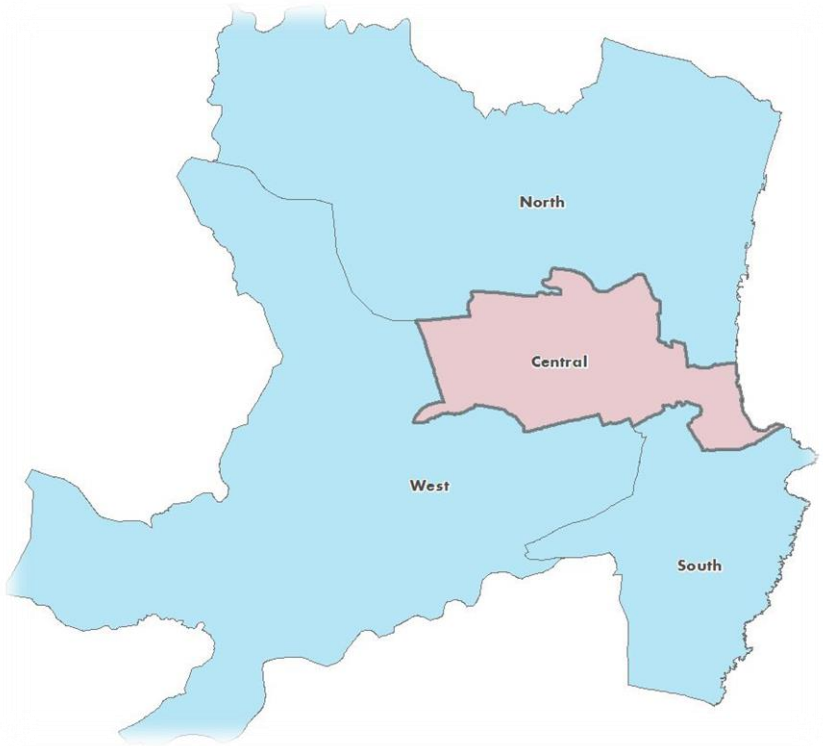
Aberdeen City Health & Social Care Partnership
A caring partnership

Central Locality Plan
(2017 – 2019)



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Foreword

Welcome to the Aberdeen City Health & Social Care Partnership's Central Locality Plan 2017 – 2019. This plan is a result of many months of gathering statistics and information and listening to what people who live and work in the locality are saying. This is a starting point, laying the foundations upon which we can build a sustainable, person-centred health and social care service for the future.

We are acutely aware of the challenging demographics that face us but we are excited at the prospect of transforming health and social care services in our locality and in the city. We will work with our communities, our staff, and the third and independent sectors to bring about the necessary changes that will allow people to receive a high quality service while remaining in their own homes, or in a homely setting, for as long as possible. We will strive to involve as many people as possible in the transformation and delivery of our future services, drawing on the many assets of our locality.

We were delighted to see that 70% of the respondents to our recent survey said that they would like to be kept informed about what we are doing. This is a very positive sign and displays an interest and enthusiasm from our colleagues and the community to learn more and get involved. It augurs well for future engagement within our locality, which is one of the major priorities in our plan. It is imperative that we continue to involve, understand and support the good work that is already taking place in our locality and we must deepen our understanding of the issues and the challenges ahead.

This plan provides an overview and insight into what we will endeavor to achieve in the coming years, as well as our ambitions for the future.

I would like to thank everyone who has been part of this process so far. I thank you for your commitment, your expertise, your inspiration and most of all your time. I look forward to your continued participation and to welcoming others who wish to be part of this journey with us into the future.

Lorraine McKenna

Head of Central Locality

Executive Summary

This locality plan sets out how health, social care and wellbeing will be taken forward in the Central Locality as part of the wider Aberdeen City Health and Social Care Partnership (ACHSCP)[1]. It includes our intentions around how we will progress with integrating and transforming our health and social care services with local communities, where appropriate.

The changing demographics of our population require health and social care services to be transformed. The people who live and work in our locatity are key to getting this transformation right. Bringing together all the assets within the locality will enable us to provide services at a more local level which means that people will be able to live at home, or in a homely setting, for as long as is reasonably possible.

To progress the transformation of services, ACHSCP has delineated the city into four localities and Locality Leadership Groups (LLGs) have been established in all of the 4 areas. The LLG has a key role in ensuring the delivery of ACHSCP's Strategic Plan, including contributing to the delivery of its associated strategic outcomes. The role of the LLG includes developing and facilitating connections and partnerships across the locality to improve the health and wellbeing of its population and reduce health inequalities. The first step to achieving this is the development of this plan.

Think Local

This plan is for everyone who lives and works in the Central Locality. It is for those who currently use health and social care services, and those who may need to do so in the future. It is also for people who are well and wish to maintain or improve their current level of independence, health and wellbeing.

There is a vast amount of work happening across the Central Locality to support people and improve their health and wellbeing – and while it is not possible to include all of this work, we have highlighted the Healthy Hoose and Tillydrone Flat as examples.

A recent survey undertaken by the LLG revealed, among other things, that people in the Central Locality value community spirit and neighbourhood very highly. This would suggest that the locality is more cohesive than perhaps people realise and is a great foundation from which to strengthen social cohesion and add social value to the community which, ultimately, contributes to health and wellbeing.

Members of the LLG have participated in "co-production training" which was commissioned by ACHSCP. Co-production is about professionals and citizens

[1] Link to ACHSCP strategic plan http://www.aberdeencityhscp.scot/en/progress/news/achscp-strategic-plan-2016-19/

working together and making use of all of their strengths and contributions to achieve better outcomes. This method will underpin the partnership's approach to locality planning and projects moving forward within the community. As part of the training, the Central Locality has identified a project to combat social isolation within our area, further details of which can be found in the priorities section at the end of this plan.

Our Vision

This plan is shaped around the overall vision for health and social care for Aberdeen City as set out in the Aberdeen City Health and Social Care Partnership Strategic Plan 2016-19[2]:

"We are a caring partnership working together with our communities to enable people to achieve fulfilling, healthier lives and wellbeing."

Early community engagement work in the Central Locality has highlighted the importance of communication as a key factor in everything that we do. Improving communication between partners, staff and local communities in the Central Locality will continue to be essential to delivering on what we have agreed.

Our Focus

We are at an early stage of developing our engagement and active participation with people who live and work in the area. This plan reflects the need to dedicate more time and resources to meaningful engagement with all of the communities in our locality, building on the good work done so far. We also need to engage more fully with staff who work and perhaps live in the locality and to harness this collective expertise to bring about positive change to the health and wellbeing of the area.

Our plan includes statistical information about how the Central Locality compares to other localities and the city as a whole. Using the locality profile information and the engagement work we have carried out so far in Central Locality, the following priorities have emerged:

- Engagement and participation of people and staff living and working in the locality, especially those who are seldom heard;
- Social isolation;
- Demographic challenges and increasing demands on health and social care services;

[2] Link to ACHSCP strategic plan http://www.aberdeencityhscp.scot/en/progress/news/achscp-strategic-plan-2016-19/http://www.aberdeencityhscp.scot/contentassets/472f1da29a8f40729b99f404721f1658/aberdeen-city--ijb-integration-scheme.pdf

- Higher prevalence of anxiety, depression and other mental health problems;
- A high level of disadvantage exists in the locality. Evidence suggests this is linked to health and other inequalities;
- Accurate identification of unpaid carers;
- Any transformed service must be fit for purpose, be future-proofed to meet the challenging changes in demographics and come within the finances available.

The intention is to deliver locally based services that have a positive impact on the health and wellbeing of individuals, families and communities.

Introduction

This locality plan sets out how health and social care will be taken forward in the Central Locality as part of the wider ACHSCP. This includes our intentions around how we integrate services with a locality or community focus, where appropriate. This is a live working document and will continue to evolve over the coming months.

The plan describes the intention of working together for the best possible outcomes for everyone living in the Central locality. This approach starts with getting to know the strengths of individuals, groups and communities and building upon these. Importantly, much of the plan is based on what people who live and work in the Central locality have been telling us about how things could be better and what would make a difference.

It sets out specific locality data for the Central Locality and examples of what is working well, as well as some of the key challenges which need to be addressed.

The ACHSCP strategic plan[3] also sets out the underpinning values that inform the partnership's approach to planning and service delivery as:

- Caring
- Person-centred
- Enabling

The focus of ACHSCP includes the health and wellbeing of the individual but also the resilience and capacity of communities to engage with and support its residents. The partnership wants to deliver locally based services that have a positive impact on the health and wellbeing of individuals, families and communities.

Our intention is to work closely with the citizens and communities across Aberdeen to develop flexible health and social care services that will address current and future demographic and resource challenges – Better Health, Better Care, Better Value.

To achieve this, the partnership needs to hear about What Matters to you? and your personal experiences of health and care services, good or bad, and to work with individuals, communities, staff and partner organisations to explore how we can work together to develop solutions.

This plan is separate to the community planning undertaken by Community Planning Aberdeen[4] (CPA) which has a far wider remit. ACHSCP is a member

[3] Link to ACHSCP strategic plan http://www.aberdeencityhscp.scot/en/progress/news/achscp-strategic-plan-2016-19/

of the CPA. Please note that the localities referred to by the CPA are specified areas within the city which have a generic focus on improving outcomes and inequalities for that particular area.

