Aberdeen City Health and Social Care Partnership

Annual Performance Report 2025-2026

Aberdeen City Health & Social Care Partnership

A caring partnership

ABERDEEN CITY COUNCIL

NHS Grampian

Foreword

I am pleased to introduce the Aberdeen City Health and Social Care Partnership's Annual Performance Report 2025-26. This year has been both busy and challenging. In the face of continued financial pressures and an increasing level of need, our staff and partners have worked with determination and compassion to ensure people across Aberdeen continue to receive safe, high-quality care and support.

We recognise that the pressures we face are also affecting the communities we serve. Too many people are living with circumstances that can negatively affect their health and wellbeing. That is why we are strengthening our focus on prevention and early intervention, supporting physical and mental wellbeing at every life stage and reducing harm wherever we can. This is not only the right thing to do; it is essential if we are to reduce the need for more intensive health and care interventions in the future.

Our Strategic Plan 2025–2029 sets out clear priorities and a renewed commitment to modernising how we deliver services, making the best use of the resources available while continuing to improve outcomes for people. In the first year of the plan, we have laid important foundations through the publication of our Public Mental Health Action Plan and Healthy Weight Action Plan, alongside the forthcoming Active Ageing Action Plan and our Workforce Plan, which will set out how we will continue to support the health and wellbeing of our staff. Alongside this, our Discharge Without Delay programme has driven significant transformation, enabling more people to be cared for in the community.

I am also delighted that, following sustained effort across many teams, our Stoneywood Complex Care facility is now operational and fully occupied. This has required considerable dedication and a shared vision for care that promotes independence, dignity and quality of life, while also making thoughtful use of technology to support people and those who care for them.

As the report shows (see page 7), our services provide vital support to people across Aberdeen every day. I want to thank everyone who has contributed to this work including our staff, partners, carers, unpaid carers and communities, for their continued commitment during a demanding year. While challenges remain, I am proud of what has been achieved and hopeful about what we can deliver together in the years ahead as we continue to work towards improving health and wellbeing across the city and looking after our most vulnerable residents and caring for those in need of our support.

Fiona Mitchelhill
Chief Officer,
Aberdeen City Health and
Social Care Partnership

Contents

Introduction

Welcome to the Aberdeen City Health and Social Care Partnership's (ACHSCP) Annual Performance Report (APR) for 2025-26. ACHSCP is legally required to publish an APR which demonstrates progress made on strategic intent, how the ACHSCP is performing against the National Integration Indicators and to provide assurance of financial best value for the public purse. This report covers the period from 1st April 2025- 31st March 2026 and demonstrates progress which has been made on the projects outlined in the Delivery Plan[1] which represents Year 1 of the 2025-2029 ACHSCP Strategic Plan.

ACHSCP was formed in 2016 to bring together planning and oversight for a range of Health and Social Care services. The creation of ACHSCP was intended to improve the City's health and wellbeing through the delivery of more efficient and effective health and social care services, and its success is measured through the National Integration Indicators. As part of its role, ACHSCP works in collaboration with a range of organisations and partners.

[1]The approved Year [1] Delivery Plan is available here: https://aberdeen.moderngov.co.uk/ieListDocuments.aspx?CId=553&MId=9718&Ver=4

Population overview

The Aberdeen City Population Needs Assessment (PNA)[2] demonstrates that the population of Aberdeen is expected to increase modestly at 1.1% by 2028. The current birth rate in Aberdeen is lower than the death rate, with projected declines in the 0–14 and 15–29 age groups. This indicates that any future population growth is expected to result primarily from inward migration to the city. The largest population increase by 2028 (26.2%) is projected for men aged 75+ which will impact upon the demand for future health and social care services.

Data indicates that Life expectancy has plateaued at 76.9 years, while healthy life expectancy fell in 2022-2024 to 58.8 years for men and 59.0 years for women, down from 60.2 and 61.2 years respectively in 2019-2021[3]. This pattern, seen across Scotland, affects deprived areas most and may further worsen due to economic pressures which will lead to a rise in the number of people and families living in challenging conditions. On average, there is a 17.9 year gap between life expectancy and healthy life expectancy, highlighting an increased need for health and social care support through professional services or unpaid care.

The demographic changes projected may place pressure on public services by reducing the tax base while increasing demand for care and support, especially among children and older adults. In Aberdeen, as in many regions, there is a growing section of residents facing work limitations, which further challenges the balance between the working population and those unable to participate in the workforce.

The social determinants of health play a significant role in the inequitable and preventable differences in health outcomes observed throughout Aberdeen. Factors such as socioeconomic status, health related behaviours, access to healthcare services collectively influence individual and population health of which ACHSCP are required to respond to.

[2]Aberdeen City Population Needs Assessment Population Needs Assessment - Community Planning Aberdeen
[3]Healthy Life Expectancy in Grampian. Available here: https://www.hi-netgrampian.scot.nhs.uk/joint-strategic-needs-assessment-supporting-data-and-what-it-means-for-service-planning/overview-of-grampians-population-characteristics-and-health-status/chronic-morbidity/healthy-life-expectancy/

Strategic Plan 2025-2029

ACHSCP is responsible for providing integrated services through the operational delivery of the Partnership's Strategic Plan. ACHSCP's Strategic Plan was approved by the Integration Joint Board (IJB) on 1st July 2025, and it represents the strategic intention of the Partnership until 2029. The full Strategic Plan is available to view on the ACHSCP website[4].

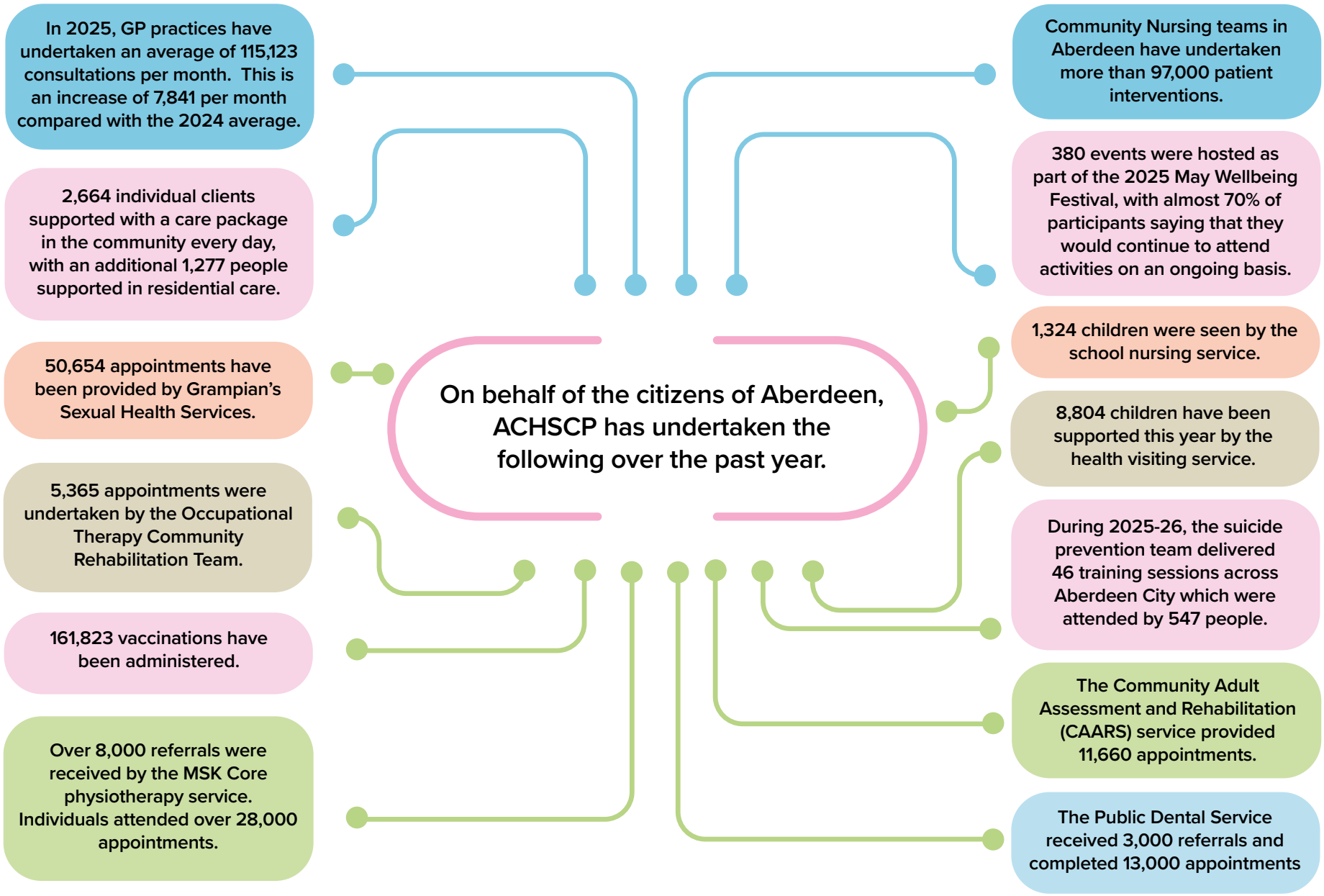
The Strategic Plan outlines two aims for ACSHCP alongside four corresponding priorities. These are outlined in diagram 1. The aims and priorities help to guide and inform how the Strategic Plan will be implemented, and this is represented within a Delivery Plan which is presented for approval at the Risk, Audit and Performance Committee on an annual basis. The creation of an annual delivery plan allows for ACHSCP to respond to the needs of communities and services in a more flexible manner.

Diagram 1. Strategic Aims and Priorities

Aims	Priority	Outcome	Measure
Modernise our approach to service delivery	Make best use of resources	Financial balance	Budget performance
	Implementing transformation	Sustainable service provision that can can meet future demand	Service measures around numbers and clients supported, waiting times, unmet need etc.System measures around delayed discharges, emergency department attendance, performance and admission.
Shift our focus towards prevention and early intervention	Improve physical and mental health	Improved population health	National health and wellbeing indicators
	Reduce harm	Reduction in health care	Level of service demand

[4]Aberdeen City Strategic Plan 2025-2029 and Route Map for Delivery. Available from: https://www.aberdeencityhscp.scot/globalassets/documents/achscp-strategic-plan-2025--2029-and-route-map-for-delivery.pdf

Overview of service delivery



Our Governance and Performance

ACHSCP is governed by a framework which provides scrutiny and assurance that services and programmes are being delivered safely for the benefit of patients, clients, carers and the public and within an acceptable budget and timeframe. ACHSCP's governance structure also connects to the broader governance frameworks of Aberdeen City Council (ACC) and NHS Grampian. The structure of ACHSCP's governance framework is shown below:

Performance management

ACHSCP is required to use the National Health and Wellbeing Outcomes, which are assessed using the National Integration Indicators and Ministerial Steering Group Indicators published by Public Health Scotland. These indicators help to assess progress being made towards integration and to benchmark our performance against other Health and Social Care Partnerships and the Scottish average. Additional local measures, for example admission rates and occupancy levels, allow us to regularly monitor performance within our governance structure. This element has been further enhanced using dashboards which provide data to assist with operational and strategic decision making. The description below outlines local reporting arrangements for performance management within the governance structure. It should be noted that these descriptions cover the performance management aspects only, and it does not reflect the full role of these committees and groups.

