Aberdeen City Health & Social Care Partnership

A caring partnership

DRAFT Strategic Plan 2025-29

March 2025

Contents

Foreword

I am delighted to present Aberdeen City Integration Joint Board's (IJB) Strategic Plan which covers the four-year period from 2025 to 2029. This is our fourth Strategic Plan since integration and the delivery of it will be our most challenging yet. Demand for health and social care services continues to grow yet the resources available to meet that demand are not increasing at a corresponding rate. Our plan therefore sets out our intention first and foremost to transform our service delivery to help ensure we can protect essential frontline services. We remain committed to our prevention and early intervention agenda which will help manage future demand and we will switch our focus to that once we have achieved the balance between demand and resource. We will work with our partners and the people of Aberdeen to improve the overall health and wellbeing of the population.

Achieving good health is impacted by many factors, for example, education and income, housing and living environment, social and community support. These are commonly known as the wider determinants of health. Inequality in these wider determinants has a direct impact on health and a key feature of this Strategic Plan is for the IJB to work with partners in Aberdeen City to try to close the inequality gap.

This plan relates to services delegated to and hosted by the IJB. The content has been informed by a detailed analysis of current and emerging local, regional, and national factors affecting health and social care delivery. This includes factors such as statutory responsibilities; current performance towards delivering better outcomes; and feedback from engagement with stakeholders including staff, citizens, and our partner organisations. The outcome of this analysis has been collated into an Evidence Document which can be found at Appendix A.

Whilst we would like to be able to have a response to every challenge highlighted in our evidence document our Medium Term Financial Framework indicates that we will not have the resources to do this. We are therefore prioritising our activity against two aims: -

1. Modernise our approach to service delivery
2. Shift our focus to prevention and early intervention

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John Cooke
Chair
Aberdeen City IJB

Introduction

Aberdeen Context

The ambition is for Aberdeen to be "a place where all people can prosper regardless of their background." At the heart of this, is a commitment to tackling poverty and inequality and supporting the city's people to live healthy lives.

Through an understanding of the needs of the city and its people, as well as the services and interventions that are provided, the suite of strategies for Aberdeen City aims to identify the things that will bring benefit to people and commit to evidence based and effective future actions.

The focus is on improving outcomes across five themes of the social determinants of health:

- Children, Families and Lifelong Learning
- Economic Stability
- Communities and Housing
- Neighbourhood and Environment
- Health and Social Care

The Population of Aberdeen

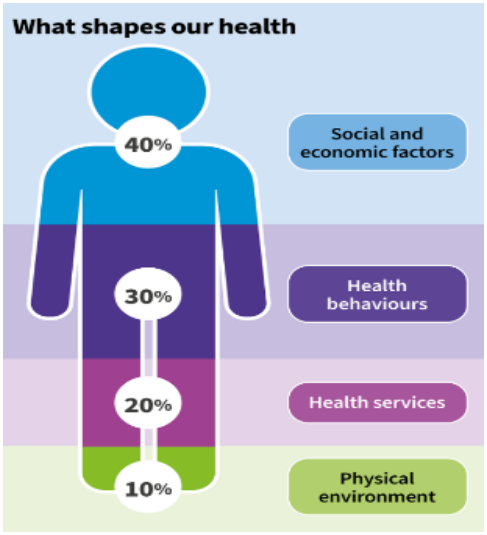
The population of Aberdeen City is estimated to be 227,750. The overall population had been declining from 2015 to 2023, primarily due to a falling birth rate and fluctuating net migration. In the coming years, Aberdeen is projected to have fewer people of working age and will see a rise in the number of older people, particularly those over 75.

A falling and ageing population pose a number of challenges to an area and can lead to a cycle of economic decline. It can also increase pressure on public services by reducing the overall tax base, whilst increasing the need to provide services and care, specifically for children and older people. Given that the falling birth rate has been a reality for a number of years, if the city's population is to be sustained, or grow in the short and medium term, this must be driven by migration; by attracting people to and keeping them in the city. Like many other areas, a growing number of people in the city are recorded as having a limitation to work, exacerbating the balance between those in work, and those who are not.

Our focus, therefore, must be to ensure Aberdeen is a place where people want to come to live and work, and to support the people who do live here to play a full social and economic part in the city's future.

The Social Determinants of Health

The social determinants of health contribute to the unfair and avoidable differences in outcomes seen across the city of Aberdeen. Social and economic factors, health behaviours, access to health services and the physical environment in which people live all contribute to shaping people's health. To ensure that the IJB's Strategic Plan helps to address health inequalities, we will concentrate on those factors upon which we have influence and encourage our partners to focus on the factors they can influence. Our Stay Well Stay connected programme helps connect people into their Communities and our Public Health and Health Improvement teams are focused on improving health behaviours. The IJB has a responsibility for disabled adaptations and that is one aspect of the physical environment we can help address.



The IJB Strategic Plan has a key role in helping ensure: -

- The promotion of social activity and connections to create and maintain communities
- The promotion of positive health behaviours
- The provision of health and care services which are available and accessible to those who require them.
- The creation of conditions for people to live in their own home through adaptations suitable to meet their health needs.

Children, Families and Lifelong Learning

It is clear that the life circumstances of children affect their educational attainment, and that educational inequality can lead to inequalities of health and wellbeing in early adulthood and beyond. It is also known that the circumstances of parents and carers directly impacts on children and young people. 237 Young Carers are currently being supported through the Young Carers Support Service, an increase of 47% from the previous year. The IJB has the responsibility to support parent carers, and support for both them and Young Carers is delivered through our Carers Strategy. We are currently supporting 127 parent carers, and it is vital that they continue to be supported in their caring role.

Around 22% of children are experiencing child poverty and 50% of households experiencing poverty have dependent children. One way in which the IJB can support children in poverty is through signposting to financial support and working with parents to help them with feeding solutions for their families. One in three school pupils are of ethnic minority background and these groups are often reluctant or unable to engage with health and care services. The IJB will continue to improve the accessibility of services to ensure children from these groups have the same opportunity to thrive as others.