Health and Wellbeing Outcomes

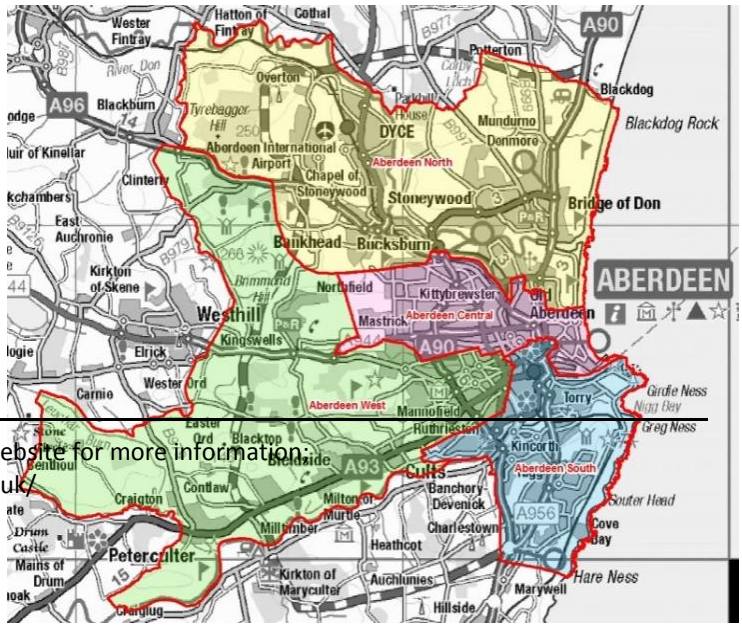
The Scottish Government has identified nine national health and wellbeing outcomes that the partnership must work towards. This plan identifies local priorities in the Central Locality which will contribute to the achievement of these outcomes.

Scottish Government, Nine Health and Wellbeing Outcomes, 2014

1. Healthier Living	People are able to look after and improve their own health and wellbeing and live in good health for longer
2. Independent Living	People, including those with disabilities, long term, conditions, or who are frail, are able to live as far as reasonably practicable, independently at home or in a homely setting in their community.
3. Positive Experiences and Outcomes	People who use health and social care services have positive experiences of those services and have their dignity respected.
4. Quality of Life	Health and social care services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of service no matter where they live.
5. Reduce Health Inequality	Health and social care services contribute to reducing health inequalities.
6. Carers are Supported	People who provide unpaid care are supported to look after their own health and wellbeing, and to reduce any negative impact of their caring role on their own health and wellbeing.
7. People are Safe	People who use health and social care services are safe from harm.
8. Engaged Workforce	People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.
9. Resources are used Efficiently and Effectively	Best Value is delivered and scarce resources are used effectively and efficiently in the provision of health and social care services.

What are health and social care localities?

All Health and Social Care Partnerships across Scotland are required under the legislation to develop localities to enable the effective planning and delivery of integrated services. Localities should be large enough to offer scope for service improvement but



[4] Community Planning Aberdeen (CPA) website for more information: http://communityplanningaberdeen.org.uk/

small enough to feel local and real for those people who live there. Services should be planned and led locally in a way which is engaged with the community including particular service users, those who look after service users and those who are involved in the provision of health or social care[5].

The main purpose of localities is to assess need and to prioritise and plan how to make best use of all of the resources available to deliver improved outcomes for people. By resources, we mean far more than what is provided by health and social care services; our resources include the strengths of individuals and communities. A key feature of how we work together in localities is to explore how we can harness all of these resources and to explore together how we can deliver better outcomes for people. It is important to remember that within each locality there are a number of distinct communities, each with unique circumstances.

Localities have been described as the engine room of integration. Planning in localities helps bring together individuals, carers, professionals from the health, social care and housing sectors, the third and independent sectors and the citizens and communities within the area, to plan and help redesign how we support health and wellbeing.

The partnership is required to involve representatives of a locality in decisions or changes that are likely to significantly affect service provision in the area. To help achieve this, Locality Leadership Groups (LLGs) have been established in all of our four localities within Aberdeen City. The LLG has a role in supporting the delivery of the strategic outcomes stated in the ACHSCP Strategic Plan and an active role in agreeing priorities to improve health and wellbeing outcomes locally.

The role of the LLG also includes developing and ensuring appropriate connections and partnerships across the locality to improve the health and wellbeing of the locality population and reduce the health inequalities that we know impact negatively on people's lives. The LLG has a direct line of communication to the strategic planning group and IJB.

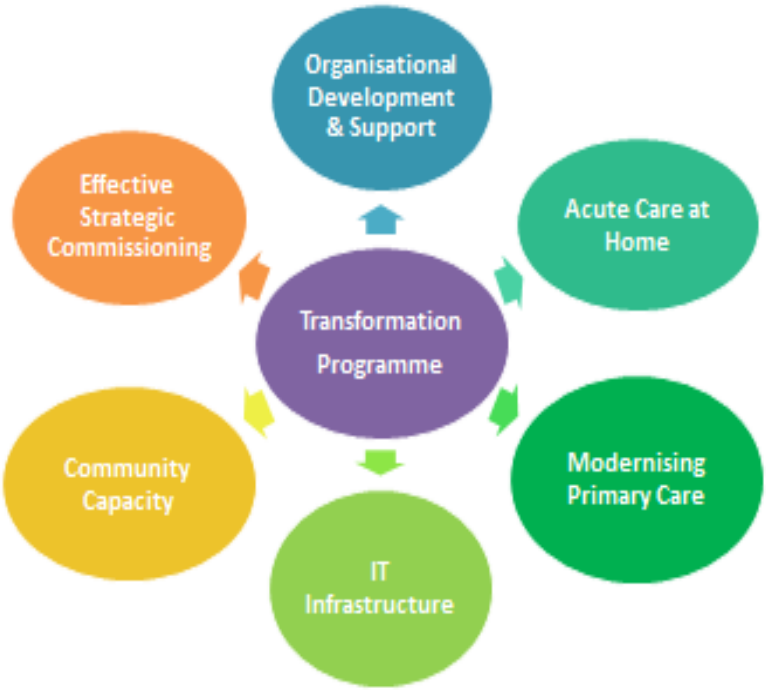
Locality development will also see the alignment of many health and social care services and functions to locality areas where it is appropriate to do so, recognising that for some services they will continue to be delivered on a city-wide basis. This will be supported by an integrated Locality Management Team.

The development of more integrated health and social care services is a legislative requirement in Scotland. The Locality Management Team will be working with the LLG and all stakeholders to integrate our local health and social care services and to test out new ways of working.

[5] Scottish Government,, Health and Social Care Delivery Principles, 2017

Health and Social Care Transformation

A transformation programme for health and social care has been developed by ACHSCP. This programme will support the development of new ways of working and share successful initiatives across other parts of the city.



Some projects will be taken forward on a city-wide basis with initial testing taking place at a locality level, projects such as:

- Integrated Neighbourhood Care Aberdeen - INCA (Buurtzorg model)
- Link Workers
- Acute Care at Home
- Developing Access to Psychological Therapies

Updates for all key projects will be available on the ACHSCP website.

What are people who live and work here telling us?

Engagement and participation with those who live and work in the Central locality is essential to developing a good understanding of health and wellbeing in the area and what challenges and opportunities there are. Below is a snapshot of some of the things people and staff have said to us during the compilation of this plan.

Thinking about how people living and working in the central locality are purposefully able to participate and work to develop local plans is at an early stage. This plan reflects the need to dedicate more time and resources to meaningful engagement with all of the communities within the locality, building on the good work done so far.

The development of the Central Locality began in the summer of 2016 with a kick-off event. Approximately 30 people attended and they were asked what assets there were in the locality to support health and wellbeing and to identify some priorities moving forward.

A community and engagement sub-group of the Central Locality Leadership Group was established with a keen membership including: public health and wellbeing, Allied Health Professions, and third sector, independent sector and

community representation. The purpose of the group was to develop a plan to engage with citizens and staff living and working in Central Locality. The key achievements of this group are as follows:

- The development of a master community contacts list for engagement purposes.
- The developed a questionnaire (April 2017) for everyone living and working in Central asking what keeps people well, what the potential gaps are and the priorities moving forward. 205 questionnaires were completed, returned and summarised into key findings to inform next steps. Contact details from the questionnaires were also used to further develop the community contacts list.
- Two workshops were held with the LLG (June and August 2017) to facilitate discussion on the health profile including: how representative it was for people living and working in the Central Locality and what were the priorities and challenges presently and moving forward.
- A Facebook page was created.
- Members of the group attended the 'Celebrate Aberdeen' day in August 2017.

Next Steps

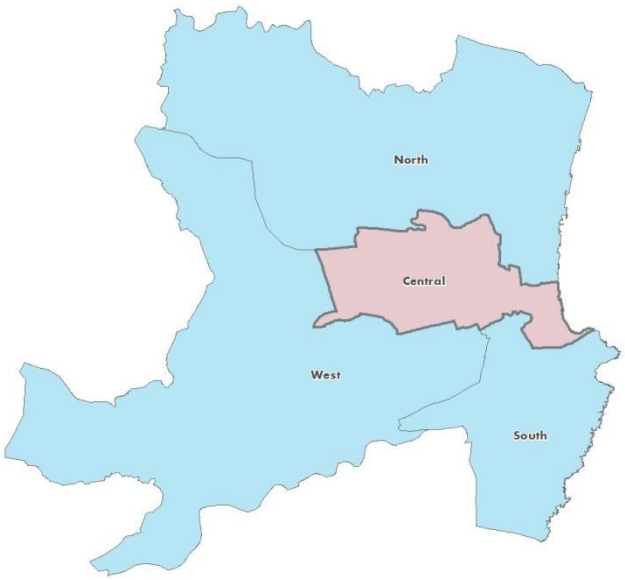
- Development of user-friendly resources that describe the partnership's localities and how people can get involved;
- Develop the use of media and other methods of sharing information;
- Reviewing the membership of the group to ensure a cross section of participation.

How will communities and professionals work together?

Co-production training was commissioned by ACHSCP with several member of the LLG participating. Co-production is about professionals and citizens working together and making use of all of their strengths and contributions to achieve better outcomes. This approach will underpin the partnership's approach to locality planning and projects moving forward within the community. The Central Locality has identified a project to combat social isolation within our area and further details can be found in the action plan at the end of this plan.

The ACHSCP website is currently under development. A section is being developed for each locality where all the background documents and information which supports this plan can be found.

About Central Locality



This section highlights key information about the Central Locality taken from the Locality Profile which was developed as an information resource for the development of the locality plans. The full profiles are available on the ACHSCP website.

In many ways, health in Aberdeen City and in the Central Locality is improving, with people living longer. As people live longer, it is important that these years are lived well and in good health. It is estimated that men in the city can expect to live 65 years of their lives in good health and about 12 years with poorer health; for women the period of their lives spent with poorer health is estimated to be around 14 years[i]. For most people, the time of poorer health tends to be towards the end of their lives.

