Aberdeen City Health & Social Care Partnership

Strategic Plan 2019-2022

ABERDEEN CITY COUNCIL

NHS Grampian

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Integration Principles.

The partnership is required to take into account the national integration principles when preparing the Strategic Plan.

These principles, stated below, clearly state that the main purpose of integrated services is to improve the wellbeing of our citizens and these services should be provided in a way in which, so far as possible:

- Is integrated from the point of view of recipients
- Takes account of the particular needs of different recipients
- Takes account of the particular needs of recipients from different parts of the area in which the service is being provided
- Takes account of the particular characteristics and circumstances of different service users
- Respects the rights of service users
- Takes account of the dignity of service users
- Takes account of the participation by service users in the community in which service users live
- Protects and improves the safety of service users
- Improves the quality of the service
- Is planned and led locally in a way which is engaged with the community (including in particular service users, those who look after service users and those who are involved in the provision of health or social care)
- Best anticipates needs and prevents them arising
- Makes the best use of the available facilities, people and other resources

Contents

Appendices.

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IJB Chair Foreword

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Chief Officer Foreword

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1. Introduction

1.1 This Strategic Plan outlines our continuing ambitions for those adult health and social care functions and services which are delegated by Aberdeen City Council (ACC) and NHS Grampian (NHSG) to the Aberdeen City Health & Social Care Partnership (ACHSCP).

It reflects the many conversations we have had with the people of Aberdeen and our professional colleagues across the health, social care, third, independent and housing sectors about the health and wellbeing of the local population across all adult age groups and what the partnership should be doing to promote and support this.

There are fundamental themes throughout this strategic plan that can be read as the Integration Joint Board's statement of intent and which are applicable to all our current activities and our future intentions. They include:

> Our focus will always be on improving, where possible, the health and wellbeing of our citizens, their experiences of using our services and the outcomes that result from this.
>
> We will develop integrated, multi-disciplinary, community-based services that will have an increased focus on early, preventative interventions. We want the formation of these teams to result in fewer avoidable hospital admissions, A&E attendances and care home admissions, and for them to be focused on the best interests and outcomes of individuals.
>
> We recognise the value of positive, enduring connections and relationships in addressing the hidden scourge of loneliness and isolation in our communities. which is the root cause of much of the increasing demand for our services.
>
> We will seek to reduce the health inequalities that exist in our city and we will focus on delivering the right care, support or treatment in the right place and at the right time for you.
>
> Improving the quality of all our services will underpin everything we do. We are committed to improving the personal experiences of everyone who uses our services and improving their personal outcomes.

We are determined to be recognised as a partnership that works closely with our staff, unpaid carers and our partner agencies in the third, independent and housing sectors to fulfil the vision and ambitions of this strategic plan. We remain ambitious to be seen as an employer of choice and one of the leading and innovative health and social care partnerships in Scotland.

This plan provides an overview of adult health and social care in Aberdeen and seeks to establish a shared understanding of our challenges and priorities. It provides a strategic framework of how we intend to deliver integrated health and social care services so that increasing complexity of needs and demands can be met more effectively within available resources. We will show how we hope to develop our community connections and activities to complement the care and support that is offered to enable people to live at home, or in a homely environment, for as long as is reasonably possible.

1.2 Our strategic vision and values underpin all of our activities, initiatives and suggested developments. We have revised these given comments made during our engagement activities but their essence remains the same.

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

Values: Caring, Person centred, Enabling

This vision and these values are relevant and applicable across the diversity and complexity of all the delegated functions across the health, social care, third, independent and housing sectors.

1.3 Our overall health profile is better than the Scottish national average however we know that within the city, there are significant differences in health and wellbeing, with some communities reporting greater levels of health problems than others.

We want to deliver locally based services that have a positive impact on the health and wellbeing of all individuals, families, and communities. We want everyone to have seamless and positive experiences of using our services, no matter where and what these are.

Efficient and effective resource allocation to the right place at the right time will provide the means to address our future challenges and achieve our desired outcomes.

Our proposed strategic priorities for the next three years are:

Figure 1.1 ACHSCP Strategic Objectives

Our emphasis will always be on the health and wellbeing of the individual, the resilience and capacity of our communities to engage with and support its residents, investment in our carers and working collaboratively with all our partner organisations to develop flexible, high quality services that achieve positive outcomes.

Objective	What is this?	Priorities	Aligned National Outcomes
Right Care, Right Place, Right Time	Ensuring a personalised response to individual needs and circumstances that can adapt to complexity and occasional or enduring use.	Deliver high quality services that have a positive impact on personal experiences and outcomes.	**People** are able to look after and improve their own health and wellbeing and live in good health for longer. **People**, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community **People** who use health and social care services have positive experiences of those services and have their dignity respected **Health** and social care services are centred on helping to maintain or improve the quality of live of people who use those services **Health** and social care services contribute to reducing health inequalities **People** who provide unpaid care are supported to look after their own health and wellbeing including to reduce any negative impact of their caring role on their own health and wellbeing **People** using health and social care services are safe from harm **People** who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support care and treatment they provide **Resources** are used effectively and efficiently in the provision of health and social care services
Communities	We will work in and with our communities, recognising the valuable role that people have in supporting themselves to stay well and support each other when care is required.	Strengthen existing community assets and resources that can help local people with their health and wellbeing	
Resilience	Supporting people so that they are able to cope with and where possible overcome the adverse health and wellbeing challenges that they might face.	Promote and support self-management and independence for individuals.	
Prevention	We will work with our partners to achieve positive individual outcomes and lessen the need for further, possibly greater supports.	Contribute to a reduction in health inequalities. Value and support those who are unpaid carers to become equal partners in the planning and delivery of services, to look after their own health and to have a quality of life outside the caring role if so desired.	
Connections	Promote meaningful connections and relationships to counter isolation and loneliness	Develop a person-centred approach which enables our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community**.**	
EMPOWERED WORKFORCE INTEGRATED SERVICES DIGITAL TRANSFORMATION SUSTAINABLE FINANCE			

2. Our profile

The population of Aberdeen on 30th June 2017 was estimated to be **228,800** (4.2% of the total population of Scotland).