The development of early speech and language skills continues to be a concern, and the uptake of childhood immunisations is lower than it should be. The mental health and wellbeing of children and young people continues to be a concern and there is an increase in the number of children declared disabled. The transition from children's to adult social care services particularly for children with a learning disability is often challenging and there is a need to ensure this is more effective and does not adversely impact outcomes for these children.

The Children's Services Annual Report 2023/24 highlighted the need to consider how best to deliver family centric approaches to support families facing complex challenges living in Scottish Index of Multiple Deprivation (SIMD) 1. The Family Support Model is a new approach to support families with complex and multi-faceted challenges to shift the focus from reactive and risk-based services to upstream and preventative approaches and this will help address inequality in these areas.

Aberdeen continues to welcome many displaced families and young people from around the world and those seeking refuge in the city will continue to require essential support including health and care support appropriate to their needs. The IJB will continue to support the multi-agency approach to meeting the needs of displaced families and young people including close cooperation with our general practice colleagues.

The IJB Strategic Plan has a key role in helping to ensure: -

- Continuing support to parent carers through delivery of our Carers Strategy
- An effective transition model for children and young people moving from children's social care services to adult social care services particularly for children with learning disabilities to ensure their needs are met efficiently and effectively.
- Continuing contribution to the coproduction of the Family Support Model to help us understand a child's needs in the broadest possible way.

Economic Stability

A healthy economy is inextricably linked to the health and wellbeing of a population. Simply put, people who experience economic inequalities have poorer health and wellbeing. People who are economically secure have better health and wellbeing.

Aberdeen is experiencing an economic transition toward a low-carbon economy, with a clear focus on developing greater diversity across business sectors. Energy remains a key component in this, though more is needed on developing the renewables sector, with tourism, and financial and business services sectors also being important in the mix. Even if the wealth gap between the region and Scotland as a whole is narrowing, in 2023 people in Aberdeen were still wealthier per head of the population than Scotland.

The estimated unemployment rate in the city in June 2024 was 4.4%, which is above the Scottish level of 3.5%, whilst the number of people claiming unemployment-related benefits matched the Scotland figure. In 2023 it was estimated that almost 1 in 6 households had no-one within the household working, but households with low income, or likely to be experiencing financial instability, are also important. It is estimated that 3 out of 5 (57%) households experiencing relative poverty will be within working households.

The ability for the local economy to help create and maintain health and wellbeing is important from a population health perspective. This means that it can sustain high quality employment that helps people to live in homes suitable to their needs, and which can be kept warm and dry. It is essential that there is a local economy that can help people and families maintain the types of financial security to put food on the table, pay their housing costs, and to afford the other necessities of everyday life. To prevent loss of health and wellbeing we must continue to address the economic inequalities and support financial security. The accessibility of financial inclusion services will continue to be important.

The IJB Strategic Plan has a key role in helping to ensure that: -

- People are kept well enough to be able to fulfil their role in the workplace, maintain their income, and provide a sense of purpose. Initiatives such as the Community Appointment Day approach will help support this.

Communities and Housing

Having somewhere to live which is affordable, warm, and secure is an essential part of wellbeing. The availability, location, type, and quality of housing is also important. So too are the housing challenges that many people face, including households that are experiencing fuel poverty; those who require specialist provision housing as a result of ill-health or disability; and those who, for a range of reasons, are without a secure place to live.

Feeling safe within your home, your place and your community are important factors in wellbeing too, so crime and anti-social behaviour, risk of house fires and being safe when using roads are also important. An ability to participate within one's community is a key element in creating and maintaining wellbeing.

Along with other local authorities across the UK, Aberdeen has strived to meet the challenges presented by the rapid influx of displaced people seeking support and refuge, and is currently home to around 2,000 displaced people, which is a ten-fold increase in arrivals over the last 3 years. Resettled families can face isolation on arrival to the UK. Such isolation can be reinforced by language barriers and varying cultural perceptions of appropriate interactions. The opportunity to build social connections is critical to support integration into local communities but there can be comfort in engaging mainly with others who share the same language and culture. This can restrict chances to make friends and to benefit from the exchange of regular information which generally supports assimilation to UK culture. Equally, host communities and services should be actively supported to

foster integration through shared community events, the celebration of cultures and positive neighbourliness.

Having a safe and suitable place to live is at the core of integration of housing, health, and social care. Being able to provide this within the context of a housing shortage has led to a range of housing options being utilised for settled accommodation beyond initial transitional arrangements, including host sponsorship, procured Ministry of Defence properties, private-sector tenancies, Aberdeen City Council and other social rented sector housing providers, and procured Home Office properties. The mismatch between available housing stock and the size of accommodation affects the resettled population, along with others on the mainstream waiting list. There is a shortage of single person accommodation as well as a need for larger properties to house UK Refugee Scheme and Afghan families.

Many citizens of Aberdeen face barriers accessing good quality, safe, sustainable, and affordable homes. Housing providers are facing increased demand for affordable housing alongside the rising costs of repairs and delivery of new build homes. To compound the challenges, the mental health needs of some citizens result in expensive repairs being necessary when properties are handed back, lengthening the time and resource required to re-let a property. New properties attract significant interest from prospective tenants, with some older homes proving harder to let.

Aberdeen City Council and its partner organisations must maximise the delivery of affordable and sustainable housing to ensure a sufficient supply of housing in the city, including wheelchair accessible homes and homes for those living with complex care needs. There is also a need to ensure sufficient investment in older properties. The varying and evolving needs of the citizens of Aberdeen need to be met through the delivery of person-centred approach which promotes independent living.

We also know that there are a range of ways in which housing can be modified to improve health outcomes for households, including improved energy efficiency and increasing the provision of affordable housing. Several factors make homes less comfortable, including limited indoor space and no access to private or shared outdoor space.

