Aberdeen City Health & Social Care Partnership

A caring partnership

DRAFT Integration Joint Board Strategic Plan 2025-29

V5 11 November 2024

Introduction

We are delighted to present the Strategic Plan 2025 – 2029 for Aberdeen City Integration Joint Board (IJB) which will be delivered by Aberdeen City Health and Social Care Partnership (ACHSCP). This is our fourth Strategic Plan since integration and the delivery of it will probably be our most challenging yet. We have chosen a four-year timescale for this plan in order that we can better align to the refresh timescales of the Aberdeen City Local Outcome Improvement Plan and the Children's Services Plan going forward. This plan relates to services delegated to and hosted by the IJB and is based on a detailed analysis of the national and local context for health and social care delivery; our statutory responsibilities; our links with our partners, not only in Aberdeen City but also in Grampian; our current performance; a horizon scan of emerging requirements; and feedback from engagement with staff and the public about what they would like to see represented in our strategic plan. The outcome of this analysis has been collated into an Evidence Document which sits alongside, and forms the basis of the content of this Strategic Plan.

From the evidence gathered it is clear that we need to make changes to the way we design and deliver services. We have achieved a lot during the three years of our previous Strategic Plan. There has been a 16% reduction in geriatric unscheduled bed days; our concentration of effort in increasing the capacity of our social care teams has seen our performance in relation to Delayed Discharges remain in the top quartile in Scotland and a reduction in unmet need; sustainability of our GP practices has improved with more practices being able to deliver a full service; we have increased services delivered in local communities making them easier to access; we have increased the use of technology in service delivery ensuring this is more effective; we have developed three Market Position Statements which help articulate our future need for certain types of services; and we have achieved the first bespoke development of supported living accommodation for people with complex care needs in Aberdeen City for quite some time enabling people to be cared for within their home city.

As our Evidence Document shows, however, there is still more to be done, and this Strategic Plan will build on these achievements and challenge us to deliver more within the restricted resources that we have.

Our Problem and Action Statements

The analysis within the Evidence Document led to the following statements in relation to the key challenges we have and the action we need to take: -

Problem Statement - Our demand is predicted to increase through a combination of an ageing population and a higher burden of disease, whilst our capacity is reducing as a result of the increased cost of service delivery and challenges with recruitment and retention.

Action Statement - We need to take action to try to reduce the predicted demand and, at the same time, identify different ways of delivering services in order that we can maximise the capacity we have.

Further analysis of the problem

The data shows there is an ageing population in Aberdeen City. One third of the population are aged 65+. By 2028 the number of 65-74 year olds will increase by 14.4% and the number of 75+ will increase by 16.1%. That represents an additional 4,000 people who will potentially require health and social care.

Our data also tells us that the burden of disease is increasing, healthy life expectancy is reducing, and our population is getting sicker. There is a correlation between physical activity levels, obesity and smoking with the main preventable diseases. More than 50% of deaths in Aberdeen City are due to cancers and circulatory diseases.

We have experienced higher than budgeted for uplifts both in relation to staff costs and to contractual rates for externally commissioned services. Prescription volume and costs have also increased. Between April 2023 and January 2024 the actual number of items prescribed was 3.87% greater than the same period in 2022/23. This is coupled with a 7.5% increase in the estimated average item price (after Tariff reduction).

Our workforce is our biggest asset, and our Workforce Plan confirms that there are recruitment and retention challenges across all sectors. Both the birth rate and net migration rate in Aberdeen city is declining meaning the workforce pool of the future is potentially restricted. There has been an overall reduction in whole time equivalent number of General Practitioners in Aberdeen City. Staff absence rates continue to fluctuate and covering frontline clinical roles can only be achieved by utilising more expensive locum or agency staff which increases the overall payroll costs.

Further detail in relation to action required

<u>Reducing Demand</u>

The analysis of our national context indicates that we need to take a population health approach. This is an approach aimed at improving the health of an entire population, in our case the population of Aberdeen. It is about improving the physical and mental health outcomes and wellbeing of the population whilst reducing health inequalities. It includes action to reduce the occurrence of ill health; deliver appropriate health and care services; and address the wider determinants of health and also requires us to work closely with our communities and partners.

The main way we can try to reduce predicted demand is to shift investment and focus towards early intervention and prevention activity. In 2017, an article published in the Journal of Epidemiology & Community Health entitled 'Return on Investment of public health:

a systematic review' by Masters, R et al demonstrated that for every £1 invested in public health, £14 will subsequently be returned to the wider health and social care economy. In order to achieve this return on investment however we would need to undertake a strategic rebalancing of our budgets between prevention, early intervention and response and that will be difficult to achieve in the current climate whilst still having to respond to high levels of need.

If we can reduce the incidence of preventable diseases, both physical and mental, through encouraging people to make healthier choices in the way they live their lives we should be able to reduce the need for health and care service provision. This early intervention approach needs to start at the earliest point and continue for the duration of a person's life.

According to the World Health Organisation obesity is one of today's most visible, yet most neglected, public health problems. A position statement on behalf of Scottish Public Health published in July 2024 stated that the Scottish Burden of Disease analysis indicates that of all healthy years lost in Scotland; one in ten are attributable to excess weight, and one in ten can be attributed to poor diet. The same statement also commented that around two-thirds of all adults in Scotland (67%) are overweight (including obesity), with one third (33%) of children starting primary school at risk of being overweight (including obesity). The annual cost of obesity in Scotland in 2022 was estimated to be £5.3billion of which £4.1billion was the value lost to people through reduced quality of life.

The Health Foundation have identified that Chronic Pain has the highest impact on health care use and mortality among those aged 30 and older in England and have projected that will increase by 2040. 38% of people suffer from Chronic Pain and 22% of GP consultations focus on Pain Management. If we can help people self-manage their pain, we could reduce waiting lists and enable people to continue their careers and boost the eonomy.

Harmful alcohol consumption has been an ongoing public health challenge in Scotland for decades. It is linked with a risk of physical and mental health problems, as well as social and economic losses to individuals and society. The number of people in Scotland whose death was caused by alcohol remains at a high level.

Problem drug use in Scotland is defined as the problematic use of opioids (including illicit and prescribed methadone), and/or illicit use of benzodiazepines, routinely and over prolonged periods. Inevitably, much of the problem drug using population is hidden, and drug prevalence figures can only ever be estimates. Deaths from drug use in Scotland are on the increase.

