Aberdeen City Health and Social Care Partnership

Annual Performance Report 2024-2025

NHS Grampian

ABERDEEN CITY COUNCIL

Aberdeen City Health & Social Care Partnership

A caring partnership

Foreword

Welcome to the Annual Performance Report for 2024-2025. This year has been an incredibly busy and demanding one for the Aberdeen City Health and Social Care Partnership. As the report demonstrates, we have achieved many successes over the past 12 months, and I am immensely proud of the hard work and dedication of our teams and services.

Among our key milestones this year was the introduction of new services at Countesswells, such as the provision of Community Treatment and Care (CTAC), childhood immunisations, and Health Visiting services. We have also embraced digital innovations, such as the pilot of an electronic Medical Administration Record (eMAR) at one of our in house learning disability services. This is already showing how we can save staff time and deliver services more efficiently and safely. In addition, we have transformed the Hospital Social Work team by aligning them with hospital wards to ensure more timely discharges home.

New initiatives, such as Community Appointment Days and the Healthy Weight Aberdeen collaboration, have been crucial in advancing our prevention agenda. These efforts are key to helping people maintain good health and reducing future demand for services. Despite these achievements, financial challenges have made it necessary to reprioritise, resulting in the pausing or cessation of some initiatives to ensure resources are directed towards frontline services.

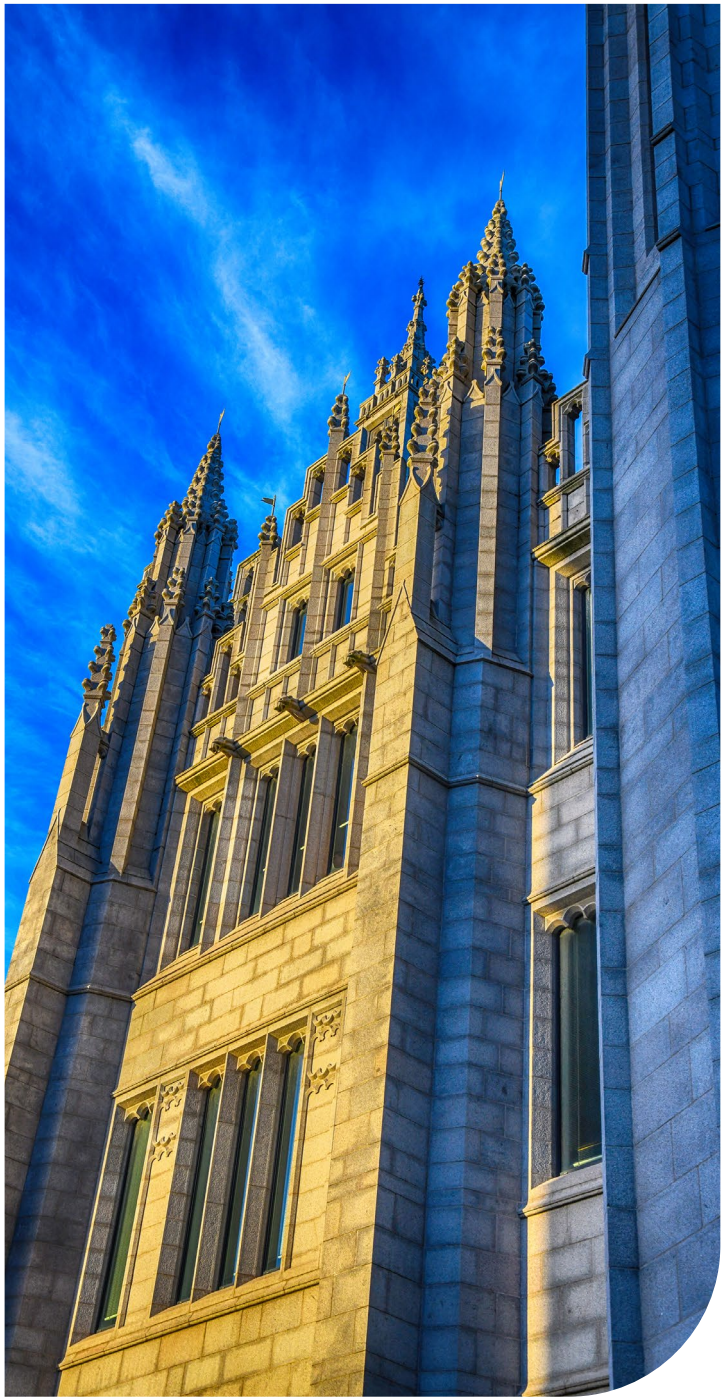
This report also serves as a reflection on the final year of our Strategic Plan for 2022-2025. Over the past three years, we have expanded the Hospital at Home service and implemented a new IT system called D365 for our social work teams. We published the Carers Strategy, which acknowledges the invaluable role of carers in sustaining our system and considers how we can better support them. In 2022, our Workforce Plan was also introduced, reinforcing our commitment to the well-being and satisfaction of our staff, who remain our most valuable resource. As these plans are renewed, we look forward to setting fresh goals and imagining the progress we can achieve with our upcoming Strategic Plan over the next four years.

Despite financial challenges, we are dedicated to exploring innovation and seizing the opportunity to tackle issues directly. We will continue to explore innovative and efficient methods for service delivery through the integration of technology, while advancing the transformation of services in a sustainable manner. In addition, we continue to remain committed to prioritising preventative measures to reduce support needs.

Finally, I wish to extend my heartfelt thanks to you for your continued engagement with our services. Over the past year, we have connected with many members of the community to better understand their priorities and how we can best serve them. I have had the privilege of attending various events that showcased remarkable achievements, and the genuine care and goodwill people have for one another and their communities.

Fiona Mitchelhill,

Chief Officer, Aberdeen City Health and Social Care Partnership.



Contents

Introduction

Welcome to the Aberdeen City Health and Social Care Partnership's (ACHSCP) Annual Performance Report (APR). ACHSCP is legally required to produce and publish an APR to reflect upon its performance against the strategic plan, the Scottish Government's Health and Wellbeing Outcomes[1] and the National Performance Indicators.

The APR covers the period from 1st April 2024-31st March 2025, which is the third and final year of the current strategic plan. The ACHSCP has navigated through significant financial constraints over the past year. These fiscal challenges have tested ACHSCP's commitment to enhancing and transforming services. However, ACHSCP continues to display adaptability in order to respond to the financial challenges.

The report will start by introducing ACHSCP and the strategic landscape in which the Partnership operates. It will then go on to outline the performance framework, national measures and the financial context which ensures best value for Aberdeen's residents. The main body of the report will highlight the progress which has been made over the past financial year on the objectives set out in the delivery plan. The delivery plan supports the implementation of the Strategic Plan, and was approved by the Integration Joint Board in March 2024[2].

[1] For more information about the National health and wellbeing outcomes framework, please navigate to https://www.gov.scot/publications/national-health-wellbeing-outcomes-framework/

[2] Details of the IJB meeting and minutes can be found here https://committees.aberdeencity.gov.uk/ieListDocuments.aspx?CId=516&MId=8712&Ver=4 %20

Overview of the Aberdeen City Health and Social Care Partnership and our population

ACHSCP was formed in 2015 as a means to bring together delegated services previously managed by Aberdeen City Council (ACC) and NHS Grampian (NHSG). Outlined below are some of the services which the Partnership is responsible for delivering. ACHSCP prides itself on working in collaboration with a wide variety of partners to provide the best care to the residents of Aberdeen.

Selection of ACHSCP Services

Allied Health Professionals (AHP) including: Speech and Language Therapy, Physiotherapy, Dietetics, Podiatry, Occupational Therapy

Community Services including: Community Nursing, Health Visiting, School Nursing, Hospital at Home, City Visits

Mental Health Services including: Inpatient services at Royal Cornhill Hosital, Community Mental Health and Learning Disability services

Social Work Services for adults, older people and adults with physical and learning disabilities

Sexual health services

Primary Care medical services

Drug and Addiction Services

Selected inpatient services (including geriatric and rehabilitation)

The Aberdeen City Population Needs Assessment 2023[3] indicates that the population of Aberdeen City is 227,430 and is projected to increase to 230,000 by 2028 based on a national population projection. In addition, it is anticipated that by 2028, the proportion of individuals in the 65-74 age group will rise by 14%, and those aged 75 and older will increase by 16%. Furthermore, data and projections suggest that life expectancy is expected to remain constant, while healthy life expectancy is declining.

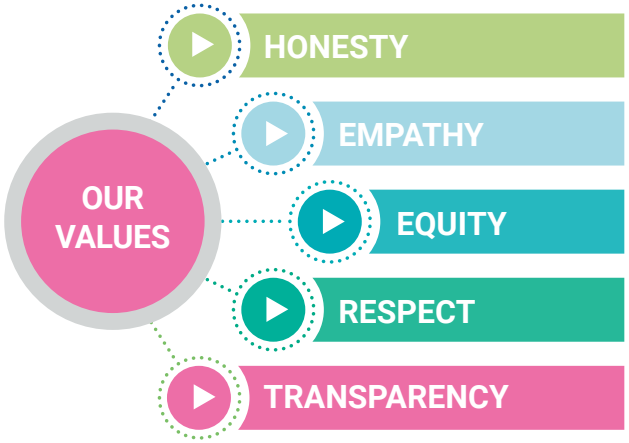
A decrease in population, combined with projections of fewer healthy years for individuals and communities, may result in various challenges for a region and could lead to economic decline. This demographic shift can put strain on public services by shrinking the tax base while simultaneously increasing the demand for care and services, particularly for children and older individuals. Like many other places, Aberdeen is experiencing a rising number of residents with work limitations, further complicating the balance between the working population and those unable to participate in the workforce.

The social determinants of health contribute to the unfair and avoidable differences in outcomes seen across the City of Aberdeen. Social and economic factors, health behaviours, access to health services and the physical environment in which people live all contribute to shaping people's health.

[3]Aberdeen Population Needs Assessment (2023). Available here https://communityplanningaberdeen.org.uk/resources/population-needs-assessment/

Strategic Plan

ACHSCP's Strategic Plan was approved in 2022 and ran for a three-year period from 2022 to 2025. This report focuses on the third year of this plan. The following gives an overview of the strategic intent for the Partnership throughout this period. ACHSCP's values have provided the framework on which the strategic plan was developed. ACHSCP develop a delivery plan each year to demonstrate how we intend to prioritise key activities to help support the Strategic Vision. This allows us to be more specific in our needs and shift with the environment as required, for example, due to financial constraints, emerging trends etc. The APR helps to provide assurance on our annual performance in delivering our strategic intent and best value through the delivery plan while also providing data on our performance against national integration measures. This report demonstrates ACHSCP's performance throughout the final year of our current Strategic Plan, the aims of which can be found overleaf.



Strategic Aims			
CARING TOGETHER	**KEEPING PEOPLE SAFE AT HOME**	**PREVENTING ILL HEALTH**	**ACHIEVE FULFILLING, HEALTHY LIVES**
Strategic Priorities			
• Undertake whole pathway reviews ensuring services are more accessible and coordinated • Empower our communities to be involved in planning and leading services locally • Create capacity for General Practice improving patient experience • Deliver better support to unpaid carers	• Maximise independence through rehabilitation • Reduce the impact of unscheduled care on the hospital • Expand the choice of housing options for people requiring care • Deliver intensive family support to keep children with their families	• Tackle the top preventable risk factors for poor mental and physical health including: - obesity, smoking, and use of alcohol and drugs • Enable people to look after their own health in a way which is manageable for them	• Help people access support to overcome the impact of the wider determinants of health • Ensure services do not stigmatise people • Improve public mental health and wellbeing • Improve opportunities for those requiring complex care • Remobilise services and develop plans to work towards addressing the consequences of deferred care

Enabling Priorities				
WORKFORCE	**TECHNOLOGY**	**FINANCE**	**RELATIONSHIPS**	**INFRASTRUCTURE**
• Develop a Workforce Plan • Develop and implement a volunteer protocol and pathway • Continue to support initiatives supporting staff health and wellbeing • Train our workforce to be Trauma informed	• Support the implementation of appropriate technology-based improvements - digital records, SPOC, D365, EMAR, Morse expansion • Expand the use of Technology Enabled Care throughout Aberdeen • Explore ways to assist access to digital systems • Develop and deliver Analogue to Digital Implementation Plan	• Refresh our Medium-Term Financial Framework annually • Report on financial performance on a regular basis to IJB and the Audit Risk and Performance Committee • Monitor costings and benefits of Delivery Plan projects • Continually seek to achieve best value in our service delivery	• Transform our commissioning approach focusing on social care market stability • Design, deliver and improve services with people around • their needs • Develop proactive communications to keep communities informed	• Develop an • interim and • longer-term solution for Countesswells • Review and update the Primary Care Premises Plan

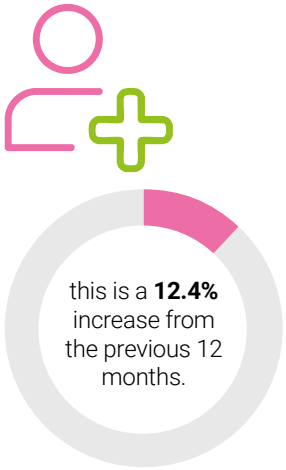
The next strategic plan for 2025-2029 has been approved by the Integration Joint Board and can be viewed using the web address below[4]. Over 2,000 people were consulted as part of its formation to ensure that the strategy is fit for purpose and inclusive of what the people of Aberdeen want and need from the ACHSCP.

[4]Aberdeen Health and Social Care Partnership Strategic Plan 2025-2029
https://www.aberdeencityhscp.scot/about-us/our-strategic-plan2/our-strategic-plan/

Service Highlights

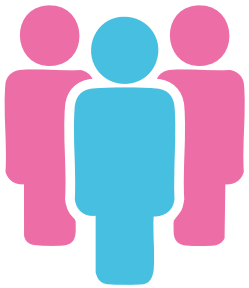
These highlights aim to demonstrate the impact of some of our services on the population of Aberdeen by treating individuals when necessary, enabling them to maintain their health and independence within their communities, and promoting preventative measures to reduce the likelihood of future periods of ill health.

1265
patient admissions to Hospital at Home in the 2024 – 2025 period



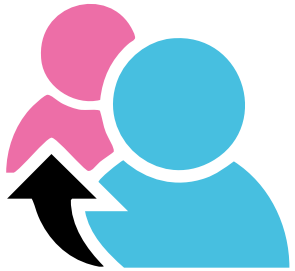
This year, there have been
170,000
Community Treatment and Care appointments available across Aberdeen City.

Stay Well, Stay Connected activities and events increased from 660 people in 2023 to
1777 people
in 2024, this is an annual increase of 169%.



1530
adaptations have been made to people's homes to support independent living.

Community Link Workers have received
1,694
referrals and delivered
2,280
appointments



The City Visits team have undertaken
6,216
visits this year.

264 events
as part of the 2024 May Wellbeing Festival

170,489
vaccinations have been administered across Aberdeen City in 2024/25

369
people attended the Grampian Gathering

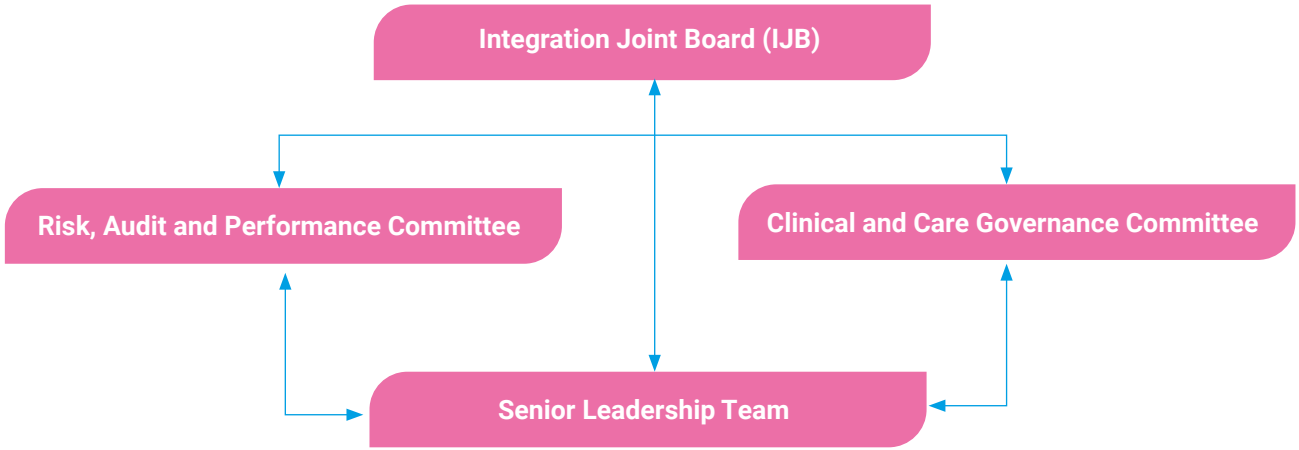
48,000
appointments have been provided by Grampian's Sexual Health Services

Over 50 families
have participated in the Peers Early Education Partnership (Peep) programme.

Over 9,000
Vitamin B12 injections have been administered at the Aberdeen Vaccination and Wellbeing Centre

Our Governance and Performance Framework

The governance of ACHSCP is provided by a framework which provides scrutiny and assurance that services and programmes are being delivered safely for the benefit of patients, clients, carers and the general public and within an acceptable budget and timeframe. ACHSCP's governance structure also feeds into the overarching governance structure of ACC and NHSG as the Partnership's funding partners. The structure of the ACHSCP's governance framework is shown below:



Performance framework

ACHSCP is required to use the National Health and Wellbeing Outcomes and the National Performance Indicators published by Public Health Scotland to assess progress being made towards integration and to compare our performance against other Partnerships and the overall average in Scotland. By using these and adding additional local measures, for example admission rates and occupancy levels, we can monitor performance regularly throughout the year within our governance structure to ensure that the Partnership continues to perform as expected. The following describes the local reporting arrangements in the context of our governance structure. It should be noted that these descriptions cover the performance management aspects only, and does not reflect the full role of these committees and groups.

