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Aberdeen City Health & Social Care Partnership
A caring partnership

Town House,
ABERDEEN 17 February 2026

RISK, AUDIT AND PERFORMANCE COMMITTEE

The Members of the **RISK, AUDIT AND PERFORMANCE COMMITTEE** are requested to meet in **Virtual - Remote Meeting on TUESDAY, 24 FEBRUARY 2026 at 10.00 am.**

JENNI LAWSON
CHIEF OFFICER - GOVERNANCE

B U S I N E S S

RISK APPETITE STATEMENT

DECLARATION OF INTERESTS AND TRANSPARENCY STATEMENTS

AUDIT

5.1   Internal Audit Update - HSCP.26.011 (Pages 31 - 38)

5.2   Internal Audit Report - ACHSCP Health Care Staffing Scotland Act 2019 -
         HSCP.26.013 (Pages 39 - 62)

5.3   Internal Audit Plan 2026-29- HSCP.26.012 (Pages 63 - 74)

PERFORMANCE

6.1   Delivery Plan Update - HSCP.26.009 (Pages 75 - 96)

COMMITTEE DATES

7.1   Date of Next Meeting - 26 May 2026

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

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.

1

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.
Safety	The IJB has a low appetite for risks which could cause harm to patients/clients or to staff.

Dimension of Risk	Corresponding Risk Appetite
	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

3

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

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Risk, Audit and Performance Committee

Minute of Meeting

Wednesday, 19 November 2025
10.00 am Virtual - Remote Meeting

Present: Councillor Martin Greig <u>Chair</u>; and Councillor John Cooke, Ritchie Johnson and Hussein Patwa.

Also in attendance: Martin Allan, Bernadette Bularan, Niki Couper (for article 5), Jamie Dale, Susie Downie, John Forsyth, Caroline Howarth (from article 9), Kate Humphrey, Calum Leask (for articles 5 and 6), Alison MacLeod, Rachael Marples (for article 5), Fiona Mitchelhill, Sandy Reid, Val Vertigans and Claire Wilson.

Apologies: Jonathan Belford.

The agenda and reports associated with this minute can be found <u>here</u>.

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

DECLARATIONS OF INTEREST OR TRANSPARENCY STATEMENTS

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

EXEMPT BUSINESS

2. There was no exempt business.

MINUTE OF PREVIOUS MEETING OF 27 AUGUST 2025

3. The Committee had before it the minute of its previous meeting of 27 August 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 Business, Resilience and Communications Lead.

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The Committee resolved:-
(i)   to note the reasons outlined for the removal of line 41 (Service Update – Digital Inclusion); and
(ii)   to otherwise agree the Planner.

COMMUNITY NURSING ROLE TEST OF CHANGE EVALUATION - HSCP.25.094

5.   The Committee had before it a report prepared by the Transformation Programme Manager providing assurance that the necessary efforts to transform service delivery were being undertaken as set out within the ACHSCP Strategic Plan 2025-2029. An example of one such innovation from within the Health Visiting Service was detailed within the report and the Committee received a presentation from the Deputy Chief Nurse and Principal Information Analyst, Public Health Scotland in this regard.

The report recommended:-
that the Committee:
(a)   note the findings and lessons learned from the test of change;
(b)   endorse the approach undertaken by the service to develop and test
        different models of care in order to modernise service delivery; and
(c)   note and thank colleagues from the Public Health Scotland Local Intelligence Support Team for ensuring the robust evaluation of this test of change.

The Committee resolved:-
to agree the recommendations.

QUARTER 2 DELIVERY PLAN UPDATE - HSCP.25.092

6.   The Committee had before it a report prepared by the Transformation Programme Manager providing assurance and relating to the progress of the Delivery Plan as set out within the Aberdeen City Health and Social Care Partnership Strategic Plan 2025-2029.

The report recommended:-
that the Committee agree to the proposed Year 1 Delivery Plan actions as detailed in Appendix A of the report.

The Committee resolved:-
(a)   to instruct the Transformation Programme Manager to issue a Service Update in respect of the digital inclusion plan;

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(b)   to instruct the Chief Officer to bring a report to the Committee in respect of prescribing expenditure; and

(c)   to otherwise agree the recommendation.

JUSTICE SOCIAL WORK SERVICE ANNUAL PERFORMANCE REPORT 2024-25 - HSCP.25.087

7.   The Committee had before it the Justice Social Work Annual Performance Report 2024-25 prepared by the Strategic Service Manager - Justice Social Work Service.

The report recommended:-
that the Committee note the Justice Social Work Annual Performance Report 2024-25 (at Appendix A of the report) which provided assurance about progress made over the year.

The Committee resolved:-
to agree the recommendation.

QUARTER 2 - 2025/2026 BUDGET AND SAVINGS MONITORING UPDATE INCLUDING PER SERVICE LINE - HSCP.25.090

8.   The Committee had before it a report prepared by the Deputy Chief Finance Officer – Aberdeen City Council, summarising the financial performance of the second quarter of 2025 for the services within the remit of the Integration Joint Board (IJB); presenting the projected results up to the end of financial year 2025/2026; and advising on areas of risk and management mitigating action.

The report recommended:-
that the Committee:
note the results shown for the following periods and the related risks and mitigating measures:
- Updated funding / income for the year 2025/26
- Projected / forecasted costs of services / expenditure up to the end of the fiscal year, 31 March 2026
- Q2 / 2025/26 Costs of Services against budget for the same period

The Committee resolved:-
to agree the recommendations.

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DIRECTIONS AND DATA PROTECTION IMPACT ASSESSMENTS UPDATE REPORT - HSCP.25.091

9. The Committee had before it a report prepared by the Strategy and Transformation Lead, presenting the six-monthly update on the status of Directions and Data Protection Impact Assessments made by the IJB to Aberdeen City Council and NHS Grampian.

The report recommended:-
that the Committee note the detail and updates contained within the report and the two appendices.

The Committee resolved:-
to agree the recommendations.

STRATEGIC RISK REGISTER - HSCP.25.088

10. The Committee had before it an updated version of the Strategic Risk Register prepared by the Business, Resilience and Communications Lead.

The report recommended:-
that the Committee approve the IJB revised Strategic Risk Register at Appendix A of the report.

The Committee resolved:-
to agree the recommendation.

ABERDEEN CITY HSCP: PRESCRIBING EFFICIENCIES UPDATE REPORT - HSCP.25.093

11. The Committee had before it a report prepared by the Deputy Primary Care Lead – ACHSCP, advising members of the programme of prescribing efficiencies work within Grampian and Aberdeen City, noting areas of obligations, ongoing risk and management of mitigating actions for 2025/26.

The report recommended:-
that the Committee:
(a) note the update regarding prescribing costs and forecast budget position for 2025/26; and
(b) note areas of risk and management of mitigating actions that formed part of the overall NHS Grampian's Primary Care Prescribing work programme.

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The Committee resolved:-
to agree the recommendations.

INTERNAL AUDIT UPDATE - HSCP.25.095

12.   The Committee had before it an update on Internal Audit's work prepared by the Chief Internal Auditor, providing details of progress against the approved Internal Audit plans, audit recommendations follow up, and other relevant matters for the RAPC to be aware of.

The report recommended:-
that the Committee:
(a)   note the contents of the RAPC - Internal Audit Update Report August 2025 ("the Internal Audit Update Report"), as appended at Appendix A of the report, and the work of Internal Audit since the last update; and
(b)   note the progress against the approved 2025/26 Internal Audit Plan as detailed in the Internal Audit Update Report.

The Committee resolved:-
to agree the recommendations.

AOCB

13.   The Chair advised that this was his last meeting as Chair of the Committee. On behalf of the IJB, Hussein Patwa expressed his thanks to Councillor Greig for his leadership. On behalf of the Senior Leadership Team, the Business, Resilience and Communications Lead thanked Councillor Greig for his support.

DATE OF NEXT MEETING - 24 FEBRUARY 2026

14.   The Committee had before it the date of the next meeting: 24 February 2026 at 10am.

The Committee resolved:-
to note the date of the next meeting.
-    **COUNCILLOR MARTIN GREIG, <u>Chair</u>.**

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	A	B	C	D	E	F	G	H	I	J
	RISK and AUDIT PERFORMANCE COMMITTEE BUSINESS PLANNER									
	The Business Planner details the reports which have been instructed by the Committee as well as reports which the Functions expect to be submitting for the calendar year.									
	Date Created	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Report Number**	**Report Author**	**Lead Officer / Business Area**	**Directorate**	**Update/Status**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
	24 February 2026									
	Standing Item	Quarter 3 – 2025/2026 Updates on Budget and Savings Monitoring and Financial Risks Mitigations	To summarise the financial performance, in reference to the budget approved for 2025/26 fiscal year; to present the indicative results up to the end of FY 2025/26; and to advise on any areas of risk and management mitigating action.	HSCP.26.008	Bernadette Bularan	Jonathan Belford	ACHSCP			
	04.11.25	Audit Scotland Section 22 Report on NHS Grampian	Incorporated into the Finance Report HSCP.26.008		Bernadette Bularan	Jonathan Belford	ACHSCP			
	Standing Item	Internal Audit Update report	To provide an update on Internal Audit's work since the last update. Details are provided of the progress against the approved Internal Audit plans, audit recommendations follow up, and other relevant matters for the RAPC to be aware of.	HSCP.26.011	Jamie Dale	Chief Internal Auditor	Governance			
	28.01.26	Internal Audit Report - ACHSCP Health Care Staffing Scotland Act 2019	To present the outcome from the planned audit of Health and Care (Staffing) Scotland Act 2019 that was included in the Internal Audit Plan.	HSCP.26.013	Jamie Dale	Chief Internal Auditor	Governance			
	15.01.26	Internal Audit Plan 2026-29	To seek approval of the Internal Audit Plan for the Aberdeen City Integration Joint Board for 2026-29.	HSCP.26.012	Jamie Dale	Chief Internal Auditor	Governance			
	Standing Item	Delivery Plan Update and Quarterly Report	To provide assurance and relates to the progress of the Delivery Plan as set out within the Aberdeen City Health and Social Care Partnership (ACHSCP) Strategy Plan 2025-2029	HSCP.26.009	Calum Leask	Alison MacLeod	ACHSCP			
	26 May 2026									
	Standing Item	Budget Savings Update	To summarise the financial performance, in reference to the budget approved for 2025-2026 fiscal year.		Bernadette Bularan	CFO	ACHSCP			
	Standing Item	Delivery Plan Update and Quarterly Report	To provide assurance and relates to the progress of the Delivery Plan as set out within the ACHSCP Strategy Plan. Report to every RAPC meeting.		Calum Leask	Alison MacLeod	ACHSCP			
	Standing Item	External Audit Strategy 2025/26	To provide a summary of the work plan for Audit Scotland's 2025/26 external audit of Aberdeen City Integration Joint Board (IJB).		Anne MacDonald	Audit Scotland	Audit Scotland	Last considered at RAPC 30 April 2025		
	23.09.21	Primary Care Improvement Plan Update	IJB agreed on 30 September 2025 to transfer bi-annual reporting to RAPC in May and September, commencing May 2026 with data driven reports focussing on outcomes and the effects of the plan. All RAPC papers are available to IJB members on Aberdeen City Councils website. Any issue which impacts on the delivery of PCIP will be notified to the IJB through a report where a decision is required, or updates provided in CO report /Service Update.		Emma King / Alison Penman	Emma King	ACHSCP	May 2026		Agreed by the IJB on 30 September 2025 to transfer to RAPC.
	Standing Item	Directions and Data Protection Impact Assessments Update Report	To present the six-monthly update on the status of Directions and Data Protection Impact Assessments made by the IJB to Aberdeen City Council and NHS Grampian.		Alison MacLeod	Alison MacLeod	ACHSCP			
	Six-monthly	Strategic Risk Register	To present an updated version of the Strategic Risk Register.		Martin Allan	Business and Resilience Manager	ACHSCP			
	Standing Item	Internal Audit Update report	To provide an update on Internal Audit's work since the last update. Details are provided of the progress against the approved Internal Audit plans, audit recommendations follow up, and other relevant matters for the RAPC to be aware of.		Jamie Dale	Chief Internal Auditor	Governance			
		Internal Audit - Financial Sustainability Report	To present the Financial Sustainability Report.		Jamie Dale	Chief Internal Auditor	Governance			

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4	Date Created	Report Title	Minute Reference/Committee Decision or Purpose of Report	Report Number	Report Author	Lead Officer / Business Area	Directorate	Update/Status	Delayed or Recommended for removal or transfer, enter either D, R, or T	Explanation if delayed, removed or transferred
21		Internal Audit Annual Report	To provide the Committee with Internal Audit's Annual Report.		Jamie Dale	Chief Internal Auditor	Governance			
22		Review of Duties and Year End Report - Annual Review of RAPC	To present a review of reporting for 2026/27 and an early draft intended schedule of reporting for 2025/26 to provide assurance that the Committee is fulfilling all the duties as set out in its terms of reference.		Alison Macleod	CFO	ACHSCP			
23					**25 August 2026**					
24	Standing Item	Budget Savings Update	To summarise the financial performance, in reference to the budget approved for 2025-2026 fiscal year.		Bernadette Bularan	CFO	ACHSCP			
25	Standing Item	Delivery Plan Update and Quarterly Report	To provide assurance and relates to the progress of the Delivery Plan as set out within the ACHSCP Strategy Plan.		Calum Leask	Alison MacLeod	ACHSCP			
26	Standing Item	Board Assurance and Escalation Framework (BAEF)	To note the Framework (reviewed by the Committee on an annual basis as per resolution on 26.08.2020)		Martin Allan	Business Manager	ACHSCP	Last presented to RAPC on 27 August 2025 - this is an annual requirement.		
27	Standing Item	Workforce Plan Annual Progress Update Report	To provide an overview of the current workforce and the progress made against the Workforce Plan Priorities - Members agreed at IJB in November 2022 to instruct the Chief Officer to report progress annually to the Risk, Audit, and Performance Committee. Last reported on 27 August 2025.		Stuart Lamberton / Grace Milne	Sandy Reid	ACHSCP	Last presented to RAPC on 27 August 2025 - this is an annual requirement.		
28	Standing Item	Internal Audit Update report	To provide an update on Internal Audit's work since the last update. Details are provided of the progress against the approved Internal Audit plans, audit recommendations follow up, and other relevant matters for the RAPC to be aware of.		Jamie Dale	Chief Internal Auditor	Governance			
29	19.09.2023	Locality Planning Annual Reports	To present the locality plan annual reports 2025-26 for approval.		Alison Macleod / Iain Robertson	Lead Strategy and Performance Manager	ACHSCP			
30	30.08.24	Health and Care Experience Report 2025-2026	To present findings from the Health and Care Experience survey for 2025/26.		Calum Leask	Alison MacLeod	ACHSCP	On 2 December 2025 transferred from IJB as this does not require a decision from the IJB. Due in September 2026, last presented 24/09/24 - check with CL if August or November meeting.		
31					**24 November 2026**					
32	Standing Item	Budget Savings Update	To summarise the financial performance, in reference to the budget approved for 2025-2026 fiscal year.		Bernadette Bularan	CFO	ACHSCP			
33	Standing Item	Delivery Plan Update and Quarterly Report	To provide assurance and relates to the progress of the Delivery Plan as set out within the ACHSCP Strategy Plan.		Calum Leask	Alison MacLeod	ACHSCP			
34	19.09.2023	Justice Social Work Service Annual Performance Report 2025-26	To present the Risk, Audit and Performance Committee with the updated Justice Social Work Service (JSWS) Annual Performance Report 2025/26. Last reported on 19 November 2025.		Val Vertigans	Chief Social Work Officer	ACHSCP			
35	12.06.2024	Adult Support and Protection - Biennial Report	To share the Adult Protection Committee (APC) Independent Convener's Biennial Report for 2024-26 for assurance purposes, in terms of the delivery and impact of 'adult support and protection' in the City.		Val Vertigans/ Claire Wilson	Claire Wilson	ACHSCP	Last reported 3 December 2024 - due late 2026		
36	Six-monthly	Strategic Risk Register	To present an updated version of the Strategic Risk Register.		Martin Allan	Business and Resilience Manager	ACHSCP			
37					**23 February 2027**					

	A	B	C	D	E	F	G	H	I	J
4	Date Created	Report Title	Minute Reference/Committee Decision or Purpose of Report	Report Number	Report Author	Lead Officer / Business Area	Directorate	Update/Status	Delayed or Recommended for removal or transfer, enter either D, R, or T	Explanation if delayed, removed or transferred
38	Standing Item	Budget Savings Update	To summarise the financial performance, in reference to the budget approved for 2025-2026 fiscal year.		Bernadette Bularan	CFO	ACHSCP			
39	Standing Item	Delivery Plan Update and Quarterly Report	To provide assurance and relates to the progress of the Delivery Plan as set out within the ACHSCP Strategy Plan.		Calum Leask	Alison MacLeod	ACHSCP			
40					TBC					
41		Approval of Unaudited Accounts	To present the draft annual accounts.		CFO	CFO	ACHSCP	Last presented to RAPC on 17 June 2025 - this is an annual requirement.		
42	01.05.2025	Health Improvement Fund Annual Report	To present the Health Improvement fund annual report for approval.		Calum Leask	Alison MacLeod	ACHSCP	Last presented to RAPC on 17 June 2025		
43	30.09.2025	External Audit Action Plan - monitoring	At the IJB on 30 September 2025, Audited Final Accounts and EA Annual Report: Members resolved to note the draft action plan created by officers in response to the External Auditor's report, attached at Appendix D of the report. Progress would be monitored through the Risk, Audit and Performance Committee.		Bernadette Bularan	Jonathan Belford	ACC			
44	20.08.2024	Accounts Commission: IJB Finance and Performance Report 2025.	To provide a summary of the Accounts Commission's Finance and Performance Report for IJBs in 2025 and to provide assurance across the Accounts Commission's recommendations.		Sarah Gibbon	Jonathan Belford	ACHSCP	HSCP.24.072 report reported to RAPC on 10 September 2024.		
45	30-Sep-25	Unscheduled Care Improvement Plan - Financial Oversight	Report presented to the IJB on 30 September 2025: Unscheduled Care Improvement - Aberdeen City Health & Social Care Partnership's Plan and Impact - HSCP.25.074. Members resolved to note that financial oversight of spend against this additional money would be monitored through the Risk, Audit and Performance Committee.		Julie Warrender, Bernadette Bularan	Fiona Mitchelhill	ACHSCP	As required		

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RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	24 February 2026
Report Title	Q3 – 2025/2026 Updates on Budget and Savings Monitoring and Financial Risks Mitigations
Report Number	HSCP.26.008
Lead Officer	Fiona Mitchelhill Chief Officer - ACHSCP
Report Author Details	Bernadette Bularan Deputy Chief Finance Officer, ACC bbularan@aberdeencity.gov.uk
Consultation Checklist Completed	No
Directions Required	No
Exempt	No
Appendices	None
Terms of Reference	Clauses 15 – 19 of the Terms of Reference for the Aberdeen City IJB

1. Purpose of the Report

1.1. To summarise the financial performance, in reference to the budget approved for 2025/26 fiscal year, of the third quarter (Q3) ending 31 December 2025 for the services within the remit of the Integration Joint Board (IJB);

1.2. To present the indicative results up to the end of FY 2025/26; and

1.3. To advise on any areas of risk and management mitigating action.

2. Recommendations

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

a) Notes the results herein shown for the following periods and the related risks and mitigating measures:

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       i. Updated funding (income) and cost of services (expenditure) for the fiscal year 2025/26 up to and including the end of Q3;

      ii. Indicative costs of services / expenditure up to the end of the fiscal year, 31 March 2026.

b) Notes that the Chief Officer and Chief Financial Officer will ensure that they maintain a focus on quantifying and managing the key risks identified, and responding to the recommendations, arising from the complex financial environment as evidenced in section 5 of the report, namely:

       i. Audit Scotland's Annual Audit Report of 2024/25[1]

      ii. The Auditor General's NHS Grampian s.22 Audit Report 2024/25[2];

     iii. The IJB Strategic Risk Register[3]; and

     iv. Internal Audits relating to the financial planning of the IJB for the IJB's Budget Setting and Monitoring of 2024.

