the disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality (YLLs) and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability (YLDs). One DALY represents the loss of the equivalent of one year of full health. DALYs are a way of identifying future health need. The latest figures show that under 15s are predicted to have better health in future whereas males over 85 are predicted to have a DALY score double to that for this cohort currently if nothing is done to intervene.

The Scottish Burden of Disease study forecasts a 21% increase in the annual disease burden in Scotland over the next 20 years. Applied to the local context this would mean potentially an additional 6% reporting limiting, long term conditions.

In relation to local demand the following are areas of note: -

- Occupancy rates for Hospital at Home have increased from 70% in March 2022 to 77.7% in June 2024.
- Weekly contacts for Grampian General Medical Services have increased by 27%.
- Occupancy at Woodend has increased from 93.7% in March 2022 to 109.2% in June 2024.
- Length of stay at Woodend has also increased by 56%.
- Occupancy at Royal Cornhill has increased from 87% in March 2022 to 98% in June 2024.
- Visits to the Sexual Health Clinic have increased by 6.8% between March 2022 and March 2023.
- The number of people waiting for Psychological Therapy increased by 15.4% between April 2023 and March 2024.
- Waiting times for physiotherapy for Musculoskeletal conditions increased from 15 weeks in October 2023 to 21 weeks in March 2024
- Monthly referrals for community physiotherapy services increased from 266 in April 2023 to 296 in March 2024, however had been as high as 392 in November 2023 and 366 in February 2024.
- The waiting times for the Dietetics Child Healthy Weight Team increased from 59 weeks in November 2023 to 99 weeks in September 2024
- The waiting times for an assessment call for adult weight management is approximately 30 weeks and waiting times for one: one treatment another 30 weeks. The treatment time for digital and group options is less.

What does this mean for our Strategic Plan?

We need to increase the support we offer for Older People

We need to focus on early intervention and prevention to address the growing burden of disease.

We need to work with General Practitioners to help them cope with the increase in demand.

We need to consider more community-based options for rehabilitation to reduce the demand on Woodend.

We need to promote prevention and early intervention in relation to sexual health to help reduce the demand on the service.

We need to seek alternative supports for those on waiting lists to help them manage their condition during their waiting time.

Budget

A report to the IJB on 18th March 2025 confirmed that the final outturn position for 2024/25 indicated that there is a recurring overspend of £16.786m, that this will be resolved using a combination of funding from partners and available reserves and that there will be no remaining uncommitted reserves with which to balance financial risks for 2025/26 onwards.

The in year budget pressure for 2025/26 is £20.132m with additional funding to offset these totalling £11,655. The main budget pressures for 2025/26 are: -

- Pay Inflation
- Additional National Insurance Contributions
- Increased Prescribing Costs
- Increased costs in relation to Commissioned Services
- Non-pay Inflationary Pressures

This leaves an in year deficit of £8.477m to which the £16.786m needs to be added giving a total budget deficit of £25.263m. £14.354m Savings have been identified to be delivered to help balance the 2025/26 budget and £10.909m has been secured from partners to cover the remaining deficit. Whilst it would appear that out budget is balance it is absolutely crucial that the £14.354m identified budget savings are achieved in order for this to be the case.

What does this mean for our Strategic Plan?

In the short term we need to review service delivery models to reduce spend and achieve savings to balance our budget, thereafter we need to transform service delivery to ensure demand can be met within resources stated within the Medium-Term Financial Forecast.

Risks

The risks currently listed on our Strategic Risk Register are noted below.

1. Potential failure of commissioned services to deliver on their contract
2. Demand outstrips available budget
3. Hosted Services do not deliver the expected outcomes
4. Service provided by the IJB fail to meet the national, regulatory and local standards
5. Failure to deliver transformation and sustainable systems change
6. IJB fails to maximise the opportunities created for engaging with our communities
7. Insufficient staff to provide patients/clients with services required
8. Lack of funding to maintain buildings, not having adequate staff resources to operate from buildings, failing to adequately plan which buildings ACHSCP need and where, and failure to collaborate with partners on wider planning

What does this mean for our Strategic Plan?

We need to continue to consider our strategic risks when determining what actions we take in the Strategic Plan.

Capacity

So demand for health and social care services in Aberdeen City is predicted to grow, both in relation to an increased older population and in terms of a higher burden of disease. But the resources we have to deliver services are not predicted to grow to meet this demand.

Aberdeen City's draft Medium Term Financial Framework (MTFF) approved by the IJB in March 2025 identifies funding gaps in future years. As we are funded by our statutory partners – Aberdeen City Council (ACC) and NHS Grampian (NHSG), who are both also facing financial challenges, we have to seek efficiencies and better use of our resources to balance our budgets from within our current resources. Indeed, we have a legal obligation to balance our budget.

Of course, our resources are not just about finance. There are almost 2,200 staff working in ACHSCP, almost 80% of these employed by NHSG with the remainder employed by ACC. Approximately 18% of our £435 million budget (£78 million) is committed to paying our in-house workforce, and a further £164 million, or 38% is spent on commissioning social care services from third and independent sector providers who collectively employ just under 3,000 staff. ACHSCP values the staff in commissioned services equally to our in-house staff as they are crucial to delivering services and we are as concerned about their wellbeing as we are for our own employed staff.

The Accounts Commission report referred to in Section 1 earlier, noted that the workforce is driven and committed but is under immense pressure. In addition, it noted that across the community health and social care sector there are difficulties in recruiting and retaining a skilled workforce. The Covid-19 pandemic, the cost-of-living crisis and the impact of the withdrawal from the European Union have deepened existing pressures. The report concluded that without significant changes in how services are provided and organised, these issues will get worse as demand continues to increase and the workforce pool continues to contract.

Neither the Aberdeen City IJB nor ACHSCP own any premises. Health and social care services are delivered from a variety of settings in ownership of NHSG, ACC, or private landlords. GP practices often own or lease their premises and the funding of their building is an inherent part of their business model. The premises we utilise are in various states of condition and suitability. There is no doubt we could make better use of buildings we operate from and a key feature of our sustainability discussions during 2024 have been around how efficiently we can use these buildings currently, making us more efficient and also improving collaboration opportunities.

What does this mean for our Strategic Plan?

We have to seek efficiencies and better use of our resources to balance our budgets from within our current resources. Indeed, we have a legal obligation to balance our budget.

We need to deliver our Workforce Plan to ensure a workforce fit for the future.
We need to make better use of our buildings to ensure we can continue to deliver services within restricted budgets.

Performance

Our performance in relation to Integration Principles

Principle – Our services: -	Performance
1. Are joined up and easy for people to access	We have redesigned a number of our pathways but have yet to make significant progress on developing arrangements to make it easier for people to access our services.
2. Take account of people's individual needs	We have revised our Guidance for Community Engagement based on the Scottish Government and COSLA's updated Planning with People Guidance. Our focus for future years will be a person centred approach.
3. Take account of the particular characteristics and circumstances of different service users in different parts of the city	We have revised our Equality Outcomes aligned to our Strategic Plan and continue to deliver our Equality Outcomes and Mainstreaming Framework. Our Equality Outcomes will be revised again in light of our refreshed Strategic Plan 2025-29.
4. Respect the rights and dignity of service users	Our staff have undertaken Trauma Informed training and we continue to embed our Equality and Human Rights approach to service design and delivery.
5. Take account of the participation by service users in the community in which service users live	We continue to embed our joint approach to community engagement and participation along with our Community Development colleagues in Aberdeen City Council. 2024 saw the refresh of the Local Outcome Improvement Plan and the three Locality Plans in conjunction with communities. By 2026 a new 10 year LOIP will have been developed and ACHSCP staff will be fully engaged in that process ensuring alignment with our Strategic Plan. All of our commissioning activity includes participation from relevant groups of service users and providers.
6. Protect and improve the safety of service users	We continue to deliver our legal duty around both Adult Support and Protection and Child protection.
7. Improves the quality of the service	We continue to use the results from inspections, audits and feedback to make improvement to service design and delivery.
8. Are planned and led locally for the benefit of service users, people who look after service users and the people who provide health or social care services	The Locality Empowerment Groups are now meeting regularly and membership (and diversity of membership) is increasing.
9. Anticipate people's needs and prevent them arising	We continue to deliver our Stay Well Stay Connected initiative, which is a programme of holistic community health interventions and part of our prevention agenda designed to anticipate health issues in certain cohorts of the population. Participation in some of these initiatives such as Boogie in the Bar and Soup and Sarnies is increasing. Our prevention agenda continues to grow.

Principle – Our services: -	Performance
10. Make the best use of facilities, people and resources	We continue to deliver on our enabling priorities in relation to Workforce, Technology, Finance, Relationships and Infrastructure. Our new Chief Finance Officer has undertaken a forensic examination of our budget and is implementing robust monitoring processes to ensure we remain in balance. Support for our workforce including those employed by our partner organisations continues. In 2024 we began a review of our use of premises and that will continue into 2025 and beyond ensuring that we make the best use of these and help deliver a balanced budget.

Our performance in relation to the 4 Drivers of Health and Wellbeing

Social and Economic – the PNA notes that there is a link between economy and health. Child health starts before birth and continues during development. Whether a child lives in an affluent family or in an area of deprivation has an impact on their health. SDS performance is significantly lower than the Scottish average (36.2% v 88.5%)

Places and Communities – the PNA confirms that place is another important consideration in relation to population health and wellbeing. The design, build, and maintenance of 'place' are important aspects. Hospital admissions are reducing and there are high levels of care usage out with hospital setting. Safety is also a consideration – both in terms of levels of crime and having a safe place to live (temporary accommodation or homelessness).

Equity, Prevention and Early Intervention – the PNA tells us that poverty exists in Aberdeen City and is worse in areas of deprivation. Relative poverty is evident even in working households. The Covid-19 pandemic had an impact, particularly on women, children and ethnic minority groups. Child poverty is on the increase and financial insecurity, fuel poverty and food poverty exist. Climate Change also has an impact on health mostly on those living in more deprived areas. 13% of the population of Aberdeen identify as Unpaid Carers, the average in Scotland is 15%.

Healthy Living – the PNA confirms that smoking, obesity and physical activity are all closely related to preventable disease and that more than 50% of deaths in Aberdeen City are due to cancers and circulatory disease (linked to smoking, obesity and physical activity). High Blood Pressure/Hypertension and Depression are the main presentations in Primary Care. Drug use or smoking in pregnancy will affect child health as will breastfeeding, uptake of pre-school immunisations, healthy weight, physical activity, oral and mental health, are again all impacted by whether the child is living in an affluent or deprived area. There are variations across the city in inequality and there is no single cause. Rates of Bowel and Cervical Screening in Aberdeen are lower than ideal. Childhood immunisation rates are not as high as we would like. Improvement is required in vaccination uptake.

Our Performance in relation to National and MSG Indicators

Our latest Annual Performance Report for 2023/24 can be found here and an analysis of the results for Aberdeen City from the latest Health and Care Experience (HACE) Survey can be found here.

A high level analysis of these including our proposed response is below: -

In terms of the National Performance Indicators, most of the HACE related ones are Amber or Red. The biggest reductions are: -

- Adults supported at home who felt they had a say in how their care is provided (-12% from previous report)
- % of people with a positive experience of care provided by their GP (-11% from previous report)
- % adults supported at home who agreed they felt safe (-9% from previous report)

We will respond to the Scottish Parliament's Health, Social Care and Sport Committee, post legislative scrutiny of the Self-directed Support (Scotland) Act 2013, as part of business as usual. We will implement our General Practice Vision to improve people's experience of GP services. We will continue to deliver Adult Support and Protection services as part of business as usual to help keep people safe in their homes.

70% of 'health' related indicators are 'Green', with one Amber and two Reds. The Amber and Reds are as follows: -

- Care Inspectorate Gradings (Red)
- Number of days delayed (those aged 75+) (Red)
- % resource spent on hospital stays (Amber)

We will continue to develop positive relationships with our commissioned providers helping them to explore ways to improve services and increased their Care Inspectorate gradings. As part of business as usual we will continue our focus on reducing delayed discharges where possible.

Of the 11 MSG indicators, 4 are showing a negative (increasing) trend, 3 a positive (decreasing trend) and 4 a stable trend.

- The worst increasing trend is the number of delayed discharge bed days
- The most improved trend is unscheduled bed days in both acute and geriatric specialities.

Our business-as-usual focus on delayed discharges will include a focus on delays relating to those with the most complex needs which tend to have the highest delayed discharge bed days. Our Market Position Statements for Complex Care and Independent Living and Specialist Housing Provision will try to address the shortage in destinations for discharge for those with the most complex needs and thereby reduce delayed discharge bed days. They will also help to inform our partners priorities including Aberdeen city Council's Housing Strategy and the city's Local Development Plan. We will participate in the Grampian wide Discharge Without Delay (DWD) programme which aims to pulling best practice, individual services and pathways into an integrated model that strives to deliver comprehensive geriatric assessment (CGA) in the timeliest manner, while ensuring no negative impact from hospital induced harm or dependency to the person.

Whilst our ultimate aim is to reduce unmet need and delayed discharges this requires resources to achieve. Previous reductions have been achieved through additional funding being received. Without this, and given the current demands on reduced funding, we anticipate it will be difficult to sustain positive performance in relation to Delayed Discharges.

The current trend for increasing demand is being driven not only by increases in the proportion of the older population in our society and the increase in the burden of disease, but also in terms of population behaviour and expectations. Traditionally, the population have expected health and social care services to be available on demand. Times, and budgets have changed and the model for delivery of health and social care services also needs to change.

What does this mean for our Strategic Plan?

We need to improve access to services, particularly GP Services
We need to embed a person centred approach to service delivery
We need to take account of the needs of those experiencing inequality.
We need to increase participation from our communities
We need to recognise the link between health and the economy.
We need to support the reduction in poverty in Aberdeen City.
We need to reduce delayed discharges and lengths of stay in hospital
We need to continue to support our commissioned providers and improve the quality of services they deliver.

What ACHSCP has achieved from its Current Strategic plan

In no particular order, the following are key highlights from the delivery of our current Strategic Plan (2022-25).

- In 2022/23 a total of 622 Naloxone Kits were supplied to persons at risk – up from 426 in 2021/22.
- In Q3 2022/2023, 113 people accessed specialist drug treatment services, up from 84 in Q3 2021/22.
- Up to Q3 2022/2023, a total of 327 people accessed specialist drug treatment services.
- The percentage of adults who are current smokers has decreased to 15% from 18% in 2016-19 and 23% in 2014-17.
- Our social care unmet need has reduced significantly however this was due to investment and is not sustainable. As noted above the focus resulted in a budget overspend.
- Bookings at our Community Treatment and Assessment Centres (CTACs) increased tenfold between June 2022 and March 2023, and we have created two Priority intervention Hubs – one at the bon Accord Centre and one at Get Active Northfield.
- Our GP sustainability has improved. Only one GP Practice was providing a full service in March 2023, but that number had risen to 8 in March 2024.
- The Adult Mental Health Pathway and our Neurological Rehabilitation Services were both reviewed, and implementation of the findings is underway.
- A new development of bespoke specialist supported living accommodation for people with complex needs is underway. It should be completed by Spring 2025, and it is hoped to enable the service to bring back people who have previously been cared for out with authority.
- Three Market Positions Statements have been developed to articulate what services we need to be provided in future. It is hoped these will stimulate providers and developers to come up with innovative solutions to meet these needs.
- We have progressed with the implementation of innovative technology. The MORSE system roll out to Community Nursing and Allied Health Professionals in Grampian continues despite financial challenges. This is led by a post within ACHSCP. We have replaced 99% of our Community Alarms and are finalising arrangements for a new technology to support the Alarm Receiving Centre in readiness for the switchover from analogue to digital in January 2026. We have also adopted a Technology Enabled Care (TEC) First approach to social care assessments, supporting the creation of a TEC Hub in Aberdeen City and promoting the increase of the use of TEC in social care provision.

The following summarise Aberdeen City performance in relation to MSG Indicators over the lifetime of the current Strategic Plan (NB: timescales are as close as available to the Strategic Plan start and end dates)

- Emergency Admissions increased by almost 14% between June 2022 and March 2024
- Admissions from A&E increased by just over 4% between June 2022 and June 2024.
- Unscheduled Bed Days in Acute Settings increased only slightly by 0.6% between June 2022 and December 2023.
- Unscheduled Bed Days in relation to Geriatric speciality decreased by 16% between June 2022 and June 2023.
- Unscheduled Bed Days in relation to Mental Health speciality increased by 4.6% between June 2022 and March 2023.
- A&E attendances increased slightly by 1.7% between June 2022 and June 2024.
- Performance against the 4 hour waiting time target for A&E deteriorated from 67.8% in June 2022 to 60.4% in June 2024.
- Delayed Discharge Bed Days almost doubled from 738 in June 2022 to 1,381 in June 2024 however they had been as low as 255 in April 2023.
- The percentage of people who spent the last 6 months of their lives in a community setting decreased slightly from 90.9% in 2021/22 to 90.3% in 2022/23.
- In relation to the measure around Shifting the Balance of Care, between 2021/22 and 2022/23 the percentage of people who remained at home either unsupported or supported stayed the same whilst the number of people in a Care Home or large Hospital increased by 0.1% each.

The increases in some of the indicators above will be related to increasing demand for services and the increasing burden of disease. It is difficult to directly correlate the work of ACHSCP impacting most of these indicators or to quantify what some of the increases might have been in the absence of the work undertaken. We would suggest the significant decrease seen in unscheduled bed days in relation to geriatric speciality must in part be the result of the work undertaken in relation to the Frailty Pathway including our management of both Ward 102 in ARI and the innovative integrated facility at Rosewell House. Our performance in relation to Delayed Discharges does vary but we had a period of intense focus and investment which did result in a 65% decrease between June 2022 and April 2023. This however was unsustainable and unaffordable.

What does this mean for our Strategic Plan?

We need to increase capacity in the community to help reduce emergency admissions

We need to focus on support for mental health in the community to reduce the number of unscheduled bed days in relation to this speciality.

We need to provide more care for people in a home environment.

Horizon Scanning

We are currently aware that the following changes will impact our service delivery and planning over the lifespan of the refreshed Strategic Plan.

- Review of National Outcomes (and Performance Indicators?)
- Publication of Population Health Framework
- Implementation of National Care Service
- Implementation of Learning Disabilities, Autism and Neurodivergence Bill
- Implementation of Housing (Scotland) Bill (Ask and Act Duty in relation to prevention of homelessness)
- Implementation of new Frailty Standards

What does Horizon Scanning mean for Strategic Planning?

- We need to take cognisance of the review of national outcomes and Indicators and build any changes into our performance framework (NB: unlikely the review will be published in time for our draft Strategic Plan going out for public consultation but we may be able to include this in the final version. If not, we will incorporate it into one of our annual reviews.
- We need to plan for the implementation of the National Care Service
- We need to ensure we have a local action plan to respond to the implementation of the Learning Disabilities, Autism and Neurodivergence Bill
- We need to ensure the requirements of the Housing (Scotland) Bill (Ask and Act Duty in relation to prevention of homelessness) are embedded in day to day practice for frontline staff.
- We need to incorporate the new Frailty Standards into practice

Engagement

Outcome of engagement to date.

From LOIP
- Address inequality
- Tackle the underlying causes of the issues
- Reduce Smoking and Vaping

From Staff Drop Ins
- Inequality/Stigma
- Poverty
- Promoting Good health

From IJB and SLT
- Not everyone can be healthy so add 'as possible' or refer back to 'fulfilling lives'
- Equitable rather the equal access to care/opportunity
- Individualised care needs to also be clinically effective
- Plan on a page needs to be simpler and more impactful
- Separate physical and mental health
- Make transformation more prominent
- Different versions and comms plans for different audiences
- If service delivery needs to be affordable, be honest and say that
- Personalise care is better than individualised care
- There should be less focus on 'business as usual' service delivery i.e. what we are already doing
- We should be nurturing people and places
- Reference to co-developing both support and intervention
- Plan needs to repeat key messages
- Need to comment on what the future looks like, what our ambition we have and what transformation we need to achieve
- We must rebalance towards prevention and early intervention – falls prevention, management of long term conditions
- What do we need to do in relation to public communication and education using this as a tool for prevention encouraging self-care, improving health literacy, improving understanding that resources need to be targeted where they are needed not where they are wanted.
- Include redesignation and repurposing of building use

Feedback from ACC Strategy Board
- Co-construct rather than adopt Family Support Model
- Reference to Future Libraries Approach
- Reference to annual review of Delivery Plan ensuring alignment with refresh of LOIP and CSP

What does Engagement mean for Strategic Planning?

Most of the LOIP and staff feedback is covered in the sections above except the reference to reducing stigma which will be incorporated.
The feedback from IJB, SLT and the Strategy Board has been taken into account when developing the Strategic Plan

Challenge and Action Statements

Our Key Challenge - Our demand is predicted to increase through a combination of an ageing population and a higher burden of disease. The resource we have available to us is not enough to continue to deliver the current level of service. There is evidence of a growing divergence in outcomes between those citizens who live in more affluent areas of the city to those who live in areas of deprivation.