Aberdeen City's population is projected to rise 17% to almost 268,000 between 2014 and 2039. It is expected there will be a greater increase in males than females. There is a projected rise of 19% in the 0 to15 year age group. The working age population is projected to increase by 11% and the pensionable age population by 20% over the same period.[ii]

It is difficult to predict our future locality populations as different localities have different factors affecting population growth, such as birth rates and the number of people moving into and out of the locality.

The recent economic climate, ushering in welfare reform and increasing public sector austerity, as well as the downturn in the oil and gas sector, has been challenging for individuals, public services, the third sector and a whole host of businesses across the North-east and is likely to exert an effect on residents' health and wellbeing.

Central Locality

Central Locality has the largest population of the four localities in the Health and Social Care Partnership at 82,000 (36%). It is mainly urban yet retains multiple areas of green space including local allotments, Northfield and Hilton outdoor sports centres, Victoria Park and Westburn Park and tennis courts. Transition Extreme and the harbour area are all within the boundary of the Central Locality.

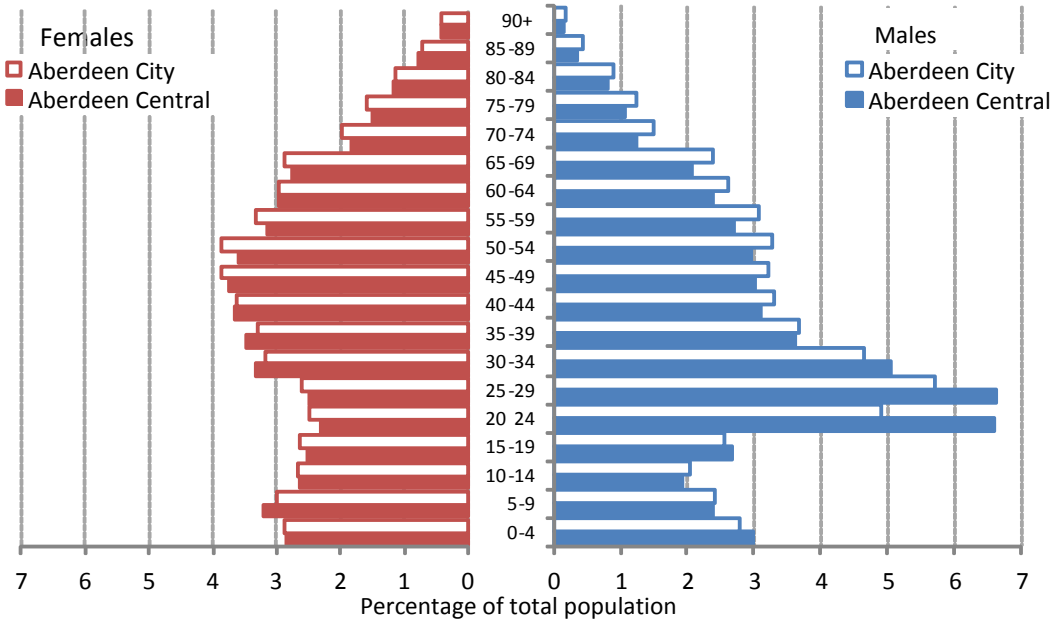
The locality encompasses multiple distinct neighbourhood areas including Hanover, Rosemount, Tillydrone, Midstocket, Hilton, Northfield and Mastrick, each with their own sense of identity. Two of the three locality partnerships formed by Community Planning Aberdeen (CPA) in 2016 are within Central Locality. These two partnerships include the neighbourhoods of Woodside and Tillydrone, along with Seaton which is in the North Locality; and Heathryfold, Cummings Park, Mastrick, Middlefield and Northfield. The eight neighbourhoods that are part of the CPA locality partnerships each have higher concentrations of multiple deprivation according to the Scottish Index of Multiple Deprivation (SIMD).

Many families have lived in local areas over a number of generations and can offer extensive local knowledge. As well as its people, Central Locality contains a number of physical assets including His Majesty's Theatre, Marischal College and other places to learn, work and play. Use of these resources by people experiencing financial difficulty is often reported to be low. Many residents in Central Locality also report poor transport links, particularly for journeys within and across the locality.

Locality Profile: Information and Data on the Locality

Who lives here? (i.e. population)

The picture of the population below shows the percentage of people in 5-year age bands by gender for Central Locality and compares the age and sex distribution with Aberdeen City.



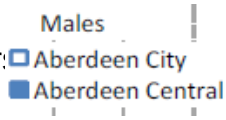
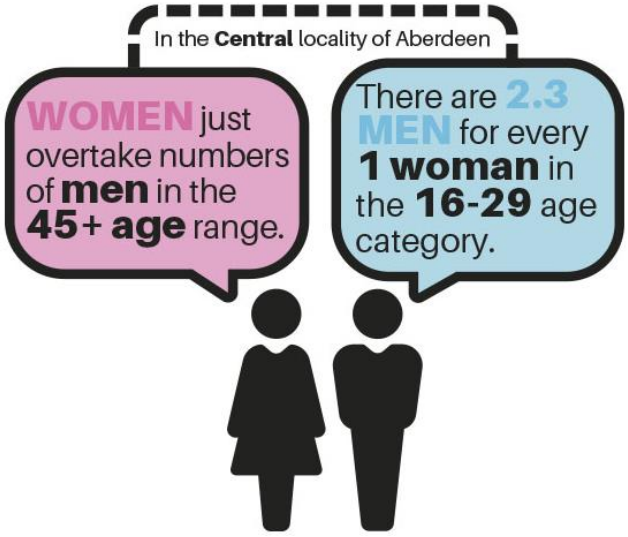


Fig. Aberdeen Central and Aberdeen City – Percentage of per
age band and gender (National Records for Scotland, 2015)

82,000 people live in Central Locality (36% of the total city population – this is the largest locality population).



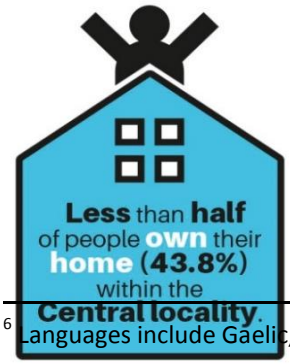
Compared to Aberdeen City, fewer men live into old age (this is shown by the sharp narrowing of the population pyramid as it gets to the top). Whilst the population of women over the age 70 also narrows, this is to a much lesser extent.

A snapshot of the population in Central Locality at the time of the 2011 Census:

Ethnicity and Language

2.6% (2054) of people aged 3 and over did not speak English well/at all;

17.3% (13771) of people spoke a language other than English at home;[6] 0.48% (379) spoke no English at all.



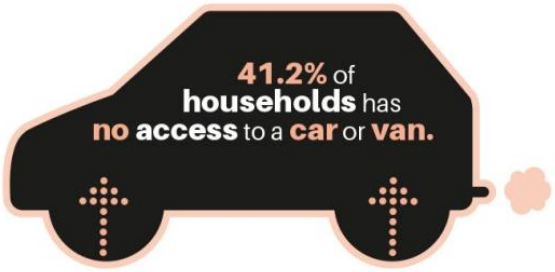
Households

Less than half the people own their house (43.8%) in Central; this is the lowest of the localities.

[6] Languages include Gaelic, Scots, British Sign Language, Polish and other languages

A number of small areas in Central Locality are within the 5% most 'housing' deprived[7] areas of Scotland. These small areas are in Rosemount (3), Hanover North and South (6), George Street (4), and Froghall, Powis and Sunnybank (4).

Access to own transport



Lowest access to a car/van amongst the four localities.

24.3% more people who say they have a life-limiting health condition (daily activities) say they don't have access to a car/van than those who have good health.

People providing unpaid care

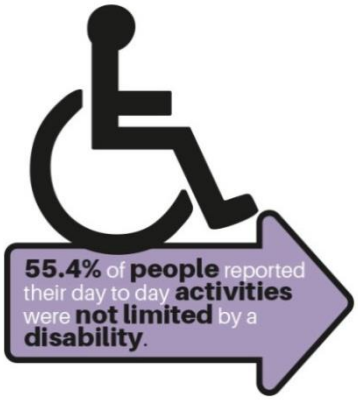
5,445 people provide unpaid care, 31.9% of whom were over 65.

Adults self-assessed health

51.4% (42208) of people described themselves as being in very good health.

63.7 % (3382) of people aged of 75+ years still describe their health as good or very good.

People limited by disability



55.4% (67553) of people said their day-to-day activities were not limited by disability.

8.2% (6750) of people reported their day-to-day activities were limited a lot by disability.

[7] Percentage of the total household population from the 2011 Census that is overcrowded or has no central heating.

Living conditions that contribute to health and wellbeing

Education

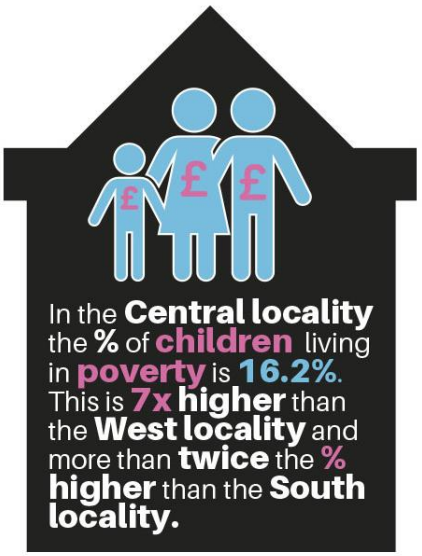
In Central, school attendance is lowest for all four localities.

Six out of those 10 small areas that are in the 5% most 'education' deprived of Aberdeen City[iii] are in Cummings Park, Heathryfold and Middlefield, and Northfield.

There are also areas within Central Locality where educational, skills and training is high.

Employment and Income

The percentage of claims for out of work (9.9%) and incapacity and severe disability living allowance (5.1%) in 2014 is the highest for all four localities.



