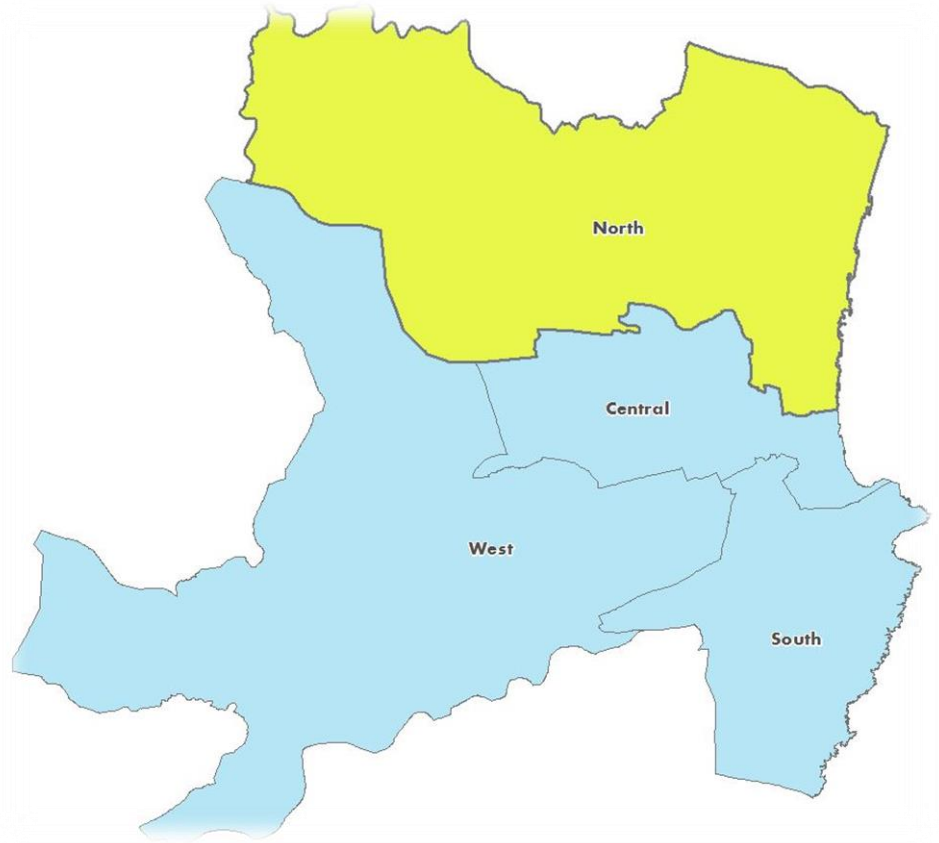
Aberdeen City Health & Social Care Partnership
A caring partnership

North Locality Plan
(2017 – 2019)



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Foreword

Localities underpinned by Legislative Guidance from Scottish Government have given us all an opportunity to bring together services and organisations such as Housing, Health, Social Care, Third and Independent Sectors and more, to partner with our local communities.

This North Aberdeen Locality plan has been drawn up by engaging with and listening to our communities and local organisations to capture our strengths, understand our challenges and identify what our priorities should be.

It is for us all to seize the opportunity to create synergies, forge alliances and partnerships and above all be creative, imaginative and audacious in the face of challenges.

Rajan Gupta

Chair LLG, North Locality

Executive Summary

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

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

To progress the transformation of services, ACHSCP has delineated the city into four localities and Locality Leadership Groups (LLGs) have been established in all of the 4 areas. The LLG has a key role in ensuring the delivery of 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 North Locality. It is for those who currently use health and social care services, and also those who may need to do so in the future. It is also for people who are well and wish to maintain or improve their current level of independence, health and wellbeing.

There is a vast amount of work happening across the North 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.

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 better outcomes. This method will underpin the partnership's approach to locality planning and projects moving forward within the community.

Our Vision

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

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

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

Our focus

- Demographic challenges, increasing demands on health and social care services and staffing recruitment and retention;
- Expanded primary care teams and test new models of primary care;
- Addressing infrastructure challenges due to new housing and impact on open/greenspace;
- Engage more with staff and communities especially with a focus on those who are seldom heard;
- Improve mental health and wellbeing;
- Prioritise and promote preventative measures;
- Unmet needs for those living with dementia;
- Transport links across the locality;
- Care at home provision for older people;
- Decrease social isolation experienced by people across the locality.

We also want to deliver locally based services that have a positive impact on the health and wellbeing of individuals, families and communities. The details of the above priorities for the area are included in the priorities section at the end of this document.

[2] Link to ACHSCP strategic plan 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 North Locality as part of the wider Aberdeen City Health and Social Care Partnership (ACHSCP)[3]. This includes our intentions around how we continue to fully integrate services with a locality or community focus. This is a live working document and will continue to evolve over the coming months.

This plan describes the intention of working together for the best possible outcomes for everyone living in the North 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 North 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 North Locality and examples of what is working well, as well as some of the key challenges which need to be addressed.

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

- Caring
- Person Centred
- Enabling

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

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

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

This plan is separate to the community planning undertaken by Community Planning Aberdeen[4] (CPA) which has a far wider remit. ACHSCP is a member of the CPA. Please note the localities, referred to by CPA, are specified areas within the city and have a generic focus on improving outcomes and inequalities for that particular area.

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

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

Health and Wellbeing Outcomes

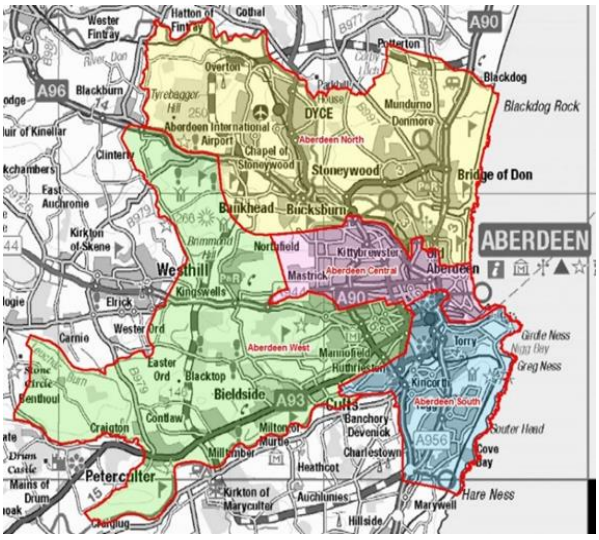
The Scottish Government has identified nine national health and wellbeing outcomes that the partnership must work towards. This plan identifies local priorities in the North Locality which will contribute to the achievement of these outcomes.

