Aberdeen City
Health & Social Care
Partnership

A caring partnership

Annual Performance Report
2023 – 2024

Foreword by our Chief Officer

I am happy to present Aberdeen City Health & Social Care Partnership's Annual Performance Report for 2023 – 2024. The report outlines some of our key areas of work over the last 12 months. The progress you will read is testament to the hard work and dedication from our staff, in collaboration with our partners, who continue to operate in a very challenging environment.

Despite these challenges, I am very proud of what we have achieved over the last year. To give just some examples, we have seen a marked reduction in our unmet social care need and a greater number of general practices returning to full service provision. Following the success of our Aberdeen Vaccination and Wellbeing Hub, we have expanded this further to co-locate a variety of services. By using a Priority Intervention Hub model, it has helped us to provide a greater range of support to people who need it. Our Health Improvement Fund has helped to support over 70 community led projects across Aberdeen City. This has allowed us to support communities to improve their health and wellbeing. We launched our Technology Enabled Care Plan to explore how we can better use technology to help people live independently for longer. We held our first 'Age Friendly City' event that almost 200 people attend as we look to support people to age well into retirement and later life. We continued to implement our Carers Strategy to improve the experience of everyone with a caring role in Aberdeen and we increased the membership and diversity of our three Locality Empowerment Groups to ensure people in our communities help us shape how we plan and deliver services. In February, we reinstated the Partnership's annual conference to celebrate the successes of our workforce, which was a fantastic event.

Finance is a challenging area for us, as it is for everyone else. This is due to factors that are difficult for us to directly control, for example the costs we pay for medicines and our reliance on agency staff as a result of difficulties recruiting health and care professionals to the North East. We are entering the final year of our Strategic Plan and planning is under way to identify our strategic priorities for our new Strategic Plan in 2025. We remain committed to providing safe and quality services to the population of Aberdeen City and to putting people front and centre of our decision making but we will have to seek innovative ways of achieving this within the resources we have.

Our population is getting older and the demand for health and social care services is increasing. We are putting renewed focus into delivering and promoting prevention and early intervention services with a view to helping people avoid preventable diseases and to remain as healthy as possible for as long as possible. We need people to engage with these services and employ self-care to help ensure everyone has access to our services in the future.

Finally, on behalf of the Integration Joint Board and the Partnership, I would like to note our appreciation and thanks to our former Chief Officer, Sandra Macleod, who left the role in February 2024. Sandra led the Partnership over a span of five and a half years and much of the progress we have made has been driven by her dedication and commitment to improving outcomes for the people of Aberdeen. We wish her well for the future and we will continue to build upon the work she started.

Fiona Mitchelhill

Chief Officer
Aberdeen City Health & Social Care Partnership

Contents

Introduction

The Aberdeen City Health & Social Care Partnership (ACHSCP) Annual Performance Report gives an overview of performance against our Strategic Plan across the 2023-2024 financial year. The Strategic Aims within the ACHSCP Strategic Plan 2022-2025 and the key national health and wellbeing and integration measures are used to demonstrate performance over the year.

The report is broken down into distinct sections. The first introduces our Strategic Plan and the intended priorities for the 2023-2024 financial year, followed by five sections detailing performance in each of the four strategic aims and the enablers. The final section looks to give an overview of performance against key elements of our governance arrangements. Finally, in Appendix 1 we detail our performance on the national measures showing performance over time and in relation to the Scottish average.

Collectively these sections are intended to demonstrate the achievement of best value. The projects showcased throughout the report and the performance detailed in the appendices demonstrate improvements we have made in the performance and quality of our service delivery.

The Finance section on pages 63 and 64 confirms that we have achieved this within our funding envelope.

ACHSCP's Strategic Plan Aims

In 2022, the ACHSCP Strategic Plan for 2022-2025 was approved by the Integration Joint Board (IJB). Having learned from our previous strategic plan and also from the experiences of the Partnership's response to Covid 19, the Strategic Plan looks to continue to focus on progressing the integration agenda. This will be achieved by promoting preventative measures and increasing access to community-based health and social care services whilst shifting the balance of care from a hospital setting to closer to home.

As a means to achieve this, strategic priorities were identified under four strategic aims along with priorities under five enablers. A Delivery Plan which supports the aims of the Strategic Plan was developed. This outlines the means by which these aims are to be achieved and Appendix 4 demonstrates how our performance this year links to the Delivery Plan objectives. The full Strategic Plan can be found here: www.aberdeencityhscp.scot/about-us/our-strategic-plan/.

The '**Strategic Plan on a page**' can be found on the next page.

The following sections of this report demonstrate the progress being made towards these aims and the associated delivery plan.

Strategic Aims				
CARING TOGETHER	**KEEPING PEOPLE SAFE AT HOME**	**PREVENTING ILL HEALTH**	**ACHIEVE FULFILLING, HEALTHY LIVES**	
Strategic Priorities				
▸ Undertake whole pathway reviews ensuring services are more accessible and coordinated ▸ Empower our communities to be involved in planning and leading services locally ▸ Create capacity for General Practice improving patient experience ▸ Deliver better support to unpaid carers	▸ Maximise independence through rehabilitation ▸ Reduce the impact of unscheduled care on the hospital ▸ Expand the choice of housing options for people requiring care ▸ Deliver intensive family support to keep children with their families	▸ Tackle the top preventable risk factors for poor mental and physical health including: - obesity, smoking, and use of alcohol and drugs ▸ Enable people to look after their own health in a way which is manageable for them	▸ Help people access support to overcome the impact of the wider determinants of health ▸ Ensure services do not stigmatise people ▸ Improve public mental health and wellbeing ▸ Improve opportunities for those requiring complex care ▸ Remobilise services and develop plans to work towards addressing the consequences of deferred care	
Enabling Priorities				
WORKFORCE	**TECHNOLOGY**	**FINANCE**	**RELATIONSHIPS**	**INFRASTRUCTURE**
▸ Develop a Workforce Plan ▸ Develop and implement a volunteer protocol and pathway ▸ Continue to support initiatives supporting staff health and wellbeing ▸ Train our workforce to be Trauma informed	▸ Support the implementation of appropriate technology-based improvements – digital records, SPOC, D365, EMAR, Morse expansion ▸ Expand the use of Technology Enabled Care throughout Aberdeen ▸ Explore ways to assist access to digital systems ▸ Develop and deliver Analogue to Digital Implementation Plan	▸ Refresh our Medium-Term Financial Framework annually ▸ Report on financial performance on a regular basis to IJB and the Audit Risk and Performance Committee ▸ Monitor costings and benefits of Delivery Plan projects ▸ Continually seek to achieve best value in our service delivery	▸ Transform our commissioning approach focusing on social care market stability ▸ Design, deliver and improve services with people around their needs ▸ Develop proactive communications to keep communities informed	▸ Develop an interim and longer-term solution for Countesswells ▸ Review and update the Primary Care Premises Plan

Priorities for 2023-2024

The ACHSCP Annual Performance Report 2022-2023 represented the first year of the 2022-2025 Strategic Plan.

The Partnership outlined the following priorities for the 2023-2024 financial year. Achieving these would help to meet our Strategic Aims as outlined on Page 6 .

ACHSCP provides regular updates on the progress being made in each of these areas have been included in the report. These can be found by navigating to the page number given, or clicking the priority to take you to that area of the report.

Implement and Embed the Carers Strategy
(Page 25)

Implement and Embed the Workforce Plan 2022-25
(Page 56)

Undertake a review of our Neuro Rehabilitation Service
(Page 31)

Continue to engage with the communities of Aberdeen in a way that suits them
(Page 38)

Ensure close alignment of Complex Care needs to the Market Position Statement and its reflection in the provision of support and accommodation
(Page 53)

Policy Context

The ACHSCP operates within a complex and dynamic policy context, which influences and shapes the delivery of health and social care services in Aberdeen City. The policies and strategies are constantly evolving and changing, and it is important to keep up to date with the latest developments and implications for our work.

ACHSCP provide regular updates and briefings on the policy context, and also engages with and influences the policy development and implementation at the national and local level.

The next two pages indicates some of the many policies we consider.

Linked National Policies

- 2018 GMS Contract - General Medical Services MoU with Scottish Government
- Coming Home Implementation
- Community Empowerment (Scotland) Act 2015
- The Annual Health Checks for People with Learning Disabilities (Scotland) Directions 2022
- Independent Living housing adaptations
- Climate Change (Emissions Reduction Targets) (Scotland) Act 2019
- NHS Grampian Three Year Delivery Plan (2023-26)
- Mental Health & Wellbeing Strategy 2023-2025
- National Strategy for Community Justice
- Creating Hope Together: suicide prevention strategy 2022 to 2032
- HIS Standards for Sexual health
- A Fairer Scotland for Older People - A framework for Action
- Scottish Housing and Dementia Framework
- The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012
- The Health and Social CareStandards: My Support, my Life (2017)
- National Health and Wellbeing Outcomes Framework 18th February 2015

Linked National Policies

Equipment and Adaptations: Guidance on Provision (2023)

Medication assisted treatment (MAT) April 2022

Womens Health Plan

National level: Tobacco and vaping framework: roadmap to 2034

Local (Grampian Region) level): Grampian Tobacco Strategy 2023

Digital Health and Care Strategy - 2021

Sexual health and BBV framework action plan

National Care Service (Scotland) Bill June 2022

Public Services Reform (Scotland) Act 2010

Adult Support and Protection (Scotland) Act 2007

GIRFE (Getting it Right For Everyone)

Housing to 2040

Scotland's Public Health Priotities: Priority 6

Civil Contingencies Act 2004

Carers (Scotland) Act 2016

Public Bodies (Joint Working) Act 2014

The Scottish Governments Technology Enabled Care (TEC) Programme - launched in late 2014

Digital health and care strategy Scotland - Enabling, Connecting and Empowering - 2021

Partnership Working

ACHSCP has key stakeholders, including NHS Grampian, Aberdeen City Council, and the third sector. These organisations work together to improve the health and wellbeing of the local population, with a focus on prevention, early intervention, and support for independent living. The Partnership also engages with service users, carers, and the wider community to ensure that their needs and views are taken into account in the planning and delivery of services. Please see some examples of the services covered by ACHSCP -

Services Delegated from ACC:

- Social Work Services for Adults and Older People
- Social Work Services for Adults with Physical and Learning Disabilities
- Mental Health Services
- Drug and Alcohol Services
- Adult Protection and Domestic Abuse
- Carers Support
- Communty Care Assessment Teams
- Support Services
- Care Home Services
- Adult Placement Services
- Health Improvement Services
- Aspects of Housing Support, including aids and adaptation
- Local Area Co-ordination
- Respite Provision
- Occupational Therapy Services
- Reablement Services, Equipment and Telecare
- Justice Social Work Services

Services Delegated from NHSG:

- Accident and Emergency Services provided in a Hospital
- Selected inpatient Hospital Services (general, geriatric, rehabilitation, respiratory medicines and Psychiatry of Learning Disability
- Continence Services/Kidney Dialysis Services provided out with a Hospital
- Services provided by Health Professional that aim to promote Public Health
- Community Learning Disability Services
- Inpatient Hospital Services provided by GMS
- Addiction or Substance Dependence Services
- Community Mental Health Services
- District Nursing
- Allied Health Professionals
- Public Dental Service
- Primary Medical Services
- General Dental Services
- Ophthalmic Services
- Pharmaceutical Services
- Out-of-Hours
- Palliative Care
- Grampian Sexual Health Service

Caring Together

The strategic theme of Caring Together means that together with our communities, the Partnership wants to ensure that health and social care services are high quality, accessible, safe, and sustainable; that people have their rights, dignity and diversity respected; and that they have a say in how services are designed and delivered both for themselves and for the people they care for, ensuring they can access the right care, at the right time, in a way that suits them. We intend to achieve this by:

- **Undertaking whole pathway reviews ensuring that services are more accessible and coordinated**
- **Empowering our communities to be involved in planning and leading services locally**
- **Creating capacity for general practice improving patient experience**
- **Delivering better support to unpaid carers.**

Redesigning Adult Social Work

In adult social work we saw significant challenges due to changing demographics, poverty and inequalities that led to increasing demand and complexity on our services and poorer outcomes for our communities. As part of aligning of our services into three localities, a redesign of adult social work began.

Vision

“The vision for adult social work in Aberdeen is based on a prevention and early intervention model, working in collaboration across sectors and services to prevent, intervene and deliver services to those who require it.”

In order to achieve our ambitions within our Strategic Plan, it was vital that there was a fundamental shift in the balance of care and a targeted joined-up approach to prevention and early intervention. Integration and the wider community planning agenda have supported more joined-up working, but further work was required to truly integrate our services and embed our shared vision, bringing with it team ownership, collaboration and system wide working.

Adult social work was considered as a whole system to realise the potential in how resources are aligned to deliver our services, achieve outcomes and meet our strategic ambitions. The first part of this work was to consider how services are redesigned through the lens of early intervention, prevention and community empowerment.

Over the past year, work has continued to design social work services for the future by aligning teams into localities. This enabled the creation of locality ownership, multi-agency and multi-disciplinary collaboration and system-working in its truest sense. The aim is to have teams who are protecting, promoting and ensuring a human rights-based approach within our local communities. It allows greater empowerment of people who need support, utilising community assets and placing supported people at the centre of care planning so they can achieve their goals and desired outcomes.

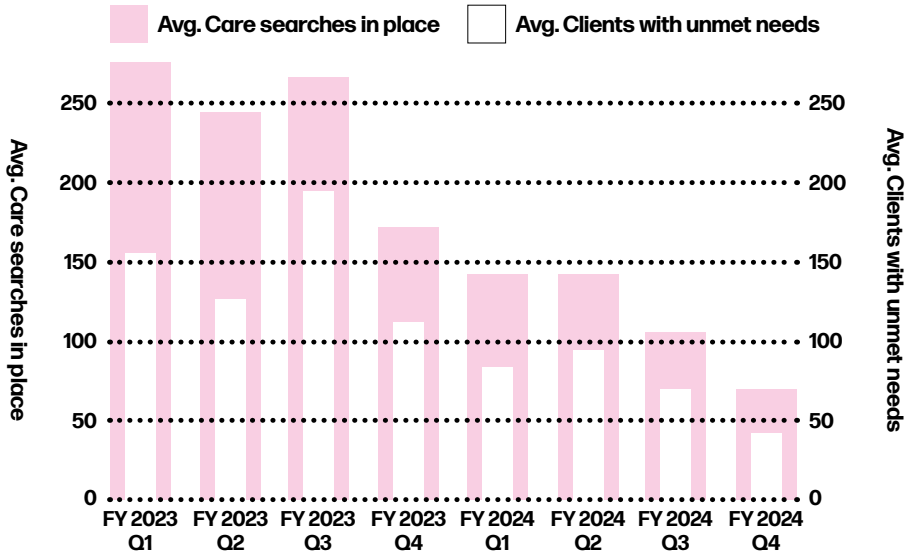
Older adults

The redesign of the Older People and Physical Disability service resulted in the enhancement of the Care Management Response Team to provide individuals and their families with a consistent entry point for screening, assessment, and care planning. Over the past year there has been a strong and sustained emphasis on addressing the waiting times for an assessment and the subsequent levels of unmet need.

An enablement-focused approach has been adopted which involves a consideration of technological support and the appropriateness of risk-assessed care. Through targeted screening and intervention, the goal is to complete high-need assessments within four weeks of referral instead nationally agreed waiting time of eight weeks. The targeted work in this team has resulted in a substantial reduction in unmet needs and delayed discharges.

Graph Showing Care Searches and Unmet Needs Clients

	FY 2023 Q1	FY 2023 Q2	FY 2023 Q3	FY 2023 Q4	FY 2024 Q1	FY 2024 Q2	FY 2024 Q3	FY 2024 Q4
Avg. Care searches in place	284.4	246.9	279.5	174.6	145.8	145.9	105.6	73.5
		▼ -38	▲ 33	▼ -105	▼ -29	● 0	▼ -40	▼ -32
Avg. Clients with unmet needs	156.7	126.5	196.0	112.1	87.4	96.7	67.3	41.0
		▼ -30.2	▲ 69.5	▼ -83.9	▼ -24.7	▲ 9.3	▼ -29.4	▼ -26.4



FY 2023 refers to the financial reporting year Apr 2022 - March 2023

FY 2024 refers to the financial reporting year Apr 2023 - March 2024

Hospital team charter

"We are a fully embedded part of the Multi-Disciplinary Team (MDT), whilst retaining our own core values and skills, to plan discharge from the point of admission; to get the individual back home to their own environment as quickly as possible with the right support. This will reduce the risks associated with lengthy hospital stays and improve patient outcomes."

A review team was also established to undertake statutory reviews triggered by adult protection concerns, targeted unscheduled reviews and annual reviews for all non-residential packages which will include those discharged from hospital. The team is now well established and has been a key driver in ensuring the right care is provided and that supported people and their families' outcomes are being met.

The Hospital Social Work review was completed in April 2023 and carried out in the context of the overall vision for social work services, it coincides with a range of other projects within the community aimed at shifting the balance of social work care and support. The recommendations contained within the review reflect the steps required now to have a Hospital Social Work Team who can function effectively and adapt within the current and future demands, alongside the aim of reducing hospital admissions with resources more directed into communities through locality structures.

The Hospital Social Work Team are a long-established team and have an essential role to play in ensuring that those patients who require Social Work assessment or support are enabled to move on from hospital and do so.

1378 reviews have been completed in the time.
1423 assessments of need completed.

Following the recommendations, hospital social workers (HSW) have been aligned to wards where the highest demand was seen. This recommendation was based on consideration of the current alignment of the hospital team, data on referral numbers, links to other related programmes of work and feedback from the HSW team and colleagues within the hospital.

The alignment of staff led to significant focus on specific areas to ensure system flow and key performance measures will be determined at the outset to monitor the impact of this change to ensure it is achieving its intended aim. Delayed discharge figures for the last year show the targeted approach brings positive results, ensuring that people are not delayed in hospital any longer than required.

Bed Days Occupied by Delayed Discharges March 2023 to April 2024, Aberdeen City

This graph shows the number of delayed discharge beds each month from April 2023 until March 2024. Despite there being an increase in these numbers, ACHSCP still maintain some of the lowest figures in Scotland. We have consistently remained within the 5 highest performing Local Authority areas in this regard. (Refer to Appendix 2 on page 79).

We have utilised several methods of interim provision, to allow service users to move on from hospital to a more homely setting, either for further rehabilitation and assessment, or to await care/care home placement.

Scottish Ambulance Service Social Care Pathway

In order to ensure better service user experience and to support colleagues working within the Scottish Ambulance Service (SAS) and in hospitals, we worked in collaboration with SAS and the Flow Navigation Centre (FNC) to develop a new Pathway.

Our vision is that people, with no clinical need, are triaged within the community and directed straight to social work for support and assistance. This prevents SAS transportation time to hospital and inappropriate use of the Accident and Emergency department. This will save SAS and A&E staff time. In addition, the Pathway will promote wellbeing, via a less traumatic experience for people identified with only social needs. The Social Pathway promotes person centered, earlier intervention and earlier access to services alongside avoiding potentially distressing removal by ambulance and time in hospital. We will apply the best evidence to the individual's problem. Right person, right time, right intervention. We aim to officially launch the Pathway in Aberdeen Summer 2024.

Adult Protection

Given the increase in complexity of risk and the need to fully upstream our services, the first part of the social work redesign was to undertake an audit of Adult Protection. A comprehensive review and options paper on the future operating model was completed in 2022. Over the past year we have continued to improve and strengthen our response to adults at risk of harm. The establishment of the Adult Protection Social Work Team has enabled a first point of contact for the triaging, screening, and response to all adult protection referrals, police concern reports and crisis intervention to those at risk. They work alongside all services such as the Community Intervention Hub, Housing, the Single Access Point, and the third and private sectors, to deliver early intervention and prevention practice. The implementation of standard operating procedures has provided robust systems and processes in our duties and created a strong, consistent and responsive approach to adult protection.

Implementation of the Adult Support and Protection (ASP) Recommendations

The purpose of this work was to implement the recommendations from the June 2022 inspection of ASP. This included work on processes and recording, access to Advocacy, and involvement of staff in improvement work. All of this work has now been completed.

