Aberdeen City Health & Social Care Partnership

A caring partnership

Annual Performance Report
2022 – 2023

Foreword

It has been another busy and challenging year for the Aberdeen City Health and Social Care Partnership. The Annual Performance Report helps to reflect some of the work we have been progressing to meet the commitments in our Strategic Plan.

The partnership aims to provide access to community-based health and social care services whilst also shifting the balance of care from hospital to more homely settings, and supporting our most vulnerable citizens. It has been great to see the gradual increase in face-to-face interactions with our communities now that we have reached the point of living with Covid. Our Public Health and Wellbeing teams, in particular, have enjoyed being out and about in communities again, helping the population to maintain and improve their health.

This year has seen the introduction of Community Treatment and Care (CTAC) Hubs which are part of our aim to respond to patient need and deliver more services as locally as possible. The Hubs offer the choice of an alternative to your medical practice for undergoing tests or treatment and have been well received by those who live or work at a distance from their GP.

During the year we launched three key strategies, the implementation of which will ensure our continued focus on improving outcomes for those in Aberdeen who need our services, and those who look after them. Our Strategic Plan for 2022-2025, and the associated Delivery Plan, outlines our Strategic Aims of Caring Together, Keeping People Safe at Home, Achieving Fulfilling, Healthy Lives and Preventing Ill Health. It details the priorities we will focus on for the next three years.

Sandra MacLeod,
Chief Officer Aberdeen City Health and Social Care Partnership

Aberdeen City Carers Strategy was developed in partnership with carers and aims to help unpaid carers identify as such and to ensure that the right advice and support is available to them when they need it. Further information about the Carers Strategy can be found on page 14. Our Workforce Plan seeks to build our workforce for the future to ensure that our communities continue to be well cared for.

A new digital platform for Adult Social Work case management was implemented this year which allows the appropriate recording and sharing of information ensuring the team has immediate access to accurate and up to date information, allowing them to make the right decisions for the people they support more efficiently.

The challenges of Accident and Emergency attendances and hospital bed occupancy have been well documented in the media. I'm pleased to be able to report that in conjunction with commissioned services we have been able to increase capacity in community-based services enabling people to get the right care in the right place at the right time. Our delayed discharges and unmet needs list have both reduced significantly.

Finally, all of this would not be possible without the continued hard work of our wider workforce not only our in-house staff but also those working on our behalf in commissioned services. I am truly humbled by the dedication that our teams continue to show to the people in our communities. While the next financial year continues to look challenging, I know with certainty that the caring, hardworking teams which surround me will continue to deliver the best possible service to the people of Aberdeen City.

Contents

Introduction

The Aberdeen City Health and Social Care Partnership (ACHSCP) Annual Performance Report gives an overview of performance against our Strategic Plan across the 2022-23 financial year. The Strategic Aims within the ACHSCP Strategic Plan 2022-25 and the key, national health and wellbeing and integration measures are used to demonstrate performance over the year.

The report is broken down into seven distinct areas. The first introduces our strategic plan and the intended priorities for the 2022/23 financial year followed by five sections detailing performance in each of the four strategic aims and the enablers. The final section looks to give an overview of performance against key elements of our governance arrangements.

Finally, in Appendix 1 we detail our performance on the national measures showing performance over time and in relation to the Scottish average. Collectively these sections are intended to demonstrate the achievements of Best Value.

The projects showcased throughout the report and the performance detailed in the Appendices demonstrate improvements we have made in the performance and quality of our service delivery. The Sustainable Finance section on **pages 46** and **47** confirms that we have achieved this within budget.

Aberdeen City Health & Social Care Partnership's Strategic Plan Aims

In 2022, the Aberdeen City Health and Social Care Strategic Plan for 2022-2025 was approved by the Integration Joint Board (IJB).

Having learned from our previous strategic plan and also from the experiences of the partnership's response to Covid 19, the Strategic Plan looks to continue to focus on progressing the integration agenda by increasing access to community-based health and social care services, shifting the balance of care from hospital to more homely settings, and supporting our most vulnerable residents.

As a means to achieve this, strategic priorities were identified under four strategic aims along with priorities under five enablers. A Delivery Plan which supports the aims of the Strategic Plan was developed. This outlines the means to how these aims are to be achieved and Appendix 3 demonstrates how our performance this year links to the Delivery Plan objectives. The 'strategic plan on a page' can be found overleaf. The full Strategic Plan can be found here.

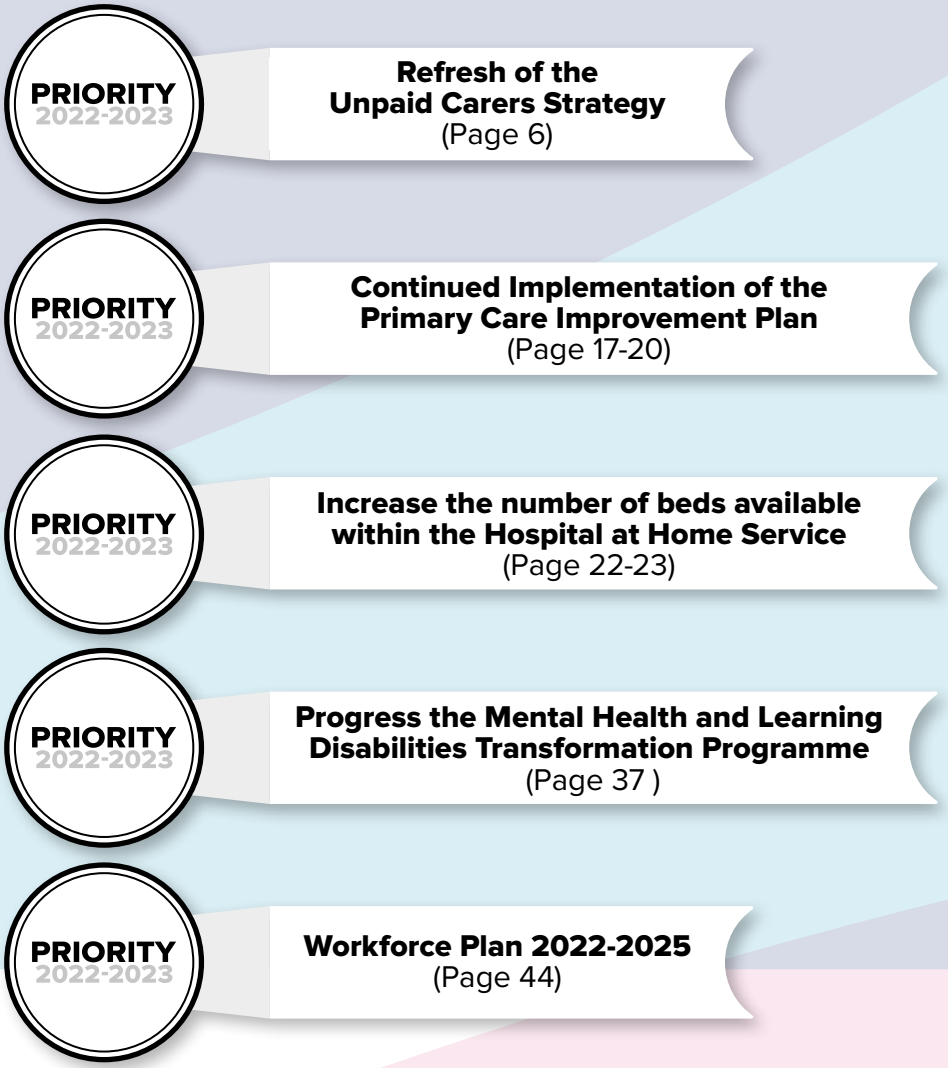
The following sections of this report demonstrate the progress being made towards these aims and the associated delivery plan.

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

Priorities for 2022 - 2023

The ACHSP Annual Performance Report 2021-22 represented the final year of the 2019-2022 Strategic Plan. As part of the 2021-22 report, the Partnership outlined the following priorities for the 2022-23 financial year. Achieving these would help to meet our Strategic Aims as outlined on Page 6. Updates on the progress being made in each of these areas have been included in the report. These can be found either by navigating to the page number given or clicking the link to take you to that area of the report.



Caring Together

The strategic theme of Caring Together means that together with our communities, the Partnership wants to ensure that health and social care services are high quality, accessible, safe, and sustainable; that people have their rights, dignity and diversity respected; and that they have a say in how services are designed and delivered both for themselves and for the people they care for, ensuring they can access the right care, at the right time, in a way that suits them. We intend to achieve this by:

- **Undertaking whole pathway reviews ensuring that services are more accessible and coordinated**
- **Empowering our communities to be involved in planning and leading services locally**
- **Creating Capacity for General Practice improving patient experience and**
- **Delivering better support to unpaid carers**

Adult Support and Protection Inspection Outcomes

The Partnership and other partners in Aberdeen are committed to an inclusive approach to preventing and responding to harm and protecting adults at risk. There is a statutory role to make enquiries when there is an awareness of potential harm to vulnerable adults, in order to support and protect them, under the Adult Support and Protection (Scotland) Act 2007.

A multi agency Joint Inspection of Adult Support and Protection (ASP) in Aberdeen was undertaken in Spring 2022, with the resulting report being published by the Care Inspectorate on 21st June 2022.

The inspection focused on our key processes and leadership and the outcome was very positive, with the main findings being as follows:

- **Our Key Processes are effective, areas for improvement which are outweighed by clear strengths supporting positive experiences and outcomes for individuals;**
- **Our Strategic Leadership is very effective, demonstrating major strengths in supporting positive experiences and outcomes for individuals.**

One of the key strengths identified during the inspection was in relation to our Adult Protection Social Work Team undertaking collaborative and effective screening of referrals. This team has continued to develop during the course of this year, and it is evident that they are making a difference, as fewer referrals are progressing through the ASP process due to the early intervention and prevention work being undertaken by the team at the screening stage.

Getting it Right for Everyone (GIRFE)

ACHSCP are currently working in collaboration with the Scottish Government and various other Health and Social Care Partnership's across Scotland to develop a national approach to 'Getting it right for everyone' (GIRFE). This approach aims to extend a model developed for children and young people 'Getting it right for every child' (GIRFEC). GIRFE is a proposed multi-agency approach of support and services from young adulthood to end of life care.

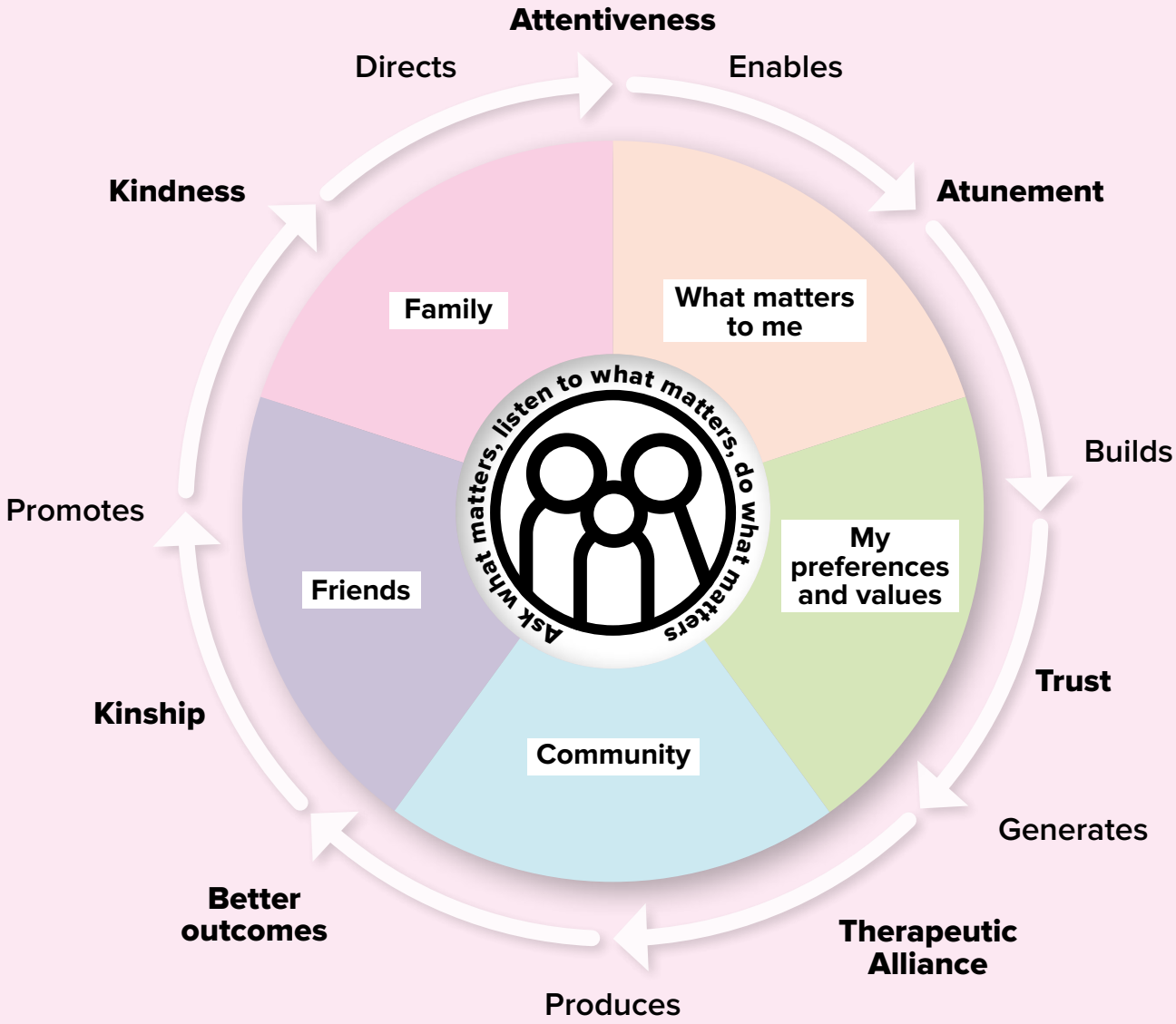
Our pathfinders are focused on:

1. **Transition pathways for young people living with learning disabilities who are approaching school leaving age.**
2. **Developing preventative and proactive approaches to supporting older people with frailty.**

Key milestones so far include involvement in the national 'design school' days which are using the Scottish Approach to Service Design to develop the national GIRFE policy. Locally this involves engagement with our workforce, young people, families, older adults and unpaid Carers to understand their experiences of our current support pathways. This work has involved 'journey mapping' to look at the individual experiences of a range of people who have required support in both pathfinder areas and beginning to evaluate where there are opportunities to do things differently in line with the GIRFE approach. Whilst the GIRFE approach is in line with existing ACHSCP strategic projects related to Learning Disability transitions pathways and those for frail older people, the commitment to the programme has extended beyond what was initially anticipated and involvement is likely to extend into 2024. Learning from the ACHSCP involvement will mature into the development of local and national ideas which will inform the national approach.

GIRFE is person centred

The Whole process reinforces conditions for kinship/kindness.



Adapted from intelligent Kindness: Reforming the culture of Healthcare (Ballat & Camping 2011)

WHEEL of Services

Placing the person at the centre of all decision making that affects them – circle of support gets bigger when more support is required.

Principal Care Team

Services that have an ongoing or enduring relationship with clients and who should meet regularly as an Multi Disciplinary Team – *likely to be involved with **all** patients*.

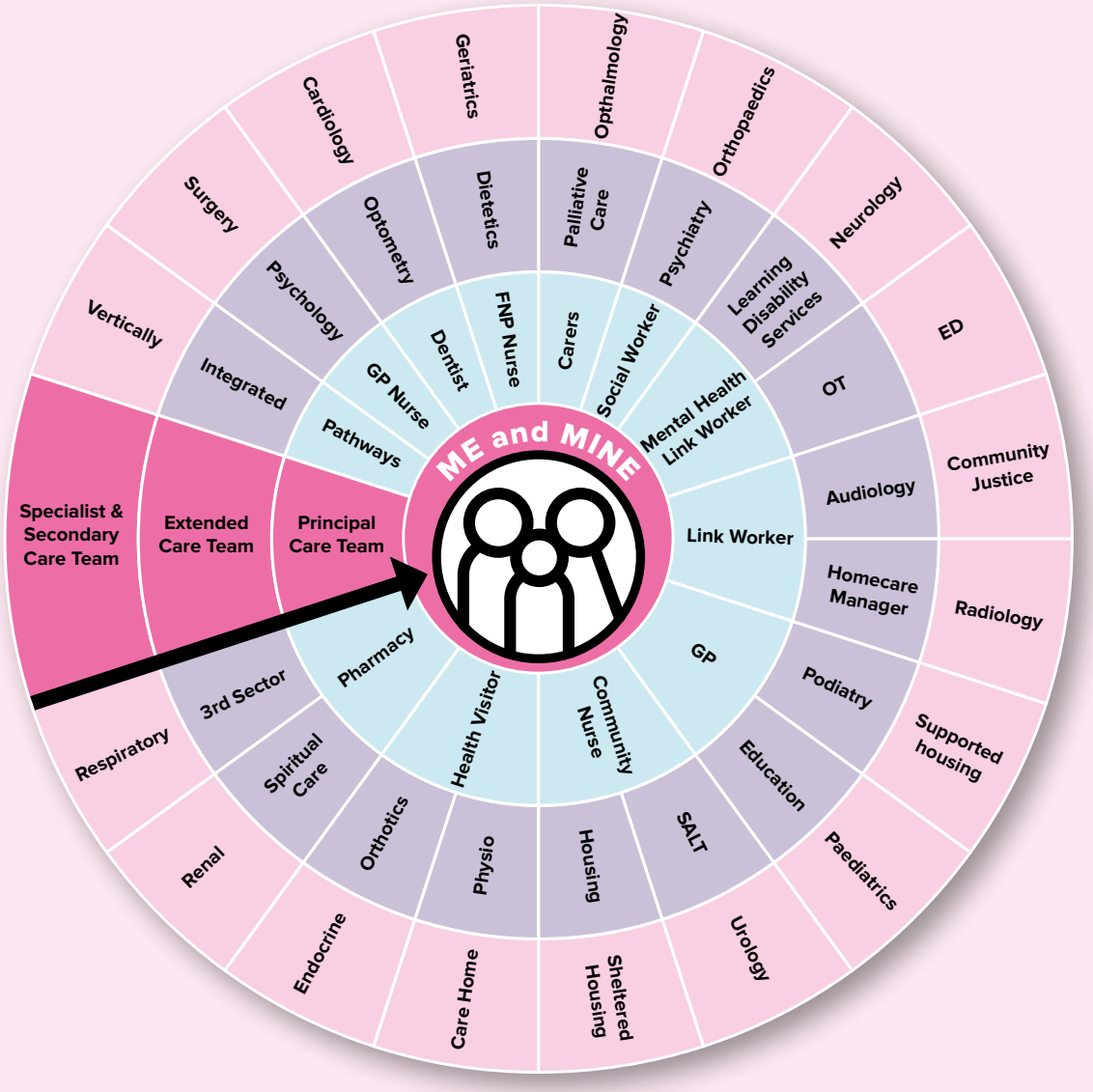
Enhanced Multi-disciplinary team (MDT)

Community based services delivered as required by core team or client – *likely to be involved with **some** but not all patients*.

Specialist Services

Specialist or emergency care either in secondary care or the community.
These may link in to Core MDTs on request for specific issues – *likely to be involved for **episodes** of care*.

Changing the centre of gravity to what matters to the person.



Note: this is an example of services around an individual and not intended to be an exhaustive list - each circle will be different for each individual

Carers Strategy

The new ACHSCP Carers Strategy for 2023 – 2026 was approved by the IJB on 31 January 2023. The development of the strategy has been progressed by the Carers Strategy Implementation Group (CSIG) who meet regularly to review actions and work together in the development of carers support in Aberdeen City. An action plan has also been developed alongside the strategy and CSIG will continue to meet to implement and monitor the actions over the coming years.

The ACHSCP Carers Strategy 2023 - 2026 was informed by the National Carers Inquiry where we worked alongside the Care Inspectorate, the National Carers Strategy, and most importantly extensive consultation with Carers themselves and organisations who support carers and unpaid carers. This was a phased approach with engagement taking place between July 2022 and October 2022 with activities including:

- **Public Consultation Survey on Citizen Space**
- **Open Consultation Events (In person and online)**
- **Targeted promotion of the consultation to relevant identified groups**
- **An open offer of targeted Consultation Events with interested groups**
- **Opportunistic promotion and discussion in public spaces, e.g. We Too relaxed session, Library event**
- **Open routes to direct feedback via phone and email**
- **Attendance at partner board meetings, including the Aberdeen City Council (ACC) Children's Services Board, ACC Strategy Board, ACHSCP Operational Leadership team meeting and IJB Development Workshop.**

The ACHSCP Carers Strategy 2023 - 2026 outlines 4 Strategic Priorities:

- **Identifying as a carer and the first steps to support**
- **Accessing advice and support**
- **Supporting future planning, decision making and wider carer involvement**
- **Community support and services for carers**

Launch materials for the strategy have now been created and published on the carers section of the ACHSCP website which can be found here - Aberdeen City HSCP. These materials are being shared partnership wide and are supported by a 3 minute summary animation which can be found here - https://www.youtube.com/watch?v=hPpYiVNeav8

Working alongside our partners, great strides have already been made and there are currently 124 Young Carers being supported by Barnardo's and Quarriers report have had a 71.3% increase in the number of adult carers accessing support (594 in 20221/22 compared to 1018 in 2022/23).

During Carers week, our Consultation and Engagement Officer took various opportunities for engagement within clinics and vaccination centres to raise awareness of our strategy and the support available for Carers across the City. On top of the various social media, emails, and text messages to Carers both Barnardo's and Quarriers had various events set during that week.

Quarriers organised a Carers talk on 'Aberdeen Days Gone By' which was well received where Councillor Barney Crockett was the speaker and an information session on telecare also took place. Barnardo's had Young Carer leads hosting in-school carer week events and 'Think Young Carer' toolkit training was delivered to NESCol staff team and students. Barnardo's also hosted a circus themed event for families and Carers at Aberdeen Football Club which included crafts, balloon modelling, face painting and much more. The Carers Strategy Implementation Group are currently progressing the first year of the Carers Strategy Action Plan after it was approved by the IJB earlier in the year.

Woodlands Care Home

To ease pressures in the acute sector which has seen patients being treated in ambulances which have been stacking at the entrance to the Emergency Department for long periods while waiting for beds, it was recognised that additional step-down beds were urgently required to add extra capacity into the system and ensure continued maximisation of patient flow.

Woodlands Care Home is a newly built care home in the west end of Aberdeen city with potential to provide 24 hour residential or nursing care across the three floors of the home.

ACHSCP initially commissioned twelve beds which opened Oct 2022 to support emergency discharges from NHS Grampian' sites. The bed capacity was then stepped up to 43 beds before being scaled back down to its current position of 24 beds, as of 15th May 2023. These beds have been an essential element to supporting the flow of early discharges into the community, freeing up acute beds when they are in such short demand.

To ensure a seamless admission and discharge process, the hospital social work discharge team has established regular contact with the care home. Weekly meetings with the Care Home Support team, Commissioning and Contracts team and GP practice also take place. Admissions have been steady to ensure maximum use of the beds based on staffing available. Challenges have been around moving on and transfers to other social care services due to the high demand for community care and care home placements in the city. The closure of another care home in Aberdeen has significantly impacted on bed capacity and availability.

Health issues in the Community (HIIC)

HIIC is a course that enables participants to develop their understanding of the range of factors that affect their health and the health of their communities and to explore how these factors can be addressed using community development approaches.

The core underpinning theme of HIIC is community development. Although this term can be used to describe many different types of activity, the perspective taken here places value on supporting individuals to work collectively; on extending participatory democracy; and on social justice and equity.

The course draws on a social model of health which views health and illness as having as much to do with economic and social factors as with individual behaviour. It seeks to promote the value of equity in terms of equal access to health, and to counter all forms of discrimination.

The course supports people to participate in decision-making processes and to take a more active role in the planning and delivery of services.

With community empowerment high on the agenda and as part of a drive to use HIIC within our communities, Health Improvement officers, Adult Learning and Community Development staff and staff from Grampian Regional Equality Council (GREC), Aberdeen Foyer and Barnardo's young carers service started their Health Issues in the Community (HIIC) tutor training journey in Spring 2023. This was funded by the Health Improvement Fund (HIF) which is helping the city build capacity and hopefully expand the tutor cohort as we see the benefits of HIIC roll out across our community.

The aim is that once accredited as tutors the cohort of staff will be able to support each other and join forces with partners to engage and to deliver HIIC with community groups across the city. Locality Empowerment Groups will be one of the first to experience the course once the staff have achieved their accreditation. The next steps will be to look at existing groups and create new groups to start a journey of empowerment and social justice our communities.

Primary Care Improvement Plan (PCIP)

Since the inception of the 2018 General Medical Services (GMS) contract, we have established six new primary care services under our 'Primary Care Improvement Plan' (PCIP) to help support our GP Practices. These continued to be implemented during 2022/23, examples of the progress being made can be found below.

Pharmacotherapy

The Pharmacotherapy Hub, located within the premises of Old Aberdeen Medical Practice, was set up in June 2022 to offer an element of support to GP practices during periods of pharmacy team staff shortages and to help maintain continuity of service. The Hub staff consists of a skill mix of Advanced Pharmacists, Clinical Pharmacists and Pharmacy Technicians and give a range of cover in terms of experience.