Action Statement - We need to take action to reduce the predicted demand. We must transform the way we deliver some services so we can maximise the resources we have. We will need to stop some services and reduce the level of service we provide. We need to take steps to improve equity of access to care and support to ensure better outcomes for people living in areas of greater deprivation.

Reduction of Demand

The main way we can try to reduce predicted demand is to shift investment and focus towards **early intervention and prevention activity**. If we can reduce the incidence of preventable diseases, both physical and mental, through encouraging people to make healthier choices in the way they live their lives we should be able to reduce the need for health and care service provision. This early intervention approach needs to start at the earliest point.

Although ACHSCP provide health and care services for adults, children are the adults of the future, so we need to work with our colleagues in Children's Services to ensure this approach to improving health starts as early as possible at pre-birth. Vaccinations provide immunity from certain diseases and the more people who come forward for these the healthier the population. If we can also promote the uptake of early screening programmes for the most common cancers that should enable earlier detection and access to treatment with a greater chance of survival.

We know that those living in areas of deprivation experience inequality and poorer health outcomes and therefore have a greater need for our services. The particular needs of people living in these areas need to be understood and the way we deliver services need to overcome any barriers in order that we provide **equity of access**.

Unpaid carers play a crucial role in the health and care system by providing care and support that would otherwise need to be provided by our in-house or commissioned services. By continuing to provide support to unpaid carers through the implementation and refresh of our Carers Strategy we will be helping unpaid carers to continue in their caring role and have a life alongside caring.

Health is impacted by a number of factors not just genetics and behaviour. The wider determinants of health include education, income, a person's physical environment such as housing and access to green space, and their social environment such as their support networks and connection to their community. These are factors that are out with the remit of ACHSCP however we can work with partners to try to have a positive influence on improving aspects of these wider determinants of health for the people of Aberdeen.

Different Ways of Working

We need to ensure our services meet the needs of our population, are affordable and that we achieve best value. We will do this in two main ways: -

We will **transform our approach to service delivery** this will encompass transformation in relation to people – patients/clients, staff, and the general public) - technology, and buildings

which will enable us to make changes to the way we currently deliver services and increase our capacity to manage current demand and enable us to do more with less.

We need to ensure that changes we make will not negatively impact our population and we also need to work with our partners in Aberdeen to ensure we are making the best use of our collective resources. We will **collaborate with our communities and partners**, engaging with them and working together to collectively improve outcomes.

Risks (and Mitigations)

1. Finance

   Risk – restricted pot, how to prioritise/distribute especially when currently heavily invested in response
   Mitigations – working collaboratively to identify innovation, transformation and more efficient ways of working to enable service delivery within restricted budget.

2. Workforce

   Risk – reducing, do we have the right skills to embrace change?
   Mitigations – implementation (and future review of our Workforce Plan)

3. Population Behaviour/Expectations

   Risk – we need to change approach, adopt new ways of working, will the public accept and embrace these?
   Mitigations – increase opportunities for engaging with the public, listening to their views and ensuring appropriate communication and re-education is undertaken.

4. Partners

   Risk – the outcomes rely on partner activity, are they committed to the same activity and will that support or detract from what we do.
   Mitigations - continue to build and develop positive relationships with providers keeping them on board with our strategy and approach.

Key Strategic Documents Supporting Strategic Plan

What key strategic documents will support delivery of our strategy (give timelines of future review/renewal/update)

- Medium Term Financial Framework (MTFF) (revised annually)
- Workforce Plan (due for revision December 25)
- Infrastructure Plan (will be published March 25??)
- Carers Strategy (due refresh March 2026)
- Market Position Statements X 3 (will be kept under regular review)

National Strategies

Housing to 2040	Housing to 2040 - gov.scot (www.gov.scot)
Scotland Public Health Priorities	Public health reform - Our context - public health in Scotland - Our organisation - Public Health Scotland
Climate Change Plan 18-31	Update to the Climate Change Plan 2018 - 2032: Securing a Green Recovery on a Path to Net Zero (www.gov.scot)
Scotland's Digital Health and Care Plan	Digital health and care strategy - gov.scot (www.gov.scot)
The Promise	About the promise
UNCRC	https://dera.ioe.ac.uk/33463/1/childrens-rights-consultation-incorporating-united-nations-convention-rights-child-domestic-law-scotland.pdf
Independent Review of Adult Social Care	https://www.gov.scot/binaries/content/documents/govscot/publications/independent-report/2021/02/independent-review-adult-social-care-scotland/documents/independent-review-adult-care-scotland/independent-review-adult-care-scotland/govscot%3Adocument/independent-review-adult-care-scotland.pdf?forceDownload=true
National Carers Strategy	National carers strategy - gov.scot (www.gov.scot)
Scottish Government GIRFE	Getting it right for everyone (GIRFE) - gov.scot (www.gov.scot)
Dementia in Scotland – Everyone's Story	Dementia in Scotland: Everyone's Story Delivery Plan 2024-2026 (www.gov.scot)

Local Linked Strategies

NHSG Plan for the Future	Plan For The Future (nhsgrampian.org)
Local Outcome Improvement Plan	LOIP_16-26-April-2024.pdf (communityplanningaberdeen.org.uk)
Locality Plans	North South Central
Housing Strategy	Local Housing Strategy 2018-2023.pdf (aberdeencity.gov.uk) – Has this been updated? No links on ACC Website.
Council Delivery Plan	Council_Delivery_Plan_23_24.pdf (aberdeencity.gov.uk)
Transport	Regional Transport Strategy | Nestrans
Primary Care Improvement Plan	Primary Care Improvement Plan | Aberdeen City HSCP
SAS Strategic Plan Report	Our 2030 Strategy (scottishambulance.com)
Aberdeen City Council – Family Support Model	Family Support Model Plan Final.pdf

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Aberdeen City
Health & Social Care
Partnership

A caring partnership

Strategic Plan 2025 – 2029

Consultation and Engagement Plan

Contents

1. Key Facts

Purpose of Paper: To present all outputs of the Engagement and Consultation stages for the Strategic Plan 2025-2029 Development.

Dates:

Engagement period – February 2024 – March 2025

Consultation period – 24th March 2025 – 18th May 2025 (7 weeks)

Leads:

- Strategy and Transformation Lead, Alison MacLeod
- Transformation Programme Manager, Stuart Lamberton
- Senior Project Manager, Grace Milne
- Development Officer, Matthew Carter

Inform	• Using different forms of media methods – relevant documents Online and as available;animation; video; social media; website pages; information stands
Consult	• Using many engagement methods – survey; in-person sessions; open house/pop up at already scheduled events
Involve	• Key Stakeholders – public, staff, partners including 3rd sector and commissioned services
Collaborate	• key networks, programme boards and project teams and lived experience involvement. Partner collaboration for Consultation exercise.

This document notes an extensive programme of engagement already undertaken as well as a joint consultation activity period. It is important to note that this has run alongside, and along with, the consultation on the Budget proposals and ACC Strategies also in consultation. We provide Community Engagement Guidance for staff to use for all our Engagement activity – you can find it here

https://www.aberdeencityhscp.scot/globalassets/documents/guidance-for-community-engagement-human-rights-and-equalities.pdf

2. Overview of Engagement undertaken to date.

The Draft Strategic Plan was informed by engagement with staff, colleagues, and partners.

It has also been informed by a number of other relevant and aligned consultations that have already taken place for the Carers Survey, City Voice (#49 on Health), the Locality Plans, the refresh of the Local Outcome Improvement Plan (LOIP), and the General Practice Vision 2024-30. The availability of this rich source of information has been extremely valuable and helped to avoid duplication and consultation/engagement fatigue. It has also enabled us to develop a more informed draft with a higher level of detail that we might have otherwise been confident to include. Our community representatives on the Strategic Planning Group advise us that they find it easier to comment on a document that contains a lot of information, saying what they like and what they don't like rather than being presented with a blank sheet of paper and being asked what they would want to see included. It is hoped that this approach meets those needs also.

Our engagement to date has, therefore, been more streamlined than in previous iterations. Our approach initially was to sense check the key components of our Strategic Plan. This included asking all partners and stakeholders if our Aims, Vision, Values and Enablers were still relevant, and if not, what was missing.

We also asked for opinions and options on how our Strategic Plan should be presented and what formats people find beneficial. During the initial engagement period we took the opportunity to check that we were covering all relevant groups and contacts for consultation.

Timeline of Engagement February 2024- March 2025

Forum	Date	Outcome
Commissioning Event	19 February 2024	Awareness raising and provider priorities
Staff Conference	29 February 2024	Awareness raising
Senior Leadership Team	6 March 2024	Initial Approval of timeline and approach
IJB CO Report	26 March 2024	Approval of timeline and approach
IJB Insights	16 April 2024	Review of performance/identification of high-level priorities. NB: SLT encouraged to attend.
Strategic Planning Group	18 April 2024	Seeking confirmation that representatives are content with approach

IJB Insights session	11 June 2024	Agreement of timeline and approach Overview of strategic context, direction and current priorities Values session and impact of budget explored
Senior Leadership Team	19 June 2024	Reviewed agreement of timeline and approach Overview of strategic context, direction and current priorities Values session and impact of budget explored
Strategic Planning Group	20 June 2024	Feedback from engagement and confirmation of agreement of strategic context, direction and priorities (as per feedback from IJB and SLT)
Engagement Update to TPM Transformation Programme Managers meeting	2 July 2024	Planning: • Strategy and Transformation Team - Jamboard- Priorities/ Delivery Plan • Staff Drop In Sessions (July/August) • Staff and Partners Questionnaire • Informed by Data / APR
ACHSCP Staff drop in session 1	24 July 2024	Partnership wide session to raise awareness of timeline and approach Overview of strategic context, direction, and feedback received so far Encourage feedback and participation in development of the refreshed Strategic Plan
Specific meeting	24 July 2024	Arranged by COO/CO to discuss progress
ACHSCP Staff drop in session 2	1 August 2024	Partnership wide session to raise awareness of timeline and approach Overview of strategic context, direction, and feedback received so far Encourage feedback and participation in development of the refreshed Strategic Plan
ACHSCP Staff drop in session 3	6 August 2024	Partnership wide session to raise awareness of timeline and approach Overview of strategic context, direction, and feedback received so far Encourage feedback and participation in development of the refreshed Strategic Plan
Strategic Planning Group	22 August 2024	Update on current progress and planning ahead for public Consultation, views on formats.
CAN Come and Network Day	14 September	Stand Event at Aberdeen City Vaccination and Health and Wellbeing Hub, Come and Network Day looking for views on key components – Aims, Values, Vision and Enablers. Views on Communication and Formats.
IJB Insights Session	17 September 2024	Update on current progress and planning ahead for public consultation, and views on draft priorities and aims.

SLT – Critical thinking session	18 September 2024	Agreement of Strategic Plan priorities and high level overview, approval of comms plan and further discussions on content of 'evidence report'
IJB meeting	24 September 2024	APR approved at this meeting information to support draft Strategic Plan.
Impact Assessment	7 October	IIA developed and DiversCity Officers consulted
ACC Strategy Board	10 October 2024	Complied Draft Strategic Plan, Evidence Doc and High Level overview on agenda for ACC Strategy Board to discuss.
IJB Consultation	11 October 2024	Compiled final version of the draft Strategic Plan containing high level overview and evidence report sent for IJB Statutory Consultation
SLT	9 October	Final version of the draft Strategic Plan presented to SLT containing high level overview and evidence report, and Consultation Plan
Grampian Gathering	12 October	Public Event, showcasing draft aims
Various	Locality Empowerment Groups	North, Central and South over October on views on Initial Priorities and Draft.
Various	Strategy and Transformation Team Sessions	Values Session – May 2024 – deep dive into our values and how we can further embed our values (feedback from Conference) Initial Priorities and Draft – October 2024 – Team thoughts on initial priorities, aims and other strategic plan key components.
Various	Stand Events – Health and Wellbeing Hubs	Feedback and Thoughts gathered through 3 stand events for views on key components – Aims, Values, Vision and Enablers. Views on Communication and Formats.
Various		Consultation and Communication Plan project team progress next steps in preparation for IJB Approval in November.
Various	Leaflet	Leaflet displayed and sent to teams, partners and network to link to us for consultation. Information back to Strategy Senior Project Manager and Consultation and Engagement Development Officer.
IJB	March 2025	Statutory Consultation with Draft to be considered for approval.

Themes to date (reflected in and incorporated within Draft Strategic Plan)

- Prevention and Early Intervention needs to stay high on our priorities if we are going to impact future health needs.
- Being honest with our financial forecast and implications, if service delivery needs to be affordable, be honest and say that.
- Honesty and Transparency are similar values do we need both?
- We need to make sure our communications are clear and any changes to access to services and new initiatives are consulted and communicated to the public
- Our current Strategic Aims are still relevant, however stigma, inequalities and sustainability are key themes mentioned in feedback.
- There should be less focus on 'business as usual' service delivery i.e. what we are already doing.
- We must rebalance towards prevention and early intervention e.g. falls prevention, management of long-term conditions
- What do we need to do in relation to public communication and education and use this as a tool for prevention encouraging self-care, improving health literacy, improving understanding that resources need to be targeted where they are needed not where they are wanted.

Informing the Draft Strategic Plan.

All the information and themes above informed the Draft Strategic Plan, this plan was agreed in March 2025 (link to papers below). In turn this launched the Consultation plans as outlined on page 8.

(Public Pack)Agenda Document for Integration Joint Board, 18/03/2025 10:00

3. Purpose of Consultation

The purpose of our consultation was to take our initial Draft Strategic Plan 2025 – 2029 and consult with our key stakeholders including, public, staff, partners to

- Share our draft Strategic Aims, Priorities, Vision, Values and Enablers
- Show our linked partnership organisations, influencing strategies and legislation
- Clearly express our indicative priorities for Strategic Plan over the period 2025-2029.
- Enable opportunities to shape and develop the draft priorities and by doing so, ensuring that we are not missing anything important
- Move focus on opportunities around prevention, service accessibility and financial position
- Collaborate with our key stakeholders to shape the delivery plan to achieve our strategic aims.
- Agree an approach on implementation of the Strategic Plan aims.

The consultation will have a particular focus on the Local Housing Strategy, Health and Social Care Partnership Strategic Plan, Community Learning and Development Plan, and the next Local Outcome Improvement Plan, Local Development Plan, and Locality Plans as identified in the interdependencies below.

Priorities will be aligned using the Place Standard tool, a nationally-approved tool to assist with long-term planning that promotes conversations about how to improve people's health, wellbeing and quality of life.

4. Interdependencies

Consultation on the Strategic Plan will run in conjunction the following:

1. ACHSCP Budget Consultation Process
2. ACC Local Development Plan
3. ACC Community Learning and Development Plan
4. ACC Housing Strategy

This will provide opportunities to work together to increase the number of opportunities to input, reduce engagement fatigue and ensure that all views are captured as well as informing our stakeholders of our performance achievements to develop from.

Approach detailed below from section 7 onwards.

NB : Not all of these opportunities will be captured here, but will be added as the plan develops further.

5. Data Protection

A joint privacy notice has been drafted and can be viewed here. As the information gathered will be hosted on ACC engagement platforms and analysed from ACC devices, the ACC DPIA process has been followed.

A DPIA has been completed on behalf of the Joint Consultation process, and can been seen here for anymore information here at EngagementDPIABrief.docx

6. Inform – Communications Activity

6.1. Website

Website link - | Aberdeen City HSCP

The following pages are required:

Consultation Drafts available with link to survey and questionnaire.

Draft documents in downloadable versions, with options for other formats as below.

If you need information provided in a different format, such as accessible PDF, large print, easy to read, audio recording or braille, or have any accessibility requirements please email **ACHSCPenquiries@aberdeencity.gov.uk**

6.2. Animation

Short video will be created on Biteable to provide more information and explaining why views are so important to hear for our next Strategic Plan. The narrative is outlined below.

- Aberdeen City Health & Social Care Partnership is responsible for the planning and delivery of community health and adult social care services in Aberdeen
- We have drafted a Strategic Plan that we would like to have your views on, and we want you to help and shape our priorities for the next 4 years
- Rundown of some of our challenges
- Quick look at our strategic aims
- Draft Priorities
- How to get in touch or invite us to your event.

6.3. Social Media

Utilising the Annual Performance Report key measures and highlights, we will be ensuring our priorities are conveyed alongside development of our previous achievements.

Social Media Post planning

- **18 March 2025 – IJB Approval of Consultation Draft**
- **24 March 2025 - Launch Consultation including Survey Link**
- **14 April 2025 – 1 month to go for Consultation**
- **7 May 2025 – 1 week to go for Consultation**
- **14 May 2025 - Closing Day for Consultation**
- **1 July 2025 - Strategic Plan approved**

Where to Share / Tag

NHSG; ACC; ACVO; BAC; GCC; SHMU; LEGS; Community Planning; Community Councils etc

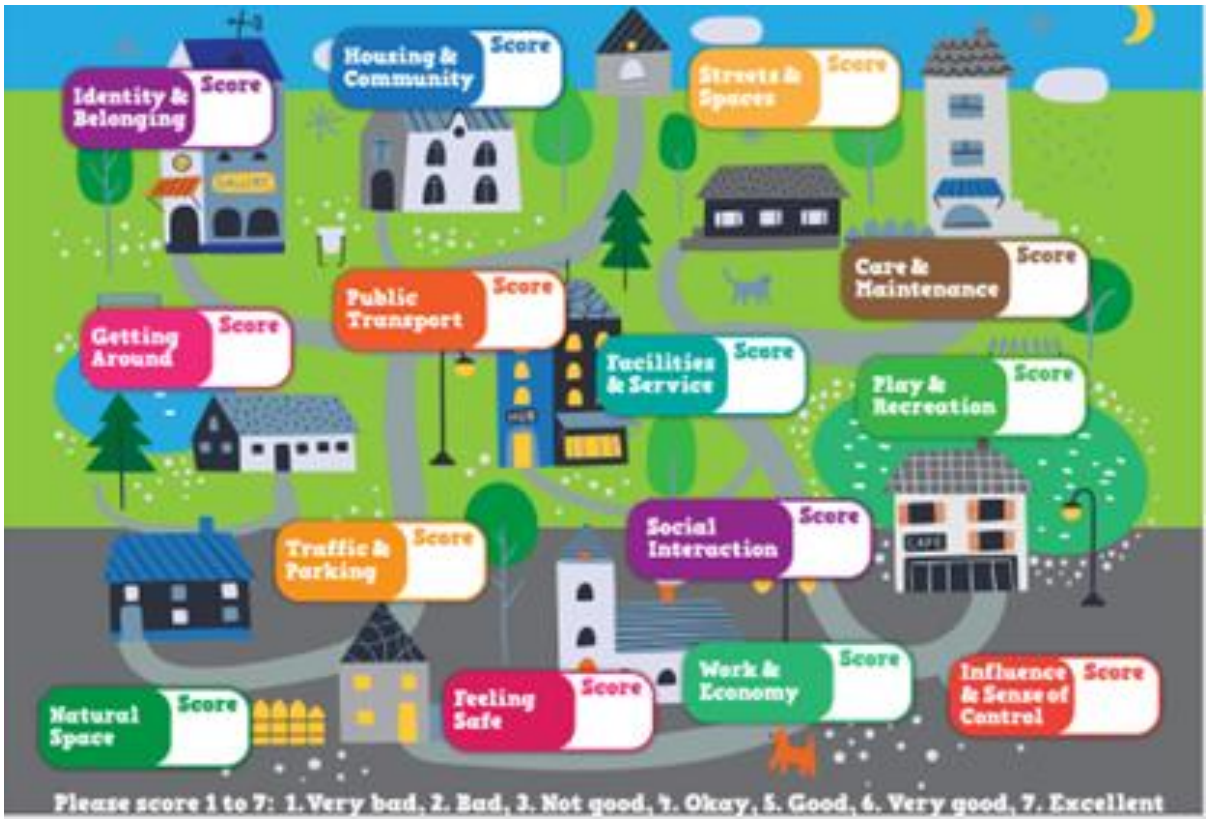
NB comments to be switched off

6.4. Visual Displays Onsite

Posters and interactive QR Boards to be developed and included at high-traffic sites including:

- Aberdeen Vaccination Centre
- Health Village
- GP Practices
- Grampian Gathering
- Aberdeen Royal Infirmary
- Woodend
- Rosewell

Example wall display below, and example poster overleaf. At times, a visual display could be manned to allow more explorative, qualitative discussions:



7. Consultation

7.1. Survey Questionnaire (Common Place)

Survey to include; - http://yourplaceyourplans.commonplace.is (Link not yet Live)

- Consultation survey will include the same information for all 4 Plans and Strategies in consultation. This will also help support the Place Standard tool on scoring the 14 themes to support development for our City. The themes that the ACHSCP IJB Strategic Plan links to are the following
  - Facilities and Services
  - Social Interaction
  - Influence and Self Control
  - Work and Economy

7.2. Consultation Approach

Largely, the approach to consulting with people about our Strategic Plan will follow an approach of "go where the people are" rather than expect them to come us. We can do this by building on our existing high-traffic areas and events. We will be encouraging conversations and questions and also promoting feedback through the online survey questionnaire.