Scottish Government, Nine Health and Wellbeing Outcomes, 2014

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

What are health and social care localities?

All Health and Social Care Partnerships across Scotland are required under the legislation to develop localities to enable the effective planning and delivery of integrated 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 and work there. In Aberdeen Health and Social Care Partnership we have four localities – South, Central, West and **North (yellow 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, third and independent sector 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 Strategic Plan.

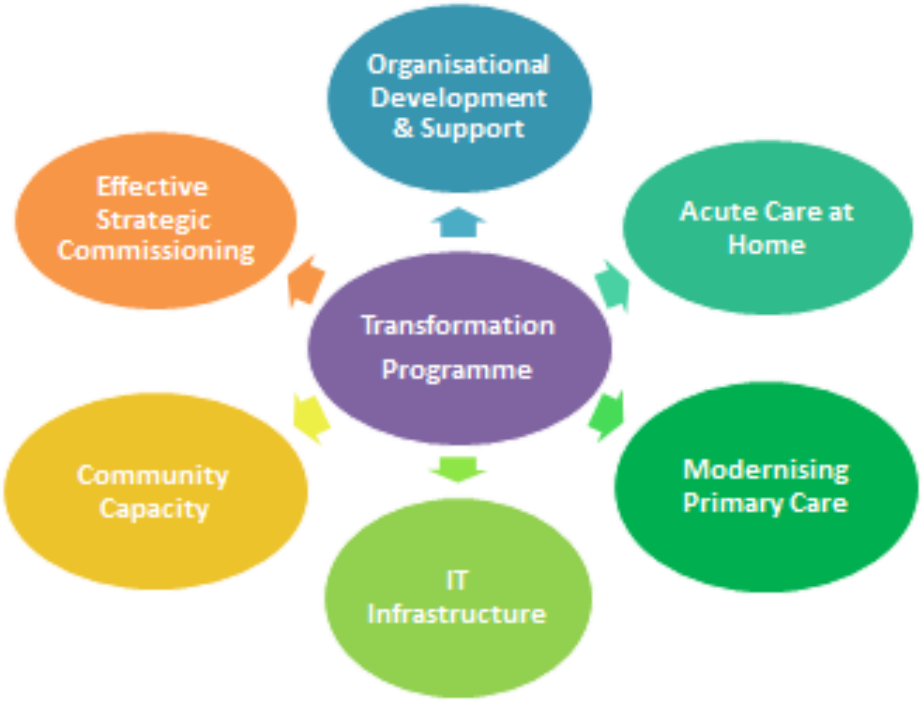
The role of the LLG includes developing and ensuring appropriate connections and partnerships across the locality to improve the health and wellbeing of the locality population and reduce the health inequalities that we know impact negatively on people's lives. The group works with services and communities 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.

Health and Social Care Transformation

A transformation programme for health and social care has been developed by the ACHSCP is 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 North Locality is essential to developing a good understanding of health and wellbeing in the area and what challenges and opportunities there are. Thinking about how people living and working in the North locality are purposefully able to participate and work to develop local plans, is at an early stage. This plan reflects the need to dedicate more time and resources to meaningful engagement with all of the communities within our locality, building on the good work done so far.

The development of the North Locality began with the formation of the Locality Leadership Group (LLG). It is attended by and has participation from a number of partner agencies, third sector organisations and community representatives. This plan reflects the need to dedicate more time and resources to meaningful engagement with our community in order to increase the level of participation of those who live in the locality.

We also need to engage more fully with staff that work and perhaps live in the locality to bring together their expertise in delivering health and social care with the expertise of those who live in the area as they know what the locality assets and needs are and any barriers that exist.

Some of the key points that came out of this engagement about what needs to be done to understand the North Locality and to plan the way forward were:

Key achievements of the LLG to date:

- The Locality Leadership Group held a 'kick off' event for the North Locality in September 2016. Attendees were asked to identify what assets there were in the locality to support health and wellbeing and identify some priorities moving forward. Approximately 30 people attended this event and a write-up of the event helped shape next steps.
- A Facebook page was created for the LLG.
- A community and engagement sub-group of the North Locality Leadership group was established with a keen membership including: public health and wellbeing, Allied Health Professionals, 3rd sector, nursing, independent sector and community representation. The purpose of the group was to develop a plan to engage with citizens and staff living and working in North Locality.
- 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 north asking what keeps people well, what the potential gaps are and the priorities moving forward. 205 questionnaires were completed, returned and summarised into key findings to

inform next steps. Contact details from the questionnaires were also used to further develop the community contacts list.

- Two workshops were held with the LLG (June and August 2017) to facilitate discussion on the health profile including how representative it was for people living and working in the north and what were the priorities and challenges presently and moving forward.
- Using the information from the questionnaire a community engagement event was held in September 2017 for all stakeholders in the North. 35 front line staff and representatives of the community attended where the health profile was presented and a world cafe format was used to discover the priorities for people living and working in the north. People were also asked to identify the assets they had that could contribute to improving health and wellbeing for all in the north.

Next steps include:

- Development of user-friendly resources that describe the partnership, localities and how people can get involved;
- Develop the use of media and other methods of sharing information e.g. use of community notice boards, key information shared through the various community newsletters, use of local community radio e.g.SHMU radio;
- Review membership of the Community Partners group – in particular how to get younger people involved;
- Take stock of work to date and consider next steps to best support the priorities within the locality action plan.

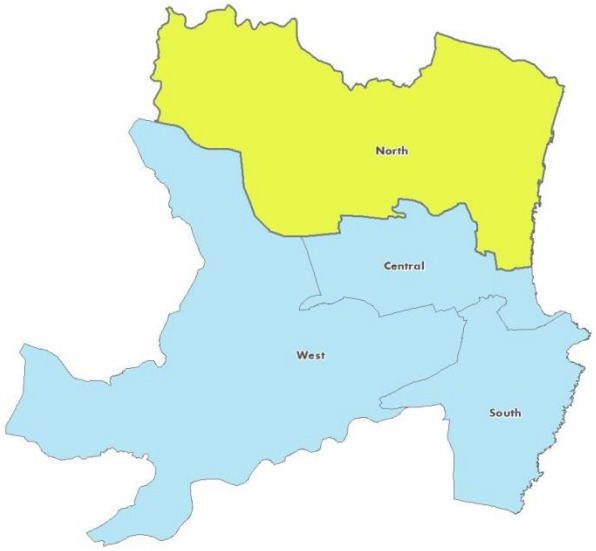
How will communities and professionals work together?

