Active Ageing Aberdeen Action Plan

Year One: 2026-27

Context

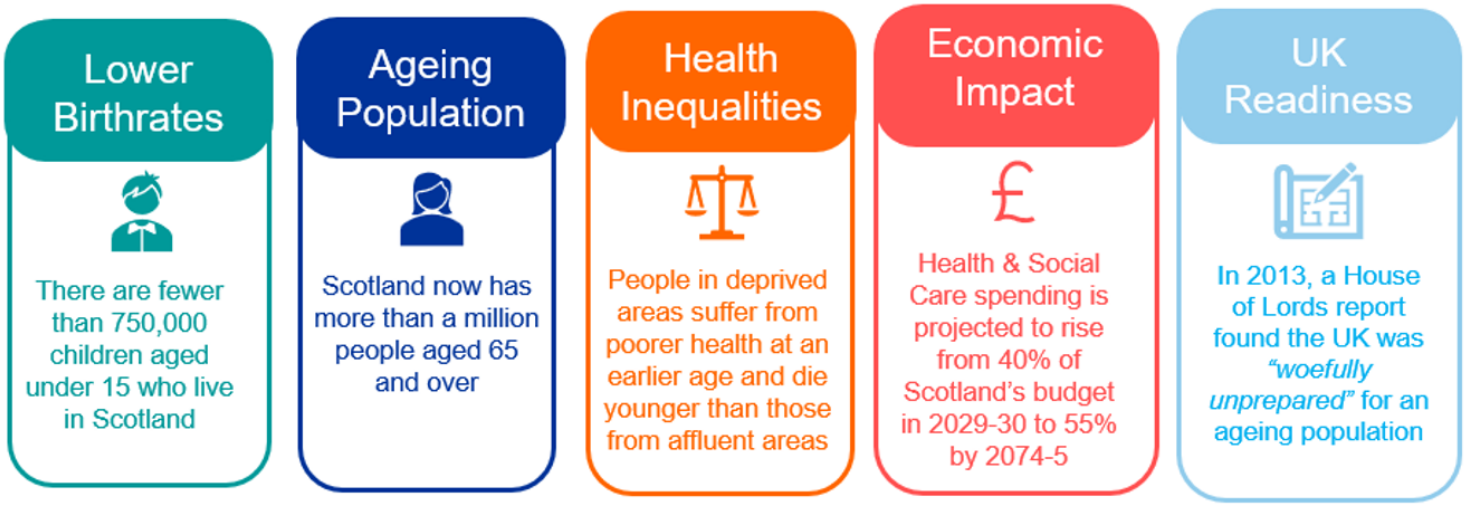
Active Ageing Aberdeen is a *whole systems approach* to ageing well launched by Aberdeen City Health and Social Care Partnership (ACHSCP) in collaboration with a range of partners including our Community Planning Partners; Third Sector organisations; academic institutions; faith groups, and local community groups across Aberdeen City. The aim of our active ageing approach is to enable Aberdonians aged between 45-75 to stay active, connected and independent as they age. This action plan supports delivery of ACHSCP's strategic priority to shift our focus towards prevention and early intervention.

Our Four Key Priorities

1. Promoting people's autonomy
2. Keeping people safe and independent at home
3. Improving quality of life
4. Increasing life expectancy

Why Action Matters: Key Data

Active Aging initiatives can help more people stay healthier and independent for longer which also reduces pressure on health and social care systems, strengthens productivity of the UK workforce, and improves national readiness for an ageing population.



How We Will Deliver Change

- We recognise we must work with our partners across the system to achieve bold and meaningful change

- We have put Prevention and Tackling Inequality at the heart of our Plan

- We will work together to influence and change local systems, policy, and practice

- Change will be delivered in different ways, through transformation, scaling up what works, integrating active ageing into important future plans, or helping to shift the focus in the wider health and social care system

- We will influence changes in attitudes, culture, and behaviours amongst professionals, across sectors, and at population level

- We will shape the places we live and work in by working with our partners and local communities to align resources around a shared vision across the whole system to deliver prevention-focused, inequality-reducing change that's trusted locally

Whole System Approach to Active Ageing

This action plan has been developed by following the six-phase model of a Whole System approach. The model; descriptions and associated key deliverables are outlined below:

Phase 1 Objective: Programme Set Up

Key Tasks: Secure high-level support; establish programme governance

Timescale: June– August 2025

Status: Complete

Phase 2 Objective: Build the Local Picture

Key Tasks: Active Ageing Working Group established; Review key local data

Timescale: August 2025 – September 2025

Status: Complete

Phase 3 Objective: Map the Local System

Key Tasks: Systems mapping undertaken; Action mapping undertaken

Timescale: October 2025 – January 2026

Status: Complete

Phase 4 Objective: Action

Key Tasks: Prioritisation undertaken; Action Plan developed, approved, and launched

