Aberdeen City Health & Social Care Partnership

A caring partnership

Strategic Plan

(Summary Version)

2022-2025

Contents

Introduction

We are delighted to present this summary version of our Strategic Plan for 2022-25. The full version can be found here which also contains our detailed Delivery Plan. Our key focus continues to be 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 citizens.

First and foremost, we need to acknowledge the impact the COVID-19 pandemic had on the health and social care system, our staff and our communities. We are grateful to our health and social care workforce and the people of Aberdeen for working with us in responding to such challenging circumstances. We were all in it together, and together, we were stronger than the sum of our parts. Our forecasting indicates that demand for health and social care services will increase over the coming years, and that, potentially, more and more people could be living with multiple, long terms conditions. If we are to achieve our policy ambition of caring for people in more homely settings, we need to increase the availability and accessibility of high-quality community-based services, particularly those for people with higher levels of need, and find more ways to keep people safe at home. Learning from the pandemic experience, we have recognised that we cannot achieve this all on our own and that we need to foster and develop the "caring together" ethos that was so evident certainly in the early stages of COVID-19.

There are four strands of Covid related legacy that will also impact on demand for services. Firstly, the pandemic has left a legacy of health debt, a consequence of deferred care. Waiting times for diagnostic services and cancer treatment have increased. There are also increased referrals to mental health services. Secondly, there is Long Covid which may not always manifest in a way that can be directly linked to Covid and consequently there is very little reliable data to help plan for additional demand. Thirdly, there is the ongoing need for some level of vaccination programme and lastly there is the potential for a resurgence of the virus in either a known or variant form. These impacts require us to work as a whole system to achieve shared goals, to enable agile and flexible responses to be able to plan for the unknown as well as increasing access to community resources which support good health and wellbeing

As well as the direct and indirect impacts of COVID-19, external influences such as climate change, housing and increasing levels of poverty caused by the cost-of-living crisis also exist. These impact on current and future health inequalities and we need to plan to address these and build resilience to prevent ill health and enable people to achieve fulfilling, healthier lives. We need to focus on recovery and renewal, building resilience for the future.

Whilst we have the challenge of this additional demand, we are aware that it is unlikely our resources will increase to match. Finances are already tight, and it continues to be very difficult to recruit and retain staff. Audit Scotland recognised this in a briefing released in January 2022, where they noted that in December 2020, the vacancy rate for social care staff was more than two and a half times the overall vacancy rate across all establishments in Scotland. In 2019, the Scottish Parliament recognised that almost a quarter of GP practices in Scotland were reporting vacancies. We will continue to transform our services to ensure we are able to meet the challenges ahead.

In Aberdeen, to date, we are confident that we have maximised the levers the integration agenda affords us. Our Integration Joint Board (IJB) has made bold and brave decisions resulting in integrated services, positive relationships, and improved outcomes for local communities. It is vital we continue this journey whilst sharing our successes to show what can be achieved when the integration principles are fully embraced.

This plan briefly outlines who we are, the approach we take, our performance to date, what our data is telling us, and our strategic context, before laying out our vision, values, priorities and enablers. Finally, we confirm how we will measure our performance against this plan and how you will know whether we have delivered what we said we would.

Who We Are

Aberdeen City Health and Social Care Partnership (ACHSCP) delivers community health and social care services, some of which are delivered with partners in other sectors. As well as our internal services such as Social Work, Community Nursing and Allied Health Professionals, the partnership "hosts" Grampian wide services such as those for Mental Health and Learning Disabilities (MHLD), Sexual Health Services, and Specialist Older Adults and Rehabilitation Services (SOARS). The IJB for Aberdeen City governs and directs the work of the partnership.

Our Approach

Our approach to service delivery follows the national Integration Principles.