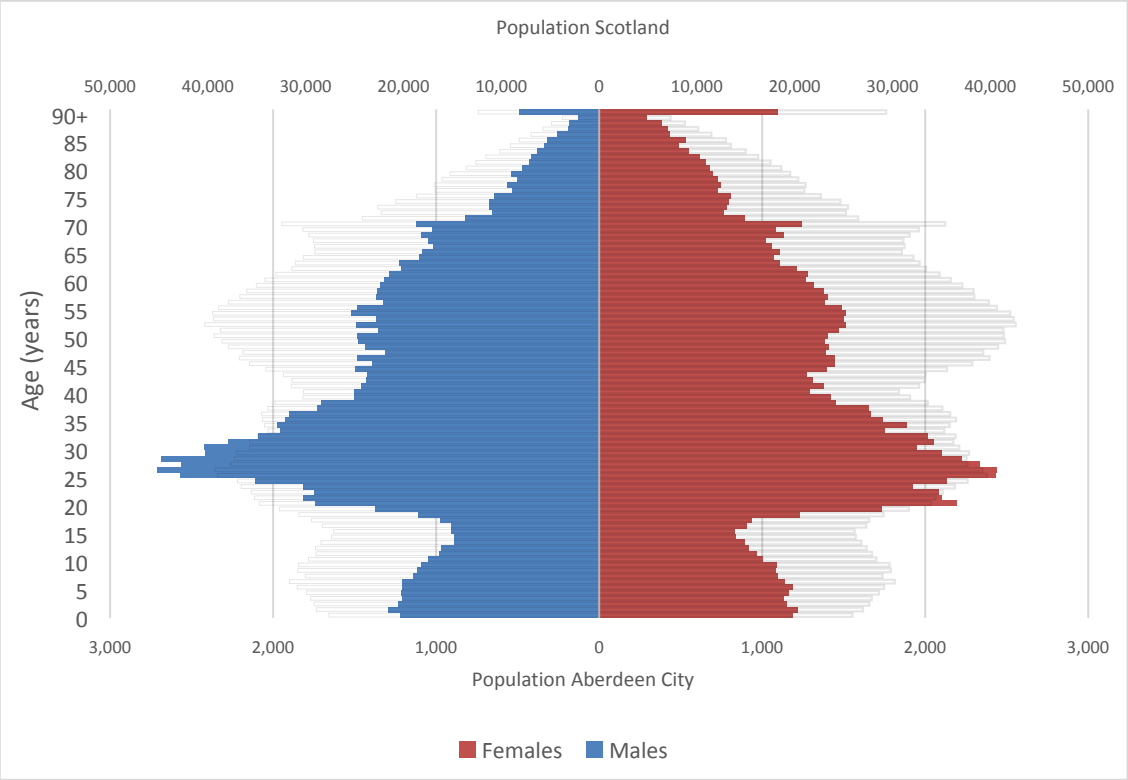
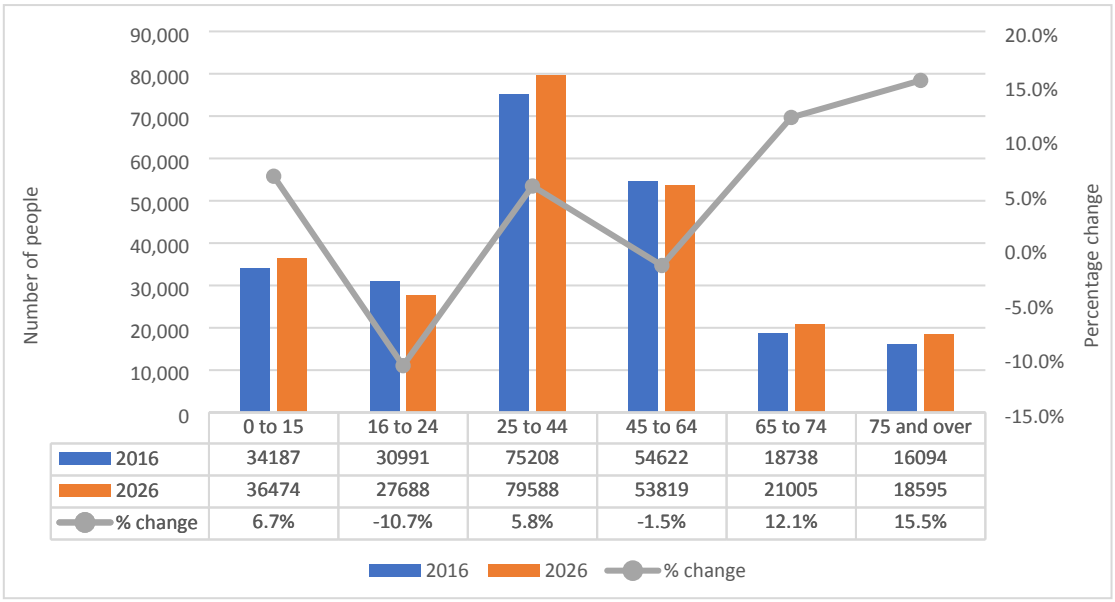


Figure 2.1 Population Pyramid, Aberdeen City and Scotland, 2017 (Source: National Records of Scotland, Mid-2017 Population Estimates, Scotland).