Key Successes

- **NHS Grampian reviewed training for staff to improve understanding about ASP. A 'Practice Note' about ASP was also developed for staff who work directly with patients.**
- **ASP case conferences, at which individual cases are discussed, are being held more often. There has been a significant rise in the number of case conferences jumping from 45 in FY 2022-2023 to 106 in FY2023-2024. These involve the adult at risk and/or their carer or representative where possible.**
- **ASA support people, to make sure their views are represented, and their voice is heard.**

What's next?

We will continue to work on improving our approach to developing chronologies - looking at what has happened to someone in their past helps us to understand their future needs. We will ask staff to complete a survey to help us understand how effective our Council Officer Support Groups are.

There has been a significant increase of 12% in the number of people supported by Advocacy Service Aberdeen (ASA).

Strategic Review of Social Care

Our aim was to undertake a strategic review of specific social care pathways utilising the Getting it Right for Everyone (GIRFE) multi-agency approach where relevant and develop an implementation plan for improving accessibility and coordination. Further information can be found here - **GIRFE**.

Key Successes

- **We have reviewed the approach to Social Work assessment within the hospital. This highlighted challenges with communication and developing relationships between social work and ward staff. Individual hospital Social Work team members have now been aligned to specific wards. This aims to improve coordination for patients and develop positive relationships with ward staff. Feedback so far has been positive.**
- **Working collaboratively with multi-disciplinary teams, and independent and third sector partners. This has included being a pathfinder area for the Scottish Government's (GIRFE) approach. This is in line with shifting to a more preventative and proactive approach locally. Our 'Wee Blether' group members are key participants in this work.**
- **Incorporating Technology Enabled Care (TEC) as a project. Improving access to TEC supports people to live independently at home for longer.**

What's next?

Developing a 'TEC FIRST' approach to preventative and proactive care, exploring how digital interventions can enhance outcomes to save both time and money.

Designing an 'Initial Point of Contact' system for accessing support and services. This will focus on Prevention first. Where a person needs support this is managed collaboratively by a multi-disciplinary team.

> **"The Ward Alignment has resulted in better working relationship between me and the staff on the ward I am aligned to."**
>
> Hospital Social Work Team member

> **"Better communication, more proactive planning."**
>
> Ward staff member

Priority Intervention Hubs

Aberdeen City Vaccination & Wellbeing Hub

The aim was to create a Health & Wellbeing Hub which delivers an easily accessible location where a range of health, social care and voluntary organisations work together, responding to local needs. The hub focuses on a prevention and early intervention model in a way that addresses the widening inequalities gap and recognising the multiple impacts of long-term ill health on people's physical health, mental health and social wellbeing.

The Hub works collaboratively with over 70 voluntary organisations.

The Hub provides a range of services including a "One Stop Shop" for clinical services such as Vaccinations, Community Treatment & Care (CTAC) for Bloods, Chronic disease management and Vitamin B12 Injections, Community Respiratory Team, Health Visitors, pre-school drop in clinics and the provision of a Community Health Information Point.

The Hub provides regular support to people from third sector & voluntary organisations attending to promote their service and provide peer support to the following areas:

- **Mental Health & Wellbeing Support**
- **Drugs & Alcohol Recovery – Peer Support**
- **Independent Living & Employability**
- **Carers Support**
- **Digital Inclusion**
- **Housing, Financial & Cost of Living Support**
- **Safer Mobility & Falls Prevention**
- **Health Conditions – Parkinsons, Epilepsy, Stroke, Liver Disease, Menopause etc**

By providing information of activities in their local areas, the Hub helps people to establish and maintain connections so they can stay well and connected.

A community cafe and workshop area is available to support people to stay well and stay connected, by promoting wellbeing activities and provide a warm space for a "cuppa and a conversation". All staff are trained in Making Every Opportunity Count (MEOC) which is a brief intervention aiming to take a preventative approach and signpost people to services offering support.

What's next?

The service will continue to work with health, social care and voluntary organisations to further enhance the range of services delivered within this location and link with work being undertaken in other Health & Wellbeing Hubs within local communities. They will continue to support a preventative approach to reduce the burden on GP Practices and Hospital settings.

The service will continue to promote this model & work with colleagues within Grampian and other Health & Social Care Partnerships in Scotland who wish to roll-out this model of preventative care.

Feedback

PUBLIC FEEDBACK

"Nice and easy to talk to staff in the café area about my mobility problems. She provided lots of information about other services and also gave me a copy of the Agile Booklet."

"Pleased to see it is a Wellbeing Hub - Men like me are more likely to come in and have a chat."

"Love the fact there is different professionals on hand to help with issues."

"Coming into town on the bus got me out of the house. Was easy to get to."

"Plenty opportunities for asking questions - as we age our needs need to be anticipated as signs of future need can be spotted quite early."

SERVICE PROVIDER FEEDBACK

"Being located in the hub has given us good access to older adults that we often struggle to engage with."

"The hub has given us the ability to reach a wider audience - providing us with an increased visibility enhancing our impact."

"The hub allows an opportunity for networking with other organisations to enhance our knowledge, joint working opportunities and better signposting for people looking for support."

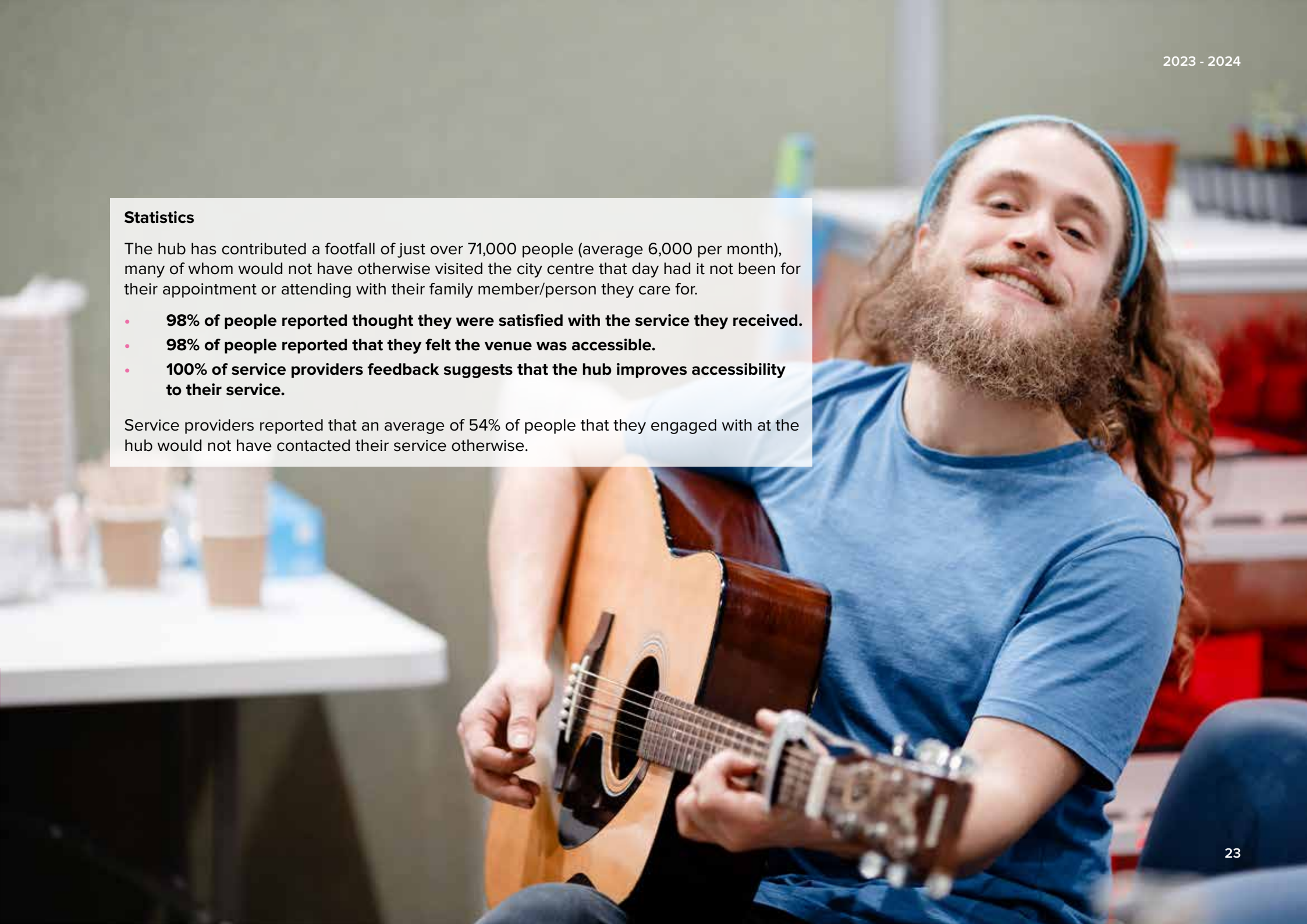
"The hub has given us a central location to meet with people who may be vulnerable that wouldn't have reached out otherwise."

"One visitor expressed their thanks for information to help support their family member who was starting to struggle at home. They now had a greater understanding of how to help prevent falls and encourage safer mobility."

"The hub's central location is great for attracting people from across the city and the friendly staff makes it welcoming."

Feedback from Public Health Scotland Visit - 24th May 2024 - Vaccination & immunisation Division (VAID)

"The visit to your hub was up-lifting; and to see how integrated, not only public health, but health and wellbeing in its wider sense is delivered by committed multi-disciplinary professionals from different organisations as one team was exemplary. You should all be proud of this achievement. All the staff we met at the wellbeing hub showed dedication, commitment and professionalism which reflects your honest, transparent and collaborative public health approach and leadership*."



Statistics

The hub has contributed a footfall of just over 71,000 people (average 6,000 per month), many of whom would not have otherwise visited the city centre that day had it not been for their appointment or attending with their family member/person they care for.

- **98% of people reported thought they were satisfied with the service they received.**
- **98% of people reported that they felt the venue was accessible.**
- **100% of service providers feedback suggests that the hub improves accessibility to their service.**

Service providers reported that an average of 54% of people that they engaged with at the hub would not have contacted their service otherwise.

GetActive@Northfield - Community Room

A programme of health, social care and wellbeing services in a sports facility was trialled. This was to bring different wellbeing, preventative and rehabilitation services to the area. Working together with Sport Aberdeen to support continued engagement in physical activity and access to health and wellbeing services under one roof. This project was additionally to support and engage the local population in uptake of services.

Services included, Speech and Language Therapy, Community Listening Services, Pulmonary Rehabilitation, Community Respiratory Services, PEEP Support Group for Health Eating Behaviours, Health Visiting and Links Practitioners among others.

Key Successes

- **Rooms were utilised four out of five days demonstrating the success of implementing a wide range of initiatives, including the long term booking of classes and clinics aligned to rehabilitation and preventative services.**
- **Community Listening Services have noted an uptake in service within the area being at Hub at Northfield in comparison to being delivered from a Medical Practice.**
- **Pulmonary Rehab and respiratory services are being regulary delivered in the community, with increased information and sustainable self-management options available to patients.**

What next?

This project was approved to continue as business as usual and move to next phase of taking the learnings from this project and implement within other hubs across Aberdeen. These include Aberdeen City Vaccination and Wellbeing Hub, Torry, Tillydrone and Countesswells. The next phase also includes branding each of these sites as Health and Wellbeing Hubs. The room in Northfield will now be called the Health and Wellbeing Hub@Northfield.

A refreshed Local Outcome Improvement (LOIP) for Chronic Pain is to be initiated. Sport Aberdeen will lead the project, taking learnings from the Pulmonary Rehabilitation project to form a pathway review of Chronic Pain, and encourage self-management through a range of initiatives. These will be tested in collaboration with ACHSCP at the Health and Wellbeing Hub@Northfield.

Monitor and Evaluate the Carers Strategy

The Carers Strategy and Action Plan aims to plan and deliver services and support for unpaid carers across Aberdeen City. Identifying carers, getting them access to support, and providing information to support them to support others are key objectives. The overarching aim of this strategy is to improve the experience of all carers in Aberdeen City, making best use of available resources to do so. You can view the carers strategy here.

Key Successes

A progress report published in February 2024 highlighted key areas such as:

- **Launch of the Young Carers Charter is a LOIP project initiated in May 2023 has the project aim to increase by 20% registered young carers accessing support from the young carers service by 2025. Progress against this charter includes reviewing the use of the Young Carers Statement and referral process and pathway. Barnardo's has also been successful at implementing the Think Young Carer training.**
- **Initiation of a Carer Reference Group will ensure Carers are empowered to have input in future service design and have their say on what information they need to support them as a Carer.**
- **Achievement of the Adult Carers Project to increase the number of unpaid carers feeling supported by 10% by 2023, allowing them to enjoy a life alongside caring and to enable the caring role to be sustained. This project led to the development of several initiatives, including the Respitality Bureau and the Time to Live project. A further initiative is the Wee Blether Cafes.**

What's next?

The recommission of both young and adult carers support services will take place throughout 2024. This will involve a collaborative commissioning process with all stakeholders for new contracts to commence April 2025. Continuation of the Young Carers Charter, as well as a refreshed aim for adult carers to support the LOIP Improvement projects.

The Wee Blether is a test of change pilot scheme, aimed at reducing the social isolation experienced by our carers post-Covid, by bringing them together for company and a chat, and to build better links to the local community. The Wee Blether groups were targeted at our unpaid carers aged 55+ who were welcome to bring along the person they cared for too.

Free soup, hot drinks, games and activities are provided for our carers. Part of our support was to also signpost our carers to ongoing activities and groups in the local community providing additional support via local businesses and organisations. Our aim was to set up five Wee Blethers in the locality.

Deliver the Primary Care Improvement Plan (PCIP)

The PCIP works alongside an agreement between the Scottish Government and General Practice (GP) called the 2018 General Medical Services Contract (GMS contract). The contract offer proposes a refocusing of the GP role as 'expert medical generalists'. This refocusing of the GP role will require some tasks currently carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care.

8 Clinic Sites including 2 CTAC Sites are now opened.

The contract also proposes significant new arrangements for GP premises, GP information technology and information sharing. The effect of these arrangements will be a substantial reduction in risk for GP partners in Scotland, and a substantial increase in practice sustainability. This is important because strong practices mean better care for patients and healthier communities.

The purpose of the PCIP is to deliver the Memorandum of Understanding (MoU) as part of the GMS contract. The support from the workstreams in the MoU is intended to support to GPs.

The Scottish Government have implemented the MoU to enable GPs to focus on becoming expert medical generalists and in turn provide better care for patients by maintaining and improving access, enabling more time with the GP for patients when it is really needed (continuity), and providing more information and support for patients (co-ordination) and better health in communities.

The PCIP is working towards delivering 6 key workstreams within the MoU:

1. Vaccination Transformation Programme (VTP)
2. Pharmacotherapy
3. Community Treatment and Care (CTAC)
4. Urgent Care
5. Additional professional roles, for example, but not limited to, musculoskeletal focused physiotherapy services & community clinical mental health professionals (e.g. nurses, occupational therapists)
6. Community Link Worker service.

CTAC delivers 4,000 x 15min weekly appointments.

Vitamin B12 injections are now available and delivered by CTAC at the Vaccination and Wellbeing Hub in the city centre. Demand has reached 600+.

Of the 6 workstreams there are 3 key workstreams of focus:

1. Pharmacotherapy
2. Community Treatment and Care (CTAC)
3. Vaccination Transformation Programme (VTP).

Plans for Urgent Care, Community Link Workers and Additional Professional roles should continue and services already in place should be maintained, but the expectation is that their further development, where required, may progress at a slower pace to allow the commitments around VTP, CTAC and pharmacotherapy to be accelerated.

Key Successes

1. **Two CTAC sites were opened over the last year, which brings the total to eight clinic sites (Inverurie Road Clinic Bucksburn, Bridge of Don Clinic, Northfield Clinic, Carden House, College Street, Kincorth Health Centre, Airyhall Health Centre and Aberdeen Vaccination and Wellbeing Clinic).**
2. **Vitamin B12 injections are now available and delivered by CTAC at the Vaccination and Wellbeing Hub in the city centre. This was Implemented in February and demand has reached 600+ patients using this service. This frees up capacity in practices and patients have the option to have their injections at the practice or book an appointment at the hub.**
3. **Electro-cardiogram provision also began in CTAC clinics within the past year.**

Improvements Made

1. Physiotherapy First Contact Practitioners - now available in 26 practices across the city, offering more direct access to physiotherapy.
2. Training to the non-medical prescribers is available and on a phased programme. Percentage of contacts being First Contact has increase in true first contact appointments, from 50% in 2022-23 to 70% in 2023-24, freeing up appointments for GPs, more appropriate use of the service / improved patients journey. Approximately 279 clinical hours of patient contact in a week.
3. Link Workers service - The service is available to all practices across the city and they provide approximately 300 hours of patient contact capacity. This is a referral service from practices and the work they do also includes PDS - Post Diagnostic Support for Dementia patients.
4. CTAC delivers over 4,000 x 15 minute appointments across the city on a weekly basis.

Physiotherapy First Contact Practitioners - Now available in 26 practices.

9th CTAC clinic planned to open in Torry Neighbourhood Centre. Hub planned for Countesswells with CTAC, Childhood Vaccinations and Health Visiting.

Next Steps

- **Continue to develop and roll out additional services in the workstreams and create new processes across ACHSCP.**
- **Develop staff training across workstream to maximise workflows and capacity.**
- **Planned opening of the ninth CTAC clinic at Torry Neighbourhood Centre in May 2024 (at the time of publish this has now opened) and planning a hub at Countesswells with CTAC, childhood vaccinations and health visiting.**

General Practice Vision Programme

In response to the evolving significant sustainability challenges within General Practice in Grampian, the GP Vision Programme was commissioned to outline a new vision and strategic objectives that will guide the future direction of General Practice across Grampian.

A Vision Statement has been created which captures the changes required to move towards a more sustainable General Practice sector within the area. A sustainable General Practice across Grampian which enables people in their communities to stay well through the prevention and treatment of ill health. The key themes and challenges that were identified throughout the facilitated workshop process and stakeholder analysis were consolidated. Key themes identified throughout the process were identified in response to reasons for change.

An objective has been created in relation to each of these:

- Data
- Models of contract
- Digital
- Premises
- Keeping the population well
- Pathways
- Multi-Disciplinary Team
- Continuity of care
- Mental health & wellbeing
- Recruitment, Retention & Education

The new vision for General Practice contributes to local, regional and national initiatives including:

- The National Health and wellbeing outcomes;
- NHS Grampian Vision, Values and Strategic Themes;
- Aberdeen City, Aberdeenshire and Moray HSCPs Vision and Priorities; and
- Local Outcome Improvement Plans across Grampian.

Key Progress Points

- **PCIP Review Group has now met 3 times and a short life working group to determine data required has been set up including representation from finance and public health**
- **Data Workstream has carried out the first workshop sessions to determine what data sets require to be collected**
- **Regular meetings with the Scottish Government established to help deliver the models of contract objective**

Additional Notable Progress within Caring Together

Project Name	Highlights
Improve Primary Care Stability	• Creation of a stakeholder engagement group to ensure co-production. • Wide stakeholder engagement including school focus groups. • Vision and objectives approved across the 3 Grampian IJBs March 2024.
Justice Social Work Delivery Plan 2021-2024	• Significant increase in Diversion from Prosecution, Structured Deferred Sentence and Bail Supervision over the past year. This reduces the number of statutory orders imposed by the court, meets our ambition for early intervention and prevention, and places an emphasis on providing support to individuals at a time when this is most needed and an opportunity for them to address issues affecting them without the requirement of statutory supervision. • The court backlog as a result of the pandemic is reducing but remand figures remain high. Justice Social Work are working to address this issue at a national and local level by increasing Bail Supervision Orders. • Justice Social Work are providing appropriate support in the community to those on Bail Supervision whilst minimising the impact on the Scottish Prison Service. • The Community Justice Partnership has provided risk management training dates for the next year and the new Supervision Policy for all services focuses on Trauma Informed Practice which supports the wellbeing of staff and training has and continues to be rolled out.
Social Work Support Mapping	• Aberdeen City Health & Social Care Partnership and our partners want to ensure that the people, their families and friends have information about living independently at home and help in finding support to Stay Safe, Stay Well and Stay Connected and informed. • Wellbeing coordinators mapping Community-Based Community-Delivered Interventions (CBCD) available in the city post pandemic and identifying any issues in access so that citizens can be supported to attend. • Hosting Granite City Gathering 2023 and Grampian Wellbeing Festival 2024.
Promote the use of Care Opinion	• Increased usage of Care Opinion by those accessing ACHSCP services. • Increased awareness on the need to promote Care Opinion within ACHSCP services.

