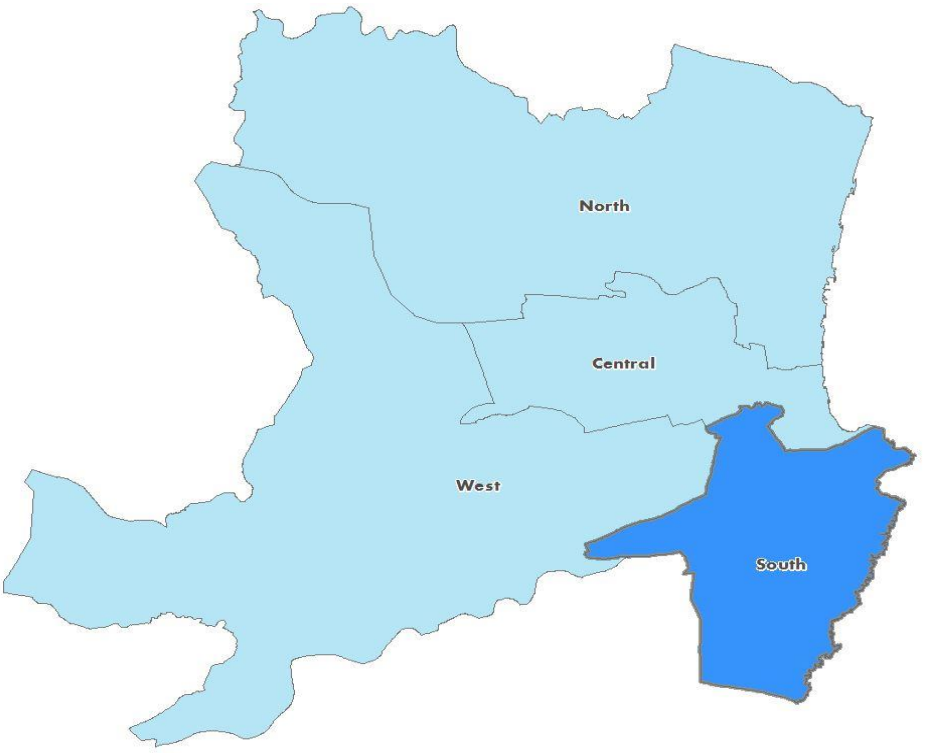
Aberdeen City Health & Social Care Partnership
A caring partnership

South Locality Plan
(2017 – 2019)



Contents

Foreword

This plan is about improving the quality and overall health and wellness of our everyday lives. The Health and Social Care Partnership is changing the way that our public services approach this challenge. It brings together a number of partners and stakeholders to plan and work together and increase engagement and participation with our local communities.

This plan is the first step on the journey ahead. There is a strong interest and enthusiasm from colleagues and from the community to learn more and get more involved. This plan is an important step and we are still learning as to how best to build upon this work for future years to come. At the heart of this plan is empowerment. The views and priorities of communities guide and shape the work that is done, and where services and stakeholders can work with our communities in a way which is truly inclusive. It is important that we share information and understanding with our communities and with each other, so that all can be as informed and empowered when making decisions.

Our Locality Leadership Groups (LLG) embody these changes at the most local levels throughout the city, made up of a number of partners and representatives involved and living in the local community –.from public health and wellbeing, social care, Active Aberdeen Partnership, allied health professionals, GP doctors, nurses, housing officers, third and independent sector representatives and importantly community representatives who can help inform and reflect the views of their communities. It is important that we recognise, understand and support so much of the good work that is already taking place in the community. We must deepen our understanding of the more embedded issues and challenges ahead to improve the quality of health, wellbeing and quality of life for all.

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

Thank you to everyone who has been a part of this process so far, and we look forward to welcoming all the more innovation, interest and inspiration of those who would like to be part of this journey with us in the future.

Alasdair Jamieson

LLG Chair

Jonathan Smith

LLG Vice-Chair

Executive Summary

This locality plan sets out how health, social care and wellbeing will be taken forward in the South Locality as part of the wider Aberdeen City Health and Social Care Partnership (ACHSCP)[1]. This includes our intentions around how we will progress with integrating our health and social care services at a locality level where possible and 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, Aberdeen City HSCP has delineated the city into four localities and Locality Leadership Groups (LLGs) have been established in all of the 4 areas. The Locality Leadership Group has a key role in ensuring the delivery of Aberdeen City HSCP'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 South 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 for people who are well and wish to maintain or improve their current levels of independence, health and wellbeing.

There is a vast amount of work happening across the South 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 work where relevant.

A recent survey undertaken by the LLG revealed, among other things, that people in the South 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 working together and making use of all of their strengths and contributions to achieve mutually beneficial better outcomes. This method will underpin the partnership's approach to locality planning and projects moving forward within the community.

Our Vision

The plan is shaped around our 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 South Locality has highlighted the importance of communication as a key factor in everything that we do in particular for those who are seldom heard. Improving communication between partners, staff and local communities in the South Locality is and will continue to be essential to delivering on what we have agreed.

Our focus in the South Locality

- Improve our understanding and address the effect of low income and poverty on health and wellbeing in the community
- Working together to improve everyone's understanding and commitment to improving their health and wellbeing through healthy diet, better nutrition and increased physical activities
- Improve mental health and wellbeing
- Decrease social isolation and increase social inclusion
- Reduce alcohol misuse and its wider impact across the locality

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

[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

Introduction

This locality plan sets out how health and social care will be taken forward in the South Locality as part of the wider Aberdeen City Health and Social Care Partnership (ACHSCP)[3]. This will include 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 South 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 South 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 South 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[4]: 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 the 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[5] (CPA) which has a far wider remit. Aberdeen City HSCP is a member of the CPA. Please note that the localities, referred to by the CPA, are specified areas within

[3] Link to ACHSCP website – www.aberdeencityhscp.scot

[4] 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

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

the city which have a generic focus on improving outcomes and inequalities for that particular area.

Health and Wellbeing Outcomes

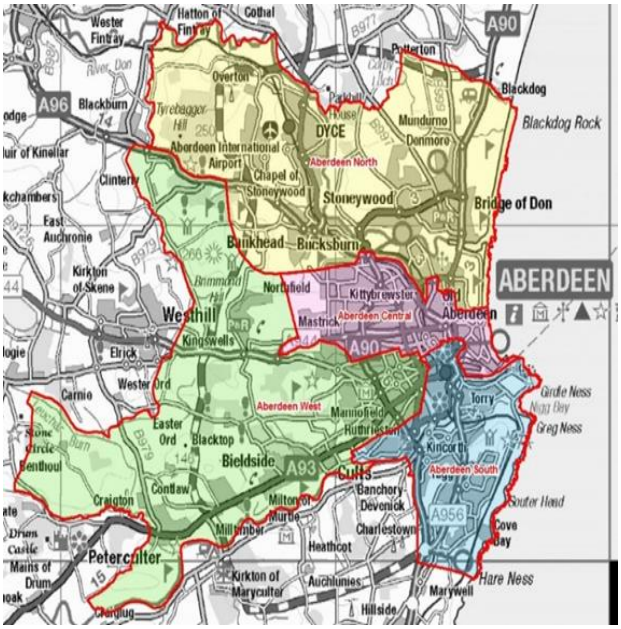
The Scottish Government has identified nine national health and wellbeing outcomes that the partnership must work towards. This plan identifies local priorities in the South Locality which will contribute to the achievement of these outcomes.