The **IJB** has responsibility for the overall direction of ACHSCP and as such, it approves the Strategic Plan. On an annual basis, it is provided with the Medium Term Financial Framework and the Delivery Plan which details planned programme work aligned with the Strategic Plan. The APR is presented to the chair of the IJB for approval prior to being published and aims to assess the Partnerships progress and performance against the Strategic Plan.

The **Risk, Audit and Performance Committee** is provided with quarterly updates which provide an overview of progress against all deliverables within the Delivery Plan. These include key achievements, challenges and mitigations against potential risks. A performance dashboard is also presented, is comprised of a variety of key metrics identified locally that are aligned to programmes of work that provide an indicative barometer of progress. The Committee also considers key standalone pieces of work as required (for example, the Health Improvement Fund's annual report).

The **Clinical and Care Governance Committee** is provided with a data report which covers a number of areas such as adverse events and complaints received. Alongside the strategic measures, this ensures that operational risks and performance are monitored.

Members of the **Senior Leadership Team** are assigned as the Senior Responsible Owner for a number of the projects outlined within the Delivery Plan. In this role, they lead the delivery of these priorities with assistance from the project team. The Senior Leadership Team then review progress being made across the Delivery Plan on a regular basis using a similar reporting means as that which is presented to the Risk, Audit and Performance Committee. This ensures that any area which requires further discussion or input can be prioritised and actioned appropriately.

Overview of our performance

The following table shows the national integration indicators. Indicators 1-9 are from the Health and Care Experience Survey and are measured every second year, and therefore these figures have not changed from what was reported in the 2023-2024 Annual Performance Report. National Indicators 10, 21,22 and 23 are no longer reported on and therefore figures have not been published for these. Where the "Year of latest data" is 2024, data has been provided for the calendar year since quarter 4 data from 2024-2025 has not been verified at the point of publication. The full publication of the National Integration Indicators can be found on the Public Health Scotland Website[1].

The indicators from the Ministerial Steering Group have been added following the National Integration Indicators. Data from indicators 1a, 2a and 2b cannot be compared with previous years due to the data being incomplete. Other measures are stable compared with previous years. Since 2020-2021, ACHSCP reported low levels of delayed discharge, however the rate seen in 2024-2025 has significantly increased. This increase is reflective of pressures seen across the whole health and care system and is one area which renewed focus will be paid.

The figures for the integration indicators are in keeping with those seen across Scotland. Across the following four measures, ACHSCP is performing above the Scottish average.

N12 - Emergency admission rate (per 100,000 population).

Indicator N12 has locally reduced from 9,805 in 2023-2024 to 8,665 in 2024 and is on downward trend from a peak in 2019-2020 of 10,295. ACHSCP has consistently been below the Scottish average since 2018-2019 when this measure started to be recorded.

N13 - Emergency bed day rate (per 100,000 population).

The rate of bed days recorded has fallen significantly to 86,474 from last years' figures where it was reported as 97,032.

NI16 - Falls rate per 1,000 population aged 65+.

The trend for the falls rate in Aberdeen City has been decreasing since 2018-2019. The figures for 2024 show that this has declined to 17.9, marking it the first year that the rate has fallen below 20.

N19 - Number of days people spend in hospital when they are ready to be discharged (per 1,000 population).

This indicator continues to be below the Scottish average in Aberdeen City. However, the rate has significantly increased from 207 to 655 per 1,000 of the population since last reporting period in 2023-2024.

ACHSCP are under performing on the following compared with the Scottish average, and more work requires to be focused in these areas.

NI14 - Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges).

Although this figure is above the national average, improvements have been made since last years reporting which was 126 compared with the 2024 figure of 117 per 1,000 discharges.

NI17 - Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections.

Improvements have been made in this figure over the past two years with the percentage continuing to increase.

NI18 - Percentage of adults with intensive care needs receiving care at home.

Although the figure for Aberdeen City is below the national average, the figure of 56.5% for 2024 is the highest recorded figure since reporting began in 2018.

Overall, reporting from the national integration indicators show that Aberdeen City is performing well and that even on the three measures which are below the Scottish average, that improvements have been made since the last reporting period.

[1] Public Health Scotland Core Suite of Integration Indicators published July 2025.
https://publichealthscotland.scot/publications/core-suite-of-integration-indicators/core-suite-of-integration-indicators-1-july-2025/

Overview of the National Integration Indicators for Aberdeen City Health and Social Care Partnership compared with the Scottish average

	Indicator	Title	Partnership rate 2024-2025 (same as 2023-2024)	Scotland rate	ACHSCP compared with Scotland Average
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	90.40%	90.70%	**Stable**
	NI - 2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	76.80%	72.40%	**Better than average**
	NI - 3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	56.50%	59.60%	**Lower than average**
	NI - 4	Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated	63.10%	61.40%	**Better than average**
	NI - 5	Percentage of adults receiving any care or support who rate it as excellent or good	74.90%	70.00%	**Better than average**
	NI - 6	Percentage of people with positive experience of care at their GP practice	60.20%	68.50%	**Lower than average**
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	74.40%	69.80%	**Better than average**
	NI - 8	Percentage of carers who feel supported to continue in their caring role	37.10%	31.20%	**Better than average**
	NI - 9	Percentage of adults supported at home who agree they felt safe	72.40%	72.70%	**Stable**
	NI - 10	Percentage of staff who say they would recommend their work-place as a good place to work	NA	NA	NA

	Indicator	Title	Partnership Rate 2023-2024	Partnership rate 2024-2025	Increased/Decreased/Stable (2023-2024 compared with 2024-2025)	Scotland rate	ACHSCP compared with Scotland Average
Data indicators	NI - 11	Premature mortality rate per 100,000 persons	Not collected	448	-	442	-
	NI - 12	Emergency admission rate (per 100,000 population)	9,805	8,665	**Decreased**	11,559	**Lower than average**
	NI - 13	Emergency bed day rate (per 100,000 population)	97,032	86,474	**Decreased**	113,627	**Lower than average**
	NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	126	117	**Decreased**	103	**Higher than average**
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	90%	91.60%	**Increased**	89.20%	**Higher than average**
	NI - 16	Falls rate per 1,000 population aged 65+	21.2	17.9	**Decreased**	22.5	**Lower than average**
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	70.70%	71.80%	**Increased**	81.90%	**Lower than average**
	NI - 18	Percentage of adults with intensive care needs receiving care at home	54.60%	56.50%	**Increased**	64.70%	**Lower than average**
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	207	655	**Increased**	952	**Lower than average**

	Indicator	Title	Partnership Rate 2023-2024	Partnership rate 2024-2025	Increased/Descreased/ Stable (2023-2024 compared with 2024-2025)	Scotland rate	ACHSCP compared with Scotland Average
Data indicators	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency		Data no longer collected		Data no longer collected	
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home		Data no longer collected		Data no longer collected	
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready		Data no longer collected		Data no longer collected	
	NI - 23	Expenditure on end of life care, cost in last 6 months per death		Data no longer collected		Data no longer collected	

Ministerial Steering Group Measures

	Indicator	Title	2023-2024	2024-2025	ACHSCP 2024-2025 compared with 2024-2023
Ministerial Group indicators	1a	Number of emergency admissions	21,069	17,773	**Data incomplete**
	1b	Percentage admitted from A&E all ages (average for year)	23	23	**Stable**
	2a	Unscheduled bed days, acute specialities	130,236	107,404	**Data incomplete**
	2b	Unscheduled bed days- Geriatric long stay	7,036	5,138	**Data incomplete**
	2c	Unscheduled bed days, Mental Health	51,687	51,535	**Stable**
	3a	A&E attendances	42,163	42,179	**Stable**
	3b	Percentage seen in A&E within 4 hours all ages (average for year)	57	57	**Stable**
	4	Delayed Discharge bed days (ag1 18+)	7,016	18,066	**Increasing**
	5	End of life care (% in community all ages)	90.2%	90.0%	**Stable**
	6	Balance of Care- %65+ living at home (supported and unsupported)	95.9%	95.9%	**Stable**

Finance and Best Value

A report to the IJB on 18th March 2025 confirmed that the final outturn position for 2024-2025 indicated that there is a recurring overspend of £16.786m. This was resolved using a combination of funding from partners and available reserves however there are no remaining uncommitted reserves with which to balance financial risks for 2025/26 onwards. The City IJB position reflects the common position across Scotland.

The future of Health and Social Care is marked by considerable financial uncertainty, driven by rising demand, inflationary pressures and the need for systematic reform. The 2025 spending review highlighted a critical funding gap for all IJB's in Scotland with all required to make savings, Aberdeen City is no different.

It is crucial that budget savings are achieved on a recurring basis for the IJB to remain in financial balance and enable the continued provision of health and social care. This will require the IJB to take action to offset these pressures, either by reducing forecasted demand, reducing costs, or both, in order to achieve a balanced budget in future years.

The main area of budget pressure is Commissioned Services. The reason for this is a combination of increasing demand for social care caused by an ageing population and a rise in the incidence of long term conditions along with the higher costs of delivering services. The other main cost pressures come from payroll and prescribing costs. The IJB has plans in place to try to mitigate these cost pressures going forward.

Whilst the IJB need to deliver within budget they are committed to protecting service delivery to the most vulnerable citizens of Aberdeen and to achieving balance between available budget, meeting client and patient needs safely, and staff welfare.

Comprehensive Income and Expenditure Statement

This statement shows the cost of providing services for the year according to accepted accounting practices.

		2023/24				2024/25
Gross Expenditure	Gross Income	Net Expenditure		Gross Expenditure	Gross Income	Net Expenditure
£	£	£		£	£	£
46,116,494	0	46,116,494	Community Health Services	49,958,169	0	49,958,169
31,323,029	0	31,323,029	Aberdeen City share of Hosted Services (health)	30,350,665	0	30,350,665
45,015,163	0	45,015,163	Learning Disabilities	51,304,195	0	51,304,195
26,985,068	0	26,985,068	Mental Health & Addictions	31,459,476	0	31,459,476
107,204,489	0	107,204,489	Older People & Physical and Sensory Disabilities	108,116,879	0	108,116,879
2,208,531	0	2,208,531	Head office/Admin	1,523,262	0	1,523,262
5,262,277	(5,114,956)	147,321	Criminal Justice	6,548,679	(6,384,627)	164,052
2,257,873	0	2,257,873	Aids, Adaptations & PSHG	1,793,981	0	1,793,981
46,349,194	0	46,349,194	Primary Care Prescribing	47,428,983	0	47,428,983
45,094,568	0	45,094,568	Primary Care	49,805,060	0	49,805,060
2,502,936	0	2,502,936	Out of Area Treatments	3,038,684	0	3,038,684
55,550,000	0	55,550,000	Set Aside Services	59,238,000	0	59,238,000
3,058,242	0	3,058,242	City Vaccinations	2,530,267	0	2,530,267
15,254,159	0	15,254,159	Transformation	17,016,957	0	17,016,957
164,965	0	164,965	Uplift funding	1,105,000	0	1,105,000
434,346,988	(5,114,956)	429,232,032	Cost of Services	461,218,257	(6,384,627)	454,833,630
0	(411,921,018)	(411,921,018)	Taxation and Non-Specific Grant Income (Note 5)	0	(444,998,793)	(444,998,793)
403,909,337	**(379,663,186)**	**24,246,151**	**(Surplus) or Deficit on Provision of Services**	**461,218,257**	**(451,383,420)**	**9,834,836**
		24,246,151	**Total Comprehensive Income and Expenditure**			**9,934,836**

Participation and Engagement

Increasing our communities ability to participate in health and social care planning is integral to how ACHSCP achieves its aims. It allows us to work collaboratively with our partners to identify how we can best tailor and deliver our services. ACHSCP has contributed towards the delivery of Aberdeen's Community Engagement Strategy. This has involved members of the Community Empowerment Group taking the lead on several Local Outcome Improvement Plan (LOIP) improvement projects to advance community emmpowerment.

We aim to increase the connection we have with our communities by using a wide range of methods such as social media and local radio stations. On social media ACHSCP have increased the partnership's reach to almost 4,000 followers with over 360,000 views of our content on Facebook over a three month period. Analytics on social media show us that people tend to watch short videos and interact more often with posts that display front line services. ACHSCP have also appeared on SHMU radio several times over the past year to discuss various public health topics or to advertise upcoming community events.

We also undertake engagement through our Local Empowerment Groups (LEGS). More information can be found out about these under the Caring Together aim.

ACHSCP at SHMU Radio helping to promote the Wellbeing Festival

Our Progress and Achievements in 2024-2025

Caring Together

The strategic aim of Caring Together means that, alongside our communities, ACHSCP strives to ensure health and social care services are:

- of high quality, accessible, safe, and sustainable;
- respectful of individuals' rights, dignity, and diversity;
- inclusive of individuals' input in the design and delivery of care, both for themselves and those they support.

Together, this helps to ensure that people can access the right care, at the right time, in a way that suits them. The following table shows a list of the national indicators which the work undertaken under the Caring Together aim intends to positively influence.

Within the Caring Together strategic aim, there are five main programmes of work. The following information is divided by programme and will thereafter give an overview of the progress being made within various strands of work aligned to these.

Strategic Measures

NI 3 - Percentage of adults supported at home who agreed they had a say in how their help, care or support was provided

NI 4 - Percentage of adults supported at home who agreed that their health and social care services seem to be well coordinated

NI 5 - Total percentage of adults receiving any care or support who rated it as excellent or good

NI 6 - % of people with positive experience of care at their GP practice

NI 8 - Total combined percentage of carers who feel supported to continue in their caring role Social Care Unmet Need

Programme:

1. Communities - provide community based services codesigned and co-delivered with our communities.

Project: *Priority Intervention Hubs. Continue to develop and evaluate the Northfield Hub as a test of change for cross-sector, easily accessible, community hubs where a range of services coalesce, all responding to local need, to feed into a wider initiative on Priority Intervention Hubs.*

The main objective of **Get Active @ Northfield** as a priority intervention hub is to enhance rehabilitation and health outcomes by integrating health and sport services. The key focus areas are:

- **Partnership between healthcare and sport** to support physical and mental rehabilitation.
- **Delivery of services** like pulmonary rehabilitation, speech therapy, and "Good Boost" musculoskeletal therapy in a familiar, non-clinical environment.
- **Promotion of inclusive, accessible physical activity** for those with health conditions.
- **Empowering individuals** to manage their health through supported activity.

Tackling health inequalities in a high-deprivation area through tailored, community-based programs.

The main objective of the Aberdeen City Vaccination and Wellbeing Hub, as a priority intervention hub is to improve population health outcomes by providing accessible, proactive services that support individuals in maintaining their health, preventing illness, and managing long-term conditions independently.

This involves:

- **Delivering vaccinations** to protect against preventable diseases.
- **Offering early interventions** to reduce the need for acute or emergency care.
- **Promoting self-management tools and support** for people with chronic conditions.
- **Providing a venue and base for innovative new approaches such as Community Appointment Days**
- **Providing holistic wellbeing services,** including mental health support, lifestyle advice (e.g., smoking cessation, healthy eating, physical activity), and social activities/community area to support people to stay well and connected.
- **Reducing health inequalities** by making services accessible to vulnerable or underserved groups.
- **Encouraging community engagement** and empowering individuals to take ownership of their health.

Together these hubs demonstrate a shift toward community-based, preventative and integrated models of care, supporting both early intervention and long-term wellbeing across Aberdeen.

Over the past year, the Aberdeen City Vaccination and Wellbeing Hub and Get Active @Northfield have achieved the following three significant milestones as priority intervention hubs:

1. The Community Room project at Get Active @ Northfield, launched in October 2022, successfully brought together health, social care, and wellbeing services in a leisure setting. Services offered included Speech and Language Therapy, community listening, pop-up vaccination clinics, and Pulmonary Rehabilitation. Due to its success in improving access and addressing inequalities in a high-deprivation area, the project will continue with annual reviews.

2. The Aberdeen Vaccination and Wellbeing Hub has transformed from a vaccination centre into a comprehensive wellbeing hub. It offers a wide range of services including vaccinations, CTAC, Vitamin B12 injections and Health Visitor reviews, while partnering with over 70 organisations to provide mental health, financial, digital, and other support. The hub emphasises community engagement through initiatives like a welcoming community area, information resources, and collaborations with local schools. The model, which blends clinical and holistic support, was presented at the NHS Scotland Conference in May 2024 and has attracted interest from other health boards.

3. Community Appointment Days (CADs) at both hubs were developed to support people living with chronic pain. The first events, held in November 2024 and February 2025, brought together health and community partners to deliver information sessions, peer support, and access to specialist advice. CADs aim to reduce barriers to care, address health inequalities, and help individuals manage chronic pain more effectively. Feedback highlighted the welcoming environment, practical advice, and enhanced collaboration among partners.

Together, these initiatives reflect a commitment to accessible, inclusive, and community-driven care in Aberdeen.