We have arranged a number of events to ensure we catch some of our key stakeholders and communities, but we are strongly encouraging and reaching out to those to invite us along to discuss with groups and communities where best suits them.

The joint consultation approach with ACC alongside other draft strategies will enable us to create less duplication and consultation fatigue within our communities. We plan to be able to answer some questions and take feedback for any of the draft strategies. A strong feedback loop will have to be created to ensure that we incorporate all we have heard and repeat that within our documents and communications.

This approach will help inform the Local Housing Strategy, Integration Joint Board (IJB) Strategic Plan, Community Learning and Development (CLD) Plan and Local Development Plan (LDP), as well as the development/refresh of remaining strategies to be developed in 2025/2026. Further targeted engagements (ACHSCP Led events detailed below), based on learning from the Place Based tool, will continue throughout the consultation and the remainder of 2025 to feed into the revised LOIP, Locality Plans, Local Development Plan and Local Transport Strategy in 2026.

ACHSCP Spaces
Health Village
Health and Wellbeing Hubs – Tillydrone, Greyhope, Healthy Hoose, GetActive@Northfield
Sports Centres, Community Centres & Libraries
Abdn City Vaccination Centre and Wellbeing Hub

Events	
Date	Event
18 March 2025	IJB Draft Consultation for Approval (Public Papers)
24th March 2025	Launch Survey and Consultation – Social Media Event and Pop Up at Aberdeen Vaccination And Wellbeing Hub
DATE TBC	Providers Event
17 April 2025	Strategic Planning Group
27 March 2025 AM	Locality Event Central – Rosemount CC
27 March 2025 PM	Locality Event South – Greyhope Community Hub
26 April 2025	Locality Event Central – Sports Village
26 April 2025	Locality Event South – Airyhall
10 May 2025	Locality Event North – GetActive@Northfield
10 May 2025	Locality Event North – Kings Church BoD
The following will be pop up events (max	North East Scotland College (NESCOL) pop-up(s) (Exam time) Robert Gordon University – (Ishbel Gordon Building) pop-up(s) Aberdeen University pop-up(s)

of 2 per site) Dates yet to be determined	
8th May 2025	BSL Session – Interpreters in Attendance
May (all month)	Wellbeing Festival Event Pop Ups
Various Lived Experience Groups Dates TBC	Wellbeing Wednesdays Carers Reference Group Wee Blether Locality Empowerment Groups Priority Neighbourhood Partnership Meetings Community council forum – first Monday of every month GREC equalities group Aberdeen Volunteer Co-ordinators Network Aberdeen Youth Movement/ Council North East Sensory Services The Aberdeen Inter-Faith Group, which represents 17 religions or denominations.

8. Involve & Collaborate

8.1. Key Stakeholders

Staff – ensuring our staff recognise their contributions and understand how their work feeds into the Strategic Plan; making sure our staff's feedback and views are represented.

Partners and Linked Services, working with partners Housing, Children's Social Work, Education, Hospital services and linking in with subsequent action plans/ strategies that we can help influence or refer to within our Strategic Plan.

Public – ensuring our public's views, concerns, priorities are addressed where possible within the strategic plan, and supporting and enabling our communities to be involved and included in decisions.

Third Sector - working with ACVO and others, to network and support opportunities within the sector and links with ACHSCP services, recognising their contributions to Health and Social Care support across Aberdeen.

Commissioned Services – Attendance at the Commissioning Academy and other commissioning or provider events to work with providers to gain more feedback on what we need to include in our Strategic Plan to support our commissioned providers.

8.2. Existing Groups with Lived Experience Representation

As these focus groups are confirmed, this document will be updated.

Existing groups within ACHSCP will be encouraged to influence the development of the Strategic Plan, and we will ensure that these groups are included in feedback within the Survey and also encouraged to include us within their meetings.

- Locality Empowerment Groups
- Carers Reference Group
- Strategic Planning Group
- Equalities Participation Network (GREC)
- Tenants and Care Home Participation Network
- Equalities and Human Rights Group
- Community Council Forum
- Aberdeen Volunteer Co-ordinators Network
- Aberdeen Youth Movement/ Council
- North East Sensory Services
- The Aberdeen Inter-Faith Group, which represents 17 religions or denominations.

9. Understanding Impact

In order to understand the potential impacts on people with protected characteristics and those considered within our Integrated Impact assessments, bespoke focus groups will be contacted and established where appropriate and as identified above.

We have considered an initial stage 1 Integrated Impact Assessment including feedback from our Engagement and Consultation for the wider Strategic Plan document.

Additionally, our projects and programmes will undertake separate engagement, inclusion and impact assessments as each progress.

10. Consultation Output

Place Standard Consultation

Consultation for the ACHSCP 2025-2029 was carried out as part of the Your Place, Your Plans, Your Future engagement exercise used to help inform the production of a number of the key strategies and proposals which will impact the citizens of Aberdeen.

Between 24 March and 18 May 2025, 2,087 citizens took the opportunity to inform our developing strategic plan for 2025-2029.

Of those who took part, 987 completed the survey (615 online and 372 paper copies), 134 took part in a locality event and 379 in facilitated outreach sessions. There were also 587 children and young people who took part in a children and young people designed version.

Considerable time has been spent reviewing the data and suggestions made for the five themes which were identified as impacting Health and Social Care delivery. The full 14 themes are included below with an indication of those which had content which was relevant to ACHSCP. These were:

- Facilities and Services
- Influence and Sense of Control
- Social Interaction
- Housing and Community
- Identity and Belonging

Participants were asked to score these areas from 1 to 7 with one being 'very bad' and 7 being 'excellent'. From the 5 themes which were relevant to ACHSCP, we can see that facilities and services scored highest with influence and sense of control scoring a mean of 3.3, which was the lowest of all 14 themes which were analysed during the consultation.

Theme	Mean Score	Base
Facilities and Services	4.2	1,144
Housing and Community	4.2	1,033
Social Interaction	4.2	1,087
Identify and Belonging	4.1	998
Influence and Sense of Control	3.3	951

A Place Standard consultation was undertaken in 2023 (ACHSCP was not explicitly part of this consultation), however from this we can see that overall, there has been a slight increase in participants' perceptions of these areas, or that these have stayed the same.

Theme	2023	2025	Change between 2023 and 2025
Facilities and Services	3.9	4.2	0.3
Housing and Community	4	4.2	0.2
Social Interaction	4	4.2	0.2
Identify and Belonging	4.1	4.1	0
Influence and Sense of Control	3.3	3.3	0

The following section will look at each theme and pick out particular areas that were commented upon as part of the consultation process which relate to ACHSCP.

Facilities and Services

Within Facilities and Services, participants were asked to give their opinion on areas of good practice and suggest what could be improved.

The positive impact of **community centres and hubs**, which offer a range of services and activities that cater to different needs were highlighted as an area which was performing well while **access to healthcare services**, particularly GP and dental services, were highlighted as a concern and an area for improvement. Participants report difficulties in accessing these services due to long waiting times and oversubscribed practices. "*Many services over-subscribed making it hard to see a doctor or dentist etc."* They call for more doctors, better appointment systems, and improved access to healthcare facilities.

Our response: Within the ACHSCP Strategic Plan 2025-2029, the delivery plan outlines the intention for the GP Vision Programme to be delivered and for the Primary Care Improvement Plan (PCIP) to be refreshed. This should target some areas for concern raised by participants.

Participants also mention that their **Safety** in public spaces was important. Participants mention issues with antisocial behaviour, drug use, and general neglect of public areas. They call for more police presence, better maintenance of public spaces, and initiatives to address substance use and homelessness. "*There is a lack of joined up thinking between services in relation to addiction and mental health."*

Our response: There is ongoing work with Mental Health Services across Grampian to improve access to services and to improve the outcomes from alcohol and drug misuse and minimise the possibility of death from substance misuse. This is outlined in the ACHSCP delivery plan for 2025-2026.

Within the Facilities and Services theme, ACHSCP also posed two specific questions around proposals. The following outlines the response from participants around these and some of the comments received before outlining our response to these comments and concerns.

	Overall % yes
Proposal 3: Refresh our Primary Care Improvement Plan to improved access to local primary care services.	**93.6% (Base = 715)**
Proposal 4: Review the allocation of social care resources to ensure more community and home-based services allowing people to live independently in their own homes.	**93.4% (Base = 731)**

Comments received centred around the difficulty of accessing healthcare services, particularly GP appointments. There is a call for better access to services particularly for the elderly and those with mental health issues. There is a feeling that the current system is overwhelmed and that more GPs are needed to improve accessibility. The impact of new housing developments on services was also raised.

"People are struggling to get appointments at GP and are either being missed or they are clogging up other areas of the NHS.", "Yes we are in desperate need for more available GP appointments." And

"I am a GP and we are working way over our working hours and doing a lot of remote working just to keep our heads above water and try to provide the best quality service we can - but constant complaints and lack of understanding from the public on how difficult the current Primary Care environment is to work in is demoralising! Please do anything you can to help - but more investment is required. We cannot afford to hire any new doctors due to NI increases and running costs. Needs sorted or more GP practices in Aberdeen will shut."

Other comments received include concerns around the **Consistency and Co-ordination** and the impact of a lack of standard procedures and the autonomy of GP practices was raised. A more coordinated approach to implementing changes in the primary care system

was suggested. There was also a suggestion for more pilot projects to be implemented before making changes to the system. *"Ensure pilots projects have been implemented first before changing and restructuring the system"* Some participants also asked for **more information** about the proposal and its objectives, as well as the financial feasibility of it.

Our Response: The primary care system is the front door to many of our services and we are aware that some members of the community are not pleased with the service that they receive. Our Delivery Plan for 2025-2026 which is embedded within the Strategic Plan 2025-2029 outlines the intention for ACHSCP to deliver the outcomes from the GP Vision programme and for a refresh of the PCIP programme. It is intended that this will assist GP Practices and allow for GP's to prioritise their work as expert General Medical Practitioners. Comments received highlight the lack of understanding around the proposal, so a communications plan will be formed from these programmes in an attempt to widen the reach of these programmes of work so that members of the public are aware of them and kept abreast of any changes to services that may impact upon them.

Proposal 4 relating to reviewing the allocation of services to ensure more community and home-based services was positively received by participants. The following comments were made which highlighted some concerns regarding **Community care,** with participants highlighting the importance of providing adequate community care and support for the elderly and those with disabilities. *"Well needed"* They emphasise the need for more resources, better training for carers, and improved access to services. Some participants were unconvinced about the proposal's **feasibility and effectiveness**. They raise concerns about funding, the availability of staff, and the potential for the proposal to be used as a cost-saving measure rather than genuinely improving care. There are also worries about the lack of detailed information and the potential **negative impact on existing services**.

Our response: as part of the planning of a proposal such as this, the negative impacts would require to be considered and assessed as part of an Equality Impact Assessment, the outcome of this assessment would be accessible to the public on the ACHSCP website.

Housing and Communities

Participants were asked to rate their feeling towards housing and the community within their area. Although housing in general is a function of Aberdeen City Council, ACHSCP has some responsibility for adapted housing. Community engagement and promoting community participation is also a priority for ACHSCP. The following comments were received in these areas.

Participants highlighted the following as positives within their areas, **Community spirit** is highlighted as good with friendly neighbours seen as important ***"Good and inclusive community"*** *and "****Community spirit is good in most areas, local projects increase participation"****.* Some participants felt that **Housing** in their area is well-maintained with many new developments under construction. ***"Homes are well kept and there are options for elderly in terms of adapted"*** *and* ***"Homes are in good condition"***

While other participants noted that there could be improvements made in **Facilities and Infrastructure** which would support the growing population in areas of new development. There were concerns about the lack of community spaces, shops, doctors, and other essential services in housing areas, especially in new developments. ***"There aren't facilities for the increased population. Doctors, dentists, school places."***

Our response: Outlined within our delivery plan for 2025-26, and in conjunction with our partners in Aberdeen City Council, ACHSCP intends to influence the redesign of sheltered housing to modernise the model of housing support. There has also been ongoing work in the likes of Counteswells to establish provision to services such as Community Treatment and Care (CTAC) services and access to Health Visting which helps to support services within communities.

Participants were asked whether they agreed with the following proposal and were encouraged to comment upon it. Some participants raise concerns about the council's ability to **implement the proposal**, citing past experiences and a **lack of trust** in the council's commitment to listening to local opinions. ***"The feeling in my area is powerlessness; that ACC will do as it wants regardless of what the locals want."*** Others are concerned about the practical implementation of the proposal, questioning how it will be achieved and whether it will address the real issues faced by the community.

	Overall % yes
Proposal 3: We will help to create thriving, inclusive communities across the city which support independent living and involve local people in decision making about the places they want to live.	**93.3%** **(Base = 686)**

Our response: ACHSCP does not have responsibility for housing, but has some input into adapted housing and encouraging communities to thrive. Since 2020, we have had an integrated locality planning team in place which works between ACHSCP and ACC. The team is responsible for planning, promoting, and delivering the three Locality Empowerment Groups across Aberdeen City. The Local Empowerment Groups function as a means to increase community involvement in decision making and strengthens our local communities. Attendance at our LEGs have grown over the past year, and we would like to see this continue over the next period to ensure that our decision making is inclusive as possible for the communities we work in.

Social Interaction

Participants were asked to comment upon good areas where they see social interaction take place. Participants mentioned different **Community Events and Activities** including local self-help groups, charity events, and social support groups. The spaces and opportunities for social interaction are plentiful, preventing people from feeling lonely. The variety of

opportunities for social interaction was praised, for example, **"knitting group which is great"**, **"free activities like museums / art galleries"** and "**very active community garden"**. Some participants also commented that there were good **Spaces for social interaction** available within their community.

When participants were asked what could be improved about social interactions, some felt that due to the closure of local resources that there was a **decline in Community Engagement**. Participants said there should be more activities that "foster social interaction without a commercial aspect, particularly for younger people" such as festivals, fun days, and creative activities, especially those that are not centred around alcohol, "More support could be given to establishing an evening cafe culture, the opening of libraries, community centres, and other public buildings to provide options for evening socialising?". Spaces to socialise that did not centre around alcohol were regarded as important with calls for "Alternatives to pubs… Community gyms, library and community spaces for different clubs to meet". It is deemed important that there is a **Variety of Activities** that cater to different interests and age groups, including more options for people with full-time jobs. There were also concerns raised relating to **Social Isolation** and that participants perceived that there was "A lot of social isolation in older generation and in young people of post-school age". Social connectedness could be improved if "More effort could be spent to get others involved", and that **promotion and communication** was important with participants suggest using local media and online platforms to keep information updated; "Bringing together the information" and running "more publicity pre-event" was suggested.

Our response: ACHSCP offer a variety of community activities under their Stay Well Stay Connected programme. These include those aimed at families and older adults. Activities are available across Aberdeen City and last year saw more than a 150% increase in uptake over the activities promoted. We hope that this increase will continue. ACHSCP are committed to increasing our social media presence and will continue to advertise events through these means alongside more traditional methods to ensure inclusivity across our communities.

Participants were asked whether they agree with the following proposal related to social interactions.

	Overall **% yes**
Proposal 1: Work with partners to develop, deliver and promote a range of activities in our communities to increase social interaction and improve both physical and mental health and wellbeing.	**93.1%** **(Base = 699)**

Participants highlighted the impact that such opportunities can have on **Health and Wellbeing Services** "*it is such an important element for good health and wellbeing."* They suggest that communities are "*included in planning events etc in order to connect socially and with confidence".* Comments also suggest including more **family-oriented events and initiatives** should be part of the proposals to "help people to get to know their neighbours would be good - we can the better support each other." Participants also suggested targeting

support for hard to reach individuals as part of the proposals. Participants highlight the particular needs of disabled people, single dads and those living in "blackholes" that are often neglected such as Stockethill and Ashgrove. They also highlighted the importance of **Involving of Multiple Partners** such as Community Councils, emergency services, local council workers and business partners should play a central role in the proposals.

Our response: As mentioned, ACHSCP play a key role in engaging with communities and empowering them to be part of decision making and to engage in activities through our Stay Well Stay Connected programme which will promote their health and wellbeing. Family focused activities such as the PEEP programme are part of the suite of activities on offer alongside others such as the Boogie in the Bar and Soup and Sannies in Seaton.

Identity and Belonging

Participants were asked what was good about identity and belonging in their area. Some said that **Community Centres, Events** and volunteer efforts contribute to a strong sense of belonging and identity in Aberdeen. Participants praised cultural events and organisers such Inspire, Spectra, Tall ships, and NuArt as helping to promote Aberdeen's sense of community. Participants also said schools and community centres help promote community and belonging and appreciated newsletters and social media which help keep people connected.

Participants were also asked about areas which may improve this and it was suggested that more could be done to target **Integration and Inclusion** and that there is a desire for better integration and inclusion of international residents who sometimes find it ***"challenging to connect with local Aberdonians."*** There is also a call for more positive promotion of the city to counteract the negative perceptions, ***"Fix the city centre, make it vibrant and people will care and be proud of this place again."***

Our response:

ACHSP works with partners and has a sub group from the Strategic Planning group focussed on equalities and diversity. Our Equalities Outcomes and how we undertake our Impact assessments is regularly reported on and we manage progress across all our services. We regularly provide updates on what Health and Social Care can contribute to identity and belonging, and this ensures that everyone has access to health and social care information and services. | *Aberdeen City HSCP*

Influence and Sense of Control

Participants felt that there was a need for **Transparency and Communication** from the council; ***"what they are doing and why"***. Participants want to be informed about what is happening in their area and how their feedback is being used. Participants also criticised the use of "jargon" and "lengthy technical documents" in consultation exercises, suggesting these ***"make it hard for us to understand".*** Participants want to be informed about what is happening in their area and how their feedback is being used. Comments were also received that **Community Outreach and Engagement** could be improved and it was recognised that "not everyone is on social media" and they used "different methods to reach out" Involving

"disabled and visually impaired individuals in consultations would make the city safer and more inclusive."

Our response: ACHSCP use a variety of methods to communicate with people, groups and communities including social media, our website and more traditional methods (e.g. posters). Community engagement is a significant part of the role of the ACHSCP and it is something which we look to improve on, we strive to make our documentation more accessible to all and make summary versions of our major documentation such as our Strategic Plan, our Annual Performance Reports and the Strategies for which we are responsible for.

As part of our engagement period, we have been targeted groups which are traditionally under-represented to ensure that opportunities were available for all residents to feedback. These have included sessions online for those with physical or mobility issues, BSL Sessions with interpreters and face to face sessions within established groups.

Proposals relating to influence and a sense of control include:

	Overall **% yes**
Proposal 1: Continue our inclusive approach when designing and delivering services ensuring the voices of our communities are heard and help influence decision making.	**91.9%** **(Base = 669)**
Proposal 2: Provide capacity building support to communities, all ages, to support them to have a voice, participate in decision making and take action to create, develop and sustain local programmes and activities which address emerging priorities.	**91.9%** **(Base = 628)**

The themes which were picked up from the comments relating to the proposals were similar to those from the main influence and sense of control topic, and there was some scepticism about the feasibility of the council's ability to execute the proposal; "No confidence that this can be achieved – aspirations should be realistic." Participants also suggested that there was "**Not much evidence that this is actually taking place.**". Participants suggested that there needs to be improved **communication** and that that the **"council don't listen to what the people want"**. Participants suggested that there needs to be better communication around decision making, suggesting the council "**Need to be clear about what is being taken forward and what isn't and how that links back to what was said."** Participants called for better communication and more opportunities for participation rather than **"token surveys"** or "**box ticking"**. Participants also emphasised the need for **genuine consultation** and the inclusion of community voices in decision-making, and that **"Moving ahead with the plans in the face of overwhelming opposition from the community is arrogant"**, and "creates distrust." Other participants welcomed the proposal suggesting it was "**Good for building trust and create services that are needed. All voices, especially ones that have felt unheard are heard."** **Inclusive consultation** was

suggested across a wide range of ages, ethnic groups and areas across the city was seen as a positive step. Townhall meetings were suggested as a way for councillors to respond to local needs, show a genuine commitment to co-production and be accountable “rather than a tick box” exercises. Participants emphasised the need for action not just consultation, "For all sectors of the community to feel represented, they need to be able see that 'people like them' are being listened to and contributing to strategies and plans." Participants highlighted the need for a “transparent strategy” for hearing from those who are “not part of existing groups”, a *way to “tackle integration” and hear from those who are “socially isolated."*

Our response: Many of the comments received were directed to our ACC partners, however this highlights the importance that our communities place on communication and consultation which is inclusive. Our Engagement Guidelines outlines how the Partnership intends to do this and how we engage with our communities on a variety of topics.

https://www.aberdeencityhscp.scot/globalassets/documents/guidance-for-community-engagement-human-rights-and-equalities.pdf

11. Completing the Feedback Loop

We recognise the importance of demonstrating how the views and impacts gathered in the consultation and engagement process have shaped the Strategic Plan 2025 -2029.