The percentage of claims has followed the city trend of a gradual reduction over the past decade; however, it is difficult to determine whether this decrease reflects improvements in people's abilities to afford everyday goods and services.

The percentage of the population described as 'income' deprived in 2014 was 12.2% (city – 8.6%) which was highest of all localities. Numbers were more than six times that of the West locality and more than twice those for South. Six out of ten most 'income' deprived areas of Aberdeen are in Central locality.[iii] This does not mean everyone living in these areas is 'income' or 'employment' deprived.

The percentage of the population described as 'employment' deprived in 2014 was 10.9% (city – 8.0%) which was highest of all localities; numbers were more

than six times West locality and more than twice that for South. Six out of the 10 most 'income' deprived areas of Aberdeen are in Central locality and four are the same as the most 'income' deprived areas.[iii] They are in George Street, Tillydrone, Woodside, Mastrick and Sheddocksley.

Local assets for health and wellbeing

Assets are factors which can be used to bring people and communities together to make positive change using their own knowledge, skills and lived experience around the issues they encounter in their own lives. Although they are difficult to define, they may include things like:

- A person: the stay-at-home parent who organises a playgroup; the informal neighbourhood leader; the community newsletter editor;
- A physical structure: a school, a GP practice, a town landmark; an unused building/room which could be used for community meetings/groups; an open space or park;
- A community service that makes life better for some or all community members – meals service, public transport, a cultural organisation;
- A business that provides employment and supports the local economy;
- Staff who work in a community.

A process of mapping to further develop our understanding of all of our assets across the Central Locality for health and wellbeing is part of the priorities outlined later in this plan.

Enabling people and communities to keep themselves well

Being resilient is our ability to bounce back from setbacks such as ill-health, change or misfortune that are all too often not predicted, and to adapt to new circumstances. It is a process that involves individuals being supported by the resources in their environment to produce positive outcomes in the face of challenge.[iv] Several factors at a community level help to promote and maintain a person's physical and mental wellbeing[v] and include participation, social networks, social support, trust and safety.

There were 5219 crimes[8] in Central Locality in 2014, which is a higher number that the South Locality. Several small areas of the Central Locality are in the 5–10% most deprived in the crime doman of 2016 SIMD. These areas are George Street (2), Summerhill (1), Midstocket (1), Ashgrove (1), Mastrick (2), Tillydrone (2), Woodside (3), Northfiled (3), Heatheryfold and Middlefield (1).[iii] Some areas such as town centres or areas around the football stadium see large numbers of people at a particular time of day or day of the week or year and can be linked to an increase in crime.[vi]

[8] Includes crimes of violence; drug offences; domestic housebreaking; minor assault; and vandalism

Physical Assets in the Central Locality

Central locality has a wealth of local assets including the resources listed below. As part of the wider asset mapping work described earlier, further work is planned to develop our understanding of the physical assets of the area and what opporltunities they may present to support health and wellbeing in the area.

Although these resources are located within the locality boundaries, many provide services for people living across Aberdeen. These include services from third and independent sector.

*this is currently known and not exhaustive list we are still developing our understanding

Category	Asset	Total Number
Health Services	GP Practices	8
	Community Pharmacies	18
	Health Centres	10
	Optometrists	7
	Dental Practices:[9] Public Dental Service (PDS) or NHSG Specialist; Independent dentist (GDP) providing NHS Care	 7 10
Social Care/ Housing	Care Homes – Older People	5
	Supported Living – People with Learning Disabilities	10
	Amenity Housing	6
	Sheltered Housing	22
	Very Sheltered Housing	1
Community	Places of worship	24
	Community Centres and Village Halls	12
	Sport and Leisure Facilities	14
	Libraries	
Education	Primary Schools	14
	Secondary Schools	2
	Tertiary	1

Access to local amenities

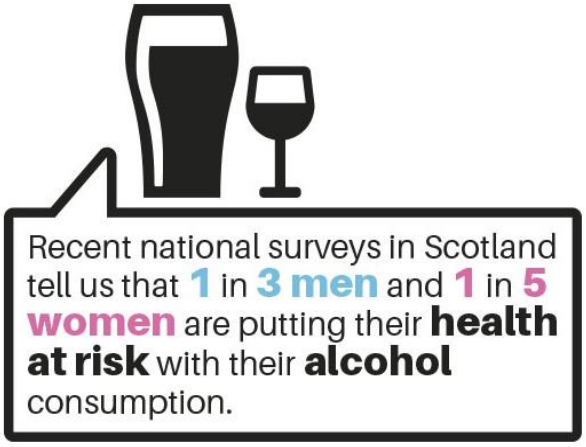
Most of the population live within a short distance of essential local amenities (doctors' surgeries, schools, shops and post offices) in the Central Locality. One small area of the locality, Sheddocksley, is one of the 10 most 'access' deprived areas of Aberdeen. 'access'

[9] The PDS delivers services to identified vulnerable groups and GDP deliver NHS Services to the population as a whole as part of their national service delivery contract.

deprived is described by average drive times to schools, GP practices, petrol stations, and retail opportunities along with public transport time to GP practices, post offices and retail centres.[ii] A further 13 small areas are in the second most deprived quintile (i.e. 20%) of 'access' deprived and are in Summerhill, Sheddocksley (3), Stockethill (5), and Heathryfold and Middlefield (3).[v] This doesn't mean that everyone living in these small areas is deprived of access to essential amenities.

Health Behaviours

Alcohol



Recent national surveys in Scotland tell us that 1 in 3 men and 1 in 5 women are drinking alcohol in a way that puts their health at risk. Whilst heavy drinking is most commonly associated with students, there is a further peak in alcohol consumption in middle age, particularly in women. Alcohol consumption can have a negative impact on the other priorities such as social isolation, anxiety, depression and mental health.

The five-year average rate of deaths from alcohol conditions (2010-20 14) was 30 per 100,000, just higher than South. Rates have been consistently higher than the city since 2002 and fairly static.

More men (50%) than women (40%) take part in sport and physical activity but this drops with age, especially after the age of 35; participation rates are not available at locality level (Scottish Health Survey, 2016 – self defined).

Childhood

Smoking in pregnancy

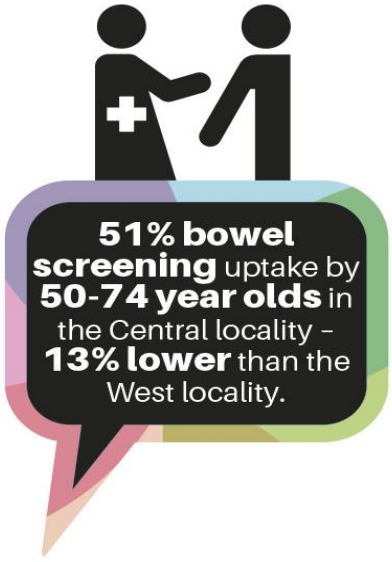
18% of mothers in the Central Locality smoked during pregnancy, half that of a decade earlier;

12.2% of children in the top 5% range for obesity – highest in the city, with a rising trend since 2009;

58% of primary 1 pupils were recorded with low-risk dental health, lower than the city average, and 38% of primary 7 children were recorded with low-risk dental health in 2013/14 – same as for South and lower than the city.

Adulthood

93 road traffic casualties per year (3-yr ave/100,000 pop) (2011-2013), but a downward trend over 10 year period;



251 drug-related hospital stays per year (3-yr ave/100,000 pop), (2010/11-2012/13);

Screening can help detect conditions early and increase likelihood of survival; figures in this locality could be improved;

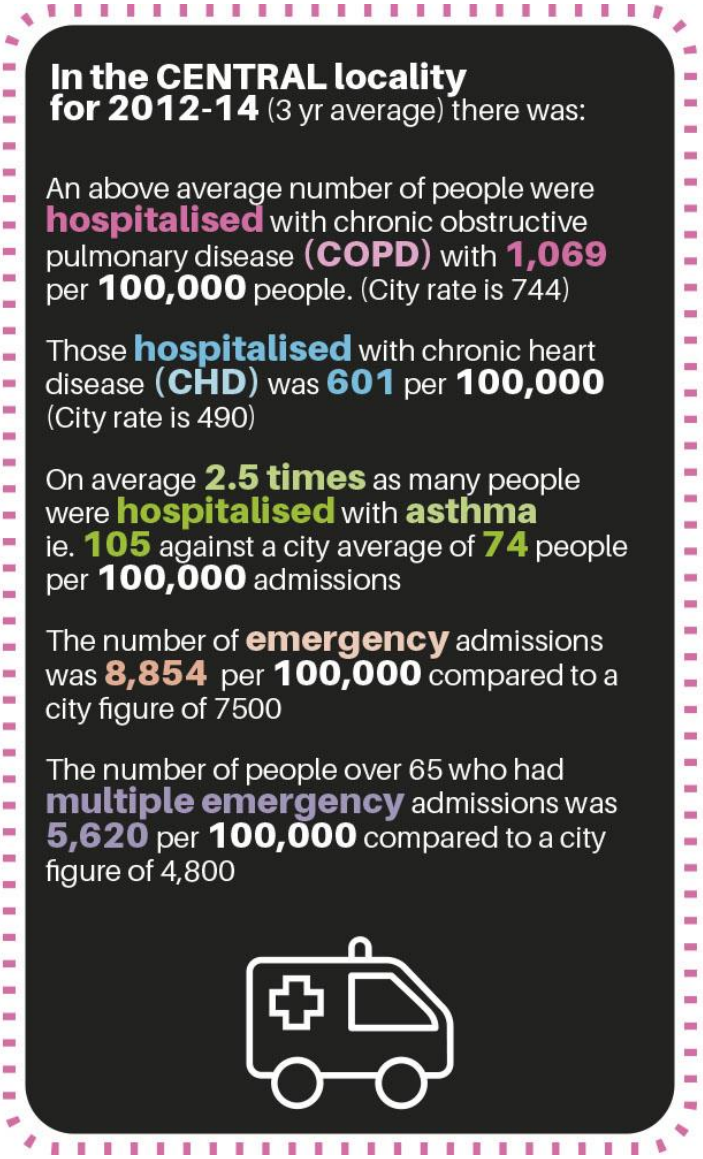
76% breast screening uptake by women aged 50-70 years (3-yr ave, 2010-12) (city-77%) – second lowest of the four localities;

Over the last decade, there has been a decline in those dying from coronary heart disease

Long-Term Conditions

Long-term conditions are health conditions that last a year or longer, impact on a person's life and may require ongoing care and support.[10] They are now more common in the population and more people live with more than one condition. According to information[11] recorded about people registered with GP practices in the locality during 2015/16 the most common conditions were depression, asthma and diabetes. Over 7846 people on the GP register had high blood pressure which, if poorly managed, could lead to heart disease and stroke.