3. Summary of Key Information

3.1. Funding (Income): Revisions up to end of Q3

Fiscal Year 2025 – 2026 commences with the IJB Budget 2025/26[4], and Medium Term Financial Forecast (MTFF), approved last 18th March 2025 and 1st July 2025[5], respectively, which included the funding for 2025/26 amounting to £439.094m, and savings of c.£14.353m.

The updated funding up to end of Q3 amounts to £465.554m as per the tables below (Figures 1 and 2), shows an increase of £26.460m from the initial funding. This additional funding resulted from further allocation tranches from the Scottish Government which were not initially awarded at the beginning of the fiscal year.

INCOME (Funding) as of Q3 / 2025 - 2026	ACC £'000	NHSG £'000	TOTAL £'000
Funding commitments 2025-2026	(137,197)	(255,207)	(392,404)
Set Asides	(1,771)	(59,238)	(61,009)
eNIC	(303)	(929)	(1,232)
Additional contribution	(4,200)	(6,709)	(10,909)
TOTAL INCOME (Funding)	**(143,471)**	**(322,083)**	**(465,554)**

Figure 1: Updated Funding as of Q3 / 2025 - 2026

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[1] Annual Audit Report 2024/25

[2] The 2024/25 audit of NHS Grampian

[3] Strategic Risk Register 21102025.pdf

[4] Budget 25-26 Report.pdf

[5] HSCP.25.053 IJB MTFF paper.pdf

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The changes in Funding from Partners is represented by the following:

PARTICULARS	ACC £'000	NHSG £'000	TOTAL £'000
As per MTFF reported in the IJB Committee meeting 01 July 2025	142,232	296,862	439,094
Adjustments from Q1 - Q3 / 2025 - 2026			
- Set Asides		3,738	3,738
- eNIC contribution		31	31
- Primary Care Improvement		7,958	7,958
- Various mental health & Substance Misuse		6,666	6,666
- Community Services		321	321
- City vaccinations		1,138	1,138
- Hosted Services		3,900	3,900
- Other minor adjustments		86	86
- Safe to Invest Digital	1,239		1,239
- City vaccinations tranche 2		1,138	1,138
- Long COVID		245	245
Total adjustments / funding change	**1,239**	**25,221**	**26,460**
Q3 funding level	**143,471**	**322,083**	**465,554**

Figure 2: Changes in Funding commencing from MTFF reference point to Q3 / 2025-2026

3.2. Cost of Services (Expenditure):

a.) The indicative costs of services <u>up to the year end 2025/26</u> in comparison to the annual budget values are as follows:

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PROJECTED GROSS EXPENDITURES COST OF SERVICES FY 25-26 (Following review of Q3 performance; Values in £'000)	Forecast Y/E 25-26	Annual Budget 25 - 26	Forecast vs Budget
Criminal Justice	281	172	109
Adult Social Care Directorate	1,703	2,093	(390)
Learning Disabilities	53,414	47,847	5,567
Mental Health & Subs Misuse	35,202	32,880	2,322
Adult Svcs OP & Physical Dis	107,121	112,972	(5,851)
Strategy & Transformation	3,406	3,628	(221)
Transformation Projects	985	1,048	(63)
Housing (Set Aside)	1,771	1,771	-
Community Health Services	50,695	50,084	611
Aberdeen City share of Hosted Services (health)	34,162	35,781	(1,619)
Primary Care Prescribing	47,023	44,503	2,520
Primary Care	60,748	62,064	(1,316)
Out of Area Treatments	3,516	2,750	766
Set aside Budget	59,238	59,238	-
City Vaccinations	2,320	2,634	(314)
Uplift Funding	2,837	6,090	(3,253)
TOTAL GROSS EXPENDITURES / COST OF SERVICES	**464,423**	**465,554**	**(1,131)**

Figure 3: Indicative year end costs against Annua Budget for FY 2025 - 2026

Some of the variances against budget shown in the table above are a result of:

1. Mental Health and Learning Disabilities (Unfavourable by £7.889m):
   1.1 Agency locums across the Older Adult Mental Health, Adult Mental Health and Substance Use pathways.
   1.2 Management of staffing requirements.
   1.3 Transitioning costs from child to adult learning disabilities coming in later during the year, with the number of transitions doubling from what was initially expected. Review of the "Transitioning Pathways" is on-going which will allow for clearer understanding of the transition criteria (i.e. including but not limited to age, status of condition, timing of transition).
   1.4 Additional purchasing of care package line items (CPLIs) for clients which mean that new care requirements have been identified to existing clients, particularly the elderly.
2. Across service lines: Increased rates in commissioning costs brought about by an increased number of care package line items' (CPLIs) and corresponding weekly care costs. Based on real time[6] data, the IJB has 4711 care packages with a weekly care costs of £2.281m equating to an annual costs of £118.612m spread across several providers.

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[6] Real time data changes on a regular basis following daily inputs and updates from the Social Care Team. Values given here are as of 11th Feb 2026.

RISK, AUDIT AND PERFORMANCE COMMITTEE

3. Primary Care Prescribing (Unfavourable by £2.520m): Though the Q3 result showed a lower number of prescription costs compared to what had been expected within the period, there is still on-going overspends projected towards year end resulting from higher prescription rates and volumes;

4. Community Health (Unfavourable by £0.611m): Additional nursing costs for clients on out of area placements;

5. Across service lines: Staffing costs brought on by long-term absences, where the costs of absent staff and bank or supply staff have to be employed;

6. Favourable variances: Primarily due to additional funding. Noting the current income level of £465.554m, and the forecast expenditure of £464.423m, an underspend of £1.131m is indicated at year end.

PARTICULARS			TOTAL £'000
PROJECTED GROSS EXPENDITURES COST OF SERVICES FY 25-26 (Following review of Q3 performance; Values in £'000)			**Forecast Y/E 25-26**
Criminal Justice			281
Adult Social Care Directorate			1,703
Learning Disabilities			53,414
Mental Health & Subs Misuse			35,202
Adult Svcs OP & Physical Dis			107,121
Strategy & Transformation			3,406
Transformation Projects			985
Housing (Set Aside)			1,771
Community Health Services			50,695
Aberdeen City share of Hosted Services (health)			34,162
Primary Care Prescribing			47,023
Primary Care			60,748
Out of Area Treatments			3,516
Set aside Budget			59,238
City Vaccinations			2,320
Uplift Funding			2,837
TOTAL GROSS EXPENDITURES / COST OF SERVICES			**464,423**
INCOME (Funding) as of Q3 / 2025 - 2026	**ACC £'000**	**NHSG £'000**	**TOTAL £'000**
Funding commitments 2025-2026	(137,197)	(255,207)	(392,404)
Set Asides	(1,771)	(59,238)	(61,009)
eNIC	(303)	(929)	(1,232)
Additional contribution	(4,200)	(6,709)	(10,909)
TOTAL INCOME (Funding)	**(143,471)**	**(322,083)**	**(465,554)**
(SURPLUS) / DEFICIT ON PROVISION OF SERVICES			**(1,131)**

Figure 4: Indicative Costs of Services up to FY-end 2025-2026 against Funding

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RISK, AUDIT AND PERFORMANCE COMMITTEE

In respect of the year to date position (YTD), as at the end of December 2025 (Q3), there is an underspend in the cost of providing services amounting to £0.524m noted in the table below. Per Service line's unfavourable / favourable variances of which is / are caused by the aforementioned causes from 3.2.a.i to 3.2.a.vi above.

PARTICULARS AS AT Q3 - 2025 / 2026	ACTUALS up to Q3 £'000	BUDGET up to Q3 £'000	Q3 ACTUALS vs Q3 BUDGET
Criminal Justice	(374)	129	(503)
Adult Social Care Directorate	1,698	1,570	128
Learning Disabilities	41,902	35,885	6,017
Mental Health & Subs Misuse	26,551	24,658	1,893
Adult Svcs OP & Physical Dis	81,193	84,729	(3,536)
Strategy & Transformation	2,609	2,720	(112)
Transformation Projects	807	786	21
Housing (Set Aside)	-	-	-
Community Health Services	37,662	37,541	121
Aberdeen City share of Hosted Services (health)	25,783	26,811	(1,028)
Primary Care Prescribing	34,838	33,847	991
Primary Care	45,110	46,550	(1,440)
Out of Area Treatments	2,439	2,079	360
Set aside Budget	44,429	44,429	-
City Vaccinations	1,755	1,976	(221)
Uplift Funding	-	3,216	(3,216)
TOTAL GROSS EXPENDITURES / COST OF SERVICES	**346,401**	**346,925**	**(524)**

Figure 5: Actual Costs of Services Q3 / 2025 - 2026 against Budget for the same period

4. Implications for the IJB

4.1. Equalities, Fairer Scotland and Health Inequality

There are no implications arising from this report.

4.2. Financial

The financial implications are contained within this report and financial risks are further analysed in section 5.

4.3. Workforce

The workforce implications are contained within this report and where appropriate further scrutinised in section 5.

4.4. Legal

There are no direct legal implications arising from this report.

4.5. Unpaid Carers

Considering the results of the public consultation which ran from 14th November until 14th December 2025, no further direct implications on this area arose from this report.

4.6. Information Governance

Information governance implications are noted in section 5.1.B.

4.7. Environmental Impacts

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

4.8. Sustainability

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

4.9. Other

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

5. Management of Financial Risks

Despite the forecast results for FY 2025/26 being favourable (Net underspend against budget of £1.131m), the financial challenges of recent years means there has been greater scrutiny of the IJB's financial arrangements and sustainability and that continues in light of the additional oversight being applied to NHS Grampian. The IJB must take account of and, where possible, address these challenges beyond this current fiscal period.

The outcome of these recent reviews has been highlighted in several audits as specified hereunder:

5.1. Identified risks(s) in Audit Scotland's <u>Annual Audit Report for 2024/25</u> and actions being taken:

RISK, AUDIT AND PERFORMANCE COMMITTEE

#	Risks	Audit Scotland Recommendations	IJB Actions
A	High CFO Turnover: Within FY 2024 – 2025, there had been 3 CFOs	IJB should implement an appropriate on-boarding plan for the Deputy CFO covering training and mentoring.	Extensive induction and handover checklist prepared by the IJB's Interim CFO and Interim Deputy CFO. The IJB Deputy CFO joins the Council on 16 February 2026.
B	Out of date financial modelling assumptions	Budget financial model should be reviewed to bring assumptions up-to-date. These assumptions should be challenged by the Board & relevant committee.	Budget 2026/27 and latest Medium Term Financial Forecast assumptions are being reviewed and will be shared as part of the budget report in March 2026. Closer working and information sharing between Partners, alongside continuing analysis of each partners' financial reports, with specifics on delegated services to be reviewed via a revisit to the Integration Scheme [7]document forming the basis of the IJB's additional governance structure.
C	Quality of monitoring of financial performance, savings, and cost pressures needing focus to ensure delivery of financial sustainability	Formal monitoring of progress reports on planned savings delivery by the Senior Leadership Team (SLT) with onward reporting to the Risk, Audit and Performance committee a must.	The Budget Savings Oversight Group (BSOG) have been tasked to review performance (status, savings, costs pressures) on a bi-monthly basis with quarterly reporting to the Risk, Audit, and Performance Committee. As a preliminary support, an initial Finance for Non-Finance workshop had been provided to the IJB SLT aimed at augmenting financial data monitoring accountabilities' awareness. This is planned to be cascaded to the Service Line Management Team recognising

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[7] Integration Scheme

			their direct responsibilities over their relevant functional coverage.
D	Limited availability of robust and regular financial data	Systems need to be developed to enable the routine extraction of fundamental management data to assist health and social care management in reviewing priorities and decision-making.	Council-sourced data: On-going development of D365 (Social Care data) and ContrOCC (Social Care financial assessment and provider data) prioritized. These source data gives the background to the financial data reported in Efinancials. This is particularly relevant considering that services delegated to the Council refer to Social Care costs that are then commissioned to contracted providers. 75 - 78% of the IJB's social care costs delegated to the Council pertain to commissioning costs. NHSG-sourced data: Kindly refer to section 5.2 below.
E	Availability of good performance data as regards increasing demands enabling scrutiny to challenge and support decision-making	Challenging targets need to be set and measures put in place to provide the management team with real-time performance information.	Set up of monitoring metrics and continuous review of costs pressures, savings targets, and financial performance covered by the BSOG and SLT meetings.

Figure 6: IJB Actions following Audit Scotland Recommendations

5.2. **Identified risks(s) in the Auditor General's <u>NHS Grampian's Section 22 Audit Report for 2024/25</u> and its impacts on the IJB's financial performance going forward:**

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RISK, AUDIT AND PERFORMANCE COMMITTEE

a.) The Findings:

The report is unequivocal: NHS Grampian cannot return to financial balance without the IJBs fundamentally changing performance, financial management, and delivery models across delegated services.

Integration Joint Boards (in reference to the 3 IJBs partnered with the NHS Grampian) are described as follows in this Audit Report:

- A major contributor to NHSG's overspend, with £290m worth of funding pressure in the 5 years from 2025/26 to 2029/30;
- A key barrier to financial balance in the medium term;
- Facing their own significant demographic, demand and workforce pressures;
- In need of transformation and clearer financial grip.

b.) IJB Action:

Proposed actions noted in Section 5.1 aims to alleviate these concerns with the goal to meet service delivery <u>within</u> original funding budget and <u>no need for additional fundings</u> from the partners.

The IJB's NHS financial mix has staff costs which are 45% of the costs baseline. The IJB is looking at:
  i.   Addressing recruitment challenges in community care & social care markets.
  ii. Reducing agency and bank reliance across HSCP services.
  iii. Introducing more flexible, productive skill-mix models.
  iv. Streamlining rota, absence, vacancy and workforce planning processes.

In addition, the IJBs participate in a monthly Finance Recovery / Resilience Board meeting steered by the NHS Grampian to openly discuss the IJB financial performance status and in-year progress, as well as effectively engaging in dialogue and collaboration across the Health and Local Authority sectors at the highest level.

5.3. Identified risks(s) in the Strategic Risk Register and its impacts on the IJB's financial performance going forward:

a) Financial sustainability: The approved budget for 2025/26 includes additional funding from both Partners amounting to £10.909m. This has helped the IJB avoid implementing the full range of budget saving options

this year which would have impacted citizens, service users and the Health and Social Care system.

The fact this funding is not recurring due to the partners' own financial challenges presents the IJB with a fiscal constraint in future years, hence further savings targets, reigning in of cost pressures, and regularised performance monitoring is being carried out to deliver, not just a balanced budget, but a contingency mechanism in the form of a resurgent reserve.

b) Year on year costs pressures indicate rising demand and unavoidable cost increases from pay and contracts in particular. In the MTFF presented to the IJB, 1 July 2025, the following costs pressures were identified. Recurring areas of concern needing focus still within pay, commissioning, and primary care prescribing.

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

Figure 7: Costs Pressures identified as per MTFF Report dated 01 July 2025

c) Savings targets in 2025 – 2026 will be echoed in FY 2026 – 2027:

As presented in the MTFF July 2025:

RISK, AUDIT AND PERFORMANCE COMMITTEE

Budget Saving Category	Budget Saving £'000
Managing staff vacancies	1,346
Anticipated savings from post reduction	884
Reducing bank nursing expenditure	999
Estates savings - consolidation of properties	153
Utility savings	50
Review of care provision older people and learning disability	3,328
Review of day care provision	1,449
Key commissioned service provider review	4,599
Reviewing mix of residential care provision	336
Review out of area care	174
Supplier review	1,035
TOTAL	**14,353**

Figure 8: Savings targets as per MTFF Report 01 July 2025

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Planned savings FY 2026 – 2027:

Service Area	2026/27 £'000 Staff	2026/27 £'000 Assets	2026/27 £'000 Spend	2026/27 £'000 Contracts	2026/27 £'000 Income
Corporate	(2,500)	0	(15)	0	0
Adult Social Work	(350)	0	(53)	(6,187)	(500)
Community Mental Health - Learning Disabilities	0	0	(667)	(400)	0
People & Property	(80)	(255)	(40)	0	0
Primary Care	(38)	(13)	(1,000)	(14)	0
Nursing	(356)	0	(1,374)	0	(39)
Allied Health Professions	(100)	0	(99)	0	(95)
Strategy and Tranformation	0	0	(347)	0	0
Specialist Mental Health - Learning Disabilities	(869)	0	(80)	(95)	(29)
	(3,424)	(268)	(3,595)	(6,601)	(634)
TOTAL	(14,522)				

Figure 9: Planned savings for FY 2026 - 2027

    d) Currently, efforts are well in place to alleviate costs burdens via:
        i. Provider contract reviews and negotiations to reign in commissioning costs;
        ii. Manpower resource control as noted in Section 5.2.b;
        iii. Stringent budget holder discussions for purposes of monitoring Service Line performance;
        iv. Data availability enhancements through systems improvement evidenced by the work on Dynamics365 / ContrOCC.
    e) The updated Medium Term Financial Forecast and Budget for 2026/27 will be presented to a meeting of the IJB on 17 March 2026.

5.4. Identified risks(s) in Internal Audit's <u>Budget Setting and Monitoring Report</u> and the planned Internal Audit of <u>IJB Financial Sustainability</u> and its impacts on the IJB's financial performance going forward.

    a) Findings from the 2024 Internal Audit of the IJB's Budget Setting and Monitoring showed a "Moderate" risk rating which means the IJB has a generally sound system of governance, risk management, and control in place.
    b) The Internal Audit of IJB Financial Sustainability is in progress at the time of writing and recommendations will be presented to a future meeting of this Committee.

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Both Internal Audits are relevant and timely as the IJB strives to meet its financial performance improvement objectives and find answers to address the sustainability issues that the sector has. to gain back its reserve structure.

5.5   The Chief Officer and Chief Financial Officer will ensure that they maintain a focus on quantifying and managing the key risks identified and responding to the recommendations arising from this complex financial environment.   The updated Medium Term Financial Forecast and Budget 2026/27 report will be the next opportunity to do this.

Aberdeen City Health & Social Care Partnership
A caring partnership

Risk, Audit and Performance Committee

Date of Meeting	24 February 2026
Report Title	Internal Audit Update Report
Report Number	HSCP.26.011
Lead Officer	Jamie Dale Chief Internal Auditor
Report Author Details	Jamie Dale Chief Internal Auditor Jamie.Dale@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	Appendix A – RAPC - Internal Audit Update Report February 2026
Terms of Reference	2. Review and approve the annual audit plans (internal and external) on behalf of the IJB, receiving reports, overseeing and reviewing actions taken on audit recommendations and escalating to the IJB as appropriate.

1. Purpose of the Report

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

2. Recommendations

2.1. It is recommended that the Committee:

a) Note the contents of the RAPC - Internal Audit Update Report February 2026 ("the Internal Audit Update Report"), as appended at Appendix A, and the work of Internal Audit since the last update; and

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      b) Note the progress against the approved 2025/26 Internal Audit Plan as detailed in the Internal Audit Update Report.