	0 to 15	16 to 24	25 to 44	45 to 64	65 to 74	75 and over
2016	34187	30991	75208	54622	18738	16094
2026	36474	27688	79588	53819	21005	18595
% change	6.7%	-10.7%	5.8%	-1.5%	12.1%	15.5%

Figure 2.2: Projected population change by age group, Aberdeen City, 2016-2026 (Source: National Records of Scotland, Population projections for Scottish Areas (2016-based).

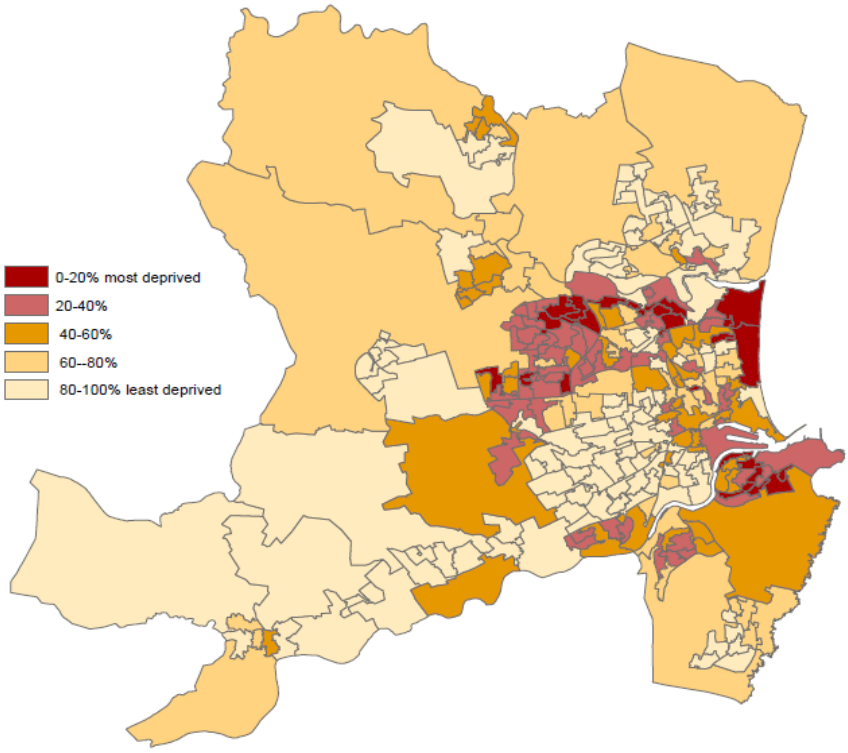


Figure 2.3 Level of deprivation by data zone, Aberdeen City, Scottish Index of Deprivation (SIMD) 2016 quintiles

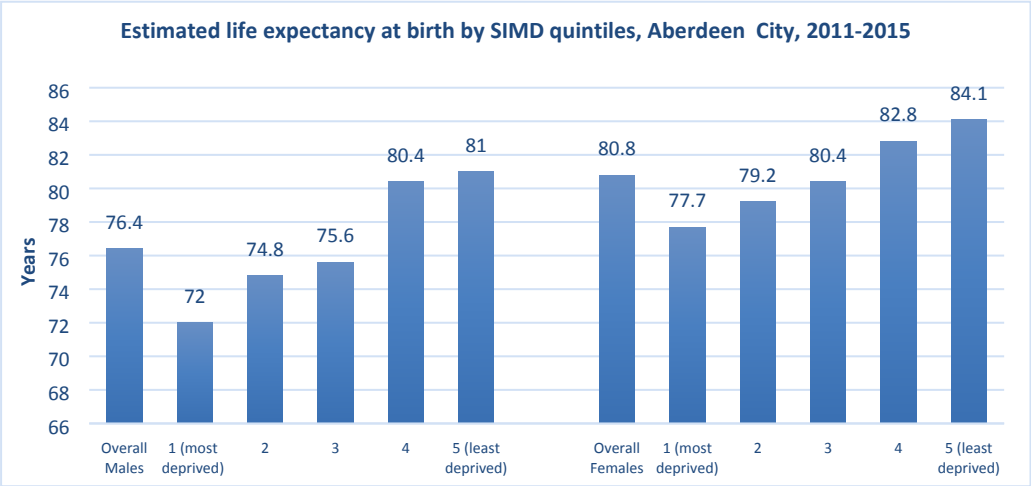
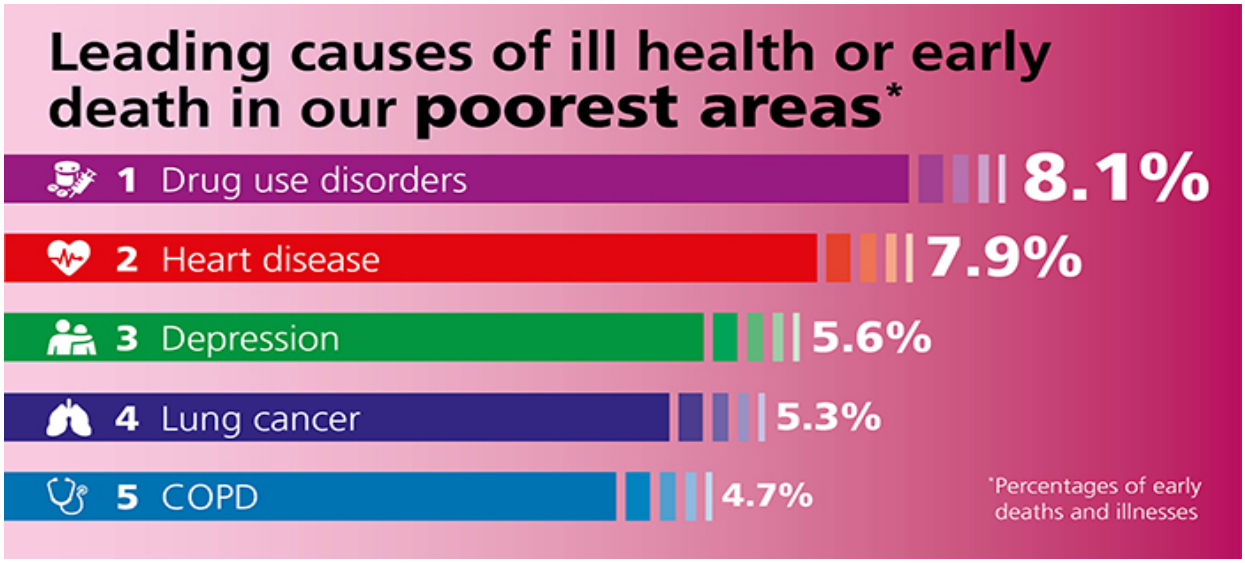