Data on adults aged 16+ in Scotland from the Smoking Toolkit Study (STS) show an increase in the proportion reporting use of e-cigarettes and heated tobacco products from 7.3% in October 2020 to 13.2% in October 2022. 6.7% of 13 to 15 year olds in Scotland have reporting regular vaping.

Mental health is as important as physical health and maintaining public mental health and wellbeing and better management of this through more effective early intervention could potentially improve both mental and physical health.

Although ACHSCP provide health and care services for adults, children are the adults of the future, so we need to work with our colleagues in Children's Services to ensure this approach to improving health starts as early as possible at pre-birth and as part of a Family Support Model.

Vaccinations provide immunity from certain diseases and the more people who come forward for these the healthier the population. If we can also promote the uptake of early screening programmes for the most common cancers that should enable earlier detection and access to treatment with a greater chance of survival.

We know that those living in areas of deprivation experience inequality and poorer health outcomes and therefore have a greater need for our services. Understanding the particular needs of people living in these areas will help shape the way we deliver services to overcome any barriers in order that we provide equity of access.

Unpaid carers play a crucial role in the health and care system by providing care and support that would otherwise need to be provided by our in-house or commissioned services. By continuing to provide support to unpaid carers through the implementation and refresh of our Carers Strategy we will be helping unpaid carers to continue in their caring role and have a life alongside caring.

Health is impacted by a number of factors not just genetics and behaviour. The wider determinants of health include education, income, a person's physical environment such as housing and access to green space, and their social environment such as their support networks and connection to their community. These are factors that Aberdeen city IJB on their own cannot fully resolve however we can work with partners to try to have a positive influence on improving aspects of these wider determinants of health for the people of Aberdeen.

Our data and Population Needs Assessments tell us that there is a link between our economy and health. Fuel and food poverty, financial instability and child poverty is on the increase and is worse in areas of deprivation. If we translate the UK figure of 4.2% of the population being inactive due to long term sickness this equates to 9,416 people in Aberdeen City. If we can improve people's physical and mental health particularly those with long term conditions or on waiting lists for treatment, we can contribute towards a healthy workforce which in turn will contribute to economic growth in the City.

Doing things differently

We need to ensure our services meet the needs of our population, are affordable and that we achieve best value. We will do this in a number of ways: -

We will transform our approach to service delivery this will encompass transformation in relation to people – patients/clients, staff, and the general public – making the best use of technology and infrastructure and undertaking specific service transformations which will enable us increase our capacity to manage both current and future demand and enable us to do more with less.

Health and social care have traditionally had a 'siloed service' approach i.e. services have been developed per speciality and the individual must fit into these and often have to navigate a very complex landscape connecting to multiple services to get all the support they require. Research has identified that improved outcomes and efficiencies can be achieved by adopting a people first or personalised care approach. There are a number of approaches such as Getting it right for everyone (GIRFE) , Human Learning Systems and the Liberated Method as well as NHS Grampian's Putting People First and we will take learning from all of these and embed them in our practice.

If we are changing practice we need to ensure that our staff are appropriately trained and equipped to deliver that and also that our patients, clients and the general public are aware of the changes and the reasons why they have to be made. We need to ensure that any changes we make will not negatively impact our population and we will engage with them in line with Planning With People Guidance and impact assess changes using feedback in line with our duties under the Public Sector Equality Duty.

We also need to work with our partners in Aberdeen to ensure we are making the best use of our collective resources. We will collaborate with our communities and partners, engaging with them and working together to collectively improve outcomes.

Advances in technology provide opportunity to make our service delivery more efficient and allow us to do more with the existing resources that we have. It requires initial investment but if we don't do this now, we will not be able to cope with demand in future. The way we use our buildings is based on traditional models of service delivery. We need to reconsider how we use the buildings we currently occupy and also be open to the prospect of sharing building use (and costs) with our partners. Whilst achieving efficiency is the driver for these considerations there are also benefits for our patients and clients who may be able to receive a variety of service provision from one location cutting down the time they have to set aside for this and the cost of travel.

Service redesign has been a constant feature under health and social care integration, and we have a number of initiatives planned for the lifespan of this new Strategic Plan. We will look at redesigning some aspects of commissioning; the hospital discharge process; the way General Practice services are delivered; some aspects of our Grampian wide Mental Health and Learning Disabilities services; move towards more community focused delivery of our rehabilitation services; and improve the transition experience of those moving from Children's to Adult Social Work services.

Our Vision and Values

Whilst the principle of our vision since the inception of the Aberdeen City IJB in 2016 has not changed, we have changed the wording slightly to reflect a stronger emphasis on our enabling role in helping our communities to achieve the best health that they possibly can. Our revised aim is to **'empower communities to achieve fulfilling and healthy lives'**.

Our values represent what is important to us. Again, we have tweaked these slightly by dropping the value of 'Transparency'. This does not mean we will not be transparent in everything that we do but the definition of honesty is 'truthful and hiding nothing' which articulates our intention. Our revised values are therefore - **Honesty, Empathy, Respect, and Equity (HERE)** – Aberdeen City IJB is HERE for the people of Aberdeen. Our values set the standard for our behaviour as colleagues and as an organisation. We will be honest in our communications and interactions. We will respect the views and the rights of the people of Aberdeen. We will empathise with our patients and clients understanding their needs, listening to their views, and involving them in decision making. We will provide services that have equity of access for all, and we will make every effort to reduce the negative impact of inequality.

Our Strategic Aims and Outcomes

Our strategic aims help shape our priorities and planning for the services we deliver. We recognise that the journey to successfully achieve these aims takes time to deliver and embed. As highlighted in our 'challenges' we are impacted by a changing and demanding financial climate and an increasing population with complex needs, but we want to retain our emphasis on prevention and early intervention with our communities, and particularly our Unpaid Carers, being at the core.

Our Strategic Aims are: -

- Shift our focus towards Prevention and Early Intervention
- Transform the way we approach service delivery
- Improve equity of access to care and support
- Collaborate with our communities and partners

The Strategic Outcomes we want to achieve by focusing on these aims are: -

- Improve future population health and Healthy Life Expectancy and reduce the predicted increase in demand for health and social care services
- Achieve affordable and sustainable service delivery and improve outcomes for individuals
- Enable those who are disadvantaged to achieve as fulfilling a life experience as possible
- Ensure our service delivery meets local need and complements the work of our partners.