The IJB Strategic Plan has a key role in helping to ensure: -

- Our published Market Position Statements quantify and clearly articulate future demand for specialist provision housing to inform the Local Development Plan and the design of future housing infrastructure.
- People's homes, regardless of tenure, are adapted to meet their changing needs.

Neighbourhood and Environment

We know that where we live, where we work, and where we spend our time has an important influence on our health and wellbeing. The design, development and maintenance of a place is important in promoting good health and sustaining wellbeing for individuals, families, and communities.

For good health and wellbeing, people need to be able to access a green space within 300m of their home, and Aberdeen City Council has a key role in ensuring access to

greenspaces and woodland, and in protecting the quality of local blue spaces (water and river sides).

The natural environment, sustainability and climate change also do, and increasingly will, impact on life in the city. Direct effects associated with climate change include increased mortality and ill-health associated with excess heat and cold, and loss associated with flooding and damage to properties. Climate change is also likely to exacerbate inequalities associated with air pollution, access to greenspaces, fuel, and food poverty. We know, for example, that the number of children hospitalised due to asthma is increasing locally and is at odds with a declining national trend.

A survey of children and young people, aligned to the Place Standard Tool indicators, asked about the same 14 themes included in the Scottish Place Standard Tool. The themes with the highest proportion of 'Not Good' responses were facilities and services (35.2%), play and recreation (34.7%) and care and maintenance (33.7%) which shows that over a third of respondents chose these options as areas for improvement.

We know that place-based approaches can improve the quality of homes and neighbourhoods and support the health and wellbeing of communities. Quality placemaking has been at the core of planning in Aberdeen for a number of years. All developments must ensure high standards of design, with biodiverse open space, sustainable transport options and a distinctive sense of place. We will involve local people in decision making about the places that they live in to allow us to shape communities in a way that people want.

The IJB Strategic Plan has a key role in helping to ensure: -

- The need for green and age friendly spaces together with good air quality continues to be highlighted.
- People are encouraged to make best use of the green space available to improve their physical and mental health.

Health and Social Care (Children and Young People)

Giving every child the best start in life and ensuring they are supported as they grow into adults is essential in creating good population health and wellbeing throughout life. Children who are born into families impacted by deprivation may be at a higher risk of suffering from health inequalities.

Challenges exist during the period from before birth to the start of school, including maternal drug and alcohol use, and smoking at the beginning of pregnancy which remains around 1 in 8 pregnancies. Premature births in Aberdeen are similar to the levels seen in Scotland and overall, 85% of children are born at a healthy weight. Rates of pre-school

immunisation by 24 months remain below the national target. In some communities, particularly those in the most deprived areas of the city, accessing a GP can be more challenging.

As for many other issues, the physical health of school age children, including healthy weight, physical activity, oral health, and early pregnancies varies across communities. Outcomes are largely determined by levels of deprivation with those in the most deprived areas experiencing the poorest outcomes.

Variation is also clear in the self-reported mental health and wellbeing of school-age children. Of primary 6 and 7 pupils surveyed, whilst, on the whole they feel that they are healthy and that this is improving, affluence within the family is clearly a factor, as the more affluent the family, the more likely the child reported being healthy and self-confident.

A growing number of unaccompanied asylum-seeking children are making Aberdeen their home. We know that some groups are more likely to experience childhood adversity including those from ethnic minorities, those with a disability, and those who are care experienced. The health outcomes for these groups remain persistently below those of their peers.

The IJB Strategic Plan has a key role in helping to ensure: -

- the number of women who are smoking in pregnancy decreases
- the uptake of childhood immunisations improves
- an agreed muti-agency Action Plan on Obesity is published
- the activity to develop a General Practice Estates Plan as part of the delivery of the Vision for General practice in Grampian continues.

Health and Social Care (Adults)

For both women and men, healthy life expectancy is declining in the city. People living in more deprived areas have shorter lives and are more likely to live with poorer health for longer. It has been suggested that people in deprived communities will have died before those in more affluent areas have started to experience symptoms of poor health. 1 in 4 adults describe themselves as having a limiting, long-term illness.

As we get older, we tend to need more health and social care support, and the support of dependants to help us manage long-term conditions or diseases. There is a rising number of adults choosing not to have children, and this is likely to impact support networks in the longer term. Preventing disease progression and encouraging the adoption of healthier behaviours are important elements for improving health outcomes.

Over half of the deaths in Aberdeen City in 2022 were associated with cancers and circulatory diseases, for which smoking, obesity, and physical inactivity are risks. It is clear that there is still work to be done promoting healthier lifestyles and this will be progressed through our Stretch Outcome 10 projects in the Local Outcome Improvement Plan supporting healthy eating behaviours, improving the uptake of cancer screening and decreasing the number of women who are smoking in pregnancy.

The rates at which people are being admitted to hospital due to alcohol and the rate of alcohol-related deaths remain a concern, however, the drug-related death rate has increased substantially. Continuing to reduce the serious consequences of alcohol and drug use remains a priority which will result in improved health outcomes for those affected, meaning that we now need to look far more holistically at how best to support our citizens to overcome the many different challenges they face by taking a family centric approach to the delivery of services.

Data suggests that more people are being prescribed drugs for anxiety and depression than ten years ago, and the rate of prescribing increases in the most deprived areas which requires a more targeted response such as that offered by the Family Support Model. The rate of people being in hospital for mental illness has fallen. Deaths from suicides have risen and the effects of the cost-of-living crisis suggest that mental health and wellbeing may further deteriorate in the near future. Also, a focus of Stretch Outcome 10 projects in the Local Outcome Improvement Plan is reducing the 5-year rolling average number of suicides in Aberdeen. Early intervention is also a focus, addressing, for example, the number of people feeling socially isolated in our communities through our Public Health and Wellbeing Teams promoting healthy lifestyles and delivering a Stay Well Stay Connected programme of events designed to encourage physical activity and better dietary choices as well as improving digital skills and social connections.