Figure 2.4 Estimated Life Expectancy at Birth by SIMD quintiles, Source: National Records of Scotland, Life Expectancy for Administrative areas within Scotland, 2014-2016



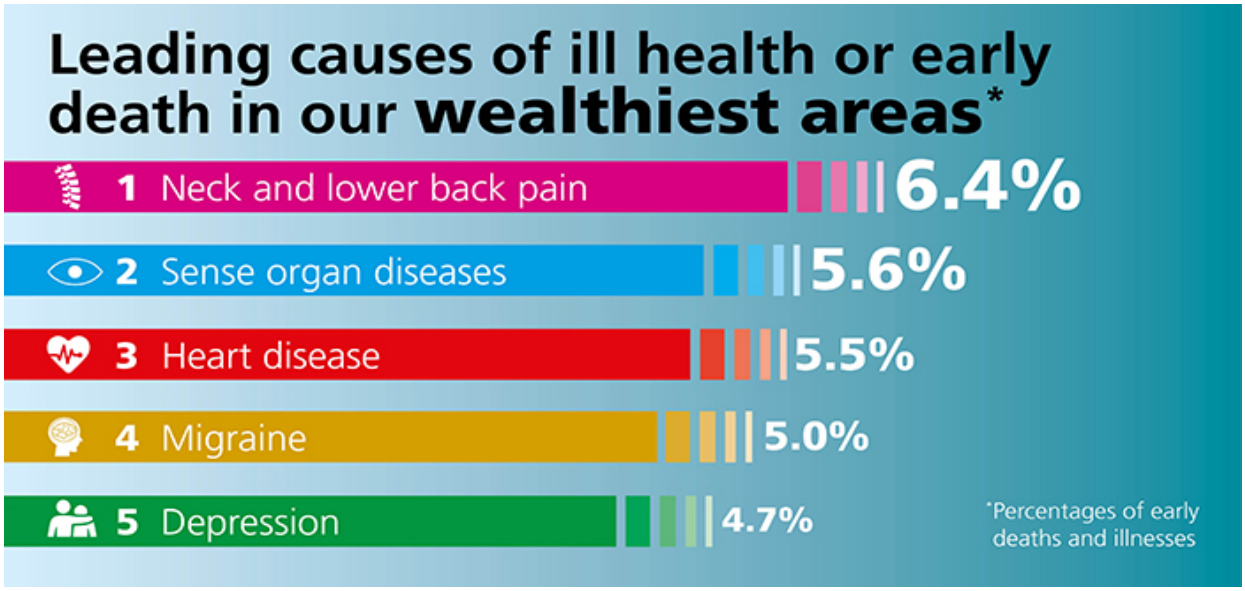


Figure 2.5 Leading Causes of Early Death in **Scotland's Poorest and Wealthiest Areas**. Source: SCOPHO

Aberdeen City	
Cause of Death	**%**
Cardiovascular Diseases	27.97
Cancer	27.03
Neurological Disorders	14.26
Chronic Respiratory Diseases	7.62
Diarrhoea…& other Infectious Diseases	5.21
Diabetes, blood & endocrine diseases	5.16
Digestive Diseases	2.98
Substance Use Disorders	2.14
Unintentional Injuries	1.98
Cirrhosis & other Liver Diseases	1.96

Table 2.5 Cause of Death (all ages) in Aberdeen. Source Scottish Public Health Observatory

3. Our strategic connections

The scope of our partnership's activities has been formally outlined in our Integration Scheme[1] and consists of services from the health, social care, third, independent and housing sectors which are all committed to providing high-quality integrated services to our citizens.

The ambitions and priorities of this plan are relevant across all of these sectors. The challenge that we accept is to make this plan a credible and meaningful document for many different people in different situations and circumstances across the city: the young adult living with autism; the person receiving palliative and end-of-life care; the frail, elderly person; the middle-aged man trying to cope with a number of physical and mental illnesses and health conditions; the woman living with mental illness; the man on his substance misuse recovery journey; the person with a sensory impairment; the woman with complex physical and learning disabilities and the unpaid carer.