Strategic Aims			
Shift our focus towards Prevention and Early Intervention	**Transform the way we approach service delivery**	**Improve equity of access to care and support**	**Collaborate with our communities and partners**
Strategic Priorities			
Improve Physical Health	**Deliver people related transformation**	**Meet the identified needs of people with learning disabilities and autism**	**Co-design and co-produce services with those with lived experience and with commissioned providers in the third and independent sectors**
Improve Mental Health	**Promote and embed use of technology**	**Meet the identified needs of people with physical disabilities**	**Collaborate with partners to influence activity that has a positive impact on the wider determinants of health.**
Improve Brain Health	**Make the best use of our infrastructure**	**Meet the identified needs of Older People**	**Undertake consultation on service change and the use of our budget in line with the Planning with People Guidance and our Budget Protocol**
Improve Sexual Health	**Deliver Service Related Transformation : -** • Explore opportunities for innovation from commissioned providers • Drive organisational change to improve the hospital discharge process • Grow community rehabilitation capacity • Deliver our responsibilities within the General Practice Vision • Deliver the Primary Care Improvement Plan • Deliver the Grampian wide MHLD Transformation programme • Improve the Transition experience for those moving from Children's to Adult Social Work	**Meet the identified needs of those who are digitally excluded**	**Collaborate with partners to ensure the service delivery from Hosted Services is transparent and accountable and that best value is achieved.**
Reduce the harms due to the use of Drugs, Alcohol, Cigarettes and Vapes.		**Meet the identified needs of those who are homeless to make homelessness rare, brief and non-recurring.**	
Co-construct the 'Family Support Model' with relevant colleagues in Aberdeen City		**Meet the identified needs of Unpaid Carers**	
		Meet the identified needs of those experiencing poverty	
		Co-design with organisations representing lesser engaged groups to ensure their voices are heard and to help reduce stigma	
		Deliver the Spiritual Care Framework	

Strategic Priorities

In order for us to achieve our strategic aims we have identified the following strategic priorities:

Aim 1 – Shift our focus towards Prevention and Early Intervention

Improve Physical Health – Within this priority we will focus on continuing to deliver our Immunisations Blueprint and, in particular, the uptake of Childhood Immunisations in areas of deprivation. Screening for the likes of breast, bowel and cervical cancers can help detect problems early, meaning treatment can be accessed sooner and the likelihood of a positive prognosis is increased. We will aim to maximise the uptake of these lifesaving services to keep the population healthy for as long as possible. In Aberdeen City, our Public Health colleagues are developing a Whole System Approach to Healthy Weight, with the aim of the city avoiding an obesity epidemic. Within this priority we will also focus on those who are on waiting lists for the treatment of Chronic Pain. Falls are the most common type of accidents in people aged 65 and over and are a major cause of hospitalisation related to injury in this age group. Injuries as a result of falls can significantly impact quality of life and in some cases precipitate death. We will work with vulnerable groups to help support people to know how to fall safely and when falls occur we will wrap around the individual and their family to develop a plan which may include the provision of rehabilitation and/or home adaptations (whether permanent or temporary) to enable a return to independent living as quickly as possible.

Improve Mental Health – there are many levels of severity of mental health disorders ranging from mild anxiety through to complex needs that require inpatient or forensic support. Our mainstream services exist to support and treat those at the more severe end of the spectrum and the Grampian Mental Health and Learning Disabilities Transformation Programme is in place to transform these services and ensure they are sustainable for the future (see Transformation Aim). There is additional support provided by a range of workplace and community-based groups, including third sector organisations, that aim to help people recognise the signs of anxiety and stress and adopt coping mechanisms to avoid these becoming more severe disorders. We will ensure that such support is visible and accessible and that our population has the opportunity to have the knowledge and confidence to consider that maintaining their mental health is as important as that of their physical health and to seek support without discrimination or stigma. An intended outcome from this will be to reduce the number of prescriptions issued for anxiety and depression. Social isolation and loneliness can affect anyone at any stage of life and increases the risk of poor mental and physical health. We will increase opportunities for social connection via social prescribing and our Stay Well Stay Connected Programme and through working with colleagues developing the 21st Century Libraries model. We will continue to implement Self Harm and Suicide prevention initiatives promoting the Prevent Suicide North East website and App which provides support and information for those with suicidal thoughts or worried about a loved one as well as those bereaved by suicide.

Improve Brain Health – specifically in the ageing population. The World Health Organisation's definition of 'Brain Health' is the state of brain functioning across cognitive, sensory, social-emotional, behavioural and motor domains, allowing a person to realize their full potential over the life course, irrespective of the presence or absence of disorders. Lifelong learning and social connection are two of the determinants that influence the way our brains develop, adapt and respond to stress and adversity. Optimising brain health by addressing these determinants not only improves mental and physical health but also creates positive social and economic impacts that contribute to greater well-being and help advance society. We will deliver events such as the Grampian Gathering and the Wellbeing Festival providing opportunities for our ageing population to learn ways of 'Ageing Well'

contributing to improved Brain Health in later life. We will develop a strategy for Ageing Well and a plan for delivering the Age Friendly Aberdeen initiative.

Improve Sexual Health – the Fast-Track Cities initiative is a global partnership between cities and municipalities around the world which outlines a set of commitments in relation to the attainment of zero new HIV infections and zero AIDS-related deaths. Aberdeen is one of the Fast Track Cities and will continue to work towards delivering the zero targets. Safe access zones are now in force in Scotland, banning people from protesting against abortion care outside clinics or hospitals offering the service. Implementation of the Sexual Health Standards are designed to improve access to sexual health care, reduce inequalities in sexual health outcomes, help services to identify areas for improvement and help services benchmark sexual health care. Grampian Sexual Health Services will continue progressing the implementation of these standards.

Reduce harms due to the use of Drugs, Alcohol, Cigarettes and Vapes - The Alcohol and Drugs Partnership will continue to work towards reducing the harm caused by alcohol consumption and in particular reducing deaths related to alcohol consumption. We will work with partners to support the reduction of harm (particularly deaths) related to the use of drugs. Although in Scotland, the average number of cigarettes smoked per day has steadily declined from 15.3 to 11.4, people from the most deprived areas smoke 13 cigarettes per day on average, compared to 10 cigarettes by those in the least deprived areas. We will work to reduce the incidence of smoking particularly in pregnant women in areas of deprivation. Although vaping is deemed to be less harmful than smoking it is nonetheless bad for heart and lungs and can be as addictive as traditional cigarettes. They can cause side effects such as throat and mouth irritation, headaches, coughs and feeling sick. We will work with partners to reduce the incidence of vaping particularly in young people.

