From: Foi Enquiries
To: [redacted]
Subject: FOI-16-0728 - Joint Strategic Needs Assessment
Date: 10 June 2016 08:45:56
Attachments: Further Information - Right to Review & Appeal.pdf
FOI-16-0728 - Joint Strategic NeedsAssessment.pdf

Dear [redacted],

Thank you for your information request of 24 May 2016. Aberdeen City Council (ACC) has completed the necessary search for the information requested.

As part of the development of the Integration Joint Boards and the development of the Strategic Plans, I believe that each IJB was required to undertake a Joint Strategic Needs Assessment providing a summary of the local population, its health and wellbeing, and variations across the region; levels of poverty and deprivation; the level of need for support and care and how this is expected to change in future; how the resources of the NHS and local authority are currently used and what the current pressures are.

Please could you provide me with a copy of this Joint Strategic Needs Assessment for Aberdeen City or provide a link to where it is publicly available?
Please see attached, FOI-16-0728 – Joint Strategic Needs Assessment.

We hope this helps with your request.

Yours sincerely,

Grant Webster
Information Compliance Officer

INFORMATION ABOUT THE HANDLING OF YOUR REQUEST

ACC handled your request for information in accordance with the provisions of the Freedom of Information (Scotland) Act 2002. Please refer to the attached PDF for more information about your rights under FOISA.

Information Compliance Team
Communications and Promotion
Office of Chief Executive
Aberdeen City Council
Room 1-24
Town House
Broad Street
ABERDEEN AB10 1AQ

foienquiries@aberdeencity.gov.uk
01224 523827/523602

Tel 03000 200 292

*03000 numbers are free to call if you have 'free minutes' included in your mobile call plan.
Calls from BT landlines will be charged at the local call rate of 10.24p per minute (the same as 01224s).

www.aberdeencity.gov.uk

A framework to inform Integrated Joint Boards' needs assessments in Grampian: a report of a partnership working group

Aberdeen City Council
Aberdeenshire Council
Moray Council
NHS Grampian

22 December 2014

Contents

Executive Summary

Situation
A working group was convened to advise Integrated Joint Board Chief Officers about strategic needs assessments to inform strategic planning.

Background
Epidemiological needs assessment involves using epidemiological analyses and research evidence to identify the gaps in current provision, and to suggest evidence-based options for how to bridge these, as part of a strategic planning process. It often includes a *participative* component to include the views of those will use the needs assessment to inform their decision-making, and those who will be affected by the decisions that are made.

Assessment
To establish a starting point for considering the health needs of the IJB populations, the group asked an initial overarching question: "will IJBs have the right resources and services, doing the right things, in the right places, to meet the population's diverse health and social care requirements?" To answer the overarching question, we turned to the Scottish Government's stated ambitions for integration, as contained in the nine national outcomes. Through doing so we confirmed that a continued sole focus on conventional service delivery will be insufficient to achieve these. **Annex 1** provides projected population and service delivery estimates for the over-65 population (given the strategic importance of an ageing population), which demonstrates the non-sustainability of existing local service delivery models.

Recommendations
We recommend that needs assessment be a function of IJB strategic planning groups (SPG). The priorities for areas requiring assessment will arise from the professional knowledge of SPG members, informed by public opinion obtained during SPG community engagement activities. SPG community engagement activities provide the opportunity for an inclusive, *participative* process with citizens, communities, and services. Based on our consideration of the requirements placed on individuals, communities, and health and social care organisations by the nine national outcomes, we provide suggested discussion points for use in these consultations in **annex 2**.

We recommend that each IJB SPG identify a named lead for needs assessment. These three leads will be required to collaborate to create an *epidemiological needs assessment* action plan to ensure the efficient use of local authority, and ISD, NHS and University of Aberdeen public health resources, within SPG-identified timescales. These epidemiological needs assessments will use data, published research evidence, and assessment of current gaps in provision to support SPGs with their evidence-based decision-making. **Annex 3** suggests questions to help with the identification of needs that would benefit from assessment.

Since needs assessment will be required as part of IJBs' ongoing planning cycles, we recommend that IJBs retain the needs assessment lead role in order to allow continued coordination of the finite available intelligence resources.

Introduction

Background

Grampian's Integrated Joint Boards (IJBs) will develop strategic plans during 2015, informed by the results of strategic health needs assessment.[1,2] Existing national strategic direction is being driven by increasing longevity and 'multi-morbidity', increasing technological advances, and rising public expectations, amidst ongoing human resource and fiscal challenges.[3,4,5] The projected fifty per cent increase in the number of people aged 65 and older in Scotland by 2032[6] might, all else being equal, be expected to lead to a fifty per cent increase in service demand. Given that all is not equal, as lifestyles and social circumstances continue to change, and the prevalence of conditions such as obesity and diabetes continue to grow, demand for services may exceed even this projection. Having considered these issues at an initial meeting with IJB Chief Officers on 24 November 2014, a group was convened to provide advice on how to take needs assessment forward in Grampian.

Method

What is a needs assessment and how is it conventionally done?

A needs assessment is a systematic process of collation, analysis and interpretation of data and information to inform priority-setting and decision-making. 'Epidemiological needs assessment' conventionally focuses on a specific condition or disease and the ability of those affected to benefit from healthcare, drawing on published research evidence, health surveillance data, and an assessment of existing provision, from a professional and/or commissioner viewpoint[7]. Such assessments often incorporate a comparative element, to benchmark local evidence, and a consultative element, to include stakeholder views and priorities. Identifying the 'gaps' between unmet need and current provision allows strategic decision-makers to rectify these. Wider 'participatory needs assessment' is intended to understand the health needs of a population from a community viewpoint.[8]

What was the group's understanding of its task?

The group identified its task as being to:

(a) develop a clear rationale to underpin strategic needs assessment in Grampian
(b) recommend key issues for inclusion in strategic needs assessments in 2015 and beyond
(c) take into account existing assessments of need and their extant recommendations
(d) deliver a written report to Chief Officers on 22 December 2014

How did the group approach its task?

The group:

(a) met three times during December 2014

---

[1] NHS National Services Scotland (2014) *A Guide to Data to Support Health & Social Care Partnerships in Joint Strategic Commissioning and Joint Strategic Needs Assessment* ISD Scotland: Edinburgh
[2] NHS National Services Scotland (2014) *Population Needs Assessment for Health and Social Care Partnerships: guidance on the use of data sources* ISD Scotland: Edinburgh
[3] www.scotland.gov.uk/resource/doc/352649/0118638.pdf
[4] www.kingsfund.org.uk/time-to-think-differently
[5] Director of Public Health Report 2013/14, NHS Grampian
[6] www.scotphn.net/projects/previous_projects/health_and_social_care_needs_assessment_of_older_people_reports
[7] www.birmingham.ac.uk/research/activity/mds/projects/HaPS/PHEB/HCNA/intro/index.aspx
[8] www.healthknowledge.org.uk/public-health-textbook/research-methods/1c-health-care-evaluation-health-care-assessment/participatory-needs-assessment

(b) endorsed the principle of joint working across Grampian between NHS, local authority, and community planning partnership representatives
(c) agreed its starting point to be, "a process of identifying the right questions to ask, not by looking only at the data which are available"

How did the group begin its task?
The group identified an overarching question:

Will IJBs have the right resources and services, doing the right things, in the right places, to address the population's diverse health and social care needs?

To answer this, the group began with the Scottish Government's stated ambitions for health and social care integration, as set out in the nine National Health and Wellbeing Outcomes[9]:

- **Outcome 1** People are able to look after and improve their own health and wellbeing and live in good health for longer
- **Outcome 2** People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- **Outcome 3** People who use health and social care services have positive experiences of those services, and have their dignity respected
- **Outcome 4** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- **Outcome 5** Health and social care services contribute to reducing health inequalities
- **Outcome 6** People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
- **Outcome 7** People who use health and social care services are safe from harm
- **Outcome 8** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- **Outcome 9** Resources are used effectively and efficiently in the provision of health and social care services

For each outcome, the group then asked:
1. What principles underlie the outcome, and what is necessary for it to be achievable?
2. What does this mean at an individual, community, and organisational level?
3. What existing strategic assessments have recently addressed such needs and what did they recommend?
4. What else do we need to know in order to understand current local circumstances?