[10] http://www.gov.scot/Topics/Health/Services/Long-Term-Conditions
[11] Recorded as part of the Quality and Outcomes Framework (QoF)



(The Scottish Public Health Observatory (ScotPHO) collaboration is co-led by ISD Scotland and NHS Health Scotland, and includes the Glasgow Centre for Population Health, National Records of Scotland, Health Protection Scotland and the MRC/CSO Social and Public Health Sciences Unit.)

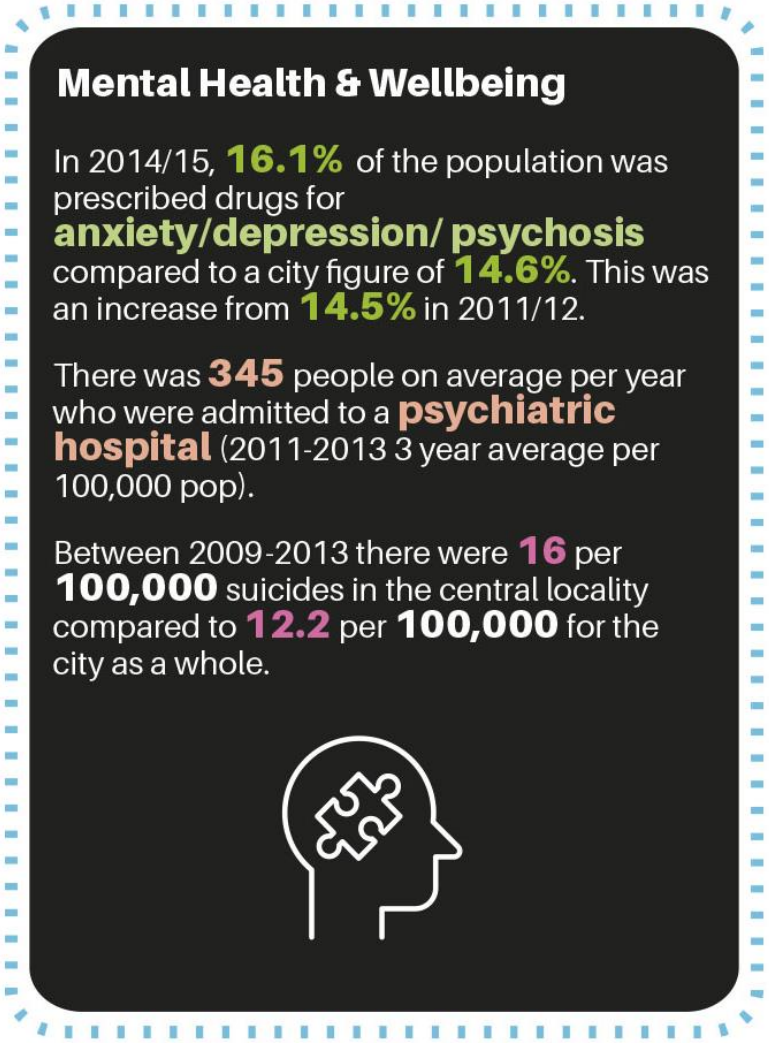
*COPD - Chronic obstructive pulmonary disorder

*CHD – Coronary heart disease

*emergency admissions – a new continuous spell of care in hospital where the patient was admitted as an emergency to hospital

*multiple emergency admissions - more than one unplanned continuous spell of treatment in hospital in one year,

Mental Health & Wellbeing



Further work is to be done to understand issues related to mental health.

Local Services and Resources

Aberdeen Health and Social Care Partnership is responsible for the delivery of health and social care services across Aberdeen City. This includes primary care, community-based health services, and adult social care.

Many of these services are delivered directly by staff who work for ACHSCP, while other services, mainly in adult social care and some of the mental health and learning disability services are delivered by other providers through commissioned services. Third and Independent sectors provide services such as care homes, housing support, support services and care at home provision.

In this section we will give you an overview of some of the services that people living within the Central Locality have access to. It is important to remember that some services will be delivered at a very local level while others will be part of a wider city-wide service, depending on the scale and sometimes the specialist nature of the service being delivered.

We are at the early stages of developing our localities and during 2017/18 we will begin to see the alignment of many of our health and social care services and functions to locality areas where that is appropriate to do so, recognising that for some services they will continue to be delivered on a city-wide basis.

This will be supported by the development of an integrated Locality Management Team under the leadership of the Head of Locality. The development of more integrated health and social care services is a key priority nationally and locally and the Locality Management Team will be working together with all staff, the third and independent sectors, other partners and stakeholders and the Locality Leadership Groups (LLGs) to explore how we develop more integrated services and to test out new ways of working.

Primary care services

Primary care services provide the first point of contact in the healthcare system, acting as the ‘front door’ of the NHS. Primary care includes general practice, community pharmacy, community dentistry, and optometry (eye health) services.

Current challenges facing primary care include:

- Recruitment,which is a national as well as a local issue; more GPs are working part-time due to the increasingly demanding nature of the job; many staff are retiring early; in some practices GPs have been replaced with other health professionals including pharmacists and nurse practitioners.
- IT; the hardware used in primary care is becoming obsolete, with frequent problems which are very disruptive both to staff and patients as all records

are electronic. There remain difficulties with software systems not talking to each other which reduces the potential for information sharing across sectors.

- Rising demand due to an ageing population, new housing developments.
- Missed GP appointments – high numbers of people book appointments which they fail to keep.
- Transfer of work out to community services without additional resources.
- Premises – some premises in the area restrict the ability to deliver services locally or in a different way.

Many of these challenges impact right across health and social care services. The challenges of rising demand, recruitment, shifting demand to primary care, premises and effective IT systems are all priorities recognised by ACHSCP and are reflected in the city-wide Transformation programme referred to earlier in this document.

General Practice

There are eight GP practices within the Central Locality – Aurora Medical Practice, Calsayseat Medical Group, Denburn Medical Practice, Elmbank Group Practice, Links Medical Practice, Rosemount Medical Practice, Westburn Medical Practice and Woodside Medical Group. All of the practices are Independent practices owned and run by the GP partners.

GP practices work to a nationally agreed contract to deliver general medical services. The current contract is being renegotiated and we are waiting to see what changes will come forward from this. In addition to these core services, some practices are contracted to deliver enhanced services – e.g. minor injuries, minor surgical procedures, contraceptive services, monitoring of certain medications.

GP practice teams include doctors, practice nursing staff, practice-attached pharmacists and their administrative teams. The practice teams work closely with a broad range of other colleagues within health and social care including community pharmacists, community nursing teams, allied health professionals, and/or care management teams. This team continues to evolve with new roles emerging to support people locally e.g. community link workers and primary care psychological therapists.

There are also close working relationships with specialty areas who are increasingly becoming more aligned to primary care e.g. practice-aligned geriatricians, psychiatrists and community psychiatric nurses, diabetologists, obstetricians/community midwifes and NHS24/G-Med out-of-hours services.

GP practices provide a wide range of services including: appointments (face-to-face or by telephone), home visits, baby checks, support for people living in nursing homes, minor surgery, long-acting contraception and chronic disease management.

Community Nursing

Community nurses play a crucial role in the primary healthcare team. They visit people in their own homes or in care homes, providing increasingly complex care for patients and supporting family members. The work of the community nursing teams is extensive and includes wound management, management of people with long-term conditions e.g. diabetes, urinary and bowel management and palliative and end of life care.

Each of the practices in the Central Locality has a practice attached Community Nursing Team as well as an aligned Health Visiting Team.

The practice-attached community nursing teams are made up of district nurses (registered nurses with an additional post-registration qualification) and community nurses (registered nurses). They are small teams who carry the caseload for their particular practice, but work extremely closely with a number of the Direct Delivery Teams (DDTs) that cover Aberdeen City on a geograohical basis. Out of Hours nursing teams cover the whole city and work out of the Emergency Care Centre in Aberdeen Royal Infimary.

In addition to the community nursing teams, there are teams of health visitors and immunisation nurses. There are also a range of specialist nurses with a city-wide remit including MacMillan Nurses, bladder and bowel specialist nurses, cardiac rehab nurses and diabetic specialist nurses. There is also a 'Healthy Hoose' drop in centre which is based in the Hendry Rae centre which provides services to Northfiled, Middlefield , Cummings Park and Heathryfold

Allied Health Professionals (AHPs)

AHPs are a distinct group of practitioners who diagnose, treat and rehabilitate people of all ages, across health, education and social care. They are experts in rehabilitation and enablement, supporting people to recover from illness or injury, manage long-term conditions with a focus on maintaining and improving independence or developing strategies to manage longer-term disabilities.

The AHP groups working across Aberdeen City are dietetics, occupational therapy, physiotherapy, podiatry, speech and language therapy and the prosthetics and orthotics service. These AHP services are delivered in a range of clinic, community and education settings, including in the person’s own home or in care homes. Some services are delivered locally with others being provided from more centrally based clinics or community teams, depending on the nature

and scale of what is being provided. The prosthetics and orthotics team are a Grampian-wide service based at Woodend Hospital.