Co-production training was commissioned by the ACHSCP 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 North 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 (Community Food Initiatives North East). This project is looking for patient experts to support this to empower the local groups.

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

About North Locality



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

In many ways, health in Aberdeen City and in the North Locality has improved in recent times. Both men and women are living longer.

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

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

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

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

North Locality

The North Locality is made up of several defined neighbourhood areas including Dyce, Bucksburn, Danestone, Bridge of Don and Seaton. The area has generous access to open spaces including Aberdeen Beach and Seaton Park and shares a large boundary with Aberdeenshire. This results in people regularly travelling between the two for education, employment and recreation purposes. Aberdeen University sits just within the north boundary and is surrounded by distinctive cobbled streets and historic buildings

including Kings College and St. Machar Cathedral. The Cruickshank Botanic Garden is situated in Old Aberdeen on the King's College campus and is a partnership between the University and the Cruickshank Charitable Trust. Aberdeen Sports Village, the premier sports and exercise facility in Scotland, and Aberdeen Football Club's Pittodrie Stadium both sit within the locality boundary.

Aberdeen Airport is also within the North Locality area along with two large industrial estates in Bridge of Don and Dyce which comprise a large number of oil and gas employers. Seaton, (along with Tillydrone and Woodside in the Central Locality), is in one of three locality partnerships formed by Community Planning Aberdeen (CPA) in 2016. The eight neighbourhoods that are part of the CPA locality partnerships each have higher concentrations of multiple deprivations according to the Scottish Index of Multiple Deprivation (SIMD).

The North Locality is also serviced by a number of amenities including retail outlets, community and sports centres, places of worship and GP practices which are spread throughout the locality.

Locality Profile: Information and Data on the Locality

Who lives here?

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

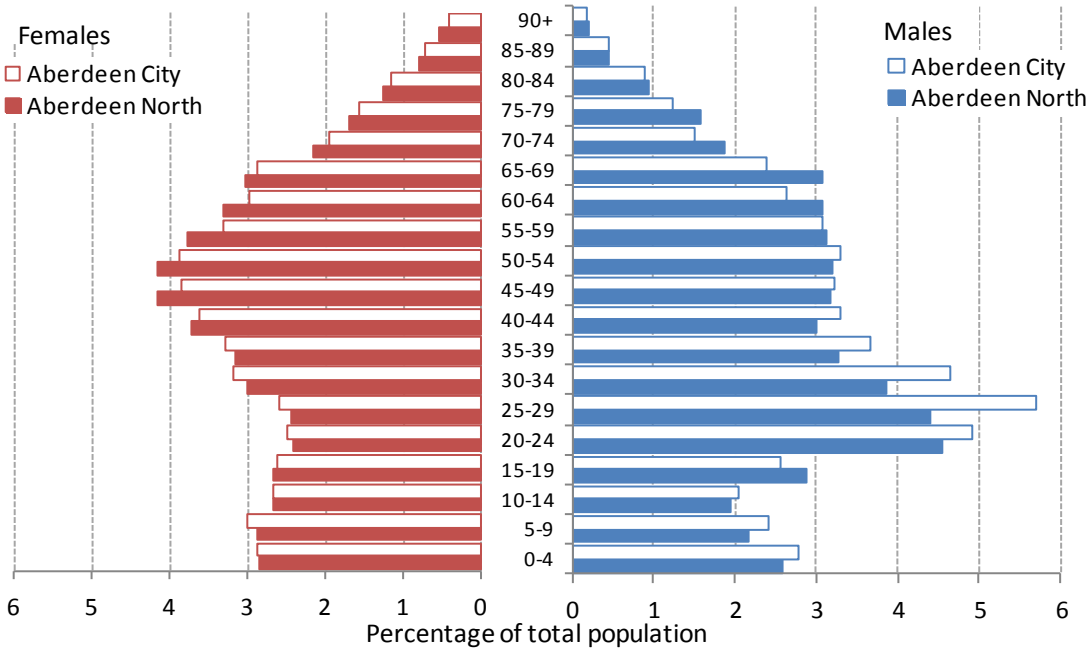


Fig. Aberdeen North and Aberdeen – Percentage of persons by 5-year age band and gender (National Records for Scotland, 2015)

45,452 people live in the North Locality, 20% of the Aberdeen population and is the smallest of all four localities;

There is a fairly even split of males and females;

A snapshot of the population in North Locality:

At the time of the 2011 Census:

There are just over 11,000 people aged 60 and over living in North Locality, 23% of Aberdeen's population;

Ethnicity

'Gypsy / Travellers' are officially recognised as an ethnic community whom have specific health and social care needs. They are protected by the Equality Act 2010 as one specific racial group. The Equality Act 2010 came into force in October 2010 and provides a legal framework to protect the rights of individuals and advance equality of opportunity for all.

12.3% (5440) of people spoke a language other than English at home;[5] with 1.8% over the age of 3 who did not speak English well or at all.

Households

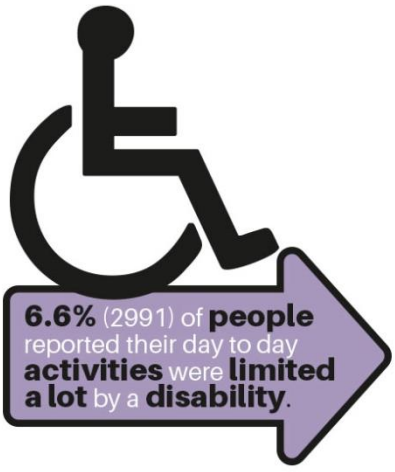
73% of people in the North Locality owned their own home. .

8% of the 19,434 households were overcrowded

Adults self-assessed health

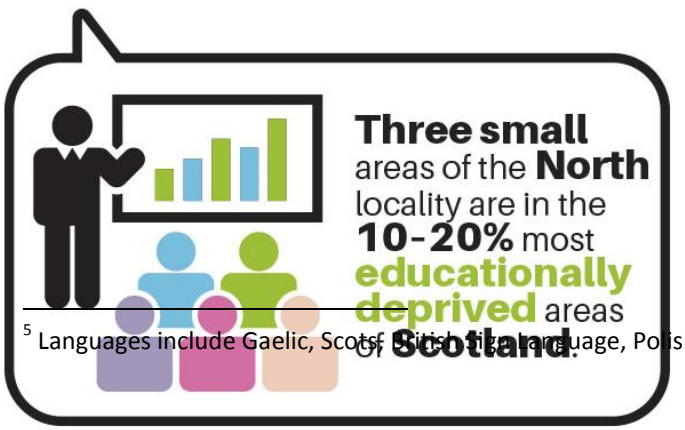
53.3% (2411) of people described themselves as being in very good health and although people reporting very good or good health falls with age; 47% of people aged 75+ still described their health as good or very good and a further 38.8% described their health as fair.