An illustrative dataset was developed to estimate population and service activity projections in the event of "no change" to the system (annex 1).The answers to questions 1 and 2 then suggested questions to inform participative needs assessment (annex 2). The answers to question 3 and 4 suggested questions to inform epidemiological needs assessment (annex 3).

[9] www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

Outcome 1 People are able to look after and improve their health and wellbeing and live in good health for longer

What principles underlie this outcome, and what is necessary for it to be achievable?

- individual autonomy and responsibility and interdependent support
- resilience of individuals, communities, and organisations
- availability and accessibility of resources (including fundamental determinants of health[10] and health and social care services) to support capabilities and functionings[11]
- participation in, and ownership of, decision-making

What does this mean for individuals?

- People should
    - be fully participant in their own decisions
    - feel safe from threat and be free from violence
    - be able to live in a warm and dry home
    - be able to drink clean water, breathe clean air, and access 'greenspace'
    - be able to obtain safe and healthy food and eat a healthy diet
    - have access to reliable information and advice
    - have someone to turn to, and advocacy if required
    - have access to opportunities for social connection with others
    - have access to education and training opportunities
    - have opportunities to obtain meaningful employment that pays a living wage
    - not have to rely on debt with exorbitant interest rates to make ends meet
    - not feel compelled to use tobacco, alcohol, or drugs to cope

What does this mean for communities?

- Communities should[12]
    - be listened to, have a voice in meaningful, participative decision-making
    - be safe places to live, which provide access to leisure and recreation facilities
    - feel a collective sense of opportunity to work together to develop and improve the environment for all who live there

What does this mean for health and social care organisations?

- health and social care organisations should
    - ensure that all service developments take account of the predicted changes in Scotland's demography[13,14]
    - facilitate public participation in their decision making processes
    - consider the potential consequences of their policy decisions[15]
    - be active participants in national and local actions to support infrastructure planning, housing, community safety, environmental protection, food safety, financial provision, and health protection

[10] www.healthscotland.com/uploads/documents/22627-HealthInequalitiesActionFramework.pdf
[11] http://plato.stanford.edu/entries/capability-approach/
[12] www.thinklocalactpersonal.org.uk/_library/Resources/BCC/Report/TLAP_Developing_the_Power_Brochure_FINAL.pdf
[13] www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf
[14] www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf
[15] www.healthscotland.com/resources/networks/shian.aspx

- work together routinely (public, community, and voluntary sector) to maximise our assets
- ensure all services are founded on personalisation, trust and respect for autonomy, while meeting statutory requirements to protect people who are at risk of harm
- promote self-directed support packages
- ensure a focus on the prevention of illness and disease, recovery following illness or disease, and the provision of support to increase self-care skills and self-management of long-term conditions[16,17,18]

What existing strategic assessments have recently addressed such needs and what did they recommend?

- Aberdeen City's Joint Commissioning Strategy for Older People[19] highlights self-responsibility, alternatives to hospital, housing, safety, social activity, and citizenship
- Aberdeen City Joint Mental Health and Wellbeing Strategy highlights prevention, self-management, and inequalities
- Aberdeen City Single Outcome Agreement highlights reducing isolation, supporting self-sufficiency, community-based service development, sustainability
- Aberdeenshire Joint Commissioning Strategy for Older People 2013-2023[20]
- Aberdeenshire Single Outcome Agreement 2013-2023[21] highlights early years, employment, equity, independence, carers, safety, and community resilience
- Moray Joint Commissioning Strategy for Older People 2013 - 2023[22]
- Moray Single Outcome Agreement
- NHS Grampian Director of Public Health Report 2012 highlights healthy working lives, cancer prevention, and healthy lifestyles
- NHS Grampian Director of Public Health Report 2013/14[23] highlights individual, community and organisational resilience
- NHS Grampian Health and Care Framework[24] highlights modernisation of healthcare services

What else do we need to know in order to understand current local circumstances?

An understanding of the current variation, and projected trends, of life contexts and life styles, disease prevalence, service demands, and service provision, within IJB administrative areas

[16] www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf
[17] www.scotland.gov.uk/Publications/2008/10/GaunYersel
[18] www.skillsforcare.org.uk/Skills/Self-care/Self-care.aspx
[19] www.aberdeencity.gov.uk/social_care_health/social_work/older_people_rehabilitation/telecare/joint_commissioning_older.asp
[20] www.aberdeenshire.gov.uk/about/departments/JointCommissioningStrategyforOlderPeople.pdf
[21] www.ouraberdeenshire.org.uk/images/media/docs/soa/FinalAberdeenshireSOA2013-2023.pdf
[22] www.moray.gov.uk/moray_standard/page_83700.html
[23] Director of Public Health Report 2013/14, NHS Grampian
[24] www.nhsgrampian.org/grampianfoi/files/item05.1Paper1HCFBoardOct270911paper1.doc

Outcome 2 People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

What principles underlie this outcome, and what is necessary for it to be achievable?

- communities and their infrastructures (e.g. housing, shops, transport) are age and long-term condition friendly
- increasing coproduction with people and community and voluntary organisations
- proactive planning of personalised care[25]
- high health literacy and self-care and self-management skills
- community-focused health and social care services

What does this mean for individuals?

- people should
    - only be admitted to hospital if that is the best place
    - have access to 'low level supports' to help us continue to live independently
    - be able to contribute and 'pay something back'
    - have more opportunities to help develop local solutions to local challenges
    - have easy access to trustworthy and reliable health information and advice
    - be supported to develop self-care and self-management skills

What does this mean for communities?

- As per outcome 1

What does this mean for health and social care organisations?

- Health and social care organisations should
    - support the requirements for health as per outcome 1
    - provide evidence-based, safe and effective models of care for primary and community healthcare, social care, and effective alternatives to a system default of hospital admission
    - predict future demand for assistive technologies, housing adaptations, sheltered and assisted housing, communal living, and nursing home care
    - work with partners to reduce and remove barriers in the built environment and transport infrastructure
    - make increased use of telecare and telehealth care
    - promote ability not disability
    - listen to what people say and respond appropriately
    - communicate with other services and providers to make sure that service response is as holistic as possible
    - ensure the workforce has the capacity and capability to deliver in a changing health and care environment
    - implement shared systems to assess risk for declining independence to allow anticipatory care planning
    - contribute to ensure the availability of local assets, providing information and advice, activities, and support services, to support self-care and self-management
    - provide extra help to those who struggle to navigate the system to stay in control of their care

[25] http://coalitionforcollaborativecare.org.uk/aboutus/house-of-care/

Outcome 2 People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

What existing strategic assessments have recently addressed such needs and what did they recommend?

- Aberdeen City See Hear Strategy (draft) highlights partnership working, independence and rehabilitation, resilience, and equal respect
- Aberdeen City Joint Dementia Strategy 2013-2023 highlights respect and dignity, information, prevention, timely diagnosis and interventions, post-diagnosis support**,** and carers
- NHS Grampian primary and secondary care modernisation programmes informed by the Health Fit 2020 strategic vision[26].

What else do we need to know in order to understand current local circumstances?

- projected demand for unscheduled care hospital admissions and how to reconfigure services to deliver care differently[27]
- projected demand for assistive technologies, housing adaptations, sheltered and assisted housing, communal living, and nursing home care
- greater understanding of expectations and awareness of entitlement
- projected workforce requirements across the system

[26] www.nhsgrampian.org/grampianfoi/files/Item_1_2020_Vision.pdf

[27] www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf

Outcome 3 People who use health and social care services have positive experiences of those services, and have their dignity respected

What principles underlie this outcome, and what is necessary for it to be achievable?

- personalisation[28]
- respect and compassion, time and trust
- effective communication
- responsive 'learning organisations'

What does this mean for individuals?