In the Central Locality area, AHP out-patient services are delivered from a number of locations. Services in these locations are not restricted to people from the geographical area but are available to people living anywhere in the city and where appropriate can be accessed by people who live in Aberdeenshire or Moray:

- Northfield Clinic – speech and language therapy (SLT), podiatry, dietetics
- Northfield Community Centre – pulmonary rehabilitation group
- Henry Rae Healthy Hoose – podiatry
- Mastrick Clinic – SLT, dietetics
- Marywell GP – podiatry
- Foresterhill Centre– SLT, podiatry, dietetics
- City Hospital – physiotherapy, occupational therapy (OT), SLT, dietetics, Focus Carers Group
- Health Village – physiotherapy, OT, SLT, dietetics, podiatry, cardiac rehab, pulmonary rehab, Parkinson's disease clinics, falls clinics and exercise classes
- Calsayseat – dietetics
- Sunnybank School – SLT, specific language impairment service
- Mile End School – additional support needs (SLT)
- Aberdeen Royal Infirmary (ARI) – podiatry in-reach, towards rheumatology, David Anderson Building (DAB) – diabetics clinics, staff physiotheraphy service
- Royal Aberdeen Children's Hospital / Roxburgh – podiatry In-reach
- Rosewell – physiotherapy and falls exercise classes
- Westburn Outdoor Centre - Falls clinics and community falls exercise classes (including for Carers)

All of the AHP services also provide a service to in-patients at Woodend Hospital, Horizons Rehabilitation Centre, Craig Court and have community teams based in the Community Health and Care Village in Fredrick Street and City Hospital that provide services across the communities of Aberdeen. Physiotherapy staff also provide a rehabilitation service into Clashieknowe Intermediate Care facility which is based in Bridge of Don.

Aberdeen Community Health and Care Village in Frederick Street is the main hub for many of the out-patient clinics provided by AHPs and provides services for people from all of the localities.

Pharmacy

Community pharmacy is probably better known to most people as “the local” or “High Street” chemist. Historically the main role of the community pharmacy has focused on supply of medication, in response to prescriptions or over-the-counter requests, and providing advice on taking these medicines. While this important service continues, community pharmacies now have a wider role in delivering care for patients with long-term conditions and health improvement, such as supporting smoking cessation and in supporting local campaigns such as raising awareness of the appropriate use of antibiotics, best use of repeat prescriptions – ‘only order what you need’.

Some community pharmacies may also provide additional services such as being part of the local palliative care network; providing treatment for urinary infections; providing travel or flu vaccinations; delivering substance misuse services/ needle exchange.

Community pharmacies are very accessible and a ‘no appointment necessary’ service, advising on managing illness (self-care) and improving health, is always available. Unlike general practice, people do not need to register with a specific community pharmacy but can choose to attend any pharmacy they wish. There are 51 community pharmacies across Aberdeen City.

In addition to services provided by community pharmacies, there are practice-based pharmacists working with all GP practices in the Central Locality to support the safe, quality and cost-effective use of medicines. The NHS provides a limited amount of support to all practices, and in addition, some practices have chosen to employ a pharmacist themselves. Practice-based pharmacists provide advice to patients, carers, GPs and practice staff, and other healthcare professionals on all aspects of medicine use. Their role also includes reviewing patients’ medication, having face-to-face or telephone consultations with patients, liaising with hospital and community pharmacist colleagues and reviewing prescribing processes and guidelines.

Adult Social Care

Adult Social Work services provides help for people over the age of 18 who experience difficulty coping with everyday activities due to disability, illness and for those over the age of 65 who have health and social care needs. The aim is to provide a comprehensive service to enable people to remain as independent as possible within the community and their own home. Using eligibility criteria and a comprehensive assessment, services are targeted at those with the greatest need to assit people to lead fulfilling lives with the the right support for them. We also support unpaid carers in various ways, by providing carers’

assessments, signposting, training, links to support groups, and providing information regarding respite and short breaks.

Following the assessment the worker will discuss with you the best possible solutions to enable you to remain as independent as possible. This may include:

- Liaison with and referral to other agencies
- Arranging for carers and/or support workers to assist you with personal care tasks
- Arranging respite, to enable a main carer to have a break from their caring role
- Arranging admission to a care home.

All adults who require support through disability or frialty need support to ensure they have good mental health and wellbeing and can take full use of leisure, education and employment opportunities. Our services work in partnership with other agencies and the health service to provide specialist services to support service users and unpaid carers. The assessment will identify personal outcomes and identify any community supports that might be appropriate. This assessment is undertaken with input from a range of professionals such as occupational therapy, nursing, and medical staff.

In November 2010 the Scottish Government produced its 10 year 'Strategy for Self-Directed Support (SDS)', with the aim of SDS becoming the way all individuals, who have been assessed as eligible to receive social care services, regardless of the nature of their needs, receive their care and/ or support.

Since the SDS legislation came into force we have looked at how we make the process of managing your own care and support as trouble free as possible, therefore we have developed the 'MyLife portal' https://aberdeencity.mylifeportal.co.uk/home/ which is a website which contains information about all the developments and changes to the way in which the 4 options are managed.

The Adult Support and Protection (Scotland) Act 2007 places a duty on all councils to investigate alleged incidents of harm affecting adults at risk of harm. This duty is discharged, on behalf of the council, by Care Managers/ Social Workers who meet the legislative criteria and who have been trained to undertake these functions. Under the Adults with Incapacity (Scotland) Act 2003 the Council also has a duty to supervise and support individuals who have applied for a Guardianship order to manage the affairs of an Adult deemed incapable as defined within the Act. Alternatively, where there is nobody who either holds Power of Attorney or or who is approropiate/ able to apply for Guardianship, we will undertake this. The Guardian in these circumstances is the Chief Social Work Officer.

Criminal Justice Social Work

Criminal Justice Social Work (CJSW) is a service managed within the IJB, with direct accountability to the Lead Social Work Officer. Scottish local authorities have a legal duty to provide criminal justice social work services. These services are provided within the framework of the Scottish Government's National Outcomes and Standards: http://www.gov.scot/Publications/2011/03/07124635/0. The service is provided to the Courts and to the Parole Board. CJSW works closely with a range of statutory and non-statutory partners. It is envisaged that integration will enable the further development of existing relationships and the opportunity to foster and build new ones.

The service's overall aims are to: reduce reoffending, increase social inclusion of offenders and ex-offenders and enhance public protection. This is done by a range of means, including:

- Providing courts with a range of community disposals
- Effective supervision of offenders in the community
- Offence focused work to assist offenders to recognise the impact of their behaviour on themselves, their families, the community and others to reduce the risk of re-offending
- Assisting those released from prison to settle in to the community
- Promoting community safety and public protection by reducing and managing risk

CJSW Services include:

- Social work services in court, including the Problem Solving Court Service
- Reports to the courts to assist in decisions on sentencing
- Bail information and supervision as an alternative to remand
- Direct measures and diversion from prosecution as direct alternative to prosecution and/ or court appearance
- Diversion from Prosecution
- Throughcare services including parole, supervised release and other prison aftercare orders to assist public safety and community protection
- Supervising individuals on Community Payback Orders, including those who are required to undertake unpaid work for the benefit of the community
- Drug and alcohol services, including Arrest Referral and supervising offenders on Drug Treatment and Testing Orders, and Community Payback Orders with drug and alcohol related requirements, to reduce drug related crime
- Multi Agency Public Protection Arrangements (MAPPA)

- Preparing reports for the Parole Board to assist in decisions about release from prison
- Women's services including the Connections programme for women in the criminal justice system
- Accommodation support services to support individuals to access, maintain and sustain stable accommodation
- In partnership with Aberdeenshire Criminal Justice Social Work service:
- The Caledonian System, which works with men who have been convicted of domestic abuse plus providing support for the women and children who have been harmed
- The Moving Forward Making Changes/Joint Sex Offender Project which provides one to one and group work programmes to those who have been convicted of sexual offences
- There is also manage a small team of Domestic Abuse Support Workers, who are able to offer a service to women at risk who are not (yet) involved in the Caledonian Programme.

Oral Health and Dental Care

Oral health is a key factor in overall health and wellbeing for people of all ages. Most oral and dental care services are provided in a primary care setting within the community, with a strong emphasis on the importance of healthy habits in the prevention of dental and oral diseases.

Independent dental practices offer a range of NHS General Dental Services and private dental treatments, and registration is not limited to a particular catchment area.

Across Aberdeen City, the Public Dental Service (PDS) is focused on providing dental care for people who may have difficulty accessing general dental services within an independent practice, for example people with additional or complex care needs. There are also national and local programmes of preventive care such as Childsmile for younger children and Caring for Smiles for dependent older people in our community. These programmes play a vital role in addressing inequalities in oral health outcomes and are supported by the PDS and independent dental practices that provide NHS services

Optometry in Aberdeen City

Optometrists were historically referred to as ophthalmic opticians. Optometrists are trained professionals who are able to examine your eyes, give advice on visual problems, prescribe and fit glasses, contact lenses or visual aids and recognise eye disease.

There are 20 optometry practices across Aberdeen City providing NHS general ophthalmic services. Everyone in Scotland is eligible for a fully-funded comprehensive NHS primary eye examination appropriate to the patients needs.

Eye Health Network

NHS Grampian's Eye Health Network was formed in 2007 to improve access to eye care services across the Health Board area. Historically eye care has been delivered almost exclusively within a hospital setting. The Eye Health Network has taken a fresh look at eye care delivery, looked at who may be effective in providing care and taken a joined up approach to share care and responsibility across the network.

The Eye Health Network consists of approx 55 Optometry practices spread across NHS Grampian, the Department of Ophthalmology at Aberdeen Royal Infirmary and Dr Grays Hospital, Elgin. They work in association with General Medical Practice and Pharmacy to have the patient seen by an eye care professional who is best placed to provide appropriate care.

Optometry is promoted as the first point of contact for all eye related problems in Grampian. Optometry practices are equipped in a similar level to Hospital Eye Clinics and can diagnose and treat an increasing number of eye conditions. They are also linked electronically to the Hospital Eye Service and can refer on rapidly if this is required.

The Eye Health Network has provided care for many thousands of patients and has been extended to include a Local Enhanced Service Agreement to allow treatment of Acute Anterior Uveitis, Herpes Simplex Keratitis and Marginal Keratitis in association with General Practice within the primary care setting.

The Eye Health Network continues to develop the Network in a patient-centred direction addressing eye care needs within NHS Grampian.