Timescale: February 2026 – May 2026

Status: Complete

Phase 5 Objective: Manage the System Network

Key Tasks: Explore and implement system changes; Monitor impact

Timescale: June 2026 – April 2027

Status: Ongoing

Phase 6 Objective: Reflect and Refresh

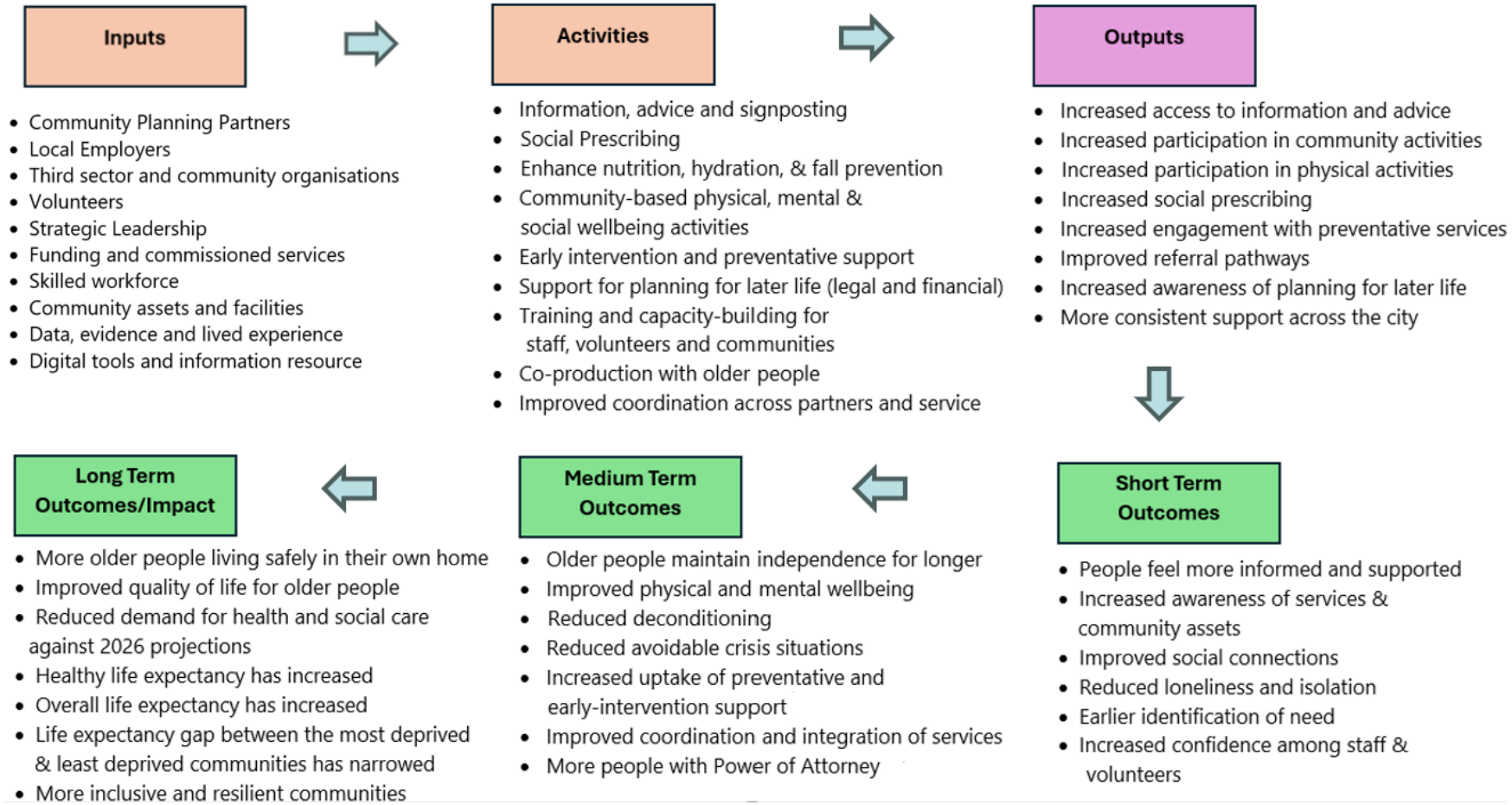
Key Tasks: Evaluate effectiveness; Review and refine action plan

Timescale: January 2027 onwards

Status: Not Started

Active Ageing Logic Model

A logic model is a simple way of showing how activities in our action plan are expected to lead to better outcomes for older people, such as staying healthy, connected, and independent for longer.



How this Plan had been Developed

This plan has been developed through a collaborative, evidence-informed process between June 2025 and April 2026. It brings together insight from people, services and communities across Aberdeen, alongside national and local data.

Development of the Plan included:

- A mapping exercise of the existing active ageing system in Aberdeen City
- A Stakeholder Workshop involving partners from health, social care, community planning, and third sector organisations
- Data gathering and analysis, drawing on:
- National datasets from Scottish Government and Public Health Scotland
- Aberdeen City Population Needs Assessment
- NHS Grampian Public Health data
- Data from Healthy Weight Aberdeen and Population Mental Health programmes
- Local data from services, community organisations and practitioners
- Prioritisation and refinement of key actions.
- Co-design of actions with partners, ensuring the plan aligns with the new Local Outcome Improvement Plan 2026-36, new Locality Plans 2026-36 and wider programmes across the city

This process ensured the Plan has been developed collaboratively, informed by local data and shaped by the people and organisations who support active ageing every day. However, we also know we can do better. A such we will keep listening to our partners and communities throughout the duration of this Plan and use their input to shape priorities for future years.

Our Active Ageing Action Plan

No.	Action	Key Priority	Lead Partner(s)
1.	Active ageing in long-term local planning decision making	Promoting People's Autonomy	Aberdeen City Council, Public Health
2.	Transition Towards Retirement	Promoting People's Autonomy	ACHSCP, Bon Accord Care
3.	Strengthen conditions that promote mental wellbeing for older adults	Keeping People Safe and Independent at Home	ACHSCP, NHS Grampian
4.	Community Appointment Days	Keeping People Safe and Independent at Home	ACHSCP, NHS Grampian, Sport Aberdeen, ACVO
5.	Post Diagnostic Support	Keeping People Safe and Independent at Home	ACHSCP, Chest Heart and Stroke Scotland, NHS Grampian, Sport Aberdeen
6.	Reablement	Keeping People Safe and Independent at Home	Bon Accord Care
7.	Menopause Support	Improving Quality of Life	ACHSCP, Bon Accord Care, NHS Grampian
8.	Physical Activity and Planning	Improving Quality of Life	Public Health, Aberdeen City Council, Nestrans, Active Aberdeen Partnership
9.	Falls Prevention	Increasing Life Expectancy	ACHSCP, Sport Aberdeen, ACVO, NHS Grampian
10.	Foot Health	Increasing Life Expectancy	ACHSCP
11.	Diet and Nutrition	Increasing Life Expectancy	ACHSCP