- People should
  - tell 'their story' only once to those who need to know
  - have a 'plan of action' for our care which is devised and available to all subsequent members of the care team
  - know who is responsible for reviewing our 'plan of action' with us
  - know who to speak to when things aren't going right
  - be admitted to hospital because it is the right place for our care
  - know where to go for help and what we can expect
  - be listened to and have our views taken into account
  - receive advocacy and/ or communication support if we need it
  - be treated with respect and dignity and that our choices will be informed
  - know there are effective feedback mechanisms both for when things go wrong and to highlight and reflect good practice
  - have confidence that their wishes and needs, and those of carers and families, are taken into account

What does this mean for communities?

- confidence in the care system and in the care of their relatives
- clear expectations of the range of care available in the community and its purpose
- recognised routes of communication with services

What does this mean for health and social care organisations?

- a commitment to 'continual improvement' in leadership, governance, and organisational culture
- personalisation of service delivery, active listening and communicating
- a growing confidence in multi-professional, multi-agency roles and responsibilities

What existing strategic assessments have recently addressed such needs and what did they recommend?

- HSJ/Serco Commission on Hospital Care for Frail Older People (2014)[29]

What else do we need to know in order to understand current local circumstances?

- Levels of satisfaction with the care received in health and social care services[30,31]
- Information from user panels

[28] http://coalitionforcollaborativecare.org.uk/aboutus/house-of-care/

[29] www.hsj.co.uk/comment/frail-older-people/commission-on-hospital-care-for-frail-older-people-main-report/5076859.article?blocktitle=Main-report&contentID=15796

[30] www.healthcareexperienceresults.org/gp/?174

[31] www.careexperience.scot.nhs.uk/Results2014/HB-Reports/NHS-Grampian-2014.pdf

Outcome 4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

What principles underlie this outcome, and what is necessary for it to be achievable?

- individual autonomy and responsibility and interdependent support
- resilience of individuals, communities, and organisations
- availability and accessibility of resources to support capabilities and functionings
- achievement of a constructive balance between the views of professional providers and the preferences and values of people who use services

What does this mean for individuals?

- People should
    - feel supported and confident in maintaining independent living
    - feel valued and included in their community
    - feel they have influence

What does this mean for communities?

- A sense of trust and neighbourliness

What does this mean for health and social care organisations?

- Health and social care services should
    - take a whole person perspective aimed at preventing future disease and supporting self-care and self-management, as well as assessing, diagnosing, treating, and assisting rehabilitation
    - be locally designed and delivered in partnership with citizens and community and voluntary organisations, in order to increase people's access to the assets and resources in their local communities
    - accept people's values and views as paramount when agreeing their care
    - facilitate people's access to local community assets and resources that support good health, self-care and self-management

What existing strategic assessments have recently addressed such needs and what did they recommend?

- Moray[32], Aberdeenshire[33] & Aberdeen City[34,35] Alcohol & Drug Partnership Strategies
- PHE (2014) Developing the power of strong, inclusive communities[36]

What else do we need to know in order to understand current local circumstances?

- Methodologies and measures of quality of life
- The extent to which communities share their IJB's aspirations
- The extent to which the workforce shares their IJB's aspirations

[32] www.madp.info/
[33] www.aberdeenshireadp.org.uk/docs/Aberdeenshire_ADP_Strategy_-_Healthier_Happier_Safer.pdf
[34] http://aberdeencityadp.org.uk/wp-content/uploads/2014/05/Aberdeen_City_Drugs_Strategy.pdf
[35] http://aberdeencityadp.org.uk/wp-content/uploads/2014/05/AlcoholStrategy20092019.pdf
[36] www.thinklocalactpersonal.org.uk/Latest/Resource/?cid=10346

Outcome 5 Health and social care services contribute to reducing health inequalities

What principles underlie this outcome, and what is necessary for it to be achievable?

- reduce observed differences in preventable morbidity and mortality within a population
- 'social justice' – Government and public service action to ensure more equitable opportunities and outcomes
- Early intervention, from conception, throughout childhood, and adulthood
- addressing the 'causes of the causes', the fundamental determinants of health[37]
- promoting a culture in which people value their own health, the health of their communities and of society as a whole
- ensuring the challenges of rurality are appropriately reflected in identifying and targeting those in greatest need

What does this mean for individuals?

- as per outcome 1, plus
- that people want to see improving health for themselves and their families, and believe they have a realistic prospect of achieving that
- a reduction in socio-economic as well as health inequalities

What does this mean for communities?

- as per outcome 1, plus
- that there is support for people to acquire the skills to be continuously employable for those for whom conventional education is less effective, including literacy and numeracy support
- agreeing to assist people who have poorer health outcomes, make better use of everyone's assets to achieve better outcomes
- create an integrated web of support across communities and agencies to support people to have increasing opportunities for improved outcomes

What does this mean for health and social care organisations?

- create the conditions by 'putting inequalities at the heart of what we do, in common cause with our communities to reduce health inequalities within a generation'[38]
- focus on inequalities-sensitive practice at every level
- tackle the 'causes of the causes' of health inequalities
- all health and social care services (statutory and sub-contracted) should guarantee their employees (at minimum) the living wage and, where wanted by the employee, a guaranteed minimum number of hours per week
- provision of resources proportionate to need, including the provision of evidence-based, targeted intensive services and other forms of support
- support during pregnancy, and childhood and the transition to adulthood
- people should be able to access recognition and reward for voluntary input to health and social care services (e.g. time banking)
- all health and social care policies should undergo screening for health impact assessment

[37] www.healthscotland.com/uploads/documents/22627-HealthInequalitiesActionFramework.pdf
[38] Director of Public Health Report 2013/14, NHS Grampian

- develop and maintain an inequalities dataset to inform community action, workforce and service modernisation
- use, routinely, a resource allocation and decision-making framework to better align available resource to address inequalities assessment

What existing strategic assessments have recently addressed such needs and what did they recommend?

- Equally well (Scottish Government Ministerial Taskforce on Inequalities)[39]
- Scottish Index of Multiple Deprivation[40]
- Health Scotland *Best preventative investments in Scotland*[41]
- Scottish Public Health Observatory *Informing Investment to reduce health Inequalities*[42]
- Moray, Aberdeenshire & Aberdeen City Alcohol & Drug Partnership Strategies
- NHS Grampian Dental Plan 2020[43]
- DPH Annual Report 2012 and 2013/14
- Aberdeenshire Local Community Planning Strategic Assessments
- NHS Grampian's Health Traffic Lights[44]

What else do we need to know in order to understand current local circumstances?

- non-random variation, across IJB administrative areas

[39] www.scotland.gov.uk/Topics/Health/Healthy-Living/Health-Inequalities/Equally-Well
[40] www.scotland.gov.uk/Topics/Statistics/SIMD [Scottish Index of Multiple Deprivation, SIMD]
[41] www.healthscotland.com/documents/24575.aspx
[42] www.scotpho.org.uk/comparative-health/health-inequalities-tools/intervention-tools/informing-investment-to-reduce-health-inequalities-iii
[43] www.hi-netgrampian.org/hinet/file/8477/item05.1DentalPlanFinalv7.doc
[44] www.nhsgrampian/traffic lights

Outcome 6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

What principles underlie this outcome, and what is necessary for it to be achievable?

- Carers are an integral part of health and social care
- People, communities and organisations are dependent socially and economically on the availability, fitness, and willingness of carers to care
- The health of carers is as important as the health of those for whom they are caring
- Carers need to be recognised and supported in their key role
- Health and social care services will involve unpaid carers as part of the care team, taking a whole person perspective. This will include considering the needs of carers

What does this mean for individuals?

- people who care will be included when health and social care services are establishing consents, and developing plans of care for those we care for
- people who care will be routinely asked about their own health, to ensure they have all the support they need
- carer's assessments will be carried out and appropriate supports identified, including respite and short breaks
- parity of access to respite provision regardless of where you live

What does this mean for communities?

- Communities include people who care in assessing service priorities
- Communities enhance the visibility of the vital role of carers
- Communities nurture respect for people who care

What does this mean for health and social care organisations?