The IJB Strategic Plan has a key role in helping to ensure: -

A focus is retained on improving healthy life expectancy through delivery of the projects under Stretch Outcome 10 in the Local Outcome Improvement Plan in relation to suicide prevention, the Stay Well Stay Connected programme, supporting healthy eating behaviours, improving the uptake of cancer screening and decreasing the number of women who are smoking in pregnancy

The problems facing our citizens

Those who experience the most disadvantage, tend to experience challenges across a range of social determinants. It is important that our Strategic Plan takes account of the complexity faced by some individuals and families across the city, as increasing complexity of needs tends to result in even poorer health outcomes.

To support the development of the Strategic Plan, a range of personas, based on the known needs of some of our citizens with the most complex needs, have been considered. The actions we deliver will take cognisance of these and endeavour to make a positive difference to lives.

Name: Amara

Frail person

> I want to live as independently as I can.

About Amara

- Amara, 83, is a retired widow who lives in sheltered housing and relies on her state pension and benefits for income.
- Her three children and two grandchildren live nearby and help her with transport and shopping now that she is too frail to use public transport.
- She lives independently within sheltered housing, socialising with neighbours, and has no need of any social care. She has a tablet and smartphone but relies on her family to help her with these technologies.
- She would like to be able to use them independently to find out what other benefits she may be entitled to and to interact with services but is underconfident.

What does Amara need?

- Support to use and understand digital technology.
- Access to groups of likeminded people with similar aspirations.
- Proactive communication from authorities on what support is available to her.

What is Amara feeling?

- Like a burden to her family because she relies on their help.
- Underconfident about her abilities to navigate digital services.
- Concern about being a victim of online fraud.
- Hopeful of being able to enhance her skills and to live as independently as she can for as long as possible.

Name: Alesha

Mother of large family

> I want my children to have their own space to help their development and comfort.

About Alesha

- Alesha, 41, is a mother of six children aged between 1 and 15. She lives in a 3 bedroom property with her partner, all six children and the family dog. Alesha does not work but her partner works full time.
- Her sister provides additional support to the family. Her oldest child is considering getting her own tenancy next year. Her second oldest child is struggling at school and is getting involved in anti-social behaviour. Her third oldest child has complex support needs and attends an Additional Support Needs Wing. Issues have also been flagged about her youngest child's development by the Health Visitor. All these issues are impacted by overcrowding within the family home.
- Her partner drinks heavily at the weekends and can be verbally and emotionally abusive leading to police intervention. Alesha suffers from chronic pain and is usually exhausted and often feels overwhelmed. She wishes to remain in her community near her sister and has applied for a larger property with the council and housing associations.

What does Alesha need?

- A larger tenancy with five bedrooms to provide enough space for the entire family.
- Effective pain management to be pain-free and able to care for her children.
- Ensuring her children have the support they need to do well in school.
- Access to specialist support for her child with additional support needs.
- Maintaining a good relationship with her partner and reducing stress within the family.
- Staying in the community to remain close to her sister and avoid disrupting her children's education.

What is Alesha feeling?

- Exhausted and overwhelmed due to her chronic back condition and the overall stress of managing a large family in an overcrowded home.
- Frustrated at the lack of housing options in her community.
- Anxious about her oldest child's desire to seek her own tenancy.
- Concerned that she could be perceived as a poor parent because of the various impacts her housing situation is having on her children's development.
- Frightened that if her housing situation is not resolved she will not be able to properly care for her children.

Name: Dave

Substance user

> I want to live somewhere I feel safe in my home and in the community.

About Dave

- Dave, 52, has used substances for a long time and is unemployed and lives in a flat. People regularly come into his flat to steal money and food and he doesn't sleep well due to being scared.
- He was in care when younger because his parents had alcohol problems, and his father was violent.
- Dave used substances from a young age, but things escalated when he left a short spell in the army with a back injury. A recent leg amputation has meant Dave is confined to a wheelchair.
- He is having treatment for his substance use but still uses substances and has overdosed in the past. His lack of mobility has increased his social isolation and his interest and ability in his self-care is declining.
- He has difficulty reading and understanding technology. He has a sister and nephew who he would like to reconnect with.

What does Dave need?

- Support to move around his flat more easily.
- A safe living environment and access to some outdoor space where he can feel secure and comfortable.
- Support to feel more confident and less scared when he is outside.
- To engage in recreational activities that he enjoys and can help improve his quality of life.
- To establish social connections and reconnect with his family. Assistance with managing his money.
- To improve his physical fitness. To continue his treatment for substance abuse.

What is Dave feeling?

- Isolation and loneliness due to his lack of mobility.
- Fear and anxiety because people come into his flat to steal.
- Frustration due to his lack of reading ability and understanding of technology.
- Lack of self-worth due to mobility issues and substance abuse.

Name: Frank

Complex Mental Health

> I don't want to live in this service. I want to be supported in the community.

About Frank

- Frank, 35, has lived in a residential facility to support him with his long-term complex mental health problems, having previously spent time as a hospital inpatient.
- The shared housing, living with others with mental health problems is causing Frank difficulties. He finds the home noisy and is unhappy at sharing his living space with people he doesn't like.
- His parents have seen a deterioration in his presentation and wellbeing as a result of his living conditions.
- The staff at the facility have also expressed concerns and, although they provide support for his health and independence, this support is not consistently applied due to frequent changes in staff.
- His parents fear he will be admitted to hospital again if his living conditions do not change.

What does Frank need?

- A living space that is quieter and feels like home, where he can choose his housemates and be closer to his family.
- Access to support within the community rather than hospital-based care.
- Consistency of support from healthcare team.
- Opportunities to make more friends to enhance his social life.
- Access to hobbies and interests that support his mental health.
- An effective and clear recovery plan is essential for Frank to manage his condition.

What is Frank feeling?

- Frustration and anger due to the lack of suitable accommodation and services that meet his needs locally and the long wait time for a more suitable environment.
- Anxiety and worry about the possibility of being detained in the hospital if his situation reaches a crisis point.
- Unhappiness with his current noisy living environment and sharing space with people he wouldn't choose to live with.
- Fear that the frequent staff changes, and inconsistent support may lead to his behaviour making the placement unsustainable, potentially resulting in another hospital admission.
- Desire for independence and connection to live independently in a quieter, homely environment close to his family, where he can access community support and engage in hobbies that support his mental health.