Principle – Our services: -	How we will achieve this
1. Are joined up and easy for people to access	Pathway Redesign
2. Take account of people's individual needs	Follow our Guidance for Public Engagement based on the Scottish Government and COSLA Planning With People Guidance
3. Take account of the particular characteristics and circumstances of different service users in different parts of the city	Deliver our Equality Outcomes and Mainstreaming Framework 2021-25
4. Respect the rights and dignity of service users	Ensure our service delivery takes a Trauma-Informed and Human Rights based approach by training our staff and encouraging more to become equality ambassadors
5. Take account of the participation by service users in the community in which service users live	Continue our joint approach to community engagement and participation along with Community Planning Aberdeen and deliver our Locality Plans
6. Protect and improve the safety of service users	Deliver our legal duty around Adult Support and Protection
7. Improves the quality of the service	Continue to promote the use of Care Opinion, expanding it into social care settings ensuring the feedback informs service improvements made through our transformation activity
8. Are planned and led locally for the benefit of service users, people who look after service users and the people who provide health or social care services	Continue to work with our Locality Empowerment Groups (LEGs) and increase community involvement through other existing networks and channels.
9. Anticipate people's needs and prevent them arising	Continue to deliver our Stay Well Stay Connected initiative, which is a programme of holistic community health interventions and part of our prevention agenda designed to anticipate health issues in certain cohorts of the population
10. Make the best use of facilities, people and resources	Deliver on our enabling priorities in relation to Workforce, Technology, Finance, Relationships and Infrastructure

Review of the last 3 years – key learning points to take forward

Our review of the last 3 years can be summarised under 3 headings: -

Learning from Covid

- Empowering our staff
- Adopting new technology
- Gaining a degree of parity of esteem for Social Care
- Shifting the balance of care to community based homely settings
- Basing our decisions on data

Whole System Collaboration

- Aberdeen Together
- Rosewell House
- Locality Planning Arrangements
- Portfolio Management Approach
- Navigator Project

Doing Things Differently

- Stay Well Stay Connected
- Care at Home
- Granite Care Consortium
- Relationships and Trust
- Vaccination Programme

Over the last three years we really put into practice our stated strategic intentions to ***work together*** with our communities and partners and focus on outcomes. The Rosewell House model, the new Care at Home contract delivered by the Granite Care Consortium, the development of the Locality Empowerment Groups and the close working relationships we have with our two statutory partners Aberdeen City Council and NHS Grampian are testament to that. Although the proposed National Care Service may alter our governance arrangements, it is our intention to continue building on these solid foundations and further develop the relationships we have with our key stakeholders to improve our overall service delivery which will ultimately have a positive impact on outcomes for the people we serve.

Our resources, our infrastructure, and the way we do business are other key areas of strength that we will build on over the coming years. Our ***staff*** have always been critical to our achievements, and they were tested to the limit throughout the pandemic. We will repay their service by ensuring that we develop a Workforce Plan that recognises their professionalism, provides flexible yet robust career opportunities, considers their health and wellbeing and seeks parity of esteem for the social care workforce. We acknowledge the benefits of ***new technology***, in service delivery, in supporting our staff to be able to do their job well, and in improving outcomes for the people of Aberdeen. We will maximise the use of technology where appropriate, and where necessary we will plan to support those who, for whatever reason, do not have equity of access. During the pandemic our decision making was strengthened because it was based on ***data***. Whilst accessing and sharing accurate and current data remains a challenge we will build on the systems and processes introduced in the last two years and seek to improve the availability of data, ensuring this is used safely and securely, for the benefit of patients, clients, and staff.

Key themes from our Strategic Context

We have undertaken a review of the key, relevant national and local strategies that impact on our service planning and delivery and the themes from these are shown below: -

- The need to focus on recovering from COVID-19
- The need to address the wider determinants of health which impact on inequity of access to health and social care services such as housing/homelessness, climate change, and cost of living concerns
- The need to ensure service delivery takes a rights-based approach for both adults and children
- The need to focus on shifting the paradigm of social care
- The need to maximise the use of new technologies and use data to inform our planning.

The Independent Review of Adult Social Care in Scotland (the Feeley Report), proposed the creation of a National Care Service (NCS) and we expect a Bill to be laid before parliament in the summer of 2022. Whilst the details of these new governance arrangements are being confirmed it is imperative that we are not distracted or diverted from our strategic focus. This is one of the reasons we have developed our Delivery Plan to help ensure we stay on track. We will be mindful of the role that ACHSCP can play in shaping the NCS and will ensure we are fully engaged at a national level, influencing and assisting with the reforms proposed, using every opportunity to bring the voice, view and opinion of our local system to those important conversations. We anticipate a local transition plan being developed with local partners to enable the local implementation of the National Care Service once the Bill has received Royal Assent. This will be presented to the IJB as a separate delivery plan.