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 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 health and social care services. Localities should be large enough to offer scope for service improvement but small enough to feel local and real for those people who live there. In Aberdeen Health and Social Care Partnership we have four localities – North, Central, West and **South (blue area on the map)**.



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 key role in ensuring the delivery of the strategic outcomes stated in the ACHSCP's Strategic Plan and an active role in agreeing priorities to improve health and wellbeing outcomes locally.

The role of the LLG 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 group works with services and communities and has a direct line of communication to the strategic planning group of the ACHSCP.

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.

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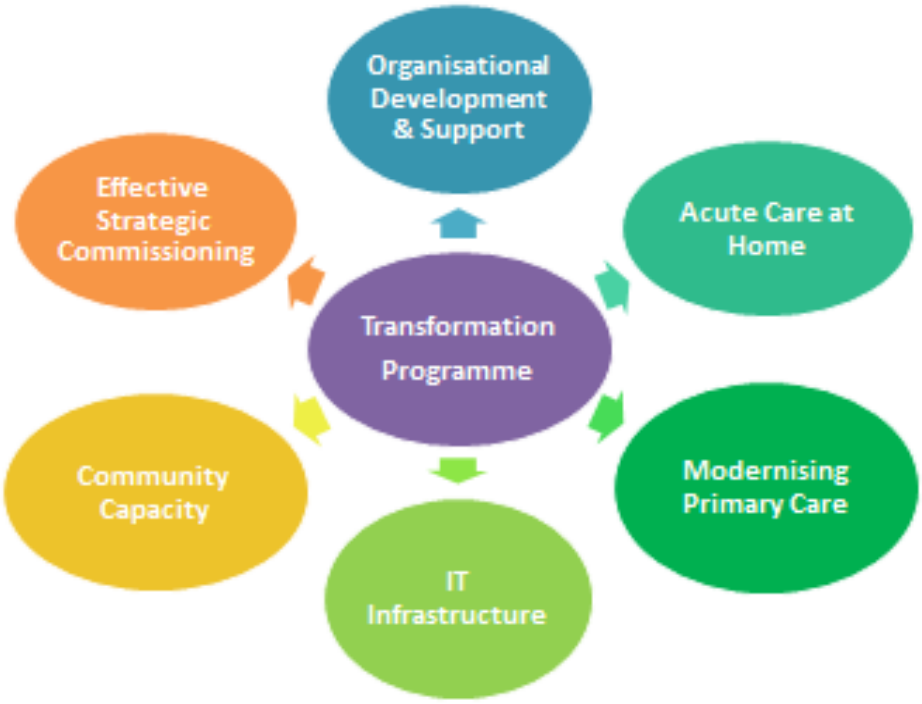
Health and Social Care Transformation

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



Some projects will be taken forward on a city-wide basis with initial testing of some of this taking place at a locality level. Projects such as:

- Integrated Neighbourhood Care – 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 South 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 the people and staff have said to us during the compilation of this plan about what needs to be done to understand the South Locality and to plan the way forward were:

The development of the South Locality began with a 'kick-off' event in summer 2016. Attendees were asked to identify what assets there were in the locality to support health and wellbeing and identify some priorities moving forward, and approximately 30 people attended this event. Since then the LLG has taken part in co-production training and a number of workshops.

A community and engagement plan of the South LLG was established with a keen membership of a locality plan sub-group including: community representation, housing, general practice, allied health professionals, public health and wellbeing, and the third and independent sectors. The purpose of the group was to develop a plan to engage with citizens and staff living and working across the South Locality.

Key Group Achievements to date:

- The first step of the sub-group was the development of a master community contacts list for engagement purposes. Thereafter the group developed a questionnaire (April 2017) for everyone living and working in the South, asking what keeps people well, what the potential gaps are and the priorities moving forward. Over 100 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.

- A locality profile workshop was held where 15 staff and representatives of the community attended. The health profile was presented and a world cafe format was used to identify the priorities for people living and working in the South. People were also asked to identify the assets they had that could contribute to improving health and wellbeing for all in the South.
- The Health and Social Care Partnership commissioned a project with 'Thrive' to support the building of relationships and collaborations with local communities and exploring priorities and actions. Well Torry and Well Kincorth were a series of events in May and June 2016. This work has also been included in the planning process.
- In addition, events were organised in Torry which were locality funded from the regeneration work through the Community Planning Partnership and with Aberdeen City Council. The meetings were to set up a wider Torry network which included local residents, community groups, and the local workforce to help shape and deliver the Torry Locality Plan. This work underpins the 10-year Improvement Plan.
- Voice Training (community online tool) has been undertaken by a number of group members including community representatives. This is an online platform which allows information and project planning to be shared, contributed to, and tracked as widely and as openly as possible. There will also be further training for more group members to ensure that we are always working toward meeting the National Engagement Standards for Scotland.
- Development of a community contacts list for engagement and communication purposes (as of late 2017, this holds over 100 contacts).
- All community councils in the LLG and a number of other groups have been given the opportunity to be engaged with in the discussion and development of the plan, including a number of representatives taking forward the view of their community online, in person and attending meetings of the locality group.
- Two community events were held in April 2017 to ask how people in the South of Aberdeen would like to be engaged with.
- A Community Events Outcome paper was produced from these events, highlighting two main issues to take forward: first, that people did not feel informed about the changes taking place in Health and Social Care Partnership; and second, the need to develop user-friendly language and materials to make all the information as understandable and accessible as possible, including the more frequent use of social media.
- A Facebook group was created and members of all LLGsin the city attended the 'Celebrate Aberdeen' Day in August 2017.