Co-construct the Family Support Model - Aberdeen City's 'Family Support Model' aims to shift the focus from reactive and risk-based services to upstream and preventative approaches. This will help to improve the level of autonomy families experience and their longer term outcomes. The adults that ACHSCP supports are often part of a family group so we have a significant part to play in contributing to the family support model and ensuring services are joined up and integrated to achieve the best outcomes for the family as a whole. Stretch Outcome 3 of the Local Outcome Improvement Plan (LOIP) focuses on working with families and young children to ensure they have the best possible start in life focusing on improving child health and helping them reach their developmental milestones and our Adult Social Work and Community Nursing Services, in particular, have a crucial role to play in reducing the impact of parental mental health, addiction, and domestic abuse problems and improving the uptake of Childhood Immunisations.

Aim 2 - Transform the way we approach service delivery

Deliver people related transformation – there are a number of approaches by which we can assess need and then put in place individual plans to provide care and support.

Human Learning Systems is an alternative approach that enables us to work effectively in a complex system to meet a variety of needs. We need to be able to hear, understand and respond to that variety. To do this we must form effective human relationships, so that we have a deep understanding of people's lives and context, and have the autonomy to respond appropriately to each person's needs as close to the person as possible. The Human. Learning. Systems approach outlines a way of being more responsive to the bespoke needs of each person and these are the systems which create positive outcomes in people's lives.

Getting it right for everyone (GIRFE) is a multi-agency approach of support and services from young adulthood to end of life care which is about providing a more personalised way to access help and support when it is needed. It places the person at the centre of all the decision making that affects them, with a joined-up consistent approach regardless of the support needed at any stage of life. It is intended that GIRFE will form the future practice model of all health, social care and public sector professionals and shape the design and delivery of services, ensuring that people's needs are met.

When you start with people and work outwards from them, things don't look like services anymore. They look like things we would recognise when we go home (if we're fortunate). They look like family, agency, community, relationships and understanding. They look like things humans are good at. Designing public services around relationships is far more effective than designing them around services. People who have bounced around various public services for years start to positively change how they see themselves, the community, and the world when they're contributing to a relationship and are understood. The 'Liberated Method' has been developed over a series of prototypes over the last five years and initially focused upon freeing up the creativity and compassion of front-line caseworkers. It has since grown to include liberating leadership, partnership, commissioning, and governance. Public services do not singularly transform lives and communities. What they can do is to support people by helping them to create the conditions to effect the changes they feel compelled to make which will be more effective both in terms of the use of resources and outcomes for the individual.

Putting People First is NHS Grampian's approach to involving people in improving services with a focus on creating equal partnerships with the public to create more preventative models of care. The approach recognises the importance of relationships and building trust between people, taking a collaborative approach and using existing networks and structures with the public sector working as one whenever possible.

Each of these approaches are similar. We will take learning from all of them and deliver a set of principles to govern our approach to personalised service delivery.

The challenges of increasing demand but reduced budget and difficulties in recruitment are forcing our hand. We know we need to change but we also need to engage with our population to enlist their help in designing alternative service delivery that still meets their needs and, at the same time, getting them on board with managing their expectations for service delivery going forward and what they can do to help. In conjunction with our partners in the Grampian health and care system we will work with our population to ensure understanding of changes to service delivery and mitigate any potential negative impacts.

Promote and embed use of technology – in line with Scotland's Digital Strategy which aims to ensure that Scotland can fully embrace the transformative power of technology by

realising the power of data to improve services, increase efficiency and deliver better outcomes in an ethical, secure, efficient and user-centred way, ACHSCP is committed to maximising the benefits that technology can bring to the efficient and cost effective delivery of services, developing preventative and early interventional supports, and improving outcomes for patients and service users. This will include initiatives in relation to improved information about care and support services available, tools to improve access to care and support, systems to enable staff to undertake their roles more efficiently, and increased use of technology in care delivery improving safety and enabling greater independence for individuals.

Make the best use of our infrastructure – the IJB does not own any buildings. Our services are based mainly in buildings owned by our two key partners Aberdeen City Council and NHS Grampian. Being mindful of the financial challenges we face this we will undertake a full review of our needs for premises based on our population need for service delivery. Initial work on a review commenced in 2024 with an analysis of our current use of buildings but no decisions have yet been made in relation to any changes. Some decisions will be forthcoming towards the end of financial year with others not being made until 2025/26. Our Strategic Plan needs to reflect that the implementation of these decisions will take place during its lifespan. Also, in relation to buildings we will continue to develop and implement both the Primary Care Premises Plan and the Infrastructure Plan. Partnership working is a key focus for ACHSCP as is a shift towards community-based service delivery. We already have robust links with a wide range of partners in Aberdeen City such as NHS Grampian, Aberdeen City Council, Bon Accord Care, Sport Aberdeen, the Sports Village and through Community Planning with Police, Fire and Rescue, further education establishments and the Third Sector. Building on the person-centred approach and in conjunction with these wider partners we will seek to connect the physical assets we have in communities in a better and more coherent way. Our Stay Well Stay Connected Programme has a strong community focus and is delivered from community-based assets. We will continue to build on this expanding the number and range of community-based services. We are working with NHS Grampian to bring Diagnostic Services closer to communities to encourage uptake. Small tests of change have already begun but we will build on the success of these in the coming years. Aberdeen City Council's 21st Century Libraries initiative provides greater opportunities for joined up services being delivered in a community asset, maximising the reach and impact we can achieve, and we will work with colleagues to explore and exploit these opportunities. Our considerations will include how we can support delivery of the Premises objective within the General Practice Vision 2024-30.

Deliver service related transformation – this will cover a number of service areas.

A significant proportion of our budget (£164 million or 38%) is spent on commissioning. 99% of our social care is delivered by externally commissioned providers. It would be remiss of us to exclude these providers from our transformation agenda. We have recently renewed the Service Level Agreement with Bon Accord Care and re-commissioned Care at Home both exercises incorporated innovation. Going forward we will redesign the contract with Scottish Care and utilise the Innovation Grant Fund set aside for use with commissioned providers.