A Communications Plan will support the Final Strategic Plan full launch, including feedback on what we have heard and what we have incorporated or not, and the reason why not. This will form the basis of our governance and delivery plan structure to ensure our key messages, initiatives, changes and impacts are clearly consulted and communicated within Aberdeen City.

Throughout the Consultation period we have been seeking views on how best people would like these messages to be relayed, there are many imaginative communication methods, and we want to ensure ACHSCP are engaging in the best way possible. The Communication Group will consider the best course of action from the feedback received to relay information back to our engagers.

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Aberdeen City
Health & Social Care
Partnership
A caring partnership

INTEGRATED IMPACT ASSESSMENT

Areas for Consideration of Impact

Protected Characteristics

Age: older people; middle years; early years; children and young people.
Disability: physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions.
Gender Reassignment: people undergoing gender reassignment
Marriage & Civil Partnership: people who are married, unmarried or in a civil partnership.
Pregnancy and Maternity: women before and after childbirth; breastfeeding.
Race and ethnicity: minority ethnic people; non-English speakers; gypsies/travellers; migrant workers.
Religion and belief: people with different religions or beliefs, or none.
Sex: men; women; experience of gender-based violence.
Sexual orientation: lesbian; gay; bisexual; heterosexual.

Fairer Scotland Duty

Low income – those who cannot afford regular bills, food, clothing payments
Low Wealth – those who can meet basic living costs but have no savings for unexpected spend or provision for the future.
Material Deprivation – those who cannot access basic goods and services, unable to repair/replace broken electrical goods, heat their homes or access to leisure or hobbies
Area of Deprivation/Communities of Place - consider where people live and where they work (accessibility and cost of transport)
Socio-Economic Background - social class, parents' education, employment, income.

Health Inequality (those not already covered in the Fairer Scotland Duty)

Low literacy / Health Literacy includes poor understanding of health and health services (health literacy) as well as poor written language skills.
Discrimination/stigma – negative attitudes or treatment based on stereotyping. Discrimination can be direct or indirect and includes harassment and victimisation.
Health and Social Care Service Provision - availability, and quality/affordability and the ability to navigate accessing these.
Physical environment and local opportunities - availability and accessibility of housing, transport, healthy food, leisure activities, green spaces, air quality and housing/living conditions, exposure to pollutants, safety of neighbourhoods, exposure to crime, transmission of infection, tobacco, alcohol and substance use.
Education and learning - availability and accessibility to quality education, affordability of further education, Early Years development, readiness for school, literacy and numeracy levels, qualifications.

Human Rights (note only the relevant ones are included below)

Article 2 - The right to life (absolute right) **–** everyone has the right to life, liberty and security of person which includes access to basic necessities and protection from risks to their life from self or others.
Article 3 - The right not to be tortured or treated in an inhuman or degrading way (absolute right) **-** which includes anything that causes fear, humiliation intense physical or mental suffering or anguish.
Article 5 - The right to liberty (limited right) **–** and not to be deprived of that liberty in an arbitrary fashion.
Article 6 - The right to a fair trial (limited right) **–** including the right to be heard and offered effective participation in any proceedings.
Article 8 - The right to respect for private and family life, home and correspondence (qualified right) **–** including the right to personal choice, accessible information and communication, and participation in decision-making (taking into account the legal capacity for decision-making).
Article 9 - The right to freedom of thought, belief and religion (qualified right) **-** including conduct central to beliefs (such as worship, appropriate diet, dress etc.)
Article 10 - The right to freedom of expression (qualified right) – to hold and express opinions, received/impart information and ideas without interference
Article 14 - The right to no discrimination – not to be treated in a different way compared with someone else in a similar situation. Indirect discrimination happens when someone is treated in the same way as others that does not take into account that person's different situation. An action or decision will only be considered discriminatory if the distinction in treatment cannot be reasonably and objectively justified.

UNCRC

Article 2 non-discrimination	**Article 15** freedom of association	**Article 30** children from minority or indigenous groups
Article 3 best interests of the child	**Article 16** right to privacy	**Article 31** leisure, play and culture
Article 4 implementation of the convention	**Article 17** access to information from the media	**Article 32** child labour
Article 5 parental guidance and a child's evolving capacities	**Article 18** parental responsibilities and state assistance	**Article 33** drug abuse
Article 6 life, survival and development	**Article 19** protection from violence, abuse and neglect	**Article 34** sexual exploitation
Article 7 Birth, registration, name, nationality, care	**Article 20** children unable to live with their family	**Article 35** abduction, sale and trafficking
Article 8 protection and preservation of identity	**Article 22** refugee children	**Article 36** other forms of exploitation
Article 9 separation from parents	**Article 23** children with a disability	**Article 37** inhumane treatment

		and detention
Article 10 family reunification	**Article 24** health and health services	**Article 38** war and armed conflicts
Article 11 abduction and non-return of children	**Article 25** review of treatment in care	**Article 39** recovery from trauma and reintegration
Article 12 respect for the views of the child	**Article 26** Benefit from social security	**Article 40** juvenile justice
Article 13 freedom of expression	**Article 27** adequate standard of living	**Article 42** knowledge of rights
Article 14 freedom of thought, belief and religion	**Article 28** right to education	

Specific groups and duties

Looked after (incl. accommodated) children and young people
Carers: paid/unpaid, family members.
Homelessness: people on the street; staying temporarily with friends/family; in hostels, B&Bs.
Involvement in the criminal justice system: offenders in prison/on probation, ex-offenders.
Addictions and substance misuse
Refugees and asylum seekers
Staff: full/part time; voluntary; delivering/accessing services.
Consumer Duty
Armed Forces Covenant

ACHSCP Impact Assessment – Stage 1 – Proportionality and Relevance

Name of Policy or Practice being developed	ACHSCP Strategic Plan 2025-2029
Name of Officer completing Proportionality and Relevance Questionnaire	Stuart Lamberton Transformation Programme Manager ACHSCP
Date of Completion	4 February 2025
What is the aim to be achieved by the policy or practice and is it legitimate?	The ACHSCP Strategic Plan 2025-2029 aims to empower communities to achieve healthy fulfilling lives by modernising service delivery and shifting our focus towards prevention and early intervention. It sets our strategic direction, the priorities required to achieve this, and the services that will be required. The Delivery Plan clearly defines the actions required to achieve the aims set out in our Strategic Plan. Section 29 of the Public Bodies (Joint Working) (Scotland) Act 2014 requires the IJB to prepare and publish a Strategic Plan. An annual report will be compiled and presented to the IJB as part of the governance responsibilities of the IJB.
What are the means to be used to achieve the aim and are they appropriate and necessary?	Under each aim there are several priorities which set out how our aims will be achieved. These priorities will each have associated workstreams, programmes, and projects to be delivered. These are represented in the Delivery Plan. Each action in the delivery plan will undergo separate engagement and consultation as part of the ACHSCP Integrated Impact Assessment process. This is necessary and will provide the rationale, understanding, and the voice of lived experience for each impact that may affect specific groups, duties or rights. The Strategic Plan has already been out for public consultation and the feedback gathered is presented in this report.
If the policy or practice has a neutral or positive impact, please describe it here.	The Strategic Plan aims to empower communities to achieve fulfilling and healthy lives, therefore it is expected our policies and practices will reflect that and ultimately have a positive impact. However, ACHSCP are cognisant of the fact we need to make our services both affordable and sustainable, this is reflected in our resource and financial planning. With that in mind some future decisions may negatively impact specific groups, duties, or rights. As highlighted,

	reassurance can be provided that robust IIAs will be carried out as part of annual reporting and/or as part of individual workstreams and projects under the Delivery Plan. All of these will be reported through the IJB.
Is an Integrated Impact Assessment required for this policy or decision (Yes/No) ***Note – if multiple assessments are required, please complete a separate template for each of these and embed them in the section below 'Rationale for Decision' with a brief supporting narrative. This will ensure all relevant assessments are connected regardless of the stage they are at in the process.***	Yes. Multiple IIAs will be required, and these will be reported either through ACHSCP Strategic Plan annual reports or as part of individual workstreams and projects under the Delivery Plan. All of these will be reported through the IJB.
Rationale for Decision **NB: consider: -** • **How many people is the proposal likely to affect?** • **Have any obvious negative impacts been identified?** • **How significant are these impacts?** • **Do they relate to an area where there are known inequalities?** • **Why are a person's rights being restricted?** • **What is the problem being addressed and will the restriction lead to a reduction in the problem?** • **Does the restriction involve a blanket policy, or does it allow for different cases to be treated differently?** • **Are there existing safeguards that mitigate the restriction?**	The Proportionality and Relevance section of the ACHSCP IIA process will be considered as part of each workstream, programme, and project under the ACHSCP Strategic Plan 2025-2029. These will be reported to the IJB as they progress Although the ACHSCP Strategic Plan 2024-2029 is expected to have positive impacts there is also the possibility of some negative impacts. These will be identified as the delivery of the plan progresses. The IIA process will ensure when these impacts are identified that they are recorded and the voice of lived experience helps to inform decision making. The financial pressures and expectations were set out in the Medium-Term Financial Framework which was presented to the IJB on 18 March 2025 The IJB will receive annual reports in relation to the delivery of the Strategic Plan. The IJB will also receive reports as part of individual workstreams and projects under the Delivery Plan. Each of these will include existing safeguards and mitigations that may already be in place or required to be put in place.
Decision of Reviewer	Approved
Name of Reviewer	Alison MacLeod
Date	9 June 2024

Scottish Specific Public Sector Duties (SSPSED)

Procured, Tendered or Commissioned Services

Is any part of this policy/service to be carried out wholly or partly by contactors and if so, how will equality, human rights including children's rights and the Fairer Scotland duties be addressed?

One of our main enablers is collaboration, and this includes a large proportion of our Commissioned services. Each of our Commissioned services are obliged to work fully in compliance with equality and human rights legislation, and Fairer Scotland Duties.

ACHSCP Impact Assessment – Stage 2 – Impact Assessment

Description of Policy or Practice being developed including intended aim.	
Is this a new or existing policy or practice?	
Name of Officer Completing Impact Assessment	
Date Impact Assessment Started	
Name of Lead Officer	
Date Impact Assessment approved	

Summary of Key Information

Groups or rights impacted.	
Feedback from consultation and engagement and how this informed development of the policy or practice	
Performance Measures identified, where these will be reported and how impact will be monitored.	

Review

Date the Impact will be reviewed	
Rationale for Date	

Having considered all of the groups, duties and rights in the list at Appendix A of the Guidance on Impact Assessment could this policy or practice have a negative impact on any of the following. Please answer Yes or No. If you answer Yes, please specify precisely which particular group, duty or right will be impacted and how and also what (if any) current evidence you have.

	Yes/No	Details	Evidence
Protected Characteristics			
Fairer Scotland Duty			
Health Inequality			
Specific Groups			
Human Rights			
UNCRC			

Will there be any cumulative impacts between this policy or decision and others	**Yes**		**No**	
Describe what this cumulative impact will be and include evidence mitigations in the sections below				

Please list below the groups of stakeholders to be engaged with or consulted, what feedback has been received and how this has influenced development of the policy or practice and what (if any) mitigating actions have been put in place.

Stakeholder Groups	Feedback Received	Influence on Policy or Practice/Mitigating Actions

APPENDIX D

ACHSCP Impact Assessment – Stage 4 – Review

Name of Impact Assessment being reviewed	
Name of Officer completing review	
Date Review Commenced	
Reason for Review (scheduled or accelerated)	
Reason for Accelerated Review	
Name of Lead Officer	
Date Review Completed	

Summary of Key Information

What amendments have been identified to the original Impact Assessment?	
What evidence do you have for these amendments?	
What actions have you taken to review the policy or practice in light of the review?	

Having considered all of the groups, duties and rights in the list at Appendix A of the Guidance on Impact Assessment has the impact of this policy or practice changed from the original assessment? Please answer Yes or No. If you answer Yes, please specify precisely what change has occurred and which particular group, duty or right it affects and how and also what (if any) current evidence you have.

	Yes/No	Details	Evidence
Protected Characteristics			
Fairer Scotland Duty			
Health Inequality			
Specific Groups			
Human Rights			
UNCRC			

Will there be any cumulative impacts between this policy or decision and others	**Yes**		**No**	
Describe what this cumulative impact will be and include evidence mitigations in the sections below				

Please list below the groups of stakeholders to be engaged with or consulted, what feedback has been received and how this has influenced development of the policy or practice and what (if any) mitigating actions have been put in place in light of the changes identified above.

Stakeholder Groups	Feedback Received	Influence on Policy or Practice/Mitigating Actions

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	01 July 2025
Report Title	Housing Contribution Statement
Report Number	HSCP.25.059
Lead Officer	Fiona Mitchelhill, Chief Officer
Report Author Details	Alison MacLeod Strategy and Transformation Lead ACHSCP AliMacleod@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	A – Draft Housing Contribution Statement
Terms of Reference	8 - The approval or amendment of the Strategic Plan and on-going monitoring of its delivery through the Annual Performance Report

1. Purpose of the Report

1.1. The purpose of this report is to present to the Integration Joint Board (IJB) the Housing Contribution Statement (HCS) which is required as part of the Strategic Plan.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Notes the content of the Housing Contribution Statement and the links between it, the IJB Strategic Plan, and the Local Housing Strategy
b) Instructs the Chief Officer to publish the Housing Contribution Statement on the Aberdeen City Health and Social Care

Partnership's website and ensure it is linked to both the IJB Strategic Plan and the Local Housing Strategy.

3. Strategic Plan Context

3.1. The statutory guidance on Health and Social Care Strategic Plans states that these should ensure correlation with other local policy directions including the Local Housing Strategy. There is a specific requirement that the Strategic Plan should contain a Housing Contribution Statement. Following discussion at the Aberdeen City Council Strategy Board it is proposed that this latest Housing Contribution Statement is a separate document that is linked to both the IJB Strategic Plan and the Local Housing Strategy.

4. Summary of Key Information

4.1. The Local Housing Strategy is a Local Authority's strategic document for housing and housing services. The Housing (Scotland) Act 2001 sets out the strategic responsibilities of Local Authorities to assess housing needs, demand and condition, (including for specialist housing and housing related services). The Housing (Scotland) Act 2006 also introduced a requirement for a Local Authority to include as part of their LHS a strategy detailing a Scheme of Assistance – for improving the condition of houses. This Scheme of Assistance outlines how a Local Authority will help people living in private sector housing (home ownership or private renting) to repair and maintain their homes as well as adapt them to meet their needs.

4.2. Housing Contribution Statements (HCS) were introduced in 2013. They provided an initial link between the strategic planning process in housing at a local level and that of health and social care, setting out the arrangements for carrying out the housing functions delegated to the Integration Authority and providing an overarching strategic statement of how the Integration Authority intends to work with housing services, whether delegated to it or not, to deliver its outcomes. The Scottish Government published updated LHS Guidance in 2019 which, amongst other things, includes a specific focus on specialist housing and independent living, including the role of housing in health and social care integration. It emphasises the need for strategic planners in both the Local Authority housing and planning functions to engage with health and social care planners to share evidence, identify needs and plan solutions for those with 'specialist' needs.

4.3. The Housing Contribution Statement contained at Appendix A details the local context in Aberdeen City, what strategic housing related documents

have been published, and which housing functions have been delegated to the IJB. It also confirms the IJB's commitment to collaboration with Aberdeen City Council's Housing Service to ensure that services to the public are strategically coordinated to achieve joined up, person centred approaches and improve health and wellbeing outcomes for the people of Aberdeen. It goes on to detail the arrangements we have in place to ensure that collaboration happens and describes the shared evidence base and housing related challenges in Aberdeen City.

4.4. The Local Housing Strategy is due to be presented to the Communities, Housing and Public Protection Committee on 26th August 2025 for final approval. The LHS contains the following priorities: -

- Adequate supply of housing, including affordable housing.
- Placemaking with communities
- Make homelessness rare, brief, and non-recurring
- Promote independent living in communities
- Promote health through housing
- Improve housing quality and energy efficiency
- Support a well-managed private rented sector

All of these priorities will help support the IJB strategic vision to empower communities to achieve fulfilling, healthy lives.

5. Implications for IJB

5.1. Equalities, Fairer Scotland and Health Inequality

An Integrated Impact Assessment (IIA) is not required for the Housing Contribution Statement itself as it is a statement of the current arrangements between the IJB and ACC Housing in terms of joint working and no changes are being proposed.

5.2. Financial

The Housing Contribution Statement will be delivered within existing budgets.

5.3. Workforce

The Housing Contribution Statement will be delivered by existing workforce.

5.4. Legal

There is 'Housing services and integrated health and social care: Housing Advice Note' Statutory Guidance which states that the IJB must put in place a Housing Contribution Statement as part of the Strategic Plan. This report fulfils that requirement.

5.5. Unpaid Carers

The housing arrangements of a cared for person will impact on their unpaid carer. The Local Housing Strategy, the IJB Strategic Plan and the Housing Contribution Statement have been shared with Carers Reference Groups to ensure their views are taken into account.

5.6. Information Governance

There are no direct information governance implications arising from the recommendations of this report

5.7. Environmental Impacts

There are no direct environmental implications arising from the recommendations of this report.

5.8. Sustainability

There are no direct sustainability implications arising from the recommendations of this report.

5.9. Other

There are no other direct implications arising from the recommendations of this report.

6. Management of Risk

6.1. Identified risks(s)

The 'Housing services and integrated health and social care: Housing Advice Note' Statutory Guidance states that Integration Authorities' Strategic Plans must include a Housing Contribution Statement. There is a risk that if we do not publish a Housing Contribution Statement we will breach our statutory obligation.

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

There is no specific risk in relation to housing but the Housing Contribution Statement could be linked to Strategic Risk 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.

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

By developing and publishing a Housing Contribution Statement we are meeting our statutory obligation and ensuring the collaborative arrangements between Aberdeen City Council Housing and the IJB continue to ensure outcomes for the people of Aberdeen are improved.

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Aberdeen City Health & Social Care Partnership

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Housing Contribution Statement

Background

The statutory guidance on Health and Social Care Strategic Plans states that Strategic Plans should ensure correlation with other local policy directions including the Local Housing Strategy (LHS). There is a specific requirement that the Strategic Plan should contain a Housing Contribution Statement (HCS).

The Local Housing Strategy is a Local Authority's strategic document for housing and housing services. The Housing (Scotland) Act 2001 sets out the strategic responsibilities of Local Authorities to assess housing needs, demand and condition, (including for specialist housing and housing related services) and to assess the level of homelessness and produce a homelessness strategy. The Housing (Scotland) Act 2006 also introduced a requirement for a Local Authority to include as part of their LHS a strategy detailing a Scheme of Assistance – for improving the condition of houses. This Scheme of Assistance outlines how a Local Authority will help people living in private sector housing (home ownership or private renting) to repair and maintain their homes as well as adapt them to meet their needs.

Housing Contribution Statements (HCS) were introduced in 2013 and provided an initial link between the strategic planning processes both in housing at a local level, and in health and social care, setting out the arrangements for carrying out the housing functions delegated to the Integration Authority and providing an overarching strategic statement of how the Integration Authority intends to work with housing services, whether delegated to it or not, to deliver its outcomes.. The Scottish Government published updated LHS Guidance in 2019 which, among other things, includes a specific focus on specialist housing and independent living, including the role of housing in health and social care integration. It emphasises the need for strategic planners in both the Local Authority housing and planning functions to engage with health and social care planners to share evidence, identify needs and plan solutions for those with 'specialist' needs.

Local Context

Aberdeen City Council (ACC) holds the statutory role as the strategic housing and planning authority assessing housing needs, demand and condition, (including for specialist housing and housing related services) and to assessing the level of homelessness. They have published a Housing Need and Demand Assessment (HNDA) and a Local Housing Strategy which is due to be updated in August 2025. Registered Social Landlords and other housing providers in the city are vital partners in both the planning and delivery of housing care and support services.

Some housing functions have been delegated to IJBs and Aberdeen City IJB is responsible for the provision of aids and adaptations and for housing support in relation to sheltered and very sheltered housing tenancies which includes responding to emergencies, a daily welfare check and support with daily living including paying bills, health and safety and security, and accessing services. The delivery arm of Aberdeen City IJB is the Aberdeen City Health and Social Care Partnership (ACHSCP).

Aberdeen City's Housing Contribution Statement

It essential that housing services are coordinated between ACC Housing, local housing providers and ACHSCP in order to achieve joined-up, person-centred approaches. Collectively we can make a contribution to the achievement of many of the National Health and Wellbeing Outcomes and specifically Outcome 2 'People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community'. Independent living is key to improving health and wellbeing. In addition, the availability of housing that meets people's specific health needs can prevent hospital admission, achieve a timely discharge, and contribute to tackling health inequalities. Housing providers also play a crucial role in supporting residents in their properties to maintain or adapt their homes to enable people to continue to live in their own home despite changing needs.