People limited by disability



Living conditions that contribute to health and wellbeing

Education



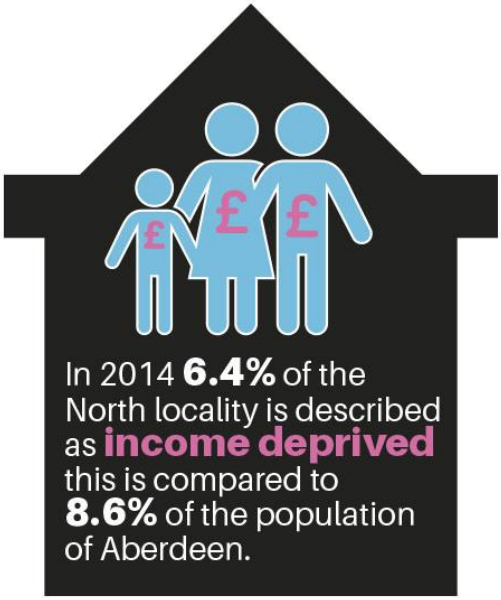
Three small areas in North Locality are in the 10 - 20% most education deprived areas of Scotland and they are in Old Aberdeen (3) and Seaton (2). This does not mean everyone living in these areas is education deprived. There are also

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

areas within North Locality where educational, skills and training is high.

Employment and Income

Percentage of claims for out of work has followed the city trend of a gradual reduction over the past decade. This doesn't necessarily reflect the impact of the most recent events in the oil and gas sector and changes in eligibility criteria for benefits. It is also difficult to determine whether this decrease reflects improvements in people's abilities to afford everyday goods and services.



In addition there are 6.2% of children living in poverty in the North locality compared to 10.2% City-wide average. This is the second lowest out of all four localities. One small area in Seaton is in the ten most income deprived areas of Aberdeen.[iii]

Housing

A number of small areas in North Locality are within the 5-10% most 'housing' deprived[6] areas of Scotland. These small areas are in Seaton (5) and Old Aberdeen (1). Again, this does not mean that everyone living in these small areas is 'housing' deprived.

Local assets for health and wellbeing

Assets or strengths 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:

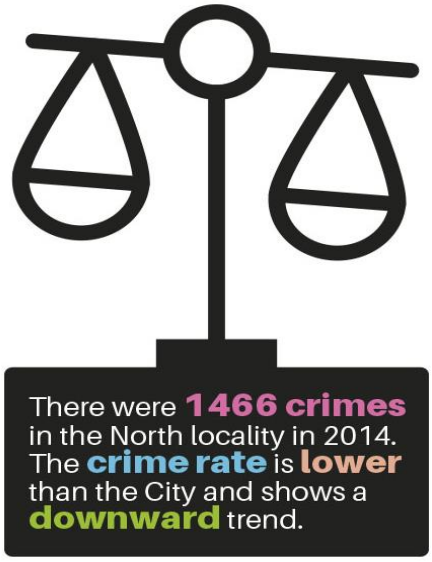
- A person: the stay-at-home parent who organises a playgroup; the informal neighbourhood leader; the community newsletter editor;
- A physical structure: a school, a GP practice, a town landmark; an unused building/room which could be used for community meetings/groups; and open space or park;
- A community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

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

Further work is planned during 2017/18 through a process of mapping, to further develop our understanding of all of our assets across the North 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 challenge.[iii]Several factors at a community level help to promote and maintain a person's physical and mental wellbeing[iv] 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.



The crime rate is lower than the city and shows a downward trend. Three small areas of Seaton (2) and Old Aberdeen (1) are in the 5-10% most deprived in the crime domain of 2016 SIMD.[iii] Some areas such as town centres or areas around a football stadium see large numbers of people at a particular time of day or day of the week or year and can be linked to an increase in crime.[v]

Physical Assets in North Locality

The North 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. These include services from the third and independent sector.

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

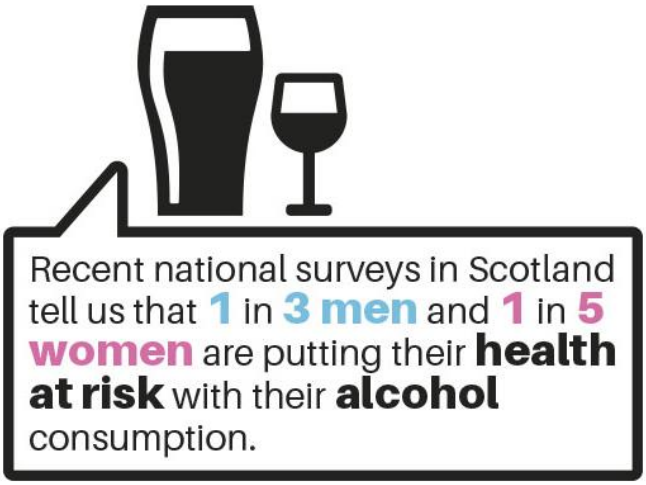
Category	Asset	Total Number
Health Services	GP Practices	7
	Community Pharmacies	7
	Health Centres Local authority flat at Seaton.	1 1
	Opticians	3

	Dental Practices:[7] Public Dental Service (PDS) or NHSG Specialist; Independent dentist (GDP) providing NHS Care	7 2 5
Social Care/ Housing	Care Homes – Older People	6
	Supported Living – People with Learning Disabilities	6
	Housing care and support	1
	Intermediate Care service	1
	Amenity Housing	2
	Sheltered Housing	7
	Very Sheltered Housing	2
Community	Places of worship	20
	Community Centres and Village Halls	5
	Sport and Leisure Facilities	11
	Libraries	5
Education	Primary Schools	12
	Secondary Schools	4
	Additional Support Needs	1
	Tertiary	1

Access to local amenities

Despite its location close to a large city, there are two small areas in the North Locality that are in the 10-15% most 'access deprived' of Aberdeen in 2014 meaning some people living there experience longer than average times to get to schools, GP practices, petrol stations, post office and retail centres either by car or public transport.[iii] These small areas form part of Dyce and Danestone. This does not mean that everyone living in these two areas is 'deprived' of access to essential amenities.