We will drive organisational change across the whole system to improve hospital discharge processes**.** Delayed hospital discharge has been a national focus for a number of years but has been brought into sharper focus with the increased pressure on hospitals evidenced by a significantly reduced performance in relation to the 4 hour waiting time target for the Emergency Department which for Aberdeen Royal Infirmary at the end of September 2024 was 50.3% against target of 95%. Achieving efficient discharge from hospital is a complex process, influenced by individual need and requiring support from a number of primary, secondary and community care services. Aberdeen City has made significant progress in

reducing delayed discharges in recent years however with increasing demand and burden of disease there is pressure to do more. We have implemented the easy fixes and what is required now is a system wide change.

During 2023/24 a General Practice Vision 2024-2030 for Grampian was developed with the aim of achieving a sustainable General Practice across Grampian which enables people in their communities to stay well through the prevention and treatment of ill health. Within the vision ACHSCP have the lead responsibility for delivering certain aspects and we will deliver our lead responsibilities within the General Practice Vision 2024-2030.

The Primary Care Improvement Plan has been in place for some time but work needs to continue to complete our commitments in relation to this. We will continue to deliver the Primary Care Improvement Plan.

Grampian wide Mental Health and Learning Disability Services (MHLD) are hosted by Aberdeen City IJB which means we have the responsibility for operational delivery including transformational activity. The Grampian MHLD Transformation Team are based within ACHSCP Strategy and Transformation, and they will continue to contribute to achieving delivery of the Grampian Mental Health and Learning Disabilities Transformation Programme.

We will grow community rehabilitation capacity - rehabilitation services are hosted by Aberdeen City IJB. The services as a whole were due to be reviewed as part of our previous Strategic Plan however only the Neuro Rehabilitation Service and the Wheelchair service were reviewed. We plan to complete the review of the remaining services with greater emphasis on the benefits that community services can bring.

Transitioning from childhood to adulthood is challenging in itself but when you are in receipt of health and social care services that transition can bring different changes which can be unsettling and negatively impact a young person's health and wellbeing. We will seek to improve the transition experience for those moving from Children's to Adult Social Work.

Aim 3 - Improve equity of access to care and support

Meet the identified needs of people with learning disabilities and autism – the imminent implementation of the Learning Disabilities, Autism, and Neurodivergence Bill has been delayed but we have the consultation draft and are aware of what the Bill will eventually encompass. We will develop an interim/holding local response to this in the form of an action plan.

Meet the identified needs of people with physical disabilities Aberdeen City IJB has delegated responsibility for the provision of Disabled Adaptations. In January 2023 the Scottish Government produced statutory Guidance on the Provision of Equipment and Adaptations. The Disabled Adaptations Group (a sub group of the Strategic Planning Group) is currently implementing their local action plan to ensure the best arrangements are in place to deliver disabled adaptations for all who need these regardless of whether they live in a privately owned, council owned or registered social landlord owned property.

Meet the identified needs of Older People - there is no typical older person and each individual ages differently depending on genetics, environment and lifestyle but many health issues commonly affect older people more than the younger generation. Our Frailty Pathway is designed to provide support for those in our population who are frail and elderly both in the community and in hospital and care settings. We will work with frail, elderly people, their carers, and families to co-design and deliver a Community Frailty Pathway that meets their needs, increasing awareness of it, and ensuring those who require the support have the awareness and knowledge in terms of what is available and how best to access it. Dementia, although not only affecting older people, mainly affects people over the age of 80. It can affect every aspect of a person's life and this impacts on care partners, unpaid carers and families. We will work with partners and people with lived experience and their carers to deliver commitments in relation to Post Diagnostic Support available for people living with Dementia and their carers.

Meet the identified needs of those who are digitally excluded – particularly with our focus on increasing the use of technology, we are aware that there are certain cohorts of our population that are digitally excluded. Working with this cohort, we will aim to support them either by helping to develop their digital skills or by ensuring alternative options for accessing care and support are provided, whichever is most appropriate to individual need.

Meet the identified needs of those who are homeless to make homelessness rare, brief and non-recurring – homeless people need bespoke support when it comes to the provision of health and social care services. During 2024, in conjunction with homeless people we undertook a review of the provision of GP services at the Marywell practice. We will implement the agreed option from that to ensure the needs of homeless people continue to be met. We will contribute to delivery of the Homewards project to inform services and our population of the needs of homeless people. The Housing (Scotland) Bill introduced in March 2024 includes a duty on public bodies to 'Ask and Act', that is, to ask in relation to a person's housing situation and to take action to avoid them becoming homeless wherever possible. The Bill will require public bodies – including Aberdeen City IJB to implement systems whereby people at risk of homelessness are easily identified and directed to the appropriate services before they reach crisis point. To comply with this legislation, we will put in place systems and procedures to embed the 'Ask and Act' approach within routine contacts with patients and clients.

Meet the identified needs of Unpaid Carers – since the implementation of the Carers Act in 2018, Aberdeen City has had a local Carers Strategy and has worked with carers to ensure it continues to meet their needs and enable them to have a life alongside their caring

role. We will continue to implement our current Carers Strategy, reporting annually on progress and will also prepare for the refresh of that strategy in March 2026.

Meet the identified needs of those experiencing poverty - when we think of 'poverty' we tend to think of very low income, but reduced income can lead to other forms of poverty such as Fuel Poverty and Food Poverty. Poverty limits access to these important building blocks of health - where a person lives, the income they have, and the conditions in which they live, and work are all important aspects impacting both physical and mental health. Low income may mean people cannot afford to heat their homes, eat nutritious food, or access preventative healthcare – all of which can impact physical health and the stress of worrying about these things can impact mental health. Children living in low-income families are similarly impacted and therefore perhaps not able to achieve the best start in life that is vital to their health as an adult. We will work with those on low incomes to understand what support they need to improve their health and provide or signpost to that where possible.

Co-design with organisations representing lesser engaged groups to ensure their voices are heard and to help reduce stigma – our Equalities and Human Rights Group (a sub group of our Strategic Planning Group) will continue to work with organisations representing lesser engaged groups to ensure their voices are heard in service delivery and planning and that we educate and inform our staff and our population to help reduce discrimination and stigma.