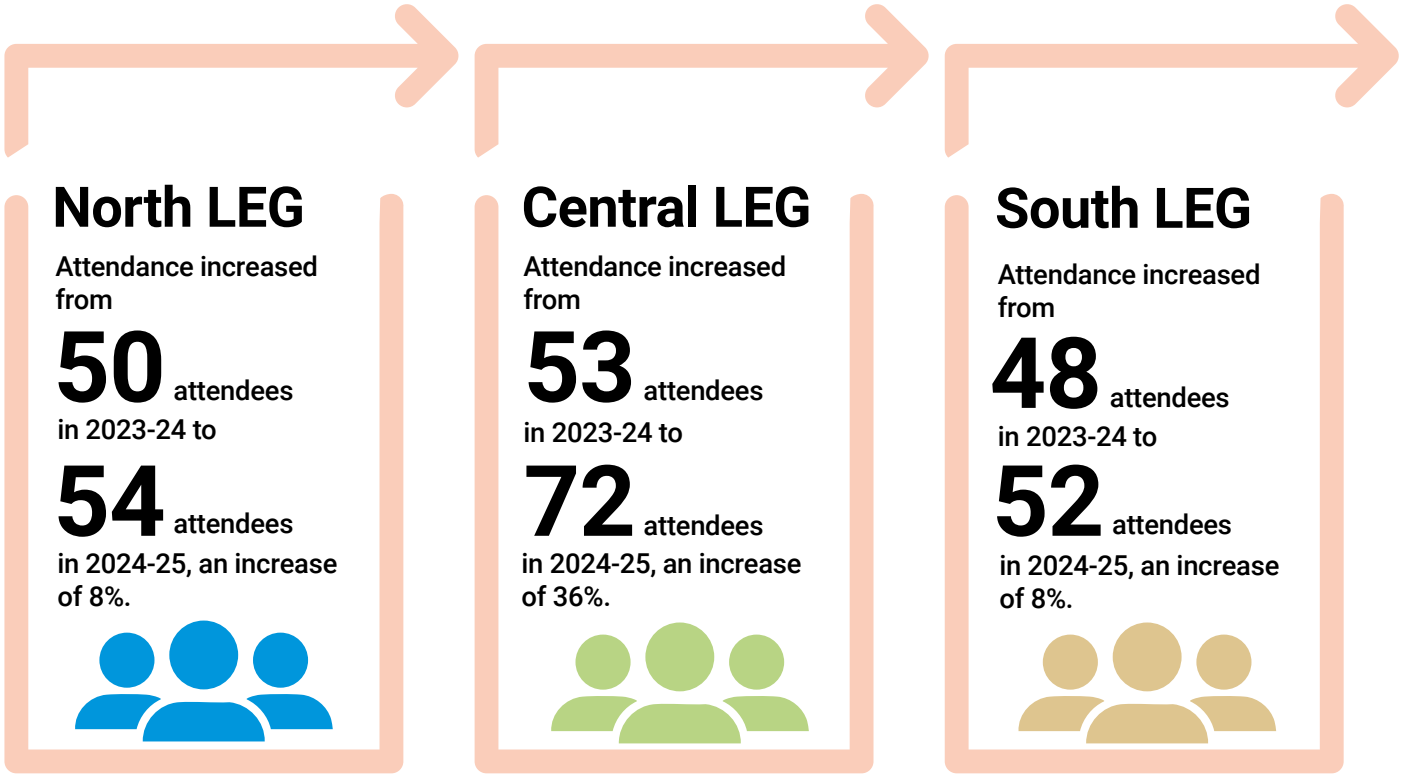
In May 2024, Get Active @ Northfield achieved the "Tackling Inequalities in Leisure Standards" accreditation with a gold rating. This recognition highlights the facility's commitment to providing inclusive and accessible physical activity opportunities, particularly for individuals with long-term health conditions.

The venue was also part of a UKactive initiative piloting leisure facilities as Musculoskeletal (MSK) Hubs and achieved the Active Standards Accreditation. Programmes like Escape Pain and the Good Boost which offer tailored water-based therapeutic exercises for those with musculoskeletal conditions were instrumental in earning this accolade.

Project: *Lead on increasing and diversifying the membership of our Locality Empowerment Groups and increasing wider participation in locality planning.*

The IJB is statutorily[5] required to have locality planning arrangements in place, and since December 2020, we have integrated our locality planning with Community Planning Aberdeen. In February 2023, an Integrated Locality Planning Team was established. The team is responsible for planning, promoting, and delivering the three Locality Empowerment Groups across Aberdeen City.

Promoting attendance at Local Empowerment Group (LEG) meetings is important because it helps to deliver our Community Empowerment Strategy, this helps to increase community involvement in decision making and strengthens our local communities. Over the past year, attendance at all three Locality Empowerment Groups has increased as shown right.



[5] IJB: Roles and responsibilities https://www.gov.scot/publications/roles-responsibilities-membership-integration-joint-board/pages/2/

LEG meetings continue to have a good gender balance and are regularly attended by people with disabilities who are fully supported to attend and participate in meetings. They are inclusive and run as hybrid meetings, meaning they are held in accessible community settings, as well as offering the option to join the meeting remotely via Microsoft Teams. Meetings alternate between mornings and evening to allow as many people to participate as possible.

During 2024, two LEG members were appointed to the IJB as Service User Representatives which provides an excellent link between the IJB and our communities.

Project: *Deliver North, Central and South Locality Plans and report on progress*

The IJB is required to conduct locality planning, and since December 2020, this has been integrated with Community Planning Aberdeen. One of the team's key functions is to develop three Locality Plans, and work alongside our communities and Community Planning partners to deliver key priorities. Performance on delivering the priorities in the Locality is reported to the Community Planning Aberdeen Board and to the Risk, Audit, and Performance Committee on an annual basis.

Successes during 2024-25

- All three Locality Plans were refreshed and approved by the Community Planning Board and Integration Joint Board in July 2024[6].
- The Locality Planning Team have engaged successfully with Community Planning's Outcome Improvement Groups to ensure improvement projects produce locality level data to make it easier to see where interventions have been successful or not.
- The Locality Planning Team have aligned different funding streams such as the Health Improvement Fund, Community Mental Health and Wellbeing Fund, and UDecide participatory budgeting to ensure community projects are helping to deliver key priorities within all three of the Locality Plans. This greater co-ordination, reduces duplication, provides greater value for money to the public, and cuts down on the number of funding applications community groups and organisations need to make during the year.

[6] Integra tion Joint Board minutes can be found here https://committees.aberdeencity.gov.uk/ieListMeetings.aspx?CommitteeId=516

Programme:

2. Social Care Pathways - Undertake a strategic review of specific social care pathways utilising the Getting It Right for Everyone (GIRFE) multi-agency approach where relevant and develop an implementation plan for improving accessibility and coordination.

Project: *Implement the recommendations from the June 2022 Adult Support and Protection inspection*

Adult Protection

The Adult Protection Social Work team (APSW) plays a crucial role in safeguarding adults at risk of harm by serving as the central point for Adult Support and Protection (ASP) inquiries and collaborating with various organisations to ensure their support and protection.

The implementation of standard operating procedures has provided robust systems and processes in their duties and created a strong, consistent and responsive approach to adult protection.

Adult Protection Committee Improvement Plan

Since the conclusion of the work around the recommendations from the ASP Inspection in June 2022, a number of processes and outcomes have been adopted by the service through the Adult Protection Committee (APC) Improvement Plan. The Aberdeen APC Improvement Plan 2024-2026 outlines several initiatives aimed at enhancing adult support and protection practices. The plan is derived from various sources, including findings from the ASP Joint Inspection June 2022, APC Improvement Plan 2021-23, APC Self-evaluation Oct 2023, and the APC Stakeholder Engagement Event Sept 23. The following indicates some key successes from this financial year.

Learning Reviews

Learning Reviews now follow a consistent approach, ensuring effective dissemination and application of insights. Processes have been implemented to promptly share good practices and align with Child Protection Learning Review procedures.

Chronologies Working Groups

A Chronologies Working Group was formed to enhance the consistency and quality of chronologies and is participating in a national self-evaluation pilot supported by the Institute for Research and Innovation in Social Services (IRISS).

Stakeholder Engagement

Developed a strategy on 'How we communicate and engage with people about Adult Support and Protection', to ensure the 'voice' of all those supported and protected is at the centre of all activities. This has supported increased awareness of ASP among staff and the public.

Project: *Review of social care charging policy and procedures and robust implementation with a view of maximising income*

This project will assist ACHSCP to be able to continue to provide services to people with a range of needs to make a contribution towards the cost of certain aspects of their care and support services, determined by a financial assessment. The key aspect is to treat people equitably and fairly through consistent application of the charging policy.

Key achievements over 2024-2025 include:

- Collaborative work across the partnership to implement the charging policy which has led to an increase in income generated across non-residential social care charging in line with the 'Contributing to Your Care' policy from **£2,573,204 in 2023-2024 to £3,434,969 in 2024-2025.**
- The excellent collaborative working that has been developed and maintained by the project team, leading to the implementation of new charges for housing support and meals, with comprehensive communication and engagement to provide a smooth transition in implementation.
- The significant cultural change which has started moving towards an understanding of why contributing to your care is required to support essential service delivery within the tight financial landscapes. Several change management models have been used to comprehensively support staff through this transition. The budget consultation also allowed the public to engage in this change. A key point was that people generally felt that charging appropriately, in a means- tested way, for services was one of the fairest ways for ACHSCP to balance its budget.

In the future, ACHSCP is committed to implementing individual (personal) budgets for social care. This would bring in a contribution-based charging policy which more closely aligns with national guidance and policy, such as COSLA's charging guidance and self-directed support.

This approach calculates individual contributions based on actual support costs and the total care package, rather than charging per service, by determining which parts are chargeable or not before finalising the individual's contribution.

Project: *Develop an overview of the Partnership's Discharge to Assess approach incorporating links between Hospital at Home and intermediate Care at Home, enablement approaches, step up and step down and Interim Bed arrangements*

ACHSCP tested a Discharge to Assess (D2A) model with patients from Ward 102, the Emergency Department (ED), and Acute Medical Initial Assessment (AMIA). This ensured that medically fit individuals were safely transported home to be supported by our care provider and assessed by Occupational Therapy.

We conducted a test of change for the D2A model, completing three cycles and incorporating feedback from each previous cycle. During this test, we successfully transitioned 18 medically fit individuals from ARI to their homes, providing short-term care with a focus on reablement. This care was gradually reduced to support the individuals in regaining independent living.

Occupational Therapy and Care Management conducted assessments within a day of the individuals' return home. Those requiring ongoing care were appropriately referred for continued support.

The positive outcomes of this test included the successful transition of 18 individuals from a hospital setting to the comfort of their own homes, where national evidence indicates improved patient outcomes and higher levels of satisfaction.

Looking ahead, the future of the D2A work is being incorporated into the Discharge without Delay programme which aims to establish a 7 day therapy provision, review existing resources to identify opportunities to transfer support to D2A, review existing community based services to support enablement and explore opportunities with external providers to support the D2A process.

Programme:

3. Primary Care - identify strategy and actions to improve Primary Care services and ensure future sustainability

Project: *Deliver the Strategic intent for the Primary Care Improvement Plan (PCIP)*

Since the inception of the 2018 General Medical Services (GMS) contract, we continue to develop the six established primary care services under our 'Primary Care Improvement Plan' (PCIP) to help support our GP Practices. These continued to grow and develop during 2024-2025, this includes:

Community Treatment and Care (CTAC)

CTAC services include, phlebotomy, management of minor injuries and dressings, ear syringing, suture removal, chronic disease monitoring, diabetic foot screening and other locally agreed services, such as B12 injections and Doppler tests.

The CTAC service is being delivered through centralised hubs, traditionally operated by GP practice-based staff. Patients have a choice of hubs at the following locations:

- **Inverurie Road**
- **Kincorth**
- **Torry**
- **Airyhall**
- **Bridge of Don**
- **College Street**
- **Carden House**
- **Northfield**
- **Vaccination and Wellbeing Hub**

The CTAC service now also provides B12 injections at the Aberdeen Vaccination and Wellbeing Centre. Training is also taking place in some GP Practices so that CTAC staff who are embedded within the practice can start to deliver B12 injections. This gives patients increased flexibility on location so that their treatment can be provided in a facility most convenient for them.

Pharmacotherapy

The Pharmacotherapy service continues to offer support to GP Practices during periods of pharmacy team members annual leave and it helps to maintain a sense of continuity of service. The Pharmacotherapy Hub is located within the premises of Old Aberdeen Medical Practice and the team consists of a skill mix of Advanced Pharmacists, Clinical Pharmacists and Pharmacy Technicians and give a range of cover in terms of experience.

Musculoskeletal - First Contact Physiotherapy

The Musculoskeletal (MSK) First Contact Physiotherapy service provides experienced physiotherapists who have the advanced skills necessary to assess, diagnose and recommend appropriate treatment or referral for MSK problems on a patient's first contact with the healthcare service. The team are undertaking training to allow the physiotherapists to attain their advanced clinical qualification.

The service has worked tirelessly to maximise the level of first contacts by creating a number of informative and supportive documents which have been shared with all GP practices and by taking this approach **increased the percentage of first contacts by 21%.** This improvement releases capacity to enable GPs to focus their time on their role as expert medical generalists.

Link Practitioners

A contract is in place following a commissioning process for the Link Practitioner Service. It is currently two years into a four year agreement with an option to extend it for up to three years giving continuity of care. Link Practitioners can offer Social Prescribing[7] which can relieve the pressure on GP's, and can often be a better fit for non- clinical issues.

GPs and Primary Care staff can refer patients when they assess that a social issue is having an impact on a patient's medical condition. The most common referrals are for the following categories: Money and Finance; Benefits; Housing and Homelessness; Mental Health; and Managing Conditions. This year, **over 1,600 people have been referred to the Link Practitioners service** for assistance.

Urgent Care/City Visits

Through PCIP, Aberdeen provides a 'City Visits' service for general practice. All GP practices now have access to the service, which provides clinical assessment, diagnosis, and initial management in patients' own homes by a team of qualified and trainee Advanced Clinical Practitioners. Healthcare Support Workers provide support to GPs and the City Visits Practitioners with phlebotomy, clinical observations, ECG monitoring and bladder scanning that will contribute to diagnosis for on-the-day urgent consultations. **Over 6,000 visits have been undertaken this year** by the City Visits team.

Project: *Deliver Aberdeen City actions in relation to the Grampian vision for Primary Care*

In response to current sustainability challenges and the evolving needs, a programme of work was commissioned in July 2023 to articulate a new vision statement and strategic objectives that capture the changes required to move towards a more sustainable general practice sector within the area.

In March 2024[8] the output of this programme of work was presented to the three Grampian IJB's. The Vision Statement, *'A sustainable General Practice across Grampian which enables people in their communities to stay well through the prevention and treatment of ill health',* was approved which encapsulates a commitment to fostering health and well-being within our communities. It signifies a commitment to providing comprehensive and accessible healthcare services that not only address illness but also promote preventive care and empowers individuals to lead healthier lives in their communities.

[7] Social prescribing is defined as an approach individuals are linked to resources and services within local communities with the aim of improving mental and physical health and wellbeing.

[8] General Practice Vision and Objectives (page 229)
https://committees.aberdeencity.gov.uk/documents/g8712/Public%20reports%20pack%2026th-Mar-2024%2010.00%20Integration%20Joint%20Board.pdf?T=10

An implementation plan was developed to deliver the set objectives within existing resources. The following five objectives have been earmarked for progress under phase 1. These are:

- **Data**
- **Multi-Disciplinary Team**
- **Models of Contract**
- **Premises**
- **Digital**

This year, the Vision project has established regular meetings with the Scottish Government to ensure consistent progress reporting and maintain alignment with national objectives. A Digital Blueprint has been drafted which will set out all existing and additional priorities for the development of digital capability for General Practice in Grampian.

Project: *Prescription Costs- Develop and implement appropriate initiatives to mitigate increasing prescription costs.*

Following the identification of significant increases in prescribing costs, there was a requirement to investigate a means to safely reduce these costs across Aberdeen City. A Grampian wide prescribing efficiencies group was set up. This was led by the Grampian Medicines Management team with representation from all three Health and Social Care Partnership's in Grampian. Various pieces of work were undertaken including communications to highlight to members of the public the impact of the cost of prescriptions. This was done using social media, posters and on local radio. Presentations were made to various professional groups including the IJB, GP Cluster meetings and non-medical prescribers to highlight the situation.

The group also developed a prescribing efficiencies document for all prescribers to highlight potential savings including medicines of low or limited clinical value and successful engagement took place with practices to make several medication switches for specific drugs where there was a cost saving with no clinical detriment to patients.

Programme:

4. Strategy - develop and implement local strategies to ensure alignment with national and regional agendas

Project: *Monitor and evaluate the impact of the Carers Strategy on an ongoing basis factoring in early preparations for the next revision*

The Aberdeen City Carers Strategy, acknowledges the contribution that all unpaid carers make to our City. The Strategy which is aligned to the Carers (Scotland) Act 2016 also sets out four key priorities and actions to help Carers to access support and have healthy lives alongside their caring responsibilities. They are:

ACHSCP has an action plan for implementing the carers strategy. This year, the Partnership has completed 15 actions, moved 10 actions into Business as Usual/Continuous Review, and has 13 actions still in progress. Six of these actions are expected to be completed by the end of 2025.

One of the significant achievements this year is the Collaborative Commissioning process for Adult and Young Carers Support Services. This initiative was invaluable in co-producing service outcomes and fostering closer working relationships, while also addressing various challenges. The process was guided by Ethical Commissioning and Getting It Right for Everyone (GIRFE) principles.

The Year 2 progress report which was presented to IJB in February 2025 indicates that both adult and young carer services have experienced **over a 40% increase in engagement and support with unpaid carers.** This marks a considerable advancement in identifying unpaid carers and ensuring they can access appropriate support.

An objective of our strategy is to achieve a minimum of 40% positive responses to our Carer Experience statements (which outline what we want carers to express about their support) when surveyed in 2026. We are optimistic about attaining this goal, as the **satisfaction rate has risen from 32% to 37% since the inception of the ACHSCP's strategy.**

The Year 2 Progress Report showed further progress with a number of improvement progress funded by the Carers Strategy Implementation Group. They include:

Barnardos – ELM Music Therapy

Barnardos – Residential Trips

PAMIS – Profound and Multiple Learning Disabilities (PMLD) Family Sessions

We Too – Ninjas (Parent Carers)

ACHSCP Podiatry – Footcare Project

Sport Aberdeen – SPACE Programme

Quarriers – Wee Blether Expansion

Bon Accord Care – Developing Young Workforce Carers SVQ

Project: *Develop the revised strategic plan for 2025-2029 taking cognisance of the strategic context, resources available and views of stakeholders.*

In March 2025 the IJB approved the draft Strategic Plan 2025 - 2029 to go out for Consultation. There has been a significant effort to align Strategies and Plans across ACC, NHSG and the IJB. Our Strategic Plan lays out the Vision, Values and Strategic Aims for the IJB and ACHSCP. There is a strong commitment for this plan to be cognisant of the challenging financial climate, and ensuring we have achievable aims while understanding the difficult challenges we will face over the next few years.

The development of this plan has also seen an unprecedented effort to join forces with colleagues to consult on plans and strategies at the same time. This predominantly was to support community involvement, and also to cut down on consultation fatigue with the public.

Overview of all projects named within the 2024-2025 Delivery Plan under the Caring Together aim.