The Integration Joint Board (IJB) has responsibility for the overall direction of ACHSCP and as such, it approves the Strategic Plan. On an annual basis, it is provided with the Medium-Term Financial Framework which outlines the planned financial spend for the upcoming year. The APR is presented to the IJB for approval prior to publication and aims to assess ACHSCP's progress and performance against the Strategic Plan.

The Risk, Audit and Performance Committee approves the Delivery Plan aligned to the Strategic Plan. Thereafter, quarterly updates are provided which give an overview of progress against all deliverables within the Delivery Plan. These include key achievements, challenges and mitigations against potential risks. The Committee also considers performance reports for key pieces of work as required (for example, the carers strategy annual report).

The Clinical and Care Governance Committee is provided with a data

report on a quarterly basis which covers several areas such as adverse events and complaints received. This ensures that clinical risks and performance is monitored and that assurance is provided to the Committee that appropriate mitigations or escalations are in place.

Members of the Senior Leadership Team are assigned as the Senior Responsible Owner for projects outlined in the Delivery Plan. In this role, they lead the delivery of these priorities with assistance from the project team. The Senior Leadership Team review progress being made across the Delivery Plan on a regular basis using a similar reporting means as that which is presented to the Risk, Audit and Performance Committee. This ensures that any area which requires further discussion or input can be prioritised and actioned appropriately.

Overview of our Performance | based on data published 7 July 2026

The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services. The National Integration indicators and Ministerial Steering Group indicators are a set of metrics which are designed to measure progress towards achieving these outcomes.

National Integration Indicators

Indicators 1-9 of the National Integration Indicators are derived from the Health and Care Experience survey which is measured every second year. The results from the Health and Care Experience survey were most recently published in May 2026[4].

As per guidance issued from Public Health Scotland, data for indicators 12,13,14,15 and 16 are reported using the calendar year rather than the financial year. Data for indicator 11 will be published later this year as part of a release from National Records Scotland and is therefore not available for this APR. Data for indicator 18 will also not be available at this point and indicator 20 is no longer measured. The full publication of the National Integration Indicators can be found on the Public Health Scotland Website[5].

Ministerial Steering Group Indicators

The indicators published from the Ministerial Steering Group have been added following the National Integration indicators. Public Health Scotland have advised that data related to indicator 1a, 2a and 2b have not been released due to data governance and disclosure control considerations. Other measures are stable compared with previous years.

All measures are assessed using the following RAG status which helps to indicate where progress has been made since publication of the APR 2024-25.

RAG Status Colour	Definition
Red	If current position is worse than previous position by 5% or more
Amber	If current position is worse, but within 5% of the previous position
Green	If current position is the same or better than the previous position

[4]Health and Care Experience Results. Available from: https://www.gov.scot/collections/health-and-care-experience-survey/
[5]Core Suite of Integration Indicators. Available from: https://publichealthscotland.scot/publications/core-suite-of-integration-indicators/core-suite-of-integration-indicators-7-july-2026/

National Integration Indicators

	Indicator	Title	ACHSCP Rate (2023-24)	ACHSCP rate (2025/26)	Percentage Change between 202324 and 2025-26 (RAG)	Scotland rate	RAG comparison of ACHSCP and Scotland results
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	90%	91%		91%	
	NI - 2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	77%	76%		74%	
	NI - 3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	57%	66%		64%	
	NI - 4	Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated	63%	71%		65%	
	NI - 5	Percentage of adults receiving any care or support who rate it as excellent or good	75%	72%		72%	
	NI - 6	Percentage of people with positive experience of care at their GP practice	60%	62%		71%	
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	74%	71%		72%	

	Indicator	Title	ACHSCP Rate (2023-24)	ACHSCP rate (2025/26)	Percentage Change between 202324 and 2025-26 (RAG)	Scotland rate	RAG comparison of ACHSCP and Scotland results
Outcome indicators	NI - 8	Percentage of carers who feel supported to continue in their caring role	37%	33%		32%	
	NI - 9	Percentage of adults supported at home who agree they felt safe	72%	77%		75%	
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work		Data for measure not collected		Data for measure not collected	

			ACHSCP Rate (previous results)	ACHSCP rate (2025/26)	Percentage difference between previous results and 2025-26 (RAG)	Scotland rate	RAG comparison of ACHSCP and Scotland results
Data indicators	NI - 11	Premature mortality rate per 100,000 persons	448	440		426	
	NI - 12	Emergency admission rate (per 100,000 population)	9,805	8,747		11,470	
	NI - 13	Emergency bed day rate (per 100,000 population)	97,032	89,201		108,988	
	NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	126	114		104	
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	90%	91%		89%	
	NI - 16	Falls rate per 1,000 population aged 65+	21	16.2		22.2	
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	72%	78%		83%	
	NI - 18	Percentage of adults with intensive care needs receiving care at home	56%	56%		65%	

			ACHSCP Rate (previous results)	ACHSCP rate (2025/26)	Percentage difference between previous results and 2025-26 (RAG)	Scotland rate	RAG comparison of ACHSCP and Scotland results
Data indicators	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	655	458		873	
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency		Data for measure no longer collected		NA	
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home		Measure under development and not currently reported on		NA	
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready		Measure under development and not currently reported on		NA	
	NI - 23	Expenditure on end of life care, cost in last 6 months per death		Measure under development and not currently reported on		NA	

Ministerial Steering Group Indicators

	Indicator	Title	2023-2024	2024-2025	2025-2026	ACHSCP 2025-2026 compared with 2024-2025
Ministerial Group indicators	1a	Number of emergency admissions	21,069	Data incomplete	Data incomplete	Data incomplete
	1b	Percentage admitted from A&E all ages (average for year)	23	Data incomplete	Data incomplete	Data incomplete
	2a	Unscheduled bed days, acute specialities	130,236	Data incomplete	Data incomplete	Data incomplete
	2b	Unscheduled bed days- Geriatric long stay	7,036	Data incomplete	Data incomplete	Data incomplete
	2c	Unscheduled bed days, Mental Health	51,687	Data incomplete	52,576	
	3a	A&E attendances	42,163	42,179	43,145	
	3b	Percentage seen in A&E within 4 hours all ages (average for year)	57	56	51	
	4	Delayed Discharge bed days (age 18+)	7,016	18,066	15,225	
	5	End of life care (% in community all ages)	90.0%	91.7%	Yet to be published	Data incomplete
	6	Balance of Care- %65+ living at home (supported and unsupported)	95.9%	95.9%	Yet to be published	Data incomplete

The figures published for the National Integration Indicators and Ministerial Steering Group (MSG) indicators show positive progress in several areas. In particular:

- NI9 – The percentage of people supported at home who reported feeling safe increased from 72% to 77%.
- NI12 – The emergency admission rate per 100,000 population decreased by 11% compared with the 2024–25 published figures and is now 24% below the national average.
- NI16 – The falls rate per 1,000 population aged 65 and over decreased by 23% and remains below the national figure.
- NI19 – The number of days people spend in hospital after they are clinically ready for discharge has fallen and is now 48% below the national average.
- MSG4 – The number of delayed discharge bed days for people aged 18 and over fell from 18,066 in 2024–25 to 15,225 in 2025–26.

These results reflect the continued focus on improving unscheduled care and the implementation of initiatives such as Discharge Without Delay, Discharge to Assess, Hospital at Home, and the work of Social Work teams in supporting admission avoidance.

Falls can have a significant impact on an individual's quality of life and may increase the support required for recovery and rehabilitation. Over the past two years, ACHSCP has seen a sustained reduction in the falls rate among people aged 65 and over. This improvement reflects the ongoing commitment to falls prevention across both community and hospital settings.

Performance during 2025–26 demonstrated encouraging progress across a number of key areas, reflecting the continued focus on service improvement and unscheduled care. Improvements were reported across the National Integration indicators requiring ongoing attention, including:

- NI6 (percentage of people reporting a positive experience of care at their GP practice),
- NI14 (rate of hospital readmissions within 28 days of discharge per 1,000 population),
- NI17 (proportion of care services graded 'good' or better by the Care Inspectorate), and
- NI18 (percentage of adults with intensive care needs receiving care at home).

While performance in these areas remains below the national average, the positive direction of travel highlights the impact of sustained improvement efforts. Continued focus is required on MSG3b, the percentage of patients of all ages seen in Accident and Emergency within four hours (annual average), which decreased from 56% in 2024–25 to 51% in 2025–26. Performance against the four-hour target is influenced by a wide range of factors across the whole health and care system and cannot be attributed solely to the contribution of ACHSCP services. There remains a strong focus on admission avoidance through community-based services, where appropriate and safe to do so, alongside ongoing work to improve patient flow within hospital settings to help reduce pressures on A&E services.

Finance and Best Value

The report to the IJB on 12 May 2026 showed that the final financial position for 2025-26 was £11.2million underspent against the revised budget. This was a significant improvement compared with 2024/25 and allowed the Partnership to rebuild it's reserves. After setting aside earmarked funds, £7.7 million remain in uncommitted reserves as at 31 March 2026.

While this provides some short-term resilience, achieving sustainable financial balance will require continued delivery of recurring savings.

For 2026-27, the financial plan requires a further £14.5 million of savings and must also absorb the withdrawal of £10.9 million of one-off in-year partner funding received in 2025-26. The financial outlook for health and social care therefore remains highly challenging, with rising demand, increasing complexity of need, inflationary pressure and the requirement for further service reform to secure long-term sustainability.

The main area of budget pressure continues to be commissioned services, driven by growth in demand, complexity of care, workforce pressures and rising provider costs. Additional pressures also remain in Learning Disabilities, Mental Health and Addictions, out-of-area placements and prescribing.

The IJB remains committed to protecting services for the most vulnerable people in Aberdeen while maintaining an appropriate balance between financial sustainability, safe and effective care, and staff wellbeing.

Comprehensive income and expenditure statement.

This statement shows the cost of providing services for the year according to accepted accounting practices.

