Aberdeen City Health & Social Care Partnership
A caring partnership

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**

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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:
	• 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. <u>Strategic Risk Register (SRR)</u> 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. <u>Operational Risk Register (ORR)</u> 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		

[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

[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 w hole. 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 w ithin 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 review ed. 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, w ith 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 w ere identified, w hich may put at risk the achievement of objectives in the area audited.	**Reasonable**
Major	Significant gaps, w eaknesses 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, w eaknesses 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 w eakness identified has an impact on the audited area's adequacy and effectiveness.
Major	The absence of, or failure to comply w ith, an appropriate internal control, w hich 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