A coherent and co-ordinated strategy will play a part in ensuring that people's experiences when they use our services match their expectations of compassionate, responsive and effective care, support or treatment.

3.1 A critical factor in the success of our ambitions and priorities will be the positive, supportive relationships that we continue to develop with our partner agencies, Aberdeen City Council and NHS Grampian.

Effective community planning arrangements will support us to deliver better services and achieve better outcomes for our citizens and communities. The Local Outcome Improvement Plan (LOIP) sets out a coherent, multi-agency vision to make Aberdeen a better place to live and work in. The actions set out in this Strategic Plan will make a significant contribution towards fulfilling the LOIP's **'Place'** and **'People'** objectives.

Similarly, a close alignment with the ambitions set out in NHS Grampian's Clinical Strategy (2016-2021) will ensure the delivery of improved experiences and outcomes to the people who use our services and their carers.

We recognise that working collaboratively with all of our community planning partners is a good and positive thing to do and we will be actively seeking to align our activities as best we can.

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1 http://www.aberdeencityhscp.scot/contentassets/47a823b8be3c4f26830d11200cb644a1/aberdeen-city--integration-scheme.pdf

3.2 There have been many strategic developments over the past few years to ensure that we have a consistent and coherent viewpoint of the health and wellbeing of our local population and the needs of the different client groups.

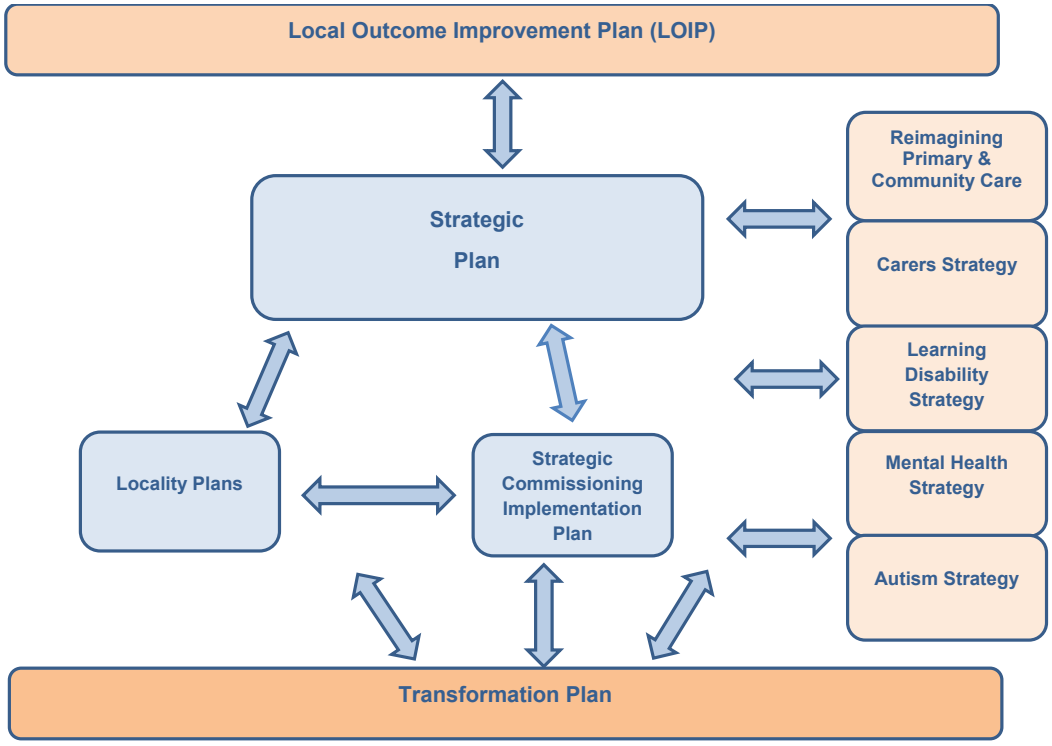

Figure 2.1 ACHSCP Strategic Portfolio

We have developed a significant strategic portfolio since integration 'Go Live' in 2016. Following the publication of this revised Strategic Plan we will take the opportunity to refresh each of these individual delivery plans to ensure there is a coherent alignment with the ambitions and priorities set out in this overarching plan.

The partnership's Strategic Commissioning Implementation Plan provides the required clarification and detail about some of our future commissioning intentions. Our proposals have focused on particular service areas which have the potential for significant, positive impacts on improving outcomes for the individuals who use our services and their families.

We will refresh our Implementation Plan in 2019 showing the key actions and activities that we will undertake or initiate to fulfil the ambitions and priorities set out in this plan.

3.3 Our approach to commissioning is one which views it as collaborative decision-making about how to achieve defined, agreed and jointly owned outcomes, generating a broader and more innovative range of options.

To achieve our vision of effective strategic commissioning, we will work towards embedding the following principles into our practice:

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

We are very aware that an individual's needs may and will vary over the course of time and so we will not adopt a uniform, one-size-fits-all commissioning approach but instead strive to be sensitive to age, wellbeing and complexity of need.

The commissioning of services will be one of the most important functions undertaken by the partnership as it seeks to ensure that all services enhance the quality of life for the individuals and their carers now and in the future. We recognise that it will be most effective if it is done in partnership with citizens, families, communities and other agencies that have an interest in the continued wellbeing of our local population.