- clear policies for staff
- knowledge of local assets, resources and services for carers
- enhancing the culture of organisations to engage with carers through relevant awareness raising and training

What existing strategic assessments have recently addressed such needs and what did they recommend?

- *Caring together, The Carers' Strategy for Scotland, 2010 -2015*[45]: 'Without the valuable contribution of Scotland's carers, the health and social care system would not be sustained. Activity should focus on identifying, assessing and supporting carers in a personalised and outcome-focused way and on a consistent and uniform basis'
- National needs assessment[46] revealed that one in eight (12%) of people aged 65 and over have a carer role

What do we need to know in order to understand current local circumstances?

- The needs of carers, of all ages, in Grampian
- Demand for and availability of respite care

[45] www.scotland.gov.uk/Publications/2010/07/23153304/0

[46] www.scotphn.net/projects/previous_projects/health_and_social_care_needs_assessment_of_older_people_reports

Outcome 7 People who use health and social care services are safe from harm

What principles underlie this outcome, and what is necessary for it to be achievable?

- "quality" of health[47] and social care services
- evidence-based practice and robust data surveillance systems
- robust governance arrangements
- a culture which values safe practice but without being risk averse
- health and social care services, with their partners, deliver on the duty to support and protect adults at risk of harm (Adult Support and Protection (Scotland) Act 2007)

What does this mean for individuals?

- the concept of "harm" may vary between individuals, so personalisation of risk-assessment will be key
- Adults at risk of harm are supported and protected

What does this mean for communities?

- confidence that systems are in place for the identification, reporting, and prevention of harm

What does this mean for health and social care organisations?

- healthcare investigations and treatments should not cause injury or harm that is both predictable and avoidable
- provision of knowledge management systems to inform evidence-based practice
- clear and robust governance arrangements
- commitment to continuous service improvement including training for staff
- provision of an integrated data system that allows intelligence to be used at all levels of the organisation, from front-line services, to senior operational management, to strategic executive management
- a culture which places safety at the heart of care through high quality leadership and example at every level
- Active participation in the Adult Protection Committee

What existing strategic assessments have recently addressed such needs and what did they recommend?

- Adult Support and Protection[48]
- Healthcare Improvement Scotland (2014) *Report on the review of the quality of care at Aberdeen Royal Infirmary*[49]
- the Scottish Patient Safety Programme, [50] reducing harm in primary care, maternity, acute adult, children, and mental health with the ten 'patient safety essentials'[51]

What do we need to know in order to understand current local circumstances?

- local levels and causes of harm[52]

[47] www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf
[48] www.scotland.gov.uk/Topics/Health/Support-Social-Care/Adult-Support-Protection
[49] www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/ari_review.aspx
[50] www.scottishpatientsafetyprogramme.scot.nhs.uk/
[51] http://news.scotland.gov.uk/News/Patient-safety-34a.aspx
[52] http://healthcareimprovementscotland.org/our_work/patient_safety/spsp/patient_safety_data_landscape.aspx

Outcome 8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

What principles underlie this outcome, and what is necessary for it to be achievable?

- continuously ensure a resilient and sustainable workforce
- increase workforce integration , adaptability and flexibility
- ensure workforce is multi-skilled to shape care and services to the needs of patients
- build a culture in which health , as well as care, is central to our business
- The workforce have an opportunity to shape and influence the development of policy, strategy and plans

What does this mean for individuals?

- People:
    - are motivated to come to work
    - believe they have the appropriate tools to do the job
    - feel supported by colleagues and management, and valued by colleagues and people for whom they provide care
    - provide high quality care
    - access to occupational health services

What does this mean for communities?

- confidence in service providers
- value service providers
- realistic expectations of service providers
- realistic expectations of their role in working with service providers

What does this mean for health and social care organisations?

- adequate staffing levels and clear recruitment and retention strategies
- training provision, particularly during change implementation
- clear lines of accountability and reporting
- feedback mechanisms
- ability to participate in decision-making
- provision of necessary equipment and infrastructure to undertake roles
- fair reward

What existing strategic assessments have recently addressed such needs and what did they recommend?

- SSSC workforce development[53]
- Healthcare Improvement Scotland (2014) *Report on the review of the quality of care at Aberdeen Royal Infirmary* [54]
- NHSG Work Plan 2014

What do we need to know in order to understand current local circumstances?

- Results of the NHS workforce survey 2014
- Sickness/absence rates

[53] www.sssc.uk.com/workforce-development

[54] www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/ari_review.aspx

Outcome 9 Resources are used effectively and efficiently in the provision of health and social care services

What principles underlie this outcome, and what is necessary for it to be achievable?

- money can only be spent once – spending on *x* means forgoing *y* – thus vital that *x* represents the best use of the money
- health economics (technical, productive, allocative efficiency[55])
- health technology appraisals (e.g. NICE)
- evidence-based practice (e.g. SIGN guidelines)
- inclusive and participative decision making
- Resource allocation decisions must be based on a transparent process where evidence is used to identify options and choose between them
- Outcomes must be measurable, and surveillance systems to collect outcome data must be complete, systematic, timely, and robust

What does this mean for individuals?

- people will understand how health and social care organisations make their decisions
- people will be confident that public funding is being used to best effect

What does this mean for communities?

- understanding of how health and social care organisations make decisions
- confidence that public funding is being used to best effect
- communities collaborate with organisations to identify where local assets can be used to help meet health and social care needs

What does this mean for health and social care organisations?

- decision-making processes that are consistent, fair, and transparent
- ensuring that the right people with the right skills and knowledge participate in decision-making groups
- decision-making groups have timely access to up-to-date evidence of effectiveness and cost-effectiveness
- decision-making groups have timely access to up-to-date health intelligence, including 'local intelligence' analyses
- local authorities sign up to the ISD *Health and Social Care Data Integration and Intelligence Project*[56]

What existing strategic assessments have recently addressed such needs and what did they recommend?

- guidance has been published to help with decision making in NHS Scotland[57]
    - draws on Daniels and Sabin's *Accountability for Reasonableness*, which specifies four conditions to be met:
        - **publicity** the public should be able to access information about decisions and the reasons for these decisions

[55] http://dx.doi.org/10.1136/bmj.318.7191.1136
[56] www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/
[57] www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/Data-Collection/

  - **relevance** the reasons for decisions must be based on evidence, reasons and principles that all fair minded parties can agree are relevant to deciding how to meet the diverse needs of a population
  - **appeals and revisions** there must be a mechanism to challenge and dispute decisions
  - **enforcement** some form of regulation to ensure that the first three conditions are met
- NHS Grampian developed a decision-making process as part of its health fit strategy
- Decision support tools are available from external sources[58]

What do we need to know in order to understand current local circumstances?
Scottish Government Health and Social Care Outcomes[59]

The ISD Integrated Resource Framework is a source of potentially valuable data:

- Mapped Health and Social Care Expenditure (Net) by IJB and age band
- Resource use across health and social care pathways of care can identify duplication of service
- Identification of "high resource individuals"
- Development work by Health Intelligence of a traffic lights assessing cost per capita by postcode by specialty to be reviewed, updated and potentially modelled in other areas

[58] www.health.org.uk/learning/star/
[59] www.scotland.gov.uk/Topics/Statistics/Browse/Health/Data/CommunityCareOutcomes

Recommendations

The strategic drivers behind integration have been known for many years, most recently put into a Scottish context by the Christie Commission, and into a Grampian context by recent Director of Public Health reports.

It is clear that conventional service delivery will be insufficient to achieve the national health and wellbeing outcomes. **Annex 1** provides projected population and service delivery estimates for the over-65 population (given the key strategic driver of demographic transition to an older population). Assuming no change, annex 1 models the non-sustainability of existing local service delivery models.