Next steps include:

- Future development of media and other methods of sharing information. For example, South Wellbeing Manual, use of community notice boards, key information shared through the various community newsletters, SHMU radio and talking to those in the community in person at identified 'community hubs' and 'bumping spaces' (Informal meeting places that present an opportunity for interaction eg. Bus stop, school gate;
- Development of a Health Network in the South Locality;
- Membership of the Locality Leadership Group by identifying younger people and other groups, equally how they can be more supported to be involved**.**

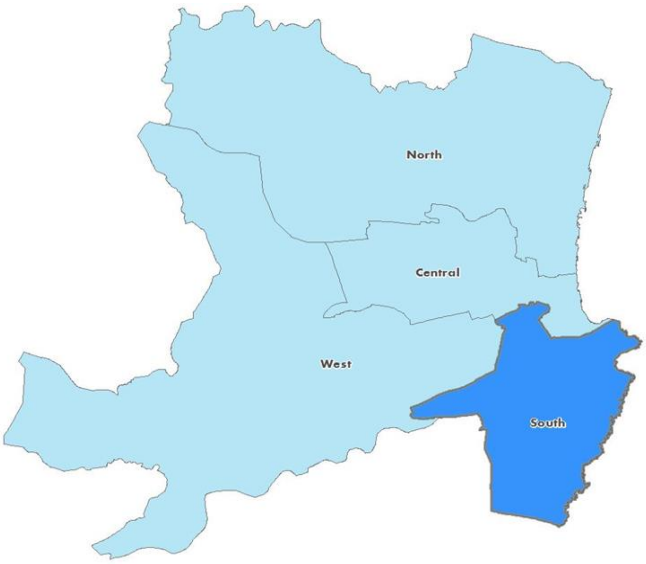
How will communities and professionals work together?

Co-production training was commissioned by the Aberdeen City HSCP with several members of the LLG participating in this opportunity. 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 South Locality has identified a project to take forward using a co-production approach, working to improve healthy eating for those with diabetes in collaboration with C-Fine, a local social enterprise which has projects of work including a food bank, cooking classes and redistribution of surplus food from industry into the community (See link for more info; Community Food Initiatives North East). This project is looking for patient experts to support this to empower the local groups.

The Aberdeen City HSCP 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 South Locality



This section highlights key information about the South Locality taken from the Locality Profiles. These were developed by information analysts 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 South Locality has improved in recent times. Both men and women are 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 South and is likely to exert an effect on residents' health and wellbeing.

South Locality

South Locality covers the areas of Kincorth and Cove, Altens, Nigg, Leggart, Ferryhill, Rutheriston, Torry, and Garthdee as well as the south of Aberdeen city centre. The locality is largely urban and shares a boundary with central and west localities of the Health and Social Care Partnership, as well as Aberdeenshire. Whilst the local economy has traditionally been based on fishing and agriculture, companies relating to the oil and gas and fishing industries as well as retail services dominate across the locality.

The Robert Gordon University has a modern and dynamic campus with several faculties and a sports centre based in Garthdee. The Aberdeen Snow Sports Centre is also based in Garthdee. The new Lochside Academy is due to open in 2018. All of this encourages a transient and active mobility for education, employment and leisure across the locality.

Tullos Hill and the adjacent Kincorth Hill form part of the coastal fringe of the Grampian Mountains – hence the cherished local name 'The Gramps'. Archaeology has revealed that this area was settled by people in early history. There is a generous access to open, green space by the Dee riverside and local nature reserves in Kincorth, as well as Duthie Park. Rubislaw, an area in the locality, boasts homes worth over £1million. The Torry area is one of the three locality partnerships formed by Community Planning Aberdeen (CPA) in 2016. The eight neighbourhoods that are part of these locality partnerships each have higher concentrations of multiple deprivation according to the Scottish Index of Multiple Deprivation (SIMD). The locality is well serviced with retail outlets, community centres, places of worship, schools, GP practices and other local amenities.

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 South Locality and compares the age and sex distribution with Aberdeen City.

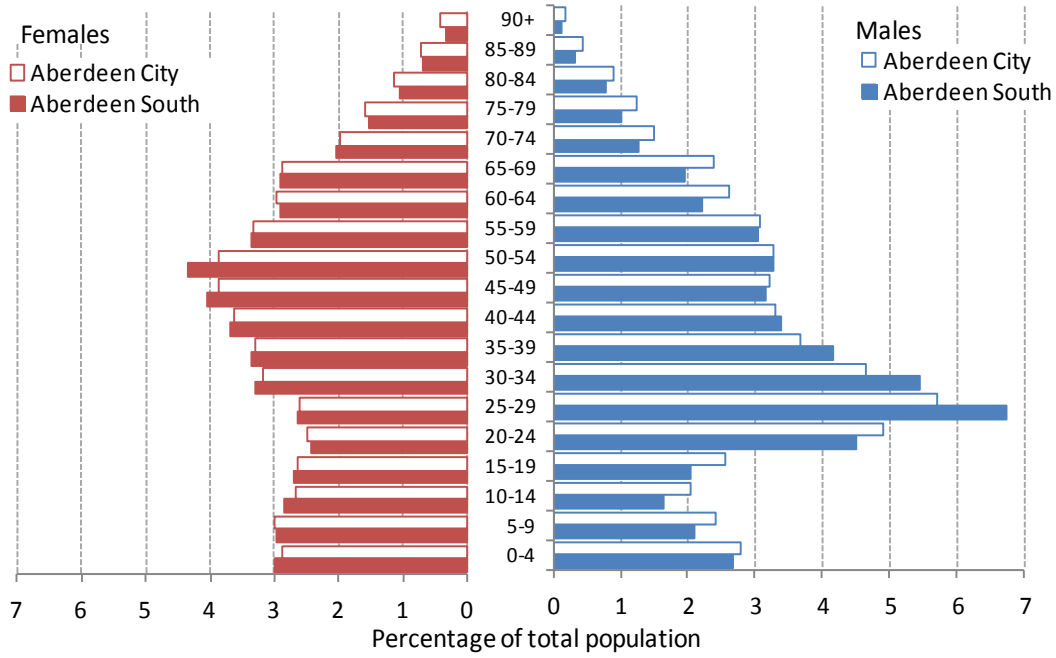
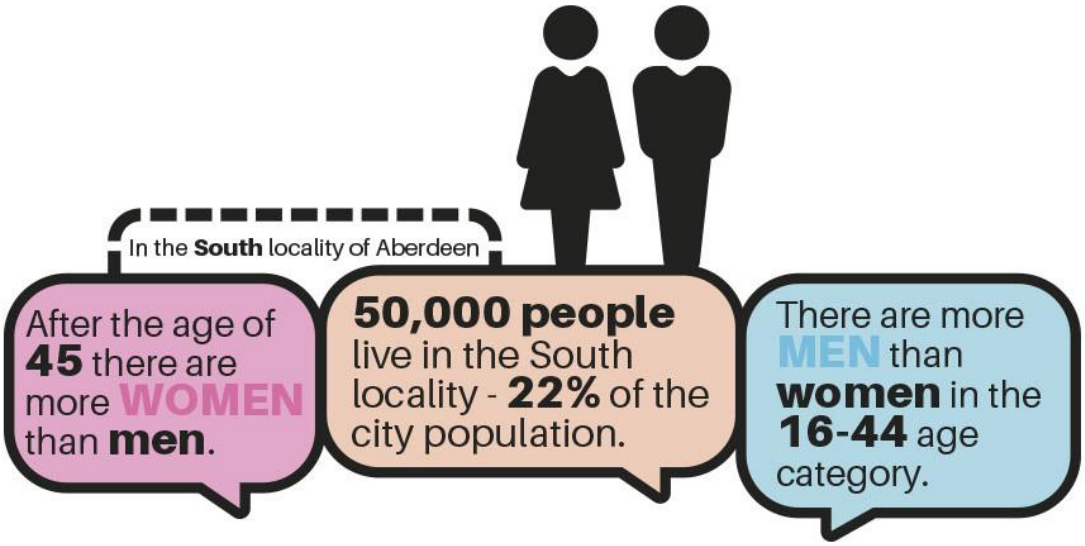