2024/25				2025/26		
Gross Expenditure	Gross Income	Net Expenditure	-	Gross Expenditure	Gross Income	Net Expenditure
£	£	£	-	£	£	£
-	-	-	-	-	-	-
49,873,614		49,873,614	Community Health Services	50,679,539	-	50,679,539
32,898,445	-	32,898,445	Aberdeen City share of Hosted Services (health)	34,087,644	-	34,087,644
51,688,650	-	51,688,650	Learning Disabilities	54,791,104	-	54,791,104
30,995,471	-	30,995,471	Mental Health & Addictions	30,490,570	-	30,490,570
110,333,861	-	110,333,861	Older People & Physical and Sensory Disabilities	105,122,809	-	105,122,809
1,523,262	-	1,523,262	Head office/Admin	1,465,707	-	1,465,707
6,548,679	(6,384,627)	164,052	Criminal Justice	7,473,638	(7,042,868)	430,770
1,793,981	-	1,793,981	Housing	1,770,542	-	1,770,542
47,428,983	-	47,428,983	Primary Care Prescribing	47,998,430	-	47,998,430
49,781,141	-	49,781,141	Primary Care	53,189,581	-	53,189,581
3,038,684	-	3,038,684	Out of Area Treatments	3,737,738	-	3,737,738
59,238,000	-	59,238,000	Set Aside Services	62,588,000	-	62,588,000
2,523,810	-	2,523,810	City Vaccinations	2,423,486	-	2,423,486
15,768,659	-	15,768,659	Transformation	15,337,101	-	15,337,101
-	-	-	-	-	-	-
463,435,238	(6,384,627)	457,050,611	Cost of Services	471,155,889	(7,042,868)	464,113,022
-	-	-	-	-	-	-
-	(447,215,776)	(447,215,776)	Taxation and Non-Specific Grant Income	-	(475,344,440)	(475,344,440)
-	-	-	-	-	-	-
463,435,238	(453,600,403)	9,834,835	(Surplus) or Deficit on Provision of Services	471,155,889	(482,387,308)	(11,231,419)
-	-	-	-	-	-	-
-	-	9,834,835	Total Comprehensive Income and Expenditure	-	-	(11,231,419)

Our Progress and Achievements in 2025-2026

The following section will give an overview of progress made on the projects and initiatives outlined as part of the Year 1 Delivery Plan. This section will be split into two main sections representing the two Strategic Aims.

These two sections will be further broken down to show the projects aligned to the strategic priorities.

Modernise our approach to service delivery

- Make best use of Resources
- Implementing Transformation

Shift our focus towards prevention and early intervention

- Improve Physical and Mental Health
- Reduce Harm

Modernise our approach to Service Delivery

By modernising and transforming ACHSCP's approach to service delivery, the Partnership aims to provide the best possible service to its communities by effectively using available resources while operating within its agreed budgets as assigned by ACC and NHS Grampian.

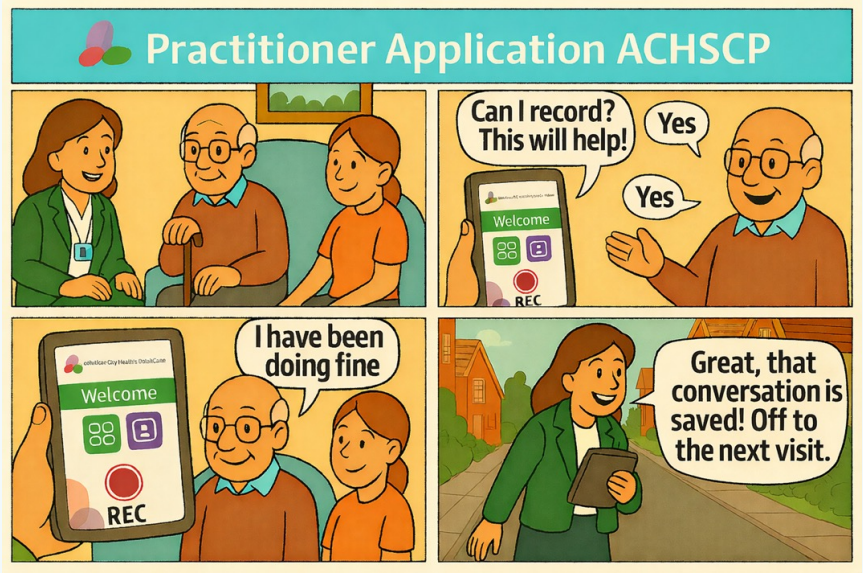
Make best use of resources

Projects aligned with this strategic priority are designed to optimise the utilisation of resources available to ACHSCP, including its workforce, financial assets, infrastructure such as buildings, and the effective delivery of services to meet individual and community's needs. Advancing data and digital capabilities enables services to be well-supported in day-to-day operations and provides leadership with robust information for improved strategic decision making.

Digital Innovation Programme.

The Digital Innovation Programme is focused on modernising and improving digital systems and processes across Adult Social Work, with the aim of enhancing practitioner efficiency, improving access to information, and delivering higher quality services. This is being achieved through the introduction of innovative digital tools, greater system integration, and more effective use of data, supported by appropriate governance, security and compliance arrangements.

A central ambition of the programme is to simplify processes and reduce administrative burden, enabling practitioners to spend less time on record- keeping and more time engaging with and supporting people. Key areas include the development of AI-enabled tools such as the Practitioner App and Practitioner Search. These developments will support the capture and transcription of conversations, streamline case recording and make it easier to access and use information. It will also help to ensure that digital solutions meet operational needs and the statutory duties of the service.



Increasing the use of Technology Enabled Care.

Technology Enabled Care (TEC) uses digital tools and equipment to support the health and wellbeing of people in their own homes. These tools can complement the care that people receive from professionals and can promote independent living. This year, the project has focused on raising awareness and evaluating the impact of TEC.

Raising Awareness of TEC.

TEC Awareness Week 2025 focused on practical, face-to-face engagement supported by targeted social media activity. Sessions were delivered at Middlefield Community Centre, Woodend Hospital and Aberdeen Vaccination and Wellbeing Hub, reaching staff, nursing students and members of the public. The strongest engagement was seen at Woodend Hospital where nursing students reported increased awareness of how TEC is used in health and care settings.

Alongside this, social media content achieved good reach, with some posts exceeding 500 views and video content performing particularly well when shared by partner organisations. Overall, the week achieved three key outcomes:

- It increased awareness of TEC among staff and nursing students who were previously unfamiliar with it.
- It demonstrated the value of direct conversations in helping people understand how TEC can support independence.
- It used engaging, practical digital content to extend the reach of in-person awareness activity.

Use of TEC at Stoneywood Care Complex.

The Stoneywood project uses TEC to support people with learning disabilities and complex needs to live more independently, safely, and with fewer restrictive care practices. During 2025–26, TEC was fully implemented and a structured evaluation process was commenced, although delays in supported people moving into Stoneywood means that only an initial evaluation has taken place. Staff and management feedback inform ongoing TEC adjustments to ensure that systems are safe, reliable and person-centred. Overall, the initial evaluation found that TEC is delivering clear benefits when combined with professional oversight, despite some technical issues that continue to be addressed.

Konpanion Maah project.

The Konpanion Maah project was a co-design pilot that tested a soft, tactile companion device and additional sensors with people who have complex needs and little or no verbal communication. This provided valuable input into the development of this prototype, demonstrating that this type of companion device can be used comfortably and safely at home and in everyday care settings. Families engaged positively, providing clear, real-world learning about what works and what doesn't, particularly around reliability, charging, and connectivity. This led the supplier to rethink and improve their technical approach. The project showed that the approach has longer-term potential, but significant development is required to address technical challenges identified.

Implement eMAR at the five in-house Learning Disability services.

The Electronic Medication Administration Records (eMAR) project aimed to replace paper medication administration records with a single digital system across all in-house learning disability services. The purpose was to improve the administration of medication, reduce errors, and make day-to-day processes easier for staff. A successful pilot completed at Back Hilton last year showed that by using eMAR, there was a reduction in medication errors, staff felt supported in their role and that there was associated time savings, this supported its further implementation to all five in- house learning disability services.

During the past year, the project has progressed from planning into full delivery. Pharmacy integration issues were identified and resolved, allowing each service to go live safely. Staff were supported through training and on site go live support, and the system became embedded into daily practice. All services are now using eMAR as their standard approach to medication administration, replacing paper Medication Administration Reporting charts. Initial feedback from services is that despite some implementation challenges, the system provides clear improvements in medication management, including reduced risk of errors and better stock control. These improvements and time savings for staff help to support the provision of safer care and free up staff to provide more direct support.

eMAR is now used in the following sites:

Back Hilton | **Rowan Road** | **Stocket Parade** | **Kaim Court** | **Balnagask Court**

Develop data dashboards to support the planning and delivery of services.

The aim was to design and deliver a suite of data dashboards to support planning, performance management and decision-making across services delegated to ACHSCP. It has strengthened ACHSCP's use of data by providing timely, accessible and meaningful performance information to senior leaders, boards and service managers. The dashboards developed will continue to evolve over time in line with service needs and strategic priorities.

Improved strategic and operational oversight

The development and implementation of core dashboards provided senior leaders and governance groups with clearer, more consistent performance information, supporting evidence-based decision-making and targeted management action.

Replacement of manual reporting processes

The Activity and Delivery Plan Dashboards replaced previously manual, resource-intensive reporting approaches, reducing duplication and improving the timeliness and accessibility of performance information.

Strong foundations for future dashboard development

Clear governance, agreed delivery approaches and strengthened relationships with services and data owners established a strong platform for further dashboard development, including work on Strategic Plan and Primary Care dashboards.

Modernise care delivery models for vulnerable adults including people with Learning Disabilities and Complex Needs.

This project aligns to the requirements to make both budget efficiencies and to ensure care and support arrangements are sustainable. The following areas have been progressed this year with work in this area ongoing.[6]

Stoneywood Complex Care facility.

The Stoneywood Complex Care facility was opened this year and now supports 8 individuals. Each person's needs are aligned to the requirements within the Scottish Government 'Coming Home' report meaning that they all have need of specific accommodation and support arrangements in order to have successful placements. There is a mix of people who have returned from out of area, discharged from hospital and moved from less appropriate placements which were at risk of placement breakdown. More information about the Stoneywood complex can be found using the link below:

https://www.youtube.com/watch?v=qh1W4v9e4FI

[6] https://www.gov.scot/publications/coming-home-action-plan-2026/

Review of the Sustainability of Care Arrangements.

This has investigated the decommissioning of services which are not sustainable through conducting a person-centred review of care packages, assessing the contribution of formal and informal support and work with contracts teams to review services and contractual arrangements, while strengthening relationships with providers.

Implement transitions process to improve service user experience and future financial planning.

The Improving Transitions project is designed to strengthen the experience of young people with additional support needs as they move from school into adult life. Its purpose is to ensure that transitions are timely, coordinated and clearly understood, so that young people and their families feel informed, supported and involved throughout the process. By creating a shared pathway, consistent guidance, and a structured approach to reviewing referrals, the project aims to deliver more predictable, person-centred transitions.

During 2025–26, significant progress was made in strengthening the experience of young people moving from school into adult life. The revised Transitions Pathway, co-designed with Education, Children's Social Work, Adult Social Work, and Health services, was approved by ACC's Education and Children's Services Committee in November 2025 and by the ACHSCP Clinical and Care Governance Committee in December 2025. This marks an important milestone in improving the coordination and clarity of support available to young people and their families.