Programme/Projects	Link if Referenced within the report
Communities	
Continue to develop and evaluate the Northfield Hub as a test of change for cross-sector, easily accessible, community hubs where a range of services coalesce, all responding to local need, to feed into a wider initiative on Priority Intervention Hubs.	Please see page 16 for an overview of the work ongoing.
Lead on increasing and diversifying the membership of our Locality Empowerment Groups and increasing wider participation in locality planning.	Please see page 18 for an overview of the work ongoing.
Deliver North, Central and South Locality Plans and report on progress	Please see page 19 for an overview of the work ongoing.
Ensure the use of Our Guidance for Public Engagement is embedded	There has been significant developments and expansion to our Guidance for Community Engagement, Human Rights, and Equalities. The purpose of this document is to ensure that the statutory regulations, national and local standards, and guidance in relation to Community Engagement are clearly set out. This also provides step-by-step information on how these principles and standards translate into practice, supporting all colleagues to provide accurate, up-to-date information to ACHSCP and the IJB. Our next progress report is due in May 2025, this will be shared with IJB as a service update.
Promote the use of Care Opinion to encourage patients, clients, carers and service users to share experiences of services, further informing choice.	The contract for the use of Care Opinion has now ended. Feedback continues to be collected directly through services and by the use of the feedback services within NHSG and ACC.

Programme/Projects	Link if Referenced within the report
Social Care Pathways	
Progress a number of priority tests of change to develop a preventative and proactive care approach for Aberdeen City including the development of an Initial Point of Contact (IPOC)	The work within the strategic review of social care pathways has focused on developing collaborative relationships with colleagues across the partnership, independent and third sector. Central to this has been the Getting it Right For Everyone (GIRFE) pathfinder work. ACHSCP participated in the co-production of the team around the person toolkit which will be launched by the Scottish Government and provides a model for person-centred working. Preparatory development work took place to map existing pathways for the public trying to access key health and social services with a view to putting in place an initial point of contact (IPOC). There are a number of challenges in doing this due to working across organisational boundaries and the need for appropriate digital infrastructure. Colleagues in Moray have been working on a national project with Digital Health and Care Innovation Centre (DHI). We have been fortunate to collaborate with them on two recent workshops where learning has been shared to inform future development. The partnership conference in December was an opportunity to showcase developments in this area including the launch of our 'enablement vision' which will be central to our social care service delivery going forward.
Implement the recommendations from the June 22 Adult Support and Protection inspection.	Please see page 20 for an overview of the work ongoing.
Review of social care charging policy and procedures and robust implementation with a view of maximising income	Please see page 21 for an overview of the work ongoing.
Develop an overview of the Partnership's Discharge to Assess approach incorporating links between Hospital at Home and intermediate Care at Home, enablement approaches, step up and step down and Interim Beds.	Please see page 21 for an overview of the work ongoing.
Deliver the Justice Social Work Delivery Plan	Aberdeen City's Justice Social Work Service (JSWS) is diverse and complex. It consists of a number of different service areas and teams: Pre-Disposal, Community Payback Orders x 3, Unpaid Work, Throughcare, Caledonian, Wome's Service, Support Work and Admin teams. Its primary remit is to provide statutory supervision and support to individuals who have offended, using interventions which are proportionate to risk and need. This supervision ranges from low level for those on Diversion to very high level, usually with multi-agency support, for the "critical few" who pose significant public protection concerns. The Service Delivery Plan outlines a coherent overview of the operation and ambitions of JSWS. The previous Plan covered the period 2021-24, and the current plan covers the period 2025-29 (to align with ACHSCP Strategic Plan timescales). The Plan details the key strategic outcomes and objectives that we wish to focus on and how we aim to achieve these in order to improve the experiences and outcomes of the individuals who use our service.

Programme/Projects	Link if Referenced within the report
Primary Care	
Deliver the strategic intent for the Primary Care Improvement Plan (PCIP)	Please see page 22 for an overview of the work ongoing.
Deliver City actions in relation to the Grampian vision for Primary Care	Please see page 23 for an overview of the work ongoing.
Develop and implement appropriate initiatives to mitigate increase in prescription costs.	Please see page 24 for an overview of the work ongoing.
Strategy	
Monitor and evaluate the impact of the Carers Strategy on an ongoing basis factoring in early preparations for the next revision	Please see page 24 for an overview of the work ongoing.
Develop the revised Strategic Plan for 2025 - 2028 taking cognisance of the strategic context, resources available and views of stakeholders.	Please see page 26 for an overview of the work ongoing.
Revisit ACHSCP contributions to early years and school health and wellbeing.	School nurses are working closely with Health Visitors in relation to supporting health and wellbeing on transition from nursery to school, likewise school nurses have increasing referrals in relation to mental health within school children. The Best Start in Life group continues to work through Local Outcome Improvement Plan (LOiP) projects in relation to neglect and dental health. There is a marked improvement of dental health amongst preschool children and work continues with the Childsmile service.
Deliver relevant recommendations from the Hosted Services Internal Audit	In March 2024, Internal Audit published a report with eight recommendations in relation to Hosted Services. Five of the eight recommendations were due to be completed by December 2024 and these have all been delivered. The remaining three recommendations are due in September 2025 and we are on track to deliver these on time.
Redesigning Adult Social Work	
Undertake evaluation of redesign work to date ensuring this links to latest service developments particularly in relation to use of digital.	The project saw the creation of the Adult Protection Social Work Team, transformation of the Hospital Social Work team into aligned wards to ensure timely discharges, the formal creation of a care home team, social care review team and the alignment of social care teams into localities. This along with redesign of the service manager team resulted in releasing certain posts used for vacancy savings. Given the current position and the need to reduce costs in social care, further work will be required as set out in our recovery plan. This refocus being on the drive to modernise social care using tec and enhancing digital opportunities alongside enablement.

Keeping People Safe at Home

It is the strategic responsibility of the IJB to transition care delivery from hospitals to primary, community, and social care settings. This shift aims to ensure that individuals receive care and support closer to home whenever possible. The objective is to enable people to live independently at home by choice, thereby enhancing their overall outcomes. The following table presents a list of national indicators that the initiatives under the Keeping People Safe objective aim to positively impact.

Strategic Measures

NI 2 – Percentage of adults supported at home who agree that they are supported to live as independently as possible
NI 9 – Percentage of adults supported at home who agree they felt safe
NI 12 – Emergency admission rate
NI 13 – Emergency bed day rate
NI 14 – Readmission to hospital within 28 days
NI 15 – Proportion of last 6 months of life spent at home or in a community setting
NI 16 – Falls rate per 1,000 population aged 65+
NI 18 – Percentage of adults with intensive care needs receiving care at home
NI 19 – Number of days people spend in hospital when they are ready to be discharged, per 1,000 population
NI 20 – Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency

Within the Keeping People Safe at Home strategic aim, there are five programmes of work. The following information is divided by programme and will thereafter give an overview of the progress being made within various strands of work aligned to this.

Programme:

1. Rehabilitation Review - undertake a strategic review of rehabilitation services across Grampian to identify new delivery models.

Project: *Develop a discussion paper to inform a strategic planning framework for the strategic review of rehabilitation across Grampian which will include Specialist Rehabilitation Services hosted by Aberdeen City IJB. This will include consideration of how partners in sports and leisure and wider community resources can assist in delivery of rehabilitation. This will consider rehabilitation delivery models including bed base and community requirements in line with national guidance including Scottish Government Progressive Stroke Pathway, SG Neurological Standards and Scottish Trauma Network Major Trauma minimal requirements guidance.*

The Specialist Rehabilitation Strategic Huddle is by the service leads and it oversees the implementation of a programme of improvement for specialist rehabilitation. It continues to make great progress in this area and key achievements include rehabilitation hubs and enhanced community working.

Rehabilitation Hubs:

Plans are underway to develop technology-enabled rehabilitation hubs at Woodend Hospital's Neuro Rehab and Stroke Units, enhancing personalised care and independent rehabilitation practice.

Enhanced Community Working:

The Specialist Rehabilitation Service is collaborating with the sports and leisure sector to improve access to facilities and offer strength and balance classes and gym support at Woodend Hospital on weekends.

Programme:

2. Home Pathways - Develop and deliver local and sustainable system flow and return to home pathways with partners, supporting reduced hospital admission, delays in hospital discharge and out of area placements.

Project: *Help people to ensure their current homes meet their needs including enabling adaptations.*

This project helps to ensure that homes of all types of tenure are suitably adapted to meet the needs of the people of Aberdeen City so that people can live independently in their own home for as long as possible. This project is managed and monitored by the Disabled Adaptations Group (DAG) who also oversee the budget expenditure, ensuring best value for money is obtained and that resources are targeted where they are needed most.

The DAG comprises of various members from ACC, ACHSCP, Registered Social Landlords, Bon Accord Care, private sector housing and Care and Repair. DAG monitors the number and type of adaptions undertaken by each organisation throughout the year and uses this data to track demand and help plan for future resources.

A major adaptation is defined as work which "addresses complex needs and involves expensive, permanent structural changes to a person's home, such as widening doors for wheelchair access, provision of shower facilities, ground floor toilet or installation of a through floor lift".

A minor adaptation is defined as work which "is relatively inexpensive and may be fitted easily and quickly, such as grab-rails for support".

Programme

3. Frailty - Ensure there is a consistent approach to supporting Frail patients in Aberdeen both in a hospital and community setting with a focus on shifting towards community based support where possible.

Project: *The following projects are overseen and incorporated here under the work of the Frailty Programme Board. The list of projects managed by the Frailty Programme Board can be found on page 35.*

The Grampian Frailty Programme Board is in place to ensure that there is appropriate support for older adults experiencing frailty within the region. It oversees the shared objectives of each of the three health and social care partnerships, Aberdeen City, Aberdeenshire, and Moray.

Representatives from frailty in Grampian worked with Health Improvement Scotland (HIS) to develop and publish the new HIS frailty standards – 'Ageing and Frailty – Standards for the Care of Older People'. These have replaced the HIS Standards of Care for Older People in Hospital (2015). The new standards apply to all settings where those with frailty receive health and social care. The adherence and alignment to these standards by each of the three partnership areas continues to be taken forward to improve the integration of their frailty services, whilst ensuring people and their rights are at the centre of this process.

A shared learning culture across the three partnership areas is embedded for frailty. A Grampian wide frailty workshop took place to understand the frailty pathways in each of the three areas through the production of detailed process maps. This exercise enabled a better understanding of the current challenges within the frailty system and the sharing of good practice.

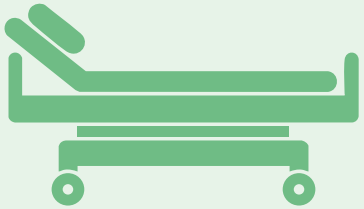
Programme:

4. Hospital at Home Expansion - increase our Hospital at Home base with an ultimate ambition of 100 beds. These will be for Medical and Respiratory Pathways as well as the current Frailty, End of Life Care and OPAT Pathways.

The Hospital at Home service in Aberdeen city provides acute level care in an individual's own home for short term, targeted interventions. Since the first patient was received by the service back in 2018 it has expanded significantly, increasing the number of patients it can care for and the conditions it manages, demonstrated by Graph 1 (on next page). The year 3 delivery plan had outlined the intention to increase the capacity in the hospital at home service to 100 beds, however the financial situation has meant that it was not possible to expand the service at this time. The team continues to predominately support older adults experiencing frailty but also manages respiratory and outpatient parenteral antimicrobial therapy patients, and more recently acute medicine patients. The service plays a significant role in the reduction of pressure on Aberdeen Royal Infirmary by enabling patients to avoid a hospital admission while also accelerating discharge for those patients with an ongoing acute need that can be managed at home. The Hospital at Home service allows patients to receive their treatment in an environment that they feel familiar with and comfortable in, giving people greater independence during their recovery.

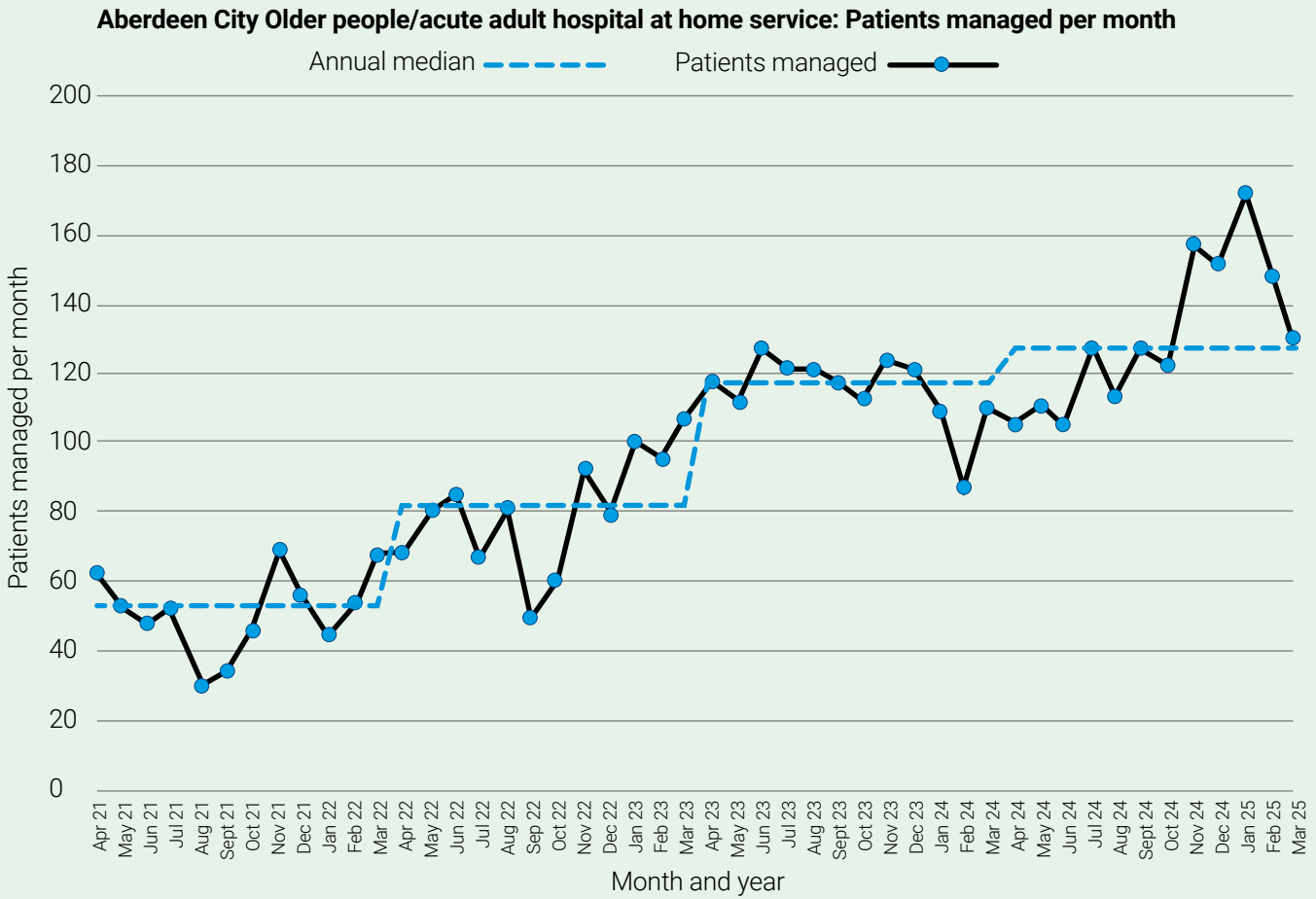
Approximately 73% of admissions were admission avoidance, and 27% were active recovery (earlier discharge from hospital).

Approximately 10,000 beds days



in acute sector were saved by admissions to Hospital at Home service in the 2024-2025 period.

Graph 1. Number of patients managed by month by the Hospital at Home Service.



Key successes in this period include, the development and embedding of a new acute medicine pathway within the service. This has been led by an acute medicine consultant and facilitates the step down of patients from Aberdeen Royal Infirmary. Direct referrals through the City Visits nursing team have been facilitated, and there continues to be increased referrals from General Practice while new pathways like Community Adults Assessment and Rehabilitation service (CAARS) and the heart failure nursing team have also been established. The service continues to receive high rates of positive patient feedback.

Here are some examples of what our patients have to say about the Hospital at Home service

"It was exceptional. All the staff who visited were informed, caring and very professional."

"The hospital at home team were amazing, very professional, caring and empathetic."

Overview of all projects named within the 2024-25 Delivery Plan under the Keeping People Safe at Home aim.

Programme/Projects	Link if Referenced within the report
Rehabilitation Review	
Implement the outcome of the strategic review of the Neuro Rehabilitation Pathway	The outcomes of the strategic neurorehabilitation review were approved by the IJB in October 2023 but have faced delays due to financial pressures. The need for implementation is under evaluation by Chief Officers of the three IJBs, with updates pending for the ACHSCP IJB as lead for the hosted service.
Develop a discussion paper to inform a strategic planning framework for the strategic review of rehabilitation across Grampian which will include Specialist Rehabilitation Services hosted by Aberdeen City IJB. This will include consideration of how partners in sports and leisure and wider community resources can assist in delivery of rehabilitation. This will consider rehabilitation delivery models including bed base and community requirements in line with national guidance including Scottish Government (SG) Progressive Stroke Pathway, SG Neurological Standards and Scottish Trauma Network Major Trauma minimal requirements guidance.	Please see page 31 for an overview of the work ongoing.
Review of Hosted Wheelchair Service model and processes to identify any areas where efficiency could be achieved.	A review of the Wheelchair Service identified improvement opportunities, focusing on safety, efficiency, and patient experience. Completed actions include a redesign of the stock management system for better storage and sustainable stock levels, a streamlined powerchair provision pathway reducing monthly costs, and a revised buggy provision process improving safety for children. Increased use of Near Me appointments has enhanced accessibility, reducing home visits from 34 per month in 2023-2024 to 19 per month in 2024-2025.
Home Pathways	
Help people to ensure their current homes meet their needs including enabling adaptations	Please see page 32 for an overview of the work ongoing.