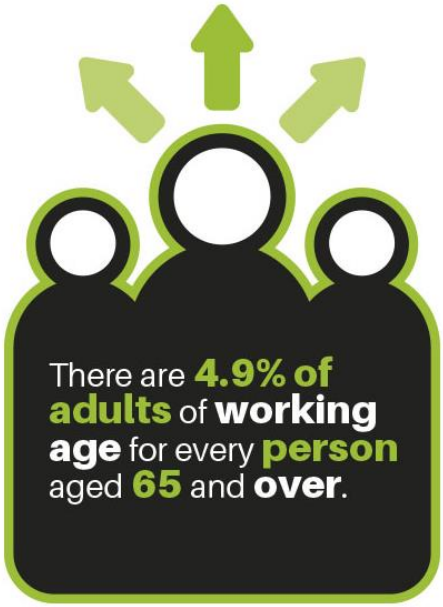
Fig. Aberdeen South and Aberdeen – Percentage of persons by 5-year age band and gender (National Records for Scotland, 2015)



The whole population is generally split evenly between men and women.

16% of the population are children under the age of 16.

19% of the population are aged over 60.



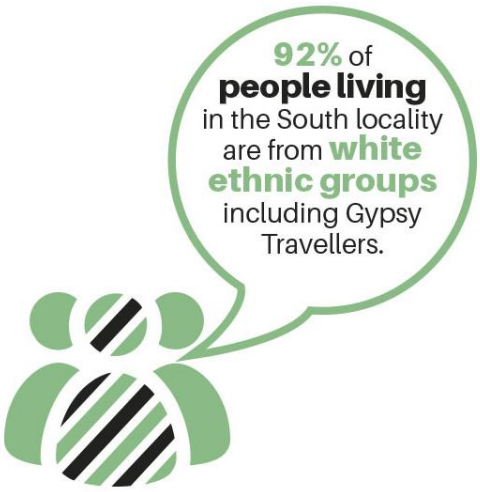
There is a steep difference in the sizes of the pre-baby boom and baby boom generation (born between 1946 and 1965) indicating that an imminent increase in the number of older adults over the age of 70 years living in South Locality should be anticipated in the next few years

The inequality in premature death rates and life expectancy that affects the South Locality can be seen as a relative narrowing of the top of the pyramid. This is particularly evident for males.

A snapshot of the population in South Locality:

At the time of the 2011 Census there were:

Ethnicity:

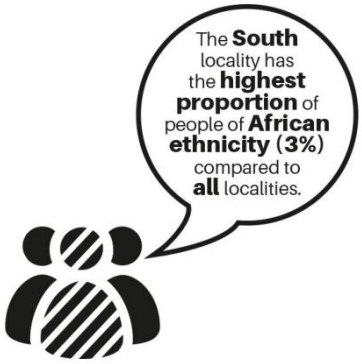


8.0% of people from black and minority and multiple ethnic groups;

2.9% of people aged 3 and over did not speak English well/at all;

14.7% of people spoke a language other than English at home.[6]

0.5% spoke no English at all.



Households

23,449 households (22.7% of Aberdeen City households);

4.9% of households included single parents with dependent children;

31% of households were one person under the age of 65

10.2% of households were one person of retirement age (65+)

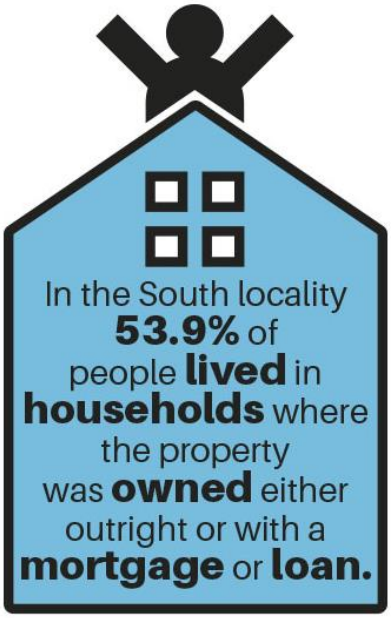
[6] Languages include Gaelic, Scots, British Sign Language, Polish and other languages

There is also a reasonable sized student population with 21% (603) of full– time students living in the South Locality.

Households by tenure:

24% (11340) of people lived in in social rented accommodation (local authority), housing association or registered social landlord (RSL);

13% (3017) of all households were considered to be overcrowded (of 23449).



Households by rooms[7] (not in the main portfolio)

13% (3047) households occupy properties with 6 -8 rooms;

1.6% (391) households occupy properties with 9 or more rooms.

Car/van

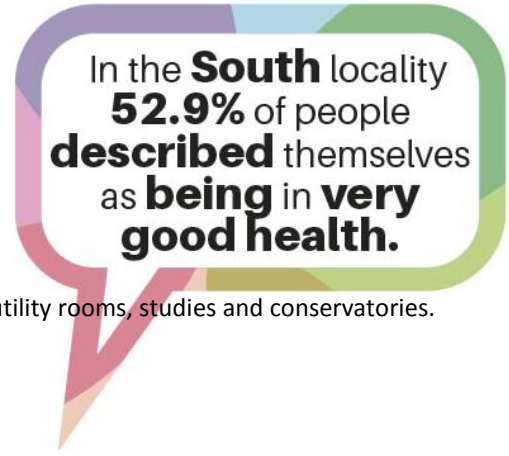
36.2% (8479) of households reported having no access to car/van, which is the lowest among the four localities.

People providing unpaid care

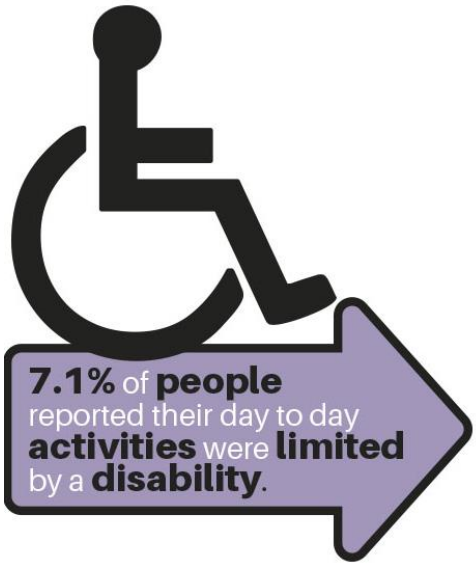
7.7% of people said they provided weekly care , a significant percentage of this was over 50 hours per week.