A new Transitions Pathway Staff Guide and updated Terms of Reference for the Social Work Transitions Group were finalised and published, providing clear guidance for professionals involved in planning support. Five training sessions were delivered for Adult Social Work, Children's Social Work and Education, helping to embed the pathway and grow shared understanding between services.

To further improve consistency, the Social Work Transitions Group now meets twice yearly to review referrals. This ensures that young people are either appropriately allocated to services or signposted early to other support services. This reinforces decision-making and helps to reduce uncertainty for families. The pathway now has a more structured and reliable approach to reviewing need.

The project also strengthened the overall coordination of the pathway. A standardised referral form, a central contact route, and clearer operating procedures was introduced to make it easier for families and professionals to navigate the process. Digital improvements are also helping Adult Social Work manage assessments more efficiently.

Work is ongoing to ensure families have clear, accessible information. A Parent and Carer Guide has been drafted and is being reviewed with parents, carers and partner organisations. Planning has also begun on a Young Person's Guide, with engagement activities scheduled with young people and key partners to shape the content and format.

Review use and cost of Out of Area care.

The development of the local Dynamic Support Register allows ACHSCP to understand the population's needs and also to report data to Public Health Scotland. ACHSCP have successfully given presentations on this work and learning around Complex Care to peers across Scotland. Whilst ACHSCP may not have achieved the financial measures outlined within the 2025-26 Delivery Plan, efficiencies in this area take time to arise, particularly as ACHSCP looks to utilise TEC and support individuals to become settled into their new homes, which can take a significant period of time due to their needs. ACHSCP have plans to undertake an evaluation to understand the financial impacts, with anticipated benefits in a number of outcomes such as fewer interventions, people being supported to access community activities, decreasing use of PRN (when required) medication, improved family connections and greater independent living skills.

Reduce spend and achieve value for money with key commissioned service provider.

This programme of work was established in response to forecasted budget pressures, particularly within Commissioned Services, alongside the recognised increase in demand for social care arising from an ageing population.

The overarching purpose of the programme is to transform how services are delivered, ensuring that available resources are used as effectively as possible. This reflects the reality that achieving financial sustainability will require difficult decisions, including the cessation of some services and reductions in the level of provision and commissioning spend.

The programme of work comprises several interconnected workstreams, grouped under the following themes:

- Social Care Contract Review
- Social Care Budget Saving Reprovisions
- Social Care Transformation

Over the course of the year, engagement has taken place with providers to ensure awareness of this programme of work and to invite collaborative working. Progress has been made in establishing a consistent contract review process and in delivering savings to date. A key area of success has been the achievement of greater efficiency across commissioning arrangements, whilst ensuring that service provision is not undermined and remains aligned with the agreed approach to prioritising eligibility. In particular, this has involved taking a more strategic and evidence led approach to reviewing the services ACHSCP commission, identifying provision that is no longer required or aligned with current and future needs, and taking steps to modernise service models so that commissioned services remain sustainable, relevant and focused on delivering the best possible outcomes within available resources.

Refresh Workforce Plan focusing on future staffing requirements taking service transformation into account.

ACHSCP's annual conference was held on 28 January 2026 and focused on the theme of Staff Health and Wellbeing. Delegate feedback on “Workforce and what matters to them” was gathered and combined with input from drop-in staff sessions held throughout Autumn and Winter 2025. This feedback informed the creation of the Workforce Plan 2026-2029, which supports the priorities of Staff Health and Wellbeing, and Supporting Staff to Maximise Integration. The plan will be submitted to the IJB for approval in early 2026-27.

Overview of projects related to making best use of resources.

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
Consolidate our use of properties	Reduction in premises costs by £153,000.	Yes	The target savings of £153,000 for this financial year have been achieved through moving Community Treatment and Care (CTAC) services and Children's Immunisations from the former Marywell Practice Building, situated on South College Street, into the newly opened Countesswells Health and Wellbeing Clinic building and the Health Village. South College Street is now fully vacated by ACHSCP. CTAC also moved out of Carden House to give the GP Practice more clinical space allowing them to see more patients. The use of the Woodside Fountain Health Centre building has also been reviewed and these together with utility savings across ACHSCP ensured that the target has been met.	Complete - budget saving achieved
Deliver savings in Utility Costs	Reduction in Utility Spend by £50,000.	Yes	Implementation of zonal heating in the Health Village and reducing the heating temperatures across sites during spring months has assisted in the successful delivery of this target.	Complete - budget saving achieved
Deliver efficiencies from robust management of vacancies	Reduction in Staff Costs by £1,346,000.	Yes	The management of vacancies was one of the IJB agreed budget options to help achieve a balanced budget in 2025-26. Savings have been achieved through the continued use of the Vacancy Management Protocol that was introduced in 2024-25. The Protocol encourages management to consider alternative options to like for like recruitment when a vacancy occurs. This has led to managers considering skills mixing and the use of digital solutions to help support services to reduce head count whilst continuing to deliver services.	Complete - budget saving achieved, however approach will be continued in 2026-27 as part of budget savings

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
Reduce the number of posts in ACHSCP establishment	Reduction in Staff Costs by £884,000	Yes	The vacancy management protocol, together with other measures, has reduced headcount across NHSG and ACC employed teams by 3% across all services.	Complete - budget saving achieved, however approach will be continued in 2026-27 as part of budget savings
Digital Innovation Programme		In Progress	Please see page 20 for more details	Continue into next Delivery Plan
Ongoing - now business as usual approach	Raise awareness of TEC. Undertake evaluation of the Stoneywood TEC system. Complete the Konpanion Maah project and end of project report.	Yes	Please see page 20 for more details	Ongoing - now business as usual approach
Implement eMAR at the five in-house Learning Disability services: Back Hilton, Rowan Road, Kaim Court, Stocket Parade and Balnagask Court	eMAR is implemented into five sites.	Yes	Please see page 22 for details	

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
Implementing the new Charging Policy	Policy developed and approved, and communications in place.	In Progress	This project relates to a new charging policy, which is based on individual budgets. This approach was approved by the ACC Finance and Resources committee in August 2025. Further collaborative scoping of changes required within Social Work, Finance and ICT indicated that the system and process changes required were materially bigger than anticipated, this has resulted in the timeline for completion to be extended to March 2027. Key success measures so far: • Ongoing change management support keeps social work staff and providers engaged. • A 5% charging increase was applied in April 2026 to maximise income. • The three-phase communication plan began with all clients notified of upcoming changes. • Social Work, Finance, and ICT are working together to improve practitioner experience and financial monitoring. • Clients receive dedicated support with financial assessments for affordability during this transition.	Implementation delayed to April 2027, included in budget savings for 2027-28
Modernise care provision for older people	Reduction in spend by £3,328,000.	Yes	In line with the Budget Savings Oversight Group, all reviews of Option 1 and Option 2 care packages have been completed, this is now being done as part of business as usual.	Complete - budget saving achieved however work will continue as part of commissioned services review

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
Review mix of residential care	Reduction in spend by £336,000.	Yes	Balnagask care home is closing and reviews around other residential care is ongoing. The number of vacancies within care homes has increased since 2024-25. We continue to work to ensure all services meet eligibility criteria.	Complete - budget saving achieved however work will continue as part of commissioned services review
Develop data dashboards to support the planning and delivery of services	Dashboards in place and reports informing work focus.	Yes	Please see page 22 for more details	Continue to deliver as Business as Usual
Modernise care delivery models for vulnerable adults including people with Learning Disabilities and Complex Needs	Increase the percentage of clients with Learning Disabilities and Complex Needs living independently. Reduction in Out of Area placements.	Yes	Please see page 23 for more details	Delivered via Stoneywood project however focus on adults with complex needs will continue both in Year 2 Delivery Plan and in the refreshed LOIP 2026-2036 where there is a specific System Change in relation to providing support for people with Complex Needs

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
Implement transition process to improve service user experience and future financial planning	Process implemented. Client feedback. Budget Performance.	Yes	A budget reduction was implemented to fulfil the specified objectives. Comprehensive reviews of day services have been conducted in collaboration with providers to ensure a consistent approach and to gain insight into the range of care and support options available as well as those commissioned. Part of this initiative involved assessing community activities and facilitating connections between individuals and existing groups, thereby mitigating potential gaps where commissioned care is unavailable. In addition, an evaluation of training, skills, and development services under contract was carried out to confirm alignment with contractual obligations and the needs of the population, supporting the long-term sustainability of these services.	Complete - process developed and implemented
Review use and cost of Our of Area placements	Reduction in spend by £174,000.	In Progress	Please see page 25 for more details	Ongoing as part of the review of commissioned services.
Reduce spend and achieve value for money with key commissioned service provider	Reduction in budget by £4,599,000.	In Progress	Please see page 25 for more details	Ongoing as part of the review of commissioned services.

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
Refresh Workforce Plan focusing on future staffing requirements taking service transformation into account	Refreshed Workforce Plan developed and implemented.	In Progress	Please see page 26 more more details	Complete - refreshed Workforce Plan developed and approved by IJB in May 2026

Modernising our approach to Service Delivery

Implementing Transformation

The Strategic Plan places emphasis on implementing transformation through ACHSCP services. This allows ACHSCP services to respond to the needs of patients, clients and communities by making these operate more efficiently.

Implement and review Primary Care Improvement Plan (PCIP) to identify, successful efficient delivery of services and areas of improvement.

The Primary Care Improvement Plan (PCIP) is a national programme that supports changes to how primary care services are provided for local populations. It focuses on moving a range of services from GP practices to wider primary care teams, so that people can access care from the most appropriate professional, closer to home and in a timely manner. This includes services such as community treatment and care (CTAC), physiotherapy, pharmacy, community link workers, vaccinations and urgent care. By developing these services, PCIP helps improve access to care for local communities, while allowing GPs to spend more time supporting people with more complex health needs.

The PCIP Review was undertaken to provide assurance on the delivery, impact and sustainability of PCIP services across NHS Grampian, including services delivered to the population of Aberdeen City. The review supports understanding of how PCIP investment is contributing to the modernisation of primary care, reducing pressure on General Practice and strengthening multidisciplinary team working so that people can access the right care, from the right professional, at the right time.