Health Behaviours



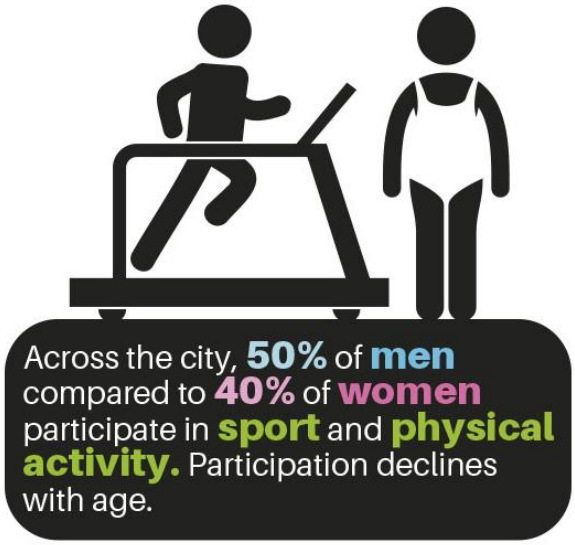
Alcohol

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

[7] 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.

The five year average rate of deaths from alcohol conditions in the north (2010-2014) was 18 per 100,000, lower than the city (city: 22 per 100,000 for same period) but showing a slight upward trend since 2002.

The rate of hospital stays from drinking alcohol was 616 per 100,000 in 2014/15 – again lower than the city but showing a slight upward trend compared to 2003/04.



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

Childhood

Child Obesity

7.6% of children were in the top 5% range for obesity; this is second lowest in the city.

This is the second highest of all four localities however by Primary 7; 56% of children were recorded with low-risk dental health, which was highest of all the localities.

Child immunisations have been declining recently, in line with the trend in the city.

Adulthood

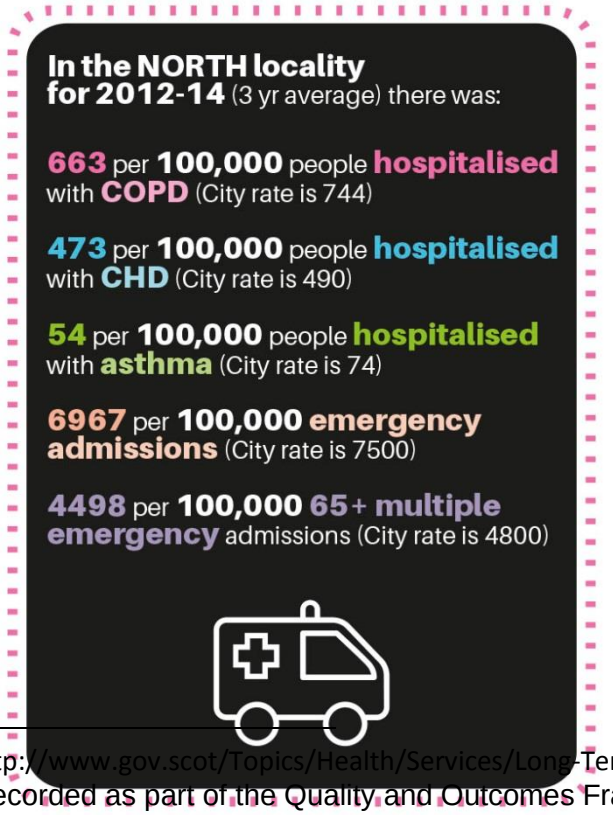
There was a 79% uptake of breast screening by women aged 50-70 years (3-yr avg, 2010-12) however this has been decreasing recently and although in line with a citywide picture the north has experienced a sharper downward trend.

57 early deaths from coronary heart disease per 100,000 population (3-yr average in under 75 year olds) – this has declined over the past decade but is slightly higher than the city.

Long-Term Conditions

Long-term conditions are health conditions that last a year or longer, impact on a person's quality of life and may require ongoing care and support. [8] They are now more common in the population and more people live with more than one condition. According to information[9] recorded about people registered with GP practices in the locality during 2015/16 the most common conditions were hypertension (high blood pressure), depression and asthma.

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



*COPD - Chronic obstructive pulmonary disorder

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

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

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

Mental Health & Wellbeing

In 2014/15 – 15.4% of the population was prescribed drugs for anxiety/depression/ psychosis compared to a city wide figure of 14.6%. This has risen across the City but greatest increase over 10 years has been in North.

Between 2009 – 2013 there were 9.9 per 100,000 suicides in the North Locality compared to 12.2 per 100,000 for the city as a whole.

There were 96 people on average per year who were admitted to a psychiatric hospital (2011-2013 3 year average per 100,000 pop).

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

Local Services and Resources

Aberdeen Health and Social Care Partnership is responsible for the delivery of health and social care services across Aberdeen. 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 ACHSCP, while other services, mainly in adult social care and some of the mental health and learning disability services are delivered by other providers through commissioned services. Third and Independent 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 North locality have access to. It is important to remember that some services will be delivered at a very local level while others will be part of a 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 sector, other partners and stakeholders and the established Locality Leadership Groups (LLGs) to explore how we develop more integrated services and to test out new ways of working.

Primary care services

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

Current challenges facing primary care include:

- Recruitment, which is a national as well as a local issue; more GPs are working part-time due to the increasingly demanding nature of the job; many staff are retiring early; in some practices GPs have been replaced with other health professionals including pharmacists and nurse practitioners.
- IT; the hardware used in primary care is becoming obsolete, with frequent problems which are very disruptive both to staff and patients as all records are electronic. There remain difficulties with software systems not talking to each other which reduces the potential for information sharing across sectors.

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

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

General Practice

There are seven GP practices within the North Locality – New Dyce Medical Practice, Scotstown Medical Practice, Danestone Medical Practice, Gilbert Road Medical Practice, Bucksburn Medical Practice, Old Aberdeen Medical Practice and Oldmachar Medical Practice. The practices cover a wide geographical area.

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

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

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

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

Community Nursing

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

Each of the practices in the North 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 7 DDTs covering Aberdeen City on a geographical basis. 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, there will be test areas (Cove, Peterculter) 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. Once tested this will be rolled out across the city (see page 10).