We recommend that needs assessment be a function of IJB strategic planning groups (SPG). The priorities for areas requiring assessment will arise from the professional knowledge of SPG members, informed by public opinion obtained during SPG community engagement activities. SPG community engagement activities provide the opportunity for an inclusive, *participative* process with citizens, communities, and services. Based on our consideration of the requirements placed on individuals, communities, and health and social care organisations by the nine national outcomes, we provide suggested discussion points for use in these consultations in **annex 2**.

We recommend that each IJB SPG identify a named lead for needs assessment. These three leads will be required to collaborate to create an *epidemiological needs assessment* action plan to ensure the efficient use of local authority, and ISD, NHS and University of Aberdeen public health resources, within SPG-identified timescales. These epidemiological needs assessments will use data, published research evidence, and assessment of current gaps in provision to support SPGs with their evidence-based decision-making. **Annex 3** suggests questions to help with the identification of needs that would benefit from assessment.

Since needs assessment will be required as part of IJBs' ongoing planning cycles, we recommend that IJBs retain the needs assessment lead role in order to allow continued coordination of the finite available intelligence resources.

Annex 1 Population and service activity projections

Prediction is very difficult, especially about the future [60]
Niels Bohr (1885 – 1962)

The population of Scotland has been ageing, a process that is predicted to continue. It is the health and care consequences of this that has driven the need to consider a new strategic approach to public service delivery[61]. This paper considers what this predicted population change will mean for the integrated joint health and social care boards (IJB) in Grampian.

What data do we have?

- Local authority population estimates for 2013[62]
- Local authority population projections to 2037[63]
- Health and social care data[64]

What can we do with this data?

We can forecast the effect of demographic changes alone on future demand for health and social care services, assuming that all other things remain the same:

1. calculate the estimated size of the local population in the future
2. calculate the current percentage of population using health and social care services
3. multiply the future population by the current percentage to calculate the predicted number of people requiring services
4. we focus below on the 65+ population, as this is the focus of the demographic transition –**when looking at the absolute numbers presented in the tables below, remember that the demand from those aged 0 to 65 also needs to be incorporated**

Why do we need to be cautious?

Predicting the future is not straightforward because

- birth rates, mortality rates, immigration, and emigration can change[65]
- subsequent generations have conventionally had improved health status, meaning today's health needs do not necessarily reflect tomorrow's
- health and social care services do change

What can we predict?

- the population will age
- if services remain configured as they are now, then demand for these will rise

[60] http://en.wikiquote.org/wiki/Niels_Bohr
[61] www.scotland.gov.uk/About/Review/publicservicescommission
[62] www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates
[63] www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections/sub-national-population-projections
[64] www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool
[65] www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections/uses-and-limitations-of-population-projections

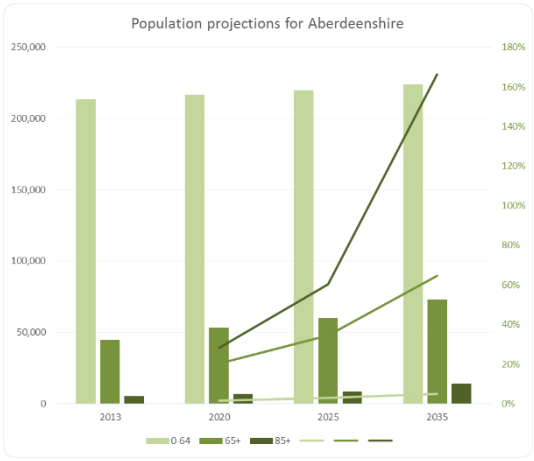
Annex 1 Population and service activity projections

Population projections for Grampian

Aberdeenshire

Predicted total population increase of 15% between 2013 and 2035, with the largest relative increase predicted to occur in the older population:

Aberdeenshire	Percent change from 2013 baseline		
Age band	**by 2020**	**by 2025**	**by 2035**
0-64	2%	3%	5%
65+	20%	35%	65%
85+	28%	60%	166%



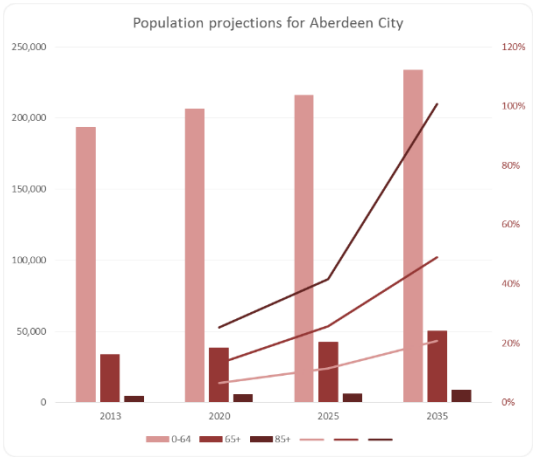
and with the largest absolute increase predicted to occur in the older population:

Aberdeenshire	Current	Projected population numbers		
Age Band	**2013**	**2020**	**2025**	**2035**
0 – 64	213,360	216,593	219,646	223,716
65+	44,380	53,319	59,735	73,008
85+	5,149	6,597	8,250	13,703

Aberdeen City

Predicted total population increase of 25% between 2013 and 2035, with the largest relative increase predicted to occur in the older population:

Aberdeen City	Percent change from 2013 baseline		
Age band	**by 2020**	**by 2025**	**by 2035**
0-64	7%	12%	21%
65+	13%	26%	49%
85+	25%	42%	101%



though with the largest absolute increase predicted to occur in the younger population:

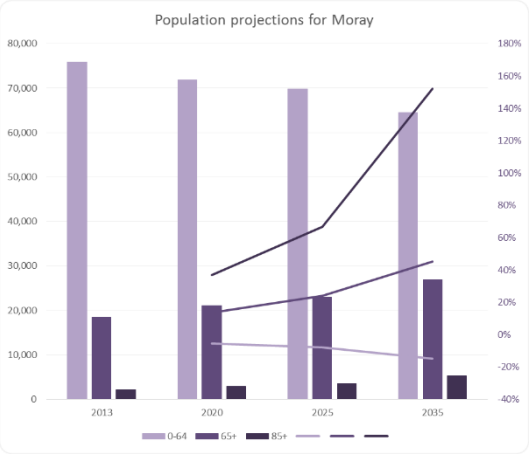
Aberdeen City	Current	Projected population numbers		
Age Band	**2013**	**2020**	**2025**	**2035**
0 – 64	193,417	206,225	215,728	233,593
65+	33,713	38,188	42,370	50,242
85+	4,392	5,502	6,217	8,811

Annex 1 Population and service activity projections

Moray

Predicted total population decrease of 3% between 2013 and 2035, consisting of a relative decrease in the younger population plus a relative increase in the older population:

Moray	Percent change from 2013 baseline		
Age band	**by 2020**	**by 2025**	**by 2035**
0-64	-5%	-8%	-15%
65+	14%	24%	45%
85+	37%	67%	152%



and absolute numbers show the same pattern:

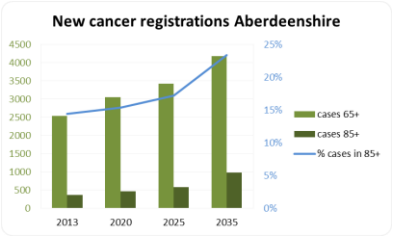
Moray	Current	Projected population numbers		
Age Band	**2013**	**2020**	**2025**	**2035**
0 – 64	75,869	75,869	71,830	69,792
65+	18,481	18,481	21,027	22,941
85+	2,120	2,120	2,900	3,537

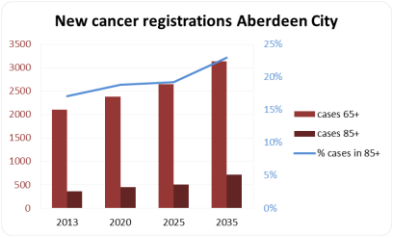
Annex 1 Population and service activity projections

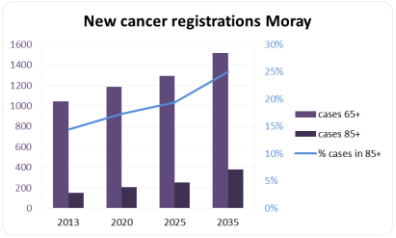
Disease prevalence projections for Grampian