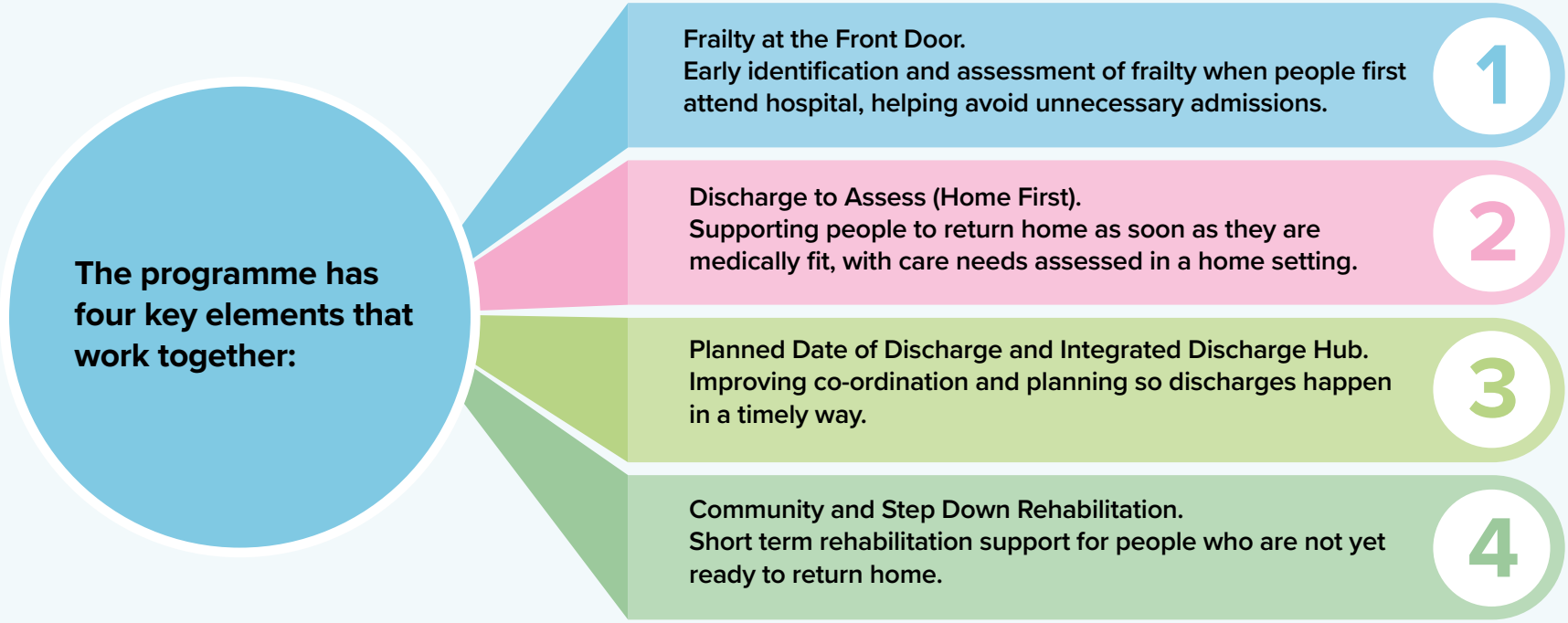
The review was undertaken as a Grampian-wide assessment, drawing together evidence from all three Health and Social Care Partnerships. Findings for Aberdeen City will be considered within this wider system context to support shared learning, consistency and assurance, while recognising local population needs and service models.

The aim of the review is to assess PCIP services across four key dimensions:

The PCIP Review will provide a clear evidence base to support performance assurance, help shape future planning and funding for PCIP delivered services, and guide the ongoing development of effective, equitable and sustainable PCIP services within Aberdeen Health and Social Care Partnership.

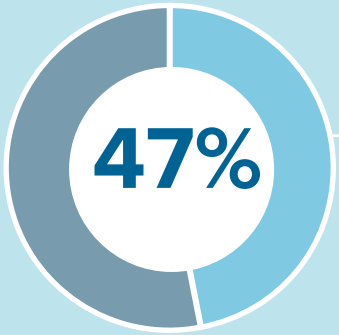
Deliver the Discharge Without Delay Collaborative commitments.

The Discharge Without Delay (DWD) Programme is a national approach designed to help people, particularly frail older adults, receive care in the most appropriate setting and avoid unnecessary time in hospital. The programme supports a shift away from hospital-based care towards care at home or in the community, helping people recover more quickly and reducing the risk of hospital related harm.



The progressive development of these key elements has supported the phased closure of Rosewell House, reflecting a reduced reliance on intermediate care beds as community-based services have grown. This shift has contributed to a significant reduction in nursing bank costs. The development of the Discharge to Assess project in ACHSCP has been a key part of DwD programme delivery in this reporting period.

Of the patients discharged to be assessed at home, almost half



stayed at home

of those needing no care at all.

The Discharge to Assess project enabled the discharge of people who may otherwise remain in hospital awaiting assessment of care home placement.

This led to

736

acute bed days saved in the first four months of the project.

Overview of projects related to Implementing Transformation

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
Deliver Aberdeen City commitments in the GP Vision programme.	Commitments Delivered	In Progress	The aim of the programme is to create a more sustainable General Practice Service across Grampian enabling communities to stay well through prevention and treatment of ill health. This is being delivered across ten workstreams, in two phases. This year, the programme published a documentary about a GP's daily routine "A Day in the life of a GP"[7] and made efforts to improve communication with patients, staff, and PCIP Providers through YouTube, site visits, social media, and local radio. As part of the programme, ACHSCP in partnership with the NHS Grampian Health Intelligence team developed a data dashboard to support operational decisions in Primary Care services which will be shared with other Grampian HSCPs in due course.	Continue to deliver Business as Usual
Implement and review Primary Care Improvement Plan (PCIP) to identify, successful efficient delivery of services and areas of improvement.	Refreshed PCIP approved	In Progress	Please see page 33 for more details	Continue to deliver as Business as Usual

[7] Video is available to watch through the following link https://www.youtube.com/watch?v=sGnY9uW9ofI&t=1s

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
Deliver the Discharge Without Delay Collaborative commitments.	Reduction in bank nursing spend by £999,000 Delivery of Discharge without Delay measures	Yes	Please see page 34 for more details	Delivery of DWD measures ongoing as business as usual
Redesign model of support to Amputees to community-based provision.	Closure of six beds Length of stay Delayed Discharge Data	In Progress	Work remains ongoing to understand the need of amputees. Options are being investigated and discussed in terms of the proposal for the future model. There are efficiencies in place that can be implemented with immediate effect to support a bed reduction, with further work to be done to support a more community focussed pathway.	Not achieved but will be included in proposed redesign of rehabilitation services proposed for year 2 Delivery Plan
Codesign alliancing work with Counselling Services	Reduction in average waiting times Increase in inter-provider collaboration. Reduction in duplication of services and waiting lists	In Progress	The project's focus was on the building of an alliance model with counselling services within Aberdeen. Initial discussions have been held with ACVO to take this forward.	Ongoing as part of the review of commissioned services.

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
Implement redesign of residential substance use service with a view to deliver a community-based support service model.	Redesign implemented	In Progress	The ultimate purpose of the project is to reprovision a new residential/housing model for the substance use service in Aberdeen city. This will result in the decommission of an existing residential building that supports 17 individuals that require support with their substance use which is no longer fit for purpose. Workshops have been held with providers to look at potential new build opportunities within the city. Engagement events have taken place with staff and stakeholders on the future needs of community substance use services. Site visits to two possible development opportunities have also taken place. This has resulted in several meetings with developments and landowners to discuss viable options. Mapping and scoping exercise of other services/models throughout Scotland that support individuals with substance use issues is ongoing.	Ongoing as part of the review of commissioned services.

[7] Video is available to watch through the following link https://www.youtube.com/watch?v=sGnY9uW9ofI&t=1s

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
In conjunction with ACC colleagues influence the redesign of Sheltered Housing to modernise the model of Housing support.	Numbers of tenants receiving low, medium and high support	In Progress	Six older sheltered housing blocks are planned for conversion to an amenity housing model. By late 2025, one site had been fully converted, while the others had reached over 88% amenity tenancies, reducing on-site care needs. Further implementation has been paused pending a broader housing review to ensure alignment with new strategic priorities and will resume after updated city-wide plans are clarified.	Paused in 2025-26 but will be picked up by work led by the Housing Integration Manager in 2026-27
Develop an Initial Point of Contact Model (pre assessment offer) for Adult Social Care	IPOC model in place demand statistics for assessment and care. Budget management	In Progress	This project was outlined within the published delivery plan, but outcomes and measures have subsumed by the Digital Innovation Programme which can be found on page 20.	Ongoing as part of the digitisation programme of work

Shift our focus towards Prevention and Early Intervention

Aligned with Scottish Government and NHS Scotland priorities, ACHSCP. This reflects a growing recognition that improving long-term outcomes for individuals and communities requires a stronger focus on preventing ill health before it develops, identifying risks earlier, and providing timely support that helps people remain healthy, independent, and connected within their communities.

A preventative approach aims to reduce inequalities in health and wellbeing by addressing the wider factors that influence health outcomes, including poverty, housing, social isolation, employment, education, and access to services. Through early intervention and partnership working, ACHSCP seeks to support people at the earliest possible stage, helping to avoid escalation of need and reducing avoidable demand on health and care services.

This approach is particularly important in the context of increasing demand, an ageing population, and the growing prevalence of long-term conditions. By investing in prevention and early support, ACHSCP aims to improve quality of life for people living in Aberdeen City while also ensuring services remain sustainable for the future.

Prevention requires a whole-system approach involving collaboration across health, social care, housing, education, third sector organisations, communities, and people with lived experience. By working together, partners can support healthier lifestyles, strengthen community resilience, and create environments that enable people to live well for longer.

Improve Physical and Mental Health

Improving both physical and mental health is fundamental to reducing inequalities and supporting people to live longer, healthier, and more independent lives. ACHSCP recognises the close relationship between physical and mental wellbeing and the importance of delivering person-centred support that addresses both.

Supporting people to maintain good physical and mental health can help reduce the likelihood of more serious illness developing in the future and may reduce the need for more intensive interventions later in life. Early support, timely access to services, and opportunities to improve wellbeing can all contribute to better long-term outcomes for individuals and communities.