The service has been fully operational since January 2023, offering support across all City practices. The pharmacotherapy support has developed to now include provision of cover for planned absences (annual leave, development & training) as well as unplanned absences (sickness). The Hub covers multiple GP practices on any given day, therefore the cover is provided for a part day, and the workload is prioritised as per the Pharmacotherapy Hub Urgent Requests and Priority List protocol.

Community Treatment and Care (CTAC)

CTAC services include, but are not limited to, phlebotomy, management of minor injuries and dressings; ear syringing; suture removal; chronic disease monitoring; diabetic foot screening and other locally agreed services. The CTAC service is being delivered through centralised hubs operated by practice-based staff and the service provides 4,000 appointments per week across Aberdeen City. Patients have a choice of hubs at the following locations:

Bridge of Don Clinic and Inverurie Road	**College Street**	**Healthy Hoose**	**Carden House**
Opened June 2022	Opened September 2022	Opened October 2022	Opened November 2022

MSK - First Contact Physiotherapy

The Musculoskeletal 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 made significant progress in the recruitment of staff and the number of First Contact Practitioners – Physiotherapists, increased by 30% during 2022/23. This has resulted in more clinical input to GP practices and the service provides 420 appointments per week across Aberdeen City.

Link Practitioners

This service completed a commissioning process and a contract was awarded to an external care provider. The contract is in place for 4 years with an option to extend for up to 3 years giving continuity of care to service users. Link Practitioners can offer Social Prescribing to service users and this can relieve pressure on GP's and is a better fit for non- clinical issues. GPs and Primary Care staff can refer patients when they assess a social issue is having a bearing 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** In 2022/23, the link workers service engaged in more than 14,500 patient contacts.

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 2,400 visits were carried out in 2022/23. As part of a service review, a questionnaire was completed by 85% of the GP practices in Aberdeen City and positive feedback in terms of quality of care provided by the team was highlighted in the responses.

The Listening Service

The Listening Service in Aberdeen City offers vital first-level support for individuals experiencing low-level mental health challenges, addressing issues such as bereavement, redundancy, and life changes that can impact overall well-being. With a total of 56 weekly listening sessions distributed among 15 GP practices across Aberdeen City, as well as the Health Village and GetActive@Northfield site, the service has expanded beyond its initial roots in the Spiritual Care Department. It now comprises both chaplain volunteers and non-chaplain staff, serving individuals of all faiths and none, with a non-religious focus. The service caters to Aberdeen City residents, as well as those unregistered with a GP practice or whose practice does not have a Listener, ensuring inclusivity for individuals aged 18 and above.

Accessible through the Health Village or GetActive@Northfield sites, individuals can seek support from the Listening Service without being tied to a specific GP practice. While face-to-face sessions within local GP practices remain the primary focus, telephone sessions are available for those unable to access physical locations. Over the past year, the service has expanded its reach by securing accommodation in four additional GP practices, enabling patients from these communities to conveniently access the support they need. The service operates on a direct appointment basis, without a referral process, and boasts minimal to no waiting lists in most practices. Each appointment can last up to 50 minutes, and individuals are welcome to attend once or return for subsequent sessions as required, recognizing that life's challenges are often ongoing, and timely access to support can prove immensely beneficial. Over 500 appointments were delivered this year and training is ongoing with the capacity of the service set to increase in 2023-24.

The link to listening service can be found here: **Listening service**

Listening Service-users Feedback:

The listening service offered me something to try when there was a long waiting list for other forms of help; they have been a great step on the way to I hope what will be a gradual recovery to a normal life once more.

Keep up the good work and keep publicising the service – I found it on Twitter at just the right time, which was helped by how easy to access it was. Thank you.

Very professional service received, thank you for being friendly, patient and kind. Wouldn't hesitate in making another appointment in the future if I felt things were getting on top of me. Will definitely be recommending this service for many issues, any gender and age group.

It would be great if doctors could be persuaded to use this service before offering antidepressants as a standard fix it.

You are never too old to need this help. Life throws things at you that you are not equipped to handle and having this service has turned me around to face a more manageable and, indeed know there is, a better future for me.

Primary Care Psychological Therapies Service

The **Primary Care Psychological Therapies Service** is a tiered service taking GP referrals for patients from mild (Tier 1) to moderate-severe (Tier 3) mental health problems. The Service received around 2,000 referrals from GPs per year.

TIER 1	TIER 2	TIER 3
5 Psychological Wellbeing Practitioners (PWPs)	**13.5 Psychological Therapists**	**3.4 Clinical Counselling Psychologists**
Delivering 3-6 sessions of interactions including one to one guided self help and groupwork for mild mental health problems	Delivering 6-12 sessions of Cognitive Behavioural Therapy or Interpersonal Therapy	Delivering up to 20 sessions for more complex patients, using a range of therapeutic approaches

Keeping People Safe at Home

It is the strategic responsibility of the IJB to shift the balance of care from hospital to be delivered in primary, community and social care settings so that where possible, a patient is seen closer to home.

We aim to enable people to remain living independently at home by choice thereby improving outcomes. We look to enable this through a variety of methods including:

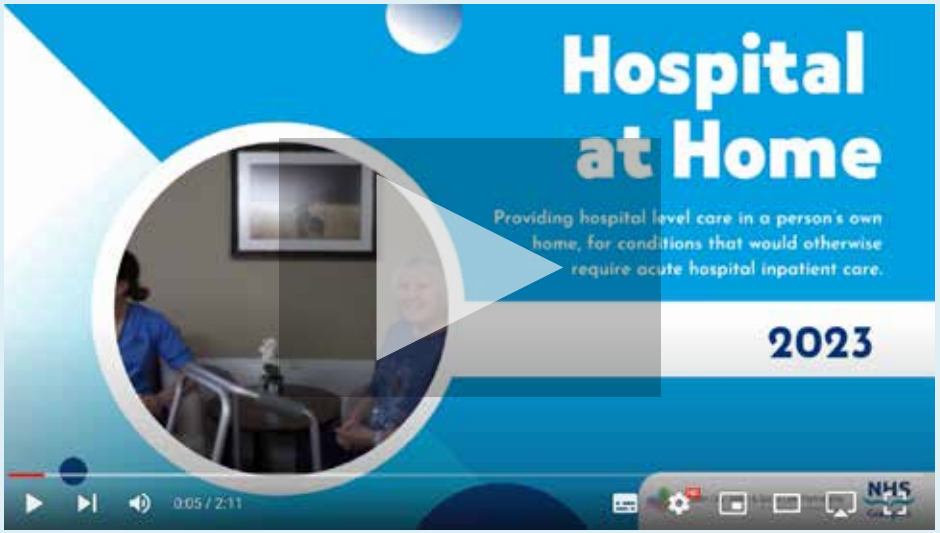
- **Maximising Independence through Rehabilitation**
- **Reducing the impact of Unscheduled Care on the Hospital**
- **Expanding the choice of housing options for people requiring care.**

Hospital at Home

Hospital at Home (H@H) provides hospital level care by healthcare professionals in a person's own home, for conditions that would otherwise require acute hospital inpatient care. H@H offers patients an alternative to hospital admission and can also support an earlier discharge from hospital when a patient is still receiving medical support. The H@H service was established in 2018, and due to its success, the service has continued to expand. Between 2020 and 2022, the number of people receiving care from the service has seen a percentage increase of 87%.

Across a range of measures, the H@H Service has higher patient satisfaction levels compared with being cared for in an acute hospital setting. Since September 2022, the H@H team have increased the number of consultant frailty led beds from 15 to 22, introduced five Advanced Nurse Practitioner frailty led beds and continued to embed and support the five Outpatient Parenteral Antimicrobial Therapy (OPAT) and five End of Life care beds within the service.

	2020	2021	2022
Looked after People	**446**	**604**	**834**



Very good efficient service which frees up hospital beds.

High level of competence and communication skill shown by all visiting staff. My wife remained relaxed throughout her treatment.

My Grandma was very scared to go into Hospital but needed medical help. Was the perfect option for us.

So much more privacy of being at home.

Provides reassurance when first home from hospital, or prevents hospital readmission.

Safe environment of home and being with family. My husband gets very agitated if he doesn't see me around.

Professional but unhurried making it easy to question and discuss concerns.

Rubislaw Park End of Life Care

As part of the Partnerships winter planning and its wish to incorporate a whole system approach to the pathway of care, five interim beds within Rubislaw Park Nursing Home were approved for use in December 2021 for End-of-Life Care. Originally approved for a 6-month test of change by the Integrated Joint Board (IJB), and following a period of evaluation, the IJB approved to further extend this contract. The pathway originally accepted referrals from the community and following recommendations from the evaluation, this has continued to expand, with referrals now being accepted across many services within Aberdeen Royal Infirmary, Rosewell House and Roxburghe House.

The overall ambition for the Service is to provide the high quality, person centred care and support in a homely setting for people reaching the end of their lives. The service is also dedicated to supporting their next of kin and carers during a stressful and challenging time. Since the opening of the End of Life beds in December 2021, over 100 patients have been admitted to the pathway to receive end of life care.

Feedback from the patient's next of kin regarding the service received from Rubislaw Park has been positive and there was confidence in the service and patients reported to feeling safe and secure knowing that there was someone there 24 hours a day and importantly, it allowed family and friends to set aside their caring role and resume their role as family or friend.

ACHSCP Community Room Project - GetActive@Northfield with Sport Aberdeen

The newly refurbished centre at Northfield has provided the opportunity to work in collaboration with Sport Aberdeen and utilise the space to provide Health and Social Care Services. ACHSCP are testing the use of the space until March 2024 focussing on rehabilitation, prevention and health educational initiatives to support local need in the area. Services include Pulmonary Rehabilitation, Speech and Language Therapy, Community Listening, Health Visiting Education Classes and PEEP Healthier Families Pilot. The project looks to continue improvements and expansion of services over 2023/24. There is a huge benefit to co-locating services in Sport Facilities to support continued physical activity. Pulmonary Rehabilitation services have seen benefits being located at the site to support classes as well as space for one-to-one assessments and educational sessions.

Peep 'Healthier Families' Pilot

A Parents as Early Education Partners (Peep) 'Healthier Families' pilot has been created using elements of the Health and Physical Development and Early Strands sections of the Peep parenting programme. This is being tested as a 'child healthy weight, healthy lifestyle' programme over an eleven-week period with a group of eight families with children aged 1-3 years old. The aim is to improve parents' knowledge, skills and confidence in nurturing their children to be happy, to establish and manage healthy routines and to include choices around healthy eating and physical activity.

Tests of Change such as the PEEP project has seen benefits of bringing services to Sport Facilities co-located to support continued Physical Activity. Pulmonary Rehabilitation services have seen benefits being located at the site to support classes as well as space for one to one assessments and educational sessions.