Priority 1: Promote Autonomy

Item 1. Active Ageing Incorporated into Long Term Local Planning Decision Making

Definition: Embed Active Ageing into the new Aberdeen City Local Development Plan 2028-38

Lead Partners: ACC Strategic Place Planning, NHSG and ACHSCP Public Health

Why this is important

Embedding active ageing into the new 10-year Aberdeen Local Development Plan is important. Planning with the aim of creating attractive, safe and accessible places improves the quality of life and wellbeing of individuals and communities and will shape how well people can live as they grow older. Well-designed places, with active travel, good neighbourhood design, walkable local facilities, access to natural and planned open space, and a good mix of homes affects people's ability to stay physically and mentally active, independent, and socially connected".

By building active ageing into the LDP from the outset, Aberdeen City can ensure new developments support healthy, accessible, and inclusive environments, rather than creating barriers that increase isolation, poor health, or dependence on services later in life. Embedding active ageing into the new LDP takes account of our ageing population and fully aligns with the purpose of Planning in Scotland to manage development and use of land in the long-term public interest. It is also important because it supports prevention and long-term sustainability across the system.

Well-designed places can promote physical and mental health, and reduce loneliness which helps people remain independent for longer and easing future pressure on health and social care services. This particularly meets three outcomes in the National Planning Framework 4: Improving the health and wellbeing of people living in Scotland; Improving equality and eliminating discrimination; and Meeting the housing needs of people living in Scotland, in particular, the housing needs for older people and disabled people. Embedding active ageing in the LDP provides a shared framework for planners, developers, and partners, aligning place-based decisions with health, social care, and community planning priorities and making active ageing a core part of how Aberdeen plans for its future.

What are we going to do?

Build on the established relationship between Aberdeen City Councils Strategic Place Planning service, and ACHSCP Public Health and NHSG as key stakeholders,

to shape the emerging Local Development Plan, review planning policy approaches, and determine how active ageing is embedded in the new 10-year plan.

Monitor the extant Local Development Plan's effectiveness

How will we measure success?

Key Measure	Target	Desired Direction of travel
Assign Public Health Practitioners to be key stakeholders in the development of the new Local Development Plan	Rota of Public Health Practitioners in place	⬆
Shape the planning policy approaches on how active ageing is embedded into the new 10-year Local Development Plan	Agreement reached on how active ageing will be embedded into LDP	⬆

Priority 1: Promote Autonomy

Item 2. Transition Towards Retirement

Definition: Develop active ageing pre-retirement guidance for managers and workforce development practitioners to better inform and support staff approaching retirement

Lead Partners: : ACHSCP, Bon Accord Care

Why this is important

Meeting with employees who are approaching retirement is important for both the individual and the organisation:

- To support employees to plan and make informed choices. A dedicated discussion gives employees space to talk through their intentions, timing, and options—such as full retirement, flexible retirement, or changes to hours or role—so they can make informed decisions rather than feeling rushed or uncertain.
- To plan handovers, knowledge transfer, and succession. Best practice guidance highlights the importance of early conversations to allow time for handover of skills, knowledge, and experience, and to support succession planning. This helps organisations manage workforce continuity and avoid sudden gaps in expertise when someone retires.
- To ensure pension and financial implications are understood. Employers play an important signposting role. Conversations can help employees access accurate information on pensions, benefits, and retirement planning resources, reducing anxiety and the risk of poor financial decisions.
- To support wellbeing and a positive transition. Pre-Retirement meetings allow employers to support a healthy, respectful transition, acknowledging contribution, discussing wellbeing needs, and ensuring people feel valued at the end of their working life.
- To listen to the employee's post retirement plans and explore opportunities for volunteering, mentorship, as well as leisure, community and civic participation to avoid social isolation
    - Reinforce the importance of remaining physically and mentally healthy into retirement to maintain quality of life, autonomy, and independence for as long as possible

What are we going to do?

- Build on existing employer retirement guidance, to include a greater focus on active ageing
- Develop enhanced guidance to be used by Managers at pre-retirement meetings and/or by HR/Workforce Development staff who deliver pre-retirement workshops for staff approaching retirement
- The enhanced guidance on active ageing would be based around the Five Ways to Wellbeing framework: Connection to avoid social isolation and loneliness; Get Active to improve physical health, strength, mobility and improve diet; Take Notice to maintain mental health and wellbeing; Learn to challenge yourself, to experience culture, and maintain cognitive health; and Give to increase rates of volunteering, mentorship, and sharing knowledge and experience with younger people
- The enhanced guidance would also cover preventative healthcare such as food, vitamins, vaccinations and screening programmes, how and where to access health and wellbeing support within the community; management of long-term conditions; information on being an unpaid carer and where to access support and resources; and importantly to encourage and signpost people to put essential legal documents in place such as Power of Attorney and Wills
- To present the enhanced guidance to Community Planning Aberdeen, the Responsible Business Network, and Third Sector Network with a recommendation to embed this into existing pre-retirement guidance for managers and staff approaching retirement

How will we measure success?