Programme/Projects	Link if Referenced within the report
Frailty	
Ensure that there is step up and step down capacity for Frailty patients including the 40 beds within Rosewell and put forward recommendations for the use of the remaining 20 beds.	Please see page 32 for an overview of the work ongoing. Please note that this is encompassed under the entry for the Frailty Programme Board.
Ensure that the acute frailty wards within ARI are able to meet patient need and allow flow through the hospital.	Please see page 32 for an overview of the work ongoing. Please note that this is encompassed under the entry for the Frailty Programme Board.
Understand the Woodend-based Frailty provision requirement (patients with acuity of need needing in-patient care) - linked to the Review of Rehab	Please see page 32 for an overview of the work ongoing. Please note that this is encompassed under the entry for the Frailty Programme Board.
Develop a process map for all City patients flowing in and out of the Frailty Pathway, linking this with wider Grampian work to ensure consistency of processes.	Please see page 32 for an overview of the work ongoing. Please note that this is encompassed under the entry for the Frailty Programme Board.
Ensure there are appropriate alternatives to Hospital for Frailty patients (delivering via Expansion of Hospital at Home	Please see page 32 for an overview of the work ongoing. Please note that this is encompassed under the entry for the Frailty Programme Board.
Develop Community, Prevention and Primary Care approaches to the HIS Frailty Standards Including those relating to falls, and align with existing prevention workstreams utilising the GIRFE approach where relevant.	Please see page 32 for an overview of the work ongoing. Please note that this is encompassed under the entry for the Frailty Programme Board.
Contribute to, and influence the decision making of, the Grampian Board for Frailty reporting to the USC Programme Board as required. (NB: programme management support being provided to Grampian Frailty Board by ACHSCP.)	Please see page 32 for an overview of the work ongoing. Please note that this is encompassed under the entry for the Frailty Programme Board.

Programme/Projects	Link if Referenced within the report
Hospital at Home Expansion	
Monitor use of Hospital at Home beds for the Frailty Pathway.	Please see pages 32-34 for an overview of the work ongoing. Please note that this is listed under the update for Hospital at Home Expansion.
Implement actions in relation to Hospital at Home beds available for Respiratory Medicine	Please see pages 32-34 for an overview of the work ongoing. Please note that this is listed under the update for Hospital at Home Expansion.
Implement actions in relation to Hospital at Home beds available for Acute Medicine	Please see pages 32-34 for an overview of the work ongoing. Please note that this is listed under the update for Hospital at Home Expansion.
Implement Workforce and Organisational Development actions for Hospital at Home expansion.	Please see pages 32-34 for an overview of the work ongoing. Please note that this is listed under the update for Hospital at Home Expansion.
Ensure digital and IT arrangements are in place for Hospital at Home expansion.	Please see pages 32-34 for an overview of the work ongoing. Please note that this is listed under the update for Hospital at Home Expansion.

Preventing Ill Health

By promoting health, we can help communities to achieve positive mental and physical health outcomes by providing advice and designing suitable support to help address the preventable causes of ill health, ensuring this starts as early as possible. The following table shows a list of the national indicators which the work undertaken under the preventing ill health aim intends to positively influence.

Strategic Measures

NI 2 – Percentage of adults supported at home who agree that they are supported to live as independently as possible
NI 9 – Percentage of adults supported at home who agree they felt safe
NI 12 – Emergency admission rate
NI 13 – Emergency bed day rate NI 14 – Readmission to hospital within 28 days
NI 15 – Proportion of last 6 months of life spent at home or in a community setting
NI 16 – Falls rate per 1,000 population aged 65+
NI 18 – Percentage of adults with intensive care needs receiving care at home
NI 19 – Number of days people spend in hospital when they are ready to be discharged, per 1,000 population
NI 20 – Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency

Within the Preventing Ill Health aim, there are two main programmes of work. The following information is divided by programme and will thereafter give an overview of the progress being made within various strands of work aligned to this.

Programme

1.Prevention - Keeping people healthy and avoiding the risk of poor health, illness, injury and early death

Project: *Reduce the use and harm from alcohol and other drugs including through the Drugs Related Deaths Rapid Response Plan*

The Alcohol and Drugs Partnership (ADP) have been working on delivering 5 main themes this year through their framework. The following outlines the themes and some of the progress which have been made on these.

Theme 1: Whole-Family Approach.

ADP is working towards full implementation of the Whole Family Approach Framework, including a commissioned Family Psychological Wellbeing Service and joint work with the Child Protection Committee. Family-inclusive practices are embedded in commissioning and care planning. Notably this year, all secondary schools have staff trained to administer naloxone, and S4 pupils receive training as part of their Level 6 first aid course

Theme 2: Reducing Harm, Morbidity, and Mortality

Aberdeen City ADP supports vulnerable groups through strategic partnerships, trauma-informed practices, and independent advocacy. Harm reduction services are widely available across various settings, including community pharmacies, hospitals, justice services, and outreach programs. Key achievements include the expansion of naloxone access and awareness through the Aberdeen Protects app and public access naloxone boxes.

Theme 3: Service Quality Improvement

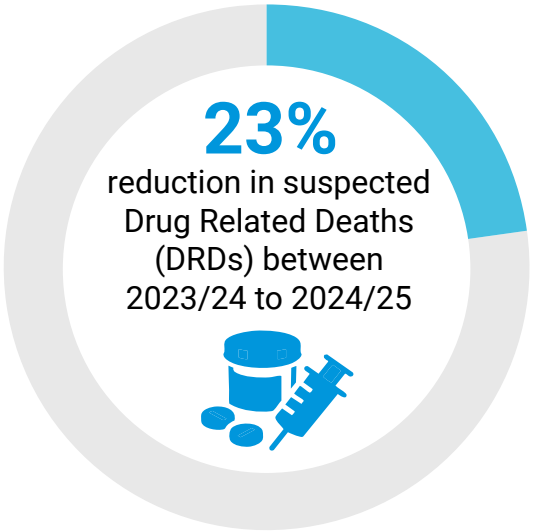
Efforts to improve service quality include outreach to engage individuals at high risk of substance use harm. The project has seen a 15% increase in the percentage of people no longer considered at risk after engagement with the service.

Theme 4: Supporting Recovery Efforts

Efforts to reduce stigma workshops and the development of a local charter of rights aligned with the national charter. Recovery initiatives include the co-design of an employability pathway with ABZ Works, which supports people in recovery into employment. Aberdeen In Recovery (AiR) runs sessions on weekends to ensure support is available when needed. The initiative has seen significant engagement, with 144 members and over 18,000 SAFE (Stable Addiction-Free Engagement) hours recorded in 2024/25.

Theme 5: Intelligence-Led Delivery

ADP has robust structures for monitoring alcohol and drug harms, including an independently chaired Substance Death Review Group and mechanisms to monitor drug trends. Protocols are being revised to address emerging threats such as nitazines, ketamine, crack cocaine, and safe sleep practices. Local data suggests that people in the most deprived communities are significantly more likely to die from substance use, and efforts are focused on high-risk individuals to address their needs holistically.



Project: *Deliver actions to meet the Healthcare Improvement Scotland (HIS) Sexual Health Standards*

Aberdeen City is committed to becoming a Fast Track city. This means the city will strive to meet the '90-90-90' targets set by the Paris Declaration by:

Ensuring
90% **of people living with HIV know their status**

Improving access to anti-retroviral treatment (ART) for people living with HIV to
90%

Increasing the proportion of people living with HIV on ART with an undetectable viral load to at least
90%

This declaration also commits cities to reduce stigma and discrimination related to HIV to zero – and also sets long-term goals by 2030 of zero new HIV transmissions, zero HIV-related deaths and zero HIV-related stigma.

In December 2024, a local awareness campaign was created to help debunk historical myths and reduce stigma. This was co-developed with partners from the Fast Track city working group and was promoted across key partners such as Education and Children's Services, and the Aberdeen City Vaccination and Wellbeing Hub in the lead up to 'World Aids Day'.

Project: *Increase uptake in Childhood Immunisations*

The declining vaccination uptake within the pre-school age range across Grampian and Scotland has become a significant concern, with factors such as vaccine hesitancy and post-COVID vaccine fatigue contributing to this trend. To address this, the Partnership aimed to improve childhood vaccinations through a variety of actions. These included:

1. Expansion of clinics

The expansion of pre-school vaccination clinics across Aberdeen has improved access and uptake of childhood immunisations. New clinics opened in mid-2024 at Tillydrone Community Campus and Inverurie Road Health Centre, followed by three more in early 2025 at Torry Health Centre, Countesswells Health and Wellbeing Clinic, and the Aberdeen Health Village. These additions complement existing sites, creating a broader, more accessible network. Families have reported increased convenience, reduced travel, and a welcoming local environment, helping address health inequalities. Early results show improved vaccination coverage and engagement with underserved communities.

2. Family Health & Wellbeing Event

The Family Health and Wellbeing Event at Aberdeen Vaccination and Wellbeing Hub in July 2024 focused on early years education, health, and wellbeing in a fun, family-friendly setting. Highlights included the "Teddy Bear Hospital" where children learned about health and vaccinations through interactive play, and appearances by mascots and characters like princesses, superheroes, and Donnie the Sheep.

Over 20 organisations participated, offering activities to promote active lifestyles, nutrition, oral health, preventative health screenings, budgeting, education, and support for neurodiverse families.

Key outcomes included:

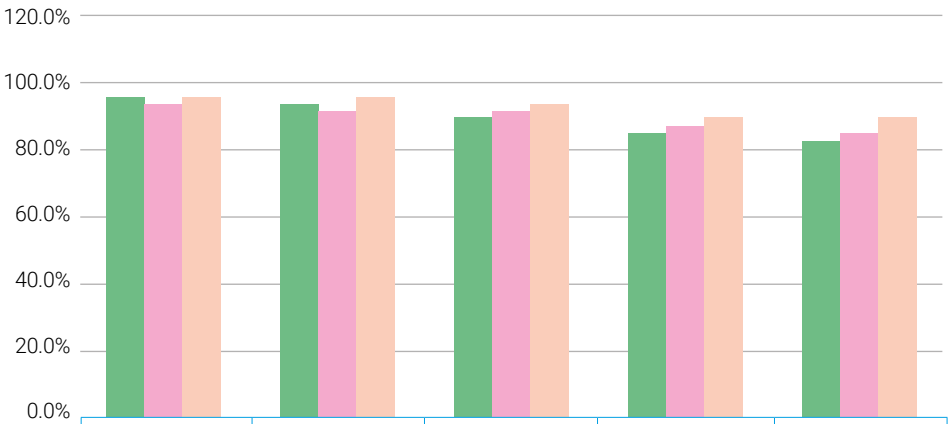
- High attendance (527) and positive feedback from families and partners
- Increased awareness of community services and health resources
- Reduced barriers to vaccination through approachable delivery
- Encouraged early development, literacy, nutrition, and physical activity
- Strengthened cross-sector collaboration among health, education, and third-sector partners
- Praised by families and partner organisations alike and serves as a model of how collaborative, community-based outreach can support both public health goals and empowering families with tools and knowledge to improve their overall wellbeing

3. Increased Social Media and in Person Promotion of Childhood Vaccinations

The childhood vaccination team effectively promoted timely vaccinations through in-person community engagement and enhanced social media activity. By attending local events and early years settings, they built trust and addressed family concerns, while their digital efforts extended outreach and reinforced key messages. This combination improved awareness, confidence, and vaccination uptake.

Based on data released by Public Health Scotland in March 2024, ACHSCP can evidence that these interventions have assisted with the uptake of vaccinations in Aberdeen City and the table below shows that by age 5, the **6 in 1 uptake has increased to 95.4%** and is within target range. The **2nd dose of MMR has increased by 2%** since December 2022, but is currently 5% below the Scottish average. Hib/MenC and the 4 in 1 vaccine have both increased in uptake between 1-2% over the past two years, however are still around 3-4% under the Scottish average and so this will continue to be an area of focus for improvement.

Uptake rates as at 5 years old



	6 in 1	MMR1	Hib/MenC	4 in 1	MMR2
Abdn Dec 22	96.1%	93.8%	90.6%	84.6%	82.70%
Abdn Dec 24	95.4%	93.1%	91.8%	86.4%	84.20%
Scotland Dec 24	96.6%	95.2%	94.5%	90.0%	89.0%

Project: *Contribute towards nicotine cessation agenda in Aberdeen City, for example by scaling up Vaping Awareness work across all localities in the City*

In 2024-2025, a new LOIP Charter was approved with the objective of reducing youth vaping. Actions from this includes the education provided to primary schools. We received valuable evaluation feedback from Greyhope Primary on our resources and further collaborated with Countesswells Primary School to plan and evaluate the impact of their vaping programme using our educational resources and connections made with ABSAFE to provide further learning. This initiative is helping organise project groups and streamline efforts to address vaping and smoking in the community.

The Partnership also developed and delivered training sessions, using ASH Scotland resources, on the Cost of Smoking for money advice staff, third sector organisations, and volunteers. These sessions increased attendees' knowledge and confidence in providing Very Brief Advice, highlighting the financial impact of smoking, and support options available for smoking cessation.

Project: *Continue to deliver our Stay Well Stay Connected programme to keep people healthy and in good wellbeing, and avoid the risk of social isolation, poor health, illness, injury and early death.*

Stay Well Stay Connected (SWSC) is a community-based programme of early intervention. The aim is to keep older people healthy, to experience good wellbeing for as long as possible, and avoid the risk of social isolation, poor health, illness, injury, and early death. **More than 1,700 people have taken part in SWSC activities** this financial year. The following provides some examples of the activities which have been on offer.

SWSC in partnership with Men's Sheds hold monthly workshop and talks on health and wellbeing topics relevant to men for both Men's Shed Bridge of Don and Dyce. The range of topics have included: prostate cancer, healthy eating, suicide prevention awareness, cooking sessions and health MOTs.

In partnership with the Scottish Football Association, SWSC delivered Menopause Goals in a programme designed around the impacts of the menopause and the support available to women during this time. The programme included understanding physical changes, relationship challenges, how to take control and what treatment options are available. 7 women completed the eight week programme in November 2024.

SWSC delivered the annual women's health and wellbeing fair as part of the 16 days of activism against Gender Based Violence. 32 stall holders from a range of organisations including statutory, voluntary and charitable took part. Feedback indicated that women who attended the event appreciated the opportunity to have meaningful conversations at the stalls.

Boogie in Bar is an older adult day time disco including a light lunch, helping those at risk of social isolation and loneliness. The boogies remain very popular with local residents and have good attendance all year round. Care homes and sheltered housing residents enjoy coming along to these too. There are several boogies being supported by SWSC in the city, including Sunnybank Football Club, Green Trees, Dee Swimming Club, The Abbott and The White cockade. Some boogies have greatly appreciated volunteers who help to run the events, provide a warm welcome and act as DJ. National Lottery, Participatory Budgeting, and Health Improvement Funding have helped to make these boogies the success they are.

SWSC Soup and Sannies continued to be very popular in 2024/2025 and from one location initially it has now spread to three. Soup and Sannies are now in Seaton, Cornhill and Torry. Successful applications for Health Improvement Funding helped establish two new Soup and Sannies in 2024 not only increasing social connectedness for isolated older people but it providing a nutritious meal. Soup and Sannies has some really engaged volunteers working alongside us in both the kitchen and serving the attendees making this a very sustainable model.

SWSC supported the Compassionate Buildings and Spaces project in two sheltered housing complexes. Input from SWSC established a monthly Boogie in the Hoose, both complexes took part in Dementia Awareness sessions run by Age Scotland and residents take part in a Fun Activities Leader Training course to enable them to run Body Boosting Bingo session with their neighbours.

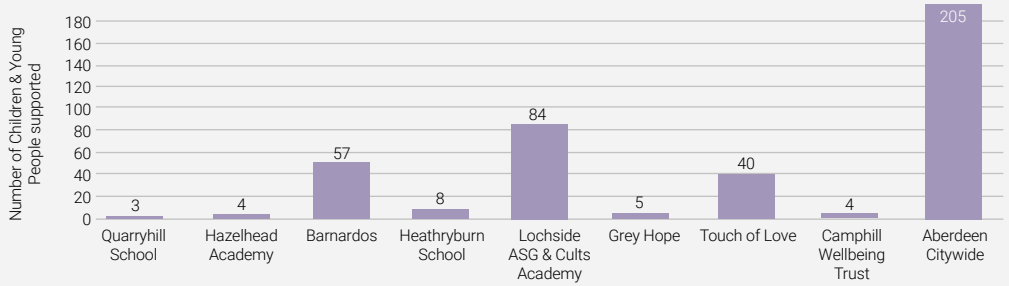
SWSC along with Strikers Walking Football has a significantly improved calendar available to promote men's health in 2024-2025. Along with the regular Walking Football there is a Parkinson's Walking Football group, Walking Padel sessions, Pilates and muscle strengthening and balance sessions, spring and autumn golf trips, annual functional fitness MOTs, talks on Men's health and wellbeing topics and regular social events.

Project: *Contribute towards addressing the obesity epidemic through promotion of healthy food and nutrition, active travel, and place planning*

The Whole Systems Approach (WSA) to healthy weight is an evidence- based programme developed by Leeds Becket University. It involves drawing on local authorities, statutory bodies strengths and engaging with communities and local assets to identify and help people make healthier choices. Adopting a WSA, will help reduce the prevalence of child and adult obesity and see further positive changes to health and lifestyle including employability and productivity of the local population. The Scottish Government initiated the Whole System Approach (WSA) Early Adopter Programme in 2019 as a key in delivering Scotland's Diet and Healthy Weight Delivery Plan (2018). This will support the ambition of halving childhood obesity by 2030.

Over the past year, the Partnership have focused on initiating Healthy Weight Aberdeen (HWA) drive by achieving milestones through the six phases of Whole Systems Approach. We have established a multiagency Healthy Weight Strategic Network Group (SNG). The group have undertaken a cross- sector mapping exercise which has identified organisations existing actions in tackling diet related inequalities and food insecurities. Please refer to Graph 2 which highlights the impact on young people of Food Champions Confidence To Cook a Tier 1 weight management prevention programme. The HWA has also been established as part of Aberdeen City LOIP. The focus on developing Healthy Weight actions will be using existing (or new) strategic approaches that can be used to ensure the delivery will focus on the wider determinants of health. Please refer to figure 1 which gives the snapshot of HWA journey. Several videos[9] are available to watch on the ACHSCP website which gives an overview of the project and some of the intended outcomes the annual report[10] which was published in August 2024 is also available for further information.