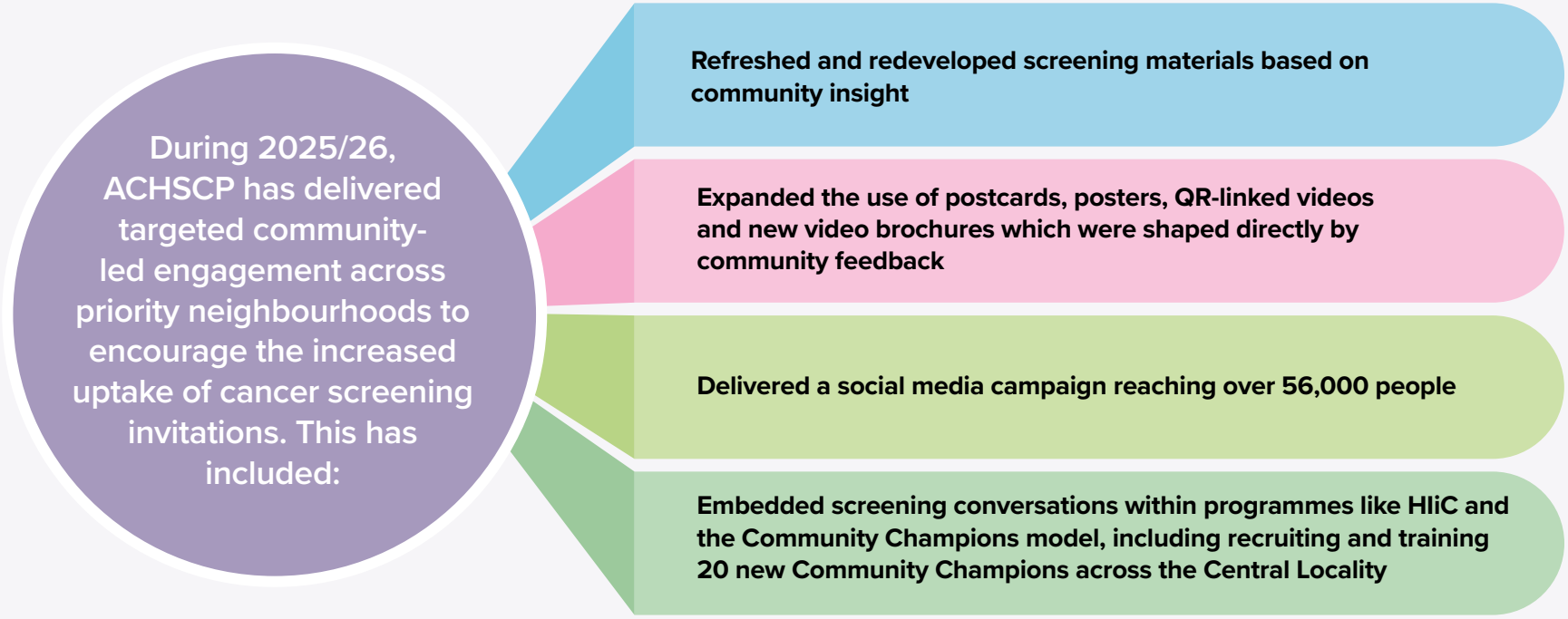
Across Aberdeen City, ACHSCP continues to support initiatives that encourage healthier lifestyles, improve emotional wellbeing, and reduce social isolation. This includes promoting physical activity, healthy weight, smoking cessation, and preventative approaches to long-term conditions, alongside supporting mental health services, community wellbeing initiatives, and social prescribing approaches.

The Partnership also recognises the importance of supporting children and young people to achieve the best possible start in life, as well as enabling older adults to remain active, connected, and independent within their communities. By intervening earlier and supporting wellbeing across the life course, ACHSCP aims to improve outcomes for current and future generations.

A continued focus on prevention and early intervention will support ACHSCP in shifting the balance of care towards community-based support, with a broader goal of reducing avoidable hospital admissions, and ensuring people receive the right care, at the right time, and in the right place.

Increase the number of people who accept the invitation of cancer screening on the basis of informed consent.

The project aims to increase the uptake of cancer screening invitations by strengthening informed consent, by ensuring people have clear, culturally appropriate, and accessible information to help them decide whether screening is right for them. This has been targeted even further in areas where uptake can be particularly low, such as neighbourhoods classifies as Scottish Index of Multiple Deprivation (SIMD)1 and ethnic minority communities.



Improve uptake of immunisations to at least the NHS Scotland average level by March 2027.

The overarching purpose of the Aberdeen City Immunisation Programme is to increase vaccination uptake across all age groups, with a particular focus on addressing health inequalities, reducing variation in uptake between communities, and ensuring that eligible populations are protected in line with national standards and the Scottish average.

This work is delivered through the Scottish Government Immunisation and Vaccination Five Year Framework[8], which provides a structured, long-term approach to improving uptake by:

- Removing barriers to access
- Providing flexible, community-based vaccination opportunities
- Embedding prevention and health promotion into routine and opportunistic contacts
- Strengthening partnerships across health, social care, education, and the third sector

The programme places a strong emphasis on equity, recognising that improving uptake overall requires tailored approaches for communities experiencing the greatest barriers, including areas of deprivation, vulnerable children and families, people experiencing homelessness, ethnic minority communities, people with learning disabilities, and those with poor engagement with traditional healthcare settings.

During 2025-26, Aberdeen City Immunisation Team has focused on moving from traditional service delivery models to more inclusive, flexible and community focused approaches, aligned to their Uptake and Equality Action Plan. This has allowed the positioning of immunisation as a core prevention and wellbeing intervention, rather than a standalone clinical activity. Through the Vaccination and Wellbeing Hub, Community Appointment Days, Making Every Opportunity Count (MEOC) conversations, and partnership working, vaccination is now routinely discussed alongside wider health needs, increasing awareness, confidence, and opportunities for uptake. This is further strengthened through joint working with Chest Heart & Stroke Scotland, bringing the Health Defence Team into Aberdeen City and embedding them within the Aberdeen Vaccination and Wellbeing Hub. The Health Defence Team now provides free health checks from the Hub, engaging with people immediately post vaccination to promote preventative health support, including blood pressure and cholesterol checks.

This co-location model ensures vaccination appointments act as a gateway to wider prevention activity, with individuals supported to access advice on healthy eating, lifestyle changes and cardiovascular risk reduction. This partnership exemplifies Making Every Opportunity Count in practice, reinforcing vaccination as part of a broader, holistic approach to improving health outcomes and supporting long term wellbeing.

[8] Scottish Government Immunisation and Vaccination Five Year Framework. Available from: https://publichealthscotland.scot/publications/scotlands-5-year-vaccination-and-immunisation-framework-and-delivery-plan/

Key areas of progress include:

Strengthening Access and Reducing Inequalities

- Expansion of community pop up vaccination clinics in priority neighbourhoods and low uptake areas
- Increased outreach to homeless services, substance misuse services, asylum seekers and ethnic minority communities, including in-reach clinics and partnership working.
- Continued development of out of hours clinics at the Aberdeen Vaccination and Wellbeing Hub to support working families and adults.
- Improved access for people with sensory impairments, learning disabilities, and neurodiversity, including quieter clinics, sensory supports and outreach via Learning Disabilities Health Checks.

Improving Childhood and School Age Uptake

- Implementation and evaluation of a School Immunisation Pilot, testing new delivery models to increase uptake, reduce disruption, and improve engagement.
- Enhanced follow up and recall processes for children who were “not brought”, with proactive re engagement.
- Increased use of hub based Saturday catch up clinics for school age and pre school children.
- Strengthened collaboration with schools, teachers, health visitors and early years settings to promote vaccination and attendance.

Embedding Prevention, MEOC and Community Engagement

- Increased focus on MEOC conversations at the Hub and through outreach activity.
- Integration of vaccination promotion into Community Appointment Days (CADs) and wider wellbeing activity.
- Launch of the Aberdeen Vaccination & Wellbeing Hub as a prevention focused space, supporting both vaccination delivery and broader health and wellbeing engagement.

Vaccination data outlined here is based on the most recent Public Health Scotland (PHS) publications. Due to the timing of national reporting cycles, there is a lag in data availability, and full 2025-26 figures are not yet published. This report therefore reflects the latest validated data available.

Area & PHS Reporting Period	Co-hort	Aberdeen City	Scotland	Variance
Pre-school PHS Report April 2026)	6 in 1 (12 Months)	93.7%	94.2%	-0.5%
	Rotavirus (12 Moths)	91.9%	92.9%	-0.3%
	MenB (2 Months)	92.6%	93.9%	-1.3%
	PCV (12 Months	93.3%	95.8%	-1.8%
	MMR1 (24 Months)	91.4%	92.4%	-0.7%
	MMR2 (5 Years)	85.9%	90%	-3.8%
	4 in 1 Booster (5 Years)	87.7%	90.3%	-2.4%
Teenage PHS Report November 2025	HPV - S2	80.1%	77.5%	+2.6%
	DTP - S3	71.4%	70.1%	+1.3%
	MenACWY – S3	71.3%	70.2%	+1.1%
Adult PHS Report November 2025	Shingles – Dose 1 Age 65	59.2%	60.3%	-1.1%
	Shingles – Dose 1 Age 70	64.0	67.9%	-3.9%
	Shingles – Dose 2 Age 65	74.3%	78.8%	-4.5%
	Shingles – Dose 2 Age 70	89.7%	84.2%	+5.5%
	Pneumococcal – 65+	24.6%	16.1%	+8.5%
	RSV	68.1%	70%	-1.9%
	Influenza – Care Home	85%	83.5%	+1.5%
	Influenza – Age 75+	80%	80%	0%
	COVID19 – Care Home (Winter)	82.5%	81%	+1.5%
	COVID19 – Age 75+ (Winter)	77.5%	76.5%	+1%
	COVID Care Home (Spring 25)	82.2%	79.5%	+2.7%
	COVID Age 75+ Spring 25)	70.2%	68.2%	+2%

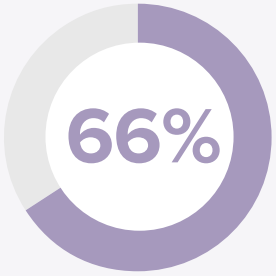
The data shows how Aberdeen City compares with the Scottish average. Further improvement is needed to meet the 2027 target of bringing immunisation uptake up to at least the national average. Performance is strongest in cohorts where delivery is structured, proactive and population-based, including school-based immunisations and programmes targeting older adults and care home residents. These models provide organised access, reduce reliance on individual engagement, and support consistently high uptake. Variation in uptake is most evident in urban populations, later stage childhood vaccines and programmes requiring ongoing engagement, which aligns with both local and national findings. In Aberdeen City, this reflects the additional complexity of delivering services within a large, diverse urban population including higher population turnover (University & Asylum Seekers) and mobility, which can result in missed appointments and challenges in maintaining continuity of care. Wider factors such as deprivation, health inequalities, language barriers, and varying levels of health literacy further influence engagement.

Publish an agreed multi-agency Health Weight Action Plan for Aberdeen City by December 2025.

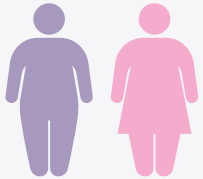
Healthy Weight Aberdeen is a Whole Systems Approach (WSA) initiative led by ACHSCP working in collaboration with Community Planning Aberdeen, NHS Grampian and Aberdeen City Council. The programme aims to address the complex drivers of obesity and reduce health inequalities across Aberdeen City by creating healthier food, physical activity and policy environments. The project aligns with national priorities including the Scottish Government's Good Food Nation Plan[9] and national approaches to tackling obesity and health inequalities.

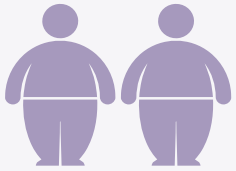
[9] National Good Food Nation Plan. Available from: https://www.gov.scot/publications/national-good-food-nation-plan/
ACHSCP Healthy Weigh Action Plan. Available from: https://www.aberdeencityhscp.scot/globalassets/healthy-weight-aberdeen--action-plan-v2-jun-26.pdf

1 in 5 **Primary 1 children are overweight or obese.**



of adults are overweight or obese.