Key Measure	Target	Desired Direction of travel
Secure agreement across the Community Planning Partnership, Third Sector Network, and Responsible Business Network to incorporate enhanced pre-retirement guidance on active ageing into their existing guidance to support managers and staff approaching retirement	Guidance approved by CPP, Third Sector Network and Responsible Business Network	

Priority 2: Keep People Safe and Independent at Home

Item 3. Strengthen conditions that promote mental wellbeing for older adults

Definition: This priority recognises that social connection, confidence, physical health, independence and having a sense of purpose all play a major role in mental wellbeing as we get older. It prioritises early, preventative action to promote connection and reduce isolation, and to support cognitive health and emotional wellbeing

Lead Partners: ACHSCP and NHSG Public Health

Why this is important

Later life can be a positive and fulfilling stage of life, but it can also bring changes that increase the risk of poor mental wellbeing. These include bereavement, long-term health conditions, caring responsibilities, reduced mobility, loss of routine, and fewer opportunities for social connection.

When people begin to lose confidence, withdraw from activities, or become isolated, this can lead to emotional distress and contribute to cognitive decline. If these changes go unnoticed, people are more likely to experience worsening mental wellbeing and increased need for health and care services. Strengthening connections, purpose and support and noticing earlier when people start to become more isolated is a key prevention priority.

Cognitive health refers to memory, attention, learning, confidence and mental flexibility, supported through social connection, activity and participation.

Evidence consistently shows that:

- Maintaining social connection, routine and purpose protects wellbeing.
- Confidence, independence and feeling useful are important for mental health.
- Intergenerational relationships are protective for wellbeing.
- Loneliness and social isolation are strongly linked to poorer mental wellbeing.
- Inequalities in health and wellbeing persist into older age.

What are we going to do?

- Build a shared understanding of current activity that supports cognitive health and identify ways to promote good cognitive health through community and connection

- Clearer framing of cognitive health as part of mental wellbeing in later life.
- One or more test and learn improvements identified and trialled including a Community Appointment Day
- Clarify how Population Mental Health and Active Ageing connect
- Agreed shared priorities for Years 2–3 with Population Mental Health Group
- Continue to expand the Stay Well Stay Connected programme

This priority supports and strengthens delivery of:

- Population Mental Health Plan
- Local Outcome Improvement Plan (LOIP) 2026-2036
- Locality Plans 2026-2036
- Aberdeen City Health and Social Care Partnership Strategic Plan 2025-2029
- Community Learning and Development (CLD) Plan
- Third Sector and Community Provision including Community Mental Health Forum

How will we measure success?

Key Measure	Target	Desired Direction of travel
Adult mental wellbeing score (WEMWBS)	49.5 (2023)	↑
Increase older people's participation in the Stay Well Stay Connected programme by 10%	5523 (2025)	↑
Adults with symptoms of common mental health problems (GHQ-12)	18% (2023)	↓

Priority 2: Keep People Safe and Independent at Home

Item 4. Community Appointment Day

Definition: Deliver an Active Ageing Community Appointment Day

Lead Partners: ACHSCP, NHSG Putting People First, Sport Aberdeen, ACVO

Why this is important

An Active Ageing Community Appointment Day (CAD) would support to people in a way that feels accessible, local and practical, rather than expecting people to navigate multiple services on their own. Evidence from previous CADs shows that bringing services, third sector organisations and community supports together in one place makes it easier for people to get the right help at the right time, particularly when delivered in trusted, familiar community settings. For active ageing, this creates a welcoming environment where people can have conversations about staying healthy, connected and independent, without the formality or barriers often associated with traditional appointments.

CADs also support the shift towards prevention and early intervention, helping people to manage issues earlier, maintain independence, and avoid escalation to more intensive services. An active ageing-focused CAD would link people to physical activity, social connections, advice, and community assets in a single visit, helping to reduce isolation and improve overall health and wellbeing in line with our programme's core themes of Autonomy, Independence, Quality of Life, and Life Expectancy.
CADs help reinforce the message that ageing well is not something that *"just happens",* but something people can actively shape through everyday choices and early support. By offering practical conversations in an accessible setting, CADs encourage people to take ownership of their health and wellbeing and see active ageing as relevant and achievable at any stage of later life.

An Active Ageing CAD would also strengthen partnership working and deepen system integration. By aligning with existing community activity and events, CADs help embed active ageing into everyday local systems, making support more visible and joined-up, while also providing valuable learning and data to inform future service planning and delivery

What are we going to do?

- Plan and deliver an Active Ageing Community Appointment Day
- Align with existing CAD priorities of cardio-vascular health, women's health, chronic pain, and podiatry
- Hold What Matters to Me Conversations with attendees
- Conduct a full evaluation on the impact of the Community Appointment Day
- Report through the Putting People First Oversight Group

- Invite stall holders who can advise community members on the following:
- Sustaining employment and planning for retirement
- Pensions and Financial Inclusion
- Key legal documents such as Wills and Power of Attorney
- Preventative healthcare such as vaccinations, screenings, smoking cessation, gambling etc
- Physical Activity and Mental Health through primary care, support within the community, and social prescribing
- Nutrition, Diet, and Healthy Lifestyle
- Preventing Frailty and Falls
- Brain Health
- Support for Carers
- Using Digital Technology to improve quality of life and sustain independence at home
- Waiting Well for a procedure and Rehabilitation
- Housing Support, Adaptations, and Feeling Safe
- Lifelong Learning and Cultural Enrichment
- Participation in community or civic life, including volunteering and mentoring opportunities

How will we measure success?