Graph 2 Number of Young people reporting improved Healthy Eating behaviour, cooking skills and knowledge 2023-2025



Healthy Weight Aberdeen Journey

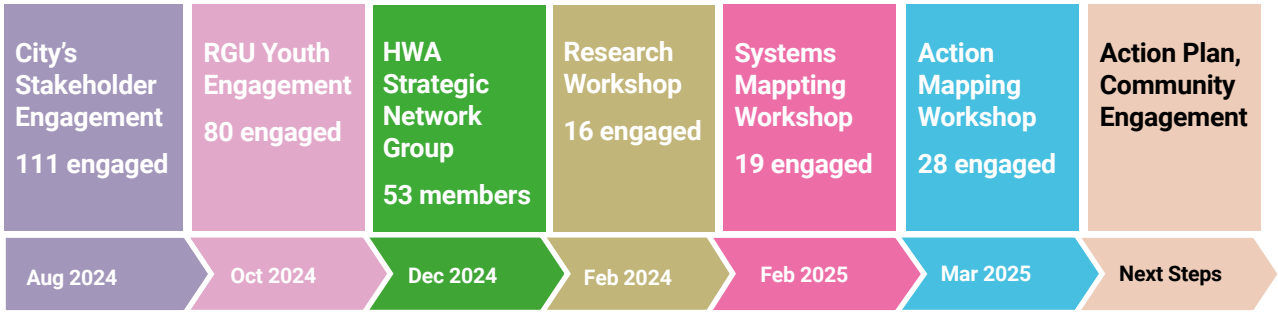


Figure 1

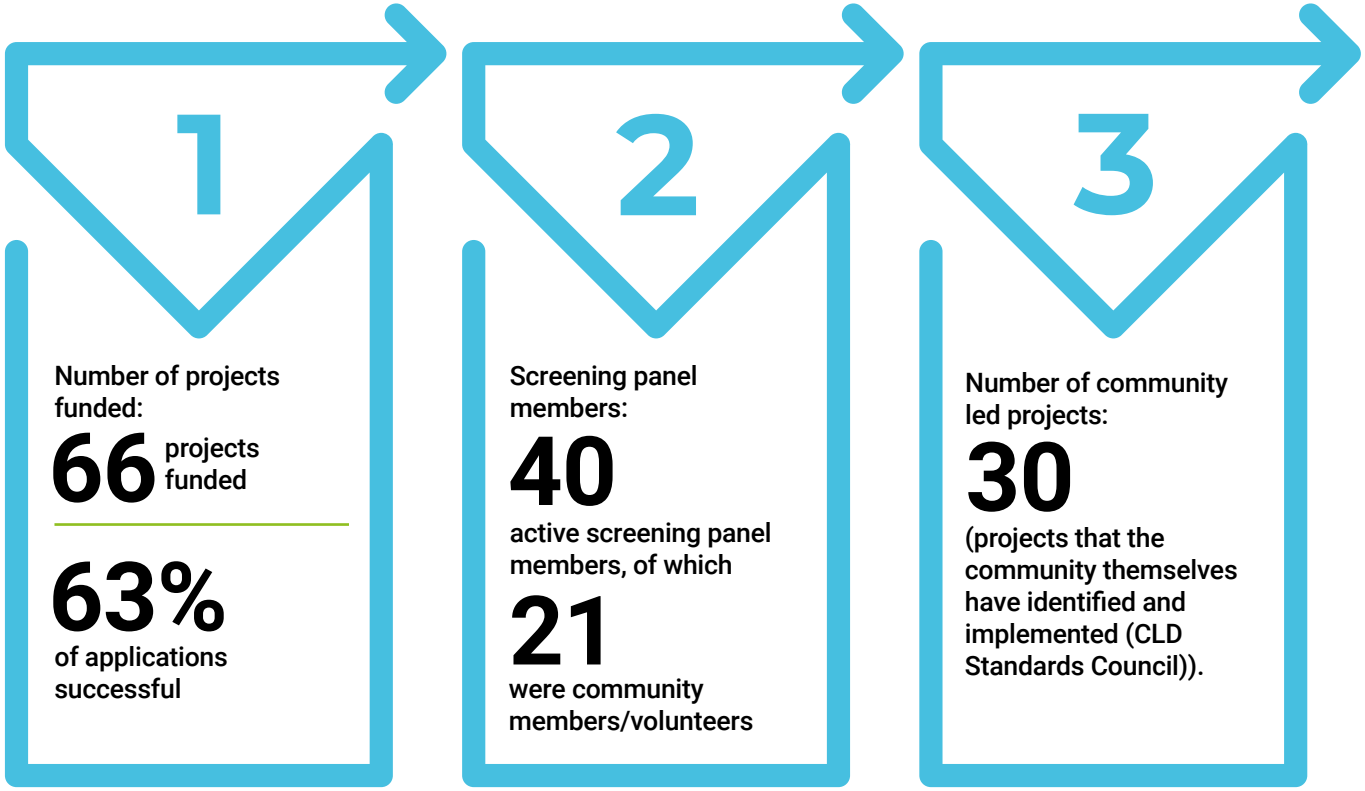
[9] Healthy Weight Aberdeen Videos are available on the ACHSCP website using the following address https://www.aberdeencityhscp.scot/our-delivery/communities-new/FH/hwavid/

[10] Healthy Weight Annual Report August 2024 https://www.aberdeencityhscp.scot/contentassets/4706d5854ae74abeb9efed35282edc6c/healthy-weight-aberdeen-report-30-aug-2024_logo.pdf

Project: *Contribute towards tackling health inequalities in Aberdeen City through delivery of the Health Improvement Fund and wider collaboration with community planning partners.*

The Health Improvement Fund (HIF) seeks to improve health and wellbeing in communities across Aberdeen City. The Fund is awarded through community grants of up to £5,000. Anyone living and/or working in Aberdeen City is eligible to apply.

All applications must support at least one priority of the ACHSCP's Strategic Plan, as well as, supporting at least one priority from the associated Locality Plan or LOIP. Applications are assessed by screening panels which consist of community members and volunteers, as well as, third and public sector staff.



Building relationships with other local funders

The Health Improvement Fund works alongside other local funders in a multi-agency project group to support priority 16.5 of the LOIP. The priority aims to ensure access to local funding is as simple as possible for communities, and expand the amount of funding distributed by local funders across Aberdeen City using non-traditional methods.

For Projects whose funding ended in 2024-2025

393 volunteers contributed 9,295 hours, valued at £146,953.95
8,884 individuals directly supported
Estimated £2.7 million return to the health and social care economy through preventative activities
A year-end review showed that 64% of projects are continuing beyond the initial funding period, demonstrating strong community integration and sustainability.

A wide range of different projects representing community priorities have been supported through the HIF fund, including:

Self-help and Self-management	23%
Children and Young People	21%
Older Adults	16%
Inclusion & Social Isolation	15%
Food & Food Growing	11%
Environmental Improvements	8%
Physical Activity	7%

Some examples of projects funded through the Health Improvement fund in 2024-2025 include:

Sustaining and Expanding Health Networks: Through joint work with NHS Grampian Public Health and supported by the Health Improvement fund we successfully supported GREC in sustaining their Health and Diversity Network and recruiting an additional 20 health champions, enhancing community health messaging and support.

Training and Engagement Initiatives: Working with CHEX Scotland we trained a multi-agency group of staff to deliver the Health Issues in the Community programme which supports a community led health approach within Aberdeen. Funding was agreed to support training GP Link Practitioners in Nature Prescriptions in partnership with the RSPB and supporting GREC have been supported to recruit a dedicated Community Connector for the Clinterty Gypsy and Travellers.

Cancer Screening Awareness: Deliver of a health issues in the Community course in Sunnybank and Old Aberdeen and tailored to support the uptake of cervical cancer screening uptake. The initiative empowered local women with health advocacy skills and supported the development of resources for community health awareness.

Project: *Scale up the Healthier Families Peep programme to support a whole family approach to health and wellbeing.*

Healthier Families Peep (Peers Early Education Partnership) is a programme that can be delivered by early years Peep for families practitioners with toddlers aged 1-3 years. The eight week programme

was developed in partnership with Peep to support child healthy weight tier one delivery. Peep programmes are fun, interactive learning experiences which provide families with simple, low cost ideas to support children's learning in everyday life. The Healthier Families programme incorporates key health messaging around food and hydration, sleep and routines, and physical activity and screen time into activities, songs and playing together.

During 2024- 2025, a successful funding application to the Child Healthy Weight Fund enabled us to recruit ten Early Years Practitioners (EYPs) to attend two days of core Peep training. Delegates then attended a further half day, in-person training session which was developed to support use of the toolkit. The half day training was evaluated to ensure Peep trained practitioners' knowledge, skills, and confidence improved in key health messaging, and practitioners felt supported on the practical delivery of the Healthier Families programme. The training has now been delivered to 27 Peep practitioners across various services in Aberdeen City and has received positive feedback. Seven groups have been created, and 51 families have participated so far in the programme.

Programme

2. Communities - provide community based services codesigned and co-delivered with our communities.

Project: *Deliver various events such as Age Friendly Aberdeen, the Gathering and a Well Being Festival to support people to live well and independently as part of their communities.*

The Grampian Gathering was held at the Beach Ballroom on Saturday 12 October 2024. The event promoted active ageing and aimed to improve population health and wellbeing, with a view to reduce demand and pressures on the wider health and social care system through preventative approaches, whilst encouraging community empowerment and greater self-management of health and wellbeing.

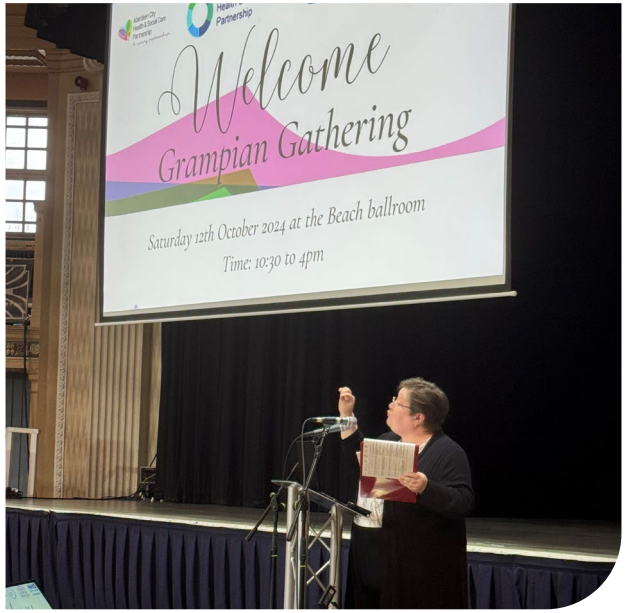
The Gathering provided an opportunity for community members to have open conversations on living well, planning for end of life, and having a good death – topics that are often uncomfortable and sometimes stigmatised. The event programme included eight celebrated speakers, taster sessions, live musical performances, and community information stalls. Evaluation data from the event is outline below:

- **369 people attended the Gathering,** including 193 community delegates which was a 16% increase on the 2023 Gathering
- **61 stall holders** from across private, public, third, independent, and community sectors provided information, training, and resources to delegates
- **84%** of community delegates who took part in the evaluation **graded their experience at the Gathering to be 8/10 or greater**

The Grampian Wellbeing Festival was held during May 2024 and was the first time that ACHSCP took part in the festival. The aims of Wellbeing Festival were to create opportunities for people to access activities which would improve their mental health and wellbeing, whilst ensuring services were not stigmatising people.

The Partnership identified and supported 37 hosts from across the public, third, and community sectors to deliver activities and events during the festival. Evaluation data from the festival is outlined below:

- **19 organisations** and groups hosted 38 single events.
- 17 organisations hosted **226 multiple events**
- Aberdeen City Health and Social Care Partnership hosted the Grampian Meaningful Activity (GMEN) Festival event with **23 stall holders and 57 attendees** on 30 May 2024
- There was a total of **264 Wellbeing Festival events** held across the city during May 2024



"I thought this event was one of the best conferences I have attended over the past year. It was great to have all the tables in the same room as the speakers - felt very inclusive and felt able to participate in everything. Looking forward to being able to participate in these events going forward."

Attendee Feedback on GMEN Festival on 30 May 2024

Project: *Work on a system-wide basis to increase community and professional capacity through community led development approaches such as Health Issues in the Community.*

Health Issues in the Community (HIIC) continues to empower community members and organisations to support health and wellbeing needs. Here are the three main achievements for 2024/2025:

1. Expansion of HIIC tutor Training Programs:

- 10 new HIIC tutors trained in Aberdeen City, expanding the reach to more community groups.
- Increased collaboration with 7 services and organisations, including new partners like Pathways, Barnardo's and Aberdeen City Community Learning and Development.

2. Enhanced Community Engagement and involvement

- 10 new HIIC tutors trained in Aberdeen City, expanding the reach to more community groups.
- Increased collaboration with 7 services and organisations, including new partners like Pathways, Barnardo's and Aberdeen City Community Learning and Development.

3. Sunnybank Community Centre Initiative:

- Continued efforts to improve cervical cancer screening uptake in Sunnybank and Old Aberdeen. The Health Issues course was arranged to support a focus on women's health and wellbeing.
- Empowered local women with health advocacy skills, resulting in:
  - 3 participants becoming GREC Health Champions.
  - A number of participants booking cervical smear tests, with several more planning to attend.
  - Expanded vaccination information sessions at the Community Centre.

These achievements highlight HIIC's ongoing commitment to fostering community health and empowerment. Next steps for 2025/26 is to support the existing tutors to support the delivery of Health Issues in the Community going forward within our communities.

Overview of all projects named within the 2024-25 Delivery Plan under the Prevention aim.

Programme/Projects	Link if Referenced within the report
Prevention	
Reduce the use and harm from alcohol and other drugs including through the Drugs Related Deaths Rapid Response Plan	Please see page 38 for an overview of the work ongoing.
Deliver actions to meet the HIS Sexual Health Standards	Please see page 39 for an overview of the work ongoing.
Increase uptake in Childhood Immunisations	Please see page 39 for an overview of the work ongoing.
Contribute towards nicotine cessation agenda in Aberdeen City, for example by scaping up Vaping Awareness work across all localities in the City	Please see page 41 for an overview of the work ongoing.
Continue to deliver our Stay Well Stay Connected programme of holistic community health interventions focusing on the prevention agenda.	Please see page 42 for an overview of the work ongoing.
Contribute towards addressing the obesity epidemic through promotion of healthy food and nutrition, active travel, and place planning	Please see page 44 for an overview of the work ongoing.
Contribute towards tackling health inequalities in Aberdeen City through delivery of the Health Improvement Fund and wider collaboration with community planning partners.	Please see page 45 for an overview of the work ongoing.
Scale up the Healthier Families PEEP programme to support a whole family approach to health and wellbeing.	Please see page 46 for an overview of the work ongoing.
Work on a system-wide basis to increase community and professional capacity through community led development approaches such as Health Issues in the Community	Please see page 48 for an overview of the work ongoing.

Programme/Projects	Link if Referenced within the report
Prevention	
Work with NHSG Public Health Directorate and alongside other Grampian Health and Social Care Partnerships to explore the development of a public mental health approach for Aberdeen City	The Partnership are supporting NHS Grampian's Public Health Directorate to develop and implement a Public Mental Health Approach in Aberdeen City. Public mental health involves a population approach to mental health, and includes treatment of mental disorder, prevention of associated impacts, prevention of mental disorder and promotion of mental well-being, including for those people recovering from mental disorder. The Communities Team are working closely with the Public Health Consultant for Aberdeen City on the development of a Public Mental Health Approach.
Continue to contribute to the Health Transport Action Plan (HTAP) and the Aberdeen Local Transport Strategy (ALTS) encouraging sustainable and active travel.	The Partnership supported the development of the HTAP for 2024-29. This included Partnership staff taking part in workshops, contributing through HTAP meetings, and reviewing the draft document with the HTAP Programme Manager. As part of the Walking Workplace programme, a monthly staff health walk has been set up with support from Paths For All. The purpose of the walks are to promote staff wellbeing and encourage active travel. The walks last approximately 20-30 minutes and have been well attended so far. As part of the Walking Workplace programme, posters to encourage active travel were also displayed across Aberdeen City Health and Wellbeing Village (Frederick Street).
Work alongside the Children's Services Board (CSB) on prevention and early intervention particularly in reducing local variations in health factors	Over the past year, we have worked closely with the CSB to support a shift towards prevention and early intervention, moving beyond project-based approaches to foster a broader culture of prevention. This includes joint work on child healthy weight and mental health, with an emphasis on integrated delivery and a refreshed focus under the upcoming Local Outcome Improvement Plan 2026. Activity has also supported children's physical wellbeing and contributed to tackling child poverty, for example through alignment with baby milk support initiatives and strengthening collaboration among statutory partners in the Children's Poverty Action Planning process. The Health Determinants Research Collaborative continues to play a key role in supporting this agenda, helping to address inequalities in children's early experiences through evidence-informed action.
Communities	
Deliver various events such as Age Friendly Aberdeen, the Gathering and a Wellbeing Festival to support people to live well and independently as part of their communities	Please see page 47 for an overview of the work ongoing.

Achieve Healthy Fulfilling Lives

The intention is that by supporting people to help overcome the health and wellbeing challenges they may face – particularly in relation to inequality, recovering from Covid-19, and the impact of an unpaid caring role – we can help to enable them to live the life they want, at every stage. The following table shows a list of the national indicators which the work undertaken under the Achieving Healthy Fulfilling Lives aim intends to positively influence.

Strategic Measures
NI 1 – Percentage of adults able to look after their health very well or quite well
NI 7 – Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life

Within the Achieving Healthy Fulfilling Lives aim, there are five main programmes of work. The following information is divided by programme and will thereafter give an overview of the progress being made within the various projects aligned to this.

Programme

1. Home Pathways - Develop and deliver local and sustainable system flow and return to home pathways with partners, supporting reduced hospital admission, delays in hospital discharge and out of area placements.