Age remains strongly associated with degenerative and neoplastic disease. Cancer registrations are given as an example, estimates calculated by applying current registration rates[66] to population projections:

Predicted number of people aged 65+ and 85+ who will be diagnosed with cancer in a three year period															
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	2543	3055	3423	4184		cases 65+	2102	2381	2642	3133		cases 65+	1043	1186	1294	1516
cases 85+	367	470	588	977		cases 85+	359	449	508	719		cases 85+	150	206	251	379
% cases in 85+	14%	15%	17%	23%		% cases in 85+	17%	19%	19%	23%		% cases in 85+	14%	17%	19%	25%







Key observations

Each IJB should expect the number of people aged 65+ who are diagnosed with cancer to increase, and the proportion of diagnosed people who are aged 85+ to also increase (e.g. in Moray the proportion of older people diagnosed with cancer who are 85+ is predicted to increase from 14% in 2013 to 25% in 2035)

In other words, **if things stay as they are just now**, IJBs should expect a continually increasing number of cancer patients, an increasing proportion of whom will be older and potentially frailer than seen now

As for cancer, so for other health conditions

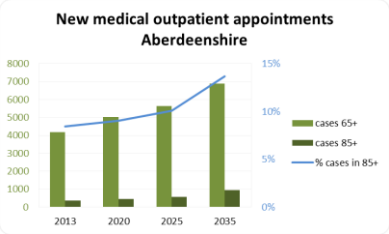
[66] Baseline data 2010 – 2012

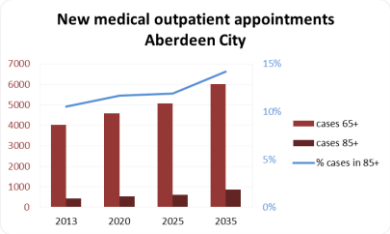
Annex 1 Population and service activity projections

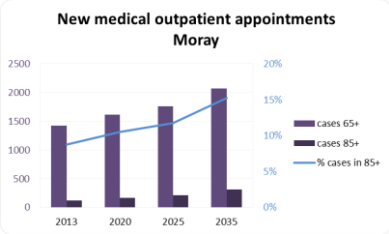
Outpatient activity projections

People with health conditions requiring specialist assessment and diagnostic tests, but who are not ill enough to warrant hospital admission, are currently sent to secondary care outpatient clinics. Estimates calculated by applying current activity rates[67] to population projections:

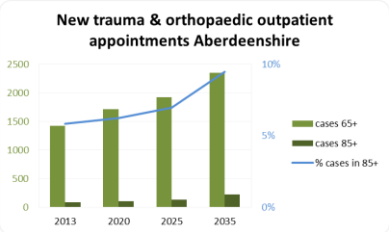
Number of people attending for a new medical outpatient appointment															
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	4181	5023	5628	6878		cases 65+	4038	4573	5074	6017		cases 65+	1421	1616	1764	2065
cases 85+	353	453	566	941		cases 85+	426	533	603	854		cases 85+	125	170	208	314
% cases in 85+	8%	9%	10%	14%		% cases in 85+	11%	12%	12%	14%		% cases in 85+	9%	11%	12%	15%

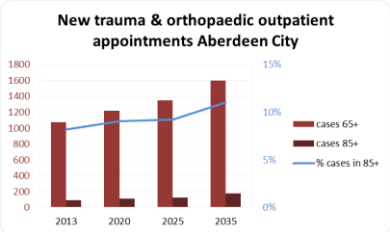


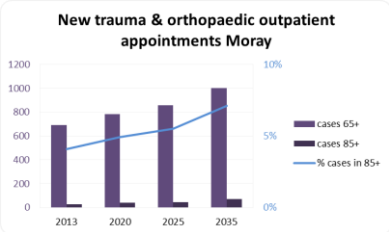




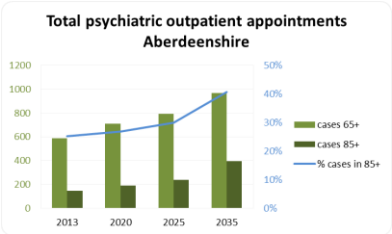
Number of people attending for a new trauma or orthopaedic outpatient appointment															
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	1429	1717	1923	2351		cases 65+	1073	1216	1349	1600		cases 65+	690	785	856	1003
cases 85+	84	107	134	223		cases 85+	88	110	124	176		cases 85+	28	39	47	71
% cases in 85+	6%	6%	7%	9%		% cases in 85+	8%	9%	9%	11%		% cases in 85+	4%	5%	6%	7%

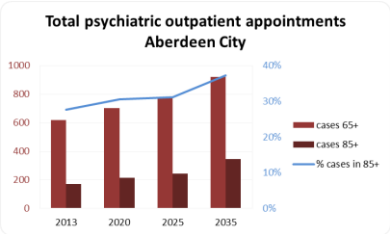


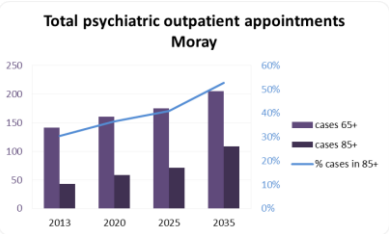




Total number of people attending for psychiatric outpatient appointments (new & returns)															
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	589	708	793	970		cases 65+	619	701	778	923		cases 65+	141	160	175	205
cases 85+	148	190	237	394		cases 85+	172	215	243	344		cases 85+	43	59	72	108
% cases in 85+	25%	27%	30%	41%		% cases in 85+	28%	31%	31%	37%		% cases in 85+	30%	37%	41%	53%







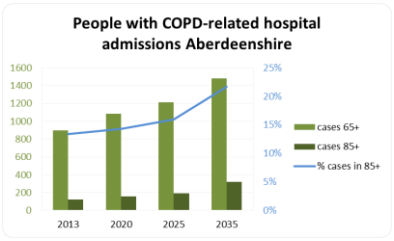
[67] Baseline data 2012

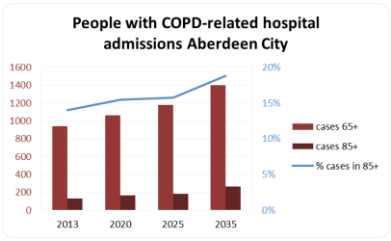
Annex 1 Population and service activity projections

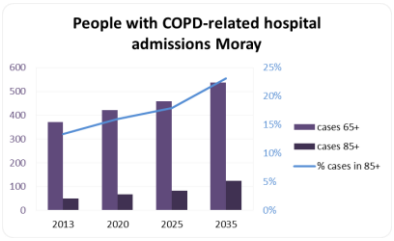
Emergency hospital admission projections

People who suddenly become ill, either with new symptoms or with a sudden worsening of existing ones, are often admitted to hospital as an emergency. Estimates calculated by applying current admission rates[68] to population projections:

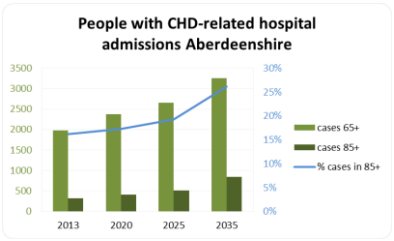
Number of people experiencing a chronic obstructive pulmonary disease-related emergency admission p.a.															
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	900	1081	1211	1480		cases 65+	939	1063	1180	1399		cases 65+	370	421	460	538
cases 85+	121	155	193	321		cases 85+	131	165	186	264		cases 85+	49	68	82	125
% cases in 85+	13%	14%	16%	22%		% cases in 85+	14%	15%	16%	19%		% cases in 85+	13%	16%	18%	23%