Pulmonary Rehabilitation

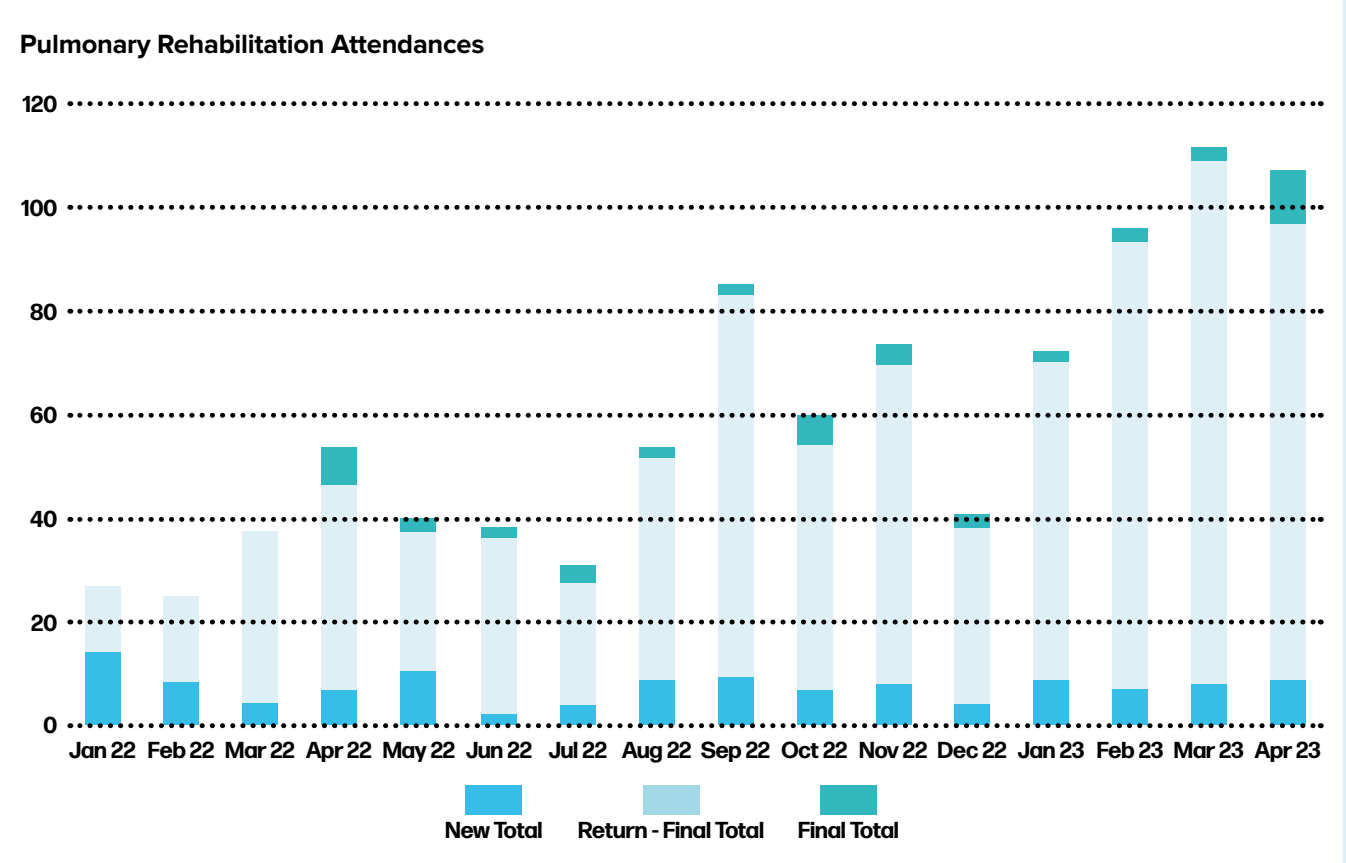
Led by Acute services, a project to increase Pulmonary Rehabilitation uptake has been underway since October 2022. The project Teams Objectives were to support:

- **Increase uptake of Pulmonary Rehabilitation**
- **Return of Face to Face Classes**
- **Streamline information**
- **Pathway review and process map**

Together with the Respiratory colleagues, Pulmonary Rehabilitation Team, RGU Student led classes and Sport Aberdeen and patient representatives - the project team has made an impact on the uptake, with numbers almost doubling since August 2022.

Undertaking a pathway review and process to create a better understanding of signposting patients to the correct place.

For 2023/24 the project looks to continue to test the use of a partnership leaflet which is designed to inform patients of the benefits of Pulmonary Rehabilitation and support self-management with the range of classes and support available to them. All helping to support capacity for teams and partners to deliver services to communities with increasing demand.



Preventing ill-Health

By preventing Ill-Health, we can help communities to achieve positive mental and physical health outcomes by providing advice and designing suitable support (which may include utilising existing local assets), to help address thepreventable causes of ill-health, ensuring this starts at as early as age as possible.

Vaccination Service

The Partnership's Vaccination Team provides all preschool, school and adult vaccinations to the population of Aberdeen City. The team delivered over 275,000 vaccinations during 2022-2023, providing protection against infectious diseases. Vaccinations are administered at vaccination centres, baby and preschool immunisation clinics, schools, sheltered housing, care homes and at home for housebound patients. Vaccinations were also administered in over 20 pop up clinics throughout the city. These took place in church halls, community centres, parks, shopping centres, football stadiums and in our mobile vaccination bus.

The Aberdeen City Vaccination Team created child and family friendly environments within Vaccination Centres and Pre-school clinics to provide support and reduce anxiety when children and families attend for their appointments. This included signing up to the "Breastfeeding Friendly Scheme" and welcoming "Angus" the Therapet to visit in the recovery area of the Aberdeen City Vaccination Centre.

The team set up a healthpoint area within the Aberdeen City Vaccination Centre and worked collaboratively with health and social care partners to promote health and wellbeing to visitors. This included visits from Childsmile, the Foster Care Team and NHS Grampian Abdominal Aortic Aneurysm Screening Programme.

Aberdeen City Vaccination Team

This infographic provides an overview of immunisations provided by the Aberdeen City Vaccination Team from **1ST APRIL 2022 – 31ST MARCH 2023** to support protecting the population of Aberdeen City against infectious disease

Pre-school Immunisations	School Immunisations (DTP & MenACWY)	Adult Routine (Shingles / Pneumococcal)	Non Routine Referrals (780 Referrals received)	Influenza & COVID	TOTAL
41,808	24,144	14,615	431	194,556	275,554

Service users' feedback:

Just a massive heartfelt thank you for everything that you do.

Very friendly, helpful staff as always.

Very well informed on procedure, professional and pleasant staff.

Was put at ease the minute I walked through the doors. Everyone has been helpful and kind as I'm deaf in both ears.

Explained very well and never even felt needles.

I received excellent service. The reception was helpful and the nurse who did the vaccination was administrable in the professionalism and kindness.

Sexual Health Services

Sexual Health Services across Grampian are hosted by the Aberdeen City Health and Social Care Partnership on behalf of the Aberdeenshire and Moray Integration Joint Boards. Appointments are held either face to face, on video or telephone and across a 12 month period, over 50,000 appointments were conducted by the service and over 35,000 tests were carried out.

This is an increase of almost 5,000 appointments compared to 2021-22's reported figures. The service also carries out Long-Acting Reversible Contraception (LARC) and are currently looking at new ways to deliver this service due to waiting lists in this area, this includes the ability for some GP Practices to assist with carrying out these procedures. Almost 3,500 LARC procedures were carried out over the past year.

Over 40,000 telephone calls were received to the service in 2022-23

We are continuing to provide a Grampian wide service in 6 locations

The Sexual Health Services team administered the monkeypox vaccination to priority patients

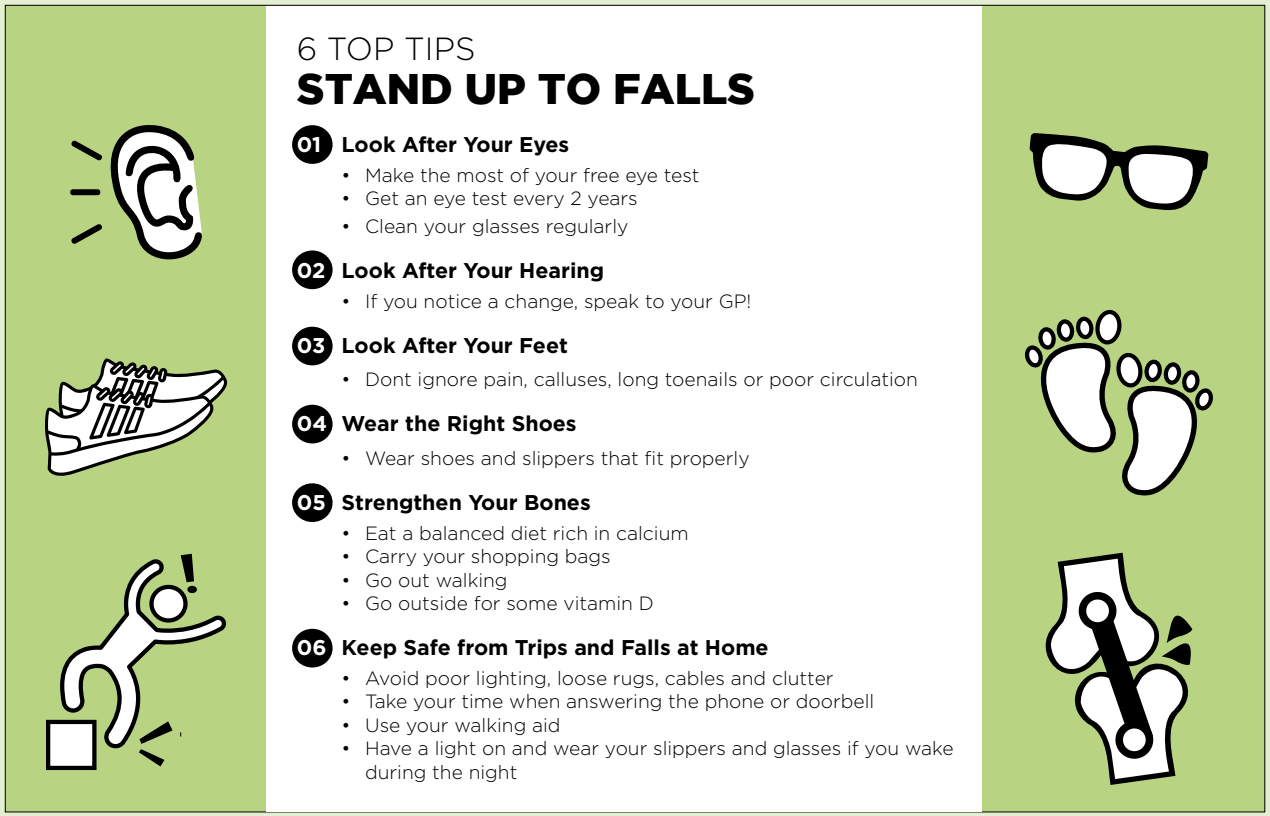
Stay Well, Stay Connected

Our Stay Well, Stay Connected programme looks to deliver a range of activities and opportunities in the local area to support individuals and their carers so that they can realise their individual and shared outcomes. The ACHCSP works closely with a number of partner organisations in order to achieve this goal. The Stay Well, Stay Connected programme aims to promote independence, resilience and a shared sense of community to its users. The following examples give a taste of what has been happening over the past year.

Stand Up to Falls - Falls Prevention Awareness

A fall can have a severe impact on an individual's life, their mobility and health needs. Of the 1,056 incidence of falls reported last year, about 21% resulted in harm to the individual involved. In Partnership with Bon Accord Care, Sport Aberdeen and NHS Grampian, we have developed a range of events, activities and resources to raise awareness of what can be done to prevent a fall, and what to do if one occurs.

Activities included visits to supermarkets where the team engaged in meaningful conversations with people about falls, the importance of reporting these to their GP, having a falls plan for their home and keeping their bones and body strong through exercise.



The Relaxed Match Day Experience

The focus of this day was to create a dementia and neurodivergent friendly environment providing a calm area for those who may have sensory or mental health challenges. The sponsors, recognised barriers that can be in place when accessing events and they enabled the partnership and other organisations to extend Aberdeen Football Club Community Trust relaxed sessions to include football.

The Relaxed Match Day Experiences are wonderful as they are a truly intergenerational project and benefits can be captured in feedback both by the young and older people attending.

The first fixture organised in conjunction with ACHSCP Wellbeing Coordinators was for Crosby House Care Home, and their feedback was hugely positive.

Upon leaving the stadium the residents had the opportunity to have their photograph taken with some of the players and the manager. It created lots of smiles of excitement.

Feedback

"I've never been to a real football match before. Best game ever."

"The staff were lovely and friendly; parking was a breeze, and it was extremely easy to find from the visual guide."

"The elation created a fantastic atmosphere at the service as others got caught up in the excitement of the day being retold."

"The staff at Pittodrie were extremely welcoming and helpful when we arrived and left, with offers of help to carry walking aids and help residents on the stairs. Staff were very attentive checking on everyone throughout the match."

Walking Football Wellbeing Model

Based at Strikers, Bridge of Don where Walking Football takes place twice a week, monthly health-related topics are held to an audience of walking football participants. Co-produced, where the participants decide on what health and wellbeing topics they want more information about. The monthly talks have attracted around 30 gentlemen to each session. Topics included:

- **Getting to know your blood pressure**
- **Prostate and associated issues**
- **Healthy Diet**
- **Functional Fitness MOTs**
- **Stress/Anxiety Management**
- **Talks are delivered by relevant local agencies. eg Penumbra, Urological Cancer (UCAN) nurses**

The model has proved so successful that the Mens Shed in Bridge of Don have asked for it to be repeated there.

RGU Students Placements - Varying Population Module and Befriending

Following on from our successful pilots reported in the 2021-22 Annual Performance Report, feedback was provided to RGU Health Sciences Department, which led to an adaption of their Varying Populations module. Now all third year Sport and Exercise students shadow specialist/ referral exercise classes in the community. The students shadow the instructor for 6 weeks on 2 different condition classes.

The successful companionship visits outlined previously are also continuing with two students befriending six older adults. These placements are hoped to embed softer skills in the students; relationship building, empathy, compassion, the ability to develop “small talk”, awareness of the issues of growing older, first hand, and encouraging students into the health and social care workforce. It is also hoped to encourage instructors to work with an older adult cohort, as there is currently a national shortage of group exercise instructors.