3.4 In addition to the fully delegated functions and services, the IJB also has a strategic planning responsibility for the city-specific hosted services and certain acute sector services (Table 2.1).

Hosted	Acute
• Intermediate Care of the Elderly and Specialist Rehabilitation • Sexual Health • Acute Mental Health and Learning Disability (to be considered)	• Accident and Emergency • Inpatient hospital Services ▪ General medicine ▪ Geriatric medicine ▪ Rehabilitation medicine ▪ Respiratory medicine ▪ Palliative Care ▪ Mental Health ▪ Learning Disability

Table 3.1 ACHSCP Strategic Planning Service Responsibilities

Hosted services are those services which have a wider Grampian provision but are assigned to particular 'lead' IJBs for strategic planning and operational management purposes. This Strategic Plan applies to the hosted services above as we need to ensure that their model of care contributes towards our city-specific objectives and priorities. We are mindful though that the other Grampian IJBs also need that reassurance and so some joined up thinking is required to ensure clarity of understanding and transparent alignment of service activity with all applicable strategic objectives.

Similarly, strategic planning at an IJB level of those acute sector services is desirable because of the significant proportion of unscheduled care that these areas experience and the positive difference that partnerships can make towards this.

We will lead or support, as appropriate, the development of service delivery plans in these key areas.

3.5 Children's services are not formally within the scope of this Strategic Plan as they are not delegated by the local authority and health board to the Integration Joint Board. We are mindful however that there are many adults in poor physical and mental health, who may have housing difficulties, substance misuse challenges and impacted family relationships who can trace a line from their current experiences back to the adverse events they experienced as a child.

We are especially mindful that it is the first few years of pre-school life which is critical to a child's later development. We do not accept that there is an inevitability of life changes being negatively impacted and are open to collaborating with other partner agencies to address enduring, inter-generational family challenges.

Transition from childhood through adolescence to becoming an adult can be unsettling for many individuals and their families. Our approach to supporting transitions gives us the opportunity to demonstrate our partnership values in our professional practice and to show our commitment to preventative and anticipatory models of care. We recognise that early, positive and consistent collaborations with young adults, their families and existing supports and services will ease any transition anxieties that may be apparent and reduce the likelihood of harmful consequences to health and wellbeing.

The IJB has no ambition to oversee the delivery of integrated children's social care services but it recognises that better outcomes for the children and young people of this city will be achieved by the partnership working more collaboratively with Integrated Children's services and aligning our respective activities where possible, more fully.

3.6 The provision of good quality housing to support a range of needs will play a key role in achieving outcomes in relation to supporting people to be able to live, as far as is reasonably practicable, independently and at home:

- Increase housing supply to meet housing need and demand.
- Improve housing conditions in both the public and private sector.
- Ensure continued supply and access to affordable housing.
- Continue to provide information and advice to improve housing conditions in the private housing sector.
- Ensure there is a supply of particular needs housing of the right type to meet future requirements.
- Improve energy efficiency in both the public and private housing sectors and alleviate fuel poverty.

The Housing Contribution Statement (see Appendix Two) sets out the role of social housing providers in Aberdeen City to achieve outcomes for health and social care.

3.7 The alignment of our own ambitions and priorities with all of these other strategic points of reference will be a crucial factor in ensuring that the effectiveness of our proposed actions and initiatives in fulfilling personal, organisational and national outcomes.

4. Our approach

We recognise that if we want to be successful in the delivery of integrated health and social care services to improve the health and wellbeing of our local population we must actively identify and overcome any barriers to change that we come across.

Some of these barriers may include our own capacity to make the desired changes and a weariness or change fatigue on the part of some of our key stakeholders. We strongly believe that compassionate and collaborative leadership will be the key to breaking down engrained attitudes and entrenched working practices and unlocking our significant potential.

We believe that we are working from a good starting place given our successful integration 'Go Live' transition and the solid progress we have made since then. We recognise that we need to shift the change emphasis from top down to bottom up; engage routinely with our citizens about the integration of health and social care and their lived experiences and have a relentless focus on improved outcomes.

4.1 Right Care in the Right Place at the Right Time

Priorities:	Deliver high quality services that have a positive impact on personal experiences and outcomes.

We recognise the value of an asset-based approach to developing effective and sustainable models of care that focus on the health and wellbeing of our local population and communities.

This approach means services are tailored to the requirements of the individual rather than a 'one size fits all' approach so that people have access to the right care, support or treatment when they need them, in ways which are personalised, empowering and effective.

We want to move away from traditional 'Deficit' models that focus on identified problems which require professional interventions to resolve them, and which do not support the active involvement of local residents and communities. We recognise though, that moving away from these models will be a challenge as they are commonly used as the basis of our statutory interventions, but this will be necessary if we are to be successful in empowering and promoting independence, rather than continuing to reinforce dependence.

A key element of our personalised approach is the promotion and availability of 'self-directed support'. Self-directed support enables people to have more informed choice and flexibility over their care and support and provides the opportunity for more people to commission and control their own care through the use of individual budgets or direct payments.

The individuals who use our services and their carers will require consistent and accurate information that clearly, without the use of jargon, explains the options and opportunities that are available to them.