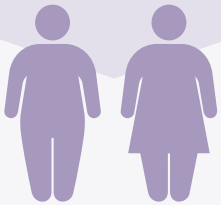
Children in deprived areas are twice as likely to be obese.

The estimated economic impact of obesity in Scotland is

£5.3billion

Key groundwork was laid this year to establish Healthy Weight Aberdeen as a system-wide programme. This included;

Whole-system foundations established	Robust evidence and systems mapping completed	Co-produced Action Plan developed
Senior leadership support, clear governance structures and multi-agency working arrangements were put in place, providing a strong platform for long-term system change.	Extensive local data review, systems mapping and action mapping were completed, enabling partners to understand the complex drivers of unhealthy weight in Aberdeen and agree priority areas for action.	A comprehensive Year 1 Healthy Weight Aberdeen Action Plan was developed and agreed, covering physical activity, food environments, planning and policy, communications, procurement, and targeted support for children, young people and families. This marked the transition from planning to implementation.



Publish an agreed multi-agency Public Mental Health action plan for Aberdeen City by March 2026.

Good mental wellbeing is shaped by everyday life; relationships, money, work, school, housing, connection and safety. The purpose of this project is to bring partners across Aberdeen together to create a shared whole city, preventative approach that strengthens these foundations, reduces inequalities and improves mental wellbeing across all ages. The aim is to shift the focus so that Aberdeen concentrates more on keeping people well, not only responding when people reach crisis.

This year, partners from health, social care, education, community planning, youth work, third sector organisations and local employers worked together to develop the city's first Population Mental Health Action Plan . Between January and March 2026, workshops, mapping exercises and lived-experience discussions were carried out to build a shared picture of needs, strengths and pressures across the life course. The plan was structured using the Building Blocks of Mental Health and Wellbeing, helping partners design preventative actions across five priority areas: infants and parents, children and young people, working-age adults, older adults, and whole-city enabling conditions[10].

[10] Aberdeen City Population Mental Health action Plan. available from: www.aberdeencityhscp.scot/contentassests/79321d5a3b6542eaabe50c845637cbae/aberdeen-city-population-mental-health-action-plan-2026-2027-5.pdf

Overview of Projects related to Improve Physical and Mental Health

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
Increase the number of people who accept the invitation of cancer screening on the basis of informed consent.	Cancer screening uptake statistics	In Progress	Please see page 41 for details	Continue to deliver as Business as Usual
Improve uptake of immunisations to at least the NHS Scotland average level by March 2027	Immunisation uptake level	In Progress	Please see page 42 for details	Continue to deliver as Business as Usual
Publish an agreed multi-agency Healthy Weight Action Plan for Aberdeen City by December 2025	Plan published following approval by relevant agencies	Yes	Please see page 45 for details	Plan developed, implementation will continue into 2026-27 and beyond
Publish an agreed multi-agency Ageing Well action plan for Aberdeen City by April 2026	Plan published following approval by relevant agencies	In Progress	The Active Ageing Aberdeen programme commenced in June 2025 and since then has established programme governance, undertaken system mapping, and delivered a stakeholder workshop session in February 2026 at the Aberdeen Art Gallery. The workshop generated over 40 ideas for system improvement and these have been refined into actions to be included in our Year 1 Active Ageing Aberdeen action plan 2026-27 which is due for publication in early 2026-27. This report has since been published and is available here: www.aberdeencityhscp.scot/our-delivery/communities-new/active-ageing-plan/	Plan developed, implementation will continue into 2026-27 and beyond
Publish an agreed multi-agency Public Mental Health action plan for Aberdeen City by March 26	Publication of Plan	Yes	Please see page 47 for details	Plan developed, implementation will continue into 2026-27 and beyond

Shifting our focus towards Prevention and Early Intervention

Reducing Harm

Reducing harm is a key priority for ACHSCP and supports the wider aim of improving health and wellbeing outcomes across Aberdeen City. Harm can arise from a range of social, physical, and behavioural factors and can have significant long-term impacts on individuals, families, and communities. Through a continued focus on prevention and early support, ACHSCP aims to reduce avoidable harm and improve outcomes for people across the city.

By taking a proactive and collaborative approach, the Partnership seeks to improve wellbeing and help ensure Aberdeen City is a safe, healthy, and inclusive place to live, work, and grow older. These harms are often experienced disproportionately by people living in areas of deprivation, contributing to wider inequalities in health outcomes.

Through partnership working and targeted prevention activity, ACHSCP continues to support initiatives that reduce risk and improve wellbeing across the life course. This includes work to decrease the number of women smoking during pregnancy, reduce the regular use of vaping products among young people and deliver local action plans aligned to suicide prevention and self-harm strategies. By focusing on early support, education, and improving access to services, ACHSCP aims to help create safer, healthier, and more resilient communities.

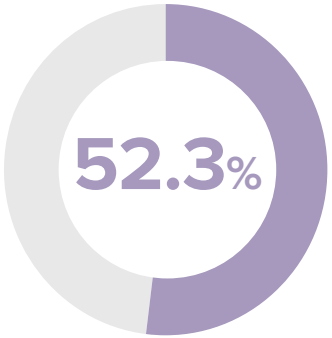
Decrease the number of women who are smoking during pregnancy in the 40% most deprived Scottish Index of Multiple Deprivation (SIMD) areas

The project aims to reduce the number of women smoking during pregnancy in the 40% most deprived SIMD areas, recognising that the prevalence of smoking is closely linked with deprivation, stress, financial pressures, household smoking and wider inequalities. Reducing smoking in pregnancy is essential for improving maternal and infant outcomes, including reducing risks such as premature birth and low birth weight.

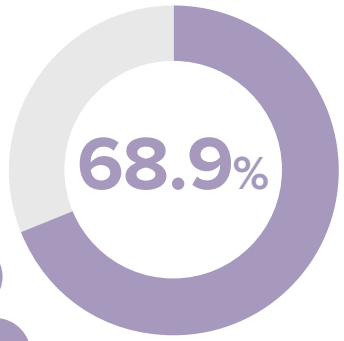
Over 2025–26, the team focused on implementing and embedding the new Tobacco Dependency in Pregnancy (TDIP) pathway, launched in March 2025, which has driven earlier identification and substantially improved contact with pregnant women who smoke. Between March and December 2025, Healthpoint successfully contacted 315 women, with referral numbers increasing due to identification happening both at the maternity booking appointment and later in pregnancy. Booking appointment CO2 testing strengthened to 80.1% by quarter 3. Community level work progressed through recruitment of Health Champions, development and testing of new harm reduction sessions on smoking and alcohol in pregnancy and strengthened public-facing messaging through the Aberdeen Protects resource.

in the number of women from SIMD 1 and 2 recorded as smokers at antenatal booking

from 164 in 2023 to 109 in 2025



of supported women set quit dates, and of these

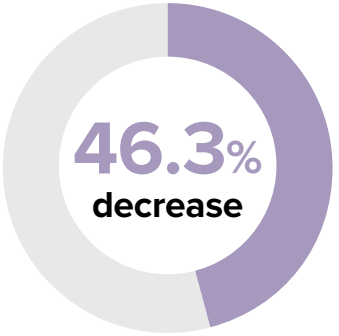


quit dates were achieved by women from SIMD 1-2

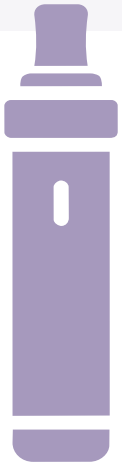
Reduce the number of 13-18 year olds in regular use of vaping products.

This project aimed to reduce the number of 13–18-year-olds who regularly vape by strengthening prevention across schools, youth settings and communities. Vaping remains a growing concern due to targeted marketing, social norms and the ease of accessing disposable vapes, all of which contribute to low perceived harm among young people. Over 2025–26, partners focused on improving teaching resources, building staff confidence, involving young people in designing materials and expanding peer-led education. Schools, Community Learning and Development youth work staff and community groups co-developed a new set of teaching resources. Absafe provided workshops to P6 classes to help consolidate learning and extended discussions about vaping. Local survey data now shows major reductions in regular vaping, demonstrating that prevention work delivered across the system is beginning to shift attitudes and behaviours at scale.

Local Health & Wellbeing survey data recorded a



in regular vaping among 13–18-year-olds.



Deliver and implement action plans for suicide and self-harm strategies.

The project aimed to reduce the five-year rolling average number of suicides in Aberdeen City by at least 5% by 2026. Suicide remains a significant public health issue in Scotland, with higher risk among men, people of working age, and those living in more deprived areas. The project aligns with the Local Outcome Improvement Plan (LOIP)[11] Stretch Outcome 10 on improving healthy life expectancy and with the national suicide prevention strategy Creating Hope Together (2022–2032).[12]

The work reflects Aberdeen City's commitment to preventing suicide through community capacity-building, stigma reduction, improved data intelligence, and multi-agency collaboration. Last year, activity focused on two core workstreams:

Building Community Capacity

- Delivery and promotion of suicide prevention training across Aberdeen City, delivered by SAMH, including ASIST, Introduction to Suicide, Introduction to Youth Suicide Prevention, and Wave After Wave.
- 49 people trained through Aberdeen City–specific sessions, with an additional 42 people attending open online sessions relevant to the city.
- Training feedback was strongly positive: 100% of respondents found training helpful professionally, 89% personally, and average post-training confidence to talk about suicide was 78%.
- Extensive awareness-raising through community events and campaigns, including NESCOL and RGU stalls, ACHSCP Health and Wellbeing Festival, Women's Wellbeing Fair, radio interviews, and World Suicide Prevention Day activities.
- Digital engagement through social media and the Prevent Suicide North East app, which reached 171,957 users in November 2025, with strong quarterly growth in views, reach, and followers.

Data Analysis and Risk Reduction

- Ongoing review of monthly suicide data from Police Scotland, discussed at bi-monthly Aberdeen City Suicide Prevention Delivery Group meetings.
- Continued pilot and implementation of the QES Suicide Surveillance System, a first in Scotland real time surveillance approach supported by Public Health Scotland.