Roving Day-Care. Wee Blether

Roving Day Care is a partnership between ACHSCP Care Management, Wellbeing Team and Quarriers and it aims to deliver an alternative to traditional day-care.

Based at the Middlefield Hub, in the north of the City, the group meet on a Monday where a light lunch, tea and coffee are served with copious amounts of conversation! The purpose is to combat social isolation in frailer older adults.

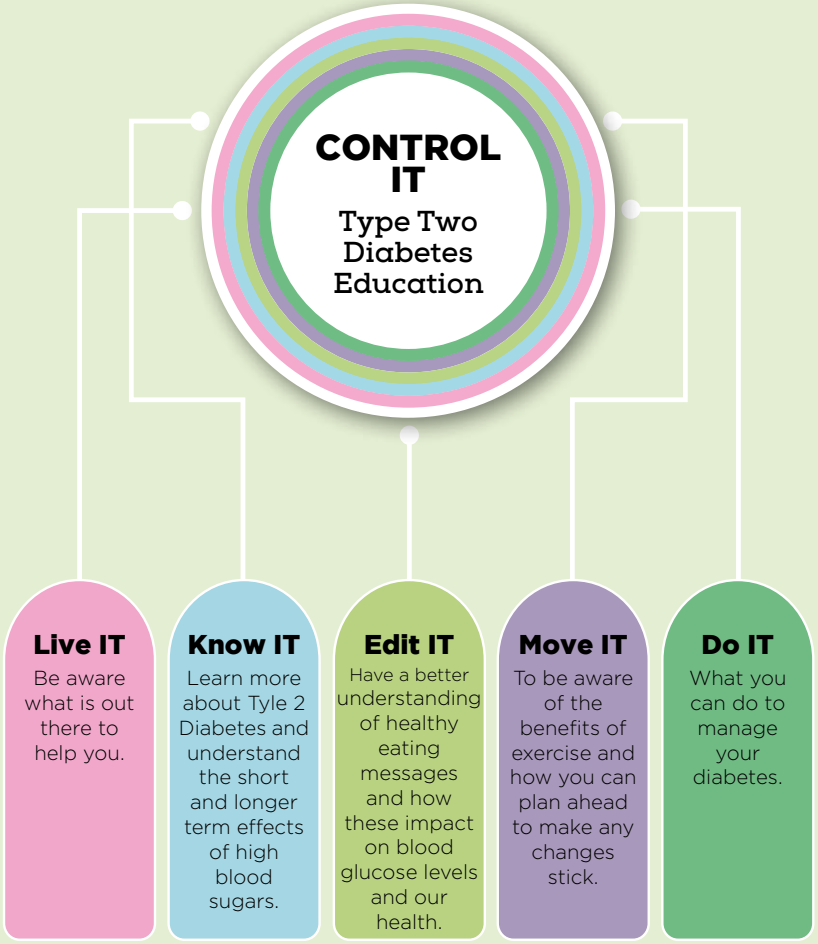
The “conversation café” can easily be moved to any “café-based” facility. An example was a trip to the Art Gallery. The group spent a few hours in the Art Gallery after a lovely lunch in the Cafe, and delivered some interesting critiques of the art work.

Act Now, Prevent It and CONTROL IT – Resources for people with (pre) diabetes

It is estimated that there are over 17,000 people in Scotland are diagnosed with diabetes each year and a further 500,000 are at risk of developing diabetes. Diabetes is known to have a significant impact on people's physical and mental health, but recent evidence has shown that for some people, with the right treatment, remission of their type 2 diabetes is possible. Aberdeen City, through the Scottish Government Framework for the Prevention, Early Detection and Early Intervention of type 2 diabetes are committed to preventing and detecting type 2 diabetes and to maximise support that best suits the needs of the population they serve. The programme is being evaluated by collecting information relating to patients and health inequalities in order to assess the reach and impact of the programme. Several programmes have recently been developed;

ACT-NOW	A self-management support programme for people with pre-diabetes, Type 2 diabetes, or current/history of gestational diabetes that puts them at an increased risk of developing Type 2 diabetes in the future. This support focuses on being more physically active, improving eating habits and patterns, and managing mild-to-moderate anxiety and/or low mood that is getting in the way of someone's effort to self-manage their condition.
PREVENT-IT	A digital education session for people with 'pre-diabetes'.
CONTROL-IT	A structured digital education programme for people living with Type 2 Diabetes designed to help people understand their condition and how to manage it.

Of those attending **Control-IT**, **57.8%** lost weight, **75.5%** achieved improvement in long term blood glucose levels and **57.7%** remained off all medication for diabetes management.



Grow Well Choices

The Grow Well Choices early years toolkit was developed in 2019 to support early years caring practitioners in delivering learning around healthy lifestyles to children aged 3-5.

An updated version of the toolkit has been launched with new features such as an online eLearning course, child-led home links, flashcards, and resource loan boxes with play equipment.

The toolkit was launched in March 2023, and its effectiveness will be evaluated in Autumn 2023 through data compiled from its use, eLearning completion and feedback from practitioners. Sustainability measures will be taken to annually advertise the toolkit and offer support to its users.

The Health Improvement Fund

The Health Improvement Fund supports initiatives that improve the health and wellbeing of people across Aberdeen. During 2022/23, 68 projects were funded through the Health Improvement Fund with over £194,000.00 shared across Aberdeen City. The projects range from community gardening and lunch clubs to birthing classes and Virtual Reality (VR) training.

Our decision-making groups are made up of Locality Empowerment Group (LEG) and Priority Neighbourhood Partnership (PNP) members. They met in November and February to discuss applications and distribute monies. In a bid to streamline funding opportunities across Aberdeen City, the Health Improvement Fund linked up with ACVO Community Mental Health and Wellbeing Fund and Aberdeen City Covid Recovery Fund to ensure an additional 14 applications could receive funding.

These links saw 72% of applications successfully funded within Round 1 and 67% of applications successfully funded within Round 2. The funded projects will be required to complete a 6-month and 1-year evaluation to measure the impact of their work and the achievement of outcomes which support the ACHSCP's strategic plan.

User feedback:

Please pass on my thanks to the whole team. You guys provide an invaluable service that makes a huge difference to folk struggling with Alzheimer's and for their carers.

Look at all these wonderful brave men you are helping. I know dad loves his time with the boys talking about his fitba. Thanks to all the volunteers for all you do.

The football memories sessions have been godsend for my father in-law. They've really brought him out of his shell and he looks forward to them.

Achieving Fulfilling Healthy 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.

We look to achieve this by:

- **Helping people to access support to overcome the impact of the wider determinants of health**
- **Ensuring services do not stigmatise people**
- **Improving public mental health and wellbeing**
- **Improving opportunities for those requiring complex care**

Mental Health and Learning Disability (MHLD) Transformation Programme

ACHSCP in conjunction with Aberdeenshire and Moray Partnerships and NHS Grampian have responsibility to deliver a range of mental health and wellbeing support and services in ways which are safe, sustainable and person centred. Prior to the Covid-19 pandemic there were significant pressures on Mental Health and Learning Disability services which required transformation activity, as doing more of the same would not meet the needs of the population. Recovering from Covid-19 it can be seen that the need for change is even stronger, with higher numbers of people experiencing mental illness and requiring care and treatment, in addition to the wider impact felt by the cost-of-living crisis on people's mental wellbeing.

Grampian wide Mental Health and Learning Disability Portfolio

This has been established to provide vision and oversight for MHLD services and to progress a range of projects which support our aims. There is a Portfolio Board and a Programme Team who support the development and delivery of projects.

Lived Experience

Community engagement is an important aspect of how MHLD services will adapt to meet need, listening to and involving people who use services in the development and design of new methods of working. The MHLD Public Empowerment Group has been established as a lived experience forum. The group provides opportunity for people with experience of Mental Health and/or Learning Disabilities to be a key partner in the transformation process.

Programme and Projects

The programme aims to transform the ways in which community and inpatient/specialist mental health services are delivered to meet the needs of the population and to ensure that there are a range or tiers of support levels which people can access. It is important to recognise that the majority of people do not require specialist services and where possible more services and supports should be provided to people in their communities. Some of the projects underway are required nationally but they will recognise the local situation such as the development and implementation of Psychological Therapies improvements, Children and Young People's Mental Health services under CAMHs and Learning Disability Health Checks.

Mental Health in Primary Care

A test of change has been carried out in Cove and Kincorth GP Practice by employing an experienced Mental Health Practitioner. Between November and March, over 200 face to face encounters have been held between the Practitioner and patients. The practitioner is able to carry out extended appointments within the practice and can refer onwards to other services if required, for example Primary Care Psychological Team, Drug and Alcohol Service, Eating Disorder Service. Between November and March, over 50 hours' worth of GP face to face appointment time is estimated to have been saved by enabling patients to access the Mental Health Practitioner service instead.

User feedback:

I was sceptical and worried about stigma. It's been good to come to the surgery and speak openly without worrying about what people think.

Getting time and understanding was so good, I felt listened to.

I felt as if I was going mad, I was really disturbed. Having a couple of appointments got me back on track.

The Mental Health Practitioner has given the opportunity to revise and transform the model of Primary Care Mental Health. It provides a huge improvement in quality and safety...and there is a significant whole service improvement recognised since the inception of the Mental Health Practitioner Service.

GP at Kincorth and Cove Medical Practice.

Climate Change

ACHSCP has a duty as part of Scotland's ambition to become Net Zero by 2045 to publicly report its emissions, and while the majority of climate reporting activities fall within the remit of the Partnership's parent organisations (NHS Grampian and Aberdeen City Council), the Partnership need to identify which climate duties fall within their remit and how best to record and report these.

Addressing climate change and its impacts is particularly important within health and social care as the impact of climate change is projected to impact vulnerable groups and our communities' health disproportionately. The World Health Organisation (WHO) has stated that climate change is "the single biggest health threat facing humanity". The ACHSCP Climate Change Programme was launched in late 2022, to ensure that, where relevant, Partnership decision-making and activities are climate-informed.

There is no doubt, climate change is real and we are already experiencing its consequences across north east Scotland. But what we cannot see yet are the ways in which climate change can lead to poorer health for us and the world around us.

We cannot underestimate the challenges that we face in adapting to climate change. We have made a good start, but there is more which is needing to be done by individuals, the communities in which they live, and the organisations that provide the services which we all use and rely on."

Phil Mackie

Public Health Consultant and Prevention Lead of ACHSCP

Complex Care

Within Learning Disability services there is a small yet significant number of people with Complex Care needs. Complex Care significantly affects the way in which care, support and environments must be delivered and this is largely due to the ways in which people with Complex Care needs can exhibit challenging behaviour, which is linked to communication relating to things like their care, support and environment. Due to the nature of Complex Care, there can be a lack of local resources to meet need and often people might be delayed within hospital or placed out of area.
To better meet local need, a Complex Care Market Position Statement, detailing the support and environmental needs for individuals with Complex Care needs including an environmental specification, was published in 2022, which can be found here **Complex Care – MPS**.

The Market Position Statement has provided clear communication of local need and forms the basis of engagement with Service Providers and Housing Providers to enhance the local service and accommodation options.

Work has been undertaken with housing partners to develop a potential local model of suitable accommodation, which is to be further progressed within 2023-24 and a sustainable funding model sought. Engagement with service providers continues on a regular basis and of priority in 2023-24 will be the re-development of a co-produced Complex Care Framework as a commissioning mechanism for care and support.

ACHSCP Complex Care Leads have been actively involved in the national development of a Dynamic Support Register which aims to support local and national strategic planning as well as enhance monitoring and oversight of Complex Care which is still delivered in hospital, out of area or inappropriate settings. We will begin to operate a local Dynamic Support Register in summer 2023 and continue to participate in national workstreams.

Suicide Prevention: “Creating Hope Together”

Aberdeen City, Aberdeenshire and Moray Health and Social Care partnerships have collaboratively commissioned a whole population suicide prevention contract to meet the requirements/outcomes within the ‘creating hope together’ strategy.

The five priority themes identified in the North East Suicide Prevention Logic Model created in partnership with the North East Suicide Prevention Leadership Group and the Oversight Group are outlined below. SAMH was awarded the contract and will focus on the following key areas across the three partnerships.

Building Community Capacity	Lived Experience	Data Analysis and Reduction of Risk	Children and Young People	Bereavement

As well as service provision SAMH will contribute their own organisation's funding and people to work alongside colleagues from across Grampian from various Health and Social Care Partnerships, Local Authorities, NHS, Police Scotland and other statutory and third sector organisations. SAMH will also have extensive and established links with a cademia and other agencies around relevant research, evaluation and evidence-based practices.