Aberdeen City Council and Aberdeen City IJB are committed to the strategic coordination of priorities in the Local Housing Strategy (link) and the Strategic Plan (link) working closely together to achieve improved outcomes for the population of Aberdeen. Our approach will include assessing the range of housing support needs across the population, including homeless households, and understanding the link with health and social care needs, identifying common priorities, and engaging with the local housing sector to jointly drive forward the housing contribution to improved population health and well-being that positively contribute to health and well-being and makes best use of the available resources within the city of Aberdeen.

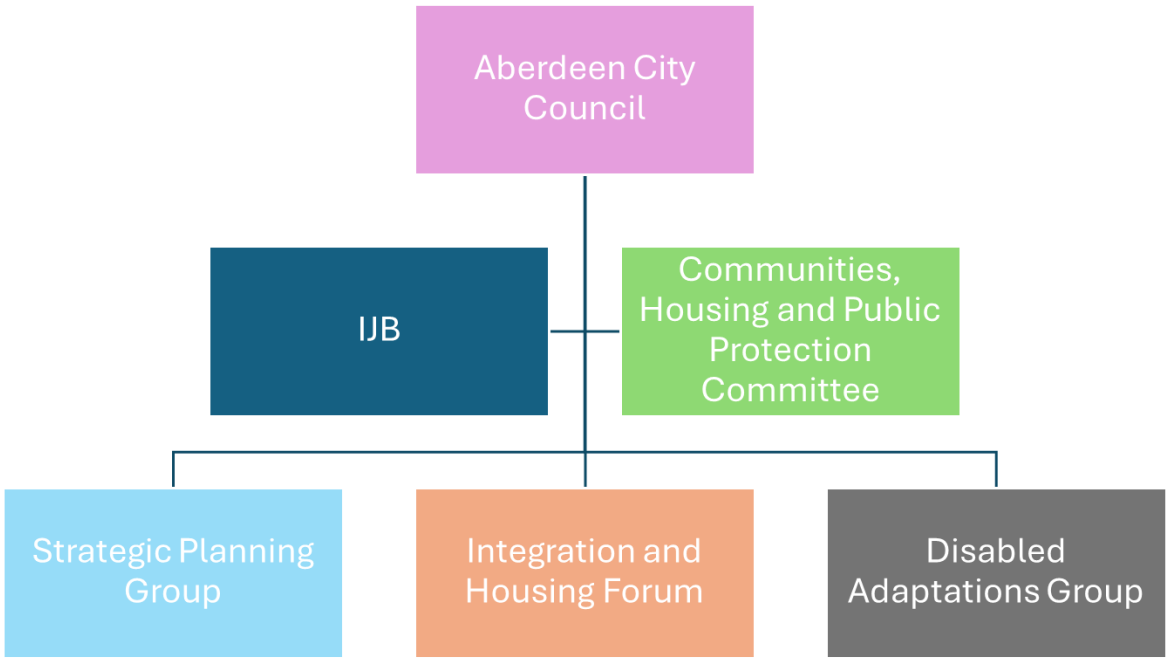
Governance Arrangements

Beginning from the shadow year of the IJB in 2015, ACHSCP set up an Integration and Housing forum which facilitates discussion and the sharing of information on the common areas of interest between Housing and Health and Social Care. It is co-chaired by strategic leads from both Housing and ACHSCP and the membership is made up of relevant representatives from both Aberdeen City Council and the Aberdeen City Health and Social Care Partnership. The Integration and Housing

meeting acts as the key forum where the critical relationship and interdependency between Aberdeen City Council (ACC) Housing and ACHSCP is discussed and explored and from where greater collaboration and improvement activity can be directed.

There is also a Disabled Adaptations Group (DAG), chaired by the strategic lead from ACHSCP which focuses on the provision of equipment and adaptations across all housing tenures. The DAG consists of representatives from Bon Accord Care who provide our Occupational Therapist service, the ACC Housing team, the Private Sector Grants (PSG) team (who administer the grants scheme for adaptations to privately owned homes in the City), the locally commissioned Care and Repair provider, and each of the Registered Social Landlords who provide housing in the city. The aim of the DAG is to manage and monitor the various processes that enable the provision of disabled adaptations in properties across all tenures in Aberdeen City. The DAG also manages and monitors the adaptation activity and budget expenditure ensuring best value for money is obtained and that resources are targeted where they are needed most.

In addition, Housing colleagues are represented on the IJB's Strategic Planning Group where our Locality Empowerment Groups are also represented, facilitating the link not only into strategic planning but also into localities. ACHSCP colleagues participate in various groups that develop the Housing Need and Demand Assessment and the Local Housing Strategy and also those that review the provision of Housing for Varying Needs and housing related Delayed Discharges.



Shared Evidence Base and Housing- related Challenges

Below is a summary of what we know about the health, wellbeing and social care needs in the City, and the links between these and housing.

The IJB's strategic vision is to 'empower communities to achieve fulfilling and healthy lives'. The Local Housing Strategy has identified seven priorities for action: -

- Adequate supply of housing, including affordable housing.
- Placemaking with communities
- Make homelessness rare, brief, and non-recurring
- Promote independent living in communities
- Promote health through housing
- Improve housing quality and energy efficiency
- Support a well-managed private rented sector

For both women and men, **healthy life expectancy** is declining in the city. People living in more **deprived areas** have shorter lives and are more likely to live with poorer health for longer. All seven priorities in the LHS will support improvement in healthy life expectancy particularly for those living in deprived areas. In particular there are commitments that those who suffer from economic inequalities will be supported to find a good quality, affordable and sustainable home as quickly as possible and that citizens will be supported to know where and how to access financial inclusion services and benefit from targeted initiatives, such as the Rent Assistance Fund.

1 in 4 adults describe themselves as having a **limiting, long-term illness**. The **population is ageing** and as people get older, they may need more health and social care support, and the support of dependants to help manage long-term conditions or diseases. There is a rising number of adults choosing not to have children, and this is likely to require very different housing models and care needs in the longer term. Preventing disease progression and encouraging the adoption of healthier behaviours are important elements for improving health outcomes. Both the Local Housing Strategy and the IJB's Strategic Plan commit to understanding the future long terms needs of citizens and to planning for longer term changes.

Whilst the rates at which people are being admitted to hospital due to alcohol and the rate of alcohol-related deaths has been declining or has been relatively stable over the last few years, the drug-related death rate has increased substantially. Continuing to reduce the **serious consequences of alcohol and drug use** remains a priority which will result in improved health outcomes for those affected. Data suggests that more people are being prescribed drugs for anxiety and depression than ten years ago, though the rate of people being in hospital for mental illness has fallen. **Deaths from suicides** have risen and the effects of the cost-of-living crisis suggest that mental health and wellbeing may further deteriorate in the near future. Early intervention should be a focus, addressing, for example, the number of people feeling socially isolated in our communities.

The Local Housing Strategy commits to ensuring that everyone in Aberdeen, particularly those with mental or physical health needs, receive housing and support

which meets their housing and wider needs to support them to live a healthy life. Providing appropriate housing for people with **complex needs** can be challenging but ACC housing and ACHSCP commit to working in partnership to monitor and review the need for specialist and support accommodation.

We know that financial, spatial and relational factors are associated with **housing insecurity and mental health**. We also know that overcrowded homes can be associated with **stress, anxiety and the spread of respiratory illness**. The Local Housing Strategy commits to ensuring that housing policies allow citizens to have sufficient space in their home and are not overcrowded.

Aberdeen City is in a fairly unique position in that almost all of adult social care is provided by externally commissioned organisations. ACHSCP produce a number of Market Position Statements that help inform housing and social care providers of the changing needs of the population over time in order that they can plan their response to these as our commissioning needs arise.

This Housing Contribution Statement has been developed jointly by Aberdeen City Council Housing Services and Aberdeen City Health and Social Care Partnership and is informed by public consultation on both the IJB Strategic Plan, the Local Housing Strategy and the Local Development Plan. All three of these documents have been contextualised around the identified social determinants of health relevant to Aberdeen city reflective of our shared and aligned endeavour to deliver better outcomes for people of Aberdeen.

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	01 July 2025
Report Title	Shifting the Balance of Care – A Community-Focused Approach to Delivery of Frailty and Specialist Rehabilitation Services within Aberdeen City Health & Social Care Partnership
Report Number	HSCP.25.054
Lead Officer	Julie Warrender, Chief Nurse and Lead for Frailty and Specialist Rehabilitation
Report Author Details	Sarah Gibbon, Programme Manager
Consultation Checklist Completed	Yes
Directions Required	Yes
Exempt	No
Appendices	1. Integrated Impact Assessment 2. Direction to NHS Grampian and Aberdeen City Council
Terms of Reference	2. Any function or remit delegated under the Aberdeen City Integration Scheme, which is bound to be undertaken by the IJB itself.

INTEGRATION JOINT BOARD

1. Purpose of the Report

1.1. This report builds on an update with the Chief Officer's report[1] considered on 13 May 2025, and the August 2023[2] IJB paper, to provide an overview of interrelated projects relating to the 'Discharge Without Delay' national programme, highlighting the implications for rebalancing the provision of care from inpatient settings to support within the patients home[3] where possible.

2. Recommendations

2.1. It is recommended that the Integration Joint Board (IJB):

a) Endorse the approach for modernising service delivery and shifting the balance of care from in-patient, bed-based settings, by investing in services provided within the community at the person's home in line with local and national strategy, as outlined in this report;

b) Agree to a gradual, phased reduction in bed capacity at the intermediate facility at Rosewell House resulting in the eventual withdrawal of services provided by ACHSCP from the facility by 31st March 2026, in support of the Discharge without Delay commitments;

c) Instruct the Chief Officer to implement the withdrawal of in-house services at Rosewell House accordingly, ensuring each reduction in bed capacity at Rosewell House is monitored to ensure no significant impact on flow within hospital setting;

d) Instruct the Chief Officer to make and implement any necessary and reasonable arrangements in furtherance of the decision at c) above; and

e) Make the Direction, as at Appendix 2, and instructs the Chief Officer to issue the Direction to NHS Grampian

[1] (Public Pack)Agenda Document for Integration Joint Board, 13/05/2025 10:00

[2] Decisions 22nd-Aug-2023 10.00 Integration Joint Board.pdf

[3] For the purposes of this report, a person's home refers to their usual 'homely setting', included care home placements where this applies

f) Instruct the Chief Officer to bring back a future report demonstrating the progress and impact of the Discharge without Delay programme of work and shifting the balance of care.

3. Strategic Plan Context

There is cohesive strategic direction through from government at the highest level to local level in the form of the latest consultation draft of the ACHSCP Strategic Plan, to support the modernising of service delivery and shifting the balance of care from in-patient bed-based settings to the person's home. This will be summarised below as essential context to this report:

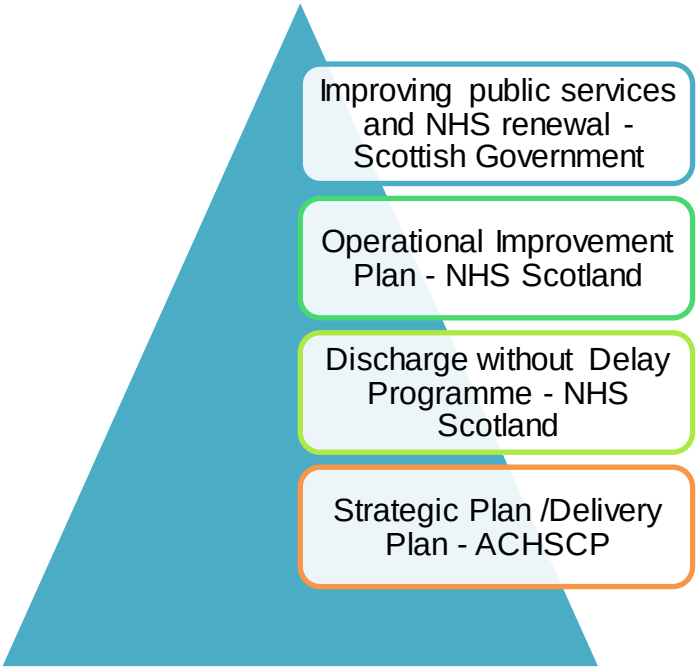


Figure 1: Strategic Context

3.1. National Strategy & Policy Framework

The Scottish Government have emphasised reform within our NHS services, towards a fundamentally patient-centred and interconnected health and social care whole-system[4]. It repeated the messaging which has been woven into the ACHSCP Strategic Plan for some time:

"Sometimes the appropriate setting is in hospital. More often, it is not"

[4] Improving public services and NHS renewal: First Minister's speech - 27 January 2025 - gov.scot

To support a systematic shift of the balance of care into communities and into homes, focus will be on three key actions:

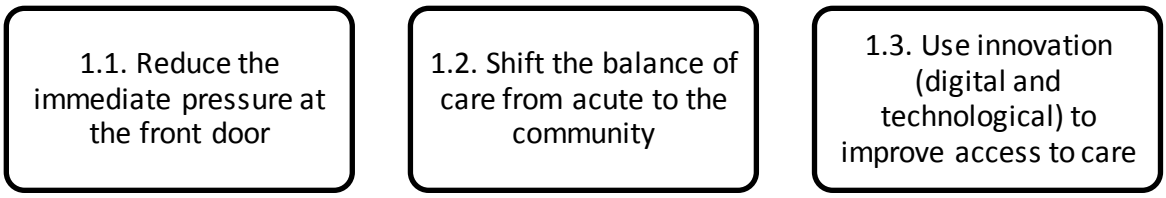


Figure 2: Key Actions from Scottish Government

The subsequent NHS Scotland Operational Improvement Plan re-emphasises the importance of these actions, and highlights the interconnected key areas to shifting the balance of care and modernising adult services, of which the following have relevance to this paper:

- Reducing the pressure in our hospitals
- Hospital at Home
- Specialist Frailty Services
- Frailty at the Front Door of the Emergency Department

Again, focusing on the impact for patients and their families, the plan seeks to *"ensure people receive the right care in the right place, recognising that acute hospitals are not always best for patients or their families".*

Operationalising the improvement plan, the programme of work seeking to progress the 'Shifting the Balance of Care' elements is the National Discharge Without Delay (DWD) Collaborative which was launched in 2025.

DWD is "*a whole-system programme for frail older people currently accessing Scottish hospitals, pulling best practice, individual services and pathways into an integrated model that strives to deliver Comprehensive Geriatric Assessment (CGA) in the timeliest manner, while ensuring no negative impact from hospital induced harm or dependency to the person*"[5]. The DWD Collaborative has an associated programme of work with four key workstreams:

[5] Quote from 2025 Discharge without Delay Paper

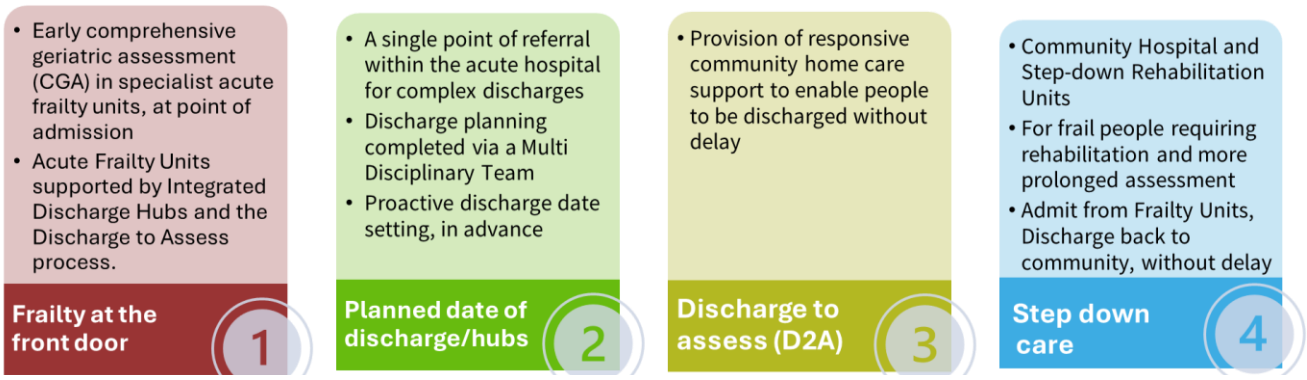


Figure 3: DWD Collaborative 4 Priority Programmes

The key to the successful implementation of the DWD programme is a whole-system, integrated approach between acute and community – current models in isolation delivery marginal impact on overall service delivery.

The outcomes of the DWD Work locally are outlined in figure 4 (below). Whilst these metrics are focused on the improvements from a systems perspective, from a patient's perspective this will mean more timely and effective access to acute-level care; a shorter hospital stay helping reduce the chances of deconditioning or negative consequences (such as hospital acquired infection), and a smoother, more supported transition back home after their hospital stay.

- Reduce acute geriatric length of stay (LOS) by >20% by end March 2026
- Reduce community hospital/ step-down LOS by > 20% (ideally less 28 days) by end March 2026
- Reduce respective HSCP delayed discharges by >20% by end March 2026 as consequence of improved flow
- With improved downstream capacity, the DWD Collaborative aims to improve 4-hour whole system performance by 3-5 % points.

Figure 4: DWD Outcomes

3.2. Local Strategy & Policy Framework

The new Strategic Plan (2025-2029) consultation draft was approved at the IJB in March 2025, with the final version on today's agenda. Within the refreshed strategic plan, there is an aim focusing on 'Modernising Service Delivery', which will be supported by delivery of the proposals within this paper. These commitments will be reflected through the inclusion of the DWD priorities within the associated ACHSCP Delivery Plan.

The consultation process on the draft Strategic Plan has shown good support for modernising our service delivery by shifting the balance of care as outlined in this paper. From 24 March 2025 to 18 May 2025, the Community Planning Aberdeen partners joined up to hold a large-scale engagement to inform their various strategic plans. This included the Health & Social Care Partnership Strategic Plan.

There was strong support for more community and home-based provision. Respondents were asked to indicate if they agree that the following statement should be a priority: "*review the allocation of social care resources to ensure more community and home-based service allowing people to live independently in their own homes*". 93.4% of 731 respondents agreed that it is right to focus on this as a priority within the draft Aberdeen City Health & Social Care Partnership Strategic Plan.

4. Summary of Key Information

4.1. Current Model & Timeline of Decisions

In 2020, the redesign of the Frailty Pathway was commissioned in line with the strategic direction of Operation Home First. This saw the transfer of resources and the realignment of staff to better support the flow of frailty patients across NHS Grampian in community settings rather than acute settings – an early example of ACHSCP's commitment to shifting the balance of care.

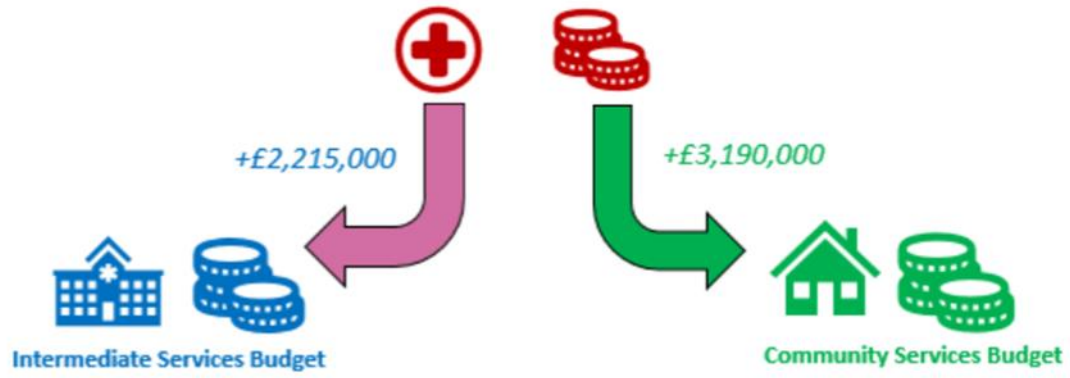


Figure 5: Resource Shift from Frailty Pathway Redesign

Alongside the shifting of resource and staffing from in-patient to community settings, key successes of the redesign of the Frailty Pathway were:

- the provision of Geriatricians within Acute Medical Initial Assessment (AMIA);
- an initial step towards shifting the balance of care from acute-hospital settings, with the establishment of an intermediate care facility at Rosewell House;
- additional capacity in the Community Rehabilitation team which improved the discharge of patients;
- the development and expansion of the Aberdeen City "Hospital at Home" service.

The priority actions of DWD reinforce these successes and further progresses the commitment of the initial Frailty Programme.

4.2. Need for Change

Nationally, the demand on Frailty services continues to grow[6] leading to challenges managing the flow of patients within the hospital, evidenced most visibly in increased ambulance 'stacking' and pressure at the Front Door of the hospital.