[11] Local Outcome Improvement Plan - Community Planning Aberdeen. Available from: https://communityplanningaberdeen.org.uk/community-planning-structure/our-plans-and-strategies/local-outcome-improvement-plan/
[12] Creating Hope Together: suicide prevention strategy 2022 to 2032. Available from: https://www.gov.scot/publications/creating-hope-together-scotlands-suicide-prevention-strategy-2022-2032/

Overview of projects related to Reduce Harm

Programme/Project	Success Measure	Achieved?	Update/Reference	Outcome
Decrease the number of women who are smoking during pregnancy in the 40% most deprived SIMD	Reduction in smoking prevalence at booking. Number of pregnant women who set a quit date.	Yes	Please see page 49 for details	Continue to deliver Business as Usual
Reduce the number of 13-18 year olds in regular use of vaping products	Number of 13-18 year olds regularly vaping	Yes	Please see page 50 for details	Continue to deliver as Business as Usual
Reduce harm caused by the use of drugs and alcohol	Reduction in deaths related to drugs and alcohol by 10%	In Progress	There is an overall 5 year decline of Drug Related Deaths (DRD) population adjusted rate. But potentially a significant increase in DRD in 2025 due to synthetic opioids in circulation. Progress has been made in reducing deaths by; launching naloxone app, maintaining Medication Assisted Treatment (MAT) Standards and conducting a Community Appointment Day in Torry.	Ongoing as business as usual and will form part of the Health and Social Care System Change in the refreshed LOIP 2026-2036
Deliver and implement action plans for suicide and self-harm strategies	5 year rolling average number of suicides to reduce by 5% by March 2026	In Progress	Please see page 51 for details	Ongoing as business as usual and will form part of the Health and Social Care System Change in the refreshed LOIP 2026-2036

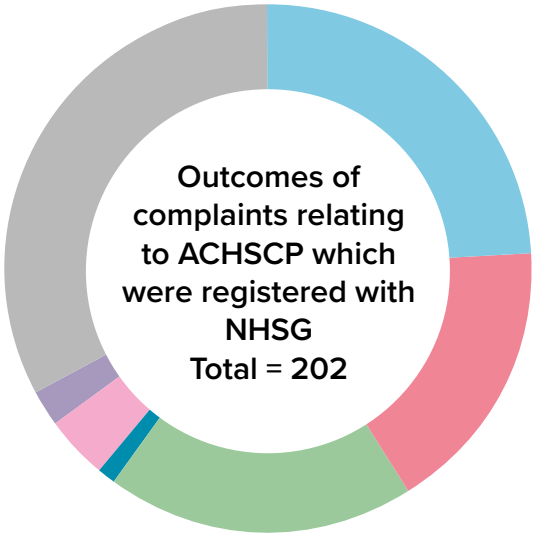
Additional Governance

Complaints.

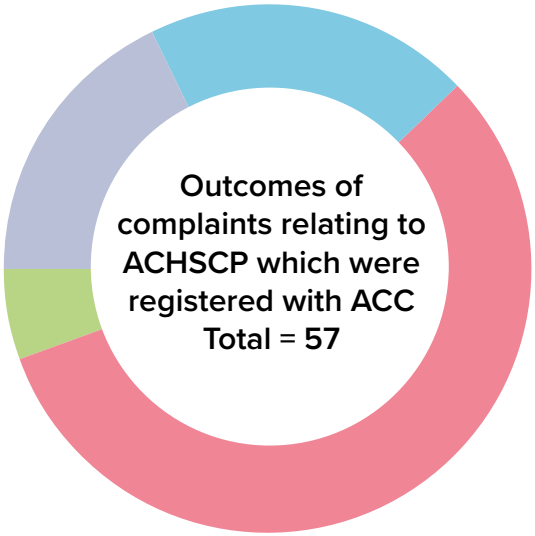
At ACHSCP, we welcome feedback and are committed to listening, learning, and continuously improving to provide compassionate care. Robust governance processes are in place to ensure that all complaints are reviewed thoroughly and that, where appropriate, learning is identified to inform service improvement, this is monitored by the Clinical and Care Governance Committee.

In 2025-26, a total of 259 complaints were recorded across ACHSCP, received through either NHS Grampian or ACC. This represents a 17% increase compared to 2024-25.

Of the total complaints received, approximately 22% were fully upheld meaning that ACHSCP recognised the complaint to be justified. A further 15% were partially upheld. 33% of complaints are currently uncategorised which ACHSCP aim to reduce. A breakdown of complaint outcomes is presented below and further information on complaints and feedback is available on the ACHSCP website[13] and is updated on a quarterly basis.



- 24% Fully upheld
- 17% Partially upheld
- 19% Not upheld
- 1% Transferred to another unit
- 4% Consent not received
- 2% Complaint withdrawn
- 33% Uncategorised



- 18% Upheld
- 51% Not upheld
- 5% Partially upheld
- 26% Resolved

[13] ACHSCP Feedback and Complaints. More information available here: https://www.aberdeencityhscp.scot/about-us/feedback-and-complaints2/feedback-and-complaints-documents/

Complaints Response Times and Outcomes

Stage 1:

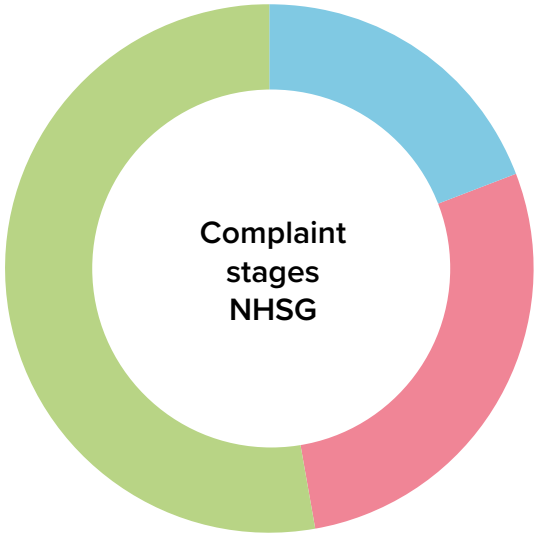
- Early Resolution
- Resolved within five working days.

Stage 2 (non-escalated):

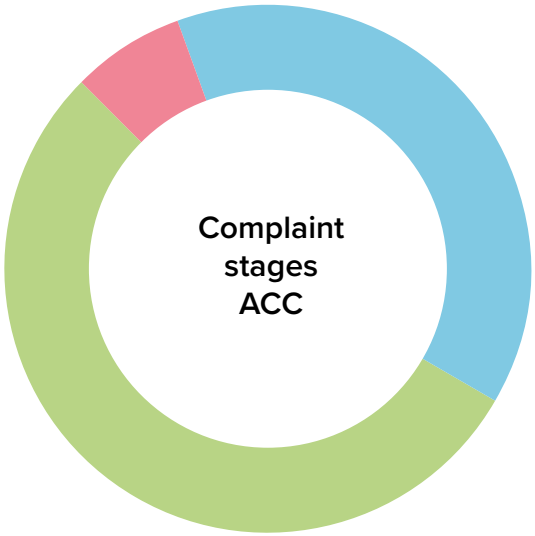
- Not able to be resolved at early resolution
- Investigation and response in 20 working days.

Stage 2 (escalated):

- Immediately passed for full investigation
- Response within 20 working days.



- 19% Stage 1 - Early Resolution
- 53% Stage 2 - Non Escalation
- 28% Stage 2 - Escalated



- 39% Stage 1
- 54% Stage 2- Non escalated
- 7% Stage 3 - Escalated

Whistleblowing

The Independent National Whistleblowing Officer introduced National Whistleblowing Standards on 1 April 2021.

NHS Grampian, the Health and Social Care Partnerships and their partner organisations are committed to creating an open and supportive culture where people feel comfortable raising concerns. They want concerns to be listened to, taken seriously and acted upon when needed.

Work has been carried out across health and social care services in Grampian to make sure there is a clear and consistent approach to reporting concerns and learning from them.

Anyone who provides, or has provided, NHS services can raise a whistleblowing concern. This includes:

- NHS staff
- Health and social care staff
- Primary care staff, including GP practices
- Contractors providing NHS services
- Agency staff and locums
- Students, trainees and apprentices
- Volunteers
- Third-sector organisations.

ACC's Whistleblowing Policy explains what whistleblowing is, the legal protections available, and how concerns can be reported. It provides a clear process for raising concerns safely, including for agency workers, contractors and self-employed workers.

In July 2021, the IJB approved its own Whistleblowing Policy. The policy applies to Board Members and Office Holders and supports the reporting of any concerns about possible wrongdoing or poor practice within the organisation. It also ensures that concerns are handled openly, fairly and professionally.

The policy aims to make sure people understand what concerns should be reported and how to report them. It encourages concerns to be raised early and without fear of unfair treatment.

No concerns have been raised through the IJB Whistleblowing Policy since it was introduced. However, this does not necessarily mean that no concerns exist. It is important that people know how to raise concerns and feel confident in doing so.

Although no concerns have been reported through the policy, having a whistleblowing process remains an important part of good governance. Promoting the policy helps support openness, transparency and confidence in reporting concerns.

During 2025/26, no whistleblowing concerns relating to ACHSCP were reported through either the National Whistleblowing Policy or Aberdeen City Council's Whistleblowing Policy.

While no concerns have been reported, it is important to continue promoting whistleblowing arrangements and ensuring that staff feel safe and supported to speak up when they have concerns.

It is proposed that the ACHSCP works with NHS Grampian and Aberdeen City Council to raise awareness of whistleblowing and promote the available policies and support. It is also proposed that the IJB Whistleblowing Policy is promoted on the Partnership's website.

IJB Directions

Directions are a legal mechanism intended to clarify responsibility requirements between partners. Directions are how ACHSCP directs NHS Grampian and ACC on what services are to be delivered using the integrated budget. Directions must be given in respect of functions that have been delegated to the ACHSCP. Specific directions can be given to NHS Grampian, ACC or both depending on the services to be provided. The following directions were approved by the IJB in 2025-26.

- **Medium Term Financial Framework - All adult social care services covered by the Aberdeen City Integration Scheme**
- **Medium Term Financial Framework - All community health services covered by the Aberdeen City Integration Scheme**
- **Grants for Voluntary Organisations**
- **Annual Procurement Workplan - Care home for people with Alcohol and Drug Misuse**
- **Annual Procurement Workplan 2025-26 - Direct Award of six contracts to Care Homes for adults with Learning Disabilities**
- **Annual Procurement Workplan 2025-26 - Extension of existing National Care Home Contracts**
- **Grants funding for Voluntary Organisations**
- **Discharge to Assess Service Annex 2, Part 2- Support Services**
- **Shifting the balance of care - A Community Focused Approach to Delivery of Frailty and Specialist Rehabilitation Services within ACHSCP**
- **Digital Innovation Programme and Technology Enabled Care**
- **Grant Funding for Voluntary Organisations: Update relating to Future Funding**

All directions are evidenced by the Medium Term Financial Framework or Delivery Plan for 2025-26 and none were taken outwith this. The papers supporting these directions can be found on the Aberdeen City Council Website under the IJB Committee[14].

[14] Committee details - Integration Joint Board. Available from: https://aberdeen.moderngov.co.uk/mgCommitteeDetails.aspx?ID=516

Notes

Notes

If you require any further information about any aspect of this document, please contact:

Aberdeen City Health and Social Care Partnership
Business Hub 8, 1st Floor North
Marischal College
Broad Street
Aberdeen
AB10 1AB

t: 01224 523237
e: ACHSCPenquiries@aberdeencity.gov.uk
w: aberdeencityhscp.scot

Aberdeen City Health & Social Care Partnership
A caring partnership

BON ACCORD
ABERDEEN CITY COUNCIL

NHS Grampian