Key Measure	Target	Desired Direction of travel
Deliver a dedicated Active Ageing Community Appointment Day in Aberdeen City with good community attendance	100 people attend	↑
Deliver an Active Ageing Community Appointment Day with services from across the system supporting the event	15 services attend	↑

Priority 2: Keep People Safe and Independent at Home

Item 5. Post Diagnostic Support

Definition: Set up a community-based Post Diagnostic Support Functional Fitness MOT pilot programme for people who have recently been diagnosed with dementia in Aberdeen City

Lead Partners: ACHSCP, Chest Heart and Stroke Scotland, NHSG Occupational Therapy, Sport Aberdeen

Why this is important

Providing post diagnostic support to people who have recently been diagnosed with dementia is critical because the period immediately after diagnosis is often marked by shock, uncertainty, and anxiety for both the individual and their family. Timely, structured support helps people understand their diagnosis, plan for the future, and access practical, emotional, and social support at an early stage. This can reduce distress, build confidence, and strengthen functional fitness to help people maintain independence for longer, while also supporting carers to cope and plan.

Post diagnostic support is a key early intervention approach which can reduce the risk of crisis, escalation, or unnecessary reliance on acute or long-term care services. Local data shows that 35 people per week are diagnosed with dementia in Aberdeen City. PDS is also crucial in preparing family members and carers on what to expect over time as the dementia becomes more advanced and where to access support and resources.

Post diagnostic support aligns strongly with an active ageing approach as it focuses on autonomy, independence, and quality of life rather than illness alone. By helping people living with dementia stay healthy, socially connected, informed, and engaged in their communities, post diagnostic support enables individuals to continue participating in everyday life and making decisions which matter to them. Embedding post diagnostic support within active ageing helps shift the system from reactive care to proactive support, supporting people to remain safe, independent, and connected for as long as possible.

What are we going to do?

- To adapt the Functional Fitness MOT model which has been successfully operating for 13 years in Aberdeen City to provide post diagnostic support (PDS) for people newly diagnosed with dementia in Aberdeen City
- The PDS Functional Fitness MOT model will be delivered by Chest Heart and Stroke Scotland (CHSS), Sport Aberdeen, and the ACHSCP Wellbeing Team.

People will be referred to the pilot programme by NHS Grampian's Occupational Therapy Team specialising in dementia

- A pilot programme will be delivered over three months to monitor uptake and learn lessons on how the programme is delivered and promoted, taking into account feedback from users, carers, and partners. Outcome measures will be set to determine the success of the pilot programme
- Sessions will be delivered on a monthly basis within community venues in priority neighbourhoods across Aberdeen City's three localities, and will involve the following:
- Participants will be given a Health MOT from CHSS to measure height, weight, and blood pressure, tested on physical and cognitive functionality by Sport Aberdeen, invited to draw up a physical health, lifestyle, and cognitive activity personal plan with the Wellbeing Team based around the Five Ways to Wellbeing framework, and then provided a tea/coffee as part of a wellbeing conversation to provide an opportunity to catch anything not covered during the previous three stages
- An evaluation will be conducted after three months to assess delivery of outcomes, and to inform decision making on whether to scale up the pilot programme.

How will we measure success?

Key Measure	Target	Desired Direction of travel
Newly diagnosed people with dementia are appropriately referred, and receive Post Diagnostic Support through the pilot programme	30 people supported	⬆

Priority 2: Keep People Safe and Independent at Home

Item 6. Reablement

Definition: Provide coordinated support enabling independence through improved responsive services, streamlined telecare, and timely assessments and interventions

Lead Partner: Bon Accord Care

Why this is important

Supporting older people to remain independent at home through early intervention and reablement helps people stay confident, active, and in control of their own lives for longer. As people age, changes such as reduced mobility, long-term health conditions or loss of confidence can gradually affect day-to-day functioning. If these early signs are noticed and supported quickly, reablement can help people relearn skills, adapt their routines and regain independence rather than becoming reliant on ongoing support. Key principles of enablement are:

- Encourages people to “do for yourself” rather than “doing for you”.
- Emphasis on what people can do rather than what they are unable to do.
- Improves quality of life by promoting engagement in support needs
- Ensures people’s views and choice are central to their support
- Improves communication to ensure views are fully understood

Early intervention, enablement and reablement also improve health and wellbeing outcomes by reducing the risk of decline, hospital admissions and social isolation. When people lose independence, they are more likely to withdraw from activities, experience loneliness and see their mental wellbeing worsen. Evidence within local plans show that maintaining routine, confidence and social connection protects wellbeing and supports cognitive health in later life. By focusing on practical, short-term support at the right time, reablement helps older people remain active in their communities and maintain purpose, rather than entering a cycle of dependency on formal care services.

From a system perspective, supporting independence at home through early intervention is also more sustainable and effective for health and social care services. Long-term care placements are often costly and can be avoided or delayed when people receive timely, preventative support in their own homes. Local programmes have already demonstrated that investment in home-based support, adaptations and preventative approaches strengthens outcomes while reducing pressure on hospitals and residential care. By shifting the focus from crisis response to early, preventative action, services can better meet growing demand while supporting older people to live well at home for as long as possible.

What are we going to do?

- Enhance the responsive services that enable independence for people we support
- Support safe, independent living by delivering essential home adaptations, guided by Occupational Therapy, Joint Equipment Store, the Bon Accord care Enablement Team and strengthened by a focus on reablement and enablement
- Utilise new technology to support independence and make homes safer through use of small pieces of consumable technology such as a smart plugs to switch on lights and curtain bots to close curtains
- Bon Accord Care has developed a structured framework, with associated training at each level. This supports staff to gain and apply the appropriate knowledge and skills, enabling them to promote enablement and re-ablement consistently at every opportunity. The objective this year is to embed this across the workforce and explore opportunities to work with partners to adopt this approach.
- Building on the successful pilot of overnight care with Grampian Care Consortium, which helped stabilise demand within the responder service, we will undertake a review of the responder service this year. This will include exploring opportunities to work more closely with reablement facilitators, particularly within the early intervention and prevention space

How will we measure success?