Outcomes to be achieved:

- **Increase capacity for suicide prevention activity through raising awareness, delivering training, and incorporating the outcomes within the suicide prevention strategy “Creating Hope Together” and the North East Suicide Prevention (NESP) Logic Model as agreed with both the North East Suicide Prevention Leadership Group (NESPLG) and Oversight Group.**
- **Outcomes to be achieved through this service are to be aligned to the national Suicide Prevention Strategy but developed within the three Health and Social Care Partnerships and the newly developed Logic Model.**
- **SAMH to work with each Partnership to support the development and delivery of their own identified delivery plans/outcomes.**

Health Assessment Team for Refugees and Asylum Seekers

The primary objective of the team is to empower individuals and families to take charge of their health and well-being while also supporting and ensuring the smooth functioning of Primary and Secondary healthcare services. This is achieved by providing valuable information to people about the right care, at the right place, and at the right time.

In the Grampian area, individuals arrive through various routes into the UK, and the team are present to welcome them, offer assistance and conduct a health needs assessment (HNA) within 24-48 hours. In cases of urgent health needs, immediate support is prioritised. The HNA allows the team to address any immediate health concerns and record essential information for their patient history and GP registration.

As the initial point of contact, the team play a crucial role in guiding individuals on how to access medical, optical, and dental help. They are also a direct point of contact for professionals and other services, facilitating seamless communication within the healthcare network. Support is provided either face to face, by email or telephone depending on the needs of the individual.

Encouraging independence is at the heart of the teams approach and to equip people with the knowledge of available healthcare services and how to use these effectively. For example, we educate individuals about the expertise of pharmacists through the pharmacy first service, promoting the understanding that a GP is not always the first option for certain conditions.

We facilitate GP registrations, assist in using online services like e-consults and ordering repeat prescriptions, and provide language support to make appointments for those whose first language isn't English.

Strategic Enablers

Our Strategic Enablers are an incredibly important part of our delivery plan and enable our strategic intent to be delivered by supporting its main aims.

Our Strategic Enablers include:

- **Workforce**
- **Technology**
- **Finance**
- **Infrastructure**
- **Relationships**

Workforce Plan

The 2021-2022 Annual Performance Report highlighted that the development and implementation of a Workforce Plan was a priority for 2022-23. After a significant period of data gathering, analysis and development work, the ACHSCP Workforce Plan 2022-2025 was presented to, and approved by the Integration Joint Board (IJB) in November 2022.

Data shows that around half of our staff are over the age of 50, and therefore likely to retire within the next 15 years. Between 2023 and 2027, it is estimated that 11% of our NHSG employed staff members will reach retirement age. This combined with the population increase expected of over 75's in Aberdeen City and increase in co and multimorbidity means that service demands are likely to increase over the next 10 years. It is, therefore of great importance that our Workforce Plan takes into account the three key aims as set out in the diagram.

The plan looks to clearly set out how changes and improvements will be made on these priority areas. Examples of these include establishing, developing and maintaining links with secondary schools and universities to encourage the next generation of the workforce and supporting staff to have a healthy life/work balance. The plan also outlines how these improvements will be made and how progress and the impact of the plan will be measured.

Dynamics 365- Electronic Case Management or Social Work

A multi-million pound investment took place to replace the previous Social Work application with Dynamics 365 (D365). The previous application had run its course and was found to no longer meet our service needs. In partnership with Microsoft, development of the new D365 application started in 2019 and was operational within our social work and justice teams in October 2022. The new system was co-produced alongside staff whose views were captured and used to determine the key elements of its functionality. It is anticipated that the new system will reduce duplication, improve reporting and provide the facility for cross team collaboration.

Morse- Electronic Patient Records for Community Nursing

It was reported in the 2021-2022 strategic plan that the ACHSCP had implemented a Patient Management System to our Health Visiting Service. Based upon the success of this implementation and the benefits it brought to the teams it was decided to invest and further implement this to School Nursing, and Adult Community Nursing services including Macmillan Nursing and the H@H team. Following its implementation to these teams, an evaluation took place showing that the duplication of information had reduced within teams and that the sharing of information between teams had increased meaning that there was an improvement in communication.

Sustainable Finance

Financial Year 2022/23 continued to challenge our normal expenditure patterns of previous years as we recovered from the pandemic, and we endeavoured to return to business as usual.

Robust financial monitoring continued throughout the year to ensure we ended 2022/23 with a stable financial position. Our Income and Expenditure for 2021/22 and 2022/23 is shown, right. Reserves were drawn down to fully balance the deficit position at the year end. Our Medium-Term Financial Framework for 2023/24 to 2029/30 was approved by the IJB on 28 March 2023 and our unaudited Annual Accounts were approved by the Risk, Audit and Performance committee on 2 May 2023.

In March 2023, Aberdeen City Council outlined an ambitious plan to align work to a Tiered Prevention model. It was agreed by the IJB that ACHSCP would affiliate our development plan and our financial expenditure to demonstrate our commitment to the three tiers of Prevention (prevention, early intervention, response). Our financial overview in the 2023/24 Annual Performance Report will demonstrate this further.

Details of our 2022/23 budget are shown on the next page.

Gross Expenditure £	Gross Income £	2021/22 Net Expenditure £		Gross Expenditure £	Gross Income £	2022/23 Net Expenditure £
36,816,513	0	36,816,513	Community Health Services	40,236,645	0	40,236,645
26,329,493	0	26,329,493	Aberdeen City share of Hosted Services (health)	29,125,768	0	29,125,768
34,689,647	0	34,689,647	Learning Disabilities	40,665,018	0	40,665,018
22,857,455	0	22,857,455	Mental Health & Addictions	24,964,561	0	24,964,561
84,433,334	0	84,433,334	Older People & Physical and Sensory Disabilities	97,907,284	0	97,907,284
706,721	0	706,721	Head office/Admin	1,889,544	0	1,889,544
11,977,726	0	11,977,726	Covid	10,012,029	0	10,012,029
4,931,999	(4,840,312)	91,687	Criminal Justice	5,119,400	(4,958,384)	161,016
1,862,505	0	1,862,505	Housing	2,139,020	0	2,139,020
40,165,525	0	40,165,525	Primary Care Prescribing	42,928,059	0	42,928,059
43,058,027	0	43,058,027	Primary Care	41,544,380	0	41,544,380
2,494,721	0	2,494,721	Out of Area Treatments	2,514,611	0	2,514,611
49,408,000	0	49,408,000	Set Aside Services	52,719,000	0	52,719,000
7,048,615	0	7,048,615	Transformation	12,144,018	0	12,144,018
366,780,281	**(4,840,312)**	**361,939,968**	**Cost of Services**	**403,909,337**	**(4,958,384)**	**398,950,953**
0	(395,096,188)	(395,096,188)	Taxation and Non-Specific Grant Income (Note 1)	0	(374,704,802)	(374,704,802)
366,780,281	**(399,936,500)**	**(33,156,221)**	**Surplus or Deficit on Provision of Services**	**403,909,337**	**(379,663,186)**	**24,246,151**
		(33,156,221)	**Total Comprehensive Income and Expenditure**			**24,246,151**

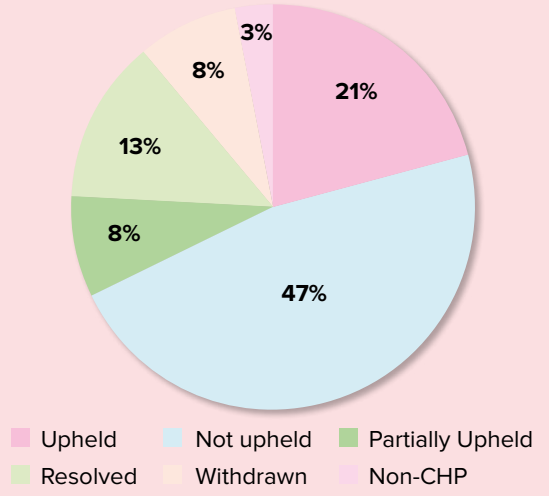
Governance

Complaints

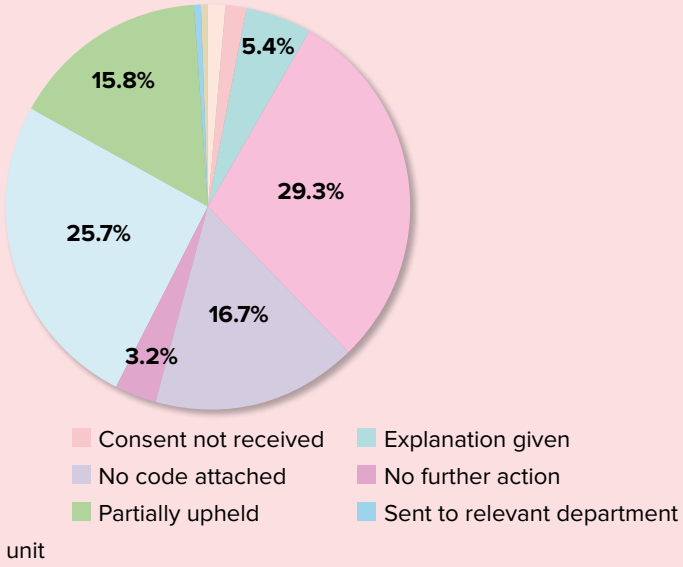
As an organisation, we take complaints made relating to our services very seriously and we have a number of governance processes in place to ensure that these are reviewed, and where possible lessons are learned.

There were 260 complaints registered with ACHSCP through either NHS Grampian or Aberdeen City Council in 2022/2023. This was a reduction of 7% compared with the number of complaints received in 2021/22. The following shows the outcomes of the complaints received, with around 28% of them upheld.

Outcomes of complaints relating to ACHSCP which were registered with ACC
Total = 38



Outcomes of complaints relating to ACHSCP which were registered with NHSG
Total = 222



Our Leadership Team

The Partnership is committed to publishing research articles in scientific journals when relevant initiatives are developed so that we can share our learning with other Partnerships and Services. In March 2023, a research paper was successfully published in the journal BMJ Leader, a journal run by the British Medical Journal.

This research article was about how the senior leadership team within the ACHSCP work together. Over the last few years, we have taken a different approach not just to how the team is structured, but also to trying to create an environment that makes it easier for us to work closer together.

The results from this research show that the team now works better together than it did previously, and we describe how we hope this is an important step towards developing health and social care services that better meet the needs of our population. This also shows the Partnership's commitment to sharing our learning with other areas, both nationally and internationally, so they can use our experiences to improve their local areas.

The link to the research paper is available here: **https://bmjleader.bmj.com/content/leader/early/2023/03/28/leader-2022-000664.full.pdf**

Locality Planning

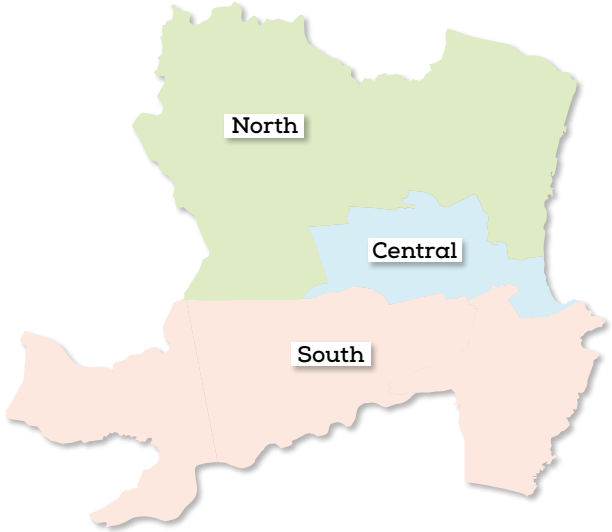
Locality Planning is when local communities work together with community planning partners to improve our local economy, improve people's lives, and the areas they live in. ACHSCP is required by law to put in place a locality planning system and we prepare Locality Plans to report progress to the IJB and Community Planning Aberdeen Board on an annual basis. Locality Empowerment Groups and Priority Neighbourhood Partnerships are our Locality Planning groups and this is one of the main ways we connect with our local communities. In December 2020, ACHSCP agreed joint locality planning arrangements with Community Planning Aberdeen.

There are three Locality Empowerment Groups (LEGs), one for each of the City's three locality areas in North, Central, and South. The LEGs restarted their dedicated meetings in April after a pause during 2022 as we recovered from the Covid-19 pandemic and now form an integral part of our refreshed approach to community engagement as set out in Aberdeen City's Community Empowerment Strategy 2023-26.

Each locality area has a priority neighbourhood within it, and each of these areas has a dedicated Priority Neighbourhood Partnership (PNP) to represent and serve the area. The PNPs are in Middlefield, Mastrick, Cummings Park, Northfield, Heathryfold (North Locality); Seaton, Woodside, Tillydrone (Central Locality); and Torry (South Locality).