Finance

The Integration Joint Board (IJB) has an ambitious strategic plan which seeks to transform the health and social care services under its remit within Aberdeen City. In order to facilitate this, additional funding has been provided by the Scottish Government which can be used to help transform services, support integration and reduce delayed discharges. It is important to note that whilst the allocation of this funding is extremely useful in terms of delivery of the strategic plan, other services are being transformed from within mainstream budgets on a continuous basis. A good example of this is our public health and wellbeing team who are now undertaking new duties linked to the delivery of the strategic plan. In reality the whole budget is available to integrate, change and transform.

At this stage the financial information reported below is city-wide however the process for establishing locality budgeting is being progressed.

Service	Gross Expenditure (£)
Community Health Services	31,649,313
Learning Disabilities	29,264,461
Mental Health & Addictions	18,304,741
Older People, Physical & Sensory Impairments	69,719,818
Criminal Justice	4,413,345
Housing	2,197,288
Primary Care	36,846,589
Primary Care Prescribing	40,125,916
Hosted services	21,207,851
Out-of-Area Treatments	1,219,506
Set-Aside Treatments	46,732,000
Head Office/Admin	1,007,021
Transformation	2,856,283
	305,544,132

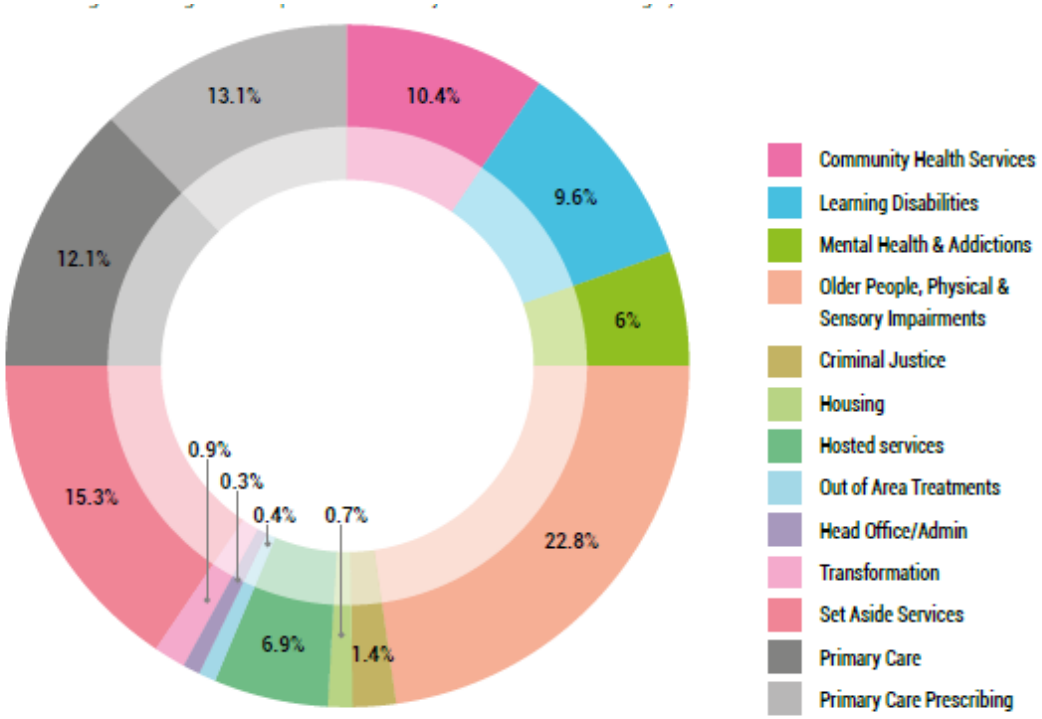
ACHSCP, Service Expenditure (this is a notional budget). Taken from the Annual Report, 2016/17.

*Out-of-Area Treatment budget is based on the numer of ACHSCP patients receiving care outside of the Grampian area.

*Set Aside Treatments budget is based on the consumption of hospital services by the IJB population based on an analysis of hospital activity and cost information.

How do we spend our budget?

ACHSCP Service Expenditure (this is a notional budget)



What's Working Well Right Now?

Importantly, much of this plan is based on what people who live in Central Locality and those currently involved in delivering health and social care in the locality have been telling us about how things could be better and what would make a difference.

There is a vast amount of work happening across the Central Locality to support people and improve their health and wellbeing and it is not possible to include all the valuable work happening in this plan. We know we are in the early stages of fully understanding what goes on in the locality, but the following is a snapshot of some of the work being undertaken.

The Healthy Hoose

The Healthy Hoose is a nurse-led service established in 1999. Originally located in a converted residential property, it is now based at The Hub, a community centre also hosting a cafe, nursery and youth flat.

Initially started as a project to improve access to healthcare, The Hoose provides a unique service to those who may not otherwise access care, or find it challenging to do so due to their personal circumstances.

Examples include Ted*, an 83-year–old gentleman with literacy issues. Ted has angina and attends The Hoose for medical reviews, treatment and help to read the letters required for him to manage his condition. Ted is anxious walking into new situations, and the relationships he has built with Healthy Hoose staff mean he feels comfortable enough to accept this support.

Dan*, 49, also has literacy issues and, like Ted, appreciates the inclusive and non-judgemental environment The Hoose provides. Often struggling to navigate other services due to his anxiety, Dan would not maintain the appointments required to manage his diabetes without The Hoose.

'I don't feel like I'm being judged here'- Dan

Another large component of The Hoose's work is seeing and treating young families who logistically may find it difficult to access other services due to transport, financial or practical difficulties including navigating childcare and school times. The Hoose also provides a vital link to contraceptive services and treatment for minor ailments.

Tillydrone Network

The Tillydrone Network was re-established in February 2015 with the purpose of bringing together a range of partners and community members from across the Tillydrone area. Membership includes residents, volunteers and staff from agencies including the NHS, the police and the local authority. The Network provides an opportunity forum to share information, promote positive images of what's happening in Tillydrone, and to identify local solutions to identified local issues. The Network also provides members and residents with an opportunity to get involved in the planning and development of local services.

Examples of The Network in action include:

- The 'Tilly Clean-Up', where residents can get involved in tidying up their community area and raising any issues that need addressed with the relevant local authority department;

- Organising the annual Tilly Gala, a hugely successful event which brings the community together for a few hours of fun each summer and provides an opportunity for local groups working in the area to promote their activities;

- Input to the recent Aberdeen City Council participatory budgeting event, which allowed the Tillydrone community to get involved in bidding for project funding specific to their area.

Community Spirit & Neighbourhood

The results of our recent questionnaire indicated that people in the Central Locality value community spirit and neighbourhood very highly. This would suggest that the locality is more cohesive than perhaps people realise. This forms the building blocks from which to strengthen social cohesion and add social value to the community which, essentially, contributes to health and wellbeing.

Known Challenges in the Central Locality

It is known that there are Increasing demands on health and social care services due to people living longer and with more complex longer term conditions to manage. This is against a backdrop of limited resources in the public sector and real challenges in the recruitment and retention of the workforce required to support local needs. This is not unique to our locality or to Aberdeen City, nor the rest of the UK. However, there are some specific challenges in terms of recruitment to the North-east of Scotland.

During the span of this locality plan there are areas that we need to further develop our understanding of. We will use the information we gather to inform how we can make the most efficient and effective use of our collective resources across health and social care services. It is recognised that good communication and involvement is essential to ensuring the locality can achieve its identified priorities. Meaningful engagement with members of the locality who are seldom heard is crucial. From the locality profile information and the engagement work we have carried out so far with people who live and work in the Central locality, the following priorities have emerged.

- Engagement and participation of people and staff living and working in the locality, especially those who are seldom heard;
- Social isolation;
- Demographic challenges and increasing demands on health and social care services;
- Higher prevalence of anxiety, depression and other mental health problems;
- A high level of disadvantage exists in the locality;evidence suggests this is linked to health and other inequalities;
- Accurate identification of unpaid carers;

- Any transformed service must be fit for purpose, be future proofed to meet the challenging changes in demographics and come within the financial resources available.

The main focus needs to be around how we can work differently in a more integrated way across health and social care services and with the wider community and partners to better meet current and future demand.

The priorities on the following pages are the start of what we need to do and will form the basis for other priorities that will emerge as we go forward.

Central Locality Priorities: 2017 – 2019

This high-level plan sets out the priorities for the Central Locality for the period 2017-19. To deliver the actions set out below, a more detailed programme of work will be developed with the relevant stakeholders by the end of April 2018 to describe the key activities, milestones and how we will measure what we do. Due cognisance will be taken of existing assets and supports already available in the locality to ensure there is no duplication of effort or resources.

In addition to these, the Central Locality will contribute to a wide range of priorities that are common to the whole city. These include some of the challenges we have around recruitment and retention of the skills we need to deliver health and care services including the current challenges we have around GP recruitment and retention.

All actions underpin the delivery of the nine National Outcomes for Health and Wellbeing.