Keeping People Safe at home

It is the strategic responsibility of the IJB to shift the balance of care from hospital to be delivered in primary, community and social care settings so that, where possible, people are cared for and supported closer to home. The aim is to enable people to remain living independently at home by choice, thereby improving outcomes. This is enabled through a variety of methods including:

- **Maximising independence through rehabilitation**
- **Reducing the impact of unscheduled care on the hospital**
- **Expanding the choice of housing options for people requiring care.**

Strategic Review of Rehabilitation Services

A review involving patients, carers and other key stakeholders designed alternative ways for specialist neuro rehabilitation to be delivered across Grampian. The review listened to a range of voices, to consider how to create a model of transitional rehabilitation support delivery that was patient-centred with increased accessibility.

Key Successes

- **Agreement from all Grampian IJBs on progressing with a hybrid model of support for providing neuro rehabilitation to patients.**
- **Continued engagement from across Grampian in creating and delivering an accessible service for patients within neuro rehabilitation pathway.**
- **Learning from engagement with all stakeholders that can be readily used for taking forward wider rehabilitation review.**

What's next?

- Workshops with all participants from across Grampian are actively designing a pathway that considers both patient and strategic priorities.
- Ongoing engagement is ensuring that feedback can support service development.

Key Measures

The number of patients admitted to the neuro rehabilitation service has remained consistent, with 76 admissions recorded for both the 2022-23 and 2023-24 periods, with an average of 19 admissions per quarter.

Occupancy rates remained high throughout the year, averaging 97 per quarter in 2023-24.

Increase the Capacity of Hospital@Home Beds

The aim of the Hospital@Home Team is to provide patients with high-quality acute care in their own home. The team aim to empower and enable patients and carers to take an active role in their recovery. The team predominantly support older adults experiencing frailty and have embedded geriatricians. They also have a remit for end-of-life care, respiratory care, outpatient parental antimicrobial therapy and are expanding into acute medicine and general surgery. There are two pathways into the service:

1. A step-up pathway from the community
2. A step-down pathway from hospital.

Key Successes

- **Sustaining high rates of patient satisfaction and positive feedback.**
- **Developing creative approaches to recruitment when there have been challenges. The team take a flexible approach to identifying roles to meet patient need. An example is the team are undertaking a test of change to incorporate Band 4 Coordinator roles, who will be responsible for a range of tasks including case management, administration and equipment checks, releasing capacity for clinical staff to carry out patient facing care.**
- **The team has moved into a locality model which is improving overall efficiency. Patient contact is better coordinated, with the aim of releasing capacity. A better understanding of patients' needs is possible when in a smaller group. Feedback from a senior staff member highlighted that this model makes it "easier for the team to focus on a smaller patient group rather than considering everyone at once. Our attention to detail is better and we can better support one another as a team."**

What's next?

1. Continue to develop the skill mix and range of roles within the team to support different patient cohorts and levels of acuity. e.g. development of paramedic role (dependent on clinical cover in place to support).Continuing to develop physiotherapy staff skills to support respiratory beds.
2. Continue to expand the capacity of the team to support more patients in line with the overall vision of the service to expand to 100 beds. This proved challenging over the 2023-24 financial year due to funding and recruitment challenges. Recruitment to key roles at the end of this financial year, for example to the Team Leader post, will act as a key enabler towards ensuring additional capacity can be prioritised on further expansion of the service.

"I want to thank you for the experience of being treated by the team of the century. You were the most delightful people, a dedicated team who used their combined efforts, their knowledge, their expert talents to help a very distressed patient. Well you succeeded in giving me back confidence. Relieving my breathlessness. Lifting my mood. At the same time showing me respect. Not talking down to me. It was an honour to meet you all. From the bottom of my heart. Thank you one and all for not making me feel embarrassed."

Patient at the Partnership's Workforce Conference, February 2024

- **1105** patient admissions were made to Hospital in 2023, which represents a 31.7% increase from the previous year (839 admissions in 2022).
- An average of **209** admissions per quarter for 2022 and **276** admissions per quarter for 2023.
- **1000** were community referrals. **996** admissions were avoided.
- **104** admissions were for active recovery following an acute admission.
- This represents **8667** occupied bed days overall across all the Hospital at Home pathways.

Hospital at Home

Suitable Homes

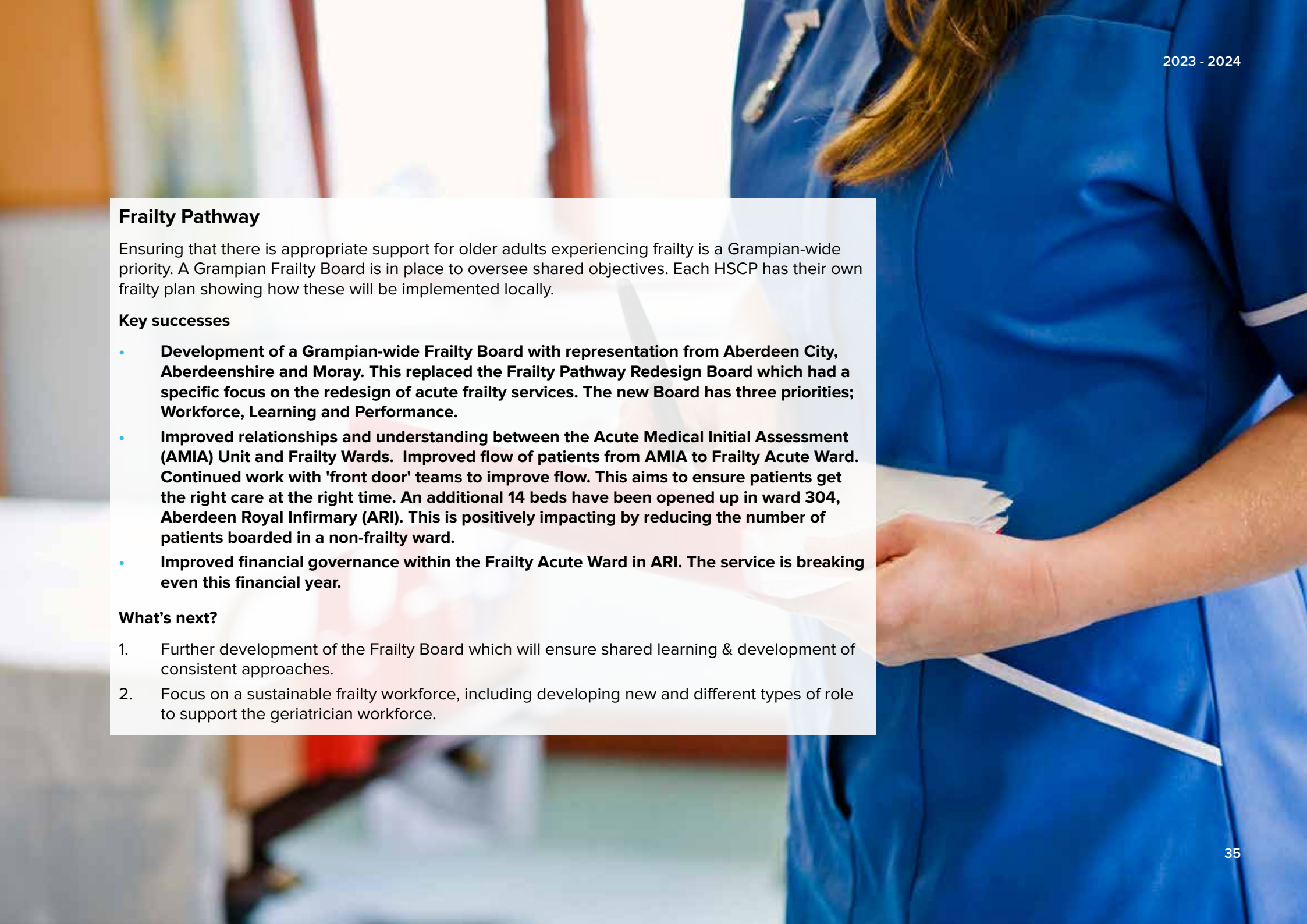
This project helps people in Aberdeen City, no matter what type of housing they live in, making sure their homes meet their needs. This includes any adaptations that may be required to support independent living.
This project is managed and monitored by the Disabled Adaptations Group (DAG), who also oversee the budget expenditure, ensuing best value for money is obtained and that resources are targeted where it is needed most.

DAG comprises of various members from Aberdeen City Council, Aberdeen City Health & Social Care Partnership, Registered Social Landlords, private sector housing and more. DAG have developed a system to track exactly what kind of changes are being made to homes.

Key Successes

- **184 major adaptations have been completed, such as installing showers you can easily step into, ceiling track hoists, and ramps.**
- **1234 minor adaptations have been completed, including shower seats, changing steps to make them safer, grab rails for support, and electrical work.**

DAG now produces regular quarterly reports and provides detail on these quarters throughout the financial year. DAG reviews the data and uses this to challenge performance and lobby for equity in budget and adaptation provision. Currently the Scheme of Assistance is being reviewed and the group are also working through the new guidance on the provision of equipment for adaptations 2023 and will provide a summary report on compliance once the review has been completed.



Frailty Pathway

Ensuring that there is appropriate support for older adults experiencing frailty is a Grampian-wide priority. A Grampian Frailty Board is in place to oversee shared objectives. Each HSCP has their own frailty plan showing how these will be implemented locally.

Key successes

- **Development of a Grampian-wide Frailty Board with representation from Aberdeen City, Aberdeenshire and Moray. This replaced the Frailty Pathway Redesign Board which had a specific focus on the redesign of acute frailty services. The new Board has three priorities; Workforce, Learning and Performance.**
- **Improved relationships and understanding between the Acute Medical Initial Assessment (AMIA) Unit and Frailty Wards. Improved flow of patients from AMIA to Frailty Acute Ward. Continued work with 'front door' teams to improve flow. This aims to ensure patients get the right care at the right time. An additional 14 beds have been opened up in ward 304, Aberdeen Royal Infirmary (ARI). This is positively impacting by reducing the number of patients boarded in a non-frailty ward.**
- **Improved financial governance within the Frailty Acute Ward in ARI. The service is breaking even this financial year.**

What's next?

1. Further development of the Frailty Board which will ensure shared learning & development of consistent approaches.
2. Focus on a sustainable frailty workforce, including developing new and different types of role to support the geriatrician workforce.

Preventing ill Health

By promoting health, we can help communities to achieve positive mental and physical health outcomes by providing advice and designing suitable support (which may include using existing local assets), to help address the preventable causes of ill health, ensuring this starts as early as possible.

Social Prescribing

Social Prescribing is a means of enabling health and social care professionals to refer people to a range of local, non-clinical services within our communities.

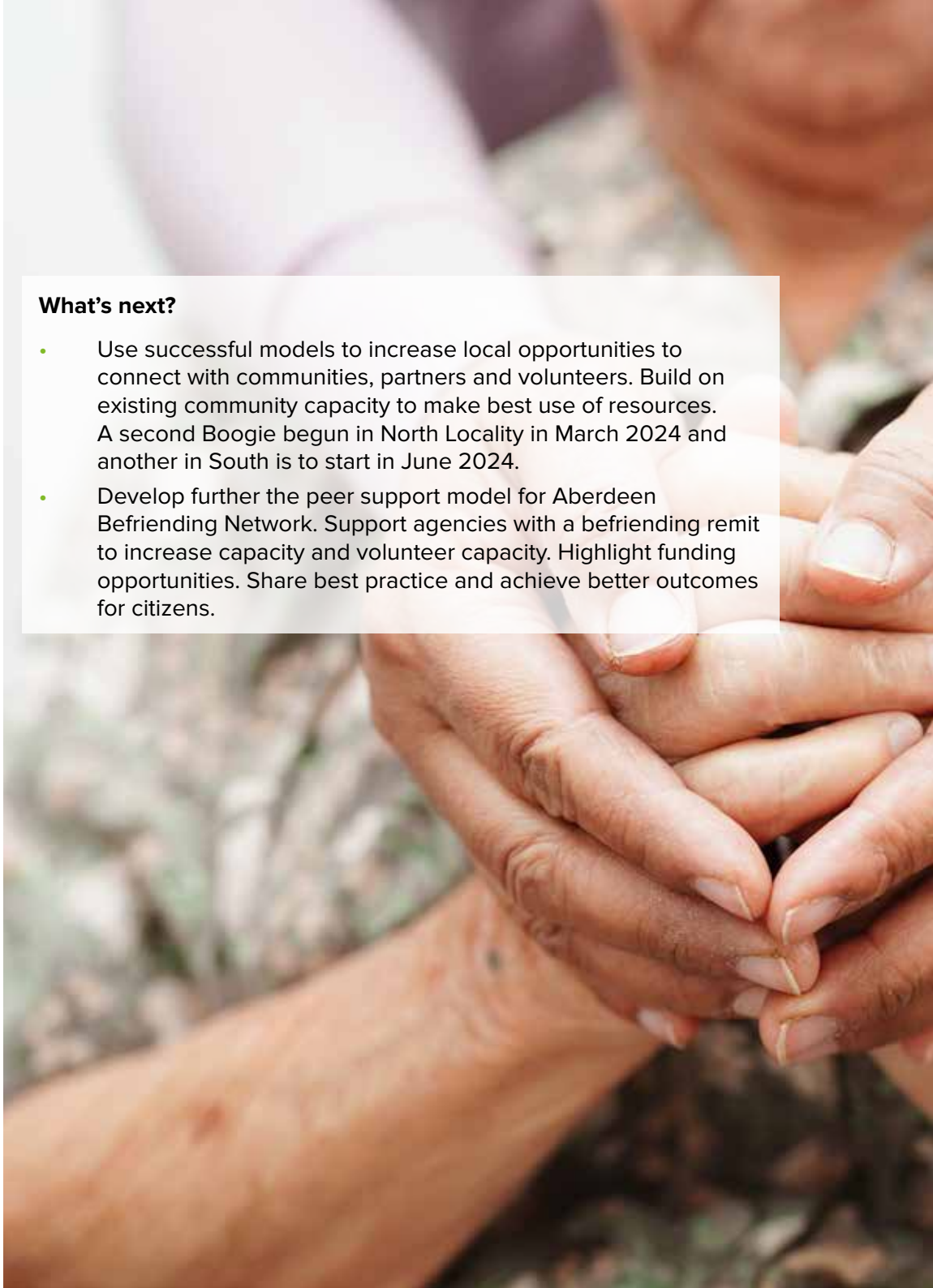
- **People's health can often be determined by a range of social, economic and environmental factors which Social Prescribing, seeks to address in a holistic way to meet people's needs. It also aims to support individuals to take greater control of their own health.**
- **Social Prescribing schemes can involve a variety of activities which are typically provided by voluntary and community organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.**
- **Social Prescribing can also reduce prescribing costs, with this used as an alternative method to traditional prescribed medicine.**
- **Social Prescribing is becoming a more common approach used across the Partnership through our Links Practitioner Service and Stay Well Stay Connected programme.**

Stay Well, Stay Connected - Social Isolation

Stay Well Stay Connected aims to help tackle the loneliness and isolation that is experienced by many older people in Aberdeen. The World Health Organisation has declared that loneliness and isolation is now an epidemic, so providing opportunities to minimise the extended periods that individuals spend lonely and / or isolated, is a priority.

Key Successes

- **Expansion of Boogie at the Bar – Keeping hundreds of older people every month socially connected and engaged in their community. Reducing isolation, it provides alternative respite, support and networking opportunities for carers. There are now six Boogies a month in Aberdeen. SWSC has secured 2 years funding from National Lottery Communities Fund to sustain 3 Boogies.**
- **Expansion of Soup & Sannies – A social connection and nutrition project in Seaton to bring older people together. The project now convenes bi-monthly gatherings that have reached full capacity, with 30 participants at each session, totalling 60 attendees per month. New Soup & Sannies runs in Torry. The Soup & Sannies along with reducing isolation allows an opportunity to signpost to sources of support.**
- **Men's Group Wellbeing – Bringing older men together to reduce isolation and improve wellbeing outcomes for older men. Using a programme of events model to engage in wellbeing topics. The model has been adopted by Men's Shed in Bridge of Don with 30-40 participants monthly. Wellbeing topics covered include blood pressure checks, healthy eating, prostate Issues, stress awareness, cooking and pilates sessions.**



What's next?

- Use successful models to increase local opportunities to connect with communities, partners and volunteers. Build on existing community capacity to make best use of resources. A second Boogie begun in North Locality in March 2024 and another in South is to start in June 2024.
- Develop further the peer support model for Aberdeen Befriending Network. Support agencies with a befriending remit to increase capacity and volunteer capacity. Highlight funding opportunities. Share best practice and achieve better outcomes for citizens.

Highlights

- Six Boogies a month in Aberdeen with an average attendance of 240 participants each month, age ranges from 20 to individuals in their nineties.
- Approximately 30 hours per month are dedicated by 10 regular volunteers across the three localities (Central five, North three, South two).
- Walking Football Wellbeing engages 64 attendees every Tuesday and Thursday.

Feedback and testimonials

“Thanks to you and the team, these checks are very much appreciated especially for those of us who probably don’t see our own GP that often so any information on our general health and wellness is very valuable, thanks again.”

“It’s great to get out and meet new people and old friends.”

“It started off as walking football but now we have progressed so much and have enjoyed health checks, wellbeing, pilates, golf, Christmas lunch, banter and met so many new friends on our journey. Let’s keep this up and with thanks to Pauline (Strikers) and our band of organisers and say what is the next challenge you have for us. Congratulations and thanks to those who make all these things happen and all we have to do is turn up.”

“Our residents thoroughly enjoyed themselves as well as the staff that accompanied them. We got lots of great pictures for our albums and look forward to joining you again next month. It really is great to see them getting out and about and having a right good boogie.”

Vaccination Service

Vaccination provides protection against a range of infections across a person's life, enabling people to live longer, healthier lives, reducing inequalities and releasing health service capacity. Vaccination can prevent or reduce the severity of disease, minimise disability and save lives.

The Partnership's Vaccination team provides all childhood and adult vaccinations to the population of Aberdeen. The main hub for the provision of Vaccinations is within the Aberdeen City Vaccination & Wellbeing hub in the city centre. This is complimented by smaller clinics at Bridge of Don and Airyhall to support provision of services in the north and south localities.

Vaccinations are also administered at baby and preschool immunisation clinics, schools, sheltered housing, care homes and at home for housebound residents. To support increasing uptake, additional pop up clinics are organised within local communities in churches and communities centres throughout the year. The following Infographic provides an overview of Immunisations provided by the Aberdeen City Vaccination from **1st April 2023 – 31st March 2024** to support protecting the population against vaccine preventable infectious disease.