Key themes from our consultation

The first step in developing our Strategic Plan was undertaking consultation and listening to what our key stakeholders were telling us. Engagement on the Strategic Plan began with a joint exercise with the Locality Empowerment Groups on the refresh of Community Planning Aberdeen's Local Outcome Improvement Plan at the beginning of 2021. NHS Grampian subsequently undertook engagement sessions on their Plan for the Future and shared with us the overall results of these as well as analysis relating to Aberdeen City residents only. ACHSCP then undertook their own engagement. The outcome of all three engagement activities have informed the development of this plan.

Theme	**Source**
Prevention/Stay Well Stay Connected	NHSG
Access to Services	ACHSCP & NHSG
Quality of Services	NHSG
Whole System, Collaboration, Partnership Working, Relationships	ACHSCP
Sustainability and Recovery from Covid	ACHSCP
Engagement/Involvement	ACHSCP, NHSG
Action on Poverty	LOIP
Support for Mental Health (all ages)	LOIP
Looking After Staff	ACHSCP
Maximising Digital Technology	NHSG

Our Progress Against National Indicators

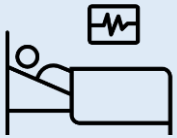
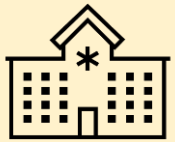
National Indicator	Title	Performance	RAG Status
1	Percentage of adults able to look after their health very well or quite well	Consistent high scoring at 94% which is slightly above Scottish average of 93%	
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	Consistent at 82%, slightly above Scottish average of 81%	
3	Percentage of adults supported at home who agreed they had a say in how their help, care or support was provided	Slight downward trend, down to 78% from 79% the previous year, although above the Scottish average of 75%	
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well coordinated	Stable performance at 76% and above the Scottish average of 73%	
5	Total percentage of adults receiving any care or support who rated it as excellent or good	Downward trend, down to 79% from 83% the previous year, and lower than the Scottish average of 80%	
6	Percentage of people with positive experience of the care provided by their GP practice	Downward trend to 77% from 82% and lower than the Scottish average of 79%	
7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	Improving picture at 84%, up from 79% the previous year and above the Scottish average of 80%	
8	Total combined percentage of carers who feel supported to continue in their caring role	Lower than we would like it to be at 34%, and down from 40% the previous year, although 34% is on a par with Scottish average.	
9	Percentage of adults supported at home who agreed they felt safe	Improving picture at 85%, up from 84% the previous year, and above Scottish average of 83%	
11	Premature mortality rate per 100,000	Rate reducing but higher than the Scottish average	
12	Emergency Admission rate per 100,000	Rate reducing and lower than the Scottish average	

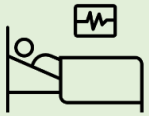
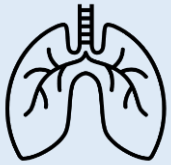
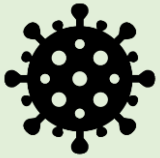
National Indicator	Title	Performance	RAG Status
13	Emergency Bed Day Rate per 100,000 population	Rate reducing and lower than the Scottish average	
14	Readmission to hospital within 28 days (per 1,000 population)	Rate increasing and higher than the Scottish average	
15	Proportion of last 6 months of life spent at home or in a community setting	Rate increasing and higher than the Scottish average	
16	Falls rate per 1,000 population aged 65+	Rate reducing but still slightly higher than the Scottish average	
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	Rate has stayed the same but is higher than the Scottish average	
18	Percentage of adults with intensive care needs receiving care at home	Although the rate has increased it is still lower than we would want it to be and 10% lower than the Scottish average	
19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	Rate has reduced significantly and is also significantly lower than Scottish average	
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	Rate has decreased but is slightly higher than Scottish average	