Adults self-assessed health

The number of people reporting very good/good health started to decrease more sharply from the 35 to 49 age bracket. However, 44% of people over the age of 75 described their health as good or very good.



[7] The definition of a room counts kitchens, living rooms, bedrooms, utility rooms, studies and conservatories.



People limited by disability

84.1% of people said their day-to-day activities were not limited by disability;

7.1% of people reported their day-to-day activities were limited a lot by disability.

Living conditions that contribute to health and wellbeing

Education

School attendance was last recorded as around 94% for primary pupils and 90% for secondary pupils (2010/11).

A range of small areas in the South Locality are recognised as being in the 20% most 'education' deprived areas of Scotland. These areas include locations in Garthdee (3), City Centre East (1), Ferryhill North (1), Kincorth, Leggart and Nigg - North (2) and South (2), Torry West (4) and Torry East (6). This includes three out of the 10 small areas that are in the 5% most 'education' deprived of Aberdeen City[iii] which are in Torry East (2) and Torry West (1). However, it is important to remember that this this does not mean everyone living in these areas is 'education' deprived. There are also areas within South Locality where educational, skills and training is high.

Employment and Income

The percentage of claims for out of work (7.9%) and incapacity and severe disability living allowance (4.1%) in 2014 were the second highest for all four localities but have followed the trend seen throughout the city of a gradual reduction over the past decade. It is also understood that there could be even greater impact due to the most recent events globally and locally in the oil, gas and energy sectors and from the recent changes of eligibility criteria for applying for and receiving benefit support. It is also

difficult to determine whether this decrease is truly reflective of an improvement in people's abilities to afford everyday goods and services or due to other factors

The percentage of children living in poverty (13.1%) in the South Locality was the second highest and almost six times higher than current levels of the West Locality.

The percentage of the population described as 'income' deprived in 2014 was 9.8% (city – 8.6%) which was lower than Central.

The percentage of the population described as 'employment' deprived in 2014 was 9.0% (city – 8.0%) which was lower than Central. Torry East is one of the 10 most employment deprived data zones in Aberdeen and it is in the 5-10% most employment deprived for Scotland.[iii]

Local assets for health and wellbeing

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

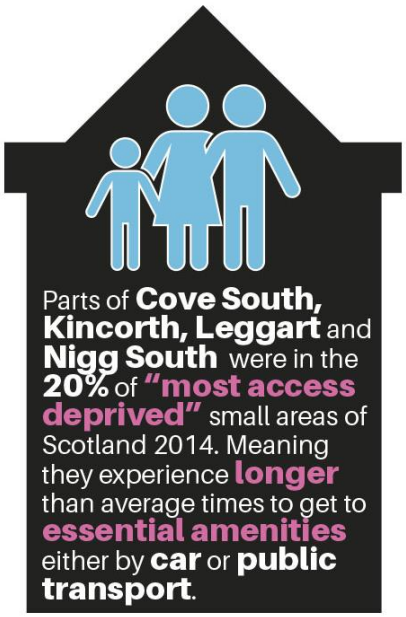
- A person: the stay-at-home parent who organises a playgroup; the informal neighbourhood leader; the community newsletter editor;
- A physical structure: a school, a GP practice, a town landmark; an unused building/room which could be used for community meetings/groups; and open space or park;
- A community 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.

Further work is planned during 2017/18 through a process of mapping, to further develop our understanding of all of our assets across the South Locality for health and wellbeing.

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 these kinds of challenges.[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. Both crime rates and fear of crime can impact negatively on a person's physical and mental health, including their sense of physical and emotional vulnerability.

Some areas such as town centres or areas around a football stadium will see large numbers of people in an area at a particular time of day or day of the week or year and can be linked to an increase in crime for the duration of these times but are not reflective of the overall areas as a whole.[vi]



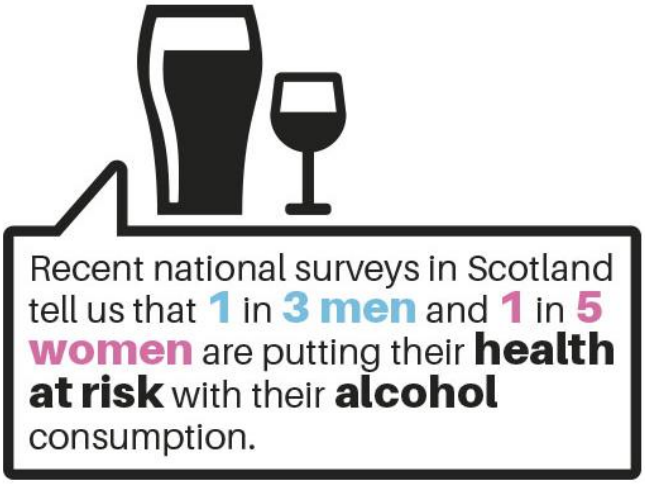
Physical Assets in South Locality

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

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

Category	Asset	Total Number
Health services	GP Surgeries	8
	Health centres	1
	Community pharmacies	12
	Optometrists	7
	Dental practices:[8] Public Dental Service (PDS) or NHSG Specialist; Independent dentist (GDP) providing NHS Care	 2 11
Social care/Housing	Care homes – older people	5
	Supported living properties – people with learning disabilities	10
	Sheltered housing	8
	Amenity housing	1
Community	Community centres and village halls	8
	Sport and leisure facilities	9
	Libraries	5
	Places of worship	8
Education	Primary schools	10
	Secondary schools	3
	Tertiary	1

[8] 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.

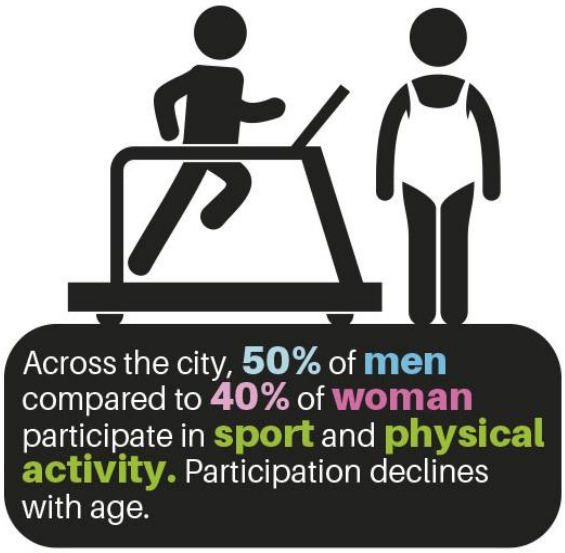


Health Behaviours

Alcohol

Scottish Health Survey data from 2015 and 2016 tell us that 1 in 4 adults in Scotland drinks above the low-risk drinking guidelines.