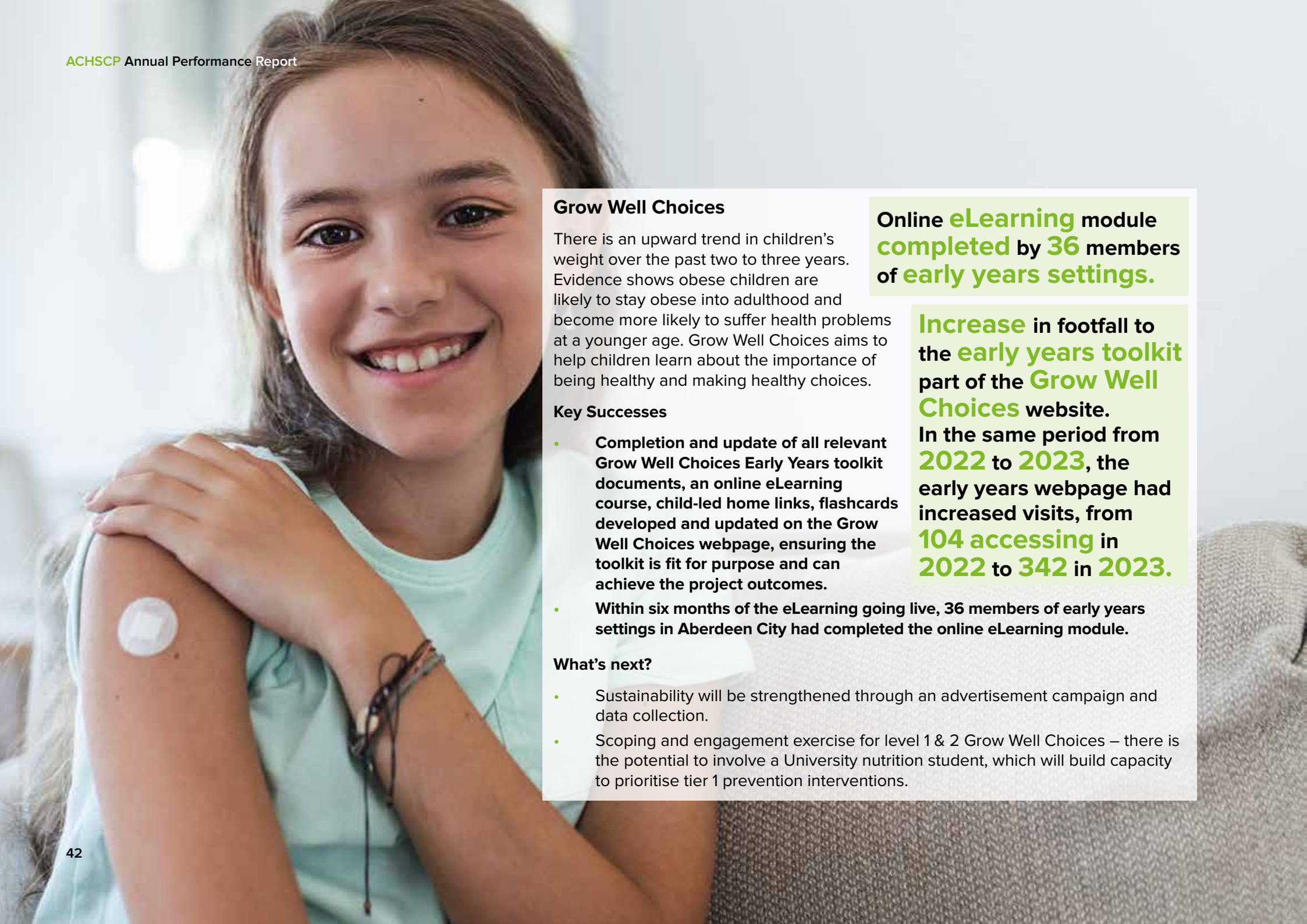
Pre-school Immunisations	**School Immunisations** (HPV, DTP & MenACWY & Influenza)	**Adult Routine** (Shingles / Pneumococcal)	**Non Routine Referrals**	**Influenza**	**COVID 19**	**TOTAL**
39,894	**21,109**	**12,602**	**977**	**61,530**	**64,784**	**200,896**

There have been declines in vaccination uptake across childhood vaccinations in both Grampian and Scotland, at the same time with outbreaks of Measles and Whooping cough, which has put more focus on the need to improve vaccination uptake rates. The team have been actively undertaking health promotion & education of vaccine benefits in schools, pre-school nurseries and on social media to aid increasing uptake to protect our communities. The team are working closely with Health Visitors to support promoting the importance of completing a child's pre-school vaccination schedule and liaise with families to support attendance. The pre-school team opened two new clinic locations during 2023 to support accessibility at Tillydrone Community Campus and Inverurie Road Medical Practice in Bucksburn. These clinics were well received by parents/carers.

The vaccination team are a multi-skilled workforce who also now provide support and cross cover for the Community Treatment and Care Team (CTAC) undertaking blood tests, chronic disease management and vitamin B12 injections. A CTAC clinic commenced in October 23 open 2 days per week until January 2024 when this was extended to 5 days per week. These clinics have been very popular and are set to increase to 2 clinics per day from June 2024. Vitamin B12 clinics commenced in February 2024.

The following number of appointments were attended during 2023/24.

Vitamin B12	CTAC	TOTAL
525	1162	1687



Grow Well Choices

There is an upward trend in children's weight over the past two to three years. Evidence shows obese children are likely to stay obese into adulthood and become more likely to suffer health problems at a younger age. Grow Well Choices aims to help children learn about the importance of being healthy and making healthy choices.

Online eLearning module completed by 36 members of early years settings.

Increase in footfall to the early years toolkit part of the Grow Well Choices website. In the same period from 2022 to 2023, the early years webpage had increased visits, from 104 accessing in 2022 to 342 in 2023.

Key Successes

- **Completion and update of all relevant Grow Well Choices Early Years toolkit documents, an online eLearning course, child-led home links, flashcards developed and updated on the Grow Well Choices webpage, ensuring the toolkit is fit for purpose and can achieve the project outcomes.**
- **Within six months of the eLearning going live, 36 members of early years settings in Aberdeen City had completed the online eLearning module.**

What's next?

- Sustainability will be strengthened through an advertisement campaign and data collection.
- Scoping and engagement exercise for level 1 & 2 Grow Well Choices – there is the potential to involve a University nutrition student, which will build capacity to prioritise tier 1 prevention interventions.

Reduce Smoking Prevalence

Smoking continues to be the greatest preventable cause of ill health and death in Scotland. It causes around one in five of all deaths, is the most significant cause of preventable cancer and contributes to much of Scotland's cardiovascular and pulmonary health problems. The project sought to decrease the number of smokers and address the rising trend of children and young people vaping.

Key Successes

- **Created and maintained a briefing for education staff to provide quality information, and links to training for staff working in Education or Youth Work. Health Improvement Officer working with a youth worker developed an education resource to use for vaping education in primary schools. This has been piloted in Charleston Primary School, with the evaluated resource being made available to all schools. Survey carried out shows that the programme improved the P7 pupils' knowledge around e-cigarettes and vaping.**
- **Vaping information and links to training have been shared with community groups and organisations. Youth workers have been supported to undertake the ASH Scotland Young People and Vaping training.**
- **Working with Midwifery and Moray Health and Social Care Partnership, our Health Improvement Officer delivered Carbon Monoxide (CO) monitoring refresher training to 75 community midwives across Grampian. The use of CO monitors was paused during the pandemic. The training will help midwives to have informed discussions with women who are pregnant about smoking.**

What's next?

Dedicated projects within the LOIP will aim to:

- Reduce the number of 13-18 year olds who regularly use vaping products to 4% by 2026.
- Decrease the number of women who are smoking in pregnancy in the 40% most deprived Scottish Index of Multiple Deprivation areas by 5% by 2026.
- We will strengthen and maintain a strong, multi-agency tobacco and nicotine-free alliance. The alliance will support action around local smoking rates and smoking-related inequalities.

Highlights

- **Education Brief has been viewed by 157 Education staff with a total time viewed of 21 hours 51 minutes.**
- **Confidence levels improved for midwives initiating conversations on smoking status with pregnant women from an average of 83% to 90%.**
- **If a pregnant women disclosed they were still smoking, there was an increased confidence from 79% to 89% to engage in supportive conversations on smoking cessation options.**
- **Knowledge of the referral pathway increased from an average of 61% to 90%. When asked whether the training was beneficial, the participants gave it an average of 94%.**

Promote Active Lives

The Aberdeen Food Champions Programme is a partnership with Aberdeen Community Food Network (local organisations and community groups) to improve access to healthy and affordable food, improve people's understanding of a healthy diet and develop practical food skills.

Key Successes

- **Volunteer Training and Certification: 55 volunteers we recruited from various organisations, community and faith groups and charities. A total of 24 volunteers completed training and became certified Food Champions, contributing to various Confidence to Cook (C2C) food projects and delivering C2C sessions.**
- **Community Impact: The project has had a significant positive impact on the community, by delivering 8 healthy eating projects across the city, including projects like the Aberdeen City Food Champions Programme and the Tillydrone Community Flat's Healthy Hangout. Improving participants' confidence, life skills, and knowledge about healthy eating on a budget. In addition 9 new food projects have been funded through the Health Improvement Fund - Food in Focus.**
- **Youth Engagement: Youth Work in Schools delivered C2C sessions to young people, with 31 participants at Deeside Family Centre and positive feedback from both young people and parents, highlighting the project's role in enhancing life skills and well-being.**

What's next?

- Support the development and implementation of Food in Focus funded projects, whilst monitoring and evaluating to ensure project objectives and outcomes have been met.
- Demonstrating the impact on target population groups and wider community and identify learnings for future improvement.
- Deliver a networking and promotional event across the City
- Continue to support Food skills capacity building (Food Champions Programme) through allocation of the 2024-2025 Food in Focus funding

Projects supported

- Cairncry Adults Cooking with Confidence (Cairncry Community Centre)
- Family Food and Fun (Cairncry Community Centre)
- Recipe for life (Homestart)
- Young Carers Integrated Food programme (Barnardo's)
- Adult Carers healthy Cooking on a budget (Barnardo's)
- Healthy hangout (Tillydrone community flat)
- Greyhope Cooking with Dorothy (Greyhope Community Hub)
- Cook'n'Chat Torry (St Fitticks Torry)
- Saturday Kitchen (Northfield Church of Scotland)
- Deeside Family Centre - Youth work
- School Flexible Learning Pathway programme (Hazelhead and St Machar youth work, Cults Academy youth work)
- Intergenerational Food growing and Cooking project (Gray street allotment/Broomhill primary school)

"Learning to cook different things, if I was never here I would not have known how to cook or that the food existed, I like Wednesdays and getting out of the house."

Food Champion, Deeside Family Centre

"He is really enjoying the sessions with you so thank you." "Beetroot burgers are tasty." "Cooking as a possible career."

"He has been cooking up a storm in the house over the holidays." "Skills for when I am older."

"I've tried all the things and I must say they've tasted pretty good, he's fair chuffed with himself."

"He is at school today and is looking forward to his cooking!" "Learning cooking skills." "Get better at cooking skills."

Parent feedback, Deeside Family Centre

"Routine has kept me going (accessing FLP), you have to cook to survive, less money spent on takeways and a lot healthier."

Food Champion, Deeside Family Centre

"Guidance Teachers have expressed verbally their ongoing support and the positive impact these sessions have in engaging young people in further learning opportunities and continue to discuss the learning offer with parents and young people and submit referrals to the Youth Work in Schools Team."

Food Champion, Deeside Family Centre

"We feel the participants have benefitted greatly from completing this course. The benefits include: Increased confidence, Increased physical and mental wellbeing, increased knowledge and understanding of budgeting, awareness of repurposing food, increased awareness of healthy eating and hugely increased capacity to socialise and contribute within group discussion."

Cairncry Community Centre, Centre Manager

"I have really enjoyed the social aspect and cooking experience of the course and don't want it to end."

"I will really miss the cooking course, I've made new friends and enjoyed doing something at the weekend now I love cooking."

"I have really enjoyed the cooking and have more confidence to cook at home."

"I am very proud of myself for gaining a qualification at my age (67)."

Cairncry Adults Cooking with Confidence

"Parents really enjoyed the groups. It gave them a space to drop their children off at our provided creche and gave themselves 2 hours to be away from everything and just focus on themselves. Having this time in the kitchen with other parents provided them a safe space and a focus to be able to open up about what's going on their life, in their head, and listen to each other and have a laugh. We had volunteers who ran the creche and had a volunteer help at groups. This was beneficial for all volunteers as they really enjoyed getting to know the children and the parents, share their skills.

"The groups provided a safe space for parents to open up about their own mental health and struggles. Knowing that they had a group to go to once a week for a month helped me keep focused and gave them a purpose for each week which helped remove the monotony of their routine."

Homestart Recipe for Life

Age Friendly City community intervention

The Granite City Gathering 2023 was hosted to help people explore what ageing well could look like, and encourage attendees to develop a real sense of purpose in retirement and seize opportunities to participate in community life. The gathering was opened by ACC Chief Executive Angela Scott, who spoke about the importance of play throughout your life.

Key Successes

- **People learning what is available in the community to keep them well and connected.**
- **29 community groups and organisations supported the event through hosting stalls, putting forward speakers, or delivering interactive sessions. This included four speakers of which one from Horseback UK resonated well with festival goers.**
- **167 attendees aged 45+ Aberdeen city residents - 1 choir, 6 crafting and art groups, 1 yoga group, 1 qigong, 20 volunteers at the Granite City Gathering explored ageing-well.**

Lasting Legacy of the Gathering:

- The Gathering provides Grampian Health and Social Care Partnerships the opportunity to promote messages of primary prevention and older people remaining independent at home for as long as possible, directly to our target population, and allow Health and Social Care Partnerships to have challenging but necessary public health conversations on planning for end of life and dying well.
- The Gathering has helped the Partnership to deliver the Aberdeen City's Community Empowerment Strategy by signposting people to volunteer and take part in civic and community groups, such as our Locality Empowerment Groups, community councils, and walking groups.
- The Gathering has also provided a focal point to promote key preventative messages about active ageing, lifelong learning, planning for retirement and end of life, and ensuring wills are completed and Power of Attorney is in place. This helps to give older people and their families more control and dignity over their future health and financial affairs and tackles a significant health inequality as people living in more deprived neighbourhoods are far less likely to have Power of Attorney than those in more affluent areas.
- The Gathering also continues to promote our Stay Well Stay Connected programme which enables people to remain healthy and connected into older age. The issue of connectiveness has become such a pressing issue that the World Health Organisation declared loneliness to be a global epidemic in November 2023.

What's next?

- Grampian Wellbeing Festival during May 2024
- Grampian wide Gathering on 12 October 2024. The Gathering has been scaled up for 2024 to now include Aberdeenshire and Moray Health and Social Care Partnerships. Our Grampian colleagues will help Aberdeen City to plan and deliver the event, and integrate its preventative messages into business as usual activity around frailty programmes, public health and wellbeing, and community empowerment.

  As a result, the Gathering is now a regional event and has greater reach and resources, meaning it will likely be more sustainable in future years.
- Age Friendly community network in Aberdeen

Alcohol & Drugs Reduction

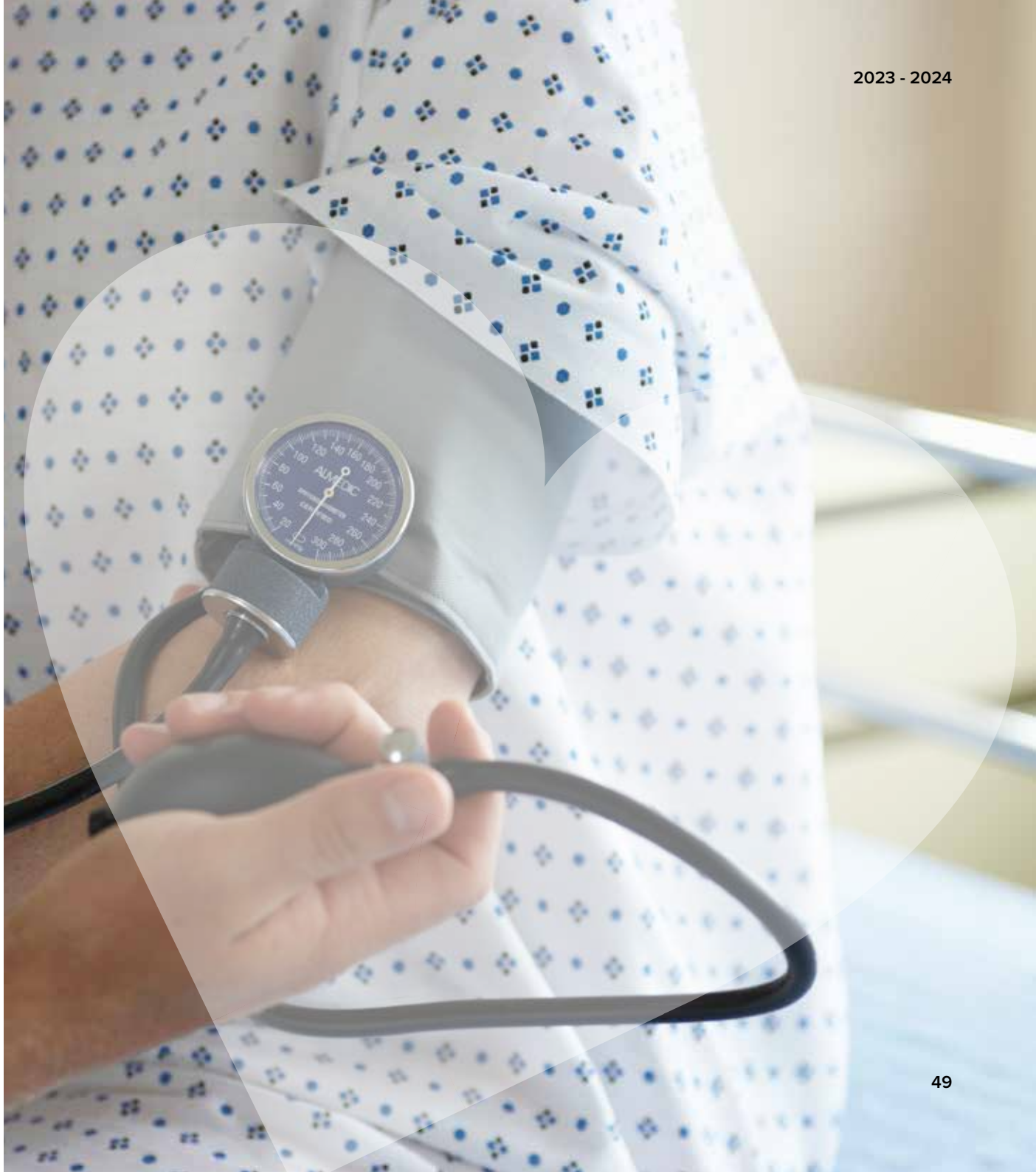
Alcohol & Drug Partnership funding was aligned to support the implementation of the Medication Assisted Treatment (MAT) standards and contribute funding to a collaborative service redesign, in partnership with primary care and the Integrated Drug Services.

Key Successes

- **The development of a health screening initiative (Health Assessments) in order to address the unmet health needs of those who use drugs**
- **Working in collaboration with the Community Nursing Outreach Team (CNOT) to provide flexible and skilled nursing input to the service**
- **Extensive engagement work with individuals to understand their needs and aspirations**

What's next?