The data above is based on the latest published data available, the most recent of which is 2019/20 i.e., pre Covid. NB: there is no data available for National Indicator 10 or 21 – 23. Red, Amber, Green (RAG) status is based on a combination of the trend pattern of the indicator and how Aberdeen City compares to the Scottish average

More detailed information on our progress against National and Ministerial Steering Group Indicators is published in our Annual Performance Reports, available here. Actions in this Strategic Plan will seek to improve our performance on all of these indicators but particularly those that are amber and red i.e., ***improving the quality of care and support***, ***enabling people to have their say in how their help, care or support is provided***, ***supporting unpaid carers to continue in their caring role, premature mortality rate, readmission to hospital after 28 days, falls rate, percentage of adults with intensive care needs receiving care at home and percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.***

Our data indicates four key areas that require our focus over the next three years. The data comes from a variety of published sources including Aberdeen City's Population Needs Assessment,. Development of locality level data was interrupted by the COVID-19 pandemic however the Locality Plans for each of our three localities are based on locality specific information and contain priorities based on what the local community told us.

Demand for services will increase		Outcomes in some areas of service delivery need to be a particular focus		More needs to be done in terms of prevention	
	The number of people **aged 75 and over** living in Aberdeen City will increase by 28.2% by 2033.		The number of **unpaid carers** feeling supported in their caring role whilst on par with the Scottish average, at 34%, has decreased for Aberdeen City.		**Emergency Attendances** at Aberdeen Royal Infirmary increased by 39% between January 2021 and January 2022.
	It is estimated that almost half of people over 80 will experience a fall at least once a year, with most falls happening in people's own homes.		In 2019/20 **Alcohol Related Admissions** (per 100,00) from the Central locality were 62% higher than the Scottish Average and were 31% higher in 2020/21.		There has been a 14% increase in **Unscheduled Bed Days** between January 2021 and January 2022.
75%	**Unmet need** for social care has increased by 75% between April 2021 and April 2022.		**Drug related hospital admissions** increased by 8.7% between 2018 and 2020 with 'overdose' being the most common presentation of Frequent Attenders at the Emergency Department in ARI in 2021.		**Healthy life expectancy** is reducing for both males and females in Aberdeen.
	There has been a 25% increase in people living with **Long Term Conditions**, by 2035 it is estimated that 66% of adults over 65 will be living with multi-morbidity.		In 2019/20 16.6% of Aberdeen's population were prescribed drugs for anxiety, depression, or psychosis.		In the period 2016-19 it was estimated that 23% of the City's adult population was **obese.** Fruit and vegetable portion intake was consistently around 3 which is below recommended 5.

	There was an average of 3.6% of **operations cancelled** in NHS Grampian in 2021	43%	Referrals of Aberdeen City residents to **Mental Health** Services in Grampian increased by 43% from 2019 to 2022.		In the period 2016-19 it was estimated that 70% of adult's **physical activity** met the recommended guidelines.
	**Waiting times for cancer treatment** increased from 42 days in July to September 2020, to 49 days for the same period in 2021 which is the latest data available.	30	In 2019 there were 25 **probable suicides** and in 2020 there were 30 probable suicides.		Referrals to clinical and medical oncology for **Lung Cancers** have increased. Smoking prevalence in the 16 to 64 age group increased by 9% between 2018 and 2019 and smoking during pregnancy was almost ten times higher for expectant mothers living in the most deprived areas than those in the least deprived between 2018/19 and 2020/21.
	The percentage of people waiting within 6 weeks for **diagnostics** increased from 39.6% in January 2021 to 51.9% in December 2021.		Significant progress has been made in reducing our Delayed Discharges by 52.8% however we have not made the corresponding improvement to those relating to patients requiring more complex care with an increase of 38% in 2020/21 and another 17.6% increase in 2021/22.	**There is a worrying trend of increasing deprivation in Aberdeen City**	
					In 2016 Aberdeen City's local share of data zones in the 20% most deprived was 8%. In 2020 that had risen to 10.25%
	It is estimated that somewhere between 0.7% and 2% of the population are projected to experience **Long Covid** (symptoms for 12 weeks or more after their first suspected COVID-19 infection). These figures equate to between 1,603 and 4,581 people in Aberdeen City.	40%	Complex care needs are increasing, current residential and supported living providers claim that 12% of services were not currently suitable and that 40% of services would not be suitable in 5 years' time.		It is estimated that 800,000 in Scotland lost employment as a result of the pandemic (as of April 21). Using a rough extrapolation from population estimates this could equate to 2,680 people in Aberdeen

Our Vision

"We are a caring partnership working in and with our communities to enable all people to achieve fulfilling, healthy lives."