Project: *Review Scheme of Assistance with a view to revising criteria for eligibility for funded application support.*

There is a concern that the demand for disabled adaptations may exceed the budget available for these services. Initially, it was considered necessary to amend the Scheme of Assistance to ensure that those with the greatest need were supported. However, upon review, it was found that the Scheme was accurate and aligned with Statutory Guidance and other health and social care partnership arrangements. It was identified that the guidance for Occupational Therapists performing assessments needed to be more robust and consistent, so a review was conducted and additional training provided. This will ensure a consistent approach to needs assessment and the provision of disabled adaptations across the city. During this review, it became clear that the support from Aberdeen City Care and Repair is crucial for individuals who do not meet the assessment criteria for mainstream services, and we are pleased to continue grant funding for this essential service.

Project: *Investigate whether we can bring people back into authority and whether this is more cost effective.*

The Stoneywood Project aims to develop specialised housing designed to support individuals with learning disabilities and complex care needs. The project focuses on creating a safe, supportive, and well-equipped environment that promotes the well-being and independence of its residents.

The project has successfully advanced through various stages of construction, with all building kits erected and the site nearing completion. The team has managed to stay on track despite some weather-related delays.

The Richmond Fellowship Scotland (TRFS) has been appointed as the service provider. They have made significant progress in recruiting key staff members, including a Team Manager, Seniors, and Support Practitioners. The recruitment process has attracted a high number of qualified candidates, ensuring a strong team to support the residents.

The project is on track for completion and handover by mid-2025. The team will focus on finalising construction, ensuring all facilities are fully operational, and preparing for the residents' move-in. Detailed plans are in place to support the transition of residents into their new homes. This includes personalised support plans, engagement with families and guardians, and ensuring that all necessary legal and logistical arrangements are in place. The project will continue to evaluate the effectiveness of the Technology Enabled Care (TEC) systems in place, with a focus on learning and improvement. This will involve collaboration with key stakeholders to ensure the technology meets the needs of the residents and staff.

Programme:

2. Mental Health and Learning Disabilities (MHLD) - deliver Grampian wide and City specific MHLD transformation taking cognisance of national strategies, standards and service specifications

Project: *Deliver a capability framework for a workforce to support complex behaviour*

The Complex Care Capability Framework was developed in response to the Scottish Government's Coming Home Report (2018) and the Coming Home Implementation Report (2022). These reports identified significant barriers in social care, particularly the need for specialised staff training to support individuals with learning disabilities and complex care needs. The primary purpose of the Capability Framework is to outline the core skills and training requirements for staff at various levels, ensuring a stable, therapeutic, and capable environment for those in need.

The development and implementation of the Capability Framework involved significant collaboration with various stakeholders, including the Principal Clinical Psychologist and providers within the Complex Care Framework. This collaborative approach has ensured that the framework incorporates best practices and meets the wider objectives of the Scottish Government's Coming Home Implementation Report. The framework was finalised and approved for use by the Complex Care Programme Board in April 2024. It outlines extensively, key training requirements including Positive Behaviour Support (PBS) training, which is crucial for managing challenging behaviours. The Capability Framework was successfully utilised as part of the commissioning process for the Stoneywood Complex Care housing build in September 2024. This set out the training and skills expectation for the preferred service provider and subsequently all staff who would deliver services to residents of the Stoneywood project.

Regular evaluations of the Capability Framework will be conducted to identify areas for improvement and ensure that the framework remains relevant and effective in meeting the needs of both staff and service users. Efforts will be made to enhance engagement with stakeholders, including service users, families, and care providers, to gather feedback and ensure that the framework continues to evolve in line with their needs and expectations.

Project: *Progress the Grampian wide MHLD Transformation Programme monitored by the Portfolio Board ensuring project groups are established to ensure delivery and implementation of national Strategies, Delivery Plans, Standards and Service Specifications.*

The Mental Health and Learning Disabilities (MHLD) Programme aims to improve mental health and learning disability services across Grampian. It focuses on enhancing patient outcomes, streamlining service delivery, and ensuring compliance with national standards. The MHLD Programme has successfully mapped out the Adult General Mental Health Pathways across Grampian, identifying 40 improvement actions which aim to enhance patient and service outcomes through better efficiency and governance.

Services have implemented high-quality care standards, secured funding for infrastructure improvements, and developed a comprehensive risk assessment and operational plan including:

1. The Psychological Therapies service have achieved significant compliance with the Referral to Treatment (RTT) standard, expanded the workforce, improved data quality, and implemented innovative approaches like Computerised Cognitive Behavioural Therapies (C-CBT).
2. The Dementia Post Diagnostic Support project has streamlined referral processes and enhanced support for individuals with dementia, while the LD Health Checks project has co-ordinated the development and implementation of delivery models across Grampian to ensure annual health checks for people with learning disabilities are provided, addressing health inequalities and promoting early intervention.

The MHLD Programme plans to continue addressing outstanding actions in Adult Mental Health Pathway Mapping, complete infrastructure improvements in Forensic Services, and enhance delivery models for LD Health Checks to ensure sustainability and improved engagement.

Project: *Review strategy and arrangements for Learning Disabilities / Autism and Neurodevelopmental needs. To be informed by new legislation (current consultation on LD, Autism and Neurodivergence Bill)*

Working on a Grampian wide basis and in tandem with the National Autism Implementation Team, the project undertakes service development work which aims to continue to provide support to the Adult Autism Assessment Team (AAAT). The team provides adult assessment and diagnosis to patients across Grampian and works with people whilst waiting

for assessment through tools such as information resources and drop in sessions.

The project is also actively involved in the consultation of the Learning Disabilities and Autism and Neurodiversity (LDAN) Bill.

Programme:

3. Strategy - develop and implement local strategies to ensure alignment with national and regional agendas

Project: *Undertake and publish Impact Assessments, where relevant, for major service change, in conjunction with people and communities with the relevant protected characteristics ensuring that the requirements of the UNCRC are incorporated.*

The Equalities Human Rights Commission (EHRC) has been conducting an improvement programme with all IJBs since 2022. As part of this initiative, compliance measures were established to ensure adherence to the Equalities Act 2010 (Specific Duties) (Scotland) Regulations 2012.

In February 2025, the Commission conducted a compliance check on ACHSCP's published work and the information available on our website. The Commission expected that the Partnership had published:

- A report on the Partnership's progress in achieving equality outcomes from within the last two years.
- A report on how the ACHSCP IJB mainstreams equality into its business and activities over the past two years.
- Any equality impact assessments of new or revised policies and practices published by the Partnership since 1 April 2023.

ACHSCP received positive feedback and met all compliance requirements set out by the Public Sector Equality Duty, as verified by the EHRC. The Commission found the development work undertaken by ACHSCP to be reassuring and noted improvements in our work with the sector over the past three years. ACHSCP have also been cited in national good practice examples shared by the EHRC for our actions in response to feedback and for incorporating a specific review stage in all of our Integrated Impact Assessments.

Project: *Climate Change and NET Zero. Embed consideration of the impact of climate change in health and social care planning and in business continuity arrangements aiming to reduce our carbon footprint and deliver on our Net Zero emissions target.*

The accountability and responsibility for climate change governance in relation to the delivery of Council and Health Board services largely lies with the Aberdeen City IJB's partner statutory bodies. ACHSCP recognises the importance of climate change adaptation and mitigation and the responsibility of the IJB to contribute to the Scottish Government's net zero and adaptation goals, within its remit and scope of influence. ACHSCP is committed to becoming a Net Zero organisation by 2045, and have a programme of work that aims to identify areas of influence within the IJB's remit, in particular in regards to Scope 3 emissions, behavioural change, and adaptation measures, as well as the reporting framework going forward; with the overall aim to ensure IJB decision-making will become climate-informed in the future.

The work is overseen by the ACHSCP Climate Change Strategic Oversight Group, consisting of representation from strategic planning, business and resilience; commissioning; sustainability and environmental policy.

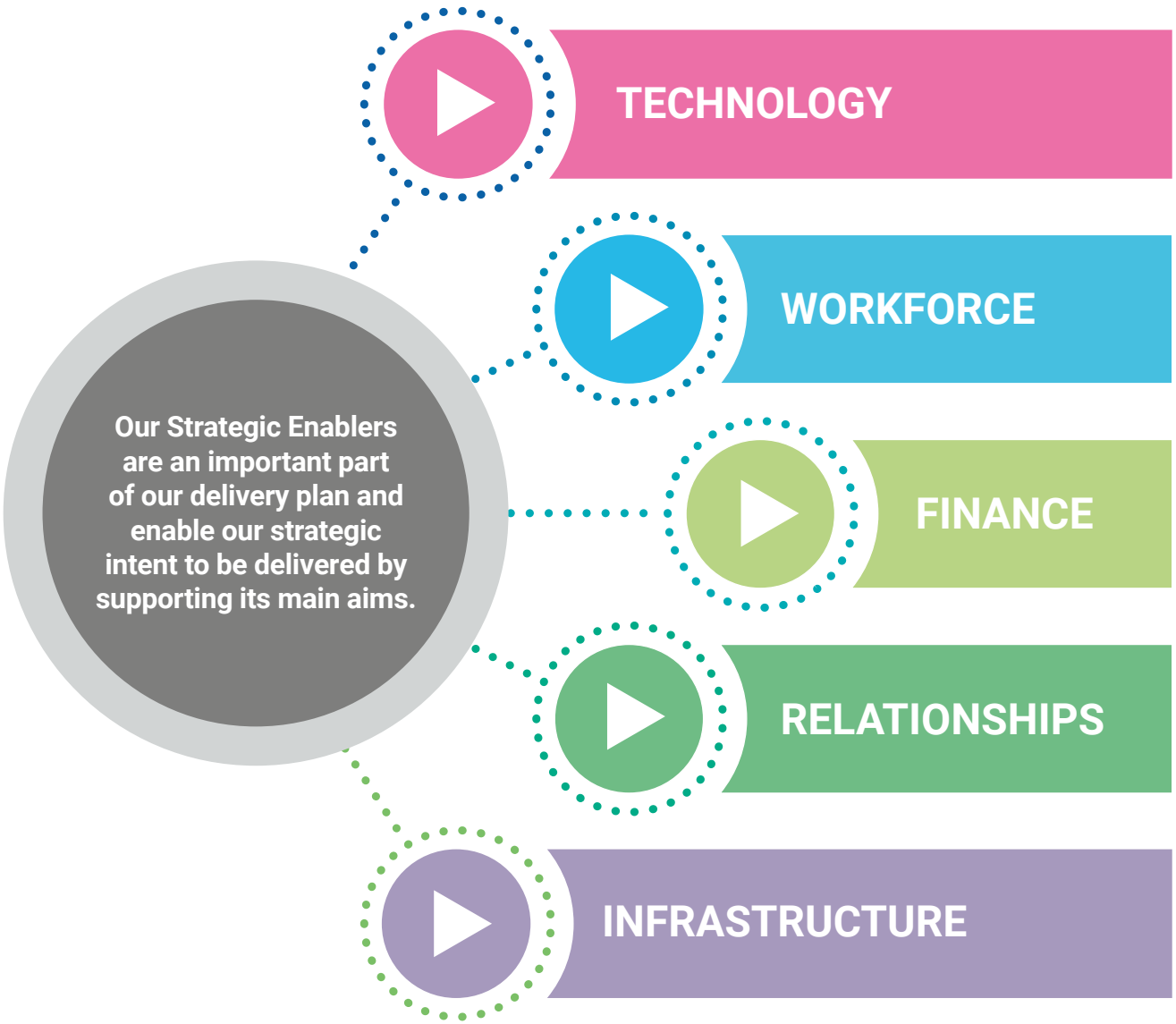
The Aberdeen City IJB, like other IJB's across Scotland, has had to reprioritise a large proportion of its focus towards financial sustainability initiatives given increasing financial pressures. This has meant that the progress on the Climate Change programme, like other programmes of work, have not progressed as quickly as originally anticipated to account for this. Given the financial situation is likely to continue to be challenging, we are considering how we can design our activities in such a way to account for this moving forward.

Overview of all projects named within the 2024-25 Delivery Plan under the Achieving Healthy Fulfilling Lives aim.

Programme/Projects	Link if Referenced within the report
Home Pathways	
Investigate whether we can bring people back into authority and whether this is more cost effective.	Please see page 51 for an overview of the work ongoing.
Review Scheme of Assistance with a view to revising criteria for eligibility for funded adaptation support.	Please see page 51 for an overview of the work ongoing.
Mental Health and Learning Disabilities	
Deliver a capability framework for a workforce to support complex behaviour.	Please see page 52 for an overview of the work ongoing.
Progress the Grampian wide MHLD Transformation Programme monitored by the Portfolio Board ensuring project groups are established to ensure delivery and implementation of national Strategies, Delivery Plans, Standards and Service Specifications.	Please see page 52 for an overview of the work ongoing.
Review arrangements for delivery of Post Diagnostic Support for people newly diagnosed with Dementia.	The Dementia Post Diagnostic Support (PDS) project has streamlined referral processes and enhanced support for individuals with dementia, a new contract is in place for PDS services which will improve experience at post-diagnosis stage.
Review NHSG Out of Authority Placements	A list of Out of Authority placements has been collated and is monitored regularly. Further work will take place to align this to Mental Welfare Commission requirements in 2025-2026 where possible utilising existing tools like the Dynamic Support Register.
Review strategy and arrangements for Learning Disabilities / Autism and Neurodevelopmental needs. To be informed by new legislation (current consultation on LD, Autism and Neurodivergence Bill)	Please see page 52 for an overview of the work ongoing.

Programme/Projects	Link if Referenced within the report
Mental Health and Learning Disabilities	
Develop and implement approaches to support Suicide Prevention and alignment to national Suicide Prevention Strategy	Whilst continuing to link in with the wider North East Suicide Prevention forums a specific Aberdeen City delivery group has been established which brings together representation from multiple agencies, for example Police Scotland, housing, third sector organisations. The group identifies and discusses local issues, gaps and priorities and uses their combined knowledge to implement an action plan targeted toward suicide prevention.
Strategy	
Deliver on our Equality Outcomes and Mainstreaming Framework, report on our progress to both the IJB and the Risk, Audit and Performance Committee and plan to revise the EOMF in advance of the 2025 deadline.	In May 2024, we produced an Annual Report displaying progress against our Equality Outcomes and Mainstreaming Framework (EOMF). Alongside this we also updated our Assessing our Impact policy and processes which support our Integrated Impact Assessments . We will continue to embed learnings identified by the DiversCity Officers Network and our Equalities and Human Rights Group who oversee the development and implementation of our guidance. The Equalities and Human Rights Commission repeated their February 2022 desktop review of IJB compliance with the Public Sector Equality Duty in February 2025 and reported that for Aberdeen City they found that improvements had been consolidated and all three compliance monitoring criteria had been fully met.
Undertake and publish Health Inequality Impact Assessments, where relevant, for major service change, in conjunction with people and communities with the relevant protected characteristics ensuring that the requirements of the UNCRC are incorporated.	Please see page 53 for an overview of the work ongoing.
Embed consideration of the impact of climate change in health and social care planning and in business continuity arrangements aiming to reduce our carbon footprint and deliver on our Net Zero emissions target.	Please see page 53 for an overview of the work ongoing.

Strategic Enablers



Programme:

Commissioning - Develop and deliver the Procurement Workplan incorporating our commissioning principles so that our commissioning is ethical, creative and co-designed and co-produced with partners and communities.

Project: *Review of Bon Accord Care (BAC) contract and redesign of associated service specifications.*

The BAC contract has now been reviewed. Utilising a co-design approach working with the various services that BAC provide, new service specifications were approved and have been added to the contract. The co-design approach allowed staff and teams to have a say and have involvement in shaping the contract and service specifications. The contract has been signed by both parties.

Project: *Explore how counselling service can work in a more collaborative, joined up way to support people experiencing care to benefit from a more holistic approach whilst achieving efficiencies*

Key members of the counselling services within Aberdeen met to discuss how services could work in a more collaborative and joined up way of working. An initial steering group meeting was organised to ensure that all opportunities were discussed and maximised at the start of 2025 however this paused due to budget discussions. Grant funding for the counselling services was recently approved at IJB and this will allow this work to progress with providers.

Project: *Review of Granite City Consortium (GCC) Contract to reflect flat cash agreement.*

The aim of the project is to develop and deliver the Procurement Workplan incorporating our commissioning principles so that our commissioning is ethical, creative and co-designed and co-produced with partners and communities.

A Care @ Home Strategic Oversight Group was convened, and a Teams site was established to support collaboration. An overarching plan is underway to align all workstreams. TEC workshops engaged professionals and individuals with lived experience to explore service improvements. The Climate Change workstream initiated training, integration and strategy development. Engagements with the Scottish Government also informed approaches to GIRFE and Ethical Commissioning, which are now being explored by the Lived Experience workstream. A GCC client feedback audit was completed to support quality improvement. A Risk Assessed Care pilot was launched with key actions including process alignment and discharge tracking. The Training Academy is comparing provider training packages and developing a collaborative framework, with leadership development and baseline data collection underway.

Programme:

Digital - maximise the use of technology to support innovation, efficiency and access to services.

Project: *Support the implementation of Electronic Medication Administration Recording (EMAR) in our care homes.*

ACHSCP has successfully implemented an electronic Medication Administration Record (eMAR) system at the partnerships Back Hilton Road Learning Disability service. This digital system replaced the paper-based system and has significantly improved the accuracy, efficiency, and safety of medication administration. The use of an eMAR system within the Back Hilton Road Learning Disability service has:

- **Led to a time saving of 22.5 hours per week** across the team
- **Reduced the number of medication errors** in the service, resulting in improvements in health and wellbeing for supported people.
- **Supported staff** to be more confident in their role managing medication using a simpler, safer and more efficient system.

ACHSCP are now proposing to roll out eMAR systems to the other four in-house Learning Disability service sites in Aberdeen to achieve similar benefits across all sites.

One of the aims of implementing eMAR as a pilot was to encourage wider adoption by care providers of these systems. We have shared our learning throughout the journey with Voluntary Services Aberdeen (VSA) who are implementing the same eMAR system. They advised that although they still would have moved forward with eMAR, it was great to hear our experience and reassuring that another organisation had done their research and would be using the same system.