3. Strategic Plan Context

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

4. Summary of Key Information

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

5. Implications for IJB

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

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

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

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

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

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

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

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

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

6. Management of Risk

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

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

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

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Internal Audit

Risk, Audit and Performance Committee Internal Audit Update Report February 2026

Contents

1 Executive Summary

1.1 Introduction and background

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

This report advises the RAP Committee of Internal Audit's work since the last update. Details are provided of the progress against the approved 2025/26 Internal Audit Plan, audit recommendations follow up, and other relevant matters for the Committee to be aware of.

1.2 Highlights

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

- Work is underway to deliver the 2025/26 Internal Audit Plan.
- Work is underway by Management with regards to the implementation of agreed audit recommendations.

1.3 Action requested of the RAP Committee

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

2 Internal Audit Progress

2.1 2025/26 Audits

Service	Audit Area	Position
Health & Social Care Partnership	Health and Social Care (staffing) Scotland Act 2019	**Final Report Issued**
Integration Joint Board	IJB Financial Sustainability	**Review in Progress**

2.2 Follow up of audit recommendations

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

As at 30 November 2025 (the baseline for our exercise), no audit recommendations were due. This is a positive position, which highlights the efforts of Management to complete their agreed upon actions. Internal Audit will continue to follow up on future recommendations and provide updates to Committee.

Aberdeen City Health & Social Care Partnership
A caring partnership

Risk, Audit and Performance Committee

Date of Meeting	24 February 2026
Report Title	Internal Audit Report – Health and Care (Staffing) Scotland Act 2019
Report Number	HSCP.26.013
Lead Officer	Jamie Dale Chief Internal Auditor
Report Author Details	Jamie Dale Chief Internal Auditor Jamie.Dale@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	Yes - Internal Audit Report AC2612 – Health and Care (Staffing) Scotland Act 2019
Terms of Reference	2. Review and approve the annual audit plans (internal and external) on behalf of the IJB, receiving reports, overseeing and reviewing actions taken on audit recommendations and escalating to the IJB as appropriate.

1. Purpose of the Report

1.1. The purpose of this report is to present the outcome from the planned audit of Health and Care (Staffing) Scotland Act 2019 that was included in the Internal Audit Plan.

2. Recommendations

2.1. It is recommended that the Committee:

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

3. Strategic Plan Context

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

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

4. Summary of Key Information

4.1. Internal Audit has completed the attached report which relates to an audit of Health and Care (Staffing) Scotland Act 2019.

5. Implications for IJB

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

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

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

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

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

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

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

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

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

6. Management of Risk

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

6.2. **Link to risks on strategic risk register:** The Internal Audit Plan, and this output report, is developed following consideration of the Aberdeen City

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Health and Social care Partnership Risk Register and through consultation with management.

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

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Internal Audit

Assurance Review of Health and Care (Staffing) Scotland Act 2019

Status: Final
Date: 28 January 2026
Risk Level: Corporate

Report No: AC2612
Assurance Year: 2025/26

Net Risk Rating	Description	Assurance Assessment
Moderate	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified, which may put at risk the achievement of objectives in the area audited.	**Reasonable**

Report Tracking	Planned Date	Actual Date
Scope issued	24-Sep-2025	24-Sep-2025
Scope agreed	01-Oct-2025	02-Oct-2025
Fieldwork commenced	02-Oct-2025	02-Oct-2025
Fieldwork completed	06-Nov-2025	10-Nov-2025
Draft report issued	27-Nov-2025	05-Dec-2025
Process owner response	18-Dec-2025	16-Jan-2026
Director response	24-Dec-2025	27-Jan-2026
Final report issued	12-Jan-2026	28-Jan-2026
RAP Committee	24-Feb-2026	

Distribution	
Document type	Assurance Report
Director	Fiona Mitchelhill, Chief Officer – Aberdeen Health and Social Care Partnership
Process Owner	Sandy Reid, Lead – People and Organisation
Stakeholder	Alison MacLeod, Strategy and Transformation Lead
	Martin Allan, Business Manager
	Neil Stephenson, Strategic Procurement Manager
	Jonathan Belford, interim Chief Finance Officer*
*Final only	External Audit*
Lead auditor	Sarah Poppe, Auditor

Contents

1 Introduction

1.1 Area subject to review

The Aberdeen City Health and Social Care Partnership (ACHSCP) formally came into existence on 6 February 2016 with approval of its Integration Scheme by Scottish ministers. The partner organisations of the ACHSP are Aberdeen City Council and NHS Grampian.

The purpose of the partnership is to deliver positive and improved outcomes for the residents of Aberdeen so that people live healthier, longer lives, are supported to be independent and have choice and control no matter who they are or where they live. These outcomes are delivered by working closely together with independent, commissioned and third sector colleagues.

The partnership's Strategic Plan for 2025-29 acknowledges that its implementation will be the most challenging to date, due to increasing demand for health and social care services. However, the resources available to meet this demand are not growing at the same pace. In response, the plan outlines a commitment to transform service delivery, with a focus on safeguarding essential frontline services.

The provisions of the Health & Care Staffing Act 2019 came into force on 1 April 2024. The Act establishes guiding principles designed to ensure safe, high-quality services and positive outcomes for service users and will assist in strengthening workforce planning for safe staffing. It sets out several duties, including:

- Ensuring appropriate staffing levels
- Maintaining a real time staffing assessment and risk escalation process
- Addressing severe and recurring risks
- Seeking clinical advice on staffing matters and ensuring adequate time for clinical leaders
- Applying the common staffing method (for specific staff groups such as nurses, midwives and medical practitioners)
- Supporting staff to share their views on staffing
- Providing staff with training, time and resources to meet their responsibilities

Data on health and care services plays a vital role in driving improvements. Under the Act organisations must report and publish information demonstrating how they have met the statutory requirements. This also requires quarterly and annual reporting, including reporting on the use of agency workers. In addition, Scottish Ministers must present these reports to Parliament, explain the actions being taken in response, and take reasonable steps to ensure that enough healthcare professionals are available.

1.2 Rationale for the review

The objective of this audit is to consider whether appropriate control is being exercised in respect of compliance with statutory guidance on safe staffing levels. The review will assess the actions taken to ensure the ACHSCP is making appropriate progress towards compliance with the Health & Care Staffing Act 2019.

The purpose of the Act is to establish a statutory basis for ensuring appropriate staffing across health and social care services. Its aim is to support safe and high-quality care and improve outcomes for service users. The Act builds on existing policies and procedures while requiring staff are kept informed about staffing decisions and have clear channels to raise concerns.

Given that the Act strengthens workforce planning duties, the review will also consider the Workforce Plan.

Failure to meet the Act's requirements could present significant risks, including inaccurate workforce forecasting leading to overstaffing or understaffing, delayed identification and mitigation of risks and ultimately non-compliance with statutory requirements.

This area has not previously undergone a dedicated audit.

1.3 How to use this report

This report has several sections and is designed for different stakeholders. The executive summary (section 2) is designed for senior staff and is cross referenced to the more detailed narrative in later sections (3 onwards) of the report should the reader require it. Section 3 contains the detailed narrative for risks and issues we identified in our work.

2 Executive Summary

2.1 Overall opinion

The full chart of net risk and assurance assessment definitions can be found in Appendix 1 – Assurance Scope and Terms. We have assessed the net risk (risk arising after controls and risk mitigation actions have been applied) as:

Net Risk Rating	Description	Assurance Assessment
Moderate	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified, which may put at risk the achievement of objectives in the area audited.	Reasonable

The organisational risk level at which this risk assessment applies is:

Risk Level	Definition
Corporate	The issue/risk level impacts the Partnership as a whole. Mitigating actions should be taken at the Senior Leadership level.

2.2 Assurance assessment

The level of net risk is assessed as **MODERATE**, with the control framework deemed to provide **REASONABLE** assurance over ACHSCP compliance with the Health & Care Staffing Act 2019. There are various processes in place covering governance, workforce planning, risk management, training and monitoring and reporting, and there are assurances in practice at the operational level (e.g. daily situation, safety, quality and planning meetings). Reporting lines are established within each Partner organisation, and these provide HSCP management with assurance over safe staffing. However regular, comprehensive, and documented sources of overall assurance regarding compliance with the Act and its guiding principles could be enhanced.

Areas where controls would benefit from improvement, to more effectively demonstrate compliance and embodiment of the Act include:

- **Governance** – ACHSCP operates within a well-defined governance framework with clear reporting lines and Terms of Reference for the Clinical Care and Governance Group, through the Clinical Care Governance Committee (CCG Committee), to the Integration Joint Board (IJB), which also receives reports from the Risk Audit and Performance Committee (RAPC) However, published minutes show minimal reference to the Health & Care Staffing Act 2019. Although evidence of initial planning was observed, follow-up activity was less clear. This reduces assurance over the extent of progress toward compliance. The lack of assurance regarding awareness and progress toward compliance creates a risk that compliance is not being prioritised, which could result in reputational damage to the ACHSCP.

- **Workforce Plan and Workforce Data** – The Workforce Plan 2022-25 is structured around three key workstreams: Staff Mental Health and Wellbeing, Recruitment and Retention, and Growth and Development Opportunities. Each workstream includes specific objectives and associated actions to achieve them and these are used to guide progress throughout the duration of the Plan. While minutes indicate a small number of workforce related actions were discussed by Management during 2025, there are no regular reviews of the Workforce Plan until preparation begins for the next one. The Delivery Plan includes four actions in respect of the Workforce Plan. These are included in regular updates to RAPC, though two (50%) have remained at an Amber status with limited progress indicated during 2025/26. Workforce data is not included in the Delivery Plan Dashboard provided to RAPC, the focus of which is largely on capacity and flow. Workforce data plays a critical role in informed decision-making by highlighting areas for improvement and enabling forecasting of staffing aligned with ACHSCP's objectives. It also supports monitoring of productivity and training. Whilst workforce data is available, there is limited evidence to show how that data is being used to inform decisions or track progress against the Workforce Plan. Data is comprehensive but there is a clear split between Health (Aberdeen City's share of NHSG staffing) and Social Care (Aberdeen City

Council) data, reports are presented and considered separately for each. A more integrated approach would further support progress toward the partnership's integration aims.

- **Clinical Advice** – The Act creates a duty for services to seek clinical advice on staffing and ensure adequate time is given to clinical leaders to undertake such assessment. Decision making within the ACHSCP can be challenging due to increasing demands on service delivery and patient care, balancing potentially conflicting demand and resource pressures. To ensure clinical advice is sought and considered in staffing decisions, all services are expected to follow the Health & Care Staffing Act quick guide (which is generic and reliant on the existence and application of local procedures) and maintain a clear escalation process. The actual process, and associated records, will vary between teams as NHSG is in the process of rolling out the SafeCare System. Plans and progress with implementing the System, and assurances over the existence and adequacy of alternative approaches still in use pending the roll-out were not available. A Self-Assessment completed in September 2024 indicated only "Limited Assurance" over compliance with this duty, and "No Assurance" on adequate time being given to clinical leaders. Details supporting this self-assessment, and of progress with reviewing and addressing identified gaps, were not available from the Service. If there are gaps these could result in the ACHSCP being non-compliant with the Health and Care Staffing Act, presenting risks to staff and patient wellbeing. NHSG has sought to collate information relating to compliance with the Act again in 2025/26. Evidence of common staffing method tools being used to assess current demand against available resource was only available for two of eight areas (25%) identified by NHSG as in scope under the Act. Where these tools indicated potential under-resourcing, risks to safe staffing were highlighted for consideration. Where the tools indicated potential over-resourcing, risks in respect of data quality were highlighted. In the absence of complete and regularly reviewed data across all relevant areas, it may be difficult to rely on it to direct resources efficiently.

- **Reporting and Escalation of Risk** – The Act requires that there is a procedure in place for the reporting and escalation of risks. ACHSCP has established a Board Assurance and Escalation Framework outlining how the IJB secures assurance over its activities. This incorporates a Strategic Risk Register, Operational Risk Register, and a Risk Appetite Statement. The Operational Risk Register, supported by data held on the Datix System, is reviewed regularly by the Clinical Care and Governance Group, and updates are provided to the Clinical Care and Governance Committee. However, there are gaps and variations in the reporting of operational risk data: neither the Group nor the Committee are being consistently provided with data that demonstrates quantification of the impact of risks and issues, assurance over mitigating actions, or reference to acceptance of risks that are within appetite. Due to variations in how this information is communicated, and given the level of autonomy at service level, there is a risk that at the operational level, scarce resources may be used to address risks which are not a strategic priority, impacting on the ability of the HSCP to deliver sustainably on its other commitments. While there is evidence of a risk management process, informed by operational risk data, and with opportunities for staffing-related risks to be escalated where required, improvements are required to demonstrate that this is working effectively in compliance with the Act and suitably weighed against other risks, across the board and in accordance with ACHSCP's agreed risk appetite.

- **Monitoring and Reporting** – The Health & Care Staffing Act 2019 requires an Annual Report to be published each year to demonstrate how relevant organisations have complied with the duties under the Act. There are separate reporting requirements for health services and care services. NHS Grampian reports to the Scottish Government directly on health duties in respect of all three HSCP areas within the Grampian area, however this is not routinely reported to the IJB to provide assurance this is being produced and acted on. Whilst it was possible to confirm the HSCP met the reporting requirements for 2024/25, the final report omitted reference to several significant pressures identified during drafting, and flagged within risk registers, including: constrained funding due to current budget challenges, recruitment and retention difficulties, increasing service user needs and the associated requirement for enhanced staff training. No supporting documentation was required to be prepared or appended to the annual report, therefore this provided management assurance only. As noted above, a detailed self-assessment of compliance with the Act was last conducted by ACHSCP in September 2024, and this indicated substantial gaps in the level of assurance over compliance. Assurance was not available over progress with related actions.

Recommendations have been made to address the above risks, including: ensuring appropriate oversight is in place to monitor and report on compliance with the Health & Care Staffing Act 2019 through the IJB's governance structure, and act on any identified risks to compliance; improving monitoring of implementation and progress with the Workforce Plan; reviewing the risk and assurance framework to reinforce risk-management decisions and explicitly incorporate compliance with the Act; and reviewing options for better integrating workforce data across the HSCP to support the efficient direction and management of resources.

2.3   Identified Risks

Risk Level	Number of Risks Identified
Severe	-
Major	1
Moderate	4
Minor	-
Total	5

2.4   Management response

Thank you for the Internal Audit Report. We appreciate the thorough review and the opportunity to provide a management response.

We recognise that there were weaknesses identified, which is why this audit was requested. These areas will be addressed through our agreed improvement actions and ongoing monitoring.

It is important to be explicit that there are no staff safety concerns daily across ACHSCP. Appropriate staffing levels are in place, and our teams are supported by equalisation of staff or supplementary staff where required to maintain safe and effective service delivery.

We continue to work within the functionality of the systems available to us and remain aligned with the digital strategies of our partner organisations, whilst ensuring compliance within our governance processes. While system limitations present challenges, we are committed to maximising their capabilities and ensuring compliance with governance processes across both NHS Grampian and Aberdeen City Council.

3 Issues / Risks, Recommendations, and Management Response

3.1 Issues / Risks, recommendations, and management response

Ref	Description	Risk Rating	Moderate
1.1	**Governance** – The ACHSCP operates under a well-defined governance structure with clear reporting lines. At the top of the structure is the Integration Joint Board (IJB) that receives reports from two key committees: the Risk Audit and Performance Committee (RAPC) and the Clinical Care and Governance Committee (CCG Committee).		

The Terms of Reference for the CCG Committee outline its purpose as providing assurance on the delivery of safe and effective care, in accordance with the statutory duties of the IJB. The Committee ensures that clinical and care governance is discharged professionally and appropriately within the partnership, under oversight of the IJB. It is also responsible for escalating risks that may impact on patient care, service delivery or the reputation of the IJB.

The CCG Committee meets four times per year. Due to the sensitive nature of its discussions, meetings are held in private and detailed minutes are not published. The Committee's focus is more operational and is involved with maintaining the Operational Risk Register. While available minutes are not comprehensive, they indicate topics such as clinical issues, staffing and day to day operational and emerging risks are routinely discussed. Published minutes for RAPC and IJB show minimal reference to the Health & Care Staffing Act 2019.

The Clinical Care and Governance Group (CCG Group) and Clinical Risk Management Group report directly to the CCG Committee providing further operational support and insight.

Throughout the review, we were advised that Senior Leadership Team (SLT) meets regularly to discuss risk, update Datix (NHSG risk management system), oversee the Workforce Plan, and review workforce data to support decision making. Examples of briefing papers in advance of the Act coming into force in April 2024, and other documentation demonstrate consideration was given to the requirements and planning. However, there was no indication a follow up exercise had taken place to ensure preparation for compliance had been undertaken, or whether areas requiring further work had been identified and addressed.

The lack of assurance regarding awareness and progress towards compliance creates a risk that compliance is not being prioritised, which could result in reputational damage to the ACHSCP.

IA Recommended Mitigating Actions

The HSCP should ensure appropriate oversight is in place to monitor compliance with the Act. Assurance should be provided through the IJB's governance structure.

Management Actions to Address Issues/Risks

The Clinical and Care Governance Group (CCGG) reporting template will be updated to prompt services when they are compiling their submissions to consider any compliance implications relevant to the Act at every cycle of reporting. The annual care report submission to Scottish Government will be presented to RAPC, this details how the HSCP have met their duties under the Act.

The amended CCGG template will facilitate the escalation of any non-compliance with the Act to the Clinical and Care Governance Committee (CCGC) on a more robust and regular basis. It should be noted that CCGC can further escalate to the NHSG Clinical Governance Committee if required.

Risk Agreed	Person(s)	Due Date

Ref	Description	Risk Rating	Moderate
	Yes	Chair of CCGG & Lead for People & Organisation	31 May 2026	

Ref	Description	Risk Rating	Moderate
1.2	**Workforce Plan and Workforce Data** – The Workforce Plan 2022-25 is structured around three key workstreams, each comprising of three targeted actions aimed at supporting strategic workforce objectives:		

Workforce Plan and Workforce Data – The Workforce Plan 2022-25 is structured around three key workstreams, each comprising of three targeted actions aimed at supporting strategic workforce objectives:

- Staff Mental Health and Wellbeing
  - Continued support for Healthy Working lives initiatives
  - Broaden use of We Care approach and framework
  - Re-establish annual workforce engagement events and celebrating achievements
- Recruitment and Retention
  - Recruitment events and ACHSCP job promotion media
  - Induction and Training review
  - Developing Young Workforce
- Growth and Development Opportunities
  - Map and explore merging technologies to support staff
  - Continued promotion of iMatter and other Staff feedback
  - Shared learning and best practice, including test of change ideas

Each workstream included specific objectives and associated actions to achieve them, to be used to guide progress throughout the duration of the workforce plan. ACHSCP benchmarks its KPI's against the Scottish average and parent organisations. While Action Plans, details of progress monitoring, KPI data and comparative analysis have been requested by Internal Audit, these have not been provided for review.

The Workforce Plan is accessible via the Partnership's website and through IJB meeting papers. However, it is not explicitly referenced within the HSCP's Publication Scheme. The Workforce Plan is formally approved by the IJB and is subject to review by RAPC and oversight by SLT. While minutes indicate a small number of workforce related actions were discussed by SLT during 2025, there are no regular reviews of the Workforce Plan until preparation begins for the next one. RAPC minutes confirm that the Workforce Plan was reviewed in November 2023 and August 2025, which generally aligns with the timing of publication of progress reports: one covering 2022-23 and a final report covering the remaining two years of the plan. No review was conducted during 2024. There is no formal commitment for the RAPC to carry out an annual review of the Workforce Plan.