The amount people drink increases with their income. 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 (2010-2014) was 28 per 100,000, just less than Central. Rates have been consistently higher than the city since 2002 (city-22 per 100,000 for same period) but show an overall decrease since 2002.

The rate of hospital stays from drinking alcohol was 934 per 100,000 in 2014/15 – the highest of all four localities but an overall drop since 2003/04.

(Scottish Health Survey, 2016 – self defined).

Smoking in pregnancy

Actions that affect the health of the next generation, e.g smoking in pregnancy and breastfeeding:

16% of mothers in the South Locality reported smoking during pregnancy, which is nearly half the figure of a decade earlier;

Breastfeeding

34% of mothers reported exclusively breastfeeding their babies at 6-8 weeks.

Childhood

South Locality has:

1.8% babies born with a low birth weight (2012-2015), reduced in a 10-year period;

11.6% of children in the top 5% range for obesity – second highest in the city;

Adulthood

Aberdeen South is highest among ScotPHO indicators for:

- 1321 all-cause death rate per 100,000 population (3-yr avg) (all ages) but showing a down ward trend;
- 116 all-cause death rate per 100,000 population (3-yr avg) for population aged 15-44 years old;
- 697 patients registered with cancer – equivalent figures for the city (634) and West (550);
- 199 per year 100,000 (3-yr avg) death rate from cancer in the under 75 population;
- 72% breast screening uptake by women aged 50-70 years (3-yr avg, 2010-12) (city-77%), lowest of all four localities and 11% lower than West;
- 51% bowel screening uptake by 50-74 year olds (3-yr avg, 2010-12), (city-57%); 13%lower than West;
- 60 early deaths per 100,000 population (3-yr avg) from coronary heart disease (under 75 year olds) – declined over past decade.

(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.)

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.[9] They are now more common in the population and more people live with more than one condition. In South Locality for 2011-13 (3-yr avg) there were:

Natural and built environment that supports health and wellbeing

A number of small areas in South Locality are within the 5% most 'housing' deprived [10] areas of Scotland. These areas are in Torry West (3) and City Centre East (1).[iii]

*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,

[9] http://www.gov.scot/Topics/Health/Services/Long-Term-Conditions

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

Mental Health and Wellbeing

In 2014/15 14.6% of the locality was prescribed drugs for anxiety, depression or psychosis compared to a City rate of 14.6%.

In 2009 – 2013 there were 12.4 per 100,000 suicides (5 year avg) compared to 12.2 per 100,000 for the city as a whole.

Further work is to be done to understand issues related to mental health especially amongst our young people and to develop strategic to support mental wellbeing.

Challenging Embedded Issues and Improving Quality of Life

From the information, data and feedback conducted and available to us so far, we have identified a number of embedded patterns which are unique to the South Locality as compared to the rest of Aberdeen City. Most strikingly, among these are the diagnosis and early deaths from cancer and all-cause mortality across all age bands.

There are a number of factors that contribute to these patterns such as lower average income, poverty, diet/nutrition, physical activity and more. These factors are systemic to the experience and quality of life of those that live in the South Locality. We will seek to challenge these issues and improve these patterns through the priorities we have identified.

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 the HSCP, 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 sector 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 the services that people living within the South Locality have access to. It is important to remember that some services will be being 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 Aberdeen City HSCP and are reflected in the city-wide Transformation programme referred to earlier in this document.

General Practice

There are eight GP practices within the South Locality – Kincorth/Cove Medical Practice, Garthdee Medical Practice, Torry Medical Practice, Holburn Medical Practice, Rubislaw Medical Practice, Carden Practice, Whinhill Medical Practice and Marywell Medical Practice (N.B. Marywell is the homeless practice which covers the whole city). The practices serve approximately 60,000 patients of which approximately 9883 patients are aged over 65 with approximately 1500 aged over 85. The practices cover a wide geographical area. Most of the practices are independent with two practices being salaried and directly employed by the Health and Social Care Partnership.

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. 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 South Locality has a practice-attached community nursing team as well as an aligned health visiting team. Some but not all of these teams are based within the GP practices.

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). There are seven DDTs covering Aberdeen City on a geographical basis – the ones most relevant to the South Locality are Central South DDT based at Airyhall Clinic and South DDT (currently being trialled). Out-of-hours nursing teams cover the whole city and work out of the Emergency Care Centre in Aberdeen Royal Infirmary.

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.

Moving forward, Cove will be one of the test areas for a new model of delivering more integrated nursing and social care – Integrated Neighbourhood Care Aberdeen (INCA) – using the principles of the Buurtzorg model of delivering person-centred care.

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 diedetics, 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 South Locality, 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;

- Garthdee – physiotherapy, dietetics, podiatry
- Torry Neighbourhood Centre - physiotherapy, dietetics, podiatry, speech and language therapy (SLT)
- Torry Sports Centre – pulmonary rehabilitation
- Carden Medical Practice – dietetic diabetic clinic
- Kincorth Clinic – SLT (Children's), falls clinic, dietetic diabetic clinic and podiatry
- Cove Clinic - SLT (Children's), dietetic diabetic clinic and podiatry
- Kincorth Sports Centre – falls exercise class

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 Health and Care Village in Fredrick Street and City Hospital that provide services across the communities of Aberdeen. Physiotherapy staff also provide a rehabilittion service into Clashieknowe Intermediate Care facility which is based in Bridge of Don.

Aberdeen 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, advice 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 South 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 **h**istorically 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.

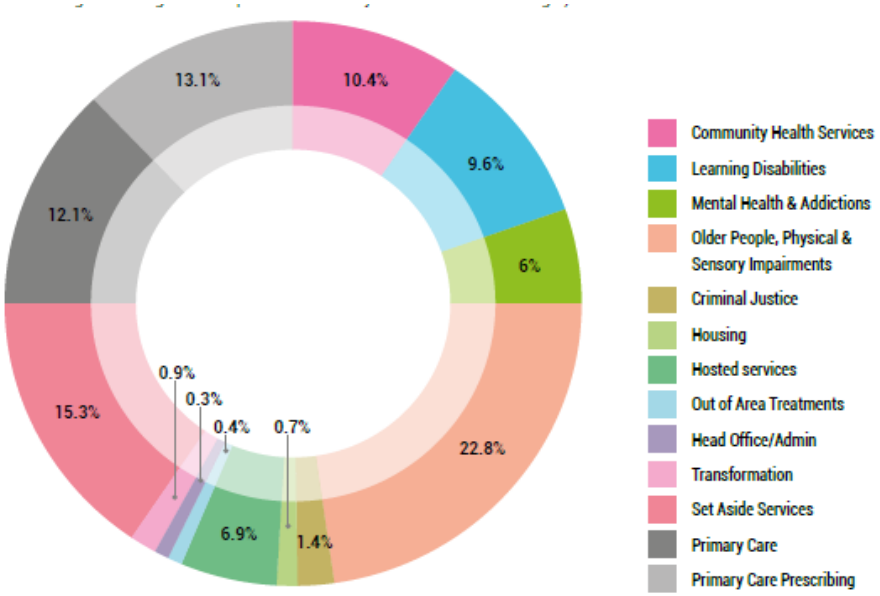
Service	Gross Expenditure (£)
Community Health Services	31,649,313
Learning Disabilities	29,264,461
Mental Health & Addictions	18,304,741
Older People, Physical & Sensory Impairments	69,719,818
Criminal Justice	4,413,345
Housing	2,197,288
Primary Care	36,846,589
Primary Care Prescribing	40,125,916
Hosted 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

Aberdeen City HSCP, 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?