[6] The number of people aged 65 and over in Scotland is projected to grow by nearly a third by 2045 (National Records of Scotland, 2023)

Locally, Rosewell House has been an important component of the Frailty pathway however it has struggled to function as originally intended (as a 60 bedded integrated, intermediate care facility delivered in partnership with Bon Accord Care, offering both step up and step down provision):

Year	Beds	Notable Changes in Service Provision
2020	60 total	Plans for creating an integrated, intermediate care facility registered with the Care Inspectorate at Rosewell House are approved by the Integration Joint Board in October 2020, however Covid19 measures restricted the ability to implement these plans.
2021	30 Aberdeen City Frailty Beds 10 Aberdeenshire Frailty Beds 20 Rehabilitation Beds[7]	Restriction on access to available capacity, due to guidance on managing Covid19 in registered Care Homes has reduced patient flow and constrained capacity across multiple step-down facilities and sites. As a result, the IJB approved an interim arrangement to utilise part of Rosewell House as an NHS facility (HIS as regulator). In August 2021, it was agreed that all 60 beds would be the responsibility of NHS Grampian.
2022	30 Aberdeen City Frailty beds 10 Aberdeenshire Frailty Beds 20 Rehabilitation beds	Issues in providing clinical oversight of the rehabilitation beds and quality of care emerge.
2023	30 Aberdeen City Frailty Beds 10 Aberdeenshire Frailty Beds 20 Beds closed	Issues providing clinical oversight of the 20-rehabilitation beds exacerbate, with a lack of assurance on quality of care improvements, leading to the closure of these 20 beds in October 2023.
2024	40 Aberdeen City Frailty Beds 20 Acute Winter Surge Beds	In March 2024 the 10 Aberdeenshire frailty beds cease due to funding and are absorbed by Aberdeen City IJB. Opening of 20 winter surge beds in the vacant Rehabilitation beds in Rosewell House in December 2024 for frailty patients.

[7] supported with a service level agreement with a GP Practice

2025	30 Aberdeen City Frailty Beds 20 Acute Winter Surge Beds 10 Beds Closed	Closure of 10 beds within City Frailty due to staffing risks and an increase in adverse events reported. NHSG CET agreed to close the 20 Acute Winter Surge Beds (10 June 2025).

The changes that have taken place within the system highlight the need to deliver on the Discharge without Delay Collaborative's programme of work with ethos of shifting the balance of care from inpatient to peoples own homes as a matter of priority. Delivering on this will ensure sustainability of the system whilst putting patients and their needs at the forefront.

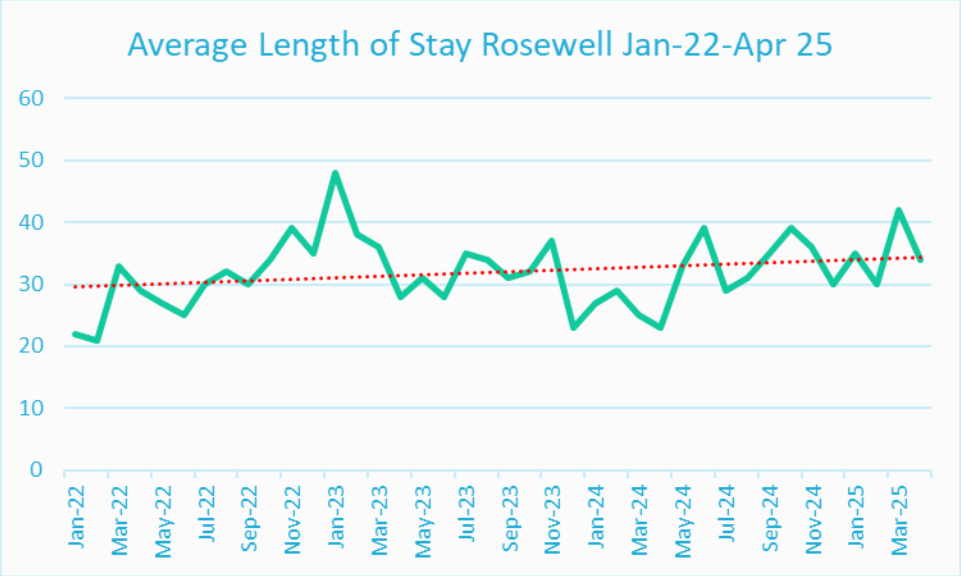
Crucially, it also demonstrates the challenges in maintaining the bed-based provision at Rosewell House, emphasising the need to shift the balance of care and resources further into a community-based model as close to a person's home as possible.

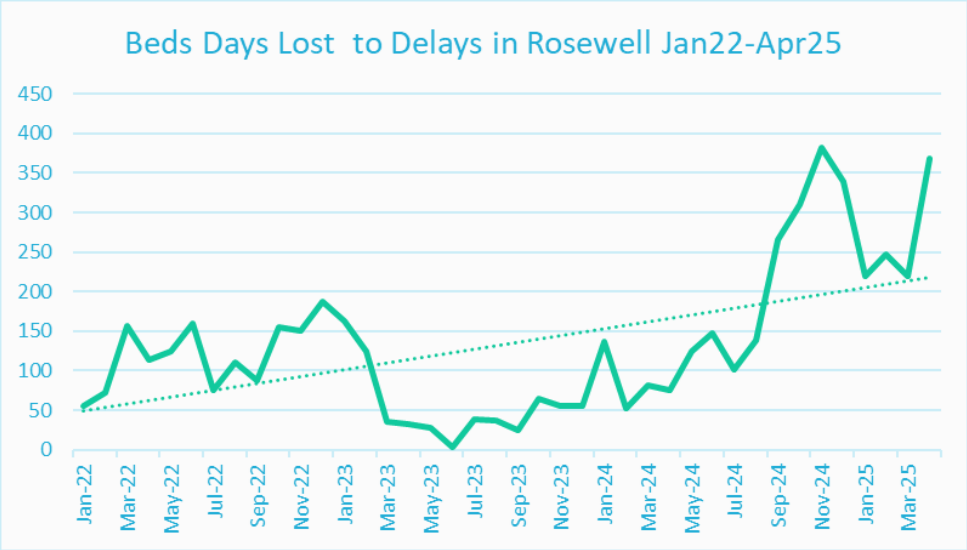
4.3. Analysis of Current Model

4.3.1. Rosewell House

Over the past 3 years, from 2022 to 2024, Rosewell House has seen a slight trend of increasing length of stay, increased number of bed days lost to delays, and a decreasing number of admissions per month. This reduces the amount of capacity the service has to meet demand, though it should be recognised that this can be affected by factors outwith the service's direct control.

Adverse event reporting in Rosewell House had also been on a decreasing-trend until the opening of the Winter Surge beds, which showed an increase in adverse events, related to the increased pressures on staffing and leadership.





Key challenges for Rosewell House over time have included:

1. **Workforce:** The 2023 evaluation of the Rosewell House identified challenges with staffing as a key issue for the service, and this has exacerbated with ongoing difficulties recruiting and retaining staff, including for leadership roles (1 WTE Senior Charge Nurse at facility), resulting in high levels of dependency on temporary staffing impacting quality and

continuity of care. There are also high levels of short and long term absence within the team (as of mid-May there was over 20% absence rate).

2. **Admission Pathway (Step-Up):** The proportion of step-up admissions at Rosewell House have been decreasing over the same time period, from around 6% of admissions, to 3.5% of admissions, indicating that the model is not functioning as originally intended and is not preventing admissions into an acute-setting, but functioning primarily as a step-down facility. This means that the opportunities to further the prevention agenda and limit the negative impacts of a hospital stay are not being realised.

3. **Front Door Pressures:** The 2023 evaluation also highlighted that there was a risk that the low proportion of step-up admissions, felt at the time to be due to prioritising of providing support to hospital-based services to improve flow during the Covid19 pandemic would become business as usual. Reprioritising resource to support Frailty patients at the Front door could reduce the need for these patients to be admitted to hospital in the first place, which would be a preferred outcome rather than admission and step-down to Rosewell.

4. **Finance:** The service has struggled with acute budget pressures, arising from the acquisition of the additional 10 Aberdeenshire beds (which was unaccounted for in the initial budget), and a high proportion of spend on bank nursing to compensate for staffing difficulties. It is a costly service per bed provided. The average cost of providing a bed within Rosewell House is approximately £167k per bed per annum.

4.3.2. Ward 102

Between January 2022 and April 2025, the average length of stay in Ward 102 has remained stable for Aberdeen City (average 2.7 days) and has increased for Aberdeenshire (average 3.3 days in 2022 to 4.3 over the past 12 months), resulting in an overall increase in length of stay. The number of admissions and average monthly boarders has decreased overall (noting a spike in boarders in Jan 2024, following a sharp decrease on opening surge beds). The number of bed days lost to delays in Ward 102 has increased, mirroring the increased in bed days lost at Rosewell House.

Delayed discharges (numbers) from City have remained very sporadic (only 6 delayed discharges total noted between Jan 22 to Dec 24), however Aberdeenshire have seen a noted and sustained increase in delayed discharges from December 2023.

There has been no notable impact of the closure of 10 Aberdeen City Frailty Beds based on the available data.

4.3.3. Hospital at Home (H@H)

In combination with the key elements of the Discharge Without Delay Programme of work, the Scottish Government remain committed to the expansion of Hospital at Home services in order shift the balance of care. The H@H service in ACHSCP has expanded over the last few years and is an essential and embedded part of the Frailty Pathway. The majority of admissions (approximately 73%) to the service come as Admission Avoidance (Step-Up), thereby bypassing the inpatient portion of the patient journey and reducing pressures on the Scottish Ambulance Service, front door and inpatient services. In the last 12 months the H@H service in Aberdeen City has saved approximately 10,000 bed days in the secondary care system.

Government expectations are that further expansion takes place, however funding to support this has yet to be agreed. Based on a commitment of 2,000 additional Hospital @ Home 'beds' and applying the National Resource Allocation Formula (NRAC) to identify a local target, it is likely that City's H@H service will be required to expand from a maximum capacity of 48 beds to 80 beds. This will further support the rebalance of care from in-patient to people's homes, potentially reducing demand for services at Rosewell House and meeting the step-up demand that it was initially envisaged that Rosewell House would provide.

4.4. Future Model & High Level Project Timescales

The DWD Collaborative programme consists of 4 closely related initiatives, with more detail given bellow. The Collaborative provided a set of 'guiding principles' which allowed HSCPs and Health Boards to assess their current performance against these principles to identify local key priorities and actions.

4.4.1. Discharge To Assess (D2A)

To ensure timely discharge and minimise hospital-induced dependency, services must offer responsive, community-based home care support, enabling patients to return home without unnecessary delay. As well as the benefits for the acute-system in terms of reducing length of stay, this model of care reduces the ongoing care need for an individual – the test of change demonstrated that 36% of patients cared for were able to remain at home with no further package of care.

Locally, Aberdeen City are making good progress developing plans to implement this service within the financial year. There is a paper on today's IJB agenda (01 July 2025) seeking approval of a business case to provide up to 1,000 hours of care at home, to support delivery of the Discharge to Assess service. It is difficult to quantify the number of people who can be supported by the service, given the varying levels of care needs, however it is a substantial increase to our capacity in the community to support discharge.

4.4.2. Frailty at the Front Door

Acute hospitals should implement early comprehensive geriatric assessment (eCGA) for identified frail older people, in Acute Frailty Units, as early in admission as possible. These units should be supported by Integrated Discharge Hubs, rehabilitation services, and when necessary, D2A pathways, facilitated through the Planned Date of Discharge (PDD) process. This approach ensures timely discharge and minimises the risk of hospital-induced dependency.

4.4.3. PDD/Integrated Discharge Hub

Acute hospitals should aim to establish a single point of referral for complex discharges, supported by a proactive multidisciplinary team (MDT) approach. This includes this team, with discharge facilitator input, setting a planned date of discharge (PDD) that is realistic and will result in discharge happening.

4.4.4. Community Rehab

These facilities should be adequately staffed and empowered to care for frail individuals requiring rehabilitation and extended assessments, ideally transitioning

from Frailty Units. Discharge back to the community should occur promptly through an agreed PDD process, ensuring no delays.

4.5. Achieving Our Future Model - Changing the Balance of Care

The aspirational model is one that delivers an integrated, multidisciplinary community model which can respond 24/7 as early as possible when a frail older person begins to show signs of a deteriorating condition. This will limit acute illness and ultimately, the need for hospital admission.

As the progress of implementing the nationally directed DWD initiatives and Hospital at Home expansion becomes apparent, it will provide opportunities to further reallocate our resource to support patients within their own homes and the community. Given the well-documented limited financial framework HSCPs are working in, it is necessary to realign existing resources in line with success from this national direction.

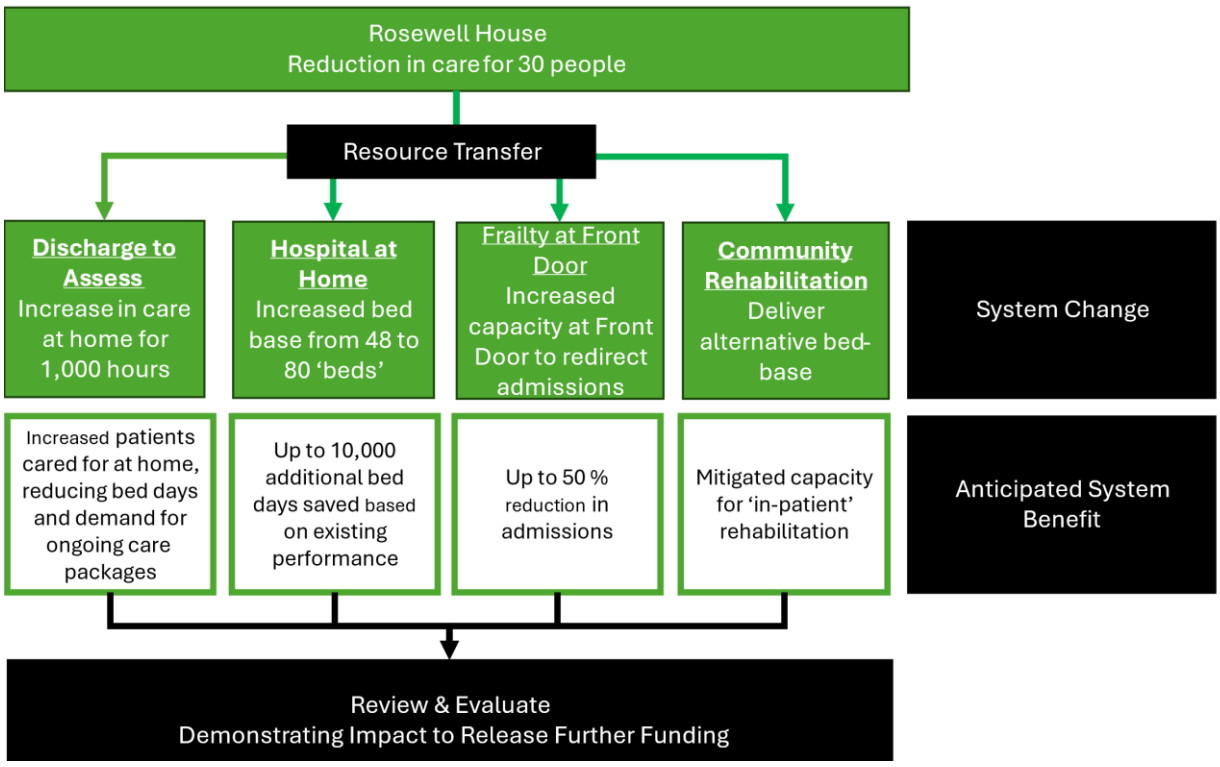
If the DWD initiatives are implemented successfully, it is expected that demand for bed-based intermediate care facilities will reduce, consequently reducing the need for the type of care provided at Rosewell House. For example, a 'Day of Care' audit of Aberdeen City patients who were delayed in Rosewell House in May, indicated that out of 16 delayed patients, up to 12 patients could have been more appropriately cared for through the Discharge to Assess model if funding had been released to explore a different model. Additionally, up to 50% of admissions at the Front Door could be avoided if geriatrician resource was freed up to support Frailty at the Front Door.

Therefore, the consequence of achieving the metrics set out by Discharge to Assess (see above) would be a reduction in demand at the Front Door and a reduction in demand for intermediate care, and the facility at Rosewell could be phased-down in response to this reduction in demand, freeing up more resource (both in terms of staffing and finances) to support further roll-out of the successful initiatives and delivery of their benefits:

- **Discharge To Assess (D2A)** – financial resource freed to support delivery of social care provider; realignment of Allied Health Professional staff to the service; increase in care in community of 1,000 hours supported by enhanced therapy input to mitigate reduction in bed base.

- **Frailty at the Front Door –** increased geriatrician capacity to support Front Door activity, realignment of Rosewell House staff to support Frailty at Front Door and Liaison service reducing the number of admissions required by up to 50%[8];
- **PDD/Integrated Discharge** – no direct resource transfer at this point.
- **Community Rehabilitation –** options are being explored to deliver several rehabilitation beds to support the revised model for those patients who are unable to return home directly.
- **Hospital at Home** – potential realignment of Rosewell House staff to support recruitment to expansion of the service through the organisational change process, increase in capacity from 48 to 80 beds (up to +10,000 bed days).

The below diagram summarises the intended system change and benefits. This demonstrates a clear link between reducing the in-house service at Rosewell House, and building on our capacity in the community in line with the strategic intent highlighted earlier in this paper. This will provide clear mitigations against the loss of capacity for these types of beds within Rosewell House, reducing demand and enabling more timely discharges.



[8] As anecdotally evidenced in small scale tests of change

The physical building at Rosewell House provides further opportunities to recommission a care model (such as residential or nursing care; or a complex care facility) which will further enhance capacity within the community.

The closure of beds within Rosewell House will commence following approval of this IJB paper, closing in 10-bed increments, with an aim of full closure by the end of the financial year. However the timeline for each phase of closure will require to be flexible to allow for increase in Discharge to Assess and impact on bed reduction to be reviewed as we step down Rosewell and step up Discharge to Assess.

In order to facilitate the phased closure, and ensure a mitigation should the intended benefits not be realised, there is a contingency fund to allow for ACHSCP to continue to hold the building running costs until the end of the financial year (March 2026). Therefore, if progress is not positive, capacity remains at Rosewell House.

This paper seeks endorsement of the approach for changing the balance of care, and the gradual moving of our resources to support this. To sustain the Discharge to Assess model, shifting resource from existing services is required:

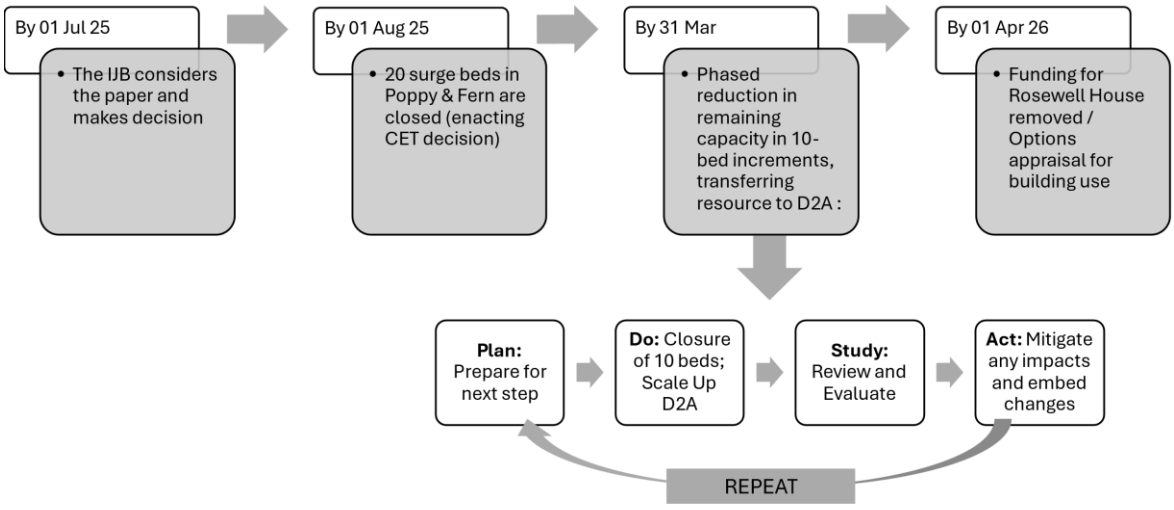


Figure 6: High Level Timeline

4.6. Assurance for the Future Model

The development and implementation of the future model is being taken forward with a Grampian-wide approach to governance and assurance. The ACHSCP Chief Officer sits on the Unscheduled Care Programme Board, ensuring clear assurance and oversight from the IJB's perspective. Project support is provided on a pan-Grampian basis at the project-level, with Aberdeen City contributing specifically towards the Frailty at the Front Door and Discharge to Assess Projects. The existing Discharge without Delay Group (chaired by the ACHSCP Chief Officer) will disband and realign into the downstream delivery group. Extensive communication and engagement has taken place across the system focusing on these governance changes, which has ensured good understanding and ownership of the different elements.