Aim 4 - Collaborate with our communities and partners

Co-design and co-produce services with those with lived experience and with commissioned providers in the third and independent sectors - the best way to ensure our services will meet the needs of the people we serve is to co-design and co-produce them with the voices of lived experience. We will do this in line with the Planning with People Guidance. As of financial year 2024/25, £164 million of our social care delivery is provided via externally commissioned providers and their expertise and experience is crucial to designing and delivering the most appropriate and relevant services in line with need. We will undertake development work with our two biggest providers Bon Accord Care and Granite City Consortium to ensure their services remain relevant to client needs. We will work with our commissioned Counselling Services to develop a commissioning led alliance contract. We will also redesign our residential service for those with problems relating to alcohol use. We will make greater use of the Health Improvement Fund as a way to empower communities and drive forward community led health. The relationships ACHSCP has with the providers who deliver services on our behalf are key and we will maintain our focus on positive relationships to help ensure a positive experience for service users.

Undertake consultation on service change and the use of our budget in line with the 'Planning with People' Guidance and our budget Protocol – with the challenges we face in relation to budget, staffing and increased demand and the need to transform the way we deliver services it is likely that there will be a lot of changes for patients and clients. We need to consult with staff and service users to assess the impact of any proposed changes to help inform our decision making on final solutions which may include implementing mitigations to reduce any negative impacts.

Collaborate with partners to influence activity that has a positive impact on the wider determinants of health – place planning, the economy, transport strategies, and the provision of education and housing all have an impact on population health. ACHSCP has close links with Aberdeen City Council who are responsible for the provision of these services. We will make best use of these links to help influence the implementation of initiatives that will have a positive impact on the health of the population in Aberdeen. In conjunction wit colleagues from Housing, we will look to redesign Provost Hogg Court from Sheltered to Very Sheltered Housing and undertake a programme of work investigate the potential of redesigning some Sheltered Housing to Amenity Housing ensuring we match the housing available to the needs of the people of Aberdeen.

Collaborate with partners to ensure the service delivery from Hosted Services is transparent and accountable and that best value is achieved – in 2024 an Internal Audit of Hosted services was undertaken with a number of recommendations on governance and reporting arrangements made which are to be implemented up to September 2025. We will implement the recommendations from the Hosted Services Audit working in partnership with colleagues from NHS Grampian and Aberdeenshire and Moray Health and Social Care Partnerships. The proposals will be agreed by the three IJBs and following implementation the new governance and reporting arrangements will monitored for their effectiveness.

Our Strategic Enablers

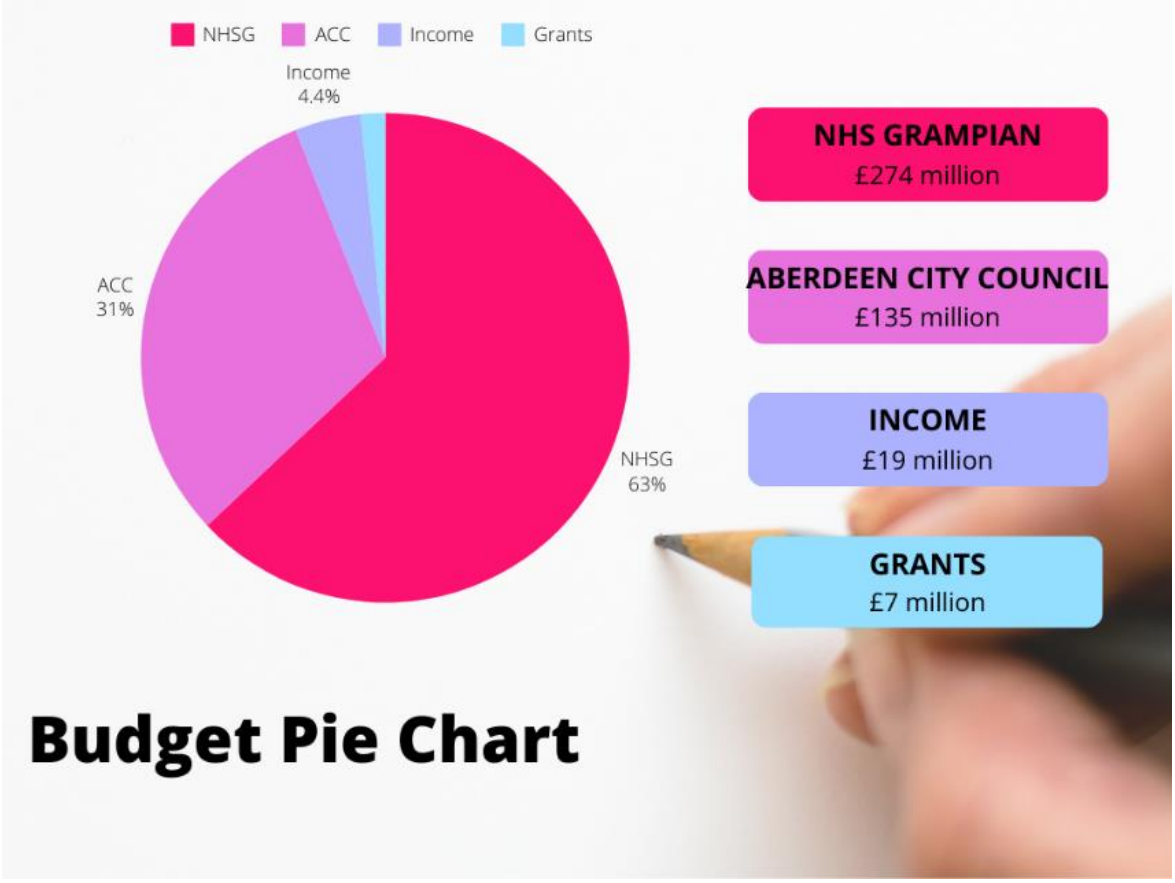
We have identified six key enablers to support the delivery of our Strategic Plan.

1. **Finance**

The Medium-Term Financial Framework (MTFF) will help inform our planning every year to support the delivery of our strategic priorities. A budget protocol will form part of the budget consultation in line with the Accounts Commission findings 2024. Our budget will be allocated in tiers to allow growth of our prevention and early intervention programmes. Our commissioning priorities will be reviewed on an annual basis to ensure best value is achieved.