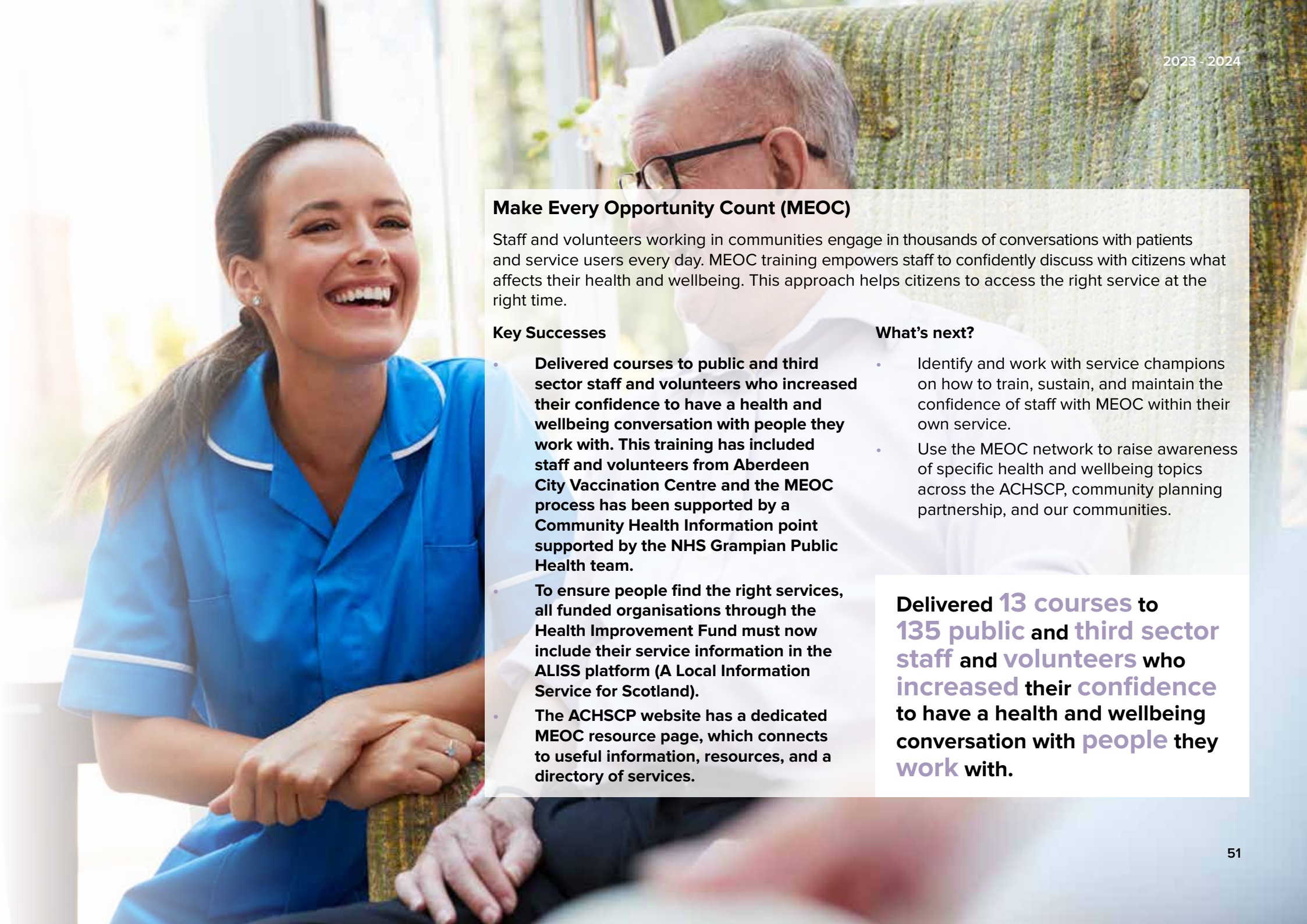
- The project team were reporting to the IJB during the Spring to outline the programme vision and framework for the next 5-10 years.



Achieve Fulfilling Healthy Lives

The intention is that by supporting people to help overcome the health and wellbeing challenges they may face – particularly in relation to inequality, recovering from Covid-19, and the impact of an unpaid caring role – we can help to enable them to live the life they want, at every stage. We look to achieve this by:

- **Helping people to access support to overcome the impact of the wider determinants of health**
- **Ensuring services do not stigmatise people**
- **Improving public mental health and wellbeing**
- **Improving opportunities for those requiring complex care**



Make Every Opportunity Count (MEOC)

Staff and volunteers working in communities engage in thousands of conversations with patients and service users every day. MEOC training empowers staff to confidently discuss with citizens what affects their health and wellbeing. This approach helps citizens to access the right service at the right time.

Key Successes

- **Delivered courses to public and third sector staff and volunteers who increased their confidence to have a health and wellbeing conversation with people they work with. This training has included staff and volunteers from Aberdeen City Vaccination Centre and the MEOC process has been supported by a Community Health Information point supported by the NHS Grampian Public Health team.**
- **To ensure people find the right services, all funded organisations through the Health Improvement Fund must now include their service information in the ALISS platform (A Local Information Service for Scotland).**
- **The ACHSCP website has a dedicated MEOC resource page, which connects to useful information, resources, and a directory of services.**

What's next?

- Identify and work with service champions on how to train, sustain, and maintain the confidence of staff with MEOC within their own service.
- Use the MEOC network to raise awareness of specific health and wellbeing topics across the ACHSCP, community planning partnership, and our communities.

Delivered 13 courses to 135 public and third sector staff and volunteers who increased their confidence to have a health and wellbeing conversation with people they work with.

Suicide Prevention

Develop and implement approaches to support suicide prevention and alignment to national Suicide Prevention Strategy. Based on the National Strategy for Suicide Prevention 'Creating hope together' and how it aligns with Aberdeen City.

Key Successes

Scottish Action for Mental Health (SAMH) have been awarded the contract for suicide prevention work and started in May 2023 to deliver this service.

- **Working across the North East with Aberdeen City, Aberdeenshire and Moray in a Grampian wide manner.**
- **Setting up the Aberdeen City Delivery Group to discuss local issues/gaps/priorities.**
- **Working alongside the LOIP.**

What's next?

- Identifying local issues, gaps and priorities and implementing a local action plan
- To establish a local Delivery Group comprised of key stakeholders in a multi-agency approach, recruited with the multi-agency members.

Feedback from suicide prevention session

"Powerful piece of training that resonated at so many different levels and with so many different people on the call."

"Thank you for a thought-provoking session. I am telling anyone who will listen about it."

The following initiatives aim to increase access to support and raise awareness of suicide prevention:

- **Prevent Suicide North East Scotland is a specially designed app and website for Aberdeen City and Aberdeenshire, providing information to those affected by Suicide. Grampian wide, the Prevent Suicide app has 142,525 downloads to date and 4,886 new downloads in Q4 of 2023-24, and is being updated with a bereavement section.** Download the app - Prevent Suicide Northeast Scotland.
- **A series of online training sessions have been undertaken on suicide prevention and youth suicide prevention. Almost 300 have registered to take part and 17 open online training sessions were organised.**
- **The Changing Room Programme, developed by to promote male mental health via discussions and interest in football, has been expanded to Elgin Football Club following the success at Aberdeen Football Club and is expanding to more football clubs in the region.**

Complex Care - Workforce & Skills Development

The Scottish Government's Coming Home Implementation Report (2022) talks about the need for a capability framework. The framework will provide specialist staff with guidance on the necessary skills to support individuals with learning disabilities and complex care needs, ensuring a stable, therapeutic and capable environment.

Key Successes

- **Several workshops were held with complex care providers, from the Complex Care Framework to discuss what skills and training they felt were needed or missing for specialist staff.**
- **A meeting was held with the Principal Clinical Psychologist to discuss how Positive Behavioural Support / Behavioural Support could be included in a Capability Framework.**
- **The Complex Care Capability Framework was presented to the Complex Care Programme Board for review in October.**

What's next?

- The Complex Care Capability Framework will be included in the Complex Care Framework and elements of supported living frameworks, which will be tendered later in 2024.

Additional Notable Progress within Achieving Fulfilling Healthy Lives

Mental Health and Learning Disabilities Programme	• The Summary Report for the Adult Mental Health Secondary Care Pathway Review is completed. • Forensic Services Review was completed and a report submitted in February 2024. • Piloting of Learning Disabilities Health Checks is now taking place in Aberdeenshire.
Mental Health Triage in Primary Care settings	• Testing was completed on a scaled- down version of the proposed model. • Practitioner was employed and provided support to one GP practice. • General feedback was favourable and scaling up was requested; however no funding source available and testing ended after one year.
Autism & Neurodevelopmental assessment review	• Working across the North East with Aberdeen City, Aberdeenshire and Moray partnerships in a Grampian widemanner. Close working relationships with National Autism Implementation Team (NAIT). • Funding has so far lasted beyond the initial two-year timescale. • Adult Autism Assessment Team (AAAT) provides adult assessment and diagnosis to patients across Grampian.
Home Pathways	• Stakeholder engagement workshops. • Lived experience engagement by the steering group. • Collaborative whole system draft of Housing for Varying Needs market position statement.
Deliver the Equality Outcomes and Mainstreaming (EOM) Framework	• Revised the Equality Outcomes and Mainstreaming Framework that was approved by the IJB. • Previous Health Inequalities Impact Assessment process and guidance has been overhauled and replaced with our new streamlined Integrated Impact Assessment (IIA), which supports staff to consider the impacts of policy and decisions on those with protected characteristics.
Health Integrated Impact Assessments (HIIA)	• Previous HIIA have been replaced by a new streamlined IIA. Further information can be found via this IIA link https://www.aberdeencityhscp.scot/about-us/assessing-our-impact/ • The DiversCity Officer Network is now established and is the forum in which staff are supported when completing IIAs but is also the forum where we directly seek the views of those with protected characteristics. • The Equality and Human Rights Commission has identified our new IIA and guidance as national good practice, especially regarding what action has been taken after consultation.
Climate Change & Net Zero Programme	• Introduction of climate change risk sections in key Partnership documentation. • Provision of advice and support to projects and programmes on climate-informed decision-making. • Further development of approach to meeting reporting requirements for commissioned services.

Strategic Enablers

Our Strategic Enablers are an important part of our delivery plan and enable our strategic intent to be delivered by supporting its main aims. Including:

- **Workforce**
- **Technology**
- **Finance**
- **Infrastructure**
- **Relationships**

Workforce Plan

We aim to support staff, partners and the general workforce for health and social care in Aberdeen City. There are three project aims to support main workforce priorities: staff health and wellbeing, recruitment and retention, growth and development opportunities.

Key Successes

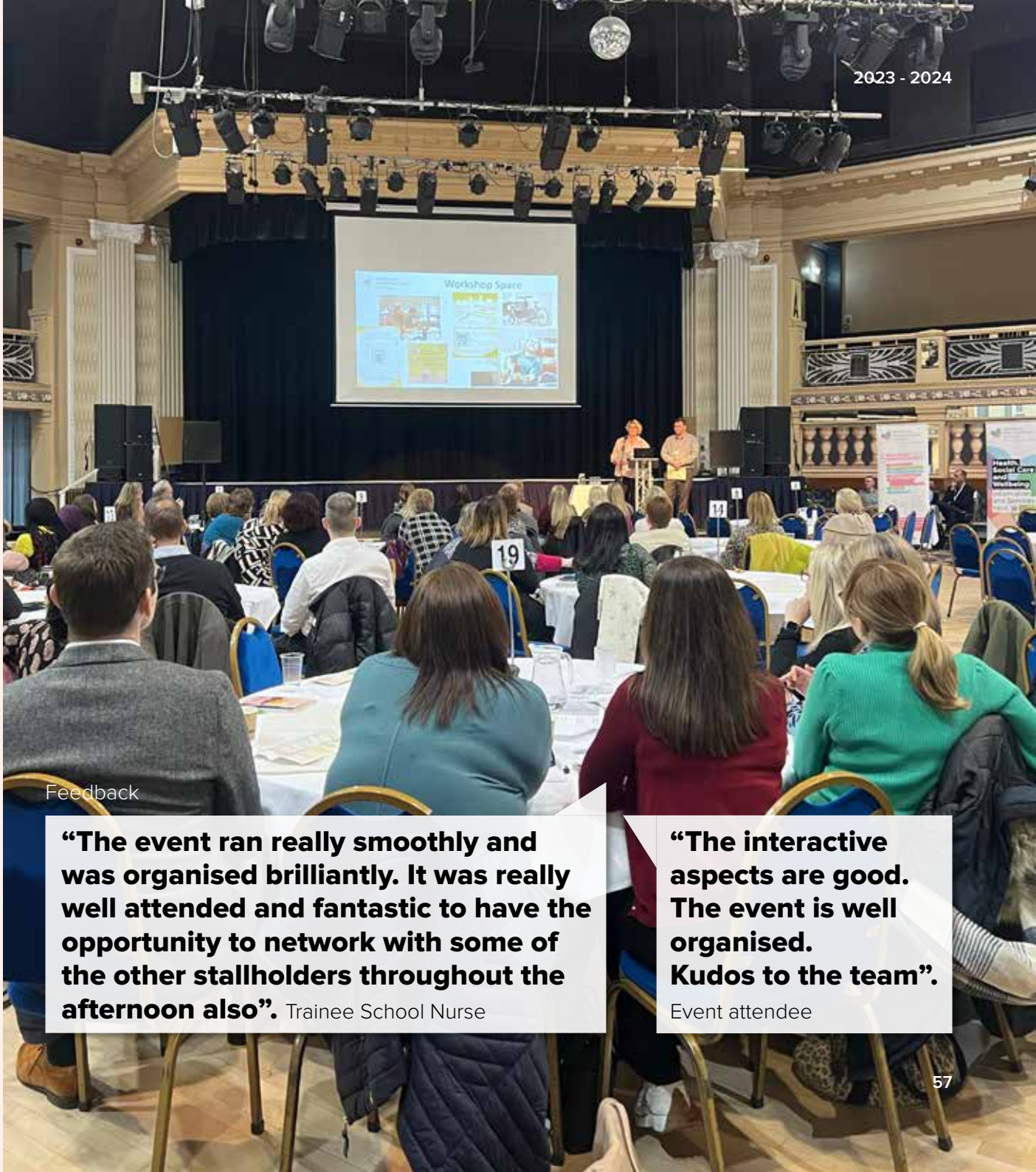
- **ACHSCP hosted a Recruitment event ahead of the winter period, supporting 19 organisations recruiting to care roles, with approximately 300 attendees on the day. You can watch our Recruitment event video here -** Recruitment Event
- **The ACHSCP Conference took place in February. This was the first partnership-wide conference since 2019, with great representation from services, charities and commissioned services. You can watch our ACHSCP Conference video here -** ACHSCP Conference
- **6 Career Ready Apprenticeships had placements with ACHSP in 2023-2024, with a good level of engagement and feedback. Career Ready also attended the conference, which has encouraged more sign-ups for mentors across the Partnership for 2024-2025.**

What's next?

- Develop and deliver a Recruitment events calendar – including media such as promotion videos for ACHSCP.
- Re-establishment of workforce engagement events and celebrating achievements
- Create an informative map of resources, training and technologies to support Partnership staff.

Recruitment Event Highlights

1. Over 100 applications per provider for care worker posts on the day, which were followed up with interviews
2. The event also included “How to” sessions every hour, which were fully booked, to raise awareness of NHSG and ACC vacancies and provide application and interview tips.
3. Feedback from attendees was generally positive, with the main draw being job opportunities, networking, and career advice.
4. The feedback highlighted the event as well-organised and useful.



Feedback

“The event ran really smoothly and was organised brilliantly. It was really well attended and fantastic to have the opportunity to network with some of the other stallholders throughout the afternoon also”. Trainee School Nurse

“The interactive aspects are good. The event is well organised. Kudos to the team”.
Event attendee

Transformation of Commissioning Approach

The project is to embed the new commissioning principles into how the Partnership commissions services. It is based upon a combination of:

- **The Ethical Commissioning Principles (for example, providing person-centred care; full involvement of people with lived experience; financial transparency and shared accountability) and**
- **Getting it Right For Everyone guidance (an initiative focusing on informed decision- making; treating people with kindness; and people working together and sharing information to deliver the best support possible).**
- **The approach places greater emphasis on engaging more with providers and people with lived experience, collaborating on how outcomes are achieved.**

Key Successes

- **Co-design of new Bon Accord Care Contract and Service Specifications.**
- **Care Home Blue Sky Thinking steering group was established with development sessions being progressed. These are in development and will look to inform what the areas of focus should be for the next financial year.**
- **Care at Home Contract Review utilising engagement events with service users/providers and stakeholders. This will help to shape what can be improved in the next iteration of the contract. The most recent engagement event had some 60 individuals attending with around 75% from service providers.**

What's next?

1. A development plan being collaboratively created following the Bon Accord Care Contract review. This is a four-year plan looking at all services and how these can be best utilised..
2. Commissioning Academy to support the sector with implementing the Ethical Commissioning Principles. The academy will also look at anything new which may appear over the horizon. The aim of the academy is to provide opportunities to network and share learning. This also helps the Partnership to support and hopefully sustain the leadership and management of care providers.

"Good discussion with a wide team of HSCP, comfortable atmosphere created to support honest and direct discussion without fear."

Engagement Session Attendee

"Opportunity for all to share their ideas and listen to others."

Engagement Session Attendee

"Real sense of open and honest conversations and partnership approach. Some of the sessions were a good giggle and already sense of good team dynamics".

Engagement Session Attendee

Transformation of Commissioning Approach

The model for funding counselling services by grants is in place until April 2025. The purpose of this project is to explore different models of funding. An 'alliance model' (a form of collaborative contracting that places “best for the person” at the heart of commissioning and procurement and promotes collaborative behaviours and decision making) is the preferred option being explored.

Key Successes

- **Collation of information on the counselling services in Aberdeen City.**
- **Approval from IJB to extend current model until March 2025.**
- **Identification of good areas of practice elsewhere in Scotland.**

What’s next?

- Contacting those who have implemented 'alliance' working for counselling, the purpose being to find out best practice in those areas implemented.
- Arrange a series of workshops for counselling services in Aberdeen to co-design new model.

Electronic Medicines Administrations Records (eMAR) Implementation

Most care homes in Aberdeen City use paper-based systems for medication which is inefficient and can lead to mistakes. This project aims to increase the number of care homes using electronic medicines administrations records (eMAR) instead. These help improve care by reducing mistakes and reduce wasted medication.

Key Successes

- **A pilot project was undertaken with a local care home. This provided useful learning on the issues to be considered when moving to an eMAR system.**
- **The learning from the pilot was included in a paper presented to the ACHSCP Senior Leadership Team (SLT). This paper provided evidence about the benefits and Senior leaders made a decision to ask for a full business case on ways to support eMAR in care homes.**
- **The paper was shared with the Scottish Government highlighting the benefits of this approach.**

What's next?

Funding has been approved for the implementation of eMAR to one in-house learning disability service, which will be rolled out over 2024-2025.

Expand the use of Technology Enabled Care (TEC)

Increasing demand on social care means new ways of delivering services require thought. Investing in technology will enable people to live longer, healthier and more independent lives. It will also help us deliver high quality, reliable and efficient services into the future. ACHSCP are committed to promoting the use of digital technology in order to explore alternative methods of care provision within the city. Using a “TEC First” approach during the assessment process, consideration is given to the use of technology to either replace or compliment in person care.

Key Successes

- **In September we held a Technology Enabled Care (TEC) 'Meet the Suppliers' event in Aberdeen. This drew in attendees from across Grampian and the Scottish Government Digital Office. The event included a mix of talks, workshops and demonstrations related to TEC and social care topics.**
- **Aberdeen City's TEC Plan 2023-25 was launched in 2023. A TEC Project Board was set up to oversee the delivery of TEC projects.**
- **A pilot project, the Digital Support Hub, was also launched in 2023. This has used a blended model of technology and face-to-face care.**
- **A comprehensive TEC library has been set up in Aberdeen you can find a short information video here -** TEC Library

What’s next?

- SRS Care Solutions have been undertaking a Pilot alongside Care Management to look at the use of digital supports. Whilst this project is still underway, there has been evidence of improved outcomes for service users and a financial benefit to this approach.
- Evaluation of the Digital Support Hub project will inform planning for future use of technology in care.
- Continue to explore opportunities to deliver more innovative solutions through use of digital.

Highlights

- **The TEC ‘Meet the Suppliers’ event in Aberdeen, which showcased a range of 7 TEC suppliers and included talks, workshops and demonstrations with 50 attendees.**
- **Bon Accord Care delivered 18 awareness sessions across the Partnership, NHS and community groups to promote the Telecare service, with 194 attendees at those sessions.**
- **24% increase in the number of referrals to Telecare.**

Eight patients within hospital who had been assessed as requiring some form of 24 hour care were all discharged home with a blended model of face to face and digital supports. Seven of the eight individuals have remained at home.