4.2 Investing in our Communities

Priorities: Strengthen existing community assets and resources that can help local people with their health and wellbeing

We want to promote and develop the resilience of our communities by increasing opportunities for the people who live in these communities to shape their own lives and take part in local decision making. This means that we:

- Start with the assets and resources in our communities and identify opportunities and strengths.
- See people as having something valuable to contribute and support them to develop their potential in adding social value to their communities.
- Focus on communities encouraging and adding social value at every opportunity

We cannot underestimate the significance of the role of localities in our partnership model. They are intended to be the engine room of integration, bringing together individuals, carers and professionals from the health, social care, third, independent and housing sectors to plan and help redesign services.

We have developed locality profiles that illustrate our understanding of the local communities including the health and wellbeing of the local population. These profiles map the available assets and resources and also highlight particular challenges.

We have used these profiles to inform the development of our Locality Plans. These plans recognise the variations in the health and wellbeing of the local population and propose tailored activities and initiatives to address these.

The decision to implement a four-locality model was taken in the pre-integration shadow year and was reflective of the significant considerations that were taken into account at that time. There is an opportunity for us to reflect on whether this model maximises the collaborations that are necessary across wider community planning arrangements including Integrated Children's services.

We will review our locality model and implement that one which best meets the needs of our citizens and communities.

4.3 Developing our Resilience

Priorities:	Promote and support self-management and independence for individuals.

As citizens, we must all take greater responsibility for our own health and wellbeing and in doing so be a part of the new solutions that we seek to develop. We will develop a stronger preventative emphasis to our activities and interventions to minimise the cumulative impact of an increasing population living with a number of long-term conditions.

Self-management means moving away from a model where individuals are passive recipients of care and treatment to a more collaborative relationship where they are active partners. To achieve this, it will be very beneficial for individuals to develop their knowledge, skills and confidence to make informed decisions and adapt their health-related behaviours. They need to have access to the necessary expertise to support them in making informed decisions, achieving their goals and overcoming barriers.

We need to spend less on some of the things we currently do and find different, and more efficient and effective ways of delivering services in the future. Many people with long term conditions make decisions, take actions and manage a broad range of factors that contribute to their health on a day-to-day basis. It makes sense that practitioners should support people to manage their health as effectively as possible.

A significant proportion of our services are delivered by our partners in the third, independent and housing sectors. We recognise the positive relationships that many organisations in these sectors have with the people who use their services and their carers, and the wider connections that they have with our local communities.

The depth and resilience of the relationships that we have with these many different organisations is important to us. Market fragility can cause uncertainty and unexpected change to the detriment of the organisations who are delivering services, their staff members and those people who use services and, in some cases, depend on them.

We strongly believe that a well-resourced and well-supported market will be better placed to make a significant contribution towards the development of enhanced models of care and a more stable health and care environment. Our Market Facilitation Statement shows how we will seek to develop the sustainability of our local market.

4.4 Supporting Early Intervention and Prevention

Priorities:	Contribute to a reduction in health inequalities. Value and support those who are unpaid carers to become equal partners in the planning and delivery of services, to look after their own health and to have a quality of life outside the caring role if so desired.

The majority of people remain healthy and active without the need for services. Although health problems generally increase with age, ill health and disability should not be an inevitable consequence of growing older in Aberdeen City. We want to focus on the promotion of health and wellbeing and strengthen early intervention and prevention.

It is a good thing to recognise and support the vital role that "unpaid" carers fulfil: they are, in many respects the experts. One test of a caring society is the readiness with which we agree to be an unpaid carer should the circumstances of our relative, friend or neighbour require this. It may be that we need to reposition our attitudes to the unpaid caring role.

Given that our health and care services could not function as well as they do were it not for the contribution of our unpaid carers, we will ensure that the support offered to all carers is targeted at their specific and individual outcomes, as well as the specific and individual outcomes of those being cared for. We recognise that there are a variety of outcomes which are unique to carers such as the need for time to themselves and for relief from challenging circumstances. We are also very aware that carers typically may not be aware of what is available to them. We need to rectify this and at the same time, promote across all our sectors and services, with high expectations regarding carer engagement.

4.5 Enabling Better Connections

Priorities:	Develop a person-centred approach which enables our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community**.**

We strongly believe that those living, working and volunteering locally are best placed to assess identified need in terms of issues relating to health and social care; to suggest how these needs might be addressed; to prioritise the needs on the basis of what is most important to the local community; and reflect all of these within an agreed action plan for the community. It is important to recognise again that some individuals may, at any given time, be isolated or unconnected within a community. This does not mean that they are not part of that community, but that there remains an opportunity to create and develop rich connections.

If we are serious about the people who use our services having an improved, seamless experience then we need better communication and improved co-ordination within the health service itself (primary care, secondary care and the acute

sector) as well as with and between the social care, third, independent and housing sectors.

We also need real time information and good decision support provided to our front line practitioners so that other appropriate options can be sourced for individuals to reduce our 'social admissions' (admissions which are not clinically necessary but are the most practicable at that time due to the absence of other options i.e. social care).

Most adults under 65 are independent with little or no contact with our health and social care services. We mostly expect to live longer and healthier lives and to have more choice and control over the support we might need to maintain our independence as we age. For that to happen, we must plan now for new ways of providing services that deliver the outcomes for health and wellbeing that people will need and expect. However, we know that there is going to be an increasing demand for our services, and our resources are unlikely to grow at the same rate, if at all.

4.6 Our Enabling Resources

Our staff groups across the health, social care, third, independent and housing sectors are pivotal to our aspirations to deliver high-quality effective services.

We accept that there is a strong relationship between people's experiences of using our health and social care services and the morale of staff who deliver those services. We are mindful though that organisational cultures can be a barrier to change and are keen to reconcile these so that different professions and staff groups understand each other's roles, responsibilities and perspectives more fully.