Name: Nicola

Recovering substance user/unemployed

> I just want a safe and secure home so I can care for my children again and get my life back on track.

About Nicola

- Nicola, 42, is an unemployed mother of three in receipt of benefits. She and her children's father have a history of substance use and domestic violence. Her children were placed in kinship care after her imprisonment. She was given temporary accommodation on her release from prison but found it unsuitable because of the presence of substance users nearby.
- She has been living off and on with her partner but has reported being a victim of domestic violence five times. Efforts to support her are difficult because she doesn't stay in touch regularly and doesn't trust the authorities.
- After she was released from prison, she found the temporary accommodation was not suitable for her because of those around her using substances. Since then, she has lived with her partner but has reported domestic violence five times. She does not trust those in authority which is hindering the support that is offered to her.

What does Nicola need?

- Assistance in understanding her housing options and accessing available support to build a home for herself and her children.
- Someone reliable to help her navigate her housing options and support systems.
- Regular contact with her children.
- A safe and secure place to live away from her ex-partner.
- Support to reduce her substance use and the risk of reoffending.
- Support to ensure she is no longer a victim of domestic violence.

What is Nicola feeling?

- Distrustful of the authorities due to her children being placed in care and being provided with accommodation that she felt was unsuitable for recovering substance users.
- Threatened by her abusive ex-partner who is always able to find her due to shared acquaintances.
- Hopeful that securing a 3-bedroom house will improve her chances of having her children returned to her care.

Name: Lena

Expectant first-time mother

> I want to give my baby the safe and comfortable childhood I never had.

About Lena

- Lena, 19, is a part-time shop assistant who is expecting her first child. The father of her child is in prison, and she doesn't plan to get back together with him when is released.
- She currently lives with her cat in a privately rented bedsit in an area plagued by anti-social behaviour and drug supply and use.
- Her accommodation is small and damp with no access to an outside area to enjoy.
- She was neglected as a child, spent most of her childhood in foster care and didn't do well in school. Her foster carers are a big support for her. She suffers from bouts of anxiety and depression.
- She has applied for a council house because her current accommodation is not a safe or comfortable environment for a mother and baby.

What does Lena need?

- A stable and safe living environment, with access to an outside space for her child and ideally near to her foster carers.
- To give her baby the happy childhood she didn't experience.
- Advice on childcare and benefits.
- To live in a community with other young mothers.
- To develop her employment opportunities.

What is Lena feeling?

- Anxiety and uncertainty about her current living situation not being resolved before the birth of her child.
- Frustration and helplessness because she feels her housing application is not being taken seriously.
- Desire to provide a safe and loving home for her child.
- Desire to develop herself socially and professionally.

Name: Lillia

Refugee mother with large extended family

> I need help caring for all my relatives.

About Lillia

- Lillia, 32, she is a stay-at-home single mother living in a 2-bedroom council flat with her two sons. Nearby, her parents live in another 2-bedroom council house with her younger sister, while her grandfather lives in a 1-bedroom adapted bungalow.
- The family all arrived in Aberdeen in 2022 as refugees from Ukraine and were homed in temporary accommodation before getting secure tenancies.
- Lillia is estranged from the fathers of her children and receives no financial contribution from them. She used to work part-time but gave that up on the birth of her youngest child.
- Her father is being treated for a terminal illness and is in poor mental and physical health and cannot work. Her mother works part-time, and her sister is a student. Her grandfather is in poor physical health and socially isolated due to mobility and lack of English, requiring round the clock company from the family for her wellbeing.
- Her parents' home has a mould issue affecting their physical and mental health. Lillia is the only member of her family who speaks English, which adds to her feelings of stress and responsibility for her extended family.

What does Lillia need?

- Access to timely and effective healthcare for her father.
- Support to ensure her grandfather, can live pain-free and maintain as much independence as possible.
- A safe and healthy living environment for all her family members in close proximity to each other.
- Access to opportunities for her children to prosper and live a normal life.
- Emotional and practical support, including assistance with caregiving duties and help with managing the household.

What is Lillia feeling?

- Stress and anxiety due to her multiple caregiving responsibilities and the health issues affecting her family.
- Determination and resilience to do everything she can for her family.
- Frustration with the healthcare system in the UK, particularly the long waiting times for her father's treatment.
- Frustration with the unresolved mould issues in her parents' home, which are affecting their physical and mental health.
- Overwhelmed with her role as the primary caregiver and the only English speaker in the family.

Name: Baran

Asylum refugee

> I am determined to build a better life for my family and myself in Aberdeen.

About Baran

- Baran, 24, is an asylum seeker from Sudan living alone in a council bedsit, having spent a year in an asylum hotel.
- His wife is still in Sudan and due to communication problems there, they only manage to talk once a month. His parents and two siblings are also still in Sudan.
- He previously worked as a mechanic and wishes to explore opportunities to do the same in Aberdeen. He is taking online English classes while he waits for a place on a language course at an Aberdeen College.
- He is currently still learning about his rights and responsibilities and needs support to manage his tenancy, finances and understanding the laws to keep himself safe and protected.

What does Baran need?

- To reunite with his wife and his family and build a positive life together in the UK.
- Continued support in studying English.
- Opportunities to pursue a career as a car mechanic in Aberdeen.
- Assistance in becoming independent and confident in living in the UK.

What is Baran feeling?

- Frustration at the long waiting times for English classes, which are essential for his integration and career aspirations.
- Longing and sadness as he is separated from his wife and family, with limited communication opportunities.
- Loneliness and isolation as he navigates his new life in Aberdeen on his own.

Name: Margaret

Elderly person who will soon need care

> I love my home because it's full of memories, but I'm finding it harder to keep it clean and tidy.