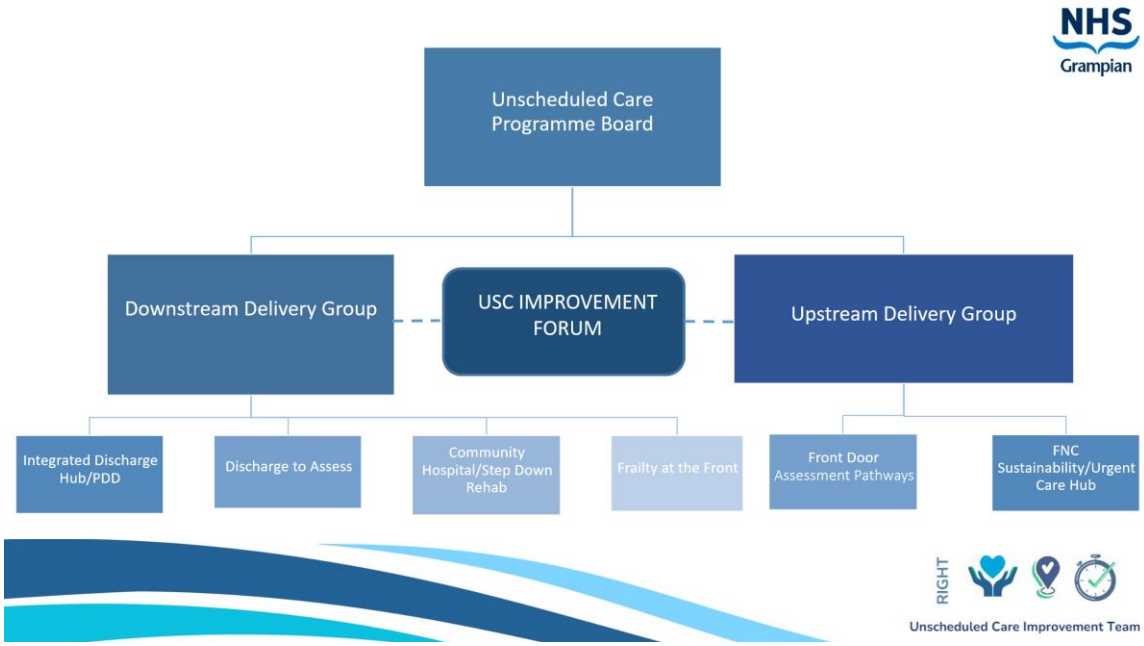


Figure 7: Governance diagram for DWD within NHS Grampian

5. Implications for IJB

5.1. **Equalities, Fairer Scotland and Health Inequality:** An integrated impact assessment has been completed and is included at appendix 1 of this report.

5.2. **Financial:** There are the following financial implications as arising from the recommendations of this report:

The total costs of delivering the service at Rosewell House was £6.4million per annum. Delivery of the DWD Commitments will be supported by redirecting this budget.

The closure of 10 beds from the ACHSCP-led bed base to ensure safe staffing levels will release £800,000 of financial resource in-year from reduction in bank spend. This resource will be realigned to support the introduction of the new Discharge to Assess service (contract value £1.6m per annum - see business case included with report HSCP.25.062 for further details)Further savings will be realised when Rosewell House is closed.

There is the possibility of additional specific funding from Scottish Government, to support the implementation of Discharge without Delay initiatives. However, due to the implications of NHS Grampian being in Level 4 of the Scottish Government's 'Support and Intervention' Framework, no funding will be confirmed locally until after the external review has been completed. Additionally, it is expected that once funding has been confirmed, it will be provided on a 'on delivery' basis – meaning that projects will need to demonstrate their impact *before* funding is released. Both of these factors mean that there is a greater need to shift our own resources to support delivery in the community in the first instance.

5.3. **Workforce:** There are implications for the workforce arising from the programmes of work outlined in this support. There will need to be a transfer of staff from in-patient settings to community-based services within people's homes in order to support the shift in the balance of care. Where this arises, the project will ensure to follow all formal organisational change processes and legislative requirements, as well as maintaining positive informal relationships with teams, trade unions and staff-side representatives to ensure a smooth transition for any affected staff members. There will be further positive implications for staffing including the opportunities provided by working closely as a multidisciplinary team in the community, working closely with other community partners who are not traditionally based in hospital settings, and supporting people in their own home.

5.4. **Legal:** There are no direct legal implications arising from the recommendations of this report.

5.5. **Unpaid Carers:** There are no direct implications for unpaid carer arising from the recommendations of this report, however the work outlined seeks

to improve service provision for their cared-for person and is expected to have a positive impact on unpaid carers.

5.6. **Information Governance:** There are no direct implications relating to information governance arising from the recommendations of this report. Each project outlined within the DWD Collaborative Programme may require information governance support to implement new processes or systems for information required to deliver the improvements. Information Governance from NHS Grampian has been closely involved in the development of the governance arrangements and is aware of the possibility of a request for their input as the projects progress.

5.7. **Environmental Impacts:** There is a possibility that the successful implementation of the Discharge without Delay Commitments reduces our need for a physical buildings footprint, which may have positive environmental impact. This will be countered to some degree by an increase in carbon footprint for staff travel however.

5.8. **Sustainability:** The proposals outlined in the paper aim to increase the IJBs sustainability both in terms of service provision and financial sustainability, by modernising service delivery and shifting the balance of care to meet anticipated demand.

5.9. **Other:** There are no other implications arising from the recommendations of this report.

6. Management of Risk

Risk Appetite Statement

Achievement of the priorities of the Discharge without Delay programme, and shifting the balance of care, will require the acceptance of a certain level of risk to support transitioning services to realise the benefits of the opportunities presented, which is within the tolerances as set out in the risk appetite statement linked above.

6.1. Identified risks(s)

Risk 1: There is a risk of impact on the Acute Sector (Front Door) during the transition between models outlined in the paper, resulting in increasing presentations and pressure for a time-limited period (Service Risk).

Cause	The period of time between phasing down existing service provision and implementing the alternative services.		
Effect /Event	Increased presentations at the Front Door.		
Likelihood	Medium	**Impact**	Medium
Controls		**Additional Mitigating Actions**	
• Monitoring of the impact of closure of 10 beds at Rosewell House have identified limited impact to date • Ongoing monitoring and evaluation		Options to mitigate the impact, which could be implemented in the case of evidence of increased impact include: • Implementation of DWD Initiatives will mitigate the impact on the Front Door. • Temporarily reinstating beds within Rosewell House or an alternative site within Woodend • Review of phased approach to shifting balance of care and pause / stop as appropriate	
Risks of non-implementation of the recommendations of this report			
The sustained and increasing delayed discharges and length of stay within Rosewell, coupled with the anticipated increasing demand in demographic changes, means that the risk of inaction results			

Risk 2: There is a risk that funding for the DWD initiatives, as a part of the Unscheduled Care, is unconfirmed (Financial Risk) .

Cause	Scottish Government have indicated that financial resource for the implementation of the DWD is likely to be awarded on delivery of the intended outcomes.		
Effect /Event	This could result in temporary financial pressures within ACHSCP awaiting confirmation and receipt of the funding.		
Likelihood	Medium	**Impact**	Low
Controls		**Additional Mitigating Actions**	
• Robust financial monitoring and internal audit processes		• Shifting balance of resource as outlined in this paper	
Risks of non-implementation of the recommendations of this report			
Not implementing the recommendations of this report could still result in increased financial risk due to the continued overspend on temporary staffing to support the current service model.			

Risk 3: There is a risk that elements of the programme are delayed due to interdependencies with other parts of the programme (Programme Risk).

Cause	Projects or partnership areas progress elements of DWD at different paces.		
Effect /Event	This may have an impact on the successful implementation of other parts of the programme – for example, successful delivery of elements of Frailty at the Front Door is dependent on an adequate resource in the community (Discharge to Assess)		
Likelihood	Medium	**Impact**	Medium
Controls		**Additional Mitigating Actions**	
• Robust governance process involving all three HSCPs and Acute NHS Grampian		• NA	
Risks of non-implementation of the recommendations of this report			
There is a risk that there continues to be inequity of delivery across the different areas of Grampian.			

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

Strategic Risk	**How might content of report impact or mitigate risk**
Risk 2 : There is a risk of IJB financial failure and projection of overspend	Outlines a process for shifting our internal resource to support delivery of priorities
Risk 3: There is a risk that hosted services do not deliver the expected outcomes, fail to deliver transformation of services, or face service failure	Outlines the identified priorities for the transformation of Frailty services, including the hosted element of acute frailty at ARI
Risk 4: There is a risk that the IJB, and the services it directions and has operational oversight of, fails to mee the national, regulatory and local standards	Outlines the plans for delivering on the Discharge without Delay commitments
Risk 5: There is a risk that the IJB experiences failure to deliver transformation and sustainable systems change	Outlines the identified priorities for the transformation of Frailty services and plans to deliver these
Risk 8: There is a risk that buildings across the city, operated by, or overseen by, the IJB /ACHSCP are not being used to maximum efficiency and are not in line with statutory /regulatory requirements	Outlines plans to withdraw from a building which is currently not being used to maximum efficiency

6.3 How might the content of this report impact or mitigate the known risks: see above

Areas for Consideration of Impact

Protected Characteristics

Age: older people; middle years; early years; children and young people.
Disability: physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions.
Gender Reassignment: people undergoing gender reassignment
Marriage & Civil Partnership: people who are married, unmarried or in a civil partnership.
Pregnancy and Maternity: women before and after childbirth; breastfeeding.
Race and ethnicity: minority ethnic people; non-English speakers; gypsies/travellers; migrant workers.
Religion and belief: people with different religions or beliefs, or none.
Sex: men; women; experience of gender-based violence.
Sexual orientation: lesbian; gay; bisexual; heterosexual.

Fairer Scotland Duty

Low income – those who cannot afford regular bills, food, clothing payments
Low Wealth – those who can meet basic living costs but have no savings for unexpected spend or provision for the future.
Material Deprivation – those who cannot access basic goods and services, unable to repair/replace broken electrical goods, heat their homes or access to leisure or hobbies
Area of Deprivation/Communities of Place - consider where people live and where they work (accessibility and cost of transport)
Socio-Economic Background - social class, parents' education, employment, income.

Health Inequality (those not already covered in the Fairer Scotland Duty)

Low literacy / Health Literacy includes poor understanding of health and health services (health literacy) as well as poor written language skills.
Discrimination/stigma – negative attitudes or treatment based on stereotyping. Discrimination can be direct or indirect and includes harassment and victimisation.
Health and Social Care Service Provision - availability, and quality/affordability and the ability to navigate accessing these.
Physical environment and local opportunities - availability and accessibility of housing, transport, healthy food, leisure activities, green spaces, air quality and housing/living conditions, exposure to pollutants,

safety of neighbourhoods, exposure to crime, transmission of infection, tobacco, alcohol and substance use.
Education and learning - availability and accessibility to quality education, affordability of further education, Early Years development, readiness for school, literacy and numeracy levels, qualifications.

Other

Looked after (incl. accommodated) children and young people
Carers: paid/unpaid, family members.
Homelessness: people on the street; staying temporarily with friends/family; in hostels, B&Bs.
Involvement in the criminal justice system: offenders in prison/on probation, ex-offenders.
Addictions and substance misuse
Refugees and asylum seekers
Staff: full/part time; voluntary; delivering/accessing services.

Human Rights (note only the relevant ones are included below)

Article 2 – The right to no discrimination – not to be treated in a different way compared with someone else in a similar situation. Indirect discrimination happens when someone is treated in the same way as others that does not that person's different situation. An action or decision will only be considered discriminatory if the distinction in treatment cannot be reasonably and objectively justified.
Article 3 - The right to life (absolute right) – everyone has the right to life, liberty and security of person which includes access to basic necessities and protection from risks to their life from self or others.
Article 5 - The right not to be tortured or treated in an inhuman or degrading way (absolute right) which includes anything that causes fear, humiliation intense physical or mental suffering or anguish.
Article 9 - The right to liberty (limited right) – and not to be deprived of that liberty in an arbitrary fashion.
Article 10 - The right to a fair trial (limited right) – including the right to be heard and offered effective participation in any proceedings.
Article 12 - The right to respect for private and family life, home and correspondence (qualified right) – including the right to personal choice, accessible information and communication, and participation in decision-making (taking into account the legal capacity for decision-making).
Article 18 - The right to freedom of thought, belief and religion (qualified right) including conduct central to beliefs (such as worship, appropriate diet, dress etc.)
Article 19 - The right to freedom of expression (qualified right) – to hold and express opinions, received/impart information and ideas without interference

UNCRC

Article 2 non-discrimination	**Article 15** freedom of association	**Article 30** children from minority or indigenous groups
Article 3 best interests of the child	**Article 16** right to privacy	**Article 31** leisure, play and culture
Article 4 implementation of the convention	**Article 17** access to information from the media	**Article 32** child labour
Article 5 parental guidance and a child's evolving capacities	**Article 18** parental responsibilities and state assistance	**Article 33** drug abuse
Article 6 life, survival and development	**Article 19** protection from violence, abuse and neglect	**Article 34** sexual exploitation
Article 7 Birth, registration, name, nationality, care	**Article 20** children unable to live with their family	**Article 35** abduction, sale and trafficking
Article 8 protection and preservation of identity	**Article 22** refugee children	**Article 36** other forms of exploitation
Article 9 separation from parents	**Article 23** children with a disability	**Article 37** inhumane treatment and detention
Article 10 family reunification	**Article 24** health and health services	**Article 38** war and armed conflicts
Article 11 abduction and non-return of children	**Article 25** review of treatment in care	**Article 39** recovery from trauma and reintegration
Article 12 respect for the views of the child	**Article 26** Benefit from social security	**Article 40** juvenile justice
Article 13 freedom of expression	**Article 27** adequate standard of living	**Article 42** knowledge of rights
Article 14 freedom of thought, belief and religion	**Article 28** right to education	

ACHSCP Impact Assessment – Proportionality and Relevance

Name of Policy or Practice being developed	Shifting the Balance of Care – A Community-Focused Approach to Delivery of Frailty and Specialist Rehabilitation Services within Aberdeen City Health & Social Care Partnership
Name of Officer completing Proportionality and Relevance Questionnaire	Sarah Gibbon, Transformation Programme Manager Julie Warrender, Chief Nurse and Lead for Frailty & Specialist Rehabilitation Services
Date of Completion	02/06/2025
What is the aim to be achieved by the policy or practice and is it legitimate?	The aim of this policy is to "ensure people receive the right care in the right place, recognising that acute hospitals are not always best for patients or their families"[1]. This will lead to a rebalance of the provision of care from inpatient settings to support delivered within the patient's home, where possible. There is cohesive strategic direction through from government at the highest level to local level (via the strategic plan), to support the modernising of service delivery and shifting the balance of care from in-patient bed-based settings to the person's home.

What are the means to be used to achieve the aim and are they appropriate and necessary?	Within Grampian this will be achieved by the participation in the Discharge Without Delay (DwD) Collaborative, which is "a whole-system programme for frail older people currently accessing Scottish hospitals, pulling best practice, individual services and pathways into an integrated model that strives to deliver Comprehensive Geriatric Assessment (CGA) in the timeliest manner, while ensuring no negative impact from hospital induced harm or dependency to the person"[2]. The DwD consists of four key workstreams:

[2] Quote from 2025 Discharge without Delay Paper

	1. Frailty at the Front Door 2. Planned Date of Discharge / Hubs 3. Discharge to Assess (D2A) 4. Step Down Care Key to the successful implementation of the DwD programme is a whole-system, integrated approach between acute and community – current models in isolation deliver marginal impact on overall service delivery. The outcomes of the DwD work are: • A reduction in geriatric length of stay • A reduction in community hospital / step down length of stay • A reduction in respective health and social care partnership (HSCP) delayed discharges. • An improvement to the 4-hour whole system performance Progress in meeting the DwD outcomes (alongside further potential hospital at home expansion) provides the opportunity to reallocate resource to support patients within their own homes and the community. Given the well-documented limited financial framework Health & Social Care Partnerships (HSCPs) are working in, it is necessary to realign existing resources in line with success from this national direction. Demand for bed-based intermediate care facilities may reduce with the successful introduction of Discharge to Assess, reducing the need for the type of care provided at Rosewell House. Rosewell House could be phased-down in response to this reduction in demand, freeing up more resource (both in terms of staffing and finances) to support further roll-out of the successful initiatives. Additionally, Rosewell House has experienced challenges in its' service delivery which reinforces that the means to achieve the aim of 'Shifting the Balance of Care' are appropriate and necessary. A comprehensive 'Shifting the Balance of Care – A Community-Focused Approach to Delivery of Frailty and Specialist Rehabilitation Services within Aberdeen City Health & Social Care Partnership paper will be taken to the July 2025 IJB. Access to the full paper can be found online: Browse meetings - Integration Joint Board

If the policy or practice has a neutral or positive impact, please describe it here.	**Neutral Impacts** The implementation of this policy will have neutral effects on the below listed characteristics as the policy aims to ensure the quality-of-service delivery continues to meet the needs of patients. **Protected Characteristics** • Gender Reassignment • Marriage & Civil Partnership • Pregnancy & Maternity • Race & Ethnicity • Religion & Belief • Sex • Sexual Orientation **Health Inequality** • Low Literacy / Health Literacy • Discrimination / Stigma • Physical Environment and Local Opportunities • Education & Learning **Positive Impacts** The shifting of the balance of care to a community focussed approach will lead to more timely and effective access to acute-level care; a shorter hospital stay helping reduce the chances of deconditioning or negative consequences (such as hospital acquired infection), and a smoother, more supported transition back home after their hospital stay. This positive impact is particularly important as "Older people, particularly those living with frailty, are known to be at greatest risk"[3] from the impact of a prolonged hospital stay. Rosewell House has experienced challenges with ensuring and maintaining safe staff levels, with a high proportion of transient staffing used within the facility. This has resulted in concerns being raised about the quality of care provided and a proportionately high level of adverse care events (Datix incidents). Shifting the balance of care to a community-focused approach will reduce the risk of harm from these staffing challenges within the existing facility.
Is an Integrated Impact Assessment required for this policy or decision (Yes/No)	Yes

Rationale for Decision **NB: consider: -** • **How many people is the proposal likely to affect?** • **Have any obvious negative impacts been identified?** • **How significant are these impacts?** • **Do they relate to an area where there are known inequalities?** • **Why are a person's rights being restricted?** • **What is the problem being addressed and will the restriction lead to a reduction in the problem?** • **Does the restriction involve a blanket policy, or does it allow for different cases to be treated differently?** • **Are there existing safeguards that mitigate the restriction?**	**Negative Impacts** Whilst a number of areas listed for consideration of the IIA process are not impacted by the implementation of this policy, there are some areas which could have the potential have a negative impact. These are primarily linked to the phasing down of care provided within Rosewell House. These are listed below. **Protected Characteristics** • Age • Disability **Fairer Scotland Duty** • Low Income • Low Wealth • Material Deprivation • Area for Deprivation / Communities of Place • Socio-Economic Background **Health Inequality** • Health and Social Care Service Provision **Other** • Carers • Staff
Decision of Reviewer	Full IIA Required
Name of Reviewer	Julie Warrender
Date	03/06/2025

Scottish Specific Public Sector Duties (SSPSED)

Procured, Tendered or Commissioned Services

Is any part of this policy/service to be carried out wholly or partly by contactors and if so, how will equality, human rights including children's rights and the Fairer Scotland duties be addressed?

Provision of care to support the Discharge to Assess service will be undertaken by a commissioned provider. ACHSCP has implemented a collaborative and ethical commissioning model which aims to ensure that people with lived experience, providers and other stakeholders are a part of the review and codesign process of contract development. This aims to ensure all new contracts are developed through an ethical and human-rights based lens.