We will promote a culture of compassionate leadership that seeks to encourage staff to flourish in their job role and to empower them to do the right thing from a person-centred perspective.

New roles and new working practices will be needed as we move towards more anticipatory and preventative approaches. We have opportunities to work collaboratively with our local schools, colleges and universities to be truly innovative in how we recruit, develop and retain our staff across all sectors and job roles.

We recognise that we have many partner agencies who are very effective in training and developing their workforce. We will consider how best to support those activities and give some thought to how we can apply the learning outcomes to other sectors and care settings. We accept that positive engagement with professional and regulatory bodies and trade union representatives will be of value to our workforce ambitions.

We will develop a Workforce Plan which will address our local challenges and outline how we will shape our workforce of the future.

4.7.1 In the next few years we will have to address the very real and significant challenge of health and social care budgets most likely reducing in real terms while the demand for services increases. To achieve our objective of optimising the health, wellbeing and independence of people to live at home for as long as is reasonably practicable, we need to look at how we manage our resources to deliver the best value for the individuals who use our services, their carers and their communities.

A medium-term financial strategy (MTFS) has been developed to pull together into one document all the known factors affecting the financial sustainability of the partnership over the medium term. This financial strategy will establish the estimated level of resources required by the partnership to operate its services over the next five financial years given the possible demand pressures and funding constraints that we are likely to experience.

The MTFS sets out the forecasted income and expenditure over the next five years based on historic trends and certain planning assumptions. It includes as a baseline the 2018-2019 budget which was approved by the IJB in March 2018.

Implementing this financial strategy will assist in delivering the ambitions and priorities of the Strategic Plan, maximise the use of our available resources and improve our strategic financial planning across the medium term. An overview of the five-year financial plan is set out below:

	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000	2022-23 £'000
Budget Pressures	4,206	6,452	6,749	6,304	6,623
Efficiency Savings	(900)	(1,150)	(1,650)	(1,650)	(1,650)
Transformation	0	(1,458)	(1,487)	(1,517)	(1,547)
Medicines Management	(200)	(1,000)	(1,000)	(1,000)	(1,000)
Service Redesign	0	(2,844)	(2,612)	(2,137)	(2,426)
Funding	(3,106)	0	0	0	0
Shortfall	0	0	0	0	0

We are committed to making the best use of our resources to deliver best value in improving outcomes for people. Careful consideration is given to the allocation of financial resources to our local authority and health board partners and also to our many partner agencies who deliver commissioned services.

We will always seek to invest in those functions and services which can demonstrate a positive impact on the health and wellbeing of the individuals who use their services and an alignment with the ambitions and priorities of our Strategic Plan. There will be times however when disinvestment options will be considered because of not-so-good impact, weak alignment and also poor value for money. Our investment/disinvestment decisions whatever they are, will always be rooted in the sustainability of our local market and the delivery of our Strategic Plan. We hope that any changes can be as a result of planned service reviews or known commissioning cycles but we accept that there will be times when circumstances arise that present us with an opportunity to reconsider the appropriate allocation of resources.

Our focus on transformation will continue. We recognise the very real challenge of asking our staff to contribute to the transformation of our services whilst at the same time asking them to ensure an ongoing consistency of the day-to-day operation. We recognise that there is a national and a local desire to see the evidence of the impact of our innovative activities and services. Our evaluation framework provides that assurance.

4.9 Digital technology is key to transforming our health and social care services across the partnership so that we can be truly person-centred, enabling and effective.

We appreciate that it is easy to get frustrated at what appears to be a lack of progress in introducing digital solutions especially when technology plays such a central and important part of our lives in so many other ways.

There are significant opportunities to introduce digital solutions across all sectors and services. We look forward to that future date when digital services are an integral part of everything we do and have become not only the first point of contact with health and care services for many people but also how they will choose to engage with us on an ongoing basis.

We will work closely with our digital partners in the local authority, health board and Scottish Government as well as with our many other partners across the partnership to ensure a seamless, co-ordinated approach to this digital transformation of how we deliver our services.

5. Achieving Healthier and Fulfilling Lives

The National Performance Framework provides broad measures of national wellbeing covering a range of economic, health, social and environmental indicators and targets.

Our plan contributes to the following national outcomes:

- we live longer, healthier lives.
- we have tackled the significant inequalities in Scottish society.
- we live in well-designed, sustainable places where we are able to access the amenities and services we need.
- we have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others
- our public services are high quality, continually improving, efficient and responsive to local people's needs respectively.
- our people are able to maintain their independence as they get older and are able to access appropriate support when they need it.

We will seek to build on our existing assets and strengths and strive to ensure that our citizens and communities are fully involved in the design and delivery of services. We will be focused on prevention and will show the advantages of investing in early interventions.

Valuing our staff and empowering them all to work as positively and collaboratively as possible will be crucial to our desire to deliver community-based integrated health and social care services.

Our emphasis will always be on fulfilling individual outcomes, that is, what actually needs to happen from the individual's point of view. We recognise though that ensuring that personal, organisational and national outcomes are linked in a coherent manner will be central to the successful implementation of a partnership-wide outcomes-focused approach.

We remain committed to improving the

- the health and wellbeing of our local population across all localities
- the experiences and outcomes of the individuals who use our services
- the quality and effectiveness of our services.

and as such, recognised as one of the highest performing partnerships in Scotland for our commitment to the people who use our services and their carers

and our performance across all sectors and services.