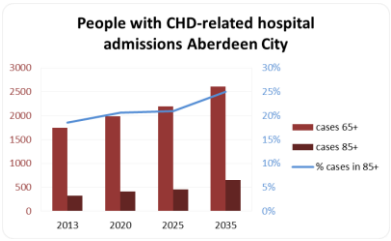


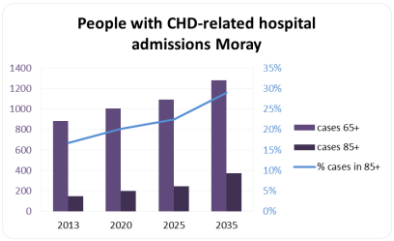




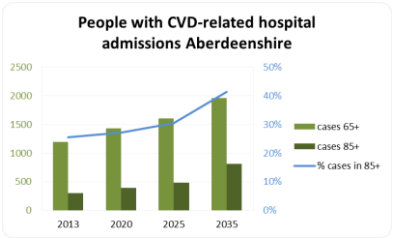
Number of people experiencing a coronary heart disease-related emergency admission each year															
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	1976	2374	2659	3250		cases 65+	1748	1980	2197	2605		cases 65+	881	1002	1094	1281
cases 85+	319	409	512	850		cases 85+	325	407	460	652		cases 85+	147	201	246	371
% cases in 85+	16%	17%	19%	26%		% cases in 85+	19%	21%	21%	25%		% cases in 85+	17%	20%	22%	29%

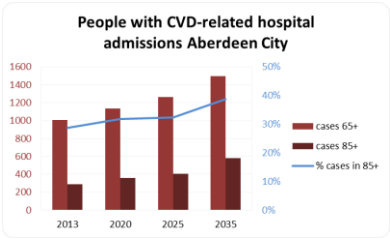


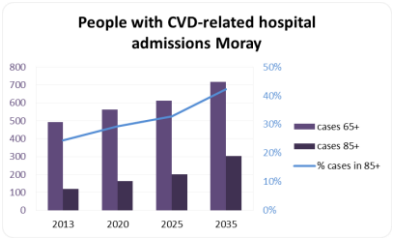




Number of people experiencing a cerebro-vascular disease-related emergency admission (e.g. stroke) p.a.															
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	1193	1434	1606	1963		cases 65+	1004	1137	1261	1496		cases 65+	494	562	613	718
cases 85+	305	390	488	811		cases 85+	288	361	408	578		cases 85+	120	165	201	304
% cases in 85+	26%	27%	30%	41%		% cases in 85+	29%	32%	32%	39%		% cases in 85+	24%	29%	33%	42%



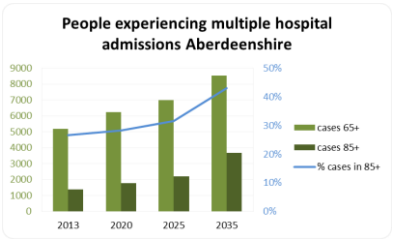


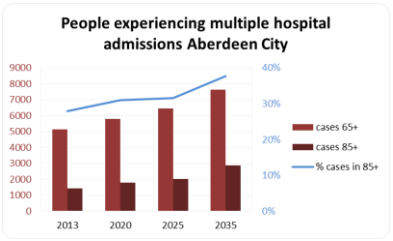


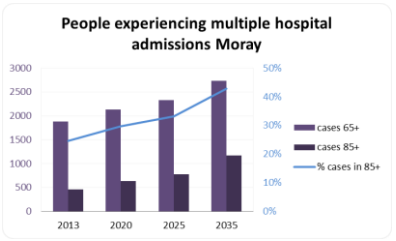
[68] Baseline data three year average based on 2010 – 2012

Annex 1 Population and service activity projections

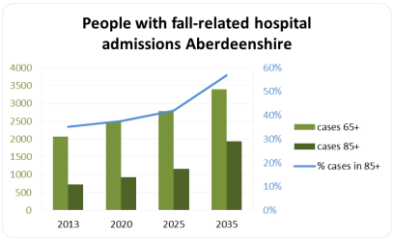
Number of people experiencing multiple emergency admissions each year																
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	5192	6238	6989	8541		cases 65+	5126	5806	6442	7639		cases 65+	1877	2135	2330	2728
cases 85+	1379	1767	2210	3670		cases 85+	1433	1795	2029	2875		cases 85+	463	634	773	1168
% cases in 85+	27%	28%	32%	43%		% cases in 85+	28%	31%	31%	38%		% cases in 85+	25%	30%	33%	43%

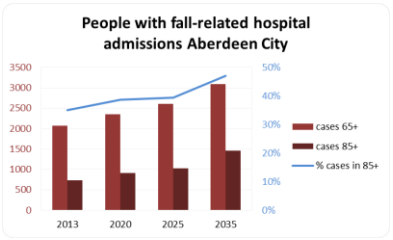


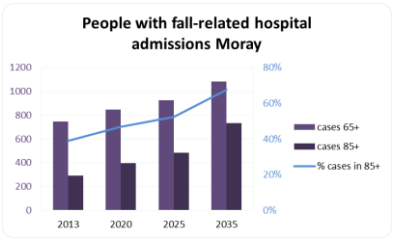




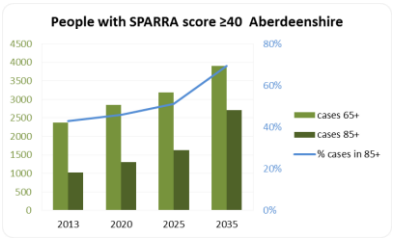
Number of people experiencing a fall-related emergency admission each year																
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	2067	2484	2783	3401		cases 65+	2073	2348	2605	3089		cases 65+	745	847	925	1083
cases 85+	727	931	1165	1935		cases 85+	726	909	1027	1455		cases 85+	290	397	484	732
% cases in 85+	35%	37%	42%	57%		% cases in 85+	35%	39%	39%	47%		% cases in 85+	39%	47%	52%	68%

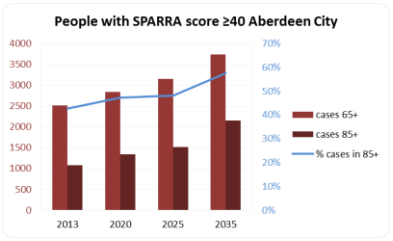


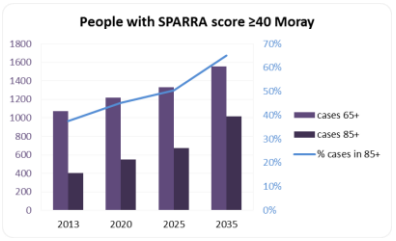




Number of people at high risk of experiencing emergency admission each year (SPARRA ≥40)[69]																
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	2371	2849	3191	3900		cases 65+	2509	2842	3153	3739		cases 65+	1070	1217	1328	1556
cases 85+	1019	1306	1633	2712		cases 85+	1073	1344	1519	2153		cases 85+	402	550	671	1014
% cases in 85+	43%	46%	51%	70%		% cases in 85+	43%	47%	48%	58%		% cases in 85+	38%	45%	50%	65%





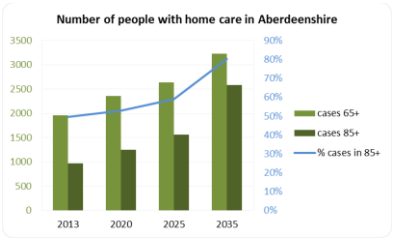


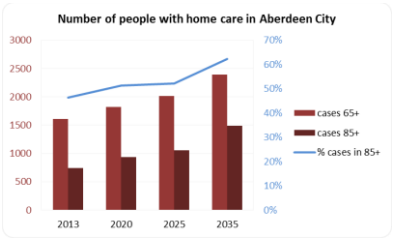
[69] Baseline data January 2014

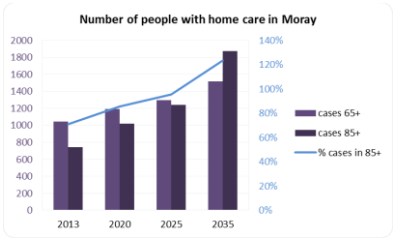
Annex 1 Population and service activity projections