About Margaret

- Margaret, 78, lives alone in a bungalow. Her husband died seven years ago. She has a son and grandson who live in England.
- Margaret struggles with household chores because of her mobility issues, frequent infections, and weight problems.
- She needs to visit her GP regularly. Her friends have noticed she is not coping well at home.
- Her kitchen is often untidy, and there is an unpleasant smell because she has trouble getting to the toilet on time.
- This discourages visitors, and she feels lonely. She orders groceries online and buys easy-to-make ready meals.

What does Margaret need?

- Support to lose weight, which would help her become more mobile and better able to manage her household chores and personal hygiene.
- To improve her knowledge about nutritious foods to make healthier choices and reduce the frequency of infections.
- To Increase her levels of physical activity to enhance her overall health and mobility.
- To be part of a community group to reduce her loneliness and provide social interaction.
- Assistance with household chores.
- To be able to get on the train to visit her family, which would require improved mobility and confidence in traveling.

What is Margaret feeling?

- Lonely and isolated.
- Frustrated and overwhelmed because she is aware that she is not coping as well as she used to.
- Embarrassed that the state of her home is discouraging visitors.
- Frustrated by her financial constraints, as she relies on a state pension and has little savings, making it challenging to buy nutritious food.
- Motivated to improve her health so she can be more mobile and better able to cope on her own.

Name: Sarah

Unpaid carer

> I need an accessible home that can accommodate my daughter's needs, within a community that has support for people with learning disabilities.

About Sarah

- Sarah, 41, is a single parent working 30 hours a week as a supervisor in a supermarket.
- She has a 16-year-old daughter with a learning disability who needs support with communication, mobility, personal care, and eating. Sarah receives help from paid carers and her sister and mother.
- Her sister's availability will soon decrease, and her mother is being assessed for dementia, meaning she may no longer be able to support Sarah, and may need support herself at some point in the future.
- Sarah relies on her smartphone for communication. She has a driving licence but relies on public transport to get around the city.

What does Sarah need?

- To maintain her flexible working hours and income.
- To ensure her daughter's health and wellbeing and develop her independent living skills.
- To undertake the guardianship process for her daughter and make decisions on her behalf as she transitions to adulthood.
- To find supportive groups for her daughter and improve her daughter's communication abilities.
- To secure alternative care for her daughter and develop a contingency plan for emergencies.
- To increase her savings for a suitable vehicle.

What is Sarah feeling?

- Concern that the support network provided by her mother and sister will be reduced.
- Concern that she may now be required to support her mother should she be diagnosed with dementia.
- Frustration at the lack of support for single parents whose children have additional support needs.
- Frustration that there is a lack of groups and activities that could support her daughter's wellbeing.
- Frustration at the lack of continuity in the people providing paid-for care.
- Frustration at the complex nature of healthcare and guardianship processes.
- Anxiety about everything she must have in place for the care of her daughter.

It is clear that there are key and recurring vulnerabilities that our policies need to take account of. These include those who are:

- Care experienced.
- Living with a disability.
- Older and frail.
- Living in single parent households.
- Socially isolated, particularly as a result of a long-term health condition.
- Experiencing, or have experienced domestic violence.
- Substance users.
- In need of long-term support for their mental health.
- Fearful as a result of repeated anti-social behaviour.
- Released from prison.
- Fleeing conflict.
- Living with trauma, particularly those who seek refuge in the city.
- Experiencing financial vulnerability.

The IJB Strategic Plan has a key role in: -

- Ensuring that those most at risk of poorer outcomes (the groups identified above) are prioritised for the health and social care support they need to be well.
- Ensuring that the Stay Well Stay Connected programme (working alongside the Aberdeen City Council Future Libraries Model) helps to address the social isolation felt by Amara, Dave, Frank, Baran and Margaret and encourages the healthy behaviours they are keen to realise, along with the development of digital skills for Amara, Dave and Frank.
- Ensuring that Alesha gets support for her chronic pain, Dave gets help with his mobility and his substance use, and Lillia's father and grandfather get support for their respective health conditions
- Working with partners to provide Frank with alternative living arrangements that still meet his needs as soon as possible ensuring that we keep him informed of progress.
- Improving information about the health and social care services and community groups available and how to access them so people like Amara can be more proactive and self-sufficient in meeting their own needs.
- As far as possible ensuring consistency of care, putting people at the centre and adopting a Getting it Right for Everyone (GIRFE) and Human Learning systems (HLS) approach for people like Frank.
- Ensuring Nicola gets support for her substance use and domestic abuse but also support from Justice Social Work to prevent re-offending.
- Ensuring Lena continues to receive appropriate antenatal care and then support from a Health Visitor when her baby is born.
- Ensuring that all those like Amara's family, Lillia and Sarah are aware of their rights as carers and of the support available to them through the Aberdeen City Carers Strategy and that where relevant and Adult Carers Support Plan
- Ensuring Sarah gets support to apply for Guardianship and to start planning for the transition of her daughter from children's to adults services.

Our Vision and Values

Our Vision is to **'empower communities to achieve fulfilling and healthy lives'**.

Our values represent what is important to us as we go about delivering their Vision. Our values are:

Honesty	We will be honest in our communications and interactions.
Empathy	We will understand citizens' needs, listen to their views, and involve them in decision making.
Respect	We will respect the views and the rights of Aberdeen's citizens.
Equity	We will provide services that have equity of access for all and address negative impacts of inequality.

We are HERE for the people of Aberdeen.

Our Challenge and Response

The analysis within our Evidence Document and exploration of the social determinants of health within the introduction to this plan led to the following statements in relation to the key challenges we have and the action we need to take to deliver our Vision.

Our Key Challenge - Our demand is predicted to increase through a combination of an ageing population and a higher burden of disease. The resource we have available to us is not enough to continue to deliver the current level of service. There is evidence of a growing divergence in outcomes between those citizens who live in more affluent areas of the city to those who live in areas of deprivation.