Allied Health Professionals (AHPs)

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

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

In the North Locality area, AHP out-patient services are delivered from a number of locations. Services in these locations are not restricted to people from the geographical

area but are available to people living anywhere in the city and where appropriate can be accessed by people who live in Aberdeenshire or Moray:

- Dyce – physiotherapy, dietetics, podiatry
- Bucksburn Health Centre – speech and language therapy (SLT) (Children's), dietetics, podiatry
- Brimmond (Inverurie Road) – dietetics
- Bucksburn Academy ASN Wing – SLT, additional support needs (ASN)
- Bridge of Don Health Centre – SLT physiotherapy, dietetics, podiatry
- Oldmachar Sports Centre – falls exercise class
- Jesmond Centre – podiatry
- Seaton Clinic – dietetics, podiatry
- Tillydrone Clinic- SLT, podiatry
- Woodside Community Centre – pulmonary rehabilitation
- Orchard Brae School and Nursery - SLT
- Clashieknowe Intermediate Care– community physiotherapy in-reach

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 rehabilitation service into Clashieknowe Intermediate Care facility which is based in Bridge of Don.

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

Pharmacy

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

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

Community pharmacies are very accessible and a 'no appointment necessary' service, advising on managing illness (self-care) and improving health, is always available. Unlike General Practice, people do not need to register with a specific community

pharmacy but can choose to attend any pharmacy they wish. There are 51 community pharmacies across Aberdeen City.

In addition to services provided by community pharmacies, there are practice-based pharmacists working with all GP practices in the North 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 assist people to lead fulfilling lives with 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 frailty 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 who is appropriate/ 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 a small team of Domestic Abuse Support Workers, who are able to offer a service to women at risk who are not (yet) involved in the Caledonian Programme.

Oral Health and Dental Care

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

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

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

and are supported by the PDS and independent dental practices that provide NHS services

Optometry in Aberdeen City

Optometrists were historically referred to as ophthalmic opticians. Optometrists are trained professionals who are able to examine your eyes, give advice on visual problems, prescribe and fit glasses, contact lenses or visual aids and recognise eye disease. There are 20 optometry practices across Aberdeen City providing NHS general ophthalmic services. Everyone in Scotland is eligible for a fully-funded comprehensive NHS primary eye examination appropriate to the patients' needs.

Eye Health Network

NHS Grampian's Eye Health Network was formed in 2007 to improve access to eye care services across the Health Board area. Historically eye care has been delivered almost exclusively within a hospital setting. The Eye Health Network has taken a fresh look at eye care delivery, looked at who may be effective in providing care and taken a joined up approach to share care and responsibility across the network. The Eye Health Network consists of approx. 55 Optometry practices spread across NHS Grampian, the Department of Ophthalmology at Aberdeen Royal Infirmary and Dr Gray's Hospital, Elgin. They work in association with General Medical Practice and Pharmacy to have the patient seen by an eye care professional who is best placed to provide appropriate care.

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

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

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

Finance

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

the strategic plan. In reality the whole budget is available to integrate, change and transform.

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

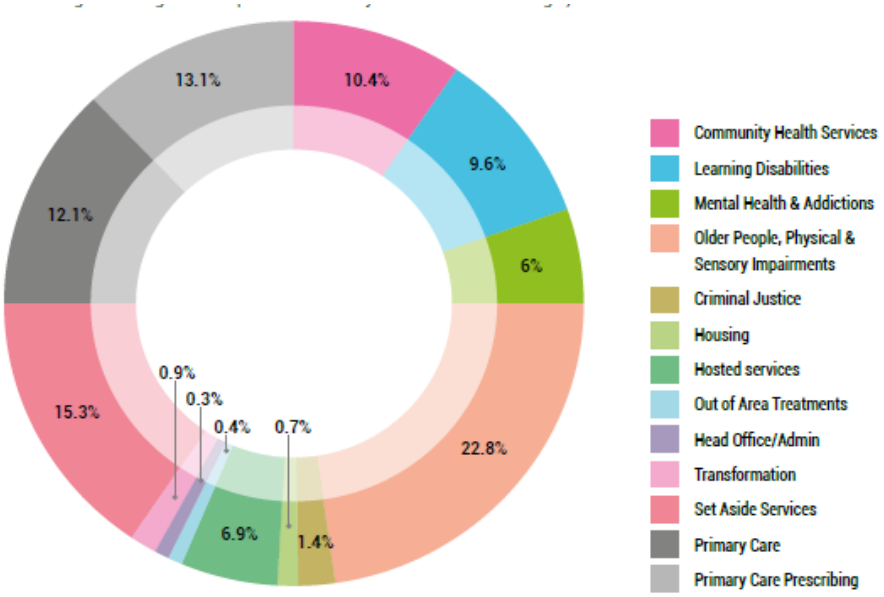
Service	Gross Expenditure (£)
Community Health Services	31,649,313
Learning Disabilities	29,264,461
Mental Health & Addictions	18,304,741
Older People, Physical & Sensory Impairments	69,719,818
Criminal Justice	4,413,345
Housing	2,197,288
Primary Care	36,846,589
Primary Care Prescribing	40,125,916
Hosted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

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

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

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

How do we spend our budget?



ACHSCP Annual Report 2016-17, Service Expenditure as percentage spend

What's Working Well Right Now?

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

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

- Volunteers and community champions
- Lunch clubs
- Community centres – Danestone and partnership with GP practice
- Support networks from places of worship
- Men's Shed – one established in Dyce and planning group set up for Bridge of Don
- EncourAGE project in Dyce

The Living Well Café

”I feel I belong here!”

“The café provides a sense of purpose for the day” “People are so kind and friendly!”

The Living Well Café has been set up to support people at the early stage of dementia and their carers. The café has been running in two venues in north. It is an open and friendly space for people with dementia and their families to meet in informal settings and to encourage social support. They offer a range of enjoyable activities providing general stimulation for thinking, concentration and memory in a friendly social setting with a fantastic group of volunteers.