The Delivery Plan includes four actions in respect of the Workforce Plan. These are included in regular updates to RAPC, though two (50%) have remained at an Amber status with limited progress indicated during 2025/26. Workforce data is not included in the Delivery Plan Dashboard provided to the Committee, the focus of which is largely on capacity and flow.

At the time audit fieldwork was completed a refresh of the Workforce Plan was underway, with a revised plan scheduled for presentation to the IJB in December 2025. The refresh was expected to focus on modernising ACHSCP's approach to service delivery and prioritising early intervention and prevention. These priorities align with the Strategic Plan and Delivery Plan.

Workforce Data supports informed decision-making, highlighting trends and areas for improvement. It can enable forecasting of staffing needs based on ACHSCP's objectives and helps monitor productivity and training. While the new Workforce Plan is being developed workforce data can be utilised to pinpoint gaps and priorities, ensuring the plan is more

Ref	Description	Risk Rating	Moderate

targeted and effective. However, SLT minutes provided limited detail on progress with workforce planning and scrutiny of workforce data, reducing assurance over its review and action. If progress is not reviewed regularly the ACHSCP may miss opportunities for early intervention, putting the achievement of strategic and corporate objectives at risk.

The Act requires employers to ensure that staff receive appropriate training and are provided with sufficient time and resources to undertake it. Partners hold lists of mandatory and statutory training requirements, and compliance is monitored regularly, though in common with other workforce data this is not collated into a single HSCP record. Targets and reported results are low, for example NHS data indicated around 70% of staff had completed statutory fire safety training against a target of 80%, and 60% completion of mandatory training against a target of 70%. Management has indicated that part of the gap may be explained by staff absence and maternity leave, however it was not possible to accurately quantify this. Although staff should have regular protected learning time, these and other workforce reports indicate this may not always be available due to the level of demand on services.

Dashboards of workforce data used by SLT were shared with Internal Audit. Whilst workforce data including attendance and training levels is available, there is limited evidence to show how that data is being used to inform decisions or track progress against the Workforce Plan. Data is comprehensive but there is a clear split between Health (Aberdeen City's share of NHSG staffing) and Social Care (Aberdeen City Council) data – reports are presented and considered separately for each. A more integrated approach would further support progress toward the partnership's integration aims.

IA Recommended Mitigating Actions

The HSCP should ensure appropriate oversight mechanisms are in place to regularly monitor the implementation and progress of the Workforce Plan, ensuring aims and objectives remain realistic, relevant and aligned with organisational needs.

The HSCP should review options for integrating review of health and care workforce data.

Management Actions to Address Issues/Risks

Annual Reports on the progress of the Workforce Plan will continue to be developed and submitted. KPI's will be considered to ensure delivery of the renewed Workforce Plan and monitored via RAPC.

The IJBs needs for workforce data have been defined and discussed with our partners and the suite of reports are the best that are currently available to us within the limitations of each partners policies and systems in relation to recording and reporting workforce data. The two staff groups have different Terms and Conditions and, in the main each service is made up of either NHS or Council staff with benchmarking being undertaken against similar staff groups in each partner organisation and nationally. The full integration of workforce data would not necessarily bring significant benefits.

There is monthly compliance monitoring of staff training data at the SLT meeting.

Risk Agreed	Person(s)	Due Date
Yes	Lead for People and Organisation	30 June 2026

Ref	Description	Risk Rating	Major
1.3	**Clinical Advice on Staffing Issues** – The Act requires services to seek clinical advice on staffing, and ensure adequate time is given to clinical leaders to undertake such assessment.		

Ref	Description	Risk Rating	Major

Decision making within ACHSCP can be challenging due to increasing demands on service delivery and patient care, balancing potentially conflicting demand and resource pressures. To ensure clinical advice is sought and considered in staffing decisions, all services are expected to follow the national Health & Care Staffing Act 'quick guide' and maintain a clear escalation process. The guide is generic, set at a national level, and relies on the existence and application of local procedures – which varies although all clinical staffing decisions are made by Senior Clinical Managers or the Chief Officer the actual process and associated records will vary between teams as NHSG is in the process of rolling out the SafeCare system. Plans and progress with implementing the system, and assurances over the existence and adequacy of alternative approaches still in use pending completion of the roll-out were not available.

A Self-Assessment completed by ACHSCP in September 2024, recorded "Limited Assurance" regarding the duty to seek clinical advice on staffing, and "No Assurance" on adequate time being given to clinical leaders. An Action Plan indicated that system mapping would be complete by November 2024, but we confirmation of progress or completion has not been received at the time of reporting. Furthermore, the draft report provided lacked supporting documentation that would have been submitted during the self-assessment; therefore, it is not possible to provide assurance that this aspect of the Act was being met at that time. If there are gaps in these arrangements these could result in the ACHSCP being non-compliant with the Health and Care Staffing Act, presenting risks to staff and patient wellbeing.

NHSG has sought to collate information relating to compliance with the Act again in 2025/26. Evidence of common staffing method tools being used to assess current demand against available resource was only available for two of eight areas (25%) identified by NHSG as in scope under the Act. Where these tools indicated potential under-resourcing, risks to safe staffing were highlighted for consideration. Where the tools indicated potential over-resourcing, management highlighted risks in respect of data quality. In the absence of complete and regularly reviewed data across all relevant areas, it may be difficult to rely on it to direct resources efficiently.

IA Recommended Mitigating Actions

The HSCP should periodically review the extent that robust arrangements are in place for seeking, considering and recording clinical advice and associated actions, and the level of assurance over progress with actions in respect of any remaining gaps.

Management Actions to Address Issues/Risks

Management will introduce a formal, scheduled quarterly review of compliance with the Health & Care Staffing Act (clinical advice duties). This review will be carried out by the Clinical and Care Governance Group (CCGG) and recorded in a standardised format on the reporting template. Findings, trends, and outstanding issues will be escalated to the Clinical and Care Governance Committee (CCGC) in the summary report.

Management will collaborate with NHS Grampian on an overview of SafeCare rollout and alternative local arrangements. Management will obtain updated information on SafeCare implementation timelines across relevant services. Where SafeCare is not yet implemented, a mapping of local processes for clinical advice and escalation will be documented and reviewed quarterly.

Through quarterly review, CCGG will monitor and report on whether clinical leaders are being provided with adequate time to fulfil their statutory responsibilities. Any shortfalls or pressures will be escalated to CCGC along with recommended mitigating actions.

A refreshed status update on all actions arising from the 2024 & 2025 self-assessment will be completed and presented at CCGG, with a focus on closing gaps relating specifically to duties on clinical advice and leadership time.

Ref	Description	Risk Rating	Major
	Risk Agreed	**Person(s)**	**Due Date**
	Yes	Chair of CCGG	30 September 2026

Ref	Description	Risk Rating	Moderate
1.4	**Reporting and Escalation of Risks** – The Act requires that there is a procedure in place for reporting and escalation of risks. The ACHSCP has established a Board Assurance and Escalation Framework (BAEF), outlining how the IJB secures assurance, or escalates concerns, over its activities. It includes reference to various sources of information and assurance for the Board, including clinical care and governance arrangements internally and within delivery partners. However, the Workforce Plan, the specific escalation of staffing risks, and review of compliance with the Act are not specifically referenced.

A Risk Appetite Statement (RAS) is in place, defining the level of risk the IJB is willing to accept under specific circumstances. The BAEF and RAS are reviewed annually by RAPC and the IJB maintains oversight over the RAS.

The Board Assurance and Escalation Framework outlines how the IJB maintains two risk registers and specifies responsibility for each. The Strategic Risk Register provides a top-down view of organisational risks, while the Operational Risk Register captures risks from the bottom up.

Strategic Risk Register (SRR)

The SRR serves to provide the IJB with assurance that the organisation can deliver its strategic objectives and goals. It identifies key risks or issues that may impact delivery and outlines how these are being actively managed.

The SRR is reviewed by SLT with updates formally submitted to RAPC twice a year. Additionally, the IJB conducts an annual review. There is documented evidence of ongoing discussions of and changes to risk ratings at Board level.

Each risk entry includes:

• A detailed description to justify the assigned risk rating
• Existing controls, assurances and mitigating actions
• Current performance indicators and any identified gaps in assurance

The SRR also explicitly incorporates and reflects the RAS: each risk includes a 'Rationale for Risk Appetite' section. For example, a risk relating to financial failure and projected overspend notes that the IJB has a low-moderate appetite for financial loss, recognising the need to maintain a balanced budget. However, at the same time it acknowledges a lower appetite for risks that may result in harm to individuals given its statutory responsibilities.

Operational Risk Register (ORR)

The Chief Officer is the designated owner of the ORR, and it is reviewed annually by the CCG Committee. The CCG Group meets every two months to identify any new risks, supported by fortnightly Clinical and Care Risk Meetings. If a risk cannot be effectively managed within the team or shows no improvement it is escalated to the CCG Group for consideration and potential inclusion within the ORR. Risks identified within service level risk registers are escalated to the ORR based on their severity typically risks rated as High or Very High; and reported to the Committee.

Each entry in the ORR includes Risk ID; Risk Title; Risk Level; Last Reviewed Date; Risk Handler; Risk Owner. Risks do not include a formal scheduled review date: this is not |

Ref	Description	Risk Rating	Moderate
	recorded or reported by the system; responsibility for reviewing risks lies with the Risk Handler and Risk Owner, who follow a review schedule based on the risk rating[1]. Recorded review dates indicate this is largely being followed. Although Datix (the NHSG Risk Management System) should contain information on existing controls and mitigating actions that are in place, the ORR presented to the CCG Group and Committee does not provide this level of detail. Neither the Group nor the Committee are being consistently provided with data that demonstrates quantification of the impact of risks and issues, assurance over mitigating actions, or reference to acceptance of risks that are within the HSCP's risk appetite. This contrasts with the covering reports that state the ORR is being reported to provide this assurance, and with the approach taken to strategic level risks which explicitly reference the RAS. Therefore, at the point decisions are being made on escalation or tolerance of risks by the CCG Committee, there may be insufficient available data to determine whether and to what extent risks are tolerable, mitigated, or require urgent action. There is a risk that at the operational level, scarce resources may be used to address risks that are not a strategic priority. Risks to safe, effective and efficient staffing are referenced regularly in reports provided by the CCG Group to the CCG Committee, however there is variation in how this information is communicated, and these risks are not routinely collated to demonstrate that due consideration has been given as required under the Act. The likelihood, scale and impact of reported risks and issues relating to staffing is not being quantified in these reports either at an individual service level or overall[2]. The reports also reference instances where operational management, at an individual service level, has elected to prioritise one risk over another. For example, staff or service-user wellbeing being prioritised over financial sustainability, and vice versa, through the override or application of recruitment controls. The extent that this is being done, and how it impacts on the risk profile and alignment with the risk appetite, is not being quantified. Whilst the Act supports and prioritises the application of clinical advice in determining appropriate staffing levels, this could result in pressure on available resources. In FY2024/25 the ACHSCP reported a substantial overspend of £17.036m, requiring use of all remaining reserves and additional partner contributions to resolve. Actions to achieve a more sustainable financial balance, including extensive savings plans, are ongoing. Staffing risks are increasing as Partners move to apply reductions in the working week, which has an impact on staff availability. Although operational risks in respect of staffing are moderated by the CCG Group, as noted above there, may be insufficient substantive data to support them to do so effectively. Due to the variations in how the information is communicated, and given the level of autonomy at service level, there is a risk that perceived pressures in one part of the system may be escalated due to how they are communicated, rather than on their specific and comparable merits. This could have an adverse impact on the ability of the HSCP to deliver sustainably on its other commitments. While there is evidence of a risk management process, informed by operational risk data, and with opportunities for staffing-related risks to be escalated where required, improvements are required to demonstrate that this is working effectively in compliance with the Act and suitably weighed against other risks, across the board and in accordance with ACHSCP's agreed risk appetite.		
	IA Recommended Mitigating Actions		

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[1] Risk rating review frequencies: Very High – Monthly; High - Every 3 months; Medium - Every 6 months; Low - Annually or upon significant change.
[2] There is an indication in meeting minutes that risks arising from the reduced working week are being collated with a view to quantifying the impact on service delivery. The output from this review had not been reported within the period of audit fieldwork.

Ref	Description	Risk Rating	Moderate

The HSCP should review its risk and assurance framework to explicitly incorporate how the IJB secures assurance over workforce risks.

Review of operational risks should clearly reference consideration of the risk appetite, rationale, gaps and mitigations, and the impact on other risk areas, in respect of each risk. Where possible, the impact of risks and issues should be quantified to aid in prioritising a response.

Risks to safe, effective and efficient staffing should be logged / coded in such a way that they can be periodically collated for review of compliance with the Act and its Guiding Principles.

Management Actions to Address Issues/Risks

Management will strengthen alignment between operational risks and the IJB's Risk Appetite Statement (RAS). A mandatory section will be added to the CCGG summary report template requiring services to describe how each staffing related risk aligns with, exceeds, or challenges the IJB's agreed risk appetite. This will ensure that the CCGG, CCGC, and RAPC receive consistent and explicit assurance on whether risks are being tolerated appropriately or require escalation.

Management will enhance the presentation of operational staffing risks to include impact, mitigations, and quantification where possible. The ORR reporting format will be expanded to include: a summary of existing controls and their effectiveness; clear commentary on mitigating actions underway, quantified impact where feasible (e.g., vacancy trends, training compliance levels, service impact indicators). Themes, trends, and any cumulative risks will be shared with CCGC and RAPC to support assurance over compliance with the Act's guiding principles.

While the BAEF is intentionally high level, we will review it to ensure clearer references to workforce-related risks as significant contributors to organisational risk. Where appropriate, minor amendments will be proposed to strengthen alignment between operational staffing risks, strategic workforce risks, and the Act's requirements.

Risk Agreed	Person(s)	Due Date
Yes	Business and Resilience Manager	31 March 2026

Ref	Description	Risk Rating	Moderate
1.5	**Monitoring and Reporting** – The Health & Care Staffing Act 2019 requires an Annual Report to be published each year to demonstrate how relevant organisations have complied with the duties under the Act. There are separate reporting requirements for health services and care services. The Service stated that NHS Grampian reports to the Scottish Government directly on health duties in respect of all three HSCP areas within the Grampian area. A copy of this report was not available for review during fieldwork, and it is not clear that the IJB is being provided with assurance this is being produced and acted on. There are specific duties on local authorities and integration authorities when planning or commissioning care services from third party providers. An annual report confirming compliance with these duties was published on 30 June 2025 and is available on the ACHSCP website.		

Whilst the report stated that procurement procedures and documentation had been revised to ensure alignment with the Act, it included limited information in response to the request to disclose any ongoing risk that may impact the HSCP's ability to comply with the Act. The only risks noted were the absence of a Lead Commissioner and continued pressures within Social Care Services, and these were not expected to affect compliance. The final report

Ref	Description	Risk Rating	Moderate

omitted reference to several significant pressures identified during drafting, and flagged within risk registers, including constrained funding due to current budget challenges, recruitment and retention difficulties, increasing service user needs and the associated requirement for enhanced staff training. Without comprehensive, accurate and honest[3], reporting from ACHSCP, the ability to identify and address systemic issues both locally and across Scotland is potentially compromised.

No supporting documentation was required to be prepared or appended to the annual report, therefore this provided management assurance only. A detailed self-assessment of compliance with the Act was last conducted by ACHSCP in September 2024, assigning a RAYG status to each of the ten duties. The results were as follows:

- Red - 2 duties (20%)
- Amber - 5 duties (50%)
- Yellow - 3 duties (30%)
- Green - 0 duties (0%)

Supporting documentation was to be appended to the report but was not provided to Internal Audit for review. It has therefore not been possible to provide assurance over the accuracy of the self-assessment.

A high-level action plan was developed to address areas of partial or non-compliance, with proposed achievement dates ranging from 31 October 2024 to April 2025. However, no evidence has been provided to confirm whether progress has been made or targets met. If actions have not been progressed, or further assurance obtained, compliance with the Act will be at risk.

IA Recommended Mitigating Actions

The HSCP should enhance transparency and completeness of annual reporting under the Health and Care Staffing Act 2019 by ensuring all relevant risks, whether currently impacting compliance or with the potential to do so, are clearly identified and documented.

The HSCP should refresh the Self-Assessment, ensuring it is supported by appropriate evidence and mapping of the existence and application of controls and compliance with the Act and its Guiding Principles. Where gaps or areas for improvement remain, progress with addressing these should be monitored regularly at a corporate level through to completion.

Management Actions to Address Issues/Risks

Annual Self-Assessment of the HCS Act will continue with documentation of the controls in place, identification of gaps in compliance, supporting analysis for all staff groups within scope. This evidence pack will be reviewed and endorsed through the Clinical and Care Governance Group (CCGG) prior to consideration by the Clinical and Care Governance Committee (CCGC).

Regular monitoring of actions arising from the self-assessment through the CCGG showing progress, deadlines and residual risks and reported quarterly to CCGC until all gaps are closed or controls are fully evidenced.

The revised CCGG summary template will require services to explicitly identify any risks or areas of non-compliance with the Act. These will be clearly signposted for CCGC, enabling escalation to NHS Grampian Clinical Governance Committee where appropriate.

The Terms of Reference for CCGG and CCGC will be reviewed to ensure that assurance over the Act's duties is clearly and consistently captured as part of their remit.

Risk Agreed	Person(s)	Due Date
Yes	Chair of CCGG	31 December 2026

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[3] In line with the HSCP's 2025-2029 Strategic Plan Values: Transparency, Honesty, Empathy, Respect, Equity.

4 Appendix 1 – Assurance Terms and Rating Scales

4.1 Overall report level and net risk rating definitions

The following levels and ratings will be used to assess the risk in this report:

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

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

Individual Issue / Risk Rating	Definitions
Minor	Although the element of internal control is satisfactory there is scope for improvement. Addressing this issue is considered desirable and should result in enhanced control or better value for money.
Moderate	An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on the audited area's adequacy and effectiveness.
Major	The absence of, or failure to comply with, an appropriate internal control, which could result in, for example, a material financial loss.
Severe	This is an issue / risk that could significantly affect the achievement of one or many of the Partnership's objectives or could impact the effectiveness or efficiency of the Partnership's activities or processes. Action is considered imperative to ensure that the Partnership is not exposed to severe risks.

5 Appendix 2 – Assurance Scope and Terms of Reference

5.1 Area subject to review

The Aberdeen City Health and Social Care Partnership (ACHSCP) formally came into existence on 6 February 2016 with approval of its Integration Scheme by Scottish ministers. The partner organisations of the ACHSP are Aberdeen City Council and NHS Grampian.

The purpose of the partnership is to deliver positive and improved outcomes for the residents of Aberdeen so that people live healthier, longer lives, are supported to be independent and have choice and control no matter who they are or where they live. These outcomes are delivered by working closely together with independent, commissioned and third sector colleagues.

The partnership's Strategic Plan for 2025-29 acknowledges that its implementation will be the most challenging to date, due to increasing demand for health and social care services. However, the resources available to meet this demand are not growing at the same pace. In response, the plan outlines a commitment to transform service delivery, with a focus on safeguarding essential frontline services.