Additional notable progress within Technology

Project	Description	Key Successes
Review of the use of a Community Electronic Patient Record in Child and Adult Community Nursing Services	Morse is used to provide an electronic patient record to the Partnership's Child and Adult Community Nursing Services. An evaluation was carried out on the use of the application in early 2024. It included a user survey and investigated the processes undertaken by the services and how the use of Morse affected these.	• Feedback shows that 88% of users believe that the use of Morse has led to a reduction in the duplication of information. This has enabled nursing services to dedicate more time to their patients. • Over 70% of users responded that the use of Morse as an electronic patient record has helped them to share information more easily within their teams. Its use has meant that more than one person can access a patients record at any given time. • Compared with those using paper records, health visitors reported a 36 minute saving on undertaking the preparatory work for a Universal Health Visiting Pathway visit. This has helped to make our services operate more efficiently.
Analogue to Digital	We are ensuring that a reliable and robust digital telecare emergency response service is delivered before the analogue networks are turned off in December 2025. This include replacing all analogue community alarms as well as deploying a digitally-capable Alarm Receiving Centre (ARC) platform.	• Worked with the Digital Office as an early adopter to establish a single supplier framework for shared ARC which went live in November 2023. • Ensuring data accuracy by completing the Data Cleansing of 16,000 records that are held in the ARC database. • ACHSCP and Bon Accord Care received on March 2024 the Bronze Award for Digital Telecare Implementation from the Scottish Government Digital Office after replacing 58% of analogue community alarms with digital-ready units.
Digital Investment	Creation of capacity through targeted digital investment and service redesign.	• Work has been undertaken with services around potential innovative digital solutions. • External consultation has commenced looking at strategic proposals. • Work has commenced with in house partners to investigate a joint digital governance structure.

Finance

Financial Year 2023/24 continued to challenge our normal expenditure patterns as we, alongside all integration authorities, face increasing budget pressures. Robust financial monitoring continued through the year, however the financial position for 2023/24 resulted in an overspend of £10,744,000 on mainstream budgets which was met from reserves, as agreed by the IJB on 07 May 2024.

Our Medium Term Financial Framework for 2024/2025 to 2028/2029 was approved by the IJB on 26 March 2024 and our unaudited annual accounts were approved by the Risk, Audit and Performance Committee on 04 June 2024. To present a balanced budget this year, significant savings have had to be allocated in 2024/2025, which are being closely monitored by the Senior Leadership Team throughout the year.

Our previous performance report outlined a commitment of our IJB to affiliate our financial expenditure to demonstrate our commitment to the three tiers of Prevention (prevention, early intervention, response). The total budget expenditure is allocated as follows:-

1. PREVENTION	**Taking Action to prevent the occurrence of harm through universal measures.**
2. EARLY INTERVENTION	**Intervention that wards off the initial onset of harm and create empowered resilient communities and staff (human demand). Intervening before further harm takes place in a way that avoids the later costs on both human and financial terms of handling the consequences of that harm (resource demand).**
3. RESPONSE	**Significant harm has occurred or is assessed as being imminent, significant resource is required to provide specialist and / or intensive support to reduce harm and demand.**

Number of Delivery Plan 2023-2024 projects per tier

Tier	Prevention	Early Intervention	Response	Total
No. of projects and %	53 (83%)	4 (6%)	7 (11%)	64 (100%)

2022/23				2023/24		
Gross Expenditure £	**Gross Income £**	**Net Expenditure £**		**Gross Expenditure £**	**Gross Income £**	**Net Expenditure £**
40,236,645	0	40,236,645	Community Health Services	46,116,494	0	46,116,494
29,125,768	0	29,125,768	Aberdeen City share of Hosted Services (health)	31,323,029	0	31,323,029
40,665,018	0	40,665,018	Learning Disabilities	45,015,163	0	45,015,163
24,964,561	0	24,964,561	Mental Health & Addictions	26,985,068	0	26,985,068
97,907,284	0	97,907,284	Older People & Physical and Sensory Disabilities	107,204,489	0	107,204,489
1,889,544	0	1,889,544	Directorate	2,208,531	0	2,208,531
10,012,029	0	10,012,029	Covid	0	0	0
5,119,400	(4,958,384)	161,016	Criminal Justice	5,262,277	(5,114,956)	147,321
2,139,020	0	2,139,020	Housing	2,257,873	0	2,257,873
42,928,059	0	42,928,059	Primary Care Prescribing	46,349,194	0	46,349,194
41,544,380	0	41,544,380	Primary Care	45,094,568	0	45,094,568
2,514,611	0	2,514,611	Out of Area Treatments	2,502,936	0	2,502,936
52,719,000	0	52,719,000	Set Aside Services	55,550,000	0	55,550,000
0	0	0	City Vaccinations	3,058,242	0	3,058,242
12,144,018	0	12,144,018	Transformation	15,254,159	0	15,254,159
0	0	0	Uplift Funding	164,965	0	164,965
403,909,337	**(4,958,384)**	**398,950,953**	**Cost of Services**	**434,346,988**	**(5,114,956)**	**429,232,032**
0	(374,704,802)	(374,704,802)	Taxation and Non-Specific Grant Income (Note 1)	0	(411,921,018)	(411,921,018)
403,909,337	**(379,663,186)**	**24,246,151**	**Surplus or Deficit on Provision of Services**	**434,346,988**	**(417,035,974)**	**17,311,014**
		24,246,151	**Total Comprehensive Income and Expenditure**			**17,311,014**

Review range of independent advocacy

Independent advocacy is a legal obligation that Aberdeen City Council is required to fulfil. There are advocacy services available for people accessing a variety of support, many of which are operationally managed by the Partnership, for example individuals being detained in Royal Cornhill Hospital for mental health reasons, in addition to advocacy services for individuals with drug and alcohol misuse. Advocacy services are designed to support people with whatever need they require, for example providing a 'voice' for these individuals at meetings, or providing feedback on the service they are in receipt of.

Key Successes

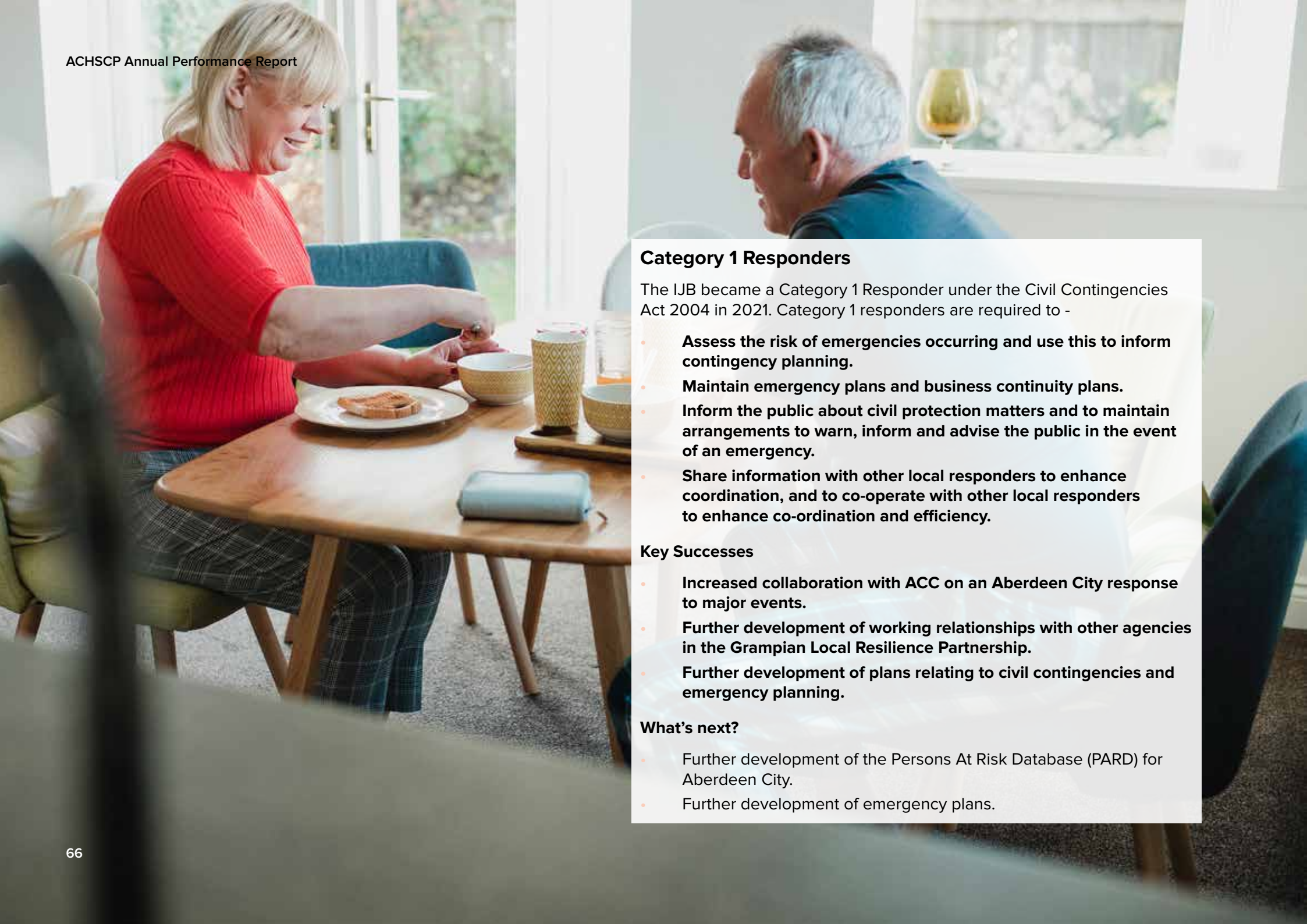
- **Delivery against the MAT Standards (optimising the use of Medication Assisted Treatment as a mechanism towards reducing drug-related deaths)**
- **Number of volunteers who have lived experience working within the service has increased to five. This equates to 135 hours of independent advocacy (volunteer support) over the past three months.**
- **100% of statutory referrals were met within the timescales.**
- **Staff have now received trauma informed (level 1), Adult Support Protection (Level 1 & 2), and a variety of substance use-related training.**
- **Secured additional funding to provide additional support to those experiencing domestic abuse.**

What's next?

1. The contract will be monitored and reviewed over the next two years.
2. Advocacy engagement events will continue to take place at various venues and environments across the city and Partnership to highlight their roles.

"My mental health has suffered due to my situation however it was really helpful for me to have an advocacy worker as they get you and don't judge you or your situation. They gave me the opportunity to show what I can do myself. Without an advocacy worker I don't think I would have been able to make decisions about my welfare or my son's. The information and knowledge that an advocacy worker can bring to the table is really helpful for meetings. I feel I would have been misguided had it not been for advocacy support and I would have struggled to navigate the systems we were dealing with. I am glad I have had advocacy. People seem to listen more. Advocacy gives you that extra confidence to go forward and speak up and not sit there and say nothing. It's good having someone by your side who stands up for you and encourages you to speak up."

Service user feedback



Category 1 Responders

The IJB became a Category 1 Responder under the Civil Contingencies Act 2004 in 2021. Category 1 responders are required to -

- **Assess the risk of emergencies occurring and use this to inform contingency planning.**
- **Maintain emergency plans and business continuity plans.**
- **Inform the public about civil protection matters and to maintain arrangements to warn, inform and advise the public in the event of an emergency.**
- **Share information with other local responders to enhance coordination, and to co-operate with other local responders to enhance co-ordination and efficiency.**

Key Successes

- **Increased collaboration with ACC on an Aberdeen City response to major events.**
- **Further development of working relationships with other agencies in the Grampian Local Resilience Partnership.**
- **Further development of plans relating to civil contingencies and emergency planning.**

What's next?

- Further development of the Persons At Risk Database (PARD) for Aberdeen City.
- Further development of emergency plans.

Single Point of Contact (SPOC) for Individuals & Professionals

The overall objective of SPOC is to better manage service requests and get service users to the right place. The SPOC will be a key tool for enabling the growth of social prescribing in future years. Partnership professionals will be contributing to and utilising this system. This should release capacity from other services. The image in the Partnership Working section of this report on page 11 shows our partners.

These are the types of resources that will be made available.

- **Referral**
- **Diagnosis, Initial Management and Prevention**
- **Guidance**
- **Patient Information**
- **Useful Resources**

Key Successes

- **Research has begun to explore the preferred approach for establishing a SPOC, reviewing both existing systems and exploring new technologies.**
- **This will be used as the basis for creating a central information bank for ACC and NHSG providing a standard searchable set of information for all professionals in the Partnership.**

Whats next

- Review available options for the most effective way to deliver this initiative to meet the needs of the service and service users.

NHS Grampian Primary Care Premises Plan

Continue to review and update the NHS Grampian Primary Care Premises Plan (PCPP) on an annual basis.

Key Successes

- **Ensuring the PCPP is up to date, in line with Scottish Government capital investment guidance and reflects the current premises requirements from primary care services across Grampian.**
- **Collaborative working between the three health and social care partnerships across Grampian, as well as the contractor leads for optometry, pharmacy & dental services.**
- **Successful updating of the PCPP, to make it more focused on capital funding projects and for the local level projects to not be included as they are held at a local level within the respective HSCP.**
- **PCPP went to NHS Grampian's Asset Management Group (AMG) in the Spring 2024 for final approval and sign-off. This ensured that the group are informed of the premises situation and the associated plans for them. So should the Scottish Government allocate any capital funding in the next financial year, NHS Grampian will be in a position to put forward plans to secure funding.**

Carden House

Finalise the arrangements for moving selected services into Carden House, following the closure of Carden Medical Practice. Identify appropriate alternative use of the building, in line with patient feedback received during the GP practice closure process.

Key Successes

- **Moving the largest GP practice in Aberdeen from Denburn Health Centre to Carden House, within a three-week period.**
- **Effective collaborative working between over a dozen ACHSCP and NHS Grampian teams and services as well as external contractors, to ensure services and the GP practice moved in on time and that the premises were reconfigured to ensure it was fit for purpose.**
- **A key facility in the centre of Aberdeen is once again operating at full capacity and providing vital services to the patients.**
- **The GP Practice, ACHSCP services and teams will continue to provide services to patients from a fit-for-purpose building located in a key location.**

What's next?

- 'Project closed' report will be presented to Senior Leadership Team (SLT), highlighting the lessons learned from this project as well as the multiple highlights.

Countesswells

Develop an interim solution for the provision of health and social care services in the Countesswells housing development and work on the long-term solution.

Key Successes

- **Premises acquired for housing the interim health solution.**
- **Developer obligations secured to provide funding for the configuration and fit-out of the interim solution.**
- **Services selected to operate from the premises after a robust application and selection process.**
- **Project was on track to be operational in Summer 2024. Premises expected to be operating at over 80% capacity from day one of opening, which is expected to increase over the coming weeks and months.**

What's next?

- Services begin operating from the premise in Summer 2024.
- Local population have more easily accessible services on their doorstep.
- Neighbouring GP practices are supported by a reduction in patients visiting them for treatments/services that will now be provided from the new premises in Countesswells.

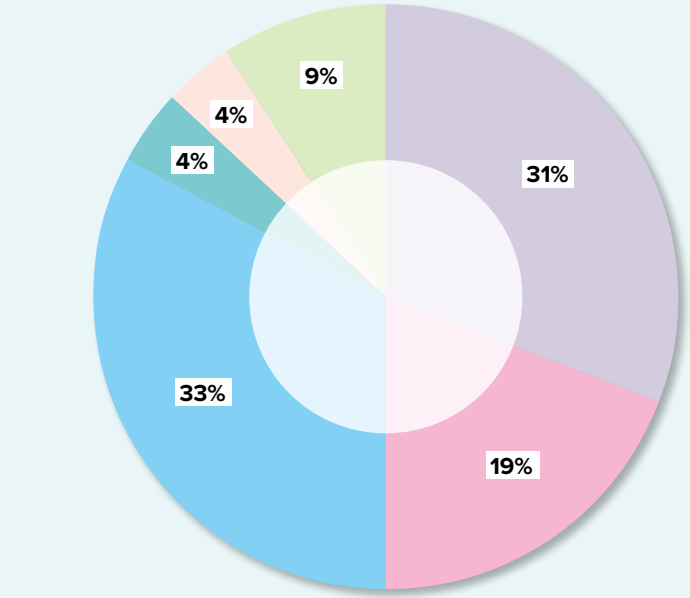
Governance

Complaints Summary

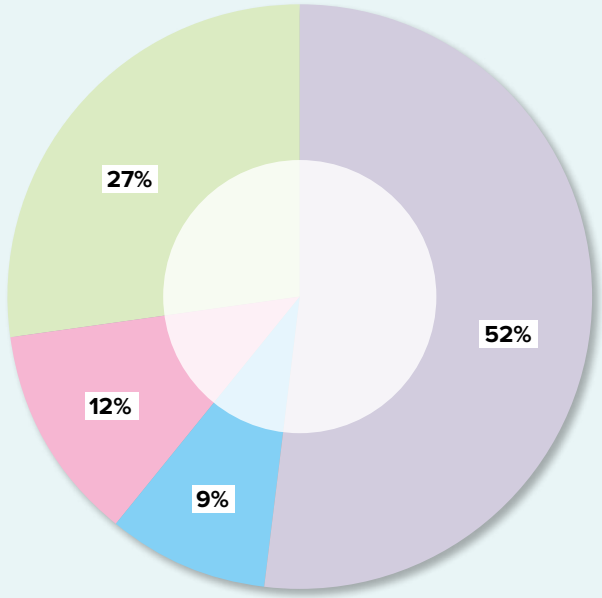
As an organisation, we take complaints made relating to our services very seriously and we have a number of governance processes in place to ensure that these are reviewed, and where possible lessons are learned. There were 195 complaints registered with ACHSCP through either NHS Grampian or Aberdeen City Council in 2023-/2024. This was a reduction of 25% compared with the number of complaints received in 2022-/23.

The following shows the outcomes of the complaints received, with around 31% of them fully upheld.

Outcomes of complaints relating to ACHSCP which were registered with NHSG
Total = 162



Outcomes of complaints relating to ACHSCP which were registered with ACC
Total = 33



Complaints Response Times and Outcomes

Stage 1:

- Early Resolution
- Resolved within five working days

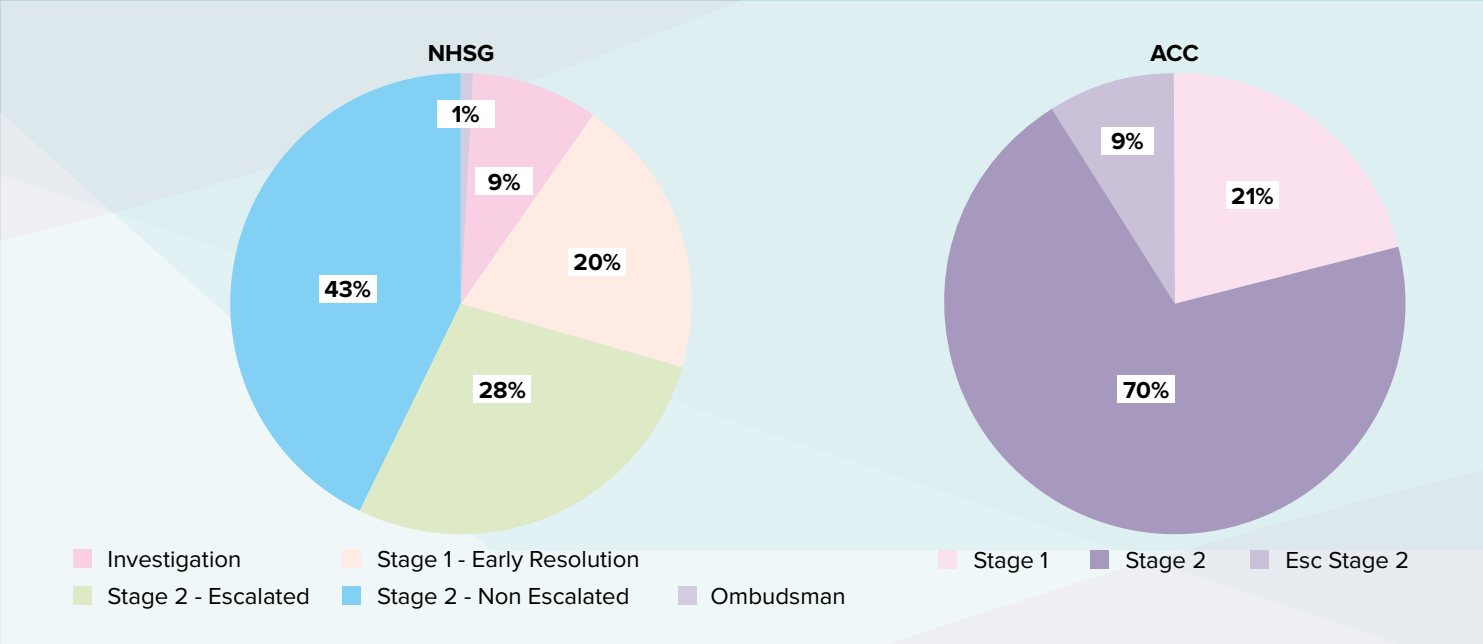
Stage 2 (non-escalated):

- 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

This chart illustrates the percentage of complaints at each stage registered through NHS Grampian or Aberdeen City Council in 2023-24.