Our Response - We need to take action to reduce the predicted demand. We must transform the way we deliver some services so we can maximise the resources we have. We will need to stop some services and reduce the level of service we provide. We need to take steps to improve equity of access to care and support to ensure better outcomes for people living in areas of greater deprivation.

Our Strategic Aims and Priorities

To deliver our action statement, we have identified two Strategic Aims:

- Shift our focus towards Prevention and Early Intervention.
- Modernise our approach to service delivery

To deliver our Strategic Aims, we have developed a set of interventions identified as Strategic Priorities. Again, these have been informed by the findings of our Evidence Document and the exploration of the social determinants of health. Below is a description of the priorities and the types of activity that will be undertaken to deliver on them. More detail of the activity will be contained in the Annual Delivery Plans that we develop to support the delivery of this Strategic Plan. The detail will include performance targets and measurements of success.

Aim 1. Shift our Focus towards Prevention and Early Intervention

Why is this aim a priority for us/what does the evidence say

Shifting our focus towards prevention and early intervention is important as not only will this improve the health and wellbeing of the population, it will also reduce the need for support from mainstream health and social care services. Our Evidence Document indicated that demand for our services was increasing whilst our capacity was reducing so a healthier population will reduce the demand on services and enable us to continue to protect frontline services for those who need them most.

Our vision is that people can achieve fulfilling healthy lives reducing the need for them to access health and social care. Being active and connected to your community can improve both physical and mental health. Wellbeing at its simplest level is about feeling good and living safely and healthily. Everything we do, think, feel and believe influences our wellbeing. Making positive lifestyle choices can really help to improve overall health and wellness. A key enabler is a focus on prevention of the risk factors that can adversely impact health. Some people are genetically predisposed to certain conditions but awareness of that can help them take preventative measures to either avoid ill health or at least mitigate the adverse impacts of it. Some conditions are brought on by lifestyle factors or choices and some early intervention or preventive action can minimise or even reverse the impact of these.

The National Records of Scotland forecast that the older population in Aberdeen City will grow over the next few years so that 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. 28% of people living in Aberdeen City report that they are living with limiting, long term conditions whilst 11% report living with non-limiting conditions. The Scottish Burden of Disease study forecasts a 21% increase in the annual disease burden in Scotland over the next 20 years. Applied to the local context this would mean potentially an additional 6% of people living in Aberdeen City reporting limiting, long term conditions.

The healthy life expectancy of a male living in Aberdeen City is 60.2 years whilst for a female it is 61.4. Taking life expectancy into account this means a male in Aberdeen City could have 16.7 years of their life when they are not healthy, and for a female that could be 19.6 years. We would like to see these figures improve and we aim to work with people to help them consider what steps they can take to improve their health in the longer term.

One of the two priority areas of the population Health Framework for Scotland is to improve prevention within planning, budgets and accountability. The Future Generations Commissioner for Wales has published a Maturity Matrix for the implementation of the Well-being of Future Generations Act one of the key elements referred to is recognising the long term value of the different forms and levels of prevention and early intervention including really understanding the root causes of current and future issues and of what needs to be prevented.

The deprivation section of the Evidence document clarifies that outcomes for people living in the most deprived areas in Aberdeen City are poorer than for those in the least deprived. Estimated life expectancy is 10 years less for males living in the least deprived and that gap is increasing. Alcohol and drugs related hospital admissions and deaths, psychiatric patient hospitalisation, probably suicide rates, cancer registrations and early deaths from cancer, hospitalisations for coronary heart disease and Chronic Obstructive Pulmonary Disease (COPD), and levels of obesity, are all higher in the most deprived areas.

What will we do to deliver this aim?

We have two priorities under this aim: -

Priority A. Improve Physical and Mental Health – activity includes: -

- improving the uptake of cancer screening to help achieve an early diagnosis and therefore improve the prospects of a good outcome.
- encouraging the uptake of immunisations which help protect against disease.
- continue to deliver, and in conjunction with Aberdeen city future Libraries Model, build on our Stay Well Stay Connected Programme which aims to promote social engagement; increase the quality of time spent with others; develop friendships and meaningful relationships; maintain sensory awareness and the ability to encourage communication and self-expression; promote a sense of feeling cared for and caring for; and to promote a sense of self-worth and a sense of value and importance.
- the development and publication of three multi-agency Action Plans in relation to Obesity, Public Mental Health and Ageing Well.

Priority B. Reduce Harm – activity under this priority includes: -

- decreasing smoking in pregnancy,
- reducing vaping in young people,
- reducing the harm caused by the use of alcohol and drugs
- delivering our Suicide Prevention Strategy.
- ensuring the homes of those with disabilities, where appropriate, are adapted to suit their needs

What outcomes do we hope to achieve?

Key outcomes we hope to achieve by delivering this aim include improved longer term health and wellbeing outcomes for the population and reduced demand for health and social care services. Our Annual Delivery Plans will contain greater detail in relation to the targets and measures we will use to determine achievement of these outcomes.

Aim 2. Modernise our Approach to Service Delivery

Why is this aim a priority for us/what does the evidence say

Modernising our approach to service delivery is important as we have a short-term imperative to manage our budget and to reduce costs. The 2025/26 budget position is indicating that savings to the value of £14.354m need to be achieved. Budget Savings Options have been identified and need to be delivered in year to balance the budget. These options in the main are looking at the way we currently do things and redesigning that to enable us to become more efficient and to reduce our costs.

One way of achieving efficiency is to explore opportunities for collaboration with partners, making better use of the sum total of resources available in Aberdeen City as a whole. This could mean sharing buildings or identifying areas where there is duplication or overlap of service delivery and determining a more joined up way of doing things. Around 60% of our total budget is spent on commissioning social care services and we have a number of Market Position Statements that help highlight our future needs in this area. It is important that the Market Position Statements are kept under review to ensure the information contained within them is as accurate as possible in order to help shape future service delivery. Also, it is crucial that we work closely with the commissioned service providers to understand their cost base and ensure we are getting value for money. Unpaid carers are a vital part of the health and care system providing support that would otherwise translate as demand on our mainstream services. Their value was recognised by the introduction of the Carers (Scotland) Act in 2018, and we articulate our commitment to continuing to support our unpaid carers through our Carers Strategy and associated Action Plan.