The provisions of the Health & Care Staffing Act 2019 came into force on 1 April 2024. The Act establishes guiding principles designed to ensure safe, high-quality services and positive outcomes for service users and will assist in strengthening workforce planning for safe staffing. It sets out several duties, including:

- Ensuring appropriate staffing levels
- Maintaining a real time staffing assessment and risk escalation process
- Addressing severe and recurring risks
- Seeking clinical advice on staffing matters and ensuring adequate time for clinical leaders
- Applying the common staffing method (for specific staff groups such as nurses, midwives and medical practitioners)
- Supporting staff to share their views on staffing
- Providing staff with training, time and resources to meet their responsibilities

Data on health and care services plays a vital role in driving improvements. Under the Act organisations must report and publish information demonstrating how they have met the statutory requirements. This also requires quarterly and annual reporting, including reporting on the use of agency workers. In addition, Scottish Ministers must present these reports to Parliament, explain the actions being taken in response, and take reasonable steps to ensure that enough healthcare professionals are available.

5.2 Rationale for review

The objective of this audit is to consider whether appropriate control is being exercised in respect of compliance with statutory guidance on safe staffing levels. The review will assess the actions taken to ensure the ACHSCP is making appropriate progress towards compliance with the Health & Care Staffing Act 2019.

The purpose of the Act is to establish a statutory basis for ensuring appropriate staffing across health and social care services. Its aim is to support safe and high-quality care and improve outcomes for service users. The Act builds on existing policies and procedures while requiring staff are kept informed about staffing decisions and have clear channels to raise concerns.

Given that the Act strengthens workforce planning duties, the review will also consider the Workforce Plan.

Failure to meet the Act's requirements could present significant risks, including inaccurate workforce forecasting leading to overstaffing or understaffing, delayed identification and mitigation of risks and ultimately non-compliance with statutory requirements.

This area has not previously undergone a dedicated audit.

5.3   Scope and risk level of review

This review will offer the following judgements:

- An overall **net risk** rating at the **Corporate** level.
- Individual **net risk** ratings for findings.

5.3.1   Detailed scope areas

As a risk-based review this scope is not limited by the specific areas of activity listed below. Where related and other issues / risks are identified in the undertaking of this review these will be reported, as considered appropriate by IA, within the resulting report.

The specific areas to be covered by this review are:

- Strategic Alignment and Governance
- Workforce Data and Modelling
- Risk Management and Assurance
- Workforce Strategy implementation
- Monitoring and Reporting

5.4   Methodology

This review will be undertaken through interviews with key staff involved in the process(es) under review and analysis and review of supporting data, documentation, and paperwork. To support our work, we will review relevant legislation, codes of practice, policies, procedures, guidance.

This review will also encompass an evaluation of the governance, risk management and controls in place to achieve Best Value and to detect, prevent, and mitigate instances of fraud.

Due to hybrid working practices, this review will primarily be undertaken remotely via electronic meetings and direct access to systems and data, with face to face contact and site visits to premises to obtain and review further records as appropriate.

5.5   IA outputs

The IA outputs from this review will be:

- A risk-based report with the results of the review, to be shared with the following:
    - Partnership Key Contacts (see 1.7 below)
    - Audit Committee (final only)
    - External Audit (final only)

5.6   IA staff

The IA staff assigned to this review are:

- Sarah Poppe, Auditor **(audit lead)**
- Colin Harvey, Audit Team Manager
- Jamie Dale, Chief Internal Auditor **(oversight only)**

5.7   Partnership key contacts

The key contacts for this review across the Partnership are:

- Fiona Mitchellhill, Chief Officer – Aberdeen Health and Social Care Partnership
- Sandy Thain, Lead – People and Organisation **(process owner)**
- Alison Macleod, Strategy and Transformation Lead
- Martin Allan, Business Manager

5.8   Delivery plan and milestones

The key delivery plan and milestones are:

Milestone	Planned date
Scope issued	24-Sep-2025
Scope agreed	01-Oct-2025
Fieldwork commences	02-Oct-2025
Fieldwork completed	06-Nov-2025
Draft report issued	27-Nov-2025
Process owner response	18-Dec-2025
Director response	24-Dec-2025
Final report issued	12-Jan-2026

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Aberdeen City Health & Social Care Partnership
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RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	24 February 2026
Report Title	Internal Audit Annual Plan 2026-29
Report Number	HSCP.26.012
Lead Officer	Jamie Dale Chief Internal Auditor
Report Author Details	Jamie Dale Chief Internal Auditor Jamie.Dale@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Exempt	No
Appendices	Appendix A – Aberdeen City IJB – Internal Audit Plan 2026-29
Terms of Reference	2. Review and approve the annual audit plans (internal and external) on behalf of the IJB, receiving reports, overseeing and reviewing actions taken on audit recommendations and escalating to the IJB as appropriate.

1.   Purpose of the Report

1.1.   The purpose of this report is to seek approval of the Internal Audit Plan for the Aberdeen City Integration Joint Board for 2026-29.

2.   Recommendations

2.1.   It is recommended that the Committee review, discuss, comment on, and thereafter approve the Internal Audit Plan for 2026-29 as attached at Appendix A.

3.   Strategic Plan Context

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NHS Grampian   **ABERDEEN CITY COUNCIL**

RISK, AUDIT AND PERFORMANCE COMMITTEE

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

4.   Summary of Key Information

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

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

5.   Implications for IJB

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

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

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

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

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

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

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

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

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

6. Management of Risk

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

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

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

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Internal Audit

Aberdeen City Integration Joint Board Internal Audit Plan 2026-29

Contents

1 Executive Summary

1.1   Introduction and background

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

The purpose of this report is to seek approval of the attached Internal Audit plan for 2026-2029.

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

2 Internal Audit Plan

2.1 Plan development

Internal Audit operates with a rolling three-year Plan, designed to provide a clearer view of priorities and the broader audit universe. This approach offers flexibility in scheduling work and adapting to changes in risk, priorities, and resources, while maintaining transparency over planned activity. The Plan is reviewed annually to ensure it remains aligned with the organisation's evolving risk environment and strategic objectives, with updates made as required.

In formation of the plan, Internal Audit:

- **Reviewed historic audit outputs** – The initial planning stage involved a review of completed work from across the previous years. This looked to gauge the assurance that had been obtained recently and develop a baseline that could be built upon with the current plan. Where it is hoped that the greatest coverage can be obtained in a single year, this is not always possible, so instead it will be ensured that there has been coverage over a number of years, both previously and forward looking.
- **Reviewed the agreed Plan for 2025-28** – In addition to the review of previous assurance work, the agreed plans for 2026/27 and 2027/28, agreed as part of the 2025-2028 plan overall, were reviewed. This is the starting position for the current plan; however this will change based on developments in year and the changing risk profile of the Board.
- **Reviewed Management's progress in implementing agreed audit recommendations** – A review of the work of Management to implement audit recommendations . This looked to identify any areas where management has struggled to implement agreed actions, and where the risks remain, for these to be factored into the audit plan.
- **Reviewed different sources of information** – A suite of information, primarily Committee reporting and the Board's Risk Register, was reviewed to further develop Internal Audit's understanding of the operations and issues of the Board.
- **Reviewed information from other assurance providers** – Discussions were held and reports reviewed from other assurance providers.
- **Held discussion with key stakeholders** – Discussions were held with key stakeholders across the Board. These discussions focused on three key areas:
  - Key risks within the auditable area.
  - Any recent or upcoming developments.
  - Suggestions for assurance reviews, including value adding pieces of work.
- **Utilised Artificial Intelligence** – For the first time, Artificial Intelligence (Microsoft CoPilot) was utilised in the development of the Plan. Where Microsoft CoPilot is employed where relevant as part of business as usual, in developing the Plan, the System was utilised for analytical support and to

provide suggestions for considerations of audits based on the Board's current operations.

- **Benchmarked against other IJBs** – A review of the Internal Audit plans for other IJBs as per their Committee reporting available online. This looked to gain an understanding of issues being faced by other IJBs and identify any auditable areas for Aberdeen City.

The Internal Audit plan for the period April 2026 to March 2029 is presented in Appendix 1 to this report, including the relevant Adult Social Care Service audits within the Aberdeen City Internal Audit Plan 2026-29; this is where Aberdeen City Council is the lead provider of the service.

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

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

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

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

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

2.2   Undertaking planned work

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

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

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

3 Appendix 1 – 2026-29 Internal Audit Plan

The below table sets out the Internal Audit Plan for 2026-29. The Plan should be read with the following considerations:

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

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

Function	Auditable Area	Objective	Principal Risk	Assurance
2026/27				
Integration Joint Board	IJB Governance	To evaluate the adequacy and effectiveness of governance arrangements within the Integration Joint Board, ensuring compliance with statutory requirements and clarity of roles, responsibilities, and decision-making processes	Strategic	Core
Integration Joint Board	Alcohol and Drugs Partnership	To review the ADP's governance and working arrangements to ensure they are effective and fit for purpose.	Operational	Wider
2027/28				
Integration Joint Board	Civil Contingencies	To provide assurance that the IJB's civil contingency arrangements are appropriate to meet relevant statutory duties.	Strategic	Core
2028/29				
Integration Joint Board	IJB Performance Management	To provide assurance that the IJB's performance controls are aligned to its Strategic Plan, Medium Term Financial Framework and national outcomes.	Strategic	Core

Function	Auditable Area	Objective	Principal Risk	Assurance
2026/27				
Health & Social Care Partnership	Child Care to Adult Care Transition[1]	To review the adequacy of procedures for transitioning individuals from child care to adult care services, ensuring continuity and compliance with statutory requirements.	Operational	Wider
Health & Social Care Partnership	Self-Directed Support Payments	To obtain assurance over the processes in place for administering self-directed support payments.	Operational	Core
2027/28				
Health & Social Care Partnership	HSCP Out of Authority Placements	To assess whether governance, approval, and monitoring arrangements for out-of-authority placements ensure compliance with policy, cost-effectiveness, and safeguarding of service users.	Financial	Core
Health & Social Care Partnership	Day Care Establishments	To consider whether adequate control is exercised over income, expenditure, and payroll across Day Care Establishments.	Operational	Core
2028/29				
Health & Social Care Partnership	Out of Hours Social Work	To ensure that out-of-hours social work arrangements are robust, responsive, and supported by appropriate governance and risk management processes.	Operational	Core
Health & Social Care Partnership	HSCP Commissioning	To evaluate whether Health and Social Care Partnership commissioning arrangements are robust, transparent, and aligned with strategic objectives, ensuring value for money and quality of services delivered.	Operational	Core

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[1] This review will also engage with the relevant functions within the Families & Communities Directorate of Aberdeen City Council.

Aberdeen City Health & Social Care Partnership
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RISK AUDIT PERFORMANCE COMMITTEE

Date of Meeting	24 February 2026
Report Title	Quarter 3 Delivery Plan Update
Report Number	HSCP.26.009
Lead Officer	Alison MacLeod
Report Author Details	Calum Leask Transformation Programme Manager CLeask@aberdeencity.gov.uk
Consultation Checklist Completed	*Yes*
Exempt	No
Appendices	a. *Delivery Plan Summary* b. *Delivery Plan Workplan*
Terms of Reference	5. Receive and scrutinise performance reports and receive assurance that actions in respect of emerging trends are proportionate to the IJB's Risk Appetite Statement.

1. Purpose of the Report

1.1. This report seeks to provide assurance to the Risk, Audit and Performance Committee (RAPC) and relates to the progress of the Delivery Plan as set out within the Aberdeen City Health and Social Care Partnership (ACHSCP) Strategy Plan 2025-2029.

2. Recommendations

2.1. It is recommended that the Risk, Audit and Performance Committee:
   a) Notes and considers the Delivery Plan Quarter 3 Workplan and Summary as appended to this report.
   b) Are satisfied that risks to the Delivery Plan are being monitored and feels assured with the mitigations highlighted with the appendices to the report

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3. Strategic Plan Context

3.1. The ACHSCP's Strategic Plan for 2025-2029 was approved by the Integration Joint Board on 1st July 2025. The Strategic Plan's Reporting Framework outlines our requirement to provide assurance to RAPC on a quarterly basis that progress is being made and this report ensures that this element of governance is achieved in a robust manner.

4. Summary of Key Information

4.1. This report represents the Quarter 3 update to the Risk, Audit and Performance Committee based upon the Year 1 Delivery Plan as approved by the Risk, Audit and Performance Committee in August 2025.

4.2. At the Committee meeting on 17th June 2025, RAPC endorsed the proposed approach to performance monitoring for the Year 1 Delivery Plan, recognising this would adapt over time to ensure it was fit for purpose. Appendix A provides a visual overview of progress by priority area. This was developed using PowerBI (a Microsoft digital platform for data visualisation), allowing for progress to be reviewed at a glance. Information is provided regarding the status of projects; mitigations implemented should projects be at risk; and any measurable progress documented during the reporting period.

4.3. At the previous Committee, the newly established criteria for BRAG status guidance was presented. Given the increasingly challenging context in which the ACHSCP operates, it was felt that the BRAG status criteria was required to be more sensitive in order to adequately account for nuances associated with delivery, for example programmes of work whereby different deliverables may be progressing at varying degrees. Further, the thresholds for projects reporting an overall status of 'at risk' or 'missed deadline' have been lowered. This was deemed to be more appropriate in recognition that all projects carry an inherent level of risk that requires active management; for example having limited staffing capacity and the need to balance delivering budget savings with transformative and preventative activity. Given this stricter criteria, projects reporting an 'at risk' position is likely to appear more frequently when compared to previous delivery plans the Committee has received.

4.4. The Delivery Plan Workplan is a spreadsheet used by our programme and project teams to provide updates to the Senior Leadership Team (SLT). This contains the full output of all Delivery Plan entries and is visible in Appendix B. It should be noted that the status of a particular project may have progressed since the update in the report was given and therefore should be deemed to be historically accurate.

4.5. For this reporting period, there are five projects that are marked as closed / complete for the following reasons:

Title	Description	Strategic Aim	Priority	Rationale for Closure / Completion
5.Technology and TEC usage	Increase the use of technology and Technology Enabled Care across the system	Modernising Service Delivery	Best use of Resources	Has been closed and split into three projects: 5a (Digital Innovation Programme); 5b (TEC); 5c (eMAR)
7.Older People Care Provision	Modernise care provision for Older People	Modernising Service Delivery	Best use of Resources	All Option 2 reviews for services completed.
20.Counselling Services	Codesign alliancing work with Counselling Services	Modernising Service Delivery	Transforming Service Delivery	Project moved to business as usual
23.Initial Point of Contact	Develop an Initial Point of Contact Model (pre assessment offer) for Adult Social Care	Modernising Service Delivery	Transforming Service Delivery	Now reported under 5a (Digital Innovation Programme)
26.Healthy Weight	Publish an agreed multi-agency Healthy Weight Action	Prevention & Early Intervention	Improve Health	Multi-agency action plan successfully developed

	Plan for Aberdeen City by December 2025			

5. Implications for IJB

5.1. Equalities, Fairer Scotland and Health Inequality

There are no direct implications arising from this report.

5.2. Financial

Budget saving activities within the Delivery Plan are supporting the ACHSCP to achieve a sustainable financial position.

5.3. Workforce

The Delivery Plan contains projects aiming to deliver efficiencies from the robust management of vacancies, therefore reducing the overall number of posts within the ACHSCP establishment.

5.4. Legal

There are no direct implications arising from this report.

5.5. Unpaid Carers

There are no direct implications arising from this report.

5.6. Information Governance

There are no direct implications arising from this report.

5.7. Environmental Impacts

There are no direct implications arising from this report.

5.8. Sustainability

There are no direct implications arising from this report.

5.9.   Other

None.

6. Management of Risk

6.1.   Identified risks(s)

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

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

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

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

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

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

5

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

The report and its appendices help to mitigate the risk by providing assurance that progress against the Strategic Plan 2025-2029 and the associated Delivery Plan is being achieved and, that this has been monitored by the Senior Leadership Team on a monthly basis who consider and direct remedial action and unblock barriers where relevant. It further provides assurance that these arrangements shall continue into the new strategic planning cycle.

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Delivery Plan Workplan Y1 Q3