As standard, within the procurement activity for any new provider duties with regard to equality, human rights and fairer Scotland duty will be contained within the evaluation process and assessed, so that the successful provider may also address these duties. The procurement strategy emphasises the legislations which could affect the specification of procurement, which includes (but is not limited to):

- The Social Work (Scotland) Act
- The Regulation of Care (Scotland) Act 2001
- The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012
- The Public Contracts (Scotland) Act 2015

ACHSCP Impact Assessment – The Integrated Impact Assessment

Description of Policy or Practice being developed including intended aim.	Shifting the Balance of Care – A Community-Focused Approach to Delivery of Frailty and Specialist Rehabilitation Services within Aberdeen City Health & Social Care Partnership
Is this a new or existing policy or practice?	New
Name of Officer Completing Impact Assessment	Sarah Gibbon, Transformation Programme Manager
Date Impact Assessment Started	May 2025
Name of Lead Officer	Julie Warrender, Chief Nurse ACHSCP, Frailty & Rehab Lead
Date Impact Assessment approved	23.06.25

Summary of Key Information

Groups or rights impacted.	<u>Patients</u> The implementation of this policy has the potential to have an impact on patients particularly those with the below protected characteristics & groups. These are primarily linked to the phasing down of care provided within Rosewell House. These are listed below. **Protected Characteristics** • Age • Disability **Fairer Scotland Duty** • Low Income • Low Wealth • Material Deprivation

	• Area for Deprivation /Communities of Place • Socio-Economic Background **Health Inequality** • Health & Social Care Service Provision <u>Other</u> • Carers • Staff Any reduction to the capacity offered within Rosewell House has the potential to impact on the frailty pathway but will likely have an effect on patient flow across the whole system if appropriate mitigations are not implemented. Reduced opportunity for hospital-based care may have a greater impact on those with an inadequate physical environment to support their recovery at home. **MITIGATIONS** Mitigations to the above will be provided by the implementation of the Discharge Without Delay Programme of work and are outlined below. These aim to ensure a measured approach to the transition of the shift of the balance of care to a more community focussed approach ensuring continuation of service delivery to patients. **Discharge Without Delay (DwD) Key Areas and Impact** <u>Frailty at the Front Door:</u> will ensure implementation of an early comprehensive geriatric assessment (eCGA) for identified frail older people, in acute frailty units, as early in admission as possible. These units will be supported by Integrated Discharge Hubs, rehabilitation services, and when necessary, discharge to assess pathways, facilitated through the Planned Date of Discharge (PDD) process. This approach ensures timely discharge and minimises the risk of hospital-induced dependency. <u>PDD/Integrated Discharge Hub:</u> will ensure a single point of referral for complex discharges is established, supported by a proactive multidisciplinary team (MDT) approach. This team, with discharge facilitator input set a planned date of discharge (PDD) that is realistic and will result in discharge happening.

	Discharge To Assess (D2A): The implementation of this will ensure timely discharge and minimise hospital-induced dependency, services must offer responsive, community-based home care support, enabling patients to return home without unnecessary delay. Step Down Care (Community Hospital / Rehab Units): The programme of work will ensure facilities will be adequately staffed and empowered to care for frail individuals requiring rehabilitation and extended assessments, ideally transitioning from Frailty Units. Discharge back to the community should occur promptly through an agreed PDD process, ensuring no delays. In addition to the above key elements of the DwD programme offering mitigations to the outlined areas of potential concern the following will also take place - A phased approach to reduction, coupled with robust monitoring of the data from Rosewell House and across the wider system (admissions, delayed discharges, boarders, length of stay) will be undertaken to ensure full understanding of the impacts of the delivery of the DwD, enabling confidence in the impact to any phasing down of the capacity offered within Rosewell House. - A contingency plan will be in place to ensure there is no immediate removal of the Rosewell building from Aberdeen City Health and Social Care Partnership (ACHSCP). - Opportunities to develop the Rosewell House building as owned by Aberdeen City Council into an alternative service (i.e. by commissioning a care home or complex care facility) to further reduce delayed discharges within ARI by providing suitable placements which could potentially be on an interim basis. Initial market-testing has indicated an appetite for this within the supplier market. - Options are being explored to deliver several rehabilitation beds to support the revised model for those patients who are unable to return home directly.

	- Patient circumstances are considered prior to the transfer of their care out with the acute environment, prioritising close working between hospital-based social work and occupational therapy teams to ensure that the persons' living environment is risk-assessed and appropriate adaptations put in place where necessary. - Appropriate Carers support as identified through Adult Carers Support Plans, supported by the work of the Carers Strategy Implementation Group - On a day-to-day basis the impact of all the pressures within the hospital system is closely managed by the Daily System Connect (DSC) meeting and indicators, including delayed discharges and delayed transfer of care will be used to monitor. - Stakeholder feedback is important, and this will continue to be incorporated as part of the process ensuring a comprehensive understanding of the impacts and to inform the mitigation strategies. This will be managed within the governance structures of the DwD programme.
Feedback from consultation and engagement and how this informed development of the policy or practice	The new Strategic Plan (2025-2029) consultation draft was approved at the IJB in March 2025. Within the refreshed strategic plan, there is an aim focusing on 'Modernising Service Delivery', which will be supported by delivery of the proposals within this paper. These commitments will be reflected through the inclusion of the DWD priorities within the associated ACHSCP Delivery Plan. The consultation process on the draft Strategic Plan has shown good support for modernising our service delivery by shifting the balance of care as outlined in this paper. From 24 March 2025 to 18 May 2025, the Community Planning Aberdeen partners joined up to hold a large-scale engagement to inform their various strategic plans. This included the Health & Social Care Partnership Strategic Plan. There was strong support for more community and home-based provision. Respondents were asked to indicate if they agree that the following statement

	should be a priority: "review the allocation of social care resources to ensure more community and home-based service allowing people to live independently in their own homes". 93.4% of 731 respondents agreed that it is right to focus on this as a priority within the draft Health & Social Care Partnership Strategic Plan. This reinforces national engagement and directives which support delivery of care closer to a patients' home.
Performance Measures identified, where these will be reported and how impact will be monitored.	The monitoring of the below measures, which are routinely captured and tracked, will enable the impact of any changes to the capacity provided by Rosewell House to be determined: <u>Service Capacity</u> • Waiting list for Rosewell House • Care package requests. • ACHSCP delayed discharges figures (number of delays and per 100,000) <u>Wider System Flow</u> • Frailty ward occupancy levels • Boarding numbers from frailty wards • Ambulance Stacking Numbers • Emergency Department (ED) Performance • Length of stay in AMIA/ED <u>Complaints</u> • Monitoring for increase and impact <u>Staffing</u> • Sickness and absence rates • Monitoring data and feedback on wellbeing <u>Vacancies</u> • Rate / levels

Review

Date the Impact will be reviewed	December 2026
Rationale for Date	In line with the timescales for a further evaluation report on progress implementing mitigating actions (DWD) to the IJB, so will require an updated / reviewed IIA to support this paper.

Having considered all of the groups, duties, and rights in the guidance on Impact Assessment could this policy or practice have a negative impact on any of the following. Please answer Yes or No. If you answer Yes, please specify precisely which particular group, duty or right will be impacted and how and also what (if any) current evidence you have.

	Yes/No	Details	Evidence
Protected Characteristics	Yes	Age The patient cohort within Rosewell House are part of the frailty pathway (generally affecting those patients over 65, however younger adults can also be affected). If capacity of this facility is phased down, without a corresponding increase in alternative service provision, there is the potential for this patient cohort to be affected. For example, if there is not capacity for discharge from the acute setting to an intermediate setting, when this would been deemed beneficial. There will likely be further impacts on the flow out of the acute setting which would result in frail elderly having longer waits in inappropriate areas such as the Emergency Department (ED) and Acute Medical Inpatient Assessment (AMIA). There is also risk that boarding numbers will increase impacting on the wider system. Disability The frail patient cohort which Rosewell House manages are often also affected by disabilities and if a reduced capacity in Rosewell House takes place there is a	The patient profile for Rosewell on average consists of 45% aged 75-84 years old, and 55% aged 85+. The service operates at a consistently high occupancy rate. 'Frailty is found in 20-30% of the elderly population aged over 75 years and increases with advancing age. It is associated with long-term adverse health-related outcomes such as increased risk of geriatric syndromes, dependency, disability, hospitalisation, institutional placement, and mortality'.[4.] 4. Topinkova E; Aging, disability and frailty. Ann Nutr Metab. 2008;52 Suppl 1:6-11. Epub 2008 Mar 7.

		potential for this patient cohort to be affected. Similar to the Age characteristic these patients may not be able to receive the benefit of an intermediate care stay if the capacity in Rosewell is reduced and they are instead discharged straight home or become a delayed discharge within ARI. An individual with disability may also require further support for their home environment to be suitable for discharge.	
Fairer Scotland Duty	Yes	Reduced opportunity for hospital-based care may have a greater impact on those with an inadequate physical environment to support their recovery at home.	Social, economic, and environmental factors all contribute to a patient's recovery following a hospital stay. Therefore, nurses' assessments of these nonclinical factors for older adults receiving home health services are crucial. [5] 4. **The Role of Social, Economic, and Physical Environmental Factors in Care Planning for Home Health Care Recipients** Elliane Irani, Karen B Hirschman, Pamela Z Cacchione , Kathryn H Bowles
Health Inequality	Yes	Health and Social Care Service Provision The phasing down of beds in Rosewell House has the potential to increase the demand for health and social care provision due to an increase in patients unable to receive the benefit of being in in-patient intermediate care stay prior to their discharge. Consequently, to prevent an increase in delayed discharges in the	The rehabilitation carried out within Rosewell House results in approximately 50% of patients returning home without care support. Any reduction in beds could result in an increase in the need for care support / long term care due to a reduction in rehabilitation for these patients, if the

		system, a greater need for social care provision for patients may be required. There could also be an impact on the Emergency Department (ED) and Acute Medical Inpatient Assessment (AMIA) as people wait longer to get a bed in the appropriate place.	outlined appropriate mitigations are not implemented.
Other Groups	Yes	<u>Carers</u> The phasing down in beds in Rosewell House has the potential to increase the demands on the unpaid carers of those patients that would have benefitted from an intermediate care stay. Less availability for an intermediate care stay could see more of these patients stay in hospital for longer if the appropriate community / social care cannot be provided.	Unpaid Carers may be affected by supporting higher level of needs if patients are discharged home with or without Care Packages, rather discharged to Rosewell House. Carers support services have seen an increase of more than 40% in carers seeking support across the system and can be monitored from referrals from relevant services. Through the Carers Strategy close working arrangements with carers are in place to ensure safeguards for carers. The Carers Strategy Annual report 24/25 showed that most carers identified are providing care more than 50 hours per week. The Carers Strategy Implementation Group work on actions against the four main priorities to support unpaid carers across Aberdeen, they are. 1. Identifying as a Carer and the first steps to support 2. Accessing advice and support

		<u>Staff</u> Potential negative impacts on staff wellbeing and retention could result due to changes to the capacity provided within Rosewell House. This change would require the appropriate Organisational Change Policy to be followed, which has been developed by NHS Grampian to provide robust employee protections in the case of large-scale service change. It seeks to ensure that those affected by the change(s) are well informed; appropriately trained; involved in decisions which affect them, treated fairly and consistently; and provided with a safe and improved working environment. It also recognises employees may experience concern about change and commits to making every effort to ensure the continued employment of employees by maximising redeployment and retraining opportunities when planning for and implementing change. However, the process can be associated with lower employee health and wellbeing and may result in the loss of some staff.	3. Supporting future planning, decision making, and wider Carer involvement 4. Community support and advice for Carers Change at work can lead to a number of different issues within the workforce. These can harm people's health, wellbeing and security. They can also have a negative impact on the business and organisation if they are not managed effectively.[6] **6**. https://prospect.org.uk/article/change-management-the-impact-of-change/
Human Rights	No	N/A	N/A
UNCRC	No	N/A	N/A

Will there be any cumulative impacts between this policy or decision and others	**Yes**	X	**No**	
Describe what this cumulative impact will be and include evidence mitigations in the sections below	**NHS Grampian** In December 2024 NHS Grampian declared a critical incident due to the pressure in ARI and the resulting ambulance stacking. This situation led to the opening of 20 surge beds within Rosewell House, these beds have been funded by NHS Grampian and these beds remain operational. The beds are currently being reviewed and may also close. This would have a cumulative impact with this change as there will be a greater number of bed closures across both City Frailty beds and Surge Bed types. **Contracted Hours Policy** Pay award agreements have seen the working week for full time NHS staff reduce from 37.5 hours to 37 hours in 24/25, with a further reduction to the weekly working hours expected to be implemented to 36 hours by April 2026. Aberdeen City Council staff are anticipated to reduce their weekly working hours to 35 hours in 2025. The consequence of this *could* impact on the capacity of the workforce to successful deliver on the policy of Shifting the Balance of Care as outlined within this paper. Mitigations against this impact include workforce modelling for new services, including Discharge to Assess, based on the projected reduction in working week. **H@H Expansion** In combination with the key elements of the Discharge Without Delay Programme of work, the Scottish Government remain committed to the expansion of Hospital at Home services in order shift the balance of care. This will have a positive cumulative impact for this decision, as it will further support the rebalance of care from in-patient to people's homes, potentially reducing demand for services at Rosewell House, meeting the step-up demand that it was initially envisaged that Rosewell House would provide and providing opportunities to further reallocate our resource to support patients within their own homes and the community.			

Please list below the groups of stakeholders to be engaged with or consulted, what feedback has been received and how this has influenced development of the policy or practice and what (if any) mitigating actions have been put in place.

Stakeholder Groups	**Feedback Received**	**Influence on Policy or Practice/Mitigating Actions**
General Public (Consultation on draft 2025-2029 Draft Strategic Plan)	Within this consultation strong support for more community and home-based provision was highlighted. Respondents were asked to indicate if they agree that the following statement should be a priority: "*review the allocation of social care resources to ensure more community and home-based service allowing people to live independently in their own homes*". 93.4% of 731 respondents agreed that it is right to focus on this as a priority within the draft Health & Social Care Partnership Strategic Plan.	The new Strategic Plan (2025-2029) consultation draft was approved at the IJB in March 2025. Within the refreshed strategic plan, there is an aim focusing on 'Modernising Service Delivery', which will be supported by delivery of the proposals within the policy of 'Shifting the Balance of Care'. These commitments will be reflected through the inclusion of the DWD priorities within the associated ACHSCP Delivery Plan.
Senior Leadership Team (SLT)	The SLT have been fully involved in the discussions and development of the plans around the aim and consequence of this policy of 'The Shifting of the Balance of care'.	With leads from across the ACHSCP key services represented within this group they are and will continue to be a key source for consultation of the future developments.
NHS Grampian Chief Executive	Consultation has taken place at the Chief Executive / Officer level on this policy of 'The Shifting of the Balance of Care' and the consequences of this.	Agreement between the Chief Executive / Officer levels is required to ensure policy and mitigations can effectively be implemented.
Unscheduled Care Programme Board	The USC Programme Board is the governing group that provides oversight and assurances on the progression of DwD programme via the	The ACHSCP Chief Officer sits on the Unscheduled Care Programme board, ensuring

(NHS Grampian Operational Board)	Downstream and Upstream Delivery Groups. Attendees from the ACHSCP are well represented on each of these groups.	clear assurance and oversight from the IJB's perspective

Scottish Specific Public Sector Duties (SSPSED)

Procured, Tendered or Commissioned Services

Is any part of this policy/service to be carried out wholly or partly by contactors and if so, how will equality, human rights including children's rights and the Fairer Scotland duties be addressed?

Provision of care to support the Discharge to Assess service will be undertaken by a commissioned provider. Provision of care to support the Discharge to Assess service will be undertaken by a commissioned provider. ACHSCP has implemented a collaborative and ethical commissioning model which aims to ensure that people with lived experience, providers and other stakeholders are a part of the review and codesign process of contract development. This aims to ensure all new contracts are developed through an ethical and human-rights based lens.

As standard, within the procurement activity for any new provider duties with regard to equality, human rights and fairer Scotland duty will be contained within the evaluation process and assessed, so that the successful provider may also address these duties. The procurement strategy emphasises the legislations which could affect the specification of procurement, which includes (but is not limited to):

- The Social Work (Scotland) Act
- The Regulation of Care (Scotland) Act 2001
- The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012
- The Public Contracts (Scotland) Act 2015

Consumer Duty

The Consumer Scotland Act 2020 places a Consumer Duty on the public sector to put consumer interests at the heart of strategic decision-making, emphasising the need for accessible and affordable public services, especially during times of financial pressure. This person-centred approach is intended to result in better quality services and outcomes for the public as consumers of public services across Scotland. This section of the IIA is used to consider the impact of the policy on consumers of any services that the policy is intended to change.

Is the proposed decision, policy or practice strategically important?	**Yes –** Proceed to the rest of this section	**No** - Provide reasoning below and then proceed past the Consumer Duty section
		No – this paper is related to the operational implementation of nationally and locally agreed strategic direction.

What impact could this have on any of the consumer groups below?

	Negative	**Neutral**	**Positive**
Individuals			
Small Businesses			

In what way could this impact people in these consumer groups?

What mitigations can be put in place?

If mitigations are in place, does this remove or reduce the negative impact?	**No – negative impact remains**	
	Yes – negative impact reduced	
	Yes – negative impact removed	

ACHSCP Impact Assessment – The Review

Name of Impact Assessment being reviewed	
Name of Officer completing review	
Date Review Commenced	
Reason for Review (scheduled or accelerated)	
Reason for Accelerated Review	
Name of Lead Officer	
Date Review Completed	

Summary of Key Information

What amendments have been identified to the original Impact Assessment?	
What evidence do you have for these amendments?	
What actions have you taken to review the policy or practice in light of the review?	

Having considered all of the groups, duties, and rights in the guidance on Impact Assessment has the impact of this policy or practice changed from the original assessment? Please answer Yes or No. If you answer Yes, please specify precisely what change has occurred and which particular group, duty or right it affects and how and also what (if any) current evidence you have.

	Yes/No	Details	Evidence
Protected Characteristics			
Fairer Scotland Duty			
Health Inequality			
Other Groups			
Human Rights			
UNCRC			

Will there be any cumulative impacts between this policy or decision and others	**Yes**		**No**	
Describe what this cumulative impact will be and include evidence mitigations in the sections below				

Please list below the groups of stakeholders to be engaged with or consulted, what feedback has been received and how this has influenced development of the policy or practice and what (if any) mitigating actions have been put in place in light of the changes identified above.

Stakeholder Groups	Feedback Received	Influence on Policy or Practice/Mitigating Actions

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INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

The **ABERDEEN CITY COUNCIL & NHS GRAMPIAN** is hereby directed to deliver for the Aberdeen City Integration Joint Board, the services noted below in pursuance of the functions noted below, for the time period noted below and within the associated budget noted below.

Services will be provided in line with the Integration Joint Board's Strategic Plan and existing operational arrangements for the duration of this Direction pending it being varied, revoked or superseded by a later Direction in respect of the same functions.

This Direction: - Supersedes a Previous Direction - HSCP.23.054 Rosewell House Evaluation. IJB meeting date 23.08.2025.

The IJB Report Number and Title relevant to this Direction is HSCP.25.054
Shifting the Balance of Care – A Community-Focused Approach to Delivery of Frailty and Specialist Rehabilitation Services within Aberdeen City Health & Social Care Partnership

This Direction relates to the following integrated health and social care function as noted in the Integration Scheme: -

Description of services/functions to which this Direction is relevant (as they appear in the Integration Scheme):-

ABERDEEN CITY COUNCIL	**REFERENCE TO INTEGRATION SCHEME**
Commission the supply of appropriate social care service for the Discharge to Assess Service	Annex 2, Part 1 • The Social Work (Scotland) Act 1968 o Section 12 (General social welfare services of local authorities) • Section 13B (Provision of care or aftercare) • Disabled Persons Consultation and Representation) Act 1986 • Section 7 (Persons discharged from hospital)
NHS GRAMPIAN	**REFERENCE TO INTEGRATION SCHEME**
Provision of nursing service including	Part 2: Services provided out-with a

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.

registered and non-registered nursing staff	hospital in relation to geriatric medicine
Provision of specialist geriatric services.	Part 2: Services provided out-with a hospital in relation to geriatric medicine
Provision of allied health profession services including physiotherapy, occupational therapy, speech and language therapy and dietetics	Part 2: Services provided by allied health professionals in an outpatient department, clinic or out-with a hospital

Detailed description of instruction:- NHS Grampian is directed to work together with ACHSCP and Aberdeen City Council to:-

- Provide the services referred to above;
- Work towards the reduction of those services provided at Rosewell
- Implement the commitments of the Discharge without Delay programme, and;
- Complete cessation of the Rosewell House service by no later than 31.03.2026, in line with the recommendations of this report.

NHS Grampian is directed to implement all necessary arrangements to complete the cessation of in-patient services at Rosewell House, including but not limited to, terminating the License to Occupy, entered into with Aberdeen City Council, relating to the occupation of Rosewell House. This can be terminated by either party by giving 4 weeks written notice to the other at any time.

Notwithstanding the cessation of in-patient services at Rosewell House, NHS Grampian and Aberdeen City Council are directed to continue to deliver the services as described in the Integration Scheme until 31 March 2026.

Link to Strategic Aim or Priority in the IJB's Strategic Plan:- Modernising Service Delivery

Timescale of this Direction:- Start date:- 01.07.2025 End date:- 31.03.2025

Associated Budget in relation to this Direction:-

- The budget for Rosewell House is £6.4 million annually. Costs will fall as the bed base is reduced working towards full closure of the facility. This will allow the shift of this resource to support delivery of services in the community as outlined in the associated report.
- Name of Budget Line:- NHS Grampian. Service: ACHSCP Frailty, and Sub Service: Rosewell House. Recurring funding (confirmed).

- Budget Holder:- Julie Warrender, Chief Nurse and Lead for Frailty & Specialist Rehabilitation

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.