Project: *Deliver Analogue to Digital Telecare Implementation Plan.*

The A2DT (Analogue to Digital Telecare) programme is dedicated to ensuring the delivery of a reliable and robust digital telecare emergency response service ahead of the decommissioning of analogue networks in January 2027. This initiative encompasses the replacement of the existing analogue Alarm Receiving Centre (ARC) software platform and the maintenance of connectivity with all currently linked alarm units and peripherals. Transitioning to a modern digital platform is anticipated to enhance reliability, efficiency, and integration with new technologies.

Aberdeen City Council's Regional Communications Centre (RCC) provides telecare alarm-monitoring services to approximately 16,000 citizens. This includes monitoring over 7,000 dispersed units and 9,000 sheltered-housing connections across Aberdeen, Aberdeenshire, and Moray.

The nearly completed replacement of analogue dispersed alarm units with digital alarms in Aberdeen has led to the Digital Office for Scottish Local Government awarding Bon Accord Care and Aberdeen City HSCP the Bronze Award for Digital Telecare Implementation.

The project leverages the Shared ARC framework, an initiative led by the Digital Office, to streamline procurement and implementation processes, ensuring compliance and cost efficiency. The contract with Chubb, the selected vendor for the shared ARC, was signed in November 2024. Onboarding activities commenced in January 2025, with the target go-live date for the new ARC set for spring 2025.

Project: *Seek to expand the use of Technology Enabled Care (TEC) throughout Aberdeen.*

The TEC Delivery Plan 2023-2025 was successfully delivered over the course of 2023-2024 and requires to be refreshed in light of the progress made. Work commenced on planning a longer term digital and TEC vision for ACHSCP with the presentation of the TEC Outline Business Case to the IJB in September 2024. The TEC Project Board was re-launched in October 2024 with a refreshed membership and purpose. A wide group of care providers are represented on this board, reflecting the intention to promote and prioritise the use of technology in this sector. Since the re-launch of the board, stakeholder engagement work has been undertaken between January and March 2025 with a series of workshops facilitated. This has provided evidence regarding the key challenges and issues across the partnership to be considered within the TEC Vision full business case to be presented to the IJB in September 2025.

The Stoneywood development will provide care for supported people with the highest level of complex care needs in their own community. Technology Enabled Care (TEC) solutions are a crucial element to enhance the safety and well-being of residents with complex care needs. This is a new build site which will feature eight wheelchair-adapted bungalows equipped with discreet and durable bespoke TEC systems designed to meet individual needs. Stoneywood is due to be completed in the spring of 2025. ACHSCP are working with the TEC provider, ACHSCPs Learning Disability Service, and the Scottish Governments Digital Office to evaluate the impact the innovative use of technology will have in this setting. This learning will be shared nationally for Health and Social Care Partnerships across Scotland to learn from.

TEC Awareness Week, held from 18th to 22nd November 2024, aimed to highlight the use and availability of technology-enabled care (TEC) in Aberdeen. The campaign included a social media campaign and several in-person events, such as drop-in sessions at Marischal College and the Aberdeen City Vaccination and Wellbeing Hub. The week successfully raised awareness of TEC despite the challenges of poor weather that week. Recommendations for future initiatives include implementing social media campaigns, improving signage at event locations, and scheduling the week when there is likely to be more favourable weather.

Funding was received in December 2024 from the Health Improvement Fund to deliver the Maah robot project. The Konpanion Maah project involves the development of a pillow-like companion robot designed to support individuals with profound learning disabilities, dementia, and loneliness, as well as the care staff who work closely with them. The robot, currently in its research phase, aims to enhance well-being through comforting tactile interactions and subtle vocalisations, while providing valuable insights into residents' behavioural markers and needs. This project is currently in discovery phase.

Programme:

Infrastructure - Assess future infrastructure needs and engage with partners to ensure these needs are met

Project: *Develop an interim solution for the provision of health and social care services within the Countesswells housing development and work on the long-term solution*

Throughout 2024 a new healthcare facility supporting primary and community care in the Countesswells area of the city was fitted out through sourcing funding from developer obligations. The new facility became fully operational on Monday 3rd March 2025. After careful consideration of which services would best support the needs of the area, the services operating from the new facility include Community Treatment and Assessment (CTAC), Children's Immunisations, Health Visiting and Speech and Language Therapy. The facility is operating at 100% capacity and is providing additional capacity which takes some pressure off surrounding GP practices.

Project: *Rapid review of assets*

The work on the premises review has progressed with a significant amount of detail gathered and analysed. This was presented to the Senior Leadership Team (SLT) in early Summer 2024.

At that meeting a very in-depth and detailed overview of the premises that ACHSCP staff operate from was presented. A mapping exercise was also carried out for staff operating from both NHSG and ACC owned buildings. The goal is to have a single, multi-agency, mapping of all services engaging with our partners - this will feed into the Infrastructure Plan. It was requested by SLT that a set of proposals be developed looking specifically at efficiencies, effective use of buildings, and potential savings. This was progressed as requested and presented back to SLT in July 2024.

Two proposals that SLT selected to be carried out in financial year 2024- 2025, have now been completed as of February 2025.

Project: *Deliver the relevant actions on each of the three Workstream Action Plans supporting the Workforce Plan.*

The next Workforce Plan annual progress report is due to be present to Committee later in 2025. The three main aims; Recruitment and Retention, Staff Health and Wellbeing and Growth and Development Opportunities are all at the forefront of actions to deliver on our workforce plan. At the point of reporting, workforce data from 2024- 2025 has not been released.

This year we hosted a half day Connect Conference at the Aberdeen Beach Ballroom where staff listened to some of the work ongoing including Adult Social Work, Enhanced Community Support Huddles and Learning Disability and Affinity trust. Feedback from the day was very positive with 94% of respondents stating that it was a good use of their time.

Overview of all projects named within the 2024-25 Delivery Plan listed under Strategic Enablers.

Programme/Projects	Link if Referenced within the report
Pledge support for Volunteer Scotland's Volunteer Charter and identify and Volunteer Champion for ACHSCP	Continuing to work with NHS Grampian to extend range of volunteer use, for example transport for unpaid carers, delivering lab tests and medication.
Deliver the relevant actions on each of the three Workstream Action Plans supporting the Workforce Plan.	Please see page 59 for an overview of the work ongoing.
Continue to support initiatives supporting staff health and wellbeing	Ongoing series of paid for and free staff well-being activities throughout year for example- staff health walk; mindfulness Mondays and complimentary therapies.
Ensure our workforce are Trauma Informed	Participating in Grampian steering group to progress training, awareness raising and services support.
Support the implementation of Electronic Medication Administration Recording (EMAR) in our care homes.	Please see page 57 for an overview of the work ongoing.
Deliver a Single Point of Contact for individuals and professionals including a repository of information on health and social care services available, eligibility criteria and how to access	ACHSCP has identified a requirement for a Single Point of Contact (SPOC) to help professionals within the partnership. This would identify and direct service users to the care or support pathway that best meets their needs. It is anticipated this would allow a faster time to access a care or support route for service users and would minimise the time service professionals may spend looking for the best service option for a client's needs.
Review the future use of Morse in Community Nursing and Allied Health Professionals	Morse is an application which is used in Adult and Child Community Nursing Services as an Electronic Patient Record. Morse allows for users to access and record information while working away from a constant WIFI connection. An evaluation was conducted and presented to the IJB in May 2024 outlining user's experiences of the application including significant reduction in the duplication of information. The IJB approved for the license covering the use of Morse to these services to be extended to 2027.

Programme/Projects	Link if Referenced within the report
Creation of capacity through targeted digital investment and service redesign	Following our technology partners Microsoft's audit of IJB activity, the project had been divided into two phases, the first to develop a Social Work Practitioner Application and secondly, a Home Care Commissioning Portal. However, given the financial challenges of digital investment at present thus project has been paused while the Partnership secures funds to progress.
Deliver Analogue to Digital Implementation Plan	Please see page 57 for an overview of the work ongoing.
Seek to expand the use of Technology Enabled Care (TEC) throughout Aberdeen.	Please see page 58 for an overview of the work ongoing.
Develop proactive, repeated and consistent communications to keep communities informed	ACHSCP Communications Trustees Group continued to meet on a monthly basis through 2024-2025. The Group produced a Communications Plan/timetable for 2024-2025 which was submitted to and approved by the SLT. As a result, regular communications were issued in support of the events in the communications plan. The Partnership's Communications Adviser continues to manage all press enquiries and works closely with the Chief Officer and others in SLT and ACC and NHSG to manage the external communications issued. A Communications Plan and Timetable for 2025-2026 is in the process of being finalised and will be submitted to SLT for approval. The Terms of Reference for the Communications Trustees Group will be amended to reflect the agreed Delivery Plan narrative relating to communications.
Review Care for People arrangements	The original project remit was to explore any conflict of interest between the Partnership's Business and Resilience Lead being the chair of the Grampian Care for People Group and the postholder being a Senior Manager On Call. This was discussed by the Grampian Local Resilience Partnership (GLRP) who have agreed to include a standing item on all response agendas to establish if a Grampian Care for People Group is needed to be established, and if so then if the postholder is SMOC at that give time then an alternative Chair for the Grampian Care For People Group will be found. The GLRP has tried and tested this in response mode and it was well received. The Aberdeen City Care For People Plan was reviewed in December 2024.
Explore other areas where charges could be raised to increase income and contribute to the cost of service delivery.	Reported under the Caring Together aim on page 22
Create and adopt a Generic Emergency Plan to reflect Aberdeen city IJB's Cat 1 Responder responsibilities	An Emergency Activation Plan was taken to the Integration Joint Board's Risk, Audit and Performance Committee in December 2024 where it was approved. The Plan was subject to consultation with Aberdeen City Council and NHSG colleagues and was taken through the Partnership's Civil Contingencies Group and SLT, prior to being submitted to the Risk, Audit and Performance Committee. It is planned to arrange training for the Senior Manager on Call on the Plan in June 2025, (this will include exercising the Plan).

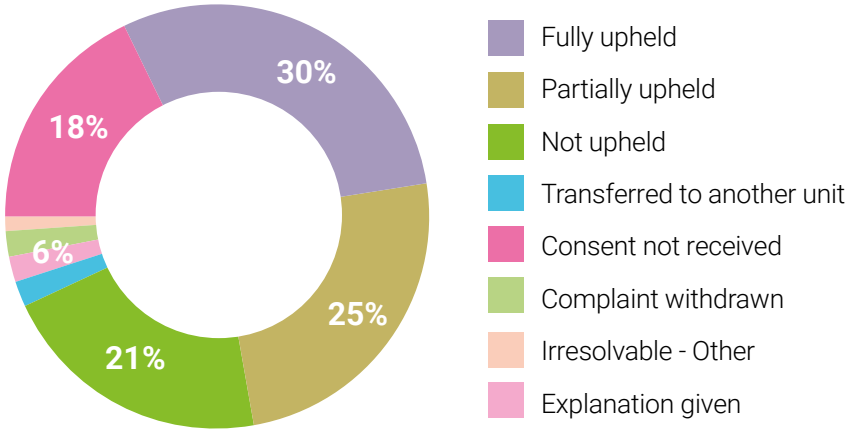
Programme/Projects	Link if Referenced within the report
Preparing for and managing the transition to a National Care Service (NCS) through the Aberdeen City NCS Programme Board	The Parliament's Health, Social Care and Sport Committee initiated formal Stage 2 amendment considerations for NCS on 25 February 2025. The committee agreed to remove Part 1 of the NCS Bill relating to legislative structural change.
Develop an interim solution for the provision of health and social care services within the Countesswells housing development and work on the long-term solution	Please see page 59 for an overview of the work ongoing.
Develop Infrastructure Plan for ACHSCP	The SLT of ACHSCP have approved a Premises Review which has identified a number of savings and efficiencies. Whilst most of these are complete, two are currently ongoing. This work will feed into the development of the wider Infrastructure Plan, the first draft of which is due in October 2025. This work will be completed alongside our ACC colleagues and the NHSG whole system Infrastructure approach for future planning. The Infrastructure Plan will also be aligned with the Medium Term Financial Framework (MTFF) and new Strategic Plan, once approved.
Rapid Review of Assets	Please see page 59 for an overview of the work ongoing
Review of Bon Accord Care contract and redesign of associated service	Please see page 56 for an overview of the work ongoing
Review of GCC Contract to reflect flat cash agreement	Please see page 57 for an overview of the work ongoing
Review use/availability of Interim Beds	The Interim Bed Contract with Woodlands Care Home ended on the 31st May 2024, however two beds remained at Deeside Care Home contracted until the end of March 2025. Funding for the Deeside beds were able to be sustained as there was some underspend from Woodlands which enabled us to extend the time the beds were commissioned.
Consolidation/streamlining of existing MHLD commissioned services	A collaborative commissioning exercise took place to develop a revised service specification to meet local needs for mental health and wellbeing services. This was then tendered and a successful provider identified, which has since commenced service delivery.
Explore how counselling service can work in a more collaborative, joined up way to support people experiencing care to benefit from a more holistic approach whilst achieving efficiencies	Please see page 56 for an overview of the work ongoing

Additional Governance

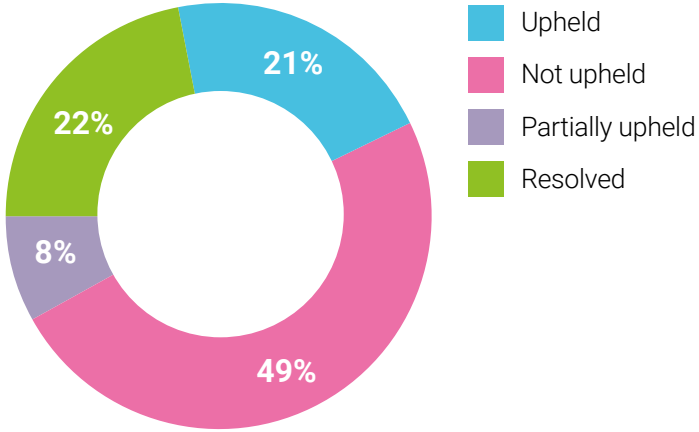
Complaints

As an organisation, we take complaints made relating to our services very seriously and we have a number of governance processes in place to ensure that these are reviewed, and where possible lessons are learned. There were 222 complaints registered with ACHSCP through either NHSG or Aberdeen City Council in 2024-2025. This was a rise of 14% compared with the number of complaints received in 2023-2024. The following shows the outcomes of the complaints received, with around 63% of the total complaints fully upheld (i.e. from the total number of complaints submitted to NHSG and ACC). Quarterly information relating to complaints and feedback are available to view on the ACHSCP Website [11].

Outcomes of complaints relating to ACHSCP which were registered with NHSG Total = 185



Outcomes of complaints relating to ACHSCP which were registered with ACC Total = 37



[11] ACHSCP Feedback and Complaints https://www.aberdeencityhscp.scot/lets-talk/feedback-and-complaints/

Additional Governance

Whistleblowing

There was a recent audit on Counter Fraud measures and the three Health and Social Care Partnership's are looking at a consistent approach to the promotion of Counter Fraud governance measures that are available to staff , which includes whistleblowing arrangements.

National Whistleblowing Standards have been produced by the Independent National Whistleblowing Officer's Department and came into effect on 1 April 2021.

Whistleblowing Concerns can be raised by anyone who is (or has been) providing services for the NHS, or working to provide services with NHS staff which includes:

- All NHSG staff.
- All Health and Social Care staff.
- All those working in non-private Primary Care Services (including both salaried and independent practices).
- Anyone contracted to provide services for NHS Grampian.
- All Agency staff and Locums.
- All Students, Trainees and Apprentices.
- All Volunteers and Third Sector Organisations.

An IJB Whistleblowing Policy was approved in July 2021 and has been promoted throughout the Partnership, along with the National Standards and the ACC Policy.

The IJB Policy relates to all IJB Members and Office Holders of the Board and is committed to dealing responsibly, openly and professionally with any genuine concerns held by staff of the ACHSCP, Members of the Board or Office Holders, encouraging them to report any concerns about wrongdoing or malpractice within the IJB, which they believe has occurred

This Policy would not relate to members of the public who have concerns regarding the IJB, members of the public would be encouraged to use the IJB Complaints Procedure.

IJB Directions

Directions are a legal mechanism intended to clarify responsibility requirements between partners. Directions are the means by which ACHSCP directs NHSG and ACC on what services are to be delivered using the integrated budget. Directions must be given in respect of functions that have been delegated to the ACHSCP. Specific directions can be given to NHSG, ACC or both depending on the services to be provided. The following directions were approved by the IJB in 2024-2025.

01 Medium Term Financial Framework (MTFF) - All adult social care services covered by the Aberdeen City Integration scheme.

02 Medium Term Financial Framework (MTFF) - All community health services covered by the Aberdeen City Integration Scheme.

03 Supplementary Work Plan - Care at Home

04 Morse Community Electronic Patient Record Evaluation and Contract Renewal

05 Evaluation of Aberdeen City Vaccination & Wellbeing Hub

06 Digital Innovation Programme: Right Care, Right Time, Right Place

07 Extension of 4 month contract of Adult Carers Support Services and recommendation to undertake a tender, and subsequent award of a contract or contracts, for Adult & Young Carers Support Services for five years

All of these directions are evidenced by the Delivery Plan for 2024-2025 and none were taken out with this. The papers supporting these directions can be found on the Aberdeen City Council Website under the IJB Committee page[12].

[12] IJB Committee details are available here https://committees.aberdeencity.gov.uk/ieListMeetings.aspx?CommitteeId=516

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

Aberdeen City Health & Social Care Partnership
Business Hub 8, 1st Floor North
Marischal College
Broad Street
Aberdeen AB10 1AB

t: 01224 523237
e: ACHSCPEnquiries@aberdeencity.gov.uk
w: aberdeencityhscp.scot
X: @HSCAberdeen

Aberdeen City
Health & Social Care
Partnership
A caring partnership

Aberdeen City Health and Social Care Partnership

Aberdeen City Health and Social Care Partnership

DESIGN: WLS0725