Title	Project Description	Strategic Aim	Priority	Project Ref.	Start Date	End Date	BRAG Status	If BRAG Status is RED, AMBER or BLUE wh. Explain why BRAG Status is RED/AMBER/BLUE	RED/AMBER Mitigation Actions	Measures	Latest Update
1. Use of Properties	Consolidate our use of properties	Modernising Service Delivery	Best use of Resources	MSD01	01/07/2025	31/03/2026	Green			Reduction in Premises Costs by £153,000	The target savings of £153k for this financial year have already been achieved through moving CTAC and Imms from South College Street into Countesswells and the Health Village. CTAC also moved out of Carden House to give the GP Practice more clinical space allowing them to see more patients. The Woodside building has also been reviewed and these together with utility savings across ACHSCP have ensured we met our target. Work is ongoing to identify savings and efficiencies for the next two financial years which will be reported in due course.Following approval from SLT, in November 2025, to go ahead with proposed moves within the Health Village. These moves are now being planned and will be completed prior to the end of the financial year, to achieve better utilisation of the HV building.
2. Utility Savings	Deliver savings in Utility costs	Modernising Service Delivery	Best use of Resources	MSD02	01/07/2025	31/10/2025	Green			Reduction in Utility Spend by £50,000	Actual utility costs are only known retrospectively , but heating in hubco buildings has been reduced and "switched off" most of the time until end September at leastOn track to save £100 k (target was £50k) on heat/ electricity costs. Zonal heating is now functioning in Health village
3. Management of Vacancies	Deliver efficiencies from robust management of vacancies	Modernising Service Delivery	Best use of Resources	MSD03	01/07/2025	31/03/2026	Green			Reduction in Staff Costs by £1,346,000	The Vacancy Management protocol has been reviewed and has been approved by Budget Savings Oversight Group and communicated to staff. The main changes relate to services adding information on: (a) specifying how long posts have been vacant for; (b) reducing Banding/Grades as part of skills mix and; (c) providing evidence of specific financial codes and sustainability of budget for any redesigned posts. Finance officers in NHS Grampian and Aberdeen City Council have confirmed that the overall saving in 25/26 has been met
4. ACHSCP Posts	Reduce the number of posts in ACHSCP establishment	Modernising Service Delivery	Best use of Resources	MSD04	01/07/2025	31/03/2026	Green			Reduction in Staff Costs by £884,000	Recent evidence via NHS that ACHSCP reduced headcount by 4% wte (65 headcount) from June '24 to June '25. a similar date is set from October '24 - October '25 indicated reduced headcount of 2.1% wte. 13 posts have been lost through VRES in ACC 5 Senior Leadership Team posts have become vacant since 01/04/2025 and one has been filled.
5. Technology and TEC usage	Increase the use of technology and Technology Enabled Care across the system	Modernising Service Delivery	Best use of Resources	MSD05	01/07/2025	31/03/2026	Blue	Closed Complete		No. of care packages including TEC	The Technology and TEC updates have been separated into project 5a. Digital Innovation Programme, 5b. Technology and TEC Usage, 5c. eMAR to assist in updates and review. SRO has agreed this project should be closed as each aspect of project is being reported under the different projects as detailed above.
5a. Digital Innovation Programme	**Digital Innovation Programme Overview** This Programme aims to transform social care delivery through digital solutions that improve service user experience, streamline practitioner workflows, and create capacity within the workforce. The initiative aligns with Scottish Government objectives for proactive, person-centred care. **Project Goals** Enable digitally capturing observations and notes in real-time, providing the social worker with a quick way to enter data.Reduce manual data entry for practitioners to free up time for direct care.Streamline casework by intelligently surfacing the relevant documentation from multiple sources, including self-service for a user. **Core Components** The the first phase consists of delivery four main use cases identified in Discovery sessions **Practitioner Application** A mobile-friendly app enabling practitioners to record observations and notes digitally—via text or voice—integrated with Dynamics 365 for seamless case management. **Practitioner Search** An AI-powered Co-pilot tool that helps practitioners quickly find relevant documents and case information to populate assessment templates efficiently. **SPOC (Single Point of Contact)** A conversational interface that guides professionals to the correct service pathway, simplifying referrals and reducing manual searches. **IPOC (Initial Point of Contact)** A citizen-facing e-form for self-referral into multiple services, supported by eligibility checks and case routing for complex scenarios.	Modernising Service Delivery	Best use of Resources	MSD05a	02/10/2025	30/06/2026	Green	Timescales		Work stream of the project has been initiated called Business Benefits Realization. This workstream will identify the current bench marks and the success measure of the project . Hopefully by next update we will have a list of success measures here.	Current Phase Inception Phase: Closed in late December 2025 after Technical Design Board approval of Agile Solution Roadmap. Construction Phase: Started 05 January 2026, operating under two-week sprints. Sprint 1 focuses on Practitioner App and Practitioner Search build and FAT (Functional Acceptance Testing) scripting. Governance Governance structures remain as previously defined: Project Board chaired by SRO Chief Adult Social Work Officer, ACHSCP Senior Project Manager. Key governance documents signed off: Programme Charter, Terms of Reference, Communication & Engagement Plan, Project Plan. Risks RIS-005 – Construction Timeline Risk Description: Potential delay in completing Construction Phase due to resource constraints (ACC Infrastructure), integration complexity (E-Forms for IPOC (Initial Point of Contact) on Contact Centre tenant), and also pending legal guidance on transcript retention. Impact: Could delay Practitioner App and Practitioner Search delivery, affecting downstream phases. Mitigation: A new timeline has been proposed by IT Supplier . Detailed sprint planning, early engagement with ACC Infrastructure, escalation to Project Board, parallel workstreams for legal and technical tasks. Device Suitability Risk Description: Current devices may not be suitable for new applications. Investigation underway alongside planned device refresh this year. Impact: Could affect rollout and user adoption if hardware cannot support app performance. Mitigation: Technical assessment in progress; potentially align device refresh schedule with deployment timeline. Next Steps Continue Sprint 1 build and FAT scripting. Technical Check-in on bi weekly basis with ACC infrastructure and engineering Ratify high-level New Construction timeline agreement at next Project Board on 22 January 2026. Prepare input for Social Work Service Managers meeting on 21 January 2026. Agenda for Social Work Service Managers Meeting (21 Jan 2026) Focus: Communication of Digital work impacting services over next 6–12 months. Topics include: New charging policy (this workstream runs parallel and may affect resource) . Updates on work with IT Supplier (Practitioner App, Practitioner Search) and implications for teams. Ask for Resources for Testing training and rollout detailed role description
5b. TEC	Increasing the use of Technology Enabled Care	Modernising Service Delivery	Best use of Resources	MSD05b	01/04/2025	31/03/2026	Amber	Deliverables; Resources	Ongoing work required to clarify clear objectives and outcomes for TEC work following conclusion of current work.	Scoping work will be undertaken to clarify specific project work moving forward that is outcome focused and evidence-based.	Raise awareness of TEC Undertake evaluation of the Stoneywood TEC system Complete the Konpanion Maah project and end of project report.	Stoneywood Just Checking: System is installed ready for supported people who are now moving in. Evaluation has commenced with baseline information gathered for all supported people. Next evaluation point is at 3 months following move in to tenancy. Konpanion Maah project: Devices were distributed to participants during last week November and first week in December and trial commenced although technical issues with devices and issues with connectivity reduced the amount of data collected. Trial ended on 19th December. Participant Information Sheets have been distributed and all consent forms returned. Konpanion will provide report of data collected and participants / families will be interviewed in January for evaluation.
5c. eMAR	Implement eMAR at the four in-house Learning Disability services, Rowan Road, Kaim Court, Stocket Parade and Balnagask Court	Modernising Service Delivery	Best use of Resources	MSD05c	09/09/2025	31/03/2026	Green				eMAR is implemented at all four sites.	Rowan Road service completed staff training and went live on the 24th November with no significant issues reported. Super-user training was scheduled for delivery on 8th January but has been re-scheduled to 15th January due to weather disruption. Digital & Technology are progressing set up and testing of devices. The Data Protection Impact Assessment (DPIA) completed and awaiting sign off. Pharmacy coordination continued, with arrangements confirmed for all services. Evaluation has commenced for all services with baseline data collection underway. **Key risks and issues:**Single Sign On (SSO) will be implemented for increased security although this entails a more complex set up and is dependent on vendor support. Continuing to ensure this is progressed.Pharmacy changeovers require close monitoring to avoid medication continuity risks. **Next actions:**Complete SSO and device setup.DPIA sign off.Super user training delivered on 15th January.Stocket Parade go-live on 19th JanuaryKaim Court and Balnagask Court go-live on 26th January The project remains on track for implementation across all in-house Learning Disability services.
6. Social Care Charging	Implementing the new Charging Policy	Modernising Service Delivery	Best use of Resources	MSD06	01/07/2025	31/03/2026	Red	Timescales; Resources	Upon further discussions it was felt that the previous AMBER status had not sufficiently helped to raise awareness of the complex issues around this delivery against a short timeline, so it was uprated to RED.	We are continuing to flag capacity issues and optimising capacity planning and once we can establish firmer delivery expectations based on that, an SBAR will go to SLT to request an extension for the delivery of this programme.	Policy developed and approved, systems and communications in place	The Programme Board has launched with its first meeting just prior to the festive break. The meeting further underlined the urgency of finding resolutions to the previously flagged issues around capacity and the delivery timeline. We are currently exploring options for delivering part of the IT requirements, which may help reduce capacity issues around IT. Recruitment issues around Finance are actively seeking resolution. The new governance model is now in place and each project group is developing PIDs and the move to SharePoint for key programme and project documentation is under way. The Programme Board will meet again on 27th Jan.
7. Older People Care Provision	Modernise care provision for Older People	Modernising Service Delivery	Best use of Resources	MSD07	01/07/2025	31/03/2026	Blue	Closed Complete		Reduction in Spend by £3,328,000	All option 2 reviews for OP/ PD services completed, reviews will continue on a BAU basis going forward
8. Residential Care Review	Review mix of residential care	Modernising Service Delivery	Best use of Resources	MSD08	01/07/2025	31/03/2026	Green			Reduction in spend by £336,000	Business Cases are being completed with the contracts team and should be completed by end of December 2025
9. Develop data dashboards	Develop data dashboards to support the planning and delivery of services	Modernising Service Delivery	Best use of Resources	MSD09	01/07/2025	31/03/2026	Green			Dashboards in place and reports informing work focus	Delivery Plan Dashboard Dashboard is live for Delivery Plan updates and was considered at Risk Audit Performance Committee for the first time in November 2025, receiving positive feedback with regard to its visual nature. PMB Dashboard Dashboard is in development. The Performance and Governance Dashboards have been presented to the Board with feedback reviewed and incorporated and sign-off received. The Strategic Dashboard has been developed and is due to be presented to the Board in January. If approved, the dashboards will thereafter transition to a maintenance phase. Activity Dashboard Dashboard has been developed and is now in regular use by the Senior Leadership Team. Reports are circulated alongside context to help understand some of the trend analysis that the data shows. This will be refined on an ongoing basis as required moving forward. Primary Care Dashboard A Primary Care Dashboard is currently under development. This will represent all Primary Care services and demonstrate operational activity. The development has been split into two phases, with the first phase underway with technical assistance from the NHSG Health Intelligence team.
10. Modernise Care Models	Modernise care delivery models for vulnerable adults including people with Learning Disabilities and Complex Needs.	Modernising Service Delivery	Best use of Resources	MSD10	01/08/2025	31/03/2026	Amber	Timescales; Deliverables; Budget/Savings	This is one of a number of priorities aligned to LD which need to be planned for. There is a a lack of both planning capacity and operational capacity to fully progress, and other projects underway will need to complete to release capacity. The Stoneywood Project for complex residential care has been top priority for the teams and this workstream.	Work continues to review care packages regularly and make adjustments when needed; providers are reviewed on a regular basis to ensure compliance and if there are issues of overprovision this is addressed. The Dynamic Support Register to log all current and at risk complex and out of area packages is now fully established; Stoneywood site has now opened and is fully functioning, and has accommodated 5 individuals with complex needs; all these people were longstanding Out of Area cases, alongside 3 other residents. Over last six months we have had to prioritise Stoneywood which will also provide key procedures, practices and learning to inform and facilitate further modernisation of all our care delivery models.	Increase in % of clients with LD and Complex Needs living independently; Reduction in Out of Area placements	Limited update available given team capacity issues and periods of leave. There has been notable progress in the numbers of out of area placements due to the opening of Stoneywood, with 5 people returning from Out of Area and another 3 people also supported who would be noted within our local Dynamic Support Register. Further care management led work is continuing on review and assessment of individuals as well as role of commissioning review work.
11. Improving Transitions	Implement transitions process to improve service user experience and future financial planning	Modernising Service Delivery	Best use of Resources	MSD11	01/07/2025	31/03/2026	Amber	Resources	Capacity within the relevant Health teams meetings have not allowed for meetings / mapping exercises to take place as yet.	Both Adult Health and CAMHS have set up internal groups to review the Transitions Pathway, clarify team roles for the Staff Guide, and identify service gaps, especially for 16–17 year olds not yet assessed, with a mapping exercise planned to address these gaps.	Process implemented, client feedback, budget performance	The reporting cycle for the Transitions Pathway report to the Education & Children's Services Committee and Clinical & Care Governance Committee concluded on the 16th December. There remains concern regarding the funding of services which will continue to be discussed between Children's and Adult services.The Transitions Pathway Integrated Impact Assessment has been signed off by the Equalities & Diversity team, approved by the Chief Officer and is now live on the ACC website.Further meetings with CAMHS consultants on 28/01 will focus on the revised Transitions Pathway and Health's integration with the new approach.Focus has now shifted to developing the Parent / Carer Guide. The refresh of the process is finalised and in place.
12. Learning Disability Day Care	Review Day Care Provision for people with Learning Disabilities	Modernising Service Delivery	Best use of Resources	MSD12	01/07/2025		Amber	Timescales; Resources	The milestones and dates have slipped over the last month because of other team workload priorities.	Slippage due to limited care management Team resources and need to focus on statutory duties and other work especially around cost control and containment.	Reduction in spend by £1,449,000	Limited update available due to team capacity and periods of leave. Care management led work continues on review and re-assessment of placements in order to align to already progressed budget changes (savings taken from top-line budget)

Ref	Description	Theme	Outcome	Code	Start	End	RAG	Risk	Issue	Mitigation	Measure	Update
13. Out of Area Placements	Review use and cost of Out of Area care	Modernising Service Delivery	Best use of Resources	MSD13	06/10/2025	31/03/2026	Amber	Timescales; Resources	The milestones and dates have slipped over the last month because of other team workload priorities.	For all our LD Out of Area 'social care provision' placements we continue to ensure :- 1) Requirements for care management review & provider engagement are met. 2) The Dynamic Support Register (SGovt requirement) is fully maintained on monthly basis. 3) Potential new placements are fully reviewed by MHLD Resource Allocation Panel. For Out of Area all specialist health needs placements, we continue to ensure 1) Placement register is maintained and reviewed quarterly. 2) Potential new placements are fully reviewed clinically and processed via formal approval processes	Reduction in spend by £174,000	Our specialist health out of area placements register has now been fully updated and there will now be ongoing review on a quarterly basis on a cross Grampian basis. Work has commenced on reviewing and updating the Standard Operating Procedure for clinical and management oversight. Immediate concerns relate to an overgoing OOA placement under significant investigation, which will impact the sustainability of placement for 4 individuals across Grampian, including for ACHSCP.The Dynamic Support Register is updated and reports regularly to Scottish Government. Most significant progress is aligned to the opening of Stoneywood, accommodating 8 individuals who are logged on the DSR, the majority of whom are from out of area placements. This is reducing our use of out of area social care placements.
14. Commissioned Service Provider Spending Reduction	Reduce spend and achieve value for money with key commissioned service provider	Modernising Service Delivery	Best use of Resources	MSD14	01/07/2025	31/03/2026	Amber	Timescales	Timeline and governance has yet to be defined for the project. At the moment this is overseen by the Budget Saving Oversight Group. Work is being progressed through the Scenario Planning Group and the Contract SLWG.	Continue to work with partners in the scenario planning group to ensure governance is determined and the timelines created and adhered to.	Reduction in budget by £4,599,000	Programme Board established, fortnightly meetings taking place, with action tracker implemented. Mapping of Mental Health Portfolio completed. Ongoing review of this portfolio currently focusing on residential provisions. Contracts approaching imminent expiry have been reviewed to allow decisions to be made on those contracts. Benchmark and scoring matrix for contracts has been created and out for feedback for approval. Work ongoing with regards to review of care home provision. Short Life Working Group established to review training skills and development framework, fortnightly meetings initiated. Ongoing work regarding possible reprovisioning of some of the Learning Disabilities residential resources.
15. Workforce Plan Refresh	Refresh Workforce Plan focusing on future staffing requirements taking service transformation into account	Modernising Service Delivery	Best use of Resources	MSD15	01/07/2025	31/03/2026	Green				Refreshed Workforce Plan developed and implemented	Final progress report for the current Workforce Plan 2022-2025 was approved at RAPC on 27 August 2025. First engagement session round took place October/November. The final refreshed plan is due at IJB in May 2026. ACHSCP Conference booked for Wednesday 28th January, where the Workforce Plan will feature as an engagement session.
16. GP Vision	Deliver city commitments in the GP Vision	Modernising Service Delivery	Transforming Service Delivery	MSD16	01/07/2025	31/03/2029	Amber	Resources	No dedicated capacity allocated to this programme of work, there is currently only resource to deliver on 6 of the 10 objectives.	A workshop was recently held to determine if there were any additional resources available or whether resource could be re-allocated to alternative workstreams, however it was determined to continue with the current resourced workstreams. There are currently no further mitigations identified.	Commitments delivered	A transition report is being drafted to outline the transition of the GP vision programme to business as usual which will be delivered via a new Primary Care Board. A workshop was recently held to determine the Terms of Reference for the new Primary care board. it is anticipated this will be in place by the end of the financial year.
17. Primary Care Improvement Plan (PCIP) Review	Implement and review Primary Care Improvement Plan (PCIP) to identify, successful efficient delivery of services and areas of improvement	Modernising Service Delivery	Transforming Service Delivery	MSD17	01/03/2025	31/03/2026	Amber	Resources	Lack of interface with certain PCIP workstreams and difficulty in accessing practice system data.	Amber : Completion within this year 25/26. Challenges in terms of data required across 3 HSCP's. Very little data available through primary care channels and this has caused the delay in completion.	Refreshed PCIP approved	The PCIP Review is included in the GP Visioning Programme and is currently being delivered across NHS Grampian in terms of revising the delivery of the plan within the 3 HSCP's. A project sub group has been set up to review the PCIP's across Grampian and the work continues to progress with a SLWG meeting every 2 weeks and a wider project group meeting monthly. Work has progressed well in terms of the activity data for 5/6 to workstreams and the exception being the Vaccination Transformation Programme. In terms of sharing good practice a system already in place in the Moray HSCP has been replicated and implemented this month (September) for the pharmacotherapy workstream for Shire and City HSCP's. The data has not been previously available and will give feedback on the 3 levels of pharmacotherapy data. Gap analysis has been carried out as the practice feedback is a that not all work is being undertaken by PCIP. Financial calculations are included in terms of the costs for workforce and a dashboard has been created for 23/24 and 24/25. Work has commence in terms of quality aspects of the project and an example is the analysis of sickness absence across the workstreams. This has also been calculated in terms of the financial cost of the gap created by staff sickness and also maternity leave as there is currently no budget for resilience plans that would support practices. DNA rate and fill rates are included for workstream with appointment systems. The final piece of the puzzle is patients engagement and staff questionnaires - PCIP and Practice staff - work has commenced and networking opportunities in terms of the PCPIP demonstrator sites looking at the patients engagement and process. The work is supported by LIST and is on track to be completed within this year, 25/26.Update : 06/01/26 VTP : Data received and also service delivery information to enable a draft report for the workstream. LIST completing the analysis of the data and creating the report. Pharmacotherapy : October and November data now completed and awaiting December. Workstream report being completed by LIST. Review meeting 06/01/26 and HSCP leads keen to continue for 12 months so enable a robust review of trends and service delivery. Next meeting will be end of April 26 to review 2 quarters of data. Patient evaluation : Completed 14 December 25 and LIST analysing the information Staff feedback : Completed 14 December 25 and LIST analysing Draft overarching report in the process and created by LIST SLWG still meeting every 2 weeks and also a monthly meeting for the wider PCIP Review group. Continued support from LIST
18. Discharge without Delay	Deliver the Discharge Without Delay Collaborative commitments	Modernising Service Delivery	Transforming Service Delivery	MSD18	01/07/2025	31/03/2026	Amber	Timescales	All projects within this programme are progressing but delivery on time is dependant on successful timely recruitment.	Recruitment for the community hospitals is progressing and changes are being actioned as staff enter posts. PDD / Integrated Discharge Hub again is progressing with recruitment, confidence remains high the hub will be up and running by the end of March 26. D2A in city is operational and Shire is progressing with recruitment, a start date is expected in January. F@FD was unsuccessful in consultant recruitment but work is taken place to add stability to F@FD by consultants with existing resource.	Reduction in Bank Nursing spend by £999,000, delivery of DWD measures	Frailty @ The Front Door (F@FD)Aberdeen City - Recruitment of Consultant Geriatrician to enable the embedding of the frailty Consultants at the front door was unsuccessful. Work is taking place to shuffle staff to ensure stability of this service. Weekend cover by consultants has been actioned to support the front door through the winter months. Additional recruitment to support the flow through frailty is progressing. Clinical Frailty Scoring (CFS) education continues. Discharge to Assess Aberdeen City - D2A service continues, with the initial 500 hours being fully utilised, scale up to the increased hours (1000hrs) is being progressed as soon as possible. Patients are moving through the service successfully with some even being stepped down without any further care, further focus is required on the back end of the service to ensure effective flow.
19. Support to Amputees	Redesign model of support to Amputees to community based provision	Modernising Service Delivery	Transforming Service Delivery	MSD19	01/07/2025	31/03/2026	Amber	Timescales	Amber - work remains ongoing to understand need of amputees and what model is most appropriate going forward. An arrangement with Clashie may be a more appropriate placement. Paper being written with findings to inform next steps.	Paper expected in next week or so to inform next steps. Will take to SLT for further planning.	Closure of 6 beds, Length of Stay and Delayed Discharge Data	Requirements and information have been gathered. The next step is for the team to pull the information together within a paper to inform the next steps.
20. Counselling Services	Codesign alliancing work with Counselling Services	Modernising Service Delivery	Transforming Service Delivery	MSD20	01/07/2025	31/03/2026	Blue	Closed Complete			Reduction in average waiting times; increase in inter-provider collaboration; and reduction in duplication of services and waiting lists	ACVO have been contacted to arrange a time to continue discussions around the alliance working with counselling services following the December IJB decision to stop grant funding. Alliance work will progress and project has moved to BAU
21. Residential Substance Use Service	Implement redesign of residential substance use service with a view to delivering a community based support service model	Modernising Service Delivery	Transforming Service Delivery	MSD21	01/07/2025	31/03/2026	Amber	Timescales	Update required from Cyrenians on lived experience feedback and project meetings to be reinstated.	Further discussions with Service Manager to explore available future options and set up project governance within project times, and clear timelines agreed.	Redesign implemented	No further update. We continue to work with cyrenians to meet the reduction for 26/27
22. Sheltered Housing Redesign	In conjunction with ACC colleagues, influence the redesign of Sheltered Housing to modernise the model of Housing support .	Modernising Service Delivery	Transforming Service Delivery	MSD22	01/07/2025	31/03/2026	Red	Resources; Deliverables; Overall Assurance/Risk Level	Project 1 facing delays in gaining approval due to resource pressures, and other Housing activities being prioritised. Also now being delayed for decision to be made around wider housing model	In order to mitigate delays ensure that project team carries out tasks set out in time for the tenants consultation meetings, as there is a small degree of buffer set within existing deadlines.	Numbers of tenants receiving low, medium and high support	Project on hold whilst discussions held around wider housing model.
23. Initial Point of Contact	Develop an Initial Point of Contact Model (pre assessment offer) for Adult Social Care	Modernising Service Delivery	Transforming Service Delivery	MSD23	01/07/2025	31/03/2026	Blue	Closed Complete			IPOC model in place, demand statistics for assessment and care, budget management	As per the Digital Innovation Programme update, Inception phase for the project is due to complete early December. EForms element for IPOC is part of another area of work that The IT Provider are working on with ACC so this is a key dependency of this project going forward. Overall this project now comes under the digital innovation programme and will be reported on there5a. Digital Innovation Programme Project Management Officer agreed with SRO that due to this project coming under Digital Innovation, the project should be closed as all reporting is done under Digital Innovation Programme.
24. Cancer Screening Invitations	Increase the number of people who accept the invitation of cancer screening on the basis of informed consent.	Prevention & Early Intervention	Improve Health	PAEI01	01/04/2024	31/03/2026	Green				Cancer Screening Uptake Stats	The team has co-developed communication materials with local communities, focusing on accessibility and cultural relevance for those in SIMD 1 and 2 and ethnic minority groups. Activities have included focus groups and the creation of tailored resources such as postcards, posters, and video brochures. These materials have been iteratively improved based on community feedback and disseminated through social media campaigns and community venues, with a particular emphasis on reaching groups who face the greatest barriers to screening. A key element of the project has been the expansion of the Community Champions model, recruiting and training local volunteers to share screening information and support behaviour change within their networks. Champions have received training on screening, vaccination, mental health, and health system navigation, with evaluations showing increased knowledge and confidence. The project has also delivered Health Issues in the Community (HIiC) courses and piloted new approaches to build trust in the healthcare system, including mapping key contacts to inform tailored training for professionals and volunteers. With the LOIP project coming to an end, these activities will be embedded into Business as Usual processes so they remain part of our ongoing work.
25. Immunisations Uptake	Improve uptake of immunisations to at least the NHS Scotland average level by March 2027	Prevention & Early Intervention	Improve Health	PAEI02	01/07/2025	31/03/2027	Green				Immunisation Uptake level	The winter programme is progressing at a good pace with uptake levels in line with or slightly above the Scottish average. Health & social care workers have seen a slight increase in uptake compared to the same period last year. The Team have implemented a successful pilot of a roving vaccinator who is currently undertaking clinics in ARI and Woodend and similar clinics will be run at Royal Cornhill Hospital. All staff can drop into the Aberdeen Vaccination & Wellbeing Hub for their Winter Flu vaccinations and there is an increased level of social media and information posted on the daily staffing brief.
26. Healthy Weight	Publish an agreed multi-agency Healthy Weight Action Plan for Aberdeen City by December 2025	Prevention & Early Intervention	Improve Health	PAEI03	01/07/2025	31/12/2025	Blue				Plan published following approval by relevant agencies.	Following the three HWA workshops from February 2025 to September 2025, gate checking of high quality evidence and wider audience survey consultation we have been successful in collaboratively developing a multi-agency Healthy Weight Aberdeen Action Plan Year 1 2026-2027. The plan highlights several actions under core themes below: 1. Promote and Support Physical Activity in Children and Young People 2. Promote and Support Physical Activity and Active Travel by Strengthening Local Policies 3. Use Strategic Planning to Improve Aberdeen's Food Environments and Strengthen Local Policies 4. StrengthenPublic Messaging and Marketing of High Fat, Sugar, Salt Food and Drink 5. Strengthen Public Food Procurement and Provision Standards and Workwith Out Of Home Sector 6. Improve Children and Young People Healthy Weight through School Meal Programmes and Breastfeeding Support 7. Improve Affordability and Availability of healthier food by Enhancing Food Knowledge and Cooking Skills. We have engaged with Aberdeen City Council Strategic Place Planning team, School Catering Team and Sport Aberdeen to draft practicalities and implementation of actions relevant to their thematic areas. One of the key actions on-Improving affordability and availability of healthier food may start its implementationfrom Jan/Feb 2026 through Grow Well Choices programme by Sport Aberdeen Next steps will be working with the multi-disciplinary Systems Network Group in taking forward other actions from the HWA action plan