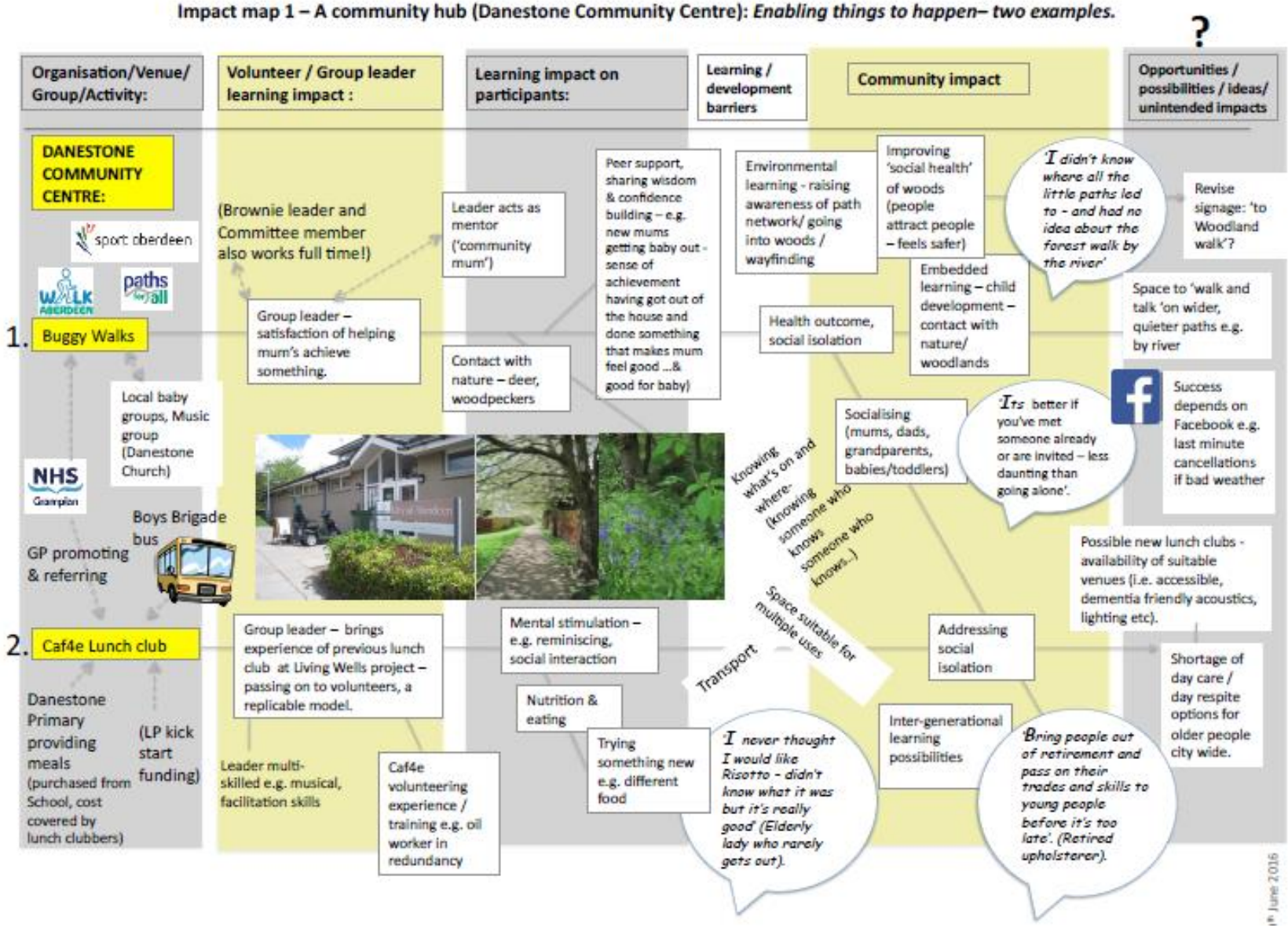
“It is often a social outing with no expectation or pressure to achieve an outcome. The café provides pleasant surroundings and people. Arrive home relaxed and happy. An afternoon to look forward to.”

The Living Well Café aims to promote a healthy daily living, participation in social activities and also reduce the burden on the care giver by creating a space of informal, friendly and listening environment. They have a very dedicated group of volunteers to support and encourage people with dementia and their carers to be positive in coping with daily life.

“We both enjoy meeting and talking with others in a warm, relaxed and accepting atmosphere. My husband loves singing and the “fly cup”!”

Please see over page example of the work being done in the community; Danestone Community Centre created an impact map to visualise and communicate the work in ‘Enabling things to happen’.

Impact map 1 – A community hub (Danestone Community Centre): *Enabling things to happen– two examples.*



Known Challenges in the North

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

During the span of this locality plan there are areas that we need to further develop our understanding of. We will use the information we gather to inform how we can make the most efficient and effective use of our collective resources across health and social care services. It is recognised that good communication and involvement is essential to ensuring the locality can achieve its identified priorities. Meaningful engagement with members of the locality who are seldom heard is crucial.

From the locality profile information and the engagement work we have carried out so far with people who live and work in the North Locality, the following priorities have emerged;

- demographic challenges, increasing demands on health and social care services and staffing recruitment and retention;
- infrastructure challenges in the area due to new housing and impact on open/greenspace;
- how to engage more with communities and staff using a co-productive approach;
- increased prevalence of poorer mental health across the locality and impact of downturn in oil and gas sector;
- the need to prioritise and promote preventative measures to support health and wellbeing within the population;
- transport links across the locality;
- challenges in provision of personal care including home carers particularly in Dyce and Bucksburn, respite care and appropriate housing provision for older people;
- social isolation experienced by people across the locality.

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

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

North Locality Priorities: 2017 – 2019

This high-level plan sets out the priorities for the North 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, North 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.

North Locality challenges	**Actions planned** What will we do?	**How will we know?**
Demographic challenges, increasing demands on health and social care services and staffing recruitment and retention New Dyce practice is a new 10,000 patient practice set up in 2015 to sustain and deliver primary care services with expanded primary care teams and continues to test new models of primary care. This was in response to a local North cluster practice failing and handing over its contract Infrastructure challenges in the area due to new housing and impact on	• Collaborative working between Primary Care Practices /General Practices would be scoped and Triage Hub supporting up to 30,000 patients would be an aspiration subject to resources for transformation and desire of practices to work together • Connect with north corridor project	Scoping of possible triage hub undertaken North corridor project standing item on LLG agenda and representatives from LLG on project board