Key Measure	Target	Desired Direction of travel
Number of internal Bon Accord Care staff trained to appropriate level of Enablement Framework	85% of internal staff trained by April 2027	⬆
Enablement Framework shared with appropriate partners and buy-in secured	Endorsement of Enablement Framework by Care at Home Oversight Group by April 2027	⬆
Undertake a review of the Responder service this year. Explore opportunities to work closer with reablement facilitators, using early intervention and prevention approaches	Publish a revised Responder model by April 2027	⬆

Priority 3: Improve Quality of Life

Item 7. Menopause Support

Definition: Increase awareness of community support for women experiencing peri-menopause or menopause

Lead Partners: ACHSCP, Bon Accord Care NHS Grampian Community Nursing and Public Health

Why this is important

Supporting women experiencing menopause is important because it can have a real impact on health, confidence and day-to-day functioning. Symptoms such as fatigue, anxiety, sleep disruption and brain fog can affect how women feel and how they perform at work, often at a stage in life when they hold significant skills, experience and leadership roles. Menopause is also linked to a drop in oestrogen, which can reduce bone strength and increase the risk of osteoporosis and frailty in later life, making early awareness and support important for long-term health and independence. Without understanding and support, many women feel isolated or worry that their symptoms will be misunderstood or dismissed.

Providing the right support in the community helps women stay well, remain in work, and continue to contribute fully. Simple actions such as open conversations, informed managers, flexible working options and reasonable adjustments can make a meaningful difference. Creating a menopause-aware workplace normalises the conversation, reduces stigma, and ensures support is available early rather than only after problems escalate into absence or loss of confidence. Its important also to note that menopause doesn't just affect women, it can also affect relationships with partners, family members, friends and work colleagues.

Supporting menopause is also an equality, inclusion and workforce sustainability issue. Women should not be disadvantaged or forced out of work because of a natural life stage. By recognising menopause as part of the wider life course and wellbeing agenda, organisations show they value their people, retain experience, and create healthier, more supportive workplaces for everyone.

What are we going to do?

- Work with Primary Care services to refer women into community menopause support, including Women’s Health Community Appointment Days
- Integrate the SFA Power of Football Programme into business as usual for ACHSCP. Deliver 8-week menopause training courses to two local football clubs over the next 12 months in North and South localities
- Support delivery of community lunch clubs for women, and encourage establishment of other peer groups in the community

- Raise public awareness on the importance of strength training for women experiencing menopause to strengthen bones and prevent frailty later in life
- Use resources such as the AGILE brochure or platforms such as Wellbeing radio show on SHMU FM, the Grampian Wellbeing Festival in May 2026, and Aberdeen Women's Fayre in October 2026 to raise awareness of resources and support for women in the community
- Establish a community focussed system-wide Women's Health Group/Network in Aberdeen City
- Support the development of a Women's Health Plan for Grampian

How will we measure success?

Key Measure	Target	Desired Direction of travel
Deliver SFA Power of Football menopause training to women across Aberdeen City	16 women trained	↑
Deliver dedicated Women's Health Community Appointment Days (CAD)	2 CADs delivered	↑
Establish a system-wide Women's Health Group/Network for Aberdeen City or Grampian	System-wide group/network set up	↑

Priority 3: Improve Quality of Life

Item 8. Physical Activity and Planning

Definition: Promote and Support Physical Activity and Active Travel by Strengthening Local Policies (shared priority with Healthy Weight Aberdeen)

Lead Partners: NHS Grampian and ACHSCP Public Health, Aberdeen City Council, Nestrans, Active Aberdeen Partnership

Why this is important

According to the 2024 Scottish Health Survey, 62% of adults report they are meeting the recommended physical activity guidelines. There are 68% of children aged 5-15 reported to be meeting these guidelines. However, when using device-based measurements (that are more accurate than self-report), the percentage of individuals meeting the guidelines is markedly reduced.

Physical activity is not just important towards maintaining healthy weight. Active individuals have a 20-30% lower risk of premature mortality and chronic disease compared to inactive individuals. People who are more physically active also tend to have fewer hospital admissions and fewer consultations with Primary Care.

What are we going to do?

- Active Travel Action Plan 2021-2026: Prioritises more sustainable and carbon neutral forms of transport, such as walking and cycling. It provides an agreed policy for Active Travel interventions and allow for future projects to be progressed as suitable funding becomes available
- Local Transport strategy 2023-2030
- The Strategy for an Active Aberdeen Action Plan 2020
- Open Space Strategy and Natural Environment Strategy
- Aberdeen Planning Guidance Policy on: outdoor access; open spaces and green infrastructure; natural heritage; trees and woodland
- Land for nature (improvement charter linked to the LOIP) https://communityplanningaberdeen.org.uk/wp-content/uploads/2024/07/15.4-Charter-Land-for-Nature-Refresh-July-2024.pdf
- City Wide nature awareness campaign (linked to LOIP) https://communityplanningaberdeen.org.uk/wp-content/uploads/2024/07/15.1-Final-Project-charter-Nature-Awareness-Campaign-2024.pd
- Aberdeen Sport Facilities Strategy by Active Aberdeen Partnership
- Health Transport Action Plan

How will we measure success?