	Action	Theme	Type	Code	Start	End	RAG		Risk	Challenges	Support	Measure Plan	Measure	Update
27. Public Mental Health	Publish an agreed multi-agency Public Mental Health action plan for Aberdeen City by March 26	Prevention & Early Intervention	Improve Health	PAEI04	01/07/2025	31/03/2026	Amber		Resources	The Health Improvement Team continues to operate with low staffing levels, with external support from colleagues in NHS Grampian necessary to progress this work.	Ongoing discussions being held regarding moving towards a more sustainable model staffing across preventative activities.	Plan published following approval by relevant agencies.		The project team is currently prioritising action themes and developing the Population Mental Health Action Plan, with a target launch in April 2026. Recent work has been around aligning with existing strategies, involving stakeholders in the prioritisation process, and ensuring robust mechanisms for monitoring and maintaining alignment across initiatives. Mapping action themes to current system activities is a key focus, helping to identify both areas of momentum and gaps—particularly in domains such as women's mental health. The team is coordinating the distribution of a prioritisation form to gather broad feedback, integrating locality planning input, and preparing supporting materials to maximise engagement. This work will then focus on smaller working groups to further develop the actions themes. There will be a strong emphasis on ensuring that initiatives are realistic, sustainable, and supported by the necessary financial planning.
28. Ageing Well	Publish an agreed multi-agency Ageing Well action plan for Aberdeen City by April 2026	Prevention & Early Intervention	Improve Health	PAEI05	01/07/2025	30/04/2026	Amber		Timescales; Deliverables; Budget/Savings; Resources	Amber rating as project is currently meeting its milestones, however challenges are very likely to emerge relating to key staff and partner availability to support the programme over the winter period, particularly as only has one member of the Strategy and Transformation Team is working on the programme. Plans are also in place for headcount reduction within the Public Health Team to achieve financial savings in the new financial year. This will likely put additional pressure on delivery of the programme.	Support from ACHSCP Prevention Lead Key documents in place such as Programme Plan and Risk Register Support and oversight of Prevention SRO, Active Ageing Aberdeen Working Group, and Public Health Oversight and Support Group Support from Communities Team to hold Active Ageing Workshop in February i.e. with registrations, room set up, group facilitators etc	Plan published following approval by relevant agencies.		The Active Ageing Aberdeen programme commenced in June 2025 and has completed phase 1 of its programme cycle (programme set up). Programme governance has been put in place, which includes development of key documents such as a programme initiation document, programme plan, and risk register. A multi-agency Active Ageing Working Group has been set up and meets every two months. The programme has now completed phase 2 (Building the Local Picture) and phase 3 (Mapping the Local System) of the programme plan. The Active Ageing Working Group at its most recent meeting on 4 December agreed to hold an action planning workshop with key partners and stakeholder identified during the mapping exercise and planning has begin to deliver this event in February 2026. This purpose of this workshop will be to secure buy-in from the wider system on delivery of the Active Ageing programme and to generate ideas on system changes to be included in the Active Ageing action plan.The programme remains on track to develop an Active Ageing action plan by 30 April 2026 which will be based on the four themes to improve active ageing from the World Health Organisation of: Autonomy; Independence; Quality of Life; and Life Expectancy. Thereafter the intention is to launch the plan during the Grampian Wellbeing Festival in May.
29. Smoking in Pregnancy	Decrease the number of women who are smoking during pregnancy in the 40% most deprived SIMD	Prevention & Early Intervention	Reduce Harm	PAEI06	01/07/2025	30/09/2025	Green					Reduction in smoking prevalence at booking, number of pregnant women who set a quit date		The new Tobacco Dependency in Pregnancy (TDiP) pathway, launched on 18 March 2025, is delivering strong results across NHS Grampian. Since implementation, 315 out of 449 identified pregnant women have been contacted, nearly tripling engagement compared to the previous year. Referrals to Healthpoint have surged from 30.9% under the old pathway to 125.1% under the new system, as referrals now occur later in pregnancy. Quit support outcomes are also stronger: 52.3% of women who engaged with Healthpoint set a quit date, compared to 51.3% previously, and 43.1% of women chose to quit smoking independently, with Healthpoint offered if needed. The service has already met its NHS Chief Executive targets for quit dates and 4-week quits for 2025/26, with 68.9% of quit dates coming from women in SIMD 1 & 2 areas, supporting health inequality priorities. Over half of clients (54.3%) requested additional wellbeing support, including oral health, mental wellbeing, financial advice, and infant feeding. Feedback highlights the value of integrated wellbeing conversations, while ongoing engagement with midwives and Healthpoint advisors will help further strengthen delivery and confidence in the pathway.
30. Young People Vaping	Reduce the number of 13-18-year-olds in regular use of Vaping products	Prevention & Early Intervention	Reduce Harm	PAEI07	01/05/2024	30/04/2026	Green					No. 13-18 year olds regularly Vaping		The project to reduce regular vaping among 13–18 year olds continues to progress, with new educational resources developed now been piloted in schools. Teachers have reported increased confidence in addressing vaping. Teaching materials are available on SharePoint to support wider delivery. Recent School Health and Wellbeing survey data shows a 46.3% decrease in the number of 13–18 year olds who regularly vape, a 13% reduction in the priority neighbourhood ASG, and a 31.3% overall decrease in those who have ever tried smoking or e-cigarettes in the last academic year.
31. Drugs and Alcohol Harms	Reduce harm caused by the use of drugs and alcohol	Prevention & Early Intervention	Reduce Harm	PAEI08	01/07/2025	31/03/2029	Amber		Deliverables; Resources; Overall Assurance/Risk Level	Aberdeen, along with other areas in Scotland, have had an increase in drug deaths in 2025 linked to synthetic opioids contaminating the illicit drug supply. This has increased pressure on services. Specialist drug and alcohol services are GOPES4. ADP/CPA system changes are ambitious but capacity to support transformation is limited	Maintaining service capacity / stability	Reduction in deaths related to drugs and alcohol by 10%		A number of initiatives are progressing, albeit slowly. Work on scenario and emergency planning is progressing. Need to get more partners proactively engaged - actions have been agreed by ADP / COG in terms of response leads. Work ongoing to refresh LOIP. Awaiting new SG plans for 26/27.Medication Assisted Treatment Standards (MAT Standard) Reporting prepared for national benchmarking - Minister has written to local CE and COs requiring quarterly update and reporting. Local review findings supporting that comorbid health factors are significant contributor to drug deaths particularly respiratory health. Initial stats suggest drug deaths in Aberdeen, as well as other parts of Scotland, have risen significantly
32. Suicide and Self Harm Prevention	Deliver & implement Action plans for Suicide & Self Harm Prevention Strategies	Prevention & Early Intervention	Reduce Harm	PAEI09	01/07/2025	31/03/2029	Green					5 Year Rolling Average No. of Suicides		Based on the National Strategy for Suicide Prevention 'Creating hope together' and how it aligns with Aberdeen City. The three year action plan has come to an end and we are awaiting the new three year action plan 2026-2029. SAMH are the service provider for Suicide Prevention work which started in April 2025 - March 2026. There are 5 priorities across Aberdeen City. These are: Building Community Capacity, Children and Young People, Lived/Living experience, Bereavement and Data analysis and risk. A local action plan has been developed for 2025/2026. This feeds into the Aberdeen/Moray Suicide Prevention Leadership Group (AMSPLG). Aberdeen City Delivery Group (multi-agency) is established to focus on local issues, aims and implement the local action plan. We link into the Aberdeen City Local Outcome Improvement Plan where the project aim is "Reduce the 5 year rolling average number of suicides in Aberdeen by at least 5% by 2026". Quarterly reports/updates are submitted. The current aim will close March 2026. Aberdeen City are piloting a multi-agency database system for death review called QES which, started on 01/10/24. Processes have been developed alongside Public Health Scotland and ongoing monitoring of this is underway.

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Quarter 3 Delivery Plan Update

Risk Audit and Performance Committee

Summary of Progress

DELIVERY PLAN DASHBOARD

Aberdeen City
Health & Social Care
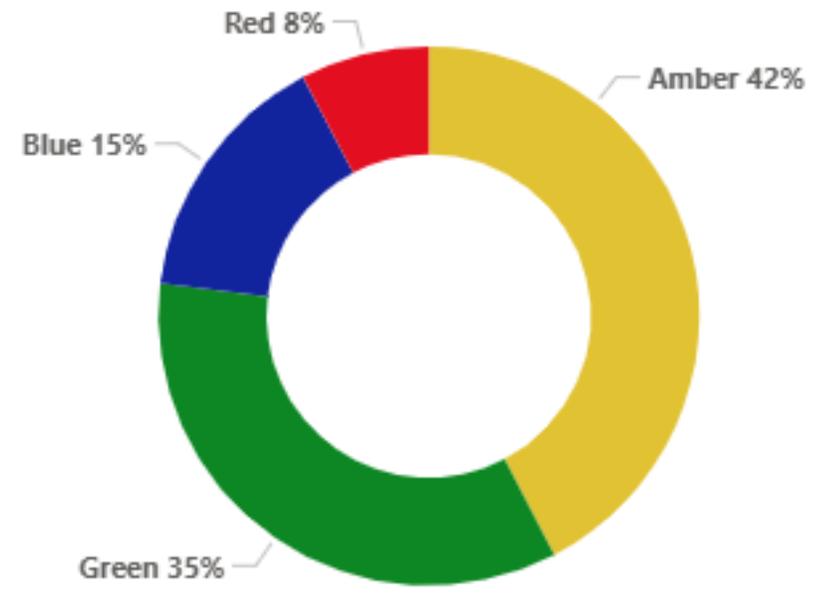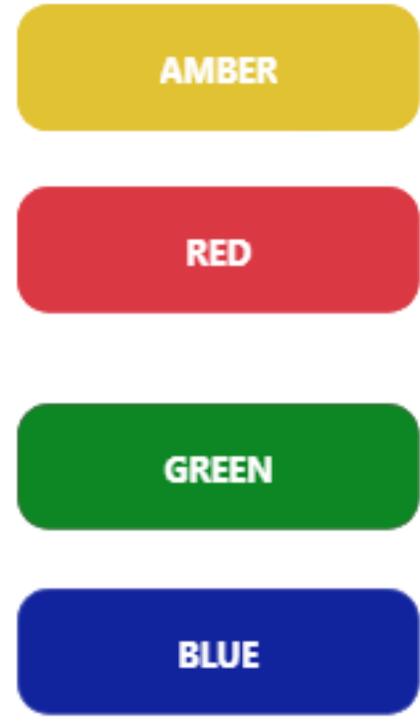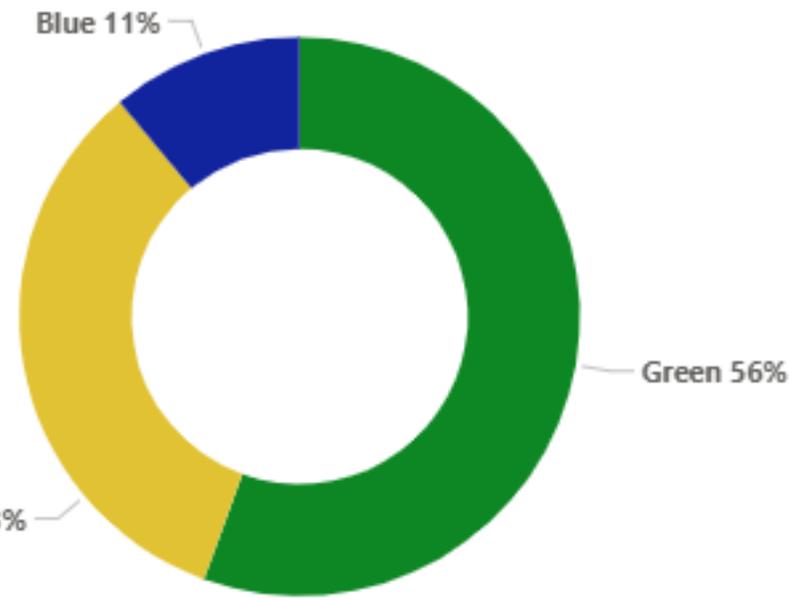Partnership
A caring partnership