Locality Planning

Develop the membership and diversity of our Locality Empowerment Groups (LEGs)

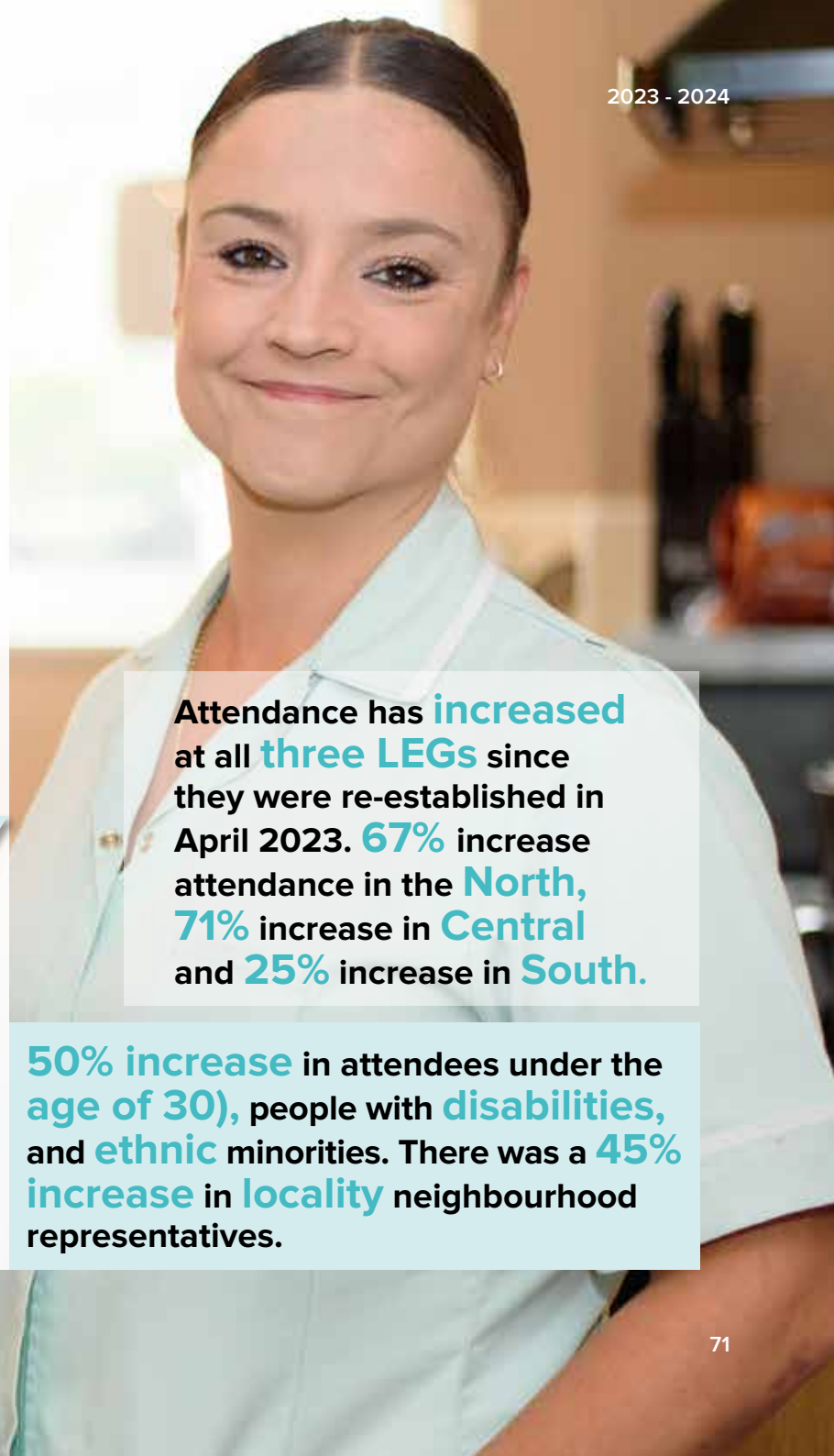
Aberdeen City has been divided into three locality areas: North, Central, and South. Each of these three areas has a Locality Plan which is monitored by a Locality Empowerment Group and Priority Neighbourhood Partnership. It is a priority to increase and diversify the membership of our three LEGs to ensure local people are able to have their say on what our shared priorities should be and where resources should be allocated. We want to make our LEGs as inclusive and representative as possible to ensure discussions and decisions are broadly reflective of the views of our wider population.

- **Attendee diversity increased at all three LEGs during 2023-24, with generally an equal gender balance, and growing numbers of younger people.**
- **Strong connections with ACHSCP locality-based services such as Allied Health Professionals, Community Nursing and the Primary Care Team resulting in increased engagement and attendance at meetings.**

"Being a member of a LEG lets me know what's going on across the locality and how I can get involved. Attending meetings gives me the chance to meet other people who also want to improve our communities and lets me know where I can access funding for community projects."

What's next?

- A new Locality Planning Communication and Engagement Plan is being produced, which aims to improve how we communicate with our communities, how we can increase their engagement in delivery of our shared locality plans, and ensure anyone who wants to participate can do so as easily as possible.



Attendance has increased at all three LEGs since they were re-established in April 2023. 67% increase attendance in the North, 71% increase in Central and 25% increase in South.

50% increase in attendees under the age of 30), people with disabilities, and ethnic minorities. There was a 45% increase in locality neighbourhood representatives.

Deliver Integrated Locality Plans

It is a statutory requirement for ACHSCP to have a locality planning structure. ACHSCP's Strategic Plan and Community Planning Aberdeen's LOIP require the Integrated Locality Planning Team (ILPT) to develop locality plans for each of our locality areas and report progress on an annual basis to the IJB's Risk, Audit and Performance Committee and the Community Planning Aberdeen Board.

- **Establishment of ILPT, comprised of membership from Aberdeen City Council and the Partnership's Public Health team, covering each locality in the city.**
- **Preparation of easy-read locality plans that improve the accessibility of information to community members about priority areas to focus on.**

What's next?

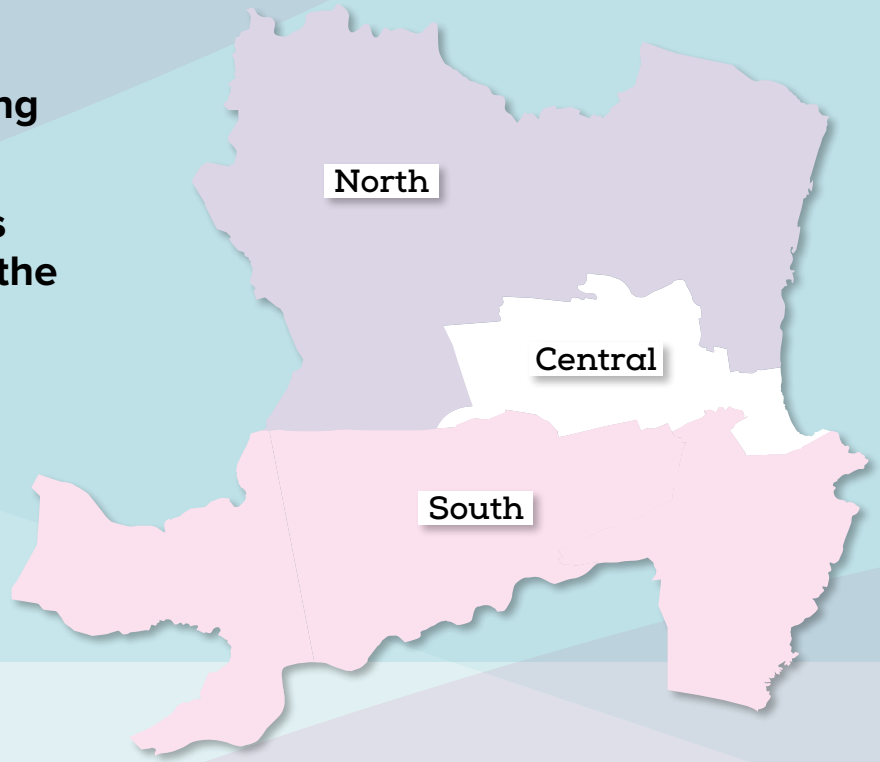
- Refreshed Locality Plans will be presented to the Community Planning Aberdeen board, alongside the refreshed LOIP in Spring 2024. If approved, the three Locality Plans will come into effect at the start of the 2024 / 2025 financial year.
- Progress on delivery of the Locality Plans will be reported as a standing agenda item at the LEG and Priority Neighbourhood Partnership meeting during 2024-25.

Delivery of Community Gathering community event in the Cowdray Hall in May 2023. This was attended by 25 community exhibitors and 121 attendees, providing information on what is happening in communities across Aberdeen.

Our Locality Planning priorities for 2024-2025

1. **Use our Locality Planning Communication and Engagement Plan to increase awareness of the LOIP and Locality Planning amongst our third sector and community partners;**
2. **Increase the membership and diversity of Locality Empowerment Group and Priority Neighbourhood Partnerships;**
3. **Increase the number of community partners helping us deliver our three Locality Plans;**
4. **Deliver the priorities and community change ideas within our three Locality Plans, including through the use of our Health Improvement Funding.**

For more information on Locality Planning, please contact us at LocalityPlanning@aberdeencity.gov.uk



Highlights

- 64% of applications received funding via the HIF
- 100% of applications received funding in the North Locality LOIP trial

“I can’t believe how quickly we received the outcome of our application, this was a really positive outcome and experience.”

“The Health Improvement Fund application is the one of the best, and easiest, funding applications to complete.”

Feedback

1. Continue to work with communities to understand the priorities and support required from the HIF to empower community-led health.
2. A showcase will take place during summer 2024 in partnership with ACVO’s Community Mental Health and Wellbeing Fund to celebrate successful projects and provide the opportunities for shared learning between projects and funders.

Health Improvement Fund (HIF) - Public Health Team (Communities)

The HIF empowers our communities to facilitate change and leaves a long-lasting legacy within local communities. During 2023-24 up to £5,000 was available for projects, focusing on preventative activities, aiming to facilitate the improved health and wellbeing of those living and/or working in Aberdeen City.

Key Successes

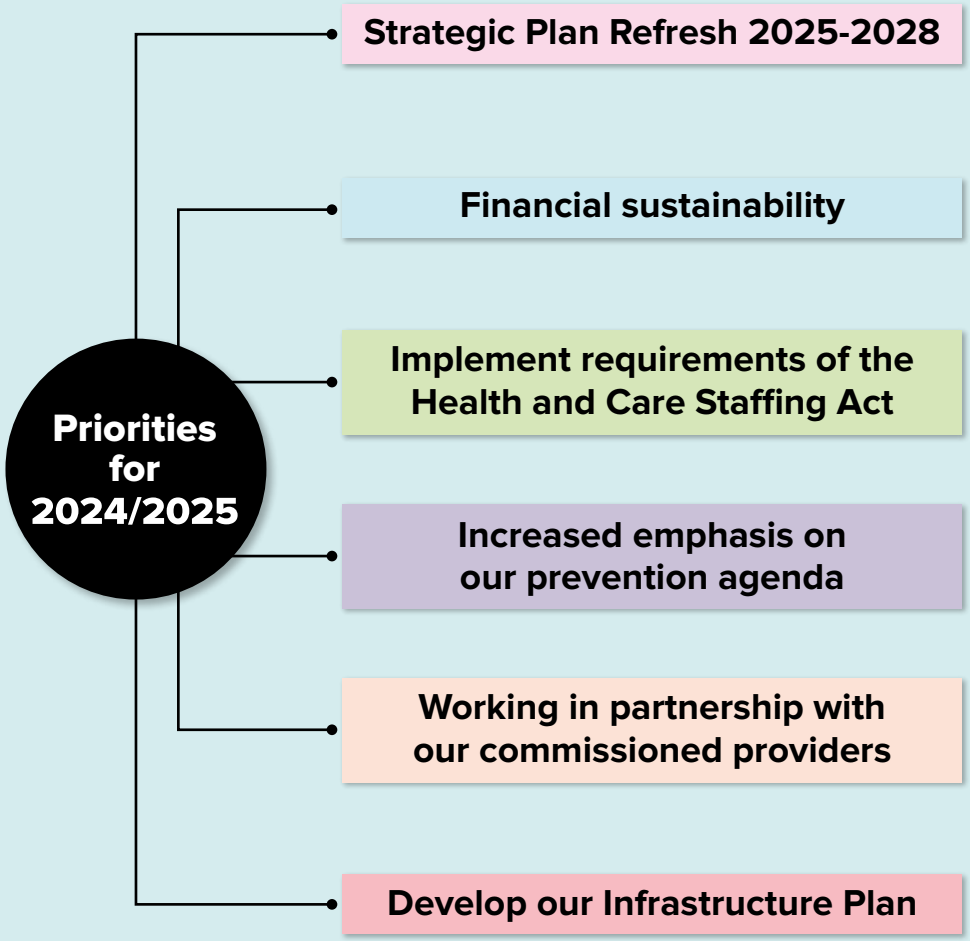
- **Across the three Localities (Central, North and South) and the city-wide area, 74 projects were successfully funded during this funding period (64% of applications approved). This is a notable increase from the previous year, where only 54% of applications received funding.**
- **Decision-making groups made up of Locality Empowerment Group (LEG), Priority Neighbourhood Partnership (PNP), third sector and public sector. Overall, 60% of the decision-making groups were made up of community and third sector members.**
- **Following the recent community consultations regarding the Locality Plans and LOIP, a trial was carried out in the North Locality aiming to assess applications within five working days from submission. 69% of applications received the outcome of their application on or before this date and 100% of applications received were approved. Positive feedback from both applicants and decision-making groups.**

Strategic Plan 2022 – 2025 and Priorities for 2024/2025

The Partnership is now entering the final year of its current strategic plan. This will look to build upon the work that has already been achieved within the previous two financial years. A delivery plan has been developed for the remainder of the existing strategic plan, and also set the foundations for what may be included within the new strategic plan that comes into existence from 2025 onwards. The delivery plan for the third year of this strategic planning cycle focuses on:

- **The continuation of key projects that have demonstrated success over the past 12 months.**
- **Adaptation of key priorities to better reflect the emergent context in which they are now operational in.**
- **New projects that are likely to form a key basis of the new Strategic Plan.**

Some of the key priority areas for 2024/2025 are highlighted to the right. Critical to the delivery of these will be continued close collaboration alongside our partners in Aberdeen City Council, NHS Grampian, and other third party organisations.



Appendix 1 - National Indicators

The tables below present the national integration indicators as compiled and published by Public Health Scotland. The raw data and the methodology for calculating these figures can be accessed here.

The reported indicators include nine measures (1-9) derived from the Health and Care Experience (HACE) Survey, which is conducted biennially. The indicators reported comprise of nine indicators (1-9) based on the Health and Care Experience (HACE) Survey which is conducted biennially and it asks about people's experiences of accessing and using various services. Additionally, there are eleven other measures (11- 20) primarily based on health activity, community and mortality data.

To indicate overall trends, arrows have been colour-coded: a pink/purple arrow signifies a positive outcome, while a white arrow denotes a negative result.

For indicators 12 to 16, the annual figures are presented by financial year until 2022/23. As April 2023 to March 2024 data are not complete for all NHS Boards, calendar year figures are shown for 2023.

Notes on Comparability of Results Between Years and Differences to HACE Publication

1. The 2023/24 results for indicators 6 and 8 are consistent with both the HACE publication and the Core Suite Integration Indicator releases, making them comparable across all years.
2. Results for indicator 1 are comparable across all years. They may differ to the HACE publication as results are unweighted in the HACE publication but weighted in the Core Suite Integration Indicators to allow comparisons over time and between areas.
3. Due to changes in the HACE survey wording, the 2023/24 results for indicators 2, 3, 4, 5, 7 and 9 are not comparable to the same indicators for previous years.

Indicators	Title	Aberdeen City Rate			Scotland Rate		
		2021/22	2023/24	Overall Trend and percentage increase/decrease	2021/22	2023/24	Overall Trend
NI1	Percentage of Adults able to look after their health very well or quite well	94%	90%	↓	91%	91%	Stable
NI2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	78%	77%	No trend given due to change in question format	79%	72%	No trend given due to change in question format
NI3	Percentage of Adults supported at home who agree that they had a say in how their help, care or support was provided	66%	57%	No trend given due to change in question format	71%	60%	No trend given due to change in question format
NI4	Percentage of adults supported at home who agree that their health and social care services seemed to be well coordinated	71%	63%	No trend given due to change in question format	66%	61%	No trend given due to change in question format
NI5	Percentage of adults receiving any care or support who rate it as excellent or good	77%	75%	No trend given due to change in question format	75%	70%	No trend given due to change in question format
NI6	Percentage of people with positive experience of care at their GP Practice	65%	60%	↓	67%	69%	↑
NI7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	79%	74%	No trend given due to change in question format	78%	70%	No trend given due to change in question format
NI8	Percentage of carers who feel supported to continue in their caring role	32%	37%	↑	30%	31%	↑
NI9	Percentage of adults supported at home who agree they felt safe	76%	72%	No trend given due to change in question format	80%	73%	No trend given due to change in question format

Indicators	Title	Aberdeen City Rate					Scotland Rate				
		2020/21	2021/22	2022	2023	Overall Trend	2020/21	2021/22	2022	2023	Overall Trend
NI11	Premature mortality rate (per 100,000 persons)	2020 432	2021 453	441	N/A		2020 457	2021 466	422	N/A	
NI12	Emergency admission rate (per 100,000 population)	9201	9655	9366	9477	↑	10,957	11,632	11,155	11,707	↑
NI13	Emergency bed day rate, (per 100,000 population)	84,774	93,427	92,026	90,378	↑	101,967	112,939	113,134	112,883	↑
NI14	Emergency readmission to hospital after 28 days of discharge (rate per 1,000 discharges)	139	121	118	126	↓	120	107	102	104	↓
NI15	Proportion of last 6 months of life spent at home or in a community setting	91%	91%	91%	90%	↓	90%	90%	89%	89%	Stable
NI16	Falls rate per 1,000 population 65+	22 (actual falls 816)	22	20 (actual falls 816)	22	↑	22	23	22	23	↑
NI17	Proportion of Care Services graded 'good' (4) or better in Care Inspectorate inspections	91%	78%	64%	2023/24 71%	↑	83%	76%	75%	2023/24 77%	↑
NI18	Percentage of adults with intensive care needs receiving care at home	N/A	2021 55%	55%	55%	Stable		2021 64%	2022 64%	65%	↑
NI19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (rate per 1,000 population)	276	318	2022/23 336	2023/24 220	↓	484	748	2022/23 919	2023/24 902	↓
NI20	Percentage of health and care resource spent on hospital stays where the parents was admitted in an emergency	2019/20 27%	N/A	N/A	N/A		2019/20 24%	N/A	N/A	N/A	

Data Source: Public Health Scotland Core Suite of Integration Indicators reported July 2024

Appendix 2 – Ministerial Steering Group (MSG)

The following tables present the Ministerial Steering Group (MSG) indicators, which are used to evaluate the performance of the Aberdeen City Health and Social Care Partnership (ACHSCP) against previous years and other regions within Scotland. The table below outlines the six indicators and the outcomes recorded for 2023/24, with the Scottish average included for context.