Key Measure	Target	Desired Direction of travel
Number of policies reviewed	TBC	⬆
Number of policies revised and updated	TBC	⬆
Number of stakeholder engagement and consultations	TBC	⬆
% of policies having delivery plan	TBC	⬆

Priority 4: Increase Life Expectancy

Item 9. Falls Prevention

Definition: Scale up the Stand Up to Falls programme within Aberdeen City to prevent older people from falling and being admitted to hospital

Lead Partners: Sport Aberdeen, ACHSCP, NHSG CAARS Team

Why this is important

Falls are a major cause of injury, loss of confidence, and rapid health decline in later life. Falls are the leading cause of emergency admissions for unintentional injuries for those aged 65 and over, with falls accounting for around 86-87% of such injuries. When older people experience a serious fall, it often leads to hospital admission, reduced mobility, and a higher risk of long-term conditions or early death. By scaling up falls prevention approaches such as Stand Up to Falls, the programme reduces avoidable harm and helps people maintain their physical health, independence, and resilience as they age.

Falls prevention also supports healthy life expectancy by slowing the progression into frailty and dependency. Avoiding falls means fewer hospital stays, less time spent inactive, and lower risk of complications such as infections or muscle loss. This aligns with the programme's preventative focus on keeping people active and living safely at home, rather than entering a cycle of crisis care.

At a population level, reducing falls helps narrow health inequalities and contributes to increased life expectancy across Aberdeen City. Falls disproportionately affect people living in deprived areas, where poor health and shorter life expectancy are already more common. Effective, community-based falls prevention such as Active Lifestyle classes supports healthier ageing in these communities and reduces preventable deaths. This directly supports wider city ambitions to increase healthy life expectancy and reduce the gap between the most and least deprived areas, reinforcing falls prevention as a practical and high-impact action within the Active Ageing programme.

What are we going to do?

- Scale up the existing Stand Up to Falls programme delivered in partnership by ACHSCP, Bon Accord Care, and Sport Aberdeen to engage older people to reduce their risk of falling through preventative measures such as: regular eyesight, hearing, and medication reviews, wearing appropriate footwear and looking after feet and bone health, nutrition and diet, keeping homes well-lit, clutter-free, and free from trip hazards and staying active to prevent muscle weakness and loss of balance. We will provide people with guidance on what to do when they've had a fall, including how to get themselves back up and how to request additional help.

- The “Super 6” strength and balance exercises and daily walking will be promoted as practical ways to stay steady and people will be encouraged to have a clear falls plan, including knowing how to get help, what to do if a fall happens, and managing their fear of falling.
- The Stand Up to Falls programme promotes prevention and early action rather than waiting until someone has already fallen or been injured; and facilitates social connection and wellbeing by enabling people to keep doing the things that matter to them.
- The programme also supports older people to access the reablement pathway and community-based support such physiotherapy, occupational therapy, telecare, and wellbeing services

How will we measure success?

Key Measure	Target	Desired Direction of travel
Increase the number of older people reached by the Stand Up to Falls programme by 10%	566 (2025)	⬆
Reduce the number of unscheduled general medicine and frailty admissions to ARI	3206 (Mar 25)	⬇
Reduce the average number of delayed discharges throughout the year in ARI for Aberdeen City residents	35 (2025-26)	⬇

Priority 4: Increase Life Expectancy

Item 10. Foot Health

Definition: Prevention of long-term foot problems and disease through early identification, education, self-management support and timely, well-coordinated access to podiatry and multidisciplinary care

Lead Partner: ACHSCP Podiatry Service

Why this is important

Early intervention in foot health is important because it can stop small problems leading to serious harm. In conditions such as diabetic foot disease, acting quickly through assessment and treatment can prevent ulcers, infection, and tissue damage, reducing the risk of hospital admission, amputation, or pre-mature death. Early support also helps with musculoskeletal foot and ankle conditions, preventing pain or stiffness from becoming long-term issues. Overall, this protects mobility, supports independence, and leads to better long-term outcomes for individuals.

Taking a preventative approach also reduces pressure on emergency and hospital services by addressing problems before they escalate. Timely care supports self-management, quicker recovery, and better patient experience, while lowering long-term complications and costs. Good foot health is essential for active ageing, as it helps older people stay mobile, confident, and socially engaged. By providing early and ongoing footcare, services can reduce falls, prevent decline, improve quality of life, support people to remain independent within their communities, and reduce escalation to hospital services.

What are we going to do?

Aberdeen City Podiatry will focus on preventing diabetic foot disease through early identification, education and proactive management. This includes working closely with primary care to support regular foot screening and risk assessment, timely access to podiatry for people at all risk levels, and clear education for patients on daily foot checks, appropriate footwear and when to seek help. Planned, responsive services and clear escalation pathways will support rapid referral to community podiatry and multidisciplinary foot teams, helping to prevent deterioration, reduce emergency admissions and improve outcomes.

The service will also support people to prevent musculoskeletal foot and ankle problems through accessible advice and self-management. This includes promoting safe physical activity, good footwear choices, gradual increases in exercise, and early recognition of warning signs such as ongoing pain, swelling or stiffness. By improving early access to advice and intervention, encouraging people not to push through pain, and supporting timely review and simple treatments, Aberdeen City Podiatry aims to

prevent minor issues becoming long-term conditions, helping people stay active, independent and reducing pressure on health services.

The service will educate the public on foot health, working, provide timely personal footcare (such as nail and skin care), and work with partners to ensure prompt referral to podiatry when concerns are identified. A strong focus will be made on early detection of pain, infection, pressure areas, and functional decline, particularly for those with long term conditions, reduced mobility, or difficulty with self-care.

How will we measure success?