Aberdeen City HSCP, Service Expenditure as percentage spend

What's Working Well Right Now?

Importantly, much of the plan is based on what people who live in the South 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.

We know that we are at an early stage of fully understanding all that is going on to support health and wellbeing in the South Locality but the following is a snapshot of some of the work being undertaken.

Some examples of these include:

- **Access to Psychological Therapies**

All GP practices in the South Locality now have access to clinical associates in applied psychology (CAPs) who are based in and work within the GP premises. They carry out psychological therapies such as Cognitive Behavioural Therapy (CBT) to support those suffering from anxiety and depression. This helps to fulfil astill unmet need in mental healthcare provision and early results are showing significant benefit to our residents, with tools for people to sustain longer-term improvements for their mental health wellbeing. To date there have been 461 referrals within the first eight months, which is a demonstration of the continuing need in the area. It is also important to recognise the role that this plays and the challenge still ahead in changing the culture of discussing and improving mental health and wellbeing within our communities.

- **Citizens Advice Bureau Money Advice Outreach Project / Cash in Your Pocket**

These projects work with those in the community to build on knowledge, skills and confidence to reduce household costs and maximise household income and saving. This includes advice and information to clients living in Aberdeen's regeneration areas using community centres as drop-in centres and for appointments. There is also assistance and advice available to clients to maximise their income from welfare benefits and to reduce levels of debt, including through creditors arrangements, sequestration and negotiation. People can also contact those involved in the project as a one-stop referral system which provides access to the full range of organisations that can assist with financial inclusion issues.

- **Health Improvement Fund**

The Aberdeen City Health Improvement Fund has been available for a number of years for projects to apply to and can make funding available to kick-start local initiatives to improve health and wellbeing in the city. The funding has also been extended to include money from Food In Focus to support community food work. Up to £2,500 is available per project.

Anyone living or working in Aberdeen can apply to the fund –members of the public, community groups (including informal groups), public service staff, voluntary and non-profit organisations – as long as the work takes place in Aberdeen.

- **Cooking, Confidence and Company**

Alcohol Drugs Action staff work with CFINE to deliver practical cooking skills and advice to participants, especially young people recovering from drugs and alcohol, and this takes place across the whole of the South Locality.

- **Pop-up pub.**

This project focuses on reducing isolation and encouraging opportunities to reminisce among older people and those living with dementia, in particular men. It was set up in Balnagask House, Torry.

- **Participatory Budgeting**

Participatory budgeting empowers communities by enabling those who live there a direct say over financial budgets and the ability to vote and to choose priority projects that can help meet the needs and lead to the best possible improvements in the area.

Known Challenges in the South

We know 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 but there are some specific challenges in terms of recruitment to the North-east of Scotland. The key 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.

From the locality profile information and the engagement work we have carried out so far with people who live and work in the South of Aberdeen there are some emerging priorities. During the span of this locality plan these are areas that we need to further develop our understanding of and use the information we gather to inform how we can make most effective use of our collective resources across health and social care services, including developing more integrated models of health and social care and more partnership working/collaboration.

It is recognised that increasing our communication and engagement is key to ensuring the locality can achieve its identified priorities. Meaningful engagement with members of the locality who are harder to reach is crucial. Recognised challenges that have been identified and that we will be working to improve include:

- High levels of disadvantage;

- High prevalence of anxiety, depression and other severe mental health challenges;
- Health and socio-economic inequality gap and high variance within the locality;
- Low uptake of preventative screening programmes;
- Social isolation.

South Locality Priorities: 2017 – 2019

This high-level plan sets out the key priorities for the South Locality for the period 2017-19. A more detailed programme of work will be explored, developed and agreed with the relevant stakeholders by the end of April 2018 to describe the key activities and, milestones and how we will measure what we do.
In addition to these, South 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 and other specific challenges.

All actions underpin the delivery of the nine National Outcomes for Health and Wellbeing referred to earlier in this plan.

South Locality challenges	Actions planned What will we do?	How will we know?
To address the effect of low income and poverty on health and wellbeing in the community	Develop structured signposting to partner services for specific support needs;build on engagement with health and social care professions	To ensure an appropriate evaluation plan is included in the project plan and wider community activities such as use of the link app, referrals, and staff surveys
	Understand broader impact of low income and poverty on health and wellbeing(e.g. in work/unemployed, ethnicity/language, mental health/disability, single parent, partner in prison, alcohol/drug problem)	Health and wellbeing survey Linkages to other priorities and Community Planning Partners; use of current and future research both nationally and locally to inform action Further data ‘drilling’ to understand low income to identify the groupings by their socio-demographic cohorts in order to consider and develop specific support Further use of Voice (online project planning

		that all can contribute to and make suggestions)
	Support population to understand 'Know Who to Turn To' and to confidently access the most appropriate health and wellbeing services Develop individual empowerment, self-esteem and confidence to take responsibility for own health and wellbeing, with support from various partners without leaving the individual feeling isolated or even more vulnerable	Improve health literacy across locality – (known to be poor understanding in lower incomes). (link to signposting work) Increase and diversify opportunities and attendance to be involved with partners and activities in the community and to help in shaping these to meet community gaps or need Encouragement of feedback and sharing of developments at every opportunity in order to be more attuned to local need
	Working with partners to provide appropriate opportunities to targets the inactive and support lifelong engagement	Develop programmes for different levels of ability and desire with low/nil cost Increase access/touch points within the area to physically engage and signpost to partners, activities, and opportunities to enhance health and wellbeing Link worker project to increase communication and signposting (as above)

South Locality challenges	Actions planned What will we do?	How will we know?
Working together to improve everyone's understanding and commitment to improving their health and wellbeing through healthy diet, better nutrition and physical activities	Employ and embed link workers at the local level to increase sign posting capacity and knowledge of support networks and opportunities from the community and services	Surveys Publicly available and service data and information relating to poor diet and/or nutrition To ensure an appropriate evaluation plan is included in the link worker programme plan
	We will work alongside with partners such as, Sustainable Food Partnership Aberdeen to tackle local food poverty, obesity/diet-related ill-health and waste	Identify and deep understanding of currently unknown barriers such as, geographical, social, financial Highlight good practice, experiences and lessons learned from projects and activities Agree with partners to explore bold actions and innovative ideas
	Work with community and business leads/groups to develop and progress innovative ideas, for example social cooking, and increase in locally grown food. e.g. allotment market stall within the locality	Development of a home grown community market