Overall, ACHSCP has performed slightly above the Scottish average across all areas within the Ministerial Steering Group Indicators:

- **Emergency Admissions:** ACHSCP experienced a 3.4% increase in the number of emergency admissions compared to the previous year. This upward trend is modest and aligns with the Scotland average, which saw a 4.8% increase.
- **Unscheduled Hospital Bed Days:** There was a 7.6% decline in the number of unscheduled hospital bed days in 2023/24 compared to the previous financial year. This also reflects an overall downward trend in ACHSCP's unscheduled bed days over the past five financial years. The dedication and commitment of teams across the partnership have ensured that many individuals receive timely and appropriate care closer to their homes. This not only alleviates pressure on emergency and acute care units but also ensures prompt discharge of patients once their need for acute medical care subsides.
- **A&E Attendances:** A&E attendances have slightly risen by 1.2% over the past year. However, this should be viewed in the context of an overall downward trend, with A&E attendances still around 400 contacts fewer than the Partnership's pre-COVID figures.
- **Delayed Discharges:** The levels of delayed discharges reported in ACHSCP have significantly reduced by 22% compared to last year's average, which is approximately half of the pre-COVID figures. This positive trend highlights the success of targeted efforts in improving discharge processes and ensuring timely patient transitions from hospital to home or community care settings.

The reduction in unscheduled hospital bed days and delayed discharge bed days are key highlights of our performance. Several initiatives have contributed to these improvements:

- The Hospital at Home Team provided high-quality acute care in patients' homes, focusing on older adults experiencing frailty. By supporting patients at home, the team helped to avoid hospital admissions and reduce the length of hospital stays. In 2023, the service supported 1105 patient admissions, avoiding 996 hospital admissions.
- The Hospital Social Work Team was aligned towards the highest demand, improving system flow and reducing delays in hospital discharges. This targeted approach ensured patients were moved on from the hospital efficiently.
- **Technology Enabled Care:** Implementation of technology-enabled care strategies to support independent living and timely interventions.

Appendix 2 - Ministerial Steering Group (MSG)

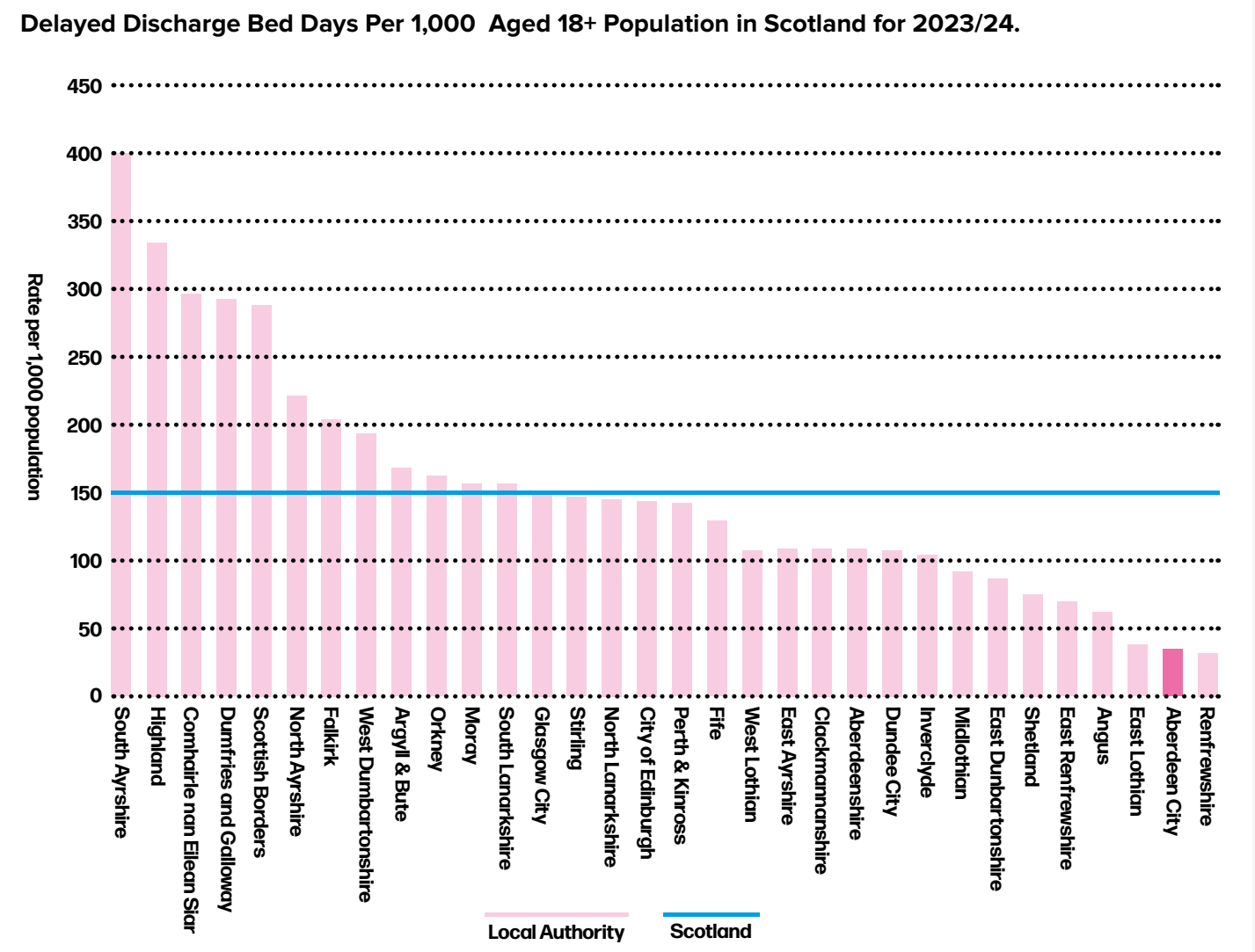
Indicators		Aberdeen City						Scotland Average	
	2019/20	2020/21	2021/22	2022/23	2023/24	Overall Trend between 2019-2024	Trend between 2022/23-2023/24	Overall Trend between 2019-2024	Trend between 2022/23-2023/24
1a. Number of emergency admissions (monthly average)	1824	1582	1700	1690	1748	↓	↑ + 3.4%	↓	↑ + 4.8%
2a. Number of unscheduled hospital bed days; acute specialties (monthly average)	11944	9133	10705	11325	10465	↓	↓ - 7.6%	↑	↓ - 3.1%
3a. A&E attendances (monthly average)	3972	2688	3244	3473	3514	↓	↑ + 1.2%	↓	↑ + 2.6%
4. Delayed discharge bed days (monthly average)	1023	494	607	745	585	↓	↓ - 21.6%	↑	↑ + 0.7%
5a. Percentage of last six months of life by setting (%)	88.6	91.4	91.0	90.3%	Not available	No trend given due to unavaiability of 2023/24 data	No trend given due to unavaiability of 2023/24 data	No trend given due to unavaiability of 2023/24 data	No trend given due to unavaiability of 2023/24 data
6. Balance of care: Percentage of population in community or institutional settings (%)	98.3	98.4	98.3	98.3	Not available	No trend given due to unavaiability of 2023/24 data	No trend given due to unavaiability of 2023/24 data	No trend given due to unavaiability of 2023/24 data	No trend given due to unavaiability of 2023/24 data

Note: Indicator 2a and 6 have been updated from last year's publication due to the release of updated data.

Data Source: Public Health Scotland MSG Indicators reported in September 2024

Table 1.
Rate of Delayed Discharge in Scotland per 1,000 population 2023-2024

Source: National Integration Indicators, Public Health Scotland.



Appendix 3 - Health and Care Experience (HACE) Report

The Health and Care Experience Survey is part of the Scottish Care Experience Survey Programme, which collects local and national information on the quality of various health and care services. The survey asks people about their experiences of accessing and using health and social care services in Scotland and covers topics such as general practice, hospital care, social care, community health services, and carer support.

This survey is conducted every two years and the 2023/2024 results are based on responses from over 100,000 people across Scotland, including 3,190 from Aberdeen City, who completed the survey.

The results was presented to IJB in August 2024 and can be found here.

The report compares Aberdeen City's results with Scotland's and the previous survey's results, it includes key findings, demographic information of respondents, and strategic plans to address community challenges and anticipate future improvement in healthcare experiences in Aberdeen City.

Appendix 4 - ACHSCP Strategic Plan 2022 - 2025

Delivery Plan Reference

The outcomes from the Strategic Plan are devised to be delivered over a three-year period, with an annual scheduled review and update so that lessons learned or emerging priorities can be taken into account and scheduled appropriately. Below is a list of programmes and projects within the Year 2 Delivery Plan which was approved by IJB in March 2023. Many of these have started over the past financial year and are ongoing.

Where reference or links has been made to particular projects within the Annual Performance Report, these have been outlined below. Delivery Plan progress is reported to our Senior Leadership Team (SLT) monthly and to the Risk, Audit and Performance Committee quarterly. The updated Delivery Plan for 2024-25 (Year 3 of the ACHSCP Strategic Plan) was presented to IJB in March 2024 and can be found here - **Our Strategic Plan | Aberdeen City HSCP**

Caring Together

Programme/Projects	Measures	Link if Referenced within the Report
Redesigning Adult Social Work		
Redesigning Adult Social Work enhancing the role of Social Work in playing a guiding role in the promotion of personalised options for care and support.	Redesign implemented & Evaluated	Please see **page 13** for an overview of the work ongoing.
Communities		
Confirm the accuracy and accessibility of the map of existing universal and social support and work with partners and the community to develop services to meet any identified gaps.	Mapping	Please see **page 29** for an overview of the work ongoing.
Continue to develop and evaluate the Northfield Hub as a test of change for cross-sector, easily accessible, community hubs where a range of services coalesce, all responding to local need, to feed into a wider initiative on Priority Intervention Hubs.	Hubs operational	Please see **page 24** for an overview of the work ongoing.
Develop the membership and diversity of our Locality Empowerment Groups.	Membership	Please see **page 71** for an overview of the work ongoing.
Increase community involvement through existing networks and channels.	Increase in LEG and PNP membership	Please see **page 71** for an overview of the work ongoing.
Deliver Integrated Locality Plans and report on progress.	Progress Report	Please see **page 72-73** for an overview of the work ongoing.
Ensure the use of Our Guidance for Public Engagement is embedded.	Percentage of Staff Trained	
Promote the use of Care Opinion to encourage patients, clients, carers and service users to share experiences of services, further informing choice.	Number of posts on Care Opinion	Please see **page 29** for an overview of the work ongoing.
Social Care Pathways		
Undertake a strategic review of specific social care pathways utilising the GIRFE multi-agency approach where relevant and develop an implementation plan for improving accessibility and coordination.	Implementation Plan	Please see **page 20** for an overview of the work ongoing.
Implement the recommendations from the June 22 Adult Support and Protection inspection.	Action Plan complete	Please see **page 19** for an overview of the work ongoing.
Deliver the Justice Social Work Delivery Plan.	Percentage of actions complete	Please see **page 29** for an overview of the work ongoing.

Caring Together

Programme/Projects	Measures	Link if Referenced within the report
Primary Care		
Improve primary care stability by creating capacity for general practice.	Report to IJB	Please see **page 26-27** for an overview of the work ongoing.
Deliver the strategic intent for the Primary Care Improvement Plan (PCIP).	Scottish Government Tracker Return. PCIP Implementation Tracker	Please see **page 26-27** for an overview of the work ongoing.
Develop a vision for Primary Care.	Vision documented	Please see **page 28** for an overview of the work ongoing.
Strategy		
Monitor and evaluate the impact of the Carers Strategy on an ongoing basis factoring in early preparations for the next revision.	Delivery of the Carers Strategy Action plan	Please see **page 25** for an overview of the work ongoing.

Keeping People Safe at Home

Programme/Projects	Measures	Link if Referenced within the Report
Rehabilitation Review		
Develop a strategic planning framework for reviewing of rehabilitation services across ACHSCP /SOARS / Portfolio for phased implementation from April 2023. Each review should consider how partners in sports and leisure can assist in delivery of rehabilitation and will consider bed base requirements.	Framework Developed	Please see **page 31** for an overview of the work ongoing.
Undertake and implement a strategic review of the Neuro Rehabilitation Pathway.	Workshop Outcomes	
Flexible Bed Base		
Build on our intermediate bed-based services to create 20 step-up beds available for our primary care multi-disciplinary teams (MDTs) to access.	20 beds created	Please see **page 32-33** for an overview of the work ongoing.
Increase our hospital at home base with an ultimate ambition of 100 beds. These will be for Medical and Respiratory pathways, as well as the current Frailty, End of Life Care and OPAT pathways.	Number of Beds available	Please see **page 32-33** for an overview of the work ongoing.
Frailty		
Deliver the second phase of the Frailty pathway and undertake a review of implementation to date to identify further improvements to be incorporated into the programme plan.	Pathway delivered	Please see **page 35** for an overview of the work ongoing.
Strategy		
Help people to ensure their current homes meet their needs including enabling adaptations.	Adaptation statistics, Telecare usage statistics	Please see **page 34** for an overview of the work ongoing.
Commissioning		
Deliver robust arrangements for medical cover for care settings	Patient/relative satisfaction, colleague surveys for baseline information	

Preventing ill Health

Programme/Projects	Measures	Link if Referenced within the report
Preventation		
Reduce the use and harm from alcohol and other drugs including through the Drugs Related Deaths Rapid Response Plan.	Drug and Alcohol related admissions and deaths, Delivery Framework Milestones	Please see **page 49** for an overview of the work ongoing.
Deliver actions to meet the HIS Sexual Health Standards.	Progress towards meeting standards	
Continue the promotion of active lives initiatives with our partners, for example the Physical Activity Academy, Active Travel etc.	Percentage of population meeting Physical activity national guidelines	Please see **page 44-46** for an overview of the work ongoing.
Reduce smoking prevalence across population and prevent e-cigarette and emerging tobacco produce use among young people.	Various within the programme	Please see **page 43** for an overview of the work ongoing.
Continue to deliver our Stay Well Stay Connected programme of holistic community health interventions focusing on the prevention agenda.	Various within the programme	Please see **page 38-39** for an overview of the work ongoing.
Continue to contribute to the Health Transport Action Plan (HTAP) and the Aberdeen Local Transport Strategy (ALTS) encouraging sustainable and active travel.	ACHSCP requirements reflected in GPTP and ALTS	
Communities		
Co-design Aberdeen as an Age Friendly City which supports and nurtures people to get ready for their best retirement and promotes the development of a social movement to encourage citizens to stay well and stay connected within their communities.	After delivery of Launch event "Granite City Gathering" will next held in September 2024	Please see **page 47-48** for an overview of the work ongoing.

Achieving Healthy, Fulfilling Lives

Programme/Projects	Measures	Link if Referenced within the report
Digital		
Make Every Opportunity Count by ensuring patients, clients and their carers are signposted to relevant services for help.	Service Directory developed	Please see **page 51** for an overview of the work ongoing.
Home Pathways		
Develop and deliver local and sustainable system flow and return to home pathways with partners, supporting reduced hospital admission, delays in hospital discharge and out of area placements.	New IJB date agreed and plan implemented to keep MPS on track to meet new IJB date	Please see **page 54** for an overview of the work ongoing.
MHLD		
Work with Children's Social Work and health services, to predict and plan for future Complex Care demand including developing and implementing a Transition Plan using the GIRFE multi-agency approach for those transitioning between children and adult social care services, initially for Learning Disabilities.	Future predicted demand identified; Improved user experience	
Deliver a capability framework for a workforce to support complex behaviour.	Skills framework developed	Please see **page 53** for an overview of the work ongoing.
Progress the Grampian wide MHLD Transformation Programme monitored by the Portfolio Board.	Plan developed; Progress Reports; Project milestones and Trajectories	Please see **page 54** for an overview of the work ongoing.
Develop a Mental Health triage approach in Primary Care to improve patient experience and promote self-management.	Improved patient experience; reduction in GP time; further impacts evaluated to enable scaling up	Please see **page 53** for an overview of the work ongoing.
Review strategy and arrangements for Autism/Neurodevelopmental including further development of the Autism Assessment service and expansion to include neurodevelopmental assessment	Review undertaken and aligned to national requirements from Scottish Government	Please see **page 53** for an overview of the work ongoing.
Develop and implement approaches to support Suicide Prevention and alignment to national Suicide Prevention Strategy	Aberdeen City suicide prevention delivery group established and action plan produced	Please see **page 52** for an overview of the work ongoing.

Achieving Healthy, Fulfilling Lives

Social Care Pathways		
Explore opportunities for working with those on Social Work unmet need lists to help support them while they wait, or divert them from the list.	Numbers supported/diverted	Please see **page 53** for an overview of the work ongoing.
Strategy		
Deliver on our Equality Outcomes and Mainstreaming Framework, report on our progress to both the IJB and the Risk, Audit and Performance Committee and plan to revise the EOMF in advance of the 2025 deadline.	IJB and Committee Reports	Please see **page 54** for an overview of the work ongoing.
Undertake and publish Health Inequality Impact Assessments, where relevant, for major service change, in conjunction with people and communities with the relevant protected characteristics ensuring that the requirements of the UNCRC are incorporated.	Number of Inequality Impact Assessments published	Please see **page 54** for an overview of the work ongoing.
Embed consideration of the impact of climate change in health and social care planning and in business continuity arrangements aiming to reduce our carbon footprint and deliver on our Net Zero emissions target.	Climate Change impacts included in Business Cases, IJB Reports and Business Continuity Plans	Please see **page 54** for an overview of the work ongoing.

Strategic Enablers

Programme/Projects	Measures	Link if Referenced within the report
Workforce		
Deliver the Workforce Plan.	Delivery of the workforce plan	Please see **page 56-57** for an overview of the work ongoing.
Develop and implement a volunteer protocol and pathway with a view to growing and valuing volunteering within the health and social care system.	Protocol developed	
Continue to support initiatives supporting staff health and wellbeing.	Initiatives delivered	
Ensure our workforce are Trauma Informed	Percentage of workforce trained	
Create and implement an SLT Team Development Plan	SLT Development Plan Implemented	
Digital		
Support the implementation of digital records where possible.	Percentage of records digitised	
Support the implementation of Electronic Medication Administration Recording (EMAR) in our care homes.	Business case developed	Please see **page 60** for an overview of the work ongoing.
Seek to expand the use of Technology Enabled Care (TEC) throughout Aberdeen.	TEC usage statistics	Please see **page 61** for an overview of the work ongoing.
Deliver a Single Point of Contact for individuals and professionals including a repository of information on health and social care services available, eligibility criteria and how to access.	Community First Programme Milestones	Please see **page 67** for an overview of the work ongoing.
Review the future use of Morse in Community Nursing and Allied Health Professionals.	Plan developed and delivered	Please see **page 62** for an overview of the work ongoing.
Explore ways we can help people access and use digital systems.	AGILE printed brochure is distributed via Care management, Wellbeing coordinators, Vaccination Center and at ARI community nurses and at all relevant events for the partnership and NHSG	
Analogue to Digital Implementation Plan.	Medium Term Financial Framework (MTFF)	Please see **page 62** for an overview of the work ongoing.

Strategic Enablers

Finance		
Develop a critical path for future budget setting and ongoing monitoring.	Medium Term Financial Framework (MTFF)	Please see **page 63** for an overview of the work ongoing.
Relationships		
Develop proactive, repeated and consistent communications to keep communities informed.	Number of proactive communications	
Review Care for People arrangements.	Percentage Remobilisation	
Review SMOC arrangements.	Agreement to a revised working arrangement	Please see **page 67** for an overview of the work ongoing.
Create and adopt a Generic Emergency Plan to reflect Aberdeen city IJB's Cat 1 Responder responsibilities.	Emergency Plan implemented	Please see **page 66** for an overview of the work ongoing.
Preparing for and managing the transition to a National Care Service (NCS) through the Aberdeen City NCS Programme Board.	Progress against NCS Programme Board workplan meeting appropriate timescales	
Review availability of the range of independent advocacy and implement any recommendations from the review.	Contract monitoring reports agreed	Please see **page 65** for an overview of the work ongoing.
Develop and deliver the Procurement Workplan incorporating our commissioning principles so that our commissioning is ethical, creative and co-designed and co-produced with partners and communities.	Number of commissioning for outcomes arrangements	Please see **page 58-59** for an overview of the work ongoing.
Infrastructure		
Develop an interim solution for the provision of health and social care services within the Countesswells housing development and work on the long-term solution.	Services operating from the unit	Please see **page 68** for an overview of the work ongoing.
Assess future infrastructure needs and engage with partners to ensure these needs are met.	PCPP revised every year	Please see **page 67** for an overview of the work ongoing.

Aberdeen City Health & Social Care Partnership

A caring partnership

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

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ABERDEEN CITY COUNCIL

NHS Grampian