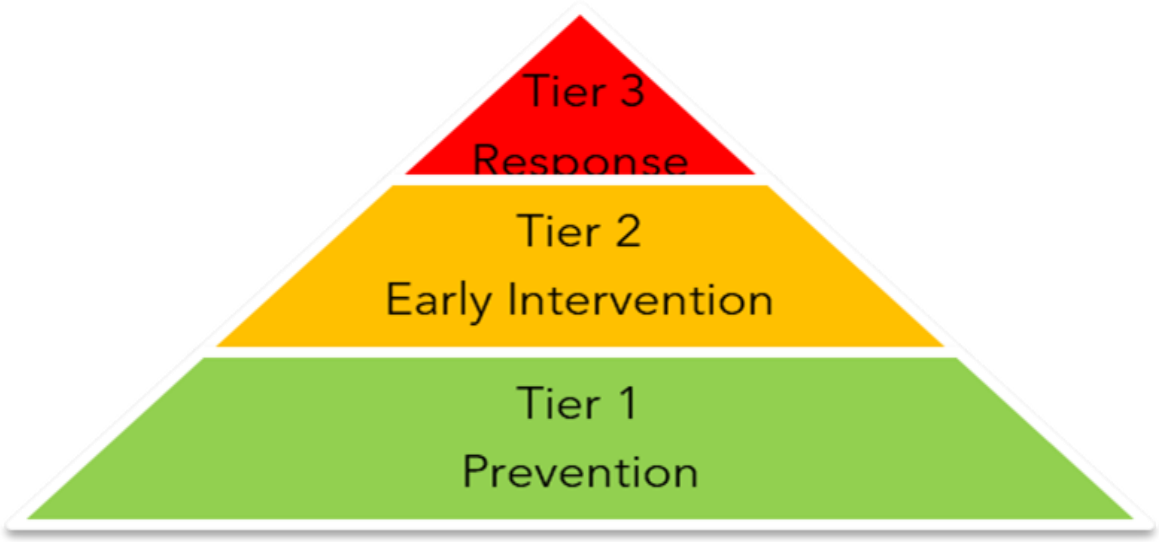
- Our budget is **COMPLEX** – and our decisions are only going to get harder with increasing pressures on health & social care partnerships across Scotland.
- Our IJB has a statutory duty to set a balanced budget each year – which is getting more challenging
- As a result, it is important to have clear and collaborative conversations with all our stakeholders around the difficult choices to achieve financial stability
- This protocol identifies the key stages in developing and delivering Aberdeen City IJB's Medium Term Financial Framework and annual budget highlighting the importance of meaningful engagement to enable a shared understanding of potential impact of budget decisions. Link to protocol?

NB: Figures below are accurate as of 2024/25



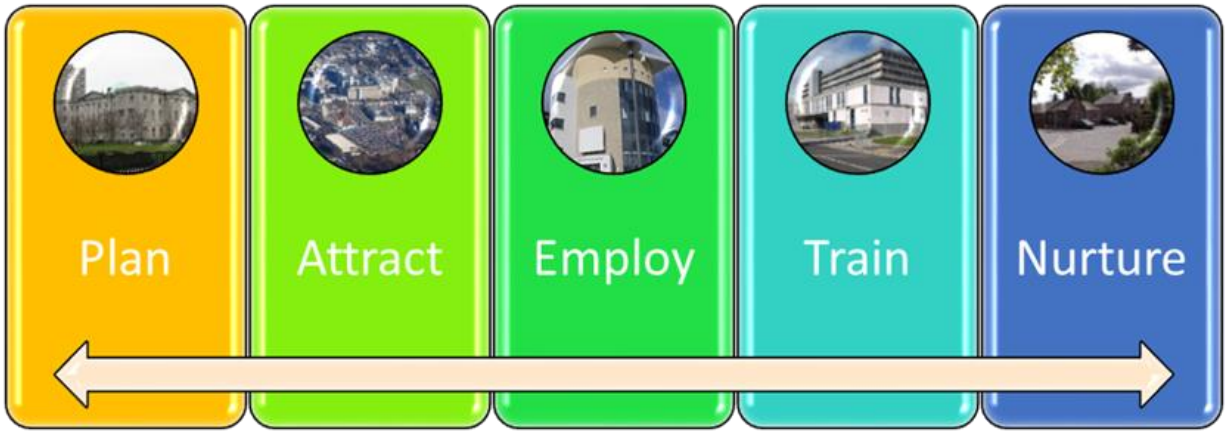
£78 million on staffing across all our services
£164m on commissioning. This includes our contracts such as care at home, care homes and voluntary organisations
£52m on prescribing. This includes prescriptions written by our GPs and pharmacies
£85m on hospital-based services. This includes the services we host on behalf of other IJBs (specialist rehabilitation and frailty); as well as unscheduled care
£46m on primary care. This includes our contracts with GPs, pharmacies, dentists and optometrists.
£10m on other costs such as supplies, premises, admin and transport

Prevention and early intervention are key ways in which pressures on care services can be better managed over time through reducing demand in the face of restricted funding. The Commission on the Future Delivery of Public Services undertaken by Dr Campbell Christie CBE and published in 2011, directed public bodies to make a deliberate shift to preventative spend. In March 2023 the IJB approved a recommendation that the Chief Officer included tiered analysis on annual reporting against the Health and Social Care Partnership Strategic Plan as part of evidencing the shift to a preventative approach. 72% of our budget for 2024/25 is allocated to prevention, 27% to Early Intervention and 1% to Response. We will continue monitoring our budget commitments to evidence the shift.



2. Workforce

It is essential we have the right capability and capacity to meet the future needs of Aberdeen. We will deliver our current workforce plan and being cognisant of future challenges develop the workforce plan for 2025-2030 to support the delivery of our strategic plan 2025-2030. Our staff across ACHSCP are our best asset and are crucial if we are to deliver on our strategic priorities. The challenge of recruitment and retention of staff continues, particularly within clinical and social care settings. Our workforce plan complements the delivery of our strategic plan, and we will support and develop our workforce using the five pillars set out the National Workforce Strategy for Health and Social Care which are: -