open/greenspace		
How to engage more with staff and communities especially with a focus on those who are seldom heard	• Asset mapping – build on work done to date to map the assets of the locality • Investigate potential to work in partnership with community assets e.g. Libraries, schools to promote health and wellbeing • Further develop the sub-group and build on the work to date to develop a longer term plan to engage front line staff and citizens with health and social care using a range of tools e.g. newsletters, use of social media etc. • Develop a health improvement network with local champions that will share practice, identify solutions and grow good examples of work funded through the Health Improvement Fund • Develop user-friendly core information about the Health and Social Care Partnership and how people can get involved	• Asset Map in place • Community Engagement Plan in place • A health improvement network in place • Easy-read information available
Concerns raised at different levels with regard to mental health and wellbeing across the locality	• Identify, discuss and address the possible causes of poorer mental health, the gaps in provision and barriers to accessing services • Further explore partnership working to support mental wellbeing within the locality including through the 3rd sector, Aberdeen University, community learning and schools	• Mapped causes of poor mental health including gaps and barriers
The need to prioritise and promote	• Explore any issues regarding participation in	Issues discussed and mapped

preventative measures to support health and wellbeing taking a cross-population approach.	screening programmes and encourage uptake • Explore use of alcohol across the locality • Explore how we support active ageing across the locality e.g. development of a self-management tool • Development of falls prevention (testing co-production model) • Support breastfeeding across the locality and in particular Seaton	and possible solutions identified • Appropriate evaluation plan incorporated into project plan • Local access to prevention interventions • Increase in breastfeeding activity/support throughout the locality e.g. breastfeeding welcome scheme
Identifying unmet need with regards dementia and influence the City's dementia strategy moving forward	• Explore how we support people and families with dementia	• Unmet need mapped and possible solutions identified
Transport links across the locality	• Understand the specific issues related to getting about in the locality	• Issues with regards to transport mapped across locality
Challenges in provision of care at home particularly in Dyce and Bucksburn, nursing respite care and appropriate housing provision for older people and homeless.	• Explore and understand the challenges and engage stakeholders • Link in with new acute care at home team	• Challenges mapped and potential solutions identified
Social isolation experienced by people across the locality	• Understand the extent and nature of social isolation and identify possible solutions working with communities • Explore how we support successful projects to become sustainable in the long term	• Social isolation mapped and possible solutions identified • Case study used to identify how successful projects are supported to be sustainable

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 consistent approach across all four localities and the wider partnership.

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

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

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

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

Public Consultation

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

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

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

The final plans are approved by the IJB.

Current LLG Membership

Anne	**McKenzie**	Head of Locality (North)
Rajan	**Gupta (Dr)**	LLG Chair, Clinical Lead, North Locality ACHSCP & GP Scotstown
Beth	**Thomson**	LLG Vice Chair, Lead Occupation Therapist, AHP Service, ACHSCP
Louise	Argo	Wellbeing Coordinator North, Public Health and Wellbeing ACHSCP
Helen	Beattie	Public Dental Service, Locality Support Mgr, ACHSCP
Laura	Borg	Wellbeing Coordinator, Public Health and Wellbeing ACHSCP
Jane	*Boyle*	*Senior Wellbeing Coordinator, Public Health & Wellbeing*
Graham	Donald	Community Development Officer, Community Housing and Infastructure, Locality 3
Susie	Downie	Transformation Programme Manager, ACHSCP
Gosia	Duncan	Enablement Trainer, Scottish Care
Jane	Fletcher	Clinical Services Mgr, Learning Disabilities, RCH
Trevor	Gillespie	Team Mgr Performance Management, ACHSCP
Irene	Jessiman	Unit Operational Manager, Medicine 2, ARI
Lyndsay	Johnstone	Manager, Danestone Community Centre
Joan	*MacLeod*	*Lead Pharmacist, North Locality, ACHSCP*
Madelene	MacSween	Development Manager, Communities, Housing and Infrastructure
Jeanette	Maitland	*Volunteer, Alzheimer Scotland*
Elaine	McConnachie	Public Health Coordinator, North Locality, ACHSCP
Caroline	McCormack (Dr)	Consultant Physician, Medicine for the Elderly, ARI
Claire	Melvin	Deputy Head Optometrist/Optometry Lead City ACHSCP
Fiona	Nairn	Development Facilitator, North Locality, ACHSCP
Les	Petrie	Directorate Nurse Mgr, Child & Adolescent Mental Hlth & Older Adults Mental Hlth
Linda	Press	Nursing Service Manager, ACHSCP
Jen	Rae	Social Work Services Manager
Hazel	Reid	Carer Advisor, VSA
Emma	Ross	Service Manager, Older Peoples Services, Care Management
Jane	Russell	Partnership Manager, ACVO TSI
John	Swinton (Prof)	Chair of Divinity & Religious Studies, Aberdeen University
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Helen	Young	Prepresentative for Bridge of Done Community Council
Vacancy	PC Manager	Practice Development Manager, North Locality, ACHSCP

Glossary of Commonly used Terms and Acronyms

ACC	Aberdeen City Council
Co-production	Combining the mutual strengths of professionals and services users so that they can work with one another on an equal basis to achieve positive change
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, which 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	A team made up of professionals across health, social care and Third Sector who work together to address the holistic needs of

Team (MDT)	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	An approach to working with people which respects and values the 44 uniqueness of the individual and puts the individual's needs and aspirations firmly at the centre of the process.
Personal Outcomes	Personal outcomes are about the impact or end result of services, support or activity on a person's life
Primary Care	Health care provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment. Main primary care services are provided by GP practices, dental practices, community pharmacies and high street optometrists, as well as community nurses and Allied Health Professionals.
Prevention	Primary prevention includes health promotion and requires action on the determinants of health to prevent disease occurring. It has been described as refocusing upstream to stop people falling in to the waters of disease. Secondary prevention is essentially the early detection of disease, followed by appropriate intervention, such as health promotion or treatment. Tertiary prevention aims to reduce the impact of the disease and promote quality of life through active rehabilitation.
Reablement	Giving people the opportunity and confidence to relearn/regain skills they may have lost as a result of poor health, disability, impairment, in hospital or care homes.
Rehab / Rehabilitation	A process restoring personal autonomy to those aspects of daily life considered most relevant by service users, their families and carers
Self-Management	Encouraging people with health and social care needs to learn about their condition and remain in control of their own health
Strategic Plan	The Strategic Plan is the statement of intent of how integrated health and social care services will work towards attaining the national health and wellbeing outcomes over the next three years
Social Inclusion	The provision of certain rights to all individuals and groups in society, such as employment, adequate housing, health care, education and training.
Social Prescribing	Linking people up to non-medical sources of support and activities in the community that they might benefit from
Third Sector	Organisations that are independent from statutory agencies and provide social or environmental benefit and which do not distribute profits.

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