Our Locality Planning priorities for 2023-24

- **Continue our recovery from the disruption caused by Covid-19 and increase community engagement activity**
- **Support the delivery of citywide community events such as the Community Gathering and Granite City Gathering**
- **Continue to deliver our three Locality Plans**
- **Publish Easy Read Locality Plans**
- **Increase awareness of Locality Planning, and our Locality Empowerment Groups and Priority Neighbourhood Partnerships**
- **Grow and diversify Locality Empowerment Group membership to ensure a wide range of groups and communities are represented on our Locality Planning groups**
- **Deliver the seven improvement projects under LOIP Stretch Outcome 16 relating to community empowerment**



Share knowledge, skills and experiences

Provide feedback on consultations

Pass information onto their networks

Get involved in work to improve your community

Identify needs in their community and possible ways to address them

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Whistleblowing

Whistleblowing is when a person, usually working within a public service, raises a concern of mismanagement, corruption, illegality, or some other wrongdoing. There are three main policies relevant to the IJB and ACHSCP:

- **The National Whistleblowing Standards**
- **Aberdeen City Council's Whistleblowing Policy**
- **The IJB's Whistleblowing Policy**

Whistleblowing incidents captured through the process will be reported to both the IJB and NHS Grampian on a quarterly basis. It is proposed that the Risk, Audit and Performance Committee receive the quarterly reports when there are incidents to report. The IJB are committed to dealing responsibly, openly and professionally with any genuine concerns held by staff of the Aberdeen City Health and Social Care Partnership, 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.

Strategic Risk Register

Our Strategic Risk Register is reviewed by the IJB annually and by the Risk, Audit and Performance Committee twice a year. The IJB also held a workshop in August 2022 where it reviewed the Board's risk appetite statement as well as undertaking a review of risks on the register. This review included the IJB considering recommendations from the Partnership's Senior Leadership Team (SLT) around the de-escalation some of the strategic risks. The SLT continue to review the strategic risks on a quarterly basis, this includes the possibility of escalations of risks from the operational risk register as well as any de-escalations.

IJB Directions

As per the Roles and Responsibilities Protocol of the Integration Joint Board (IJB) and its Committees, the IJB are obliged, "to issue Directions to the Partners under sections 26 and 27 of the Public Bodies (Joint Working) (Scotland) Act 2014, in line with the Integration Scheme and legislative framework sitting around the CEOs of the Partners."

Directions are the means by which an IJB tells the Health Board and Local Authority what is to be delivered using the integrated budget and for the IJB to improve the quality and sustainability of care, as outlined in its Strategic Plan. The statutory guidance on Directions states that "Any direction issued by the IJB must meet all clinical and care governance requirements and standards to ensure patient safety and public protection as well as ensure staff and financial governance".

A Directions Tracker is maintained which indicates when Directions are submitted to the constituent organisation(s), the financial commitment, the timescale of the Direction and the status. Most of the Directions issued by the IJB are to incur financial expenditure and are therefore centred around commissioning or our transformation programme.

The Directions Tracker is updated following every IJB meeting and is regularly reviewed alongside the IJB Business Planner to ensure Directions are being implemented as per the IJB's instructions and within the timescales and budget set. A status report is provided at the Chief Officers' monthly performance meeting and bi-annually to the Risk Audit and Performance committee. This ensures overview from ACC and NHSG Chief Executives and the Chair and Vice Chair of IJB.

Strategic Plan 2022 – 2025 and Priorities for 2023/24

The first year of the ACHSCP Strategic Plan 2022-2023 has seen a decrease in delayed discharges from acute care and a decrease in the unmet need from those referred to Social Work. However, the Partnership aims to make further improvements in order to continue to provide the best service possible to the residents of Aberdeen City. Through the continued delivery of our strategic plan and alongside our partners in Aberdeen City Council, NHS Grampian and other third party organisations, we also aim to increase the preventative measures so that where possible, people either avoid the need for intervention by Health and Social Care Services or are effectively treated at an early stage without the need for Acute hospital care.

In line with the ACHSCP's Strategic Plan and Delivery Plan, the projects for 2023-24 are outlined to the right:

Priorities for 2023/24

- **Implement and Embed the Carers Strategy**
- **Implement and Embed the Workforce Plan 2022-2025**
- **Continue to increase the number of beds within the Hospital at Home Service**
- **Undertake a review of our Neuro Rehabilitation Service**
- **Continue to engage with the Communities of Aberdeen in a way that suits them**
- **Ensure close alignment of Complex Care needs to the Market Position Statement and its reflection in the provision of support and accommodation**

Appendix 1 - National Indicators

The following tables show the Ministerial Steering Group (MSG) indicators which help to assess the ACHSCP's performance against previous years and other areas within Scotland. The table below demonstrates the 6 indicators and the outcomes recorded for 2022/23. The Scottish average has also been added for context.

Indicator	Aberdeen City						Scotland Average	
	2019/20	2020/21	2021/22	2022/23	Overall Trend	Between 2021/22 - 2022/23	Overall Trend between 2019 - 2023	Between 2021/22 - 2022/23
1a. Number of emergency admissions (monthly average)	1824	1582	1700	1690	↓	-0.6%	↓	-0.8%
2a. Number of unscheduled hospital bed days; acute specialties (monthly average)	11944	9133	10644	11161	↓	+4.9%	↑	+5.8%
3a. A&E attendances (monthly average)	3972	2688	3244	3473	↓	+7.1%	Stable	+2.2%
4. Delayed discharge bed days (monthly average)	1023	494	607	745	↓	+22.8%	↑	+22.2%
5a. Percentage of last six months of life by setting (%)	88.6	91.4	91.0	Not available	Stable		Stable	
6. Balance of care: Percentage of population in community or institutional settings (%)	91.6	92.3	92.1	Not available	Stable		Stable	

Over all areas within the Ministerial Steering Group Indicators, Aberdeen City has performed roughly in line with the Scottish average. There was a significant 23% reduction in the unscheduled bed days during the covid year compared to previous year. Although the 2021/2022 figures saw an increase of approximately 16.5%, the ACHSCP's unscheduled bed days have further rose roughly by 5% over the past financial year.

This indicates that, despite the initial substantial reduction, there has been a subsequent surge in the number of patients requiring unscheduled hospital bed days in the recent years. Across the board, the efforts made by teams across the whole partnership cannot go unnoticed. Their dedication and commitment had ensured that a large number of individuals receive timely and appropriate care, closer to their homes. This not only reduces the pressure on the emergency and acute care units but also ensures patients are discharged promptly once their need for acute medical care subsides.

Our A&E attendances look to have risen across the past year however this should be taken in context of an overall downward trend and the A&E attendances are still around 500 contacts less than the Partnership's pre covid figures. Finally, looking at the delayed discharge levels reported in Aberdeen City we see that these are roughly in keeping with the Scottish average and although there looks to have been a marked increase when we compare the 2021/22 and 2022/23 figures, this is due to using average bed days as a measurement which includes both standard and complex delays. Examples of initiatives which have been implemented to avoid hospital admissions and reduce delayed discharges include:

1. **We have aligned Social Work staff to key areas of the hospital, including the frailty wards and at 'the front door' where staff can link in with community colleagues through enhanced locality huddles in an attempt to avoid admission where appropriate and for the individual to return home with the support of a Multi-disciplinary team.**
2. **Building relationships with care at home providers and looking at an enablement focussed discharge plan where appropriate so the individual has wrap around support that can be reduced as they regain their independence at home.**
3. **Utilising Interim provision at Woodlands Care Home where individuals who are awaiting care home placement can move to a more homely environment rather than remain in a hospital ward. There are also interim options for varying levels of independence, ensuring the individual does not remain in hospital any longer than necessary and moves to an environment similar to their discharge destination as soon as possible.**

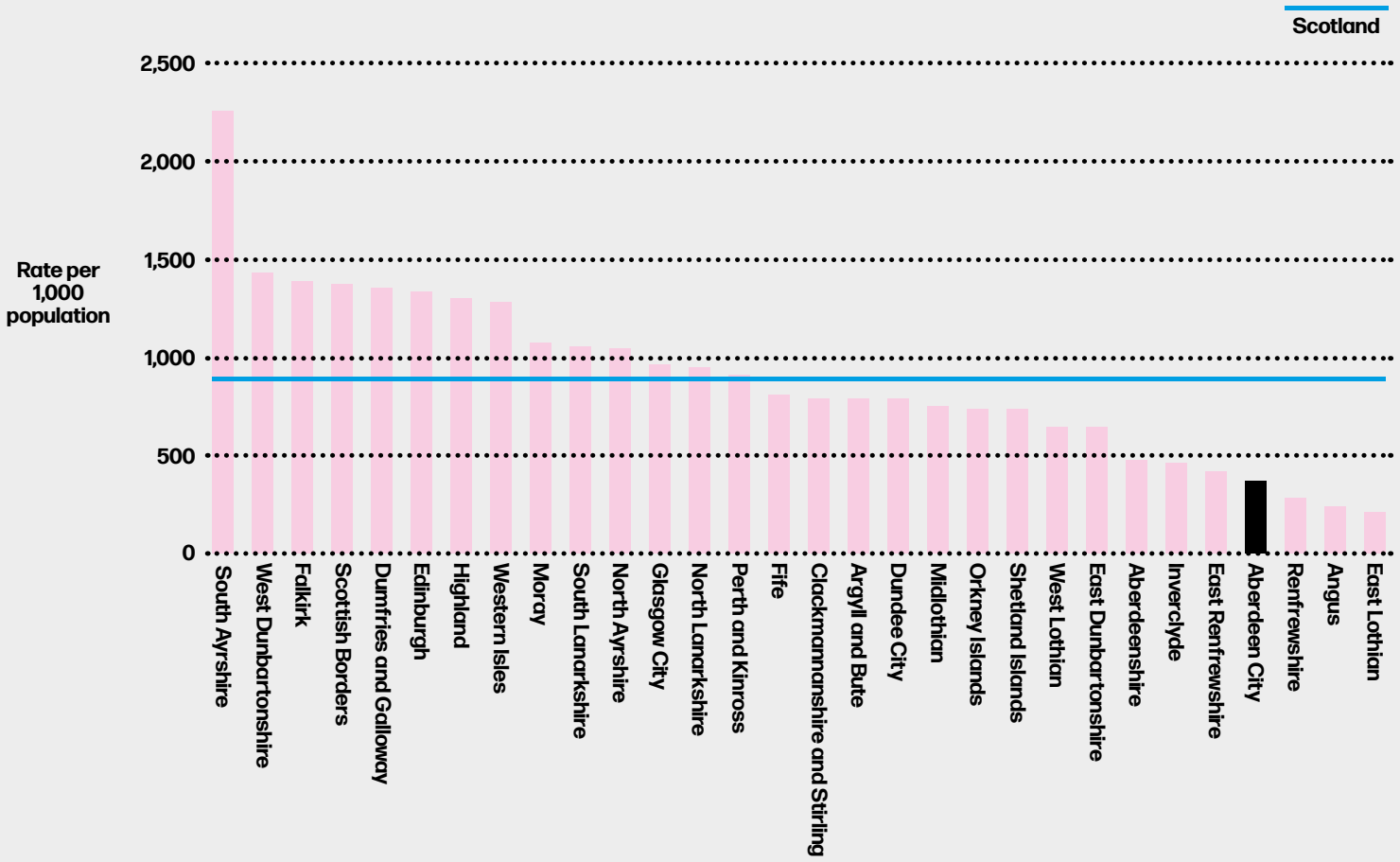

Table1. Rate of Delayed Discharge in Scotland per 1,000 population 2022-2023.
Source: National Integration Indicators, Public Health Scotland.

Appendix 2 - National Integration Indicators

The following tables display the national integration indicators as compiled and published by Public Health Scotland. The raw data and how these figures are calculated can be found here. A number of figures have not been updated since the Annual Performance Report published for 2021/2022 due to the Health and Experience Survey (HACE) being conducted bi-annually and it is therefore due to be reissued in Autumn 2023 and will be reported in the Annual Performance Report for 2023/24. Where the integration indicator falls into this category, it has been denoted with a *. Due to changes in the wording of the question, asked within the HACE report, indicator 2,3,4,5,7,9 are felt to not be directly comparable to each other and therefore no trend information has been given. In indicators number 12 to 16, the annual figures are presented by financial year until 2021/22. As January to March 2023 data is not complete for all NHS Boards and therefore the calendar year figures for 2022 were published by Public Health Scotland, this is denoted by ** in the table below. The arrows used to indicate the overall trend have been colour coded to anticipate a positive or negative result i.e. where a positive outcome has occurred, this has been indicated by a green arrow and where a negative result has occurred, this is denoted by a red arrow.