Our Values

Honesty
Empathy
Equity
Respect
Transparency

Our Enablers

Workforce
Technology
Finance
Relationships
Infrastructure

5

Our Vision Values and Strategic Aims

Our **vision** remains unchanged since the inception of ACHSCP in 2016. It is that we are a caring partnership working in and with our communities to enable all people to achieve fulfilling, healthy lives

Our **values** indicate what is important to us and set the standard for our behaviour. These have been amended after reflecting on the Planning With People Guidance and the Independent Review of Adult Social Care in Scotland. Above all we will be **honest** in everything we do; we will aim to **empathise** with the citizens of Aberdeen understanding their needs, listening to their views and involving them in decision making. Providing services that have **equity** of access for all is important to us and we will make every effort to reduce the negative impact of inequality. We will **respect** the views and the rights of the people of Aberdeen and will be **transparent** in our dealings with them.

For 2022-25 we have identified four **strategic aims**. These build on the acceleration of some of the delivery commitments made within the last strategic plan as a result of the two years of the pandemic. We have retained our emphasis on prevention, personalisation and resilience but have refocused our connections and communities aims into a wider encompassing 'Caring Together' aim.

Caring Together – together with our communities, 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.

Keeping People Safe at Home – when they need it, people can be cared for safely in their own home or in a homely setting, reducing the number of times they need to be admitted to hospital or reducing the length of stay where admission is unavoidable. This includes a continued focus on improving the circumstances of adults at risk of harm.

Preventing Ill Health – 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 the preventable causes of ill-health, ensuring this starts at as early an age as possible.

Achieving Fulfilling, Healthy Lives- support 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, enabling them to live the life they want, at every stage.

We have identified five **enablers** to help support the delivery of our strategic plan. These are: -

Workforce – our staff, and those of our partners are our biggest asset without whom we could not deliver. We need to overcome our recruitment and retention challenges, nurture skills and expertise and maintain staff health and wellbeing.

Infrastructure – the physical assets we use for service delivery need to be fit for purpose and not unnecessarily increase our carbon footprint. The built environment impacts on our service delivery with new housing developments increasing demand for services within the communities where they are situated. Transport is also a key enabler for patients and clients to access services.

Relationships – developing and maintaining positive relationships with our partners and our communities is crucial to the successful delivery of this Strategic Plan. One of the key ways we utilise positive relationships to transform community health and social care services is through our approach to Commissioning. Commissioning is the process used to understand, plan, and deliver services. We will also continue to collaborate with people with lived