	Work with partners' food in focus (Health Improvement Fund HIF) projects on impact across South Locality.	Evaluation of project and feedback of the impact Case studies

South Locality challenges	**Actions planned** What will we do?	**How will we know?**
To improve mental health & wellbeing (links to social isolation)	Further development of psychological therapies using a 'tiered model' within communities	Project evaluation. e.g. referral rates and successful outcomes
	Work with voluntary / 3rd Sector to support in times of emotional crisis; commencement of Penumbra Distress Brief Intervention support to GP practices and other partners such as police, out-of-hours services, emergency department in advancing this opportunity	Number of referrals; feedback from all partner and voluntary agencies Feedback from clients and relatives.
	Support access to wider services and identify gaps in existing provision and infrastructure	Increased use of community resources Link worker evaluation
	To explore work with individuals in communities to have a better understanding of personal networks that contribute to health and wellbeing To offer support and signposting information to 'points of contact' and existing activities in the community e.g. hairdresser, bar tender, shop owner (link worker project to aid communication)	Feedback from clients and relatives Case studies Link worker evaluation
	In support of the national campaigns, work to reduce stigma and increase openness of conversations about mental health and wellbeing, initially to establish a benchmark around current stigma with partners, for	Positive feedback and decrease stigmatisation from those suffering from mental health challenges via national research and local

	example, businesses, schools and services	feedback. Use of questionnaires at events Service information and data on mental health To utilise national resources where possible to implement locally e.g. SAMH (Scottish Association for Mental Health)
	Employ and embed link workers at the local level to increase signposting capacity and knowledge of support networks and opportunities from the community and services for mental health	Evaluation as per link worker programme

South Locality challenges	**Actions planned** What will we do?	**How will we know?**
To decrease social isolation and increase social inclusion	Work to understand the barriers, experience, needs and wants of those who may be experiencing isolation from their community, for example, community groups, local activities, befriending service, one-to-one links	Feedback and surveys e.g. household survey
	Identify and increase opportunities, skills and confidence based on above research	Increase in social opportunities and communication e.g. coffee clubs

South Locality challenges	**Actions planned** What will we do?	**How will we know?**
	Increase alcohol brief interventions which are evidenced to support reduction in alcohol harm	

To reduce alcohol misuse and its wider impact within the locality	Increase and develop locally available integrated alcohol and drug services with support from community and partners	Service information and data
	To increase signposting capacity and knowledge of broad range of support networks and opportunities in the community and other services for those with alcohol misuse e.g. frontline staff, communities, wider partners	Increased signposting and referrals
	Decrease stigma and perception of those with alcohol and substance misuse issues; increase communication and support; sharing up-to-date information, providing support around licensing and alcohol for community councils as statutory consultees and other groups who are active in the South Locality communities	Groups will be better informed and will feel more confident for active participation

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, third and independent sectors and other partners is having on the health and wellbeing of people living in the locality.

We will make sure that 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 use, carer and staff experience, case studies etc.

Public Consultation

This plan has been developed by the South LLG 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 LLGs 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

Emma	King	Head of Locality (Central) &
Alasdair	Jamieson, Dr	Chair LLG, Clinical Lead, South Locality ACHSCP & GP Kincorth & Cove
Jonathan	Smith	Vice Chair LLG, Civil Forum (Community Partner for Planning Partnership)
Nicola	Anderson	Nurse Service Manager, South Locality ACHSCP
Hilary	Benson	Carers Support Service Manager, VSA
Jane	Boyle	Senior Wellbeing Coordinator, Public Health and Wellbeing ACHSCP
Catriona	Cameron	AHP & Rehabilitation, Lead Physiotherapist South Locality ACHSCP
Liane	Cardno	Senior Analyst, Programme Support & Performance, South Locality ACHSCP
Neil	Clapperton	Independent Housing, Grampian Housing
Susie	Downie	Transformation Programme Mananger, ACHSCP
Gosia	Duncan	Enablement Trainer, Scottish Care
Iain	Duncan	Development Work Manager, Community Food Initiatives North East (cFine)
Kay	Dunn	Lead Planning Manaager (Capital and Services) ACHSCP
Jane	Fletcher	Clinical Services Manager, Learning Disabilities, Cornhill Hospital
Trevor	Gillespie	Team Manager Performance Manager, Aberdeen City Council
Norma	Groves	Representative for Kincorth Community Council
Susan	Harrold	Practice Development Manager, South Locality ACHSSCP
Alexandra (Sandra)	Low	Dental Clinical Lead, ACHSCP
Jo	Mackie	Service Manager - Communities and Partnership, Communities, Housing & Infrastructure, ACC
Cheryl	McCahery	Public Dental Service, South/West ACHSCP
Jenny	McCann	Senior Development Manager, Active Lifestyles, Sport Aberdeen
Iain	McKay	Wellbeing Coordinator, South Locality
Michelle	McPartlin	Chair of Cove & Altens Community Councils
Valerie	Maehle, Prof	Dean of Faculty of Health and Social Care at RGU.
Claire	Melvin	Deputy Head Optometrist / Aberdeen City Lead Optometrist
Leonora	Montgomery	Representative for City Centre Community Centre
Fay	Morrison	Representative for Torry Community Council
Tara	Murray	Operational Development Facilitator, ACHSCP
Donald	Newnham,	Unit Clinical Director for Elderly Care & Consultant

	Dr	Geriatrician
Keith	Nunn	Simeon Care for the Elderly
Paul	O'Connor	Chair of Garthdee Community Council; Mgr Inchgarth Community Centre, Director ACVO, Chair Community Council Forum
Shamini	Omnes	Public Health Coordinator, South Locality ACHSCP
Les	Petrie	Directorate Nurse Manager, NHS Grampian
Neil	Price	Independent Care Sector, My Care
Simon	Rayner	Development Manager, Adult Mental Health, RCH
Jane	Russell	Partnership Manager, ACVO TSI
Ann	Smith	Lead Pharmacist, South Locality ACHSCP
Graham	Soutar	Housing Manager, South Aberdeen, ACC
Stuart	Stephen	Unit Operational Manager, Medicine 5, Aberdeen Royal Infirmary
Julie	Suttar	Dementia Ambassador, Unit Manager, Balnagask House
Margaret	Waddell	Business Dev. Manager, Grampian Housing Association for Independent Housing Sector (for NC)
Sally	Wilkins	Aberdeen City Council
Jennifer	Wishart	Independent Care Home Providers, Aberdeen City

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, or 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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