Key Measure	Target	Desired Direction of travel
The number of emergency department attendances and unplanned hospital admissions for high risk foot complications direct from a Podiatry consultation	TBC	⬇
The percentage of people with diabetes who had a documented annual foot risk screening undertaken	TBC	⬆
Patient confidence in understanding why daily foot checks are important	TBC	⬆
Cost saving associated with managing foot conditions in the community and prevent referral to specialist services	TBC	⬆
The number of reported foot related problems linked with those who have experienced a fall	TBC	⬇

Priority 4: Increase Life Expectancy

Item 11.

Definition:

Lead Partners:

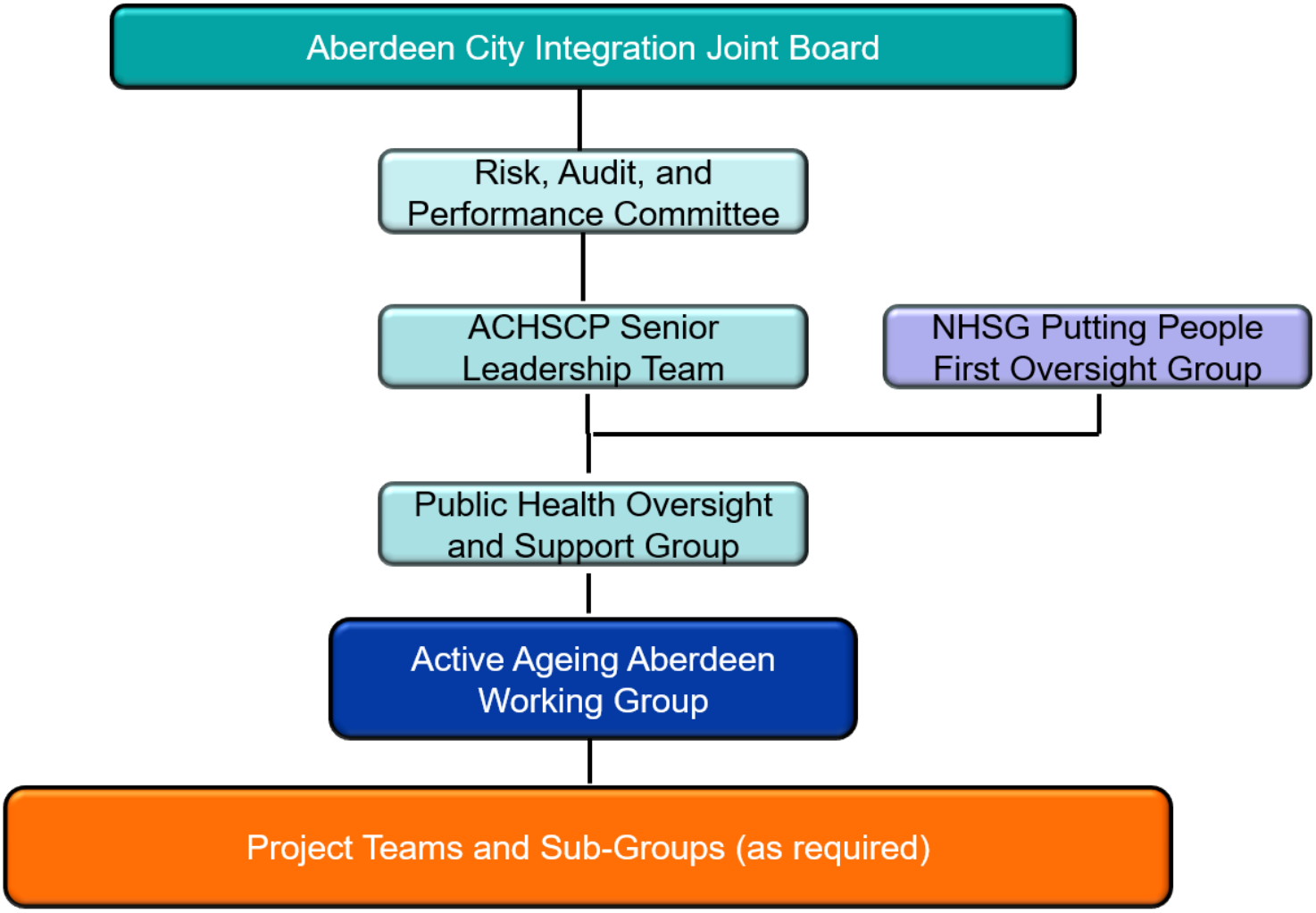
Why this is important

What are we going to do?

How will we measure success?

Key Measure	Target	Desired Direction of travel
		⬆

Programme Governance and Oversight



Aligned Programmes and Plans

- World Health Organisation Active Ageing: A Policy Framework (2014)
- Health Improvement Scotland Ageing and Frailty (2024)
- Local Outcome Improvement Plan 2026-36
- Locality Plans – North, South, and Central 2026-36
- Marmot Review Report – 'Fair Society, Healthy Lives' 2010
- Aberdeen City Population Needs Assessment
- Aberdeen City Health and Social Care Partnership Strategic Plan 2025-2029
- Healthy Weight Aberdeen Action Plan
- Aberdeen City Population Mental Health Action Plan
- Bon Accord Care Strategic Plan
- Stay Well Stay Connected programme
- NHS Grampian Plan for the Future 2022-32
- NHG Grampian Health Equity Plan 2022-28
- Aberdeen City Council Delivery Plan 2025-26
- Emerging Local Development Plan
- Local Transport Strategy
- Aberdeen City Council Play Strategy
- Public Health Scotland Strategic Plan to 2035
- Age Scotland 2025-2030 Strategy
- Centre for Ageing Better Strategy 2026-31
- Community Learning and Development (CLD) Plan
- Fairer Futures Partnership
- Third Sector and Community Provision including 3rd Sector Forum and community bodies