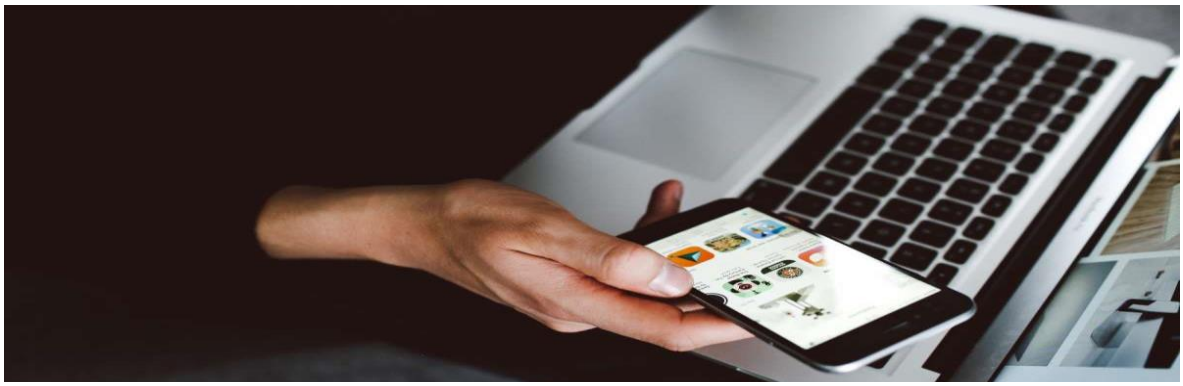
3. Infrastructure

Infrastructure Plan - our Infrastructure Plan 2025 -2030 will be derived from the need to review the allocation and use of space across premises we utilise across the City. The plan will identify and forecast the areas of pressure and demand across the City and how we intend to deliver services to respond to that demand. Aberdeen City IJB does not own any buildings or assets in this regard so our collaboration and partnership working with our partners in NHSG and ACC is crucial to achieve our aims.

The Aberdeen Community Health and Care Village, Frederick Street, Aberdeen

4. Digital Innovation and Technology

We will maximise the benefits both for staff and patients which will bring efficiency and improved outcomes. Digital technologies are transforming every element of our lives. They are radically redefining relationships between all organisations and their clients and customers. The effective use of technology can keep people at home, managing long term conditions and increasing independence, rather than remaining in hospital or a care setting. To most effectively improve outcomes, and to prevent and reduce demand, services and data need to be integrated and have the individual person and their unique circumstances at their core.

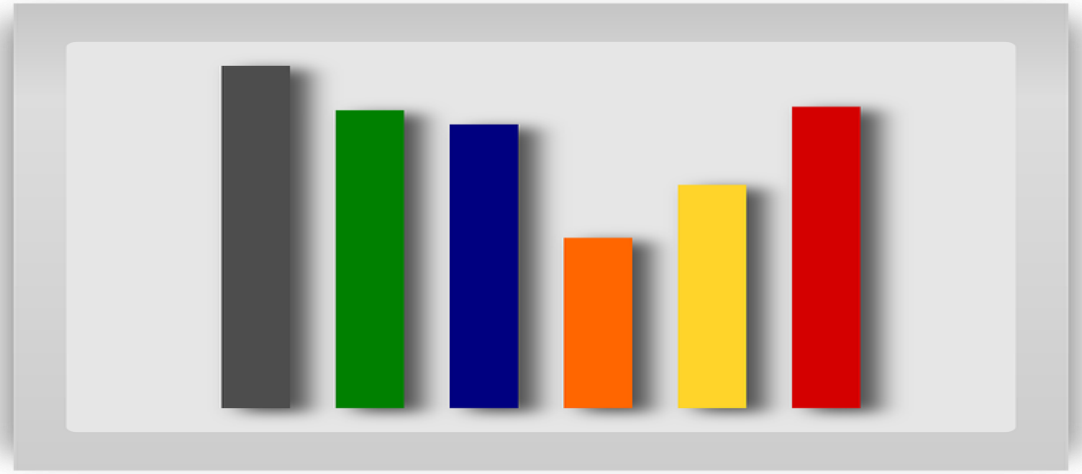


5. Relationships

99% of our care services are delivered by our commissioned services and we recognise the need to work better together to ensure we are using resources effectively to deliver the best outcomes for the citizens of Aberdeen City. Developing and maintaining positive relationships across the region with our partners, ACC and NHSG, and our communities is crucial to the successful delivery our strategic plan. We will continue to ensure that lived experience informs the design, delivery, and improvement services around the needs and requirements of the population.

6. Data

Data, both quantitative and qualitative should underpin everything we do and guide every decision we make. Data on demographics and population health are vital to forecasting future demand. Performance data helps us understand how we are doing and where we need to focus our resources to improve. Our Market Position Statements rely on data to shape future service provision. Qualitative data through surveys and engagement is crucial to help us understand how people feel about our services, whether they are meeting their needs and what we might need to change. Output from research such as that undertaken by the Health Determinants Research Collaborative (HDRC) can provide both quantitative and qualitative data and we will work closely with them to ensure we benefit from this valuable knowledge source.



Governance

Our Delivery Plan

As with our previous Strategic Plan, it's delivery will be supported by a Delivery Plan which will be reviewed annually, enabling us to be able to respond to emerging needs and anything new arising from our partners refreshing their plans. The activity reflected in our Delivery Plan going forward will be much more targeted toward specifically achieving our aims ensuring that we can deliver these within the anticipated resource. We remain ambitious in what we hope to achieve but we have ensured that we are also realistic within the challenges already mentioned in relation to reducing budgets and restrictions around recruitment.

Measuring Impact/Success

The Strategic Aims and Priorities will be translated into a number of programmes with associated projects. Key Performance Indicators (KPIs) will be developed for each project although these will be a mix of qualitative and quantitative measures. The qualitative measures will form the basis of our Delivery Plan Dashboard whilst the quantitative measures will feed into our Delivery Plan Progress Report. We will also identify data to tell us whether we are delivering on our four Strategic Outcomes. These will form the basis of our Strategic Plan Dashboard and Progress Report.

Governance and Assurance around Delivery

We will continue to use a programme and project management approach to delivering our Strategic and Delivery Plans. Each programme will have a Senior Responsible Officer from the Senior Leadership Team (SLT) and each project will have a nominated lead, also from the SLT. Delivery of the projects and programmes will be supported by the Strategy and Transformation Team.

Progress against the Delivery Plan will be reported monthly to SLT, and quarterly to both the Risk Audit and Performance Committee (RAPC) and the Chief Executives of Aberdeen City Council and NHS Grampian. Progress against our Strategic Plan including the impact of the Strategic Outcomes and data in relation to National and Ministerial Strategic Group (MSG) Performance Indicators will be reported annually to the IJB, the Scottish Government, and other stakeholders including the public, through the publication of our Annual Performance Report.