In regards to NI17, the information that contributes to the overall number for this indicator represents the grading for all registered care services within Aberdeen City. Some of these services will have a contract with Aberdeen City Council, but others such as nursing agencies or other services not contracted by Aberdeen City Council will also be reported as part of this indicator. For those services that have a contract with ACC there is evidence that care inspectorate grades have fallen with a number of services. One reason for this is that some services have not been inspected for more than a year and or there have been issues with staffing for example. ACHSCP continue to work collaboratively with all service providers to support them to continue to improve services.

		Aberdeen City			Scotland		
		2019/20	2021/22	Overall Trend and percentage increase/decrease	2019/20	2021/22	Overall Trend
NI1*	Percentage of adults able to look after their health very well or quite well	94%	94%	Stable	93%	91%	↓
NI2*	Percentage of adults supported at home who agree that they are supported to live as independently as possible	82%	78%	No trend given due to change in question format	81%	79%	No trend given due to change in question format
NI3*	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	78%	66%	No trend given due to change in question format	71%	71%	No trend given due to change in question format
NI4*	Percentage of adults supported at home who agree that their health and social care services seemed to be well coordinated	76%	71%	No trend given due to change in question format	74%	66%	No trend given due to change in question format

		Aberdeen City			Scotland		
		2019/20	2021/22	Overall Trend and percentage increase/decrease	2019/20	2021/22	Overall Trend
NI5*	Percentage of adults receiving any care or support who rate it as excellent or good	79.4%	77%	No trend given due to change in question format	80%	75%	No trend given due to change in question format
NI6*	Percentage of people with positive experience of care at their GP Practice	77%	65%	↓	79%	67%	↓
NI7*	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	84%	79%	No trend given due to change in question format	80%	78%	No trend given due to change in question format
NI8*	Percentage of carers who feel supported to continue in their caring role	34%	32%	↓	34%	30%	↓
NI9*	Percentage of adults supported at home who agree they felt safe	86%	76%	No trend given due to change in question format	83%	80%	No trend given due to change in question format

		Aberdeen City				Scotland			
		2020/21	**2021/22**	**2022**		**2020/21**	**2021/22**	**2022**	
NI11	Premature mortality rate per 100,000 persons	**2020** 432	**2021** 453	N/A		**2020** 457	**2021** 466	N/A	
NI12**	Emergency admission rate	9201	9655	9366	↑	10,957	11,632	11,155	Fluctuating
NI13**	Emergency bed day rate, per 100,000 population	84,774	93,427	92,026		101,967	112,939	113, 134	
NI4**	Readmission to hospital after 28 days	139	121	118	↓	120	107	102	↓
NI15**	Proportion of last 6 months of life spent at home or in a community setting	91	91	91	Stable	90	90	89	Stable
NI16**	Falls rate per 1,000 population 65+	22 *(actual falls 816)*	22	20 *(actual falls 750)*	↓	22	23	22	Stable
NI17	Proportion of Care Services graded 'good' (4) or better in Care Inspectorate inspections	91%	78%	64%	↓	83%	76%	75%	↓
NI18	Percentage of adults with intensive care needs receiving care at home	N/A	2021 *(55%)*	55%	Stable		2021 *64%*	2022 *64%*	Stable
NI19	Number of days people aged 75+ spend in hospital when they are ready to be discharged, rate per 1,000 population	276	318	2022/23 *336*	↑	484	748	2022/23 *919*	↑
NI20	Percentage of health and care resource spent on hospital stays where the parents was admitted in an emergency	2019/20 *27%*	N/A	N/A		2019/20 *24%*	N/A	N/A	N/A

Appendix 3 - ACHSCP Strategic Plan 2022-2025. Delivery Plan Reference

The outcomes from the Strategic Plan are devised to be delivered over a three period with an annual scheduled review and update so that lessons learned or emerging priorities can be taken into account and scheduled appropriately. Below is a list of programmes and projects within the Delivery Plan as set out within the ACHSCP Strategic Plan 2022-2025.

Many of these have commenced over the past financial year and are currently ongoing. Where reference or links has been made to particular projects within the Annual Performance Report, these have been outlined below. The absence of a reference does not mean that progress is not being made, simply that we have not included content in relation to that in this Annual Performance Report. Delivery Plan progress is reported to our Senior Leadership Team on a monthly basis and to the Risk, Audit and Performance Committee on a quarterly basis.

The updated Delivery Plan for 2023-24 (Year 2 of the ACHSCP Strategic Plan) was presented to IJB in March 2023 and can be found here.

Caring Together

Programme/Projects	Measures	Link if Referenced within the report
Redesign Adult Social Work enhancing the role of Care Managers in playing a guiding role in the promotion of personalised options for care	Redesign implemented	
Undertake a strategic review of specific social care pathways and develop an implementation plan for improving accessibility and coordination	Implementation Plan	
Implement the recommendations from the current Adult Support and Protection inspection	Action Plan complete	Please see Page 10 for an overview of the work ongoing.
Deliver the Justice Social Work Delivery Plan	Percentage of actions complete	
Develop and implement a Transition Plan for those transitioning between children and adult social care services	Plan developed	Please see Page 11 relating to the use of the Getting it Right for Everyone (GIRFE) model.
Develop cross sector, easily accessible, community hubs where a range of services coalesce, all responding to local need	Hubs operational	See progress being made in Northfield on Page 25
Community Empowerment		
Develop the membership and diversity of our Locality Empowerment Groups	Membership	Priorities relating to this is mentioned on Page 49 Health Issues in the Community (HIIC) training to be delivered to LEG outlined on Page 16
Deliver our Locality Plans and report on progress	Progress Report	Priorities relating to this are mentioned on Page 49
Train our staff and embed the use of Our Guidance for Public Engagement	Percentage of Staff Trained	
Promote the use of Care Opinion to encourage patients, clients, carers and service users to share experiences of services, further informing choice.	Number of posts on Care Opinion	
Finalise the arrangements for the closure of Carden Medical Practice and identify an alternative use of the building	Report to IJB	
Improve primary care stability by creating capacity for general practice	Report to IJB	
Deliver the strategic intent for the Primary Care Improvement Plan (PCIP)	Plan report	Please see updates given on Page 17
Develop and deliver a revised Carers Strategy with unpaid carers and providers of carers support services in Aberdeen, considering the impact of Covid 19	Strategy Approved at IJB	Please see 2022-23 updates on Page 14

Keeping People Safe at Home

Programme/Projects	Measures	Link if Referenced within the report
Rehabilitation		
Commence strategic review of rehabilitation services across ACHSCP \ SOARS \ Portfolio and have an implementation plan in place to commence by April 2023	Implementation plan in place	
Explore how other partners in sports and leisure, can assist in delivering rehabilitation across multiple areas	Community First	See progress being made in Northfield on Page 25
Unscheduled Care		
Build on our intermediate bed-based services to create 20 step-up beds available for our primary care multi-disciplinary teams (MDTs) to access	20 beds created	
Increase our hospital at home base with an ultimate ambition of 100 beds. These will be for unscheduled, older people, respiratory and cardiac pathways	Number of Beds available	Progress being made is outlined on Page 22
Deliver the second phase of the Frailty pathway	Pathway delivered	
Undertake a strategic review of the data, demographic and demand picture to understand the 'bed base' for unscheduled care across MUSC, SOARS and ACHSCP	Review the demand profile produced	
Expand Housing Options		
Working with ACC as a planning authority, create incentives for investment in specialist housing influencing new builds and enabling people to have lifetime homes	Numbers of specialist housing new build	
Help people to ensure their current homes meet their needs including enabling adaptations and encouraging the use of Telecare where appropriate	Adaptation statistics, Telecare usage statistics	
Respond to the national consultation on equipment and adaptations helping to shape future guidance in this area	Consultation submitted by deadline	
Work with ACC Housing and RSLs to ensure energy efficient, affordable housing is made available to those who need it most	Housing satisfaction results	
Work with Integrated Children's Services to support the delivery of the Family Support Model particularly in relation to children with a disability and those who are exposed to the risk of trauma	Family Support Model milestones delivered	

Preventing ill Health

Programme/Projects	Measures	Link if Referenced within the report
Reduce the use and harm from alcohol and other drugs	Drug and Alcohol related admissions and deaths, Delivery Framework Milestones	
Deliver actions to meet the HIS Sexual Health Standards	Progress towards meeting standards	Overview of the Sexual Health Service achievements given on Page 29
Deliver our Immunisations Blueprint	Immunisations Statistics	Overview of the immunisation service is given on Page 28
Continue the promotion of active lives initiatives including encouraging active travel	Percentage of population meeting Physical activity national guidelines	
Continue to contribute to the NHS Grampian Tobacco Strategic Plan for the North East of Scotland particularly in relation to encouraging the uptake of Smoking Cessation Services	Smoking/Smoking Cessation statistics	
Continue to deliver our Stay Well Stay Connected programme of holistic community health interventions focusing on the prevention agenda around achieving a healthy weight through providing advice and support for positive nutrition and an active lifestyle.		A range of projects within the Stay Well Stay Connected Programme are outlined on Page 30-32
Continue to contribute to the Grampian Patient Transport Plan (GPTP) and the Aberdeen Local Transport Strategy (ALTS) encouraging sustainable and active travel.	ACHSCP requirements reflected GPTP and ALTS	

Achieving Health Fulfilling Lives

Programme/Projects	Measures	Link if Referenced within the report
Address Inequality / Wider Determinants of Health		
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	IJB and Committee Reports	
Undertake and publish Health Inequality Impact Assessments, where relevant, for major service change, in conjunction with people and communities with the relevant protected characteristics	Progress towards meeting standards	
Make Every Opportunity Count by identifying any wider determinant issue and ensuring patients, clients and their carers are signposted to relevant services for help	Service Directory developed	
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	Climate Change impacts included in Business Cases, IJB Reports and Business Continuity Plans	Please see Page 39 for an overview of the progress to date
Mental Health and Learning Disabilities		
Continue to progress Mental Health and Learning Disabilities (MHLD) transformation to evidence increased community delivery across secondary and primary care with a clear plan for 2022 and 2023 in place by June 2022	Plan developed, Progress Reports	Please see Page 37 for an overview of progress being made in this area
Implement the actions in the MHLD Transformation Plan	Progress Reports	Page 37 gives an overview of the programme and progress being made
Remobilisation		
Explore opportunities for working with those on waiting lists to help support them while they wait, or divert them from the list	Numbers supported/diverted	
Plan service capacity to include the impact of the consequences of deferred care and Long Covid	Unmet Need	
Remobilise services in line with the Grampian Remobilisation Plan as soon as it is safe to do so	Percentage Remobilisation	
Develop a plan ready to respond to increased demand due to covid variants or vaccinations	Plan developed	

Strategic Enablers

Programme/Projects	Measures	Link if Referenced within the report
Workforce		
Develop a Workforce Plan taking cognisance of national and regional agendas	Plan developed	Page 44 gives an overview of the Workforce Plan in place.
Continue to support initiatives supporting staff health and wellbeing	Initiatives delivered	The Workforce Plan on Page 44 supports this.
Train our workforce to be Trauma Informed	Percentage of workforce trained	
Technology		
Support the implementation of digital records where possible	Percentage of records digitized	Page 45 gives more information about how this is being achieved
Seek to expand the use of Technology Enabled Care (TEC) throughout Aberdeen	TEC usage statistics	
Support the implementation of the new D365 system which enables the recording, access and sharing of adult and children's social work information	Successful implementation and use	Page 45 provides an overview of the D365 implementation
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	Community First Programme Milestones	
Explore ways we can help people access and use digital systems	Number of people supported	
Finance		
Monitor costing implications and benefits of Delivery Plan actions ensuring Best Value is delivered	Medium Term Financial Framework (MTFF)	Page 46 gives an overview of our financial position.
Relationships		
Develop proactive, repeated and consistent communications to keep communities informed	Number of proactive communications	
Continue to deliver on our commissioning principle that commissioning practice includes solutions co-designed and co-produced with partners and communities	Number of codesigned/ coproduced commissioning	
Continue to transform our commissioning approach, building on the work we undertook with our Care at Home contract, developing positive relationships with providers, encouraging collaborative approaches and commissioning for outcomes	Number of commissioning for outcomes arrangements	Page 15 displays our approach to integrating care in Woodlands Care Home.
Focus on long term contracts and more creative commissioning approaches such as direct awards and alliance contracts which will provide greater stability for the social care market	Number of long term and creative contracts	
Continue to deliver ethical commissioning in relation to financial transparency and fair working conditions for social care staff as well as progressing implementation of Unisons Ethical Care Charter	Number of ethical commissioning arrangements and % of Unison's Ethical Care Charter implemented	
Infrastructure		
Identify interim and long term solutions for the provision of health and social care services in Countesswells	Report to AMG/IJB	
Continue to review and update the Primary Care Premises Plan (PCPP) on an annual basis	PCPP revised every year	

Aberdeen City Health & Social Care Partnership

A caring partnership

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ABERDEEN CITY COUNCIL

NHS Grampian