Social care projections

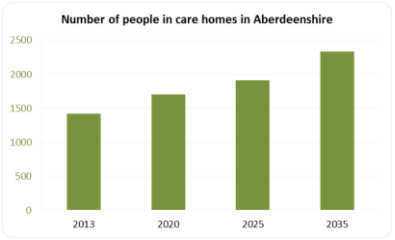
Number of people requiring home care each year[70]															
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	1959	2354	2637	3223		cases 65+	1606	1819	2018	2393		cases 65+	1046	1190	1298	1521
cases 85+	971	1244	1556	2584		cases 85+	744	932	1053	1493		cases 85+	744	1018	1241	1876
% cases in 85+	50%	53%	59%	80%		% cases in 85+	46%	51%	52%	62%		% cases in 85+	71%	86%	96%	123%

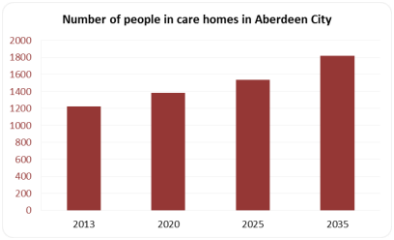


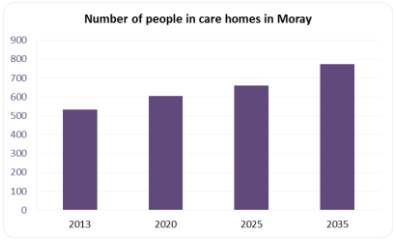




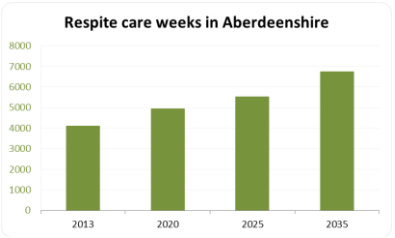
Number of people living in a care home each year (65+ population only)[71]															
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	1420	1706	1911	2335		cases 65+	1222	1384	1536	1821		cases 65+	531	604	659	772

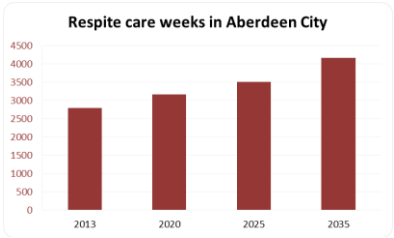


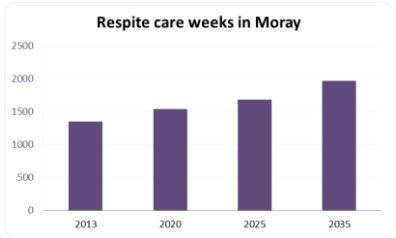




Number of respite care weeks required (65+ population only)[72]															
Aberdeenshire	2013	2020	2025	2035		Aberdeen City	2013	2020	2025	2035		Moray	2013	2020	2025	2035
cases 65+	4113	4941	5536	6766		cases 65+	2795	3166	3513	4166		cases 65+	1352	1538	1678	1965







Key observation

All else being equal, IJBs should expect service demands to continue to increase, with an increasing proportion of people presenting being older and potentially frailer than now

[70] Baseline data March 2013
[71] Baseline data 2012/13
[72] Baseline data 2012/13

Annex 2 Participative needs assessments – suggested questions

Health and social care boards are now responsible for ensuring the provision of all community health services (e.g. GP services, district nursing, mental health services), social care services (e.g. home care, respite care), and some emergency hospital services. Boards are also responsible for improving the health of their populations and helping people to avoid illness and disability.

Are any of the following suggestions contentious? What do you understand each suggestion to mean? For which population groups do the suggestions have most relevance for (by geographical location, by age group, by health condition)?

As well as ensuring service provision to those who are ill or disabled, health and social care boards should invest time, money and effort in:

- improving health and preventing illness and disability by reducing inequalities in the wider social conditions that affect our health
- ensuring that citizens and communities are able to be involved in Board's decision-making
- strengthening existing community assets and resources that can help local people with their needs
- promoting and supporting independence, self-efficacy and self-reliance
- helping people to care for their own health
- helping people to be as independent as possible in managing their long-term health conditions
- thinking ahead and planning, rather than reacting only once people are ill
- making sure that people are only admitted to hospital when that is the best place to be
- supporting third sector organisations to help local people with their needs
- making it easier for people to contribute to helping others in their communities
- giving recognition to people for helping others in their communities
- supporting those who are unpaid carers to look after their own health

Annex 3 Epidemiological needs assessment – suggested questions

The following are potential questions for IJB strategic planning groups to ask. While not all the prerequisites for health will be addressed directly by health and social care services, the do remain directly relevant to IJB strategic planning; the development and direction of coproduction efforts with local communities and third sector organisations; resource allocation to preventive activities; and IJB input to community planning.

Question What is the demographic profile of the population? How will this change and what are the likely effects of projected changes into the future?

- population density
- population age structures
- life expectancy, healthy life expectancy
- birth rates
- mortality rates

Question What variation is seen in the factors that determine the population's health? Which have the greatest local impact on health? Which are/should be of greatest local concern? Which are most amenable to intervention?

- life context factors
    - housing quality
    - water quality, air quality, greenspace quality
    - food supply and availability
    - dietary quality
    - social connectedness ('not lonely, not isolated')
    - being safe from threat and harm
    - access to education and achievement of qualifications
    - 'meaningful work'
    - employment that pays a living wage
    - avoidance of debt with exorbitant interest
    - ease of access to transport
    - domestic abuse
    - digital connectivity (e.g. internet access)
    - access to cultural activities
    - access to leisure and sports

- lifestyle factors and other risk factors
    - tobacco smoking
    - alcohol consumption
    - diet
    - physical exercise
    - illicit drug use
    - obesity
    - high blood pressure
    - high fat levels in the blood

- vaccine preventable illness
- screening programme uptake

Question What health conditions create the greatest demand for health and social care services in their current configuration? What evidence-based interventions should be provided by services? Is there evidence to support reconfiguration of services?

- prevalence and incidence
  - acute conditions (e.g. infections; falls)
  - common long-term conditions (e.g. dementia; stroke)
  - multi-morbidity
  - multiple and complex negative outcomes
  - mental illness
  - learning disability

- current and projected service activity relating to the above
  - social care activity
    - home care
    - assistive technologies and housing adaptations
    - sheltered and assisted housing
    - care home places
    - respite care provision
    - assessment, risk assessment, care planning
  - primary care activity
  - community care activity
  - secondary care activity
    - waiting times
    - unscheduled admissions
    - length of stay
    - delayed discharges
  - travel distances

- current informal care provision
  - the population of carers in Grampian

- current service provision
  - current service inputs and outcomes
  - current delivery of evidence-based interventions
  - preventative activity as a proportion of total activity
  - preventive spend as a proportion of total spend
  - self-care skills support
  - self-management skills support
  - service personalisation
  - service coproduction in routine activity
  - links to community planning agendas

Annex 4 Working Group Membership

Christopher Littlejohn	Consultant in Public Health, NHS Grampian (Chair)
Francesca Ainsworth	Partnership Analyst, Aberdeenshire CPP
Nicola Beech	Specialist Analyst, NHS Grampian
Catriona Campbell	Moray Council
Susie Downie	Aberdeenshire Council
Jillian Evans	Head of Health Intelligence, NHS Grampian
Linda Leighton-Beck	Head of Social Inclusion, NHSG
Peter McDonnell	Aberdeen City Council
Gillian Milne	Business Services Manager, Aberdeenshire Council
Graham Osler	Health Intelligence, NHSG
Jenny Rae	Aberdeen City Council
Maria Rossi	Consultant in Public Health Medicine, NHS Grampian
Lorraine Scott	Service Planning Lead, NHSG
Linda Smith	Public Health Lead, Aberdeen City CHP
Kevin Toshney	Planning and Development Manager (Integration), Aberdeen City Council
Sally Wilkins	Planning and Development Manager, Aberdeen City Council
Tracie Wills	Moray Council