	Central Locality challenges	**Actions planned** What will we do?	**Measurement** How will we know?
1.	**Engagement and participation of people and staff living and working in the locality, especially those who are seldom heard.**	• An engagement plan will be produced and made available to the LLG members • Work with individuals and communities to empower them to participate more fully in the development of their areas and to find local solutions to local issues	Map progress of the plan
	• Lack of a comprehensive database and knowledge of existing assets and resources	• Build on the initial work done to map the assets of the locality, consulting with the Community Planning Partnership and others to ensure there is no duplication • Promote the use of a communication tool containing city-wide and locality based services that promote and support self-	An asset map will be produced and circulated to ensure that existing assets and resources are matched with need Use statistics from the tool provider

	Central Locality challenges	Actions planned What will we do?	Measurement How will we know?
	• Barriers to accessing services that are available • Staff may not feel fully engaged in the transformation process	management of health and wellbeing • Link existing assets and networks to each other, matching assets and resources with need • Exploration and consultation about localised solutions to identified barriers within the locality (e.g. transport, lack of childcare) • People who work in health and social care services are encouraged and supported to become an integral part of the transformation process which will enable them to continuously improve the information, support, care and treatment they provide	Identification and prioritisation of local solutions for implementation Staff and management feedback Exemplars of engagement activities and opportunities for further involvement.
2.	**Reducing social isolation**	• Identify people who are socially isolated using existing networks • Work with individuals and communities to empower them to participate more fully in the development of their areas and to find local solutions to local issues	Numbers of people who have been identified and number of links to organisations that have social inclusion as part of their mission and remit Development of case studies to understand underlying mechanisms which make the difference

	Central Locality challenges	Actions planned What will we do?	Measurement How will we know?
		• Further develop the co-production pilot project matching volunteers with socially isolated people. This will improve people's connection to their community e.g. long-term unemployed; this action could also be linked to the engagement plan.	to socially isolated individuals The first '100 day pilot' is complete. Use of tools that measure social connectedness such as the Relationship Circle, Perceived Social Support Scale
3.	**Demographic challenges and increasing demands on health and social care services**	Through the Locality Leadership Group, set up working groups that are representative of all stakeholders and with which there is a two-way flow of information so that as services are transformed collaboratively, the changes are informed by the information and expertise of the working group members	All completed focus groups are recorded on VOICE. Number of groups and membership.
4.	**High prevalence of anxiety, depression and other severe mental health problems**	Identify and improve the uptake of existing services provided by statutory agencies, third sector and communities e.g. primary care mental health workers and psychologists, directory of mental health services on ACVO website, link workers	Statistics from the PCMHW, (Primary Care Mental Health Worker) the psychology service and link workers show an increase in patients from the Central Locality, year on year.
5.	**A high level of disadvantage exists in the locality; evidence suggests this is linked to health and other inequalities**	Using the engagement strategy outlined above, individuals and communities will be empowered to participate fully in the development and co-production of services.	Understanding individuals' perceived empowerment including exemplars of good practice.

	Central Locality challenges	Actions planned What will we do?	Measurement How will we know?
6.	**Accurate identification of unpaid carers so they may be involved in the planning and delivery of services that support them to look after their own health**	Work with well-established partners to identify unpaid carers who may require support/information; work with unpaid carers, GP practices and the acute sector to raise awareness of the issues faced by carers	Number of new carers identified; potentially increased uptake of services/resources available to unpaid carers
7.	**Any transformed service must be fit for purpose, be future-proofed to meet the challenging changes in demographics and come within the finances available.**	• Work with staff, service users and communities to develop different models of care delivery, being mindful that any change must be affordable • Participate in the development and delivery of the Acute Care @Home model which will be tested in Central Locality	New models of care developed This model will be evaluated

How will we know that progress is being made?

To help us monitor the progress of this plan, we will develop a performance framework. This ensures a consistant approach across all four localities and the wider partnership.

We have described ways in which we may monitor our progress above for the high level locality priorities. A detailed programme of work will then outline specific measures and timescales as appropriate to each project and action. Regular updates will be reported to the LLG and the Strategic Planning Group (SPG). Please note not all of the information is currently available at a locality level. We will seek to address this on an ongoing basis.

Over time, this information will allow us to see what effect the approaches we have taken to integrating services and working together with the community, the third and independent sectors and other partners, is having on the health and wellbeing of people living in the locality.

We will make sure we measure the things that matter to those using services, carers and frontline staff and those living in the locality.

A variety of methods will be used to measure quality as well as quantity including gathering service user, carer and staff experience, case studies etc.

Public Consultation

This plan has been developed by the Central Locality Leadership Group as part of Aberdeen Health and Social Care Partnership in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014.

Since the establishment of the Health and Social Care Locality Leadership Groups there has been continued encouragement for all partner, stakeholder and community representatives to come forward to express their views and experiences and help to shape and decide upon priorities for their areas. We believe that this marks a significant change from the traditional cycle of simply preparing a finished document for consultation and response.

We would like to thank everyone who has expressed a view, shared an experience and come forward to help shape the creation of this Locality Plan and look forward to welcoming even more colleagues and those in the community to help us and be part of this work and future years' plans.

The final plans are approved by the IJB.

Current LLG Membership

Lorraine	McKenna	Head of Locality (Central) & Business Manager
Nicola	Dinnie	LLG Chair, Operations Director, Bon Accord Care
Jane	Russell	LLG Vice-Chair, Partnership Manager, ACVO TSI
Sarah	Alder, Dr	Consultant Geriatrician, Medicine for the Elderly
Helen	Beattie	PDS Locality Support Manager
Hillary	Benson	Manager, Carers Support Services, VSA
Nick	Bowry	Curate, St Clements Church Aberdeen
Jane	Boyle	Senior Wellbeing Coordinator, Public Health and Wellbeing ACHSCP
Pamela	Cornwallis	Lead Speech and Language Therapist, ACHSCP
Katie	Cunningham	Public Health Co-ordinator. Central Locality, ACHSCP
Aileen	Davidson	Tillydrone Network and Community Chair & Representative
Alison	Davie	Lead Pharmacist, Central Locality ACHSCP
Kevin	Dawson	Service Manager, Mental Health
Kay	Diack	Central Locality Manager Communities/Partnerships ACC
Gosia	Duncan	Enablement Trainer, Scottish Care
Gordon	Edgar	Development Facilitator, Central Locality ACHSCP
Valerie	Fox	Unit Operational Manager, Emergency & Acute Medicine, ARI
Alison	Geddes	Interim Practice Development Manager, Central Locality ACHSCP
Amir	Iqbal (Dr)	Clinical Lead, Central Locality ACHSCP & GP Denburn
Dave	Kilgour	????
Sue	McFadyen	Service Manager/Lead Health Visitor, Locality ACHSCP
Paul	McMenemy	Northfield Total Place, Community & Housing Volunteer representative
Stephen	McNamee	Transformation Programme Manager, Central Locality
Claire	Melvin	Deputy Head Optometrist / Aberdeen City Lead Optometrist
Nick	Price	Managing Director, MyCare UK Independent Care Sector Representative
Laura	Robertson	Senior Care Manager, Care Management Central Locality ACHSCP
Nicola	Scott	Senior Care Manager, Care Management Central Locality ACHSCP
Darren	Smith	Wellbeing Coordinator, Public Health and Wellbeing ACHSCP
Martin	Smith	Housing Manager, ACC
Julie	Stewart	Tillydrone Network and Community Representative
Chris	Third	Local Officer, Scottish Health Council, Aberdeen
Paul	Tyler	Locality Manager for ACC Area 2 (Tillydrone, Woodside & Central areas)

Jenny	Wishart	Independent Care Home Providers

Glossary of Commonly used Terms and Acronyms

ACC	Aberdeen City Council
Co-production	
Commissioning	The process of identifying a community's health and social care needs and allocating resource to meet them
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disorder
Delayed Discharge	When a patient is ready for discharge cannot leave hospital because the necessary care, support or accommodation is not available
Emergency Admissions / Multiple Emergency Admissions	Emergency admissions – a new continuous spell of care in hospital where the patient was admitted as an emergency to hospital Multiple emergency admissions - more than one unplanned continuous spell of treatment in hospital in one year,
Governance	A process to ensure the management, safety and effectiveness of services and organisations
Health Inequalities	The gap which exists between the health of different populations groups such as the affluent compared to poorer communities or people with different ethnic backgrounds
H&SC	Health and social care
(AC) HSCP	(Aberdeen City) Health and Social Care partnership
Independent Sector	The independent sector encompasses individuals, employers, and organisations contributing to needs assessment, design, planning, commissioning and delivery of a broad spectrum of health and social care, who are wholly or partially independent of the public sector. This includes care homes, private hospitals and home care providers as well as consultancy and research work.
Integration	The combination of processes, methods and tools that facilitate integrated care
Integration Joint Board (IJB)	An Integration Joint Board will be established to oversee the integrated arrangements and onward service delivery. The integration joint board will exercise control over a significant number of functions and a significant amount of resource
Locality planning	Improving care in local communities, drawing on the experience of service users, carers, staff, third sector, independent sector, in planning service provision
Long Term Condition (LTC) / Chronic Condition	A condition that lasts a year or longer, that impact on aspects of a person's life and may require ongoing support and care. Long-term conditions become more prevalent with age.
Multi-disciplinary Team (MDT)	A team made up of professionals across health, social care and Third Sector who work together to address the holistic needs of their patient service users/clients in order to improve delivery of care and reduce fragmentation.

Morbidity	The incidence or prevalence of a disease or of all diseases in a population.
Mortality	The death rate, which reflects the number of deaths per unit of population in any specific region, age group, disease, or other classification, usually expressed as deaths per 1000, 10,000, or 100,000.
Person–centred	Having individuals at the heart of everything we do.
Personal Outcomes	Personal outcomes are about the impact or end result of services, support or activity on a person's life
Primary Care	Health care provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment. Main primary care services are provided by GP practices, dental practices, community pharmacies and high street optometrists, as well as community nurses and Allied Health Professionals.
Prevention	Primary prevention includes health promotion and requires action on the determinants of health to prevent disease occurring. It has been described as refocusing upstream to stop people falling in to the waters of disease. Secondary prevention is essentially the early detection of disease, followed by appropriate intervention, such as health promotion or treatment. Tertiary prevention aims to reduce the impact of the disease and promote quality of life through active rehabilitation.
Reablement	Giving people the opportunity and confidence to relearn/regain skills they may have lost as a result of poor health, disability, impairment, in hospital or care homes.
Rehab / Rehabilitation	A process restoring personal autonomy to those aspects of daily life considered most relevant by service users, their families and carers
Self Management	Encouraging people with health and social care needs to learn about their condition and remain in control of their own health
Strategic Plan	The Strategic Plan is the statement of intent of how integrated health and social care services will work towards attaining the national health and wellbeing outcomes over the next three years
Social Inclusion	The provision of certain rights to all individuals and groups in society, such as employment, adequate housing, health care, education and training.
Social Prescribing	Linking people up to non-medical sources of support and activities in the community that they might benefit from
Third Sector	Organisations that are independent from statutory agencies and provide social or environmental benefit and which do not distribute profits.

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