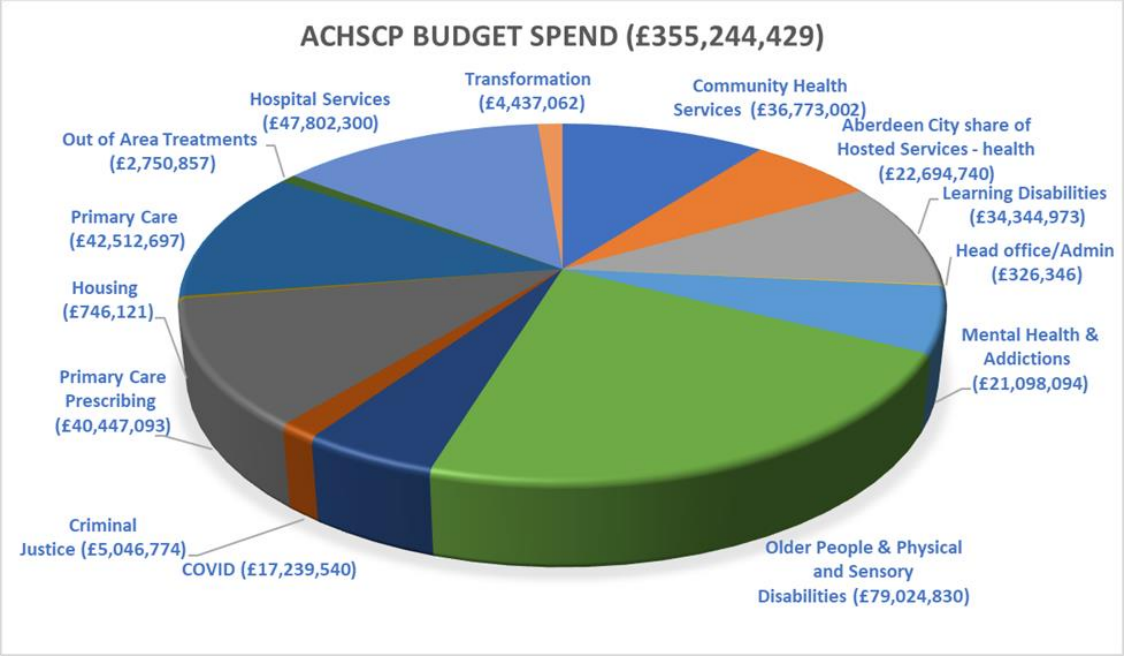
experience, hearing their voices, and designing, delivering, and improving services around their needs and personal goals (known as outcomes) based on what they say.

Our Commissioning Principles: -

- Commissioning is undertaken for outcomes (rather than for services)
- Commissioning decisions are based on evidence and insight and consider sustainability from the outset
- Commissioning adopts a whole-system approach
- Commissioning actively promotes solutions that enable prevention and early intervention
- Commissioning activities balance innovation and risk
- Commissioning decisions are based on a sound methodology and appraisal of options
- Commissioning practice includes solutions co-designed and co-produced with partners and communities

Technology - Scotland's Digital Health & Care Strategy published in November 2021 sets out the intention to make the best use of digital technologies in the design and delivery of services, in a way, place and time that works best for people and that improves the care and wellbeing of people in Scotland. This is something that we will seek to implement locally.

Finance – service delivery requires funding. With the breadth of services provided and increasing demand we need to ensure service delivery is as efficient as possible to make the best use of the funding we have. How we use our current annual funding is shown below: -



Strategic Plan on a Page

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

Strategic Enablers				
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

Our Delivery Plan and Measuring Success

Our Delivery Plan which can be found here which lists the actions we plan to take over the three years to deliver on the priorities within this Strategic Plan. The Delivery Plan provides detail on the programmes of work and individual projects to be undertaken in relation to each priority, who will be responsible for delivery, the timescale within which it will be delivered and the measures which will tell us how we will measure our success. These measures are a mixture of local and national indicators, qualitative and quantitative data.

The Delivery Plan is based on what we know now. It will be reviewed annually with any additional actions which are subsequently deemed to be essential to the delivery of the Strategic Plan added in years two and three following agreement from the IJB. This review will be undertaken at the time we undertake the annual updating of the Medium-Term Financial Framework to ensure the actions can be resourced appropriately.

Progress on this Strategic Plan will be monitored on an ongoing basis using our existing programme and project management and governance arrangements. A member of the Leadership Team is allocated to each priority and will be responsible for reporting to the Leadership Team Meetings on a monthly basis. Additional quarterly reporting will be undertaken via the Executive Programme Board to the Risk, Audit and Performance and clinical and Care Governance Committees. Our Annual Performance Report will be approved and published annually by the IJB as required under the Public Bodies (Joint Working) (Scotland) Act 2014.

The nine National Wellbeing Outcomes noted in Our Strategic context above are measured using an agreed core suite of 23 National Indicators. It is accepted that a degree of development is required in relation to the core suite however these are what we are measured on at the moment. In our Annual Performance Report, we are required to demonstrate how we are improving the National Health and Wellbeing Outcomes and across Scotland we have agreed that including an Appendix to the APR showing latest performance against the national indicators is currently the best and only way to do this that also allows for benchmarking across the country.