PREVENTION & EARLY INTERVENTION

9

TOTAL PROJECTS

35

MODERNISING SERVICE DELIVERY

26

Blue 11%
Green 56%
Amber 33%

AMBER
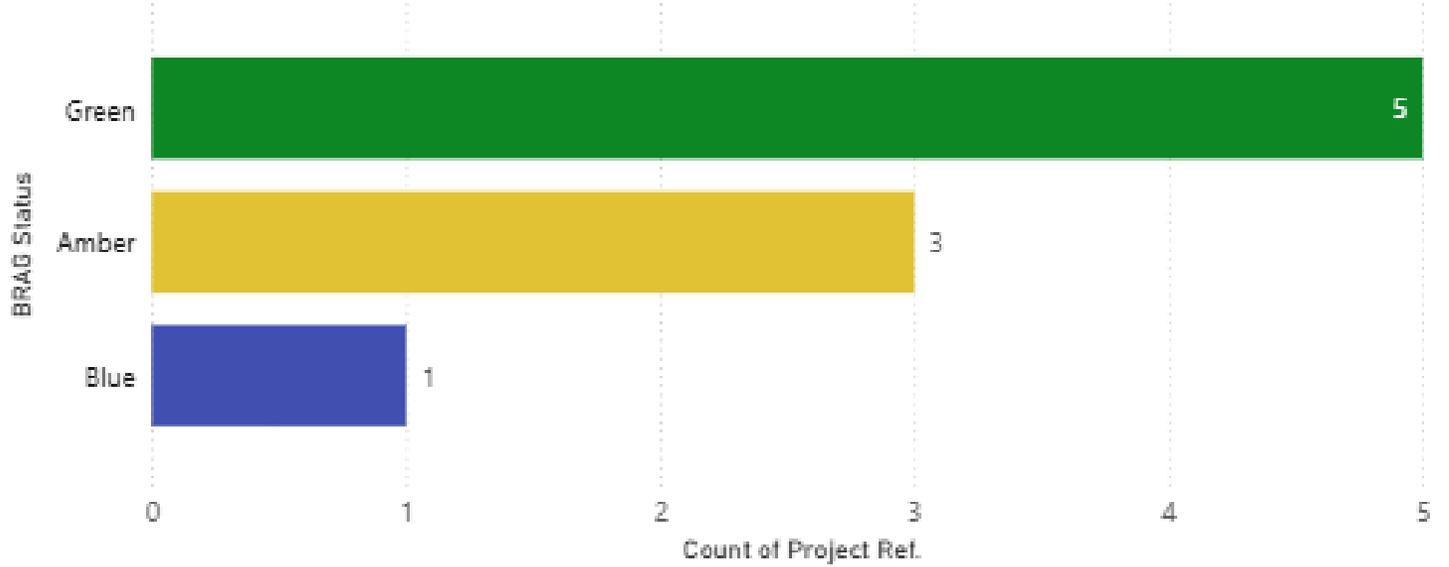RED
GREEN
BLUE
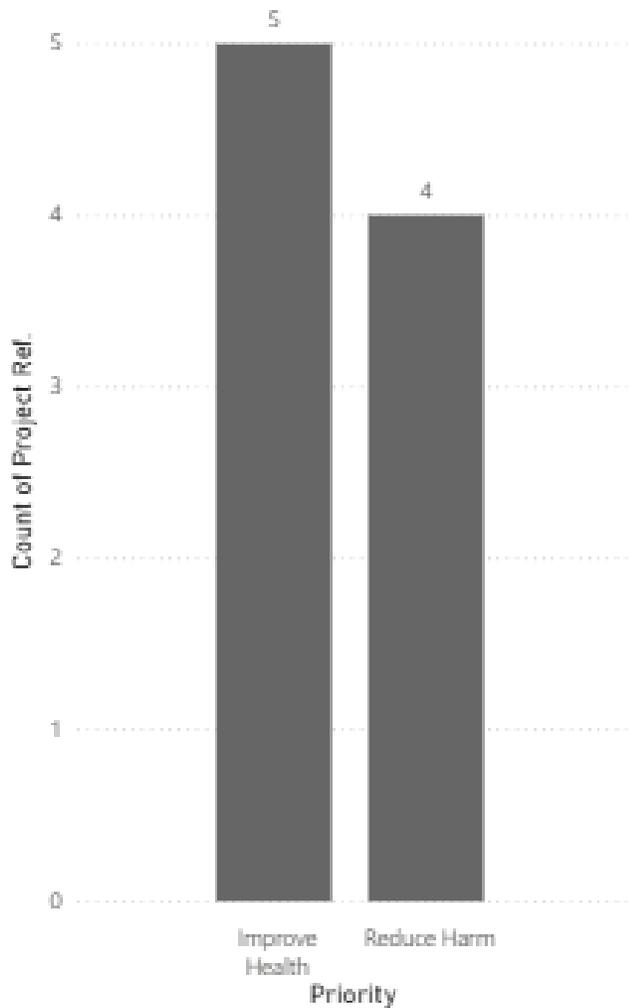
Red 8%
Amber 42%
Blue 15%
Green 35%

PREVENTION & EARLY INTERVENTION

Projects by Priority

Project by Reasons

Prevention & Early Intervention
Risks and Mitigations

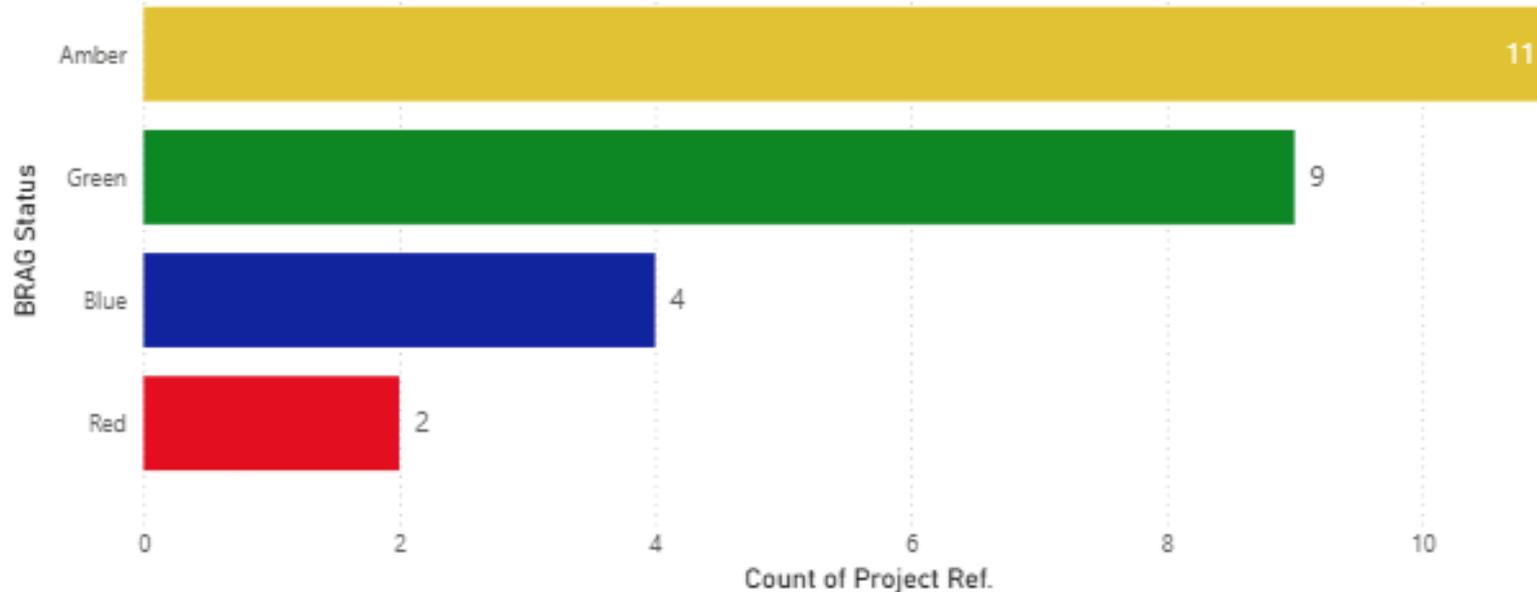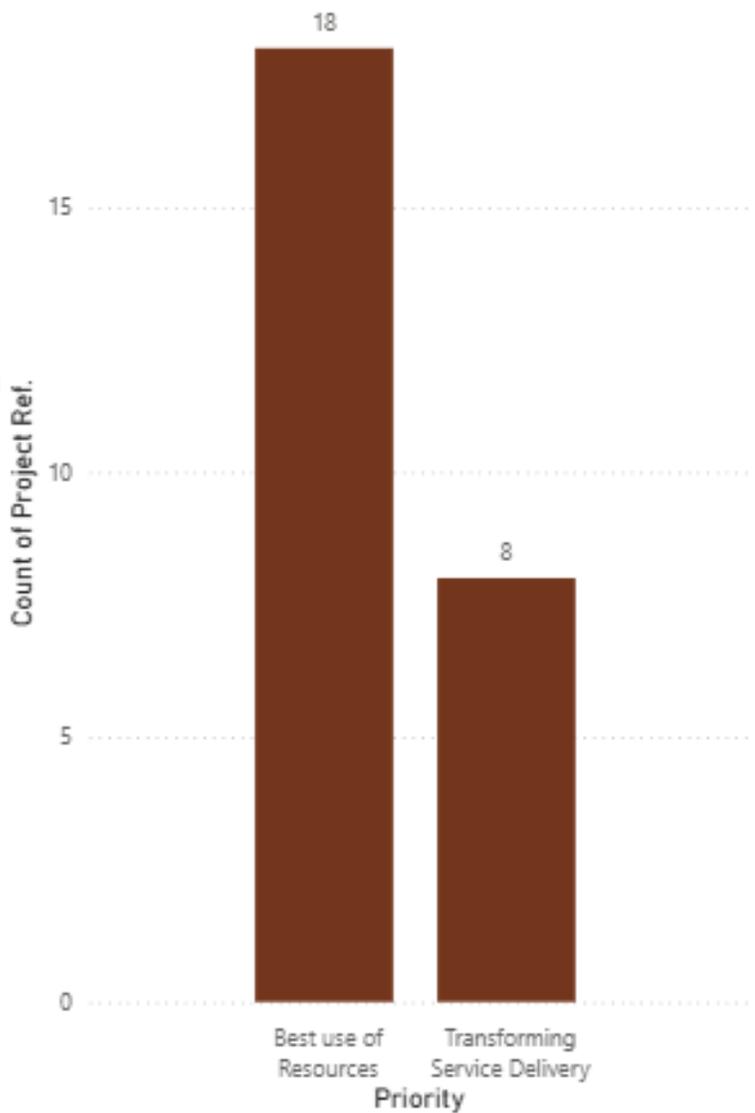| Title	Project Description	BRAG Status	Explanation	Mitigating actions
27. Public Mental Health	Publish an agreed multi-agency Public Mental Health action plan for Aberdeen City by March 26		The Health Improvement Team continues to operate with low staffing levels, with external support from colleagues in NHS Grampian necessary to progress this work.	Ongoing discussions being held regarding moving towards a more sustainable model staffing across preventative activities.
28. Ageing Well	Publish an agreed multi-agency Ageing Well action plan for Aberdeen City by April 2026		Amber rating as project is currently meeting its milestones, however challenges are very likely to emerge relating to key staff and partner availability to support the programme over the winter period, particularly as only has one member of the Strategy and Transformation Team is working on the programme. Plans are also in place for headcount reduction within the Public Health Team to achieve financial savings in the new financial year. This will likely put additional pressure on delivery of the programme.	Support from ACHSCP Prevention Lead Programme Plan Communication and Engagement Plan Risk Register Support and oversight of Prevention SRO, Active Ageing Aberdeen Working Group, and Public Health Oversight and Support Group
31. Drugs and Alcohol Harms	Reduce harm caused by the use of drugs and alcohol		Aberdeen, along with other areas in Scotland, have had an increase in drug deaths in 2025 linked to synthetic opioids contaminating the illicit drug supply. This has increased pressure on services. Specialist drug and alcohol services are GOPES4. ADP/CPA system changes are ambitious but capacity to support transformation is limited	Maintaining service capacity / stability

Prevention & Early Intervention
Summary of Measurable Progress

Priority	Title	Key Progress
Improve Health	**26. Healthy Weight**	Multi-agency action plan successfully developed
Improve Health	**27. Public Mental Health**	**Two** workshops held in November, Workshop 1 had **72 attendees** and Workshop 2 had **49 attendees**. Evaluation feedback showed average scores for clearly communicating the objectives was **4.88/5** and the format of the workshop leading to meaningful collaborative conversations was **5/5**.
Improve Health	**28. Ageing Well**	**Four** key themes agreed for programme structure: autonomy; independence; quality of life; and life expectancy.
Reduce Harm	**29. Smoking in Pregnancy**	Engagement in new Tobacco Dependency in Pregnancy pathway has nearly **tripled** compared to previous year with **315 out of 449** identified pregnant women contacted.
Reduce Harm	**30. Young People Vaping**	Recent School Health and Wellbeing survey data shows a **46.3% decrease** in the number of 13–18 year olds who regularly vape

MODERNISING SERVICE DELIVERY

Projects by Priority

Priority	Count of Project Ref.
Best use of Resources	18
Transforming Service Delivery	8

BRAG Status — Count of Project Ref.

BRAG Status	Count of Project Ref.
Amber	11
Green	9
Blue	4
Red	2

Project by Reasons

Reason	Count
Resources	8
Timescales	8
Closed Compl...	4
Deliverables	3
Budget/Savi...	1
Overall Assu...	1

Modernising Service Delivery
Risks and Mitigations

Title	Project Description	BRAG Status	Explain why BRAG Status is RED/AMBER/BLUE	RED/AMBER Mitigation Actions
5b. TEC	Increasing the use of Technology Enabled Care	🟧 (Amber)	Ongoing work required to clarify clear objectives and outcomes for TEC work following conclusion of current work.	Scoping work will be undertaken to clarify specific project work moving forward that is outcome focused and evidence-based.
6. Social Care Charging	Implementing the new Charging Policy	🟥 (Red)	Upon further discussions it was felt that the previous AMBER status had not sufficiently helped to raise awareness of the complex issues around this delivery against a short timeline, so it was uprated to RED. It will be changed to green once an SBAR is presented at SLT and an extension received to ensure effective but timeline delivery.	We are continuing to flag capacity issues and optimising capacity planning and once we can establish firmer delivery expectations based on that, an SBAR will go to SLT to request an extension for the delivery of this programme.
10. Modernise Care Models	Modernise care delivery models for vulnerable adults including people with Learning Disabilities and Complex Needs.	🟧 (Amber)	This is one of a number of priorities aligned to LD which need to be planned for. There is a a lack of both planning capacity and operational capacity to fully progress, and other projects underway will need to complete to release capacity. The Stoneywood Project for complex residential care has been top priority for the teams and this workstream.	Work continues to review care packages regularly and make adjustments when needed; providers are reviewed on a regular basis to ensure compliance and if there are issues of overprovision this is addressed. The Dynamic Support Register to log all current and at risk complex and out of area packages is now fully established; Stoneywood site has now opened and will accommodate 5 individuals with complex needs; all these people were longstanding Out of Area cases. Over last six months we have had to prioritise Stoneywood which will also provide key procedures, practices and learning to inform and facilitate further modernisation of all our care delivery models.
11. Improving Transitions	Implement transitions process to improve service user experience and future financial planning	🟧 (Amber)	Capacity within the relevant Health teams meetings have not allowed for meetings / mapping exercises to take place as yet.	Both Adult Health and CAMHS have set up internal groups to review the Transitions Pathway, clarify team roles for the Staff Guide, and identify service gaps, especially for 16–17 year olds not yet assessed, with a mapping exercise planned to address these gaps.

Modernising Service Delivery
Risks and Mitigations

Title	Project Description	BRAG Status	Explain why BRAG Status is RED/AMBER/BLUE	RED/AMBER Mitigation Actions
12. Learning Disability Day Care	Review Day Care Provision for people with Learning Disabilities		The milestones and dates have slipped over the last month because of other team workload priorities.	Slippage due to limited care management Team resources and need to focus on statutory duties and other work especially around cost control and containment.
13. Out of Area Placements	Review use and cost of Out of Area care		The milestones and dates have slipped over the last month because of other team workload priorities.	For all our LD Out of Area 'social care provision' placements we continue to ensure 1) Requirements for care management review & provider engagement are met 2) The Dynamic Support Register (SGovt requirement) is fully maintained on monthly basis 3) Potential new placements are fully reviewed by MHLD Resource Allocation Panel For Out of Area all specialist health needs placements, we continue to ensure 1) Placement register is maintained and reviewed quarterly 2) Potential new placements are fully reviewed clinically and processed via formal approval COO/CFO procedures.
14. Commissioned Service Provider Spending Reduction	Reduce spend and achieve value for money with key commissioned service provider		Timeline and governance has yet to be defined for the project. At the moment this is overseen by the Budget Saving Oversight Group. Work is being progressed through the Scenario Planning Group and the Contract SLWG.	Continue to work with partners in the scenario planning group to ensure governance is determined and the timelines created and adhered to.
16. GP Vision	Deliver city commitments in the GP Vision		No dedicated capacity allocated to this programme of work, there is currently only resource to deliver on 6 of the 10 objectives.	A workshop was recently held to determine if there were any additional resources available or whether resource could be re-allocated to alternative workstreams, however it was determined to continue with the current resourced workstreams. There are currently no further mitigations identified.
17. Primary Care Improvement Plan (PCIP) Review	Implement and review Primary Care Improvement Plan (PCIP) to identify, successful efficient delivery of services and areas of improvement		Lack of interface with certain PCIP workstreams and difficulty in accessing practice system data.	Amber : Completion within this year 25/26. Challenges in terms of data required across 3 HSCP's. Very little data available through primary care channels and this has caused the delay in completion.

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Modernising Service Delivery
Risks and Mitigations

Title	Project Description	BRAG Status	Explain why BRAG Status is RED/AMBER/BLUE	RED/AMBER Mitigation Actions
18. Discharge without Delay	Deliver the Discharge Without Delay Collaborative commitments	AMBER	All projects within this programme are progressing but delivery on time is dependant on successful timely recruitment.	Recruitment for the community hospitals is progressing and changes are being actioned as staff enter posts PDD / Integrated Discharge Hub again is progressing with recruitment, confidence remains high the hub will be up and running by the end of March 26 D2A in city is operational and Shire is progressing with recruitment, a start date is expected in January F@FD was unsuccessful in consultant recruitment but work is taken place to add stability to F@FD by consultants with existing resource.
19. Support to Amputees	Redesign model of support to Amputees to community based provision	AMBER	Work remains ongoing to understand need of amputees and what model is most appropriate going forward. Clashie may be a more appropriate placement. Paper being written with findings to inform next steps.	Paper expected imminently or so to inform next steps. Will take to SLT for further planning.
21. Residential Substance Use Service	Implement redesign of residential substance use service with a view to delivering a community based support service model	AMBER	Update required from Cyrenians on lived experience feedback and project meetings to be reinstated.	Further discussions with Service Manager to explore available future options and set up project governance within project times, and clear timelines agreed.
22. Sheltered Housing Redesign	In conjunction with ACC colleagues, influence the redesign of Sheltered Housing to modernise the model of Housing support .	RED	Project 1 facing delays in gaining approval due to resource pressures, and other Housing activities being prioritised. Also now being delayed for decision to be made around wider housing model	In order to mitigate delays ensure that project team carries out tasks set out in time for the tenants consultation meetings, as there is a small degree of buffer set within existing deadlines.

Modernising Service Delivery
Summary of Measurable Progress

Priority	Title	Key Progress
Best use of Resources	**1. Use of Properties**	The target savings of **£153k** for this financial year have already been achieved through moving CTAC and Imms from South College Street into Countesswells and the Health Village
Best use of Resources	**2. Utility Savings**	On track to save **an additional £50,000** above the original target on heat / electricity costs
Best use of Resources	**3. Management of Vacancies**	Within Aberdeen City H&SCP, **headcount has decreased by 3.3%** and **WTE has declined by 4%**
Best use of Resources	**7. Older People Care Provision**	**100%** of option 2 reviews completed
Best use of Resources	**10. Modernise Care Models**	**5** people returning from out of area placements due to Stoneywood opening with another **3** people also supported who would be noted within our local Dynamic Support Register
Transforming Service Delivery	**18. Discharge without Delay**	Initial **500 hours** of Discharge 2 Assess service being fully utilised

Updated BRAG Status Guidance

Criteria	Green	Amber	Red
Timescales (Milestones & Completion Date)	All milestones to date met. Future milestones and final completion date are on track.	One or more milestones delayed, but final completion date still achievable with mitigation.	Critical milestones missed and final completion date cannot be met.
Deliverables (Single or Multiple Outputs)	All deliverables on track for delivery.	75–99% of deliverables on track (some risk but majority expected to be achieved).	<75% of deliverables on track (significant risk to scope).
Resources	Sufficient staff, skills, and capacity available to deliver project as planned.	Some resource pressure or short-term gaps, creating risk to delivery if not addressed.	Insufficient resource available; unlikely to deliver without major intervention.
Budget / Savings	On budget or within tolerance. Financial savings on track.	Budget is forecast to be overspent but mitigations are in place to reduce	Budget is forecast to be overspent and no credible mitigations in place
Overall Assurance / Risk Level	No significant risks identified. Issues minor and easily managed.	Moderate risks present but being actively managed.	Major risks identified with no credible mitigation plan.

Blue Status

- Project completed.
- Project closed.
- Project formally on hold until a future year.
- Not started (planned to start later in the year)

Overall BRAG Status Rule

- Lowest score (i.e. if one criteria is red, overall status is red)

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