The Medium-Term Financial Framework (MTFF) recognises the growing demand for health and social care services where resources available to meet that demand are not increasing at the same rate whilst continuing to deliver support to the people who need it most. We therefore need to also plan for longer term, more transformative activity which look to bring even greater efficiency to the delivery of health and care services with the ambition to start developing savings for 2026/27 and beyond.

Technology can release capacity which helps support our drive for improving outcomes and achieving efficiencies. Another way to improve outcomes for people and make best use of resources is to work with patients and clients, hearing their voices and putting their existing relationships and their personal choice at the centre of decision making. The Grampian Hope Approach unifies a number of person centred initiatives - Getting it Right for Everyone (GIRFE), Putting People First,

Trauma Informed Practice, Human Learning systems, Self Directed Support and Realistic Medicine to consistently provide support to help people live their best lives considering a person's existing life and community, improving their knowledge to inform decision making, focusing on their strengths and supporting them to make the right choices in their care. We will embed this approach in our practice within Aberdeen City and as part of this we will undertake a self-evaluation and implement the relevant improvements from the Self Directed Support Improvement Plan.

Primary Care is a key area of focus for transformation and we will continue to deliver the Vision for General Practice as well as refreshing the Primary Care Improvement Plan.

As described in Priority A, during 2025/26 we will be identifying specific service areas where updating the way we do things or transformation is required. Part of that will be gaining a better understanding of our current service delivery and identifying ways where we can better match the care and support that is provided to current and future need. As part of this we will also need to refresh our Workforce plan to ensure we clearly set out the capability and capacity we will require to meet current and future needs.

This aim will be our focus particularly in year one of the Strategic Plan although we will not complete all of the work in one year. Part of our focus will also be on developing plans to transform and achieve efficiency in specific areas of our service delivery in subsequent years. The detail of this will be contained in our annual Delivery Plans.

What will we do to deliver this aim?

We have two priorities under this aim: -

Priority A. Make Best use of Resources – activity within this priority will include: -

- deliver Budget Savings Options to balance the 2025/26 budget
- identify service specific efficiency plans for operating within budget for 2026/27 onwards
- collaborate with partners across the city to optimise joint working and reduce duplication
- review Market Position Statements to ensure future needs for services and infrastructure are highlighted, particularly the demand for specialist housing.
- work closely with partners and providers to plan for achieving efficiencies
- continue support for unpaid carers by delivering our Carers Strategy

Priority B. Transform Service Delivery –

- maximise the use of the latest technology in all service areas and progress the Digital Innovation Programme
- embed the Grampian Hope Approach in our practice in Aberdeen City
- deliver the Vision for General Practice in Grampian

- undertake a refresh of the Primary Care Improvement Plan to take cognisance of the current environment.
- match the care and support that is provided to current and future need.
- refresh our Workforce Plan to clearly set out the capability and capacity we will require to meet current and future needs.

What outcomes do we hope to achieve?

The key outcome we hope to achieve by delivering this aim is being able to continue to be able to deliver health and social care services to the people of Aberdeen City who need them most whilst achieving a balance budget in the short, medium and longer term this achieving a sustainable service offering for future generations.
The key measurable will be our financial performance however our Annual Delivery Plans will contain greater detail in relation to the targets and measures we will use to determine achievement.

Strategic Aims	
Shift our focus towards Prevention and Early Intervention	**Update our Approach to Service Delivery**
Strategic Priorities with examples of associated actions	
Improve Physical and Mental Health ➢ Improve uptake of cancer screening ➢ Improve uptake of immunisations ➢ Increase the number of people engaged with Stay Well Stay Connected ➢ Publish an agreed multi-agency Obesity Action Plan ➢ Publish an agreed multi-agency Public Mental Health Action Plan ➢ Publish an agreed multi-agency Ageing Well Action Plan	**Make best use of Resources** ➢ Deliver Budget Savings Options for 2025/26 ➢ Identify service specific efficiency plans for operating within budget for 2026/27 onwards ➢ Collaborate with partners across the City to optimise joint working and reduce duplication ➢ Review Market Position Statements to ensure future needs for services and infrastructure are highlighted particularly demand for specialist housing ➢ Work with partners and providers to plan for achieving efficiencies ➢ Continue support for unpaid carers by delivering our Carers Strategy
Reduce Harm ➢ Decrease smoking in pregnancy ➢ Reduce Vaping amongst young people ➢ Reduce harm caused by use of drugs and alcohol ➢ Deliver Suicide Prevention Strategy ➢ Ensure the homes of those with disabilities where appropriate are adapted to suit their needs	**Transform Service Delivery** ➢ Maximise the use of technology in all services areas and progress the Digital Innovation Programme. ➢ Embed the Grampian Hope Approach in our practice in Aberdeen City ➢ Deliver the Vision for Primary Care ➢ Refresh the Primary Care Improvement Plan ➢ Match care and support provision to current and future need ➢ Refresh Workforce Plan to clearly set out the capability and capacity we will require to meet current and future needs.

Delivering Our Strategy and Measuring Impact

Delivery Plan

We will develop annual Delivery Plans which detail how we intend to deliver on our Strategic Aims and Priorities. These will be reviewed annually which will enable us to respond to emerging risks, issues and opportunities.

Measuring Impact

To tell us whether we are delivering on our Strategic Aims, we will measure ourselves against the following indicators:

National Measures	LOIP Outcomes	Key Performance Indicators
National Indicators Ministerial Strategic Group (MSG) Indicators	*Relevant measures from LOIP*	*Local Performance measures that show we are delivering on key aspects of the Strategic Plan*
…	…	…

Assurance

We will continue to use a programme and project management approach to delivering our Strategic and Delivery Plans.

Progress will be reported monthly to our Senior Leadership Team, 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.