Aberdeen City Health & Social Care Partnership

Strategic Plan 2019-2022

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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

A key challenge, which we accept unreservedly is for these principles to be part and parcel of our day-to-day professional practice across all sectors and services. It is important to us as a principled partnership that our actions meet, if not exceed the expectations that are placed on us.

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Appendices.

1. Housing Contribution Statement (tbc)
2. Equality Impact Assessment (tbc)

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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 in respect of the health and wellbeing of our local population and 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 across all adult age groups and client groups about what the partnership should be doing to promote and support everyone's health and well-being especially those with complex needs.

The ambitions and priorities of this plan are relevant across all 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 a mental health illness; the man on his substance misuse recovery journey; the person with a sensory impairment; the woman with complex physical and learning disabilities; the older person living with dementia and the unpaid carers.

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

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

"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. They define who we are and what is important to us.

1.3 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 allocation of our staffing, financial and physical resources**

It is heartening to know that our overall health profile is better than the Scottish national average however we know that within the city, there are significant differences in life expectancy, premature deaths, emergency hospital admissions and general health and wellbeing, with some communities reporting greater levels of health problems than others.

We have reduced unmet needs for social care, increased the proportion of people aged 65 years and above with intensive care needs who receive care at home, and increased the uptake of self-directed support. We have dramatically reduced the number of additional days that people spend in hospital due to their delayed discharge and the number of people whose A&E attendance results in emergency admission to hospital is markedly lower than the rest of Scotland.

People's experiences of using our services is a very useful indication of how caring and person-centred we actually are. We are committed to improving the personal experiences and outcomes of the people who use our services and their carers and, we want to hear of those examples and circumstances where expectations have not been met so we can learn from these and where necessary improve matters.

We are pleased that there has been an increase in the % of adults who said that they are supported to live as independently as possible; who say they have had a say in how their care is provided; who agree that their care is well co-ordinated and who rated their care or support as excellent or good. We are mindful though, that there has been a decrease in positive GP experiences and that our unpaid carers also feel less than satisfied but overall these local experiences reflect well against the national trend of reducing levels of satisfaction.

The safety and wellbeing of our citizens is important to us; we want to ensure that Aberdeen is a place where everyone feels safe, supported and included. We are committed to working with our public protection partners to keep people safe from any physical, sexual, psychological or financial harm or neglect. There has been significant work undertaken to both strengthen and improve the governance of adult protection services. We will continue delivering the improvements outlined in our Improvement programme 2018-2020.

1.4 We have reflected on our experiences since integration 'Go Live' in April 2016 and the impact of our current plan to shape our proposed strategic objectives for the next three years. We have also identified those key enablers that need to be in place to give our objectives and priorities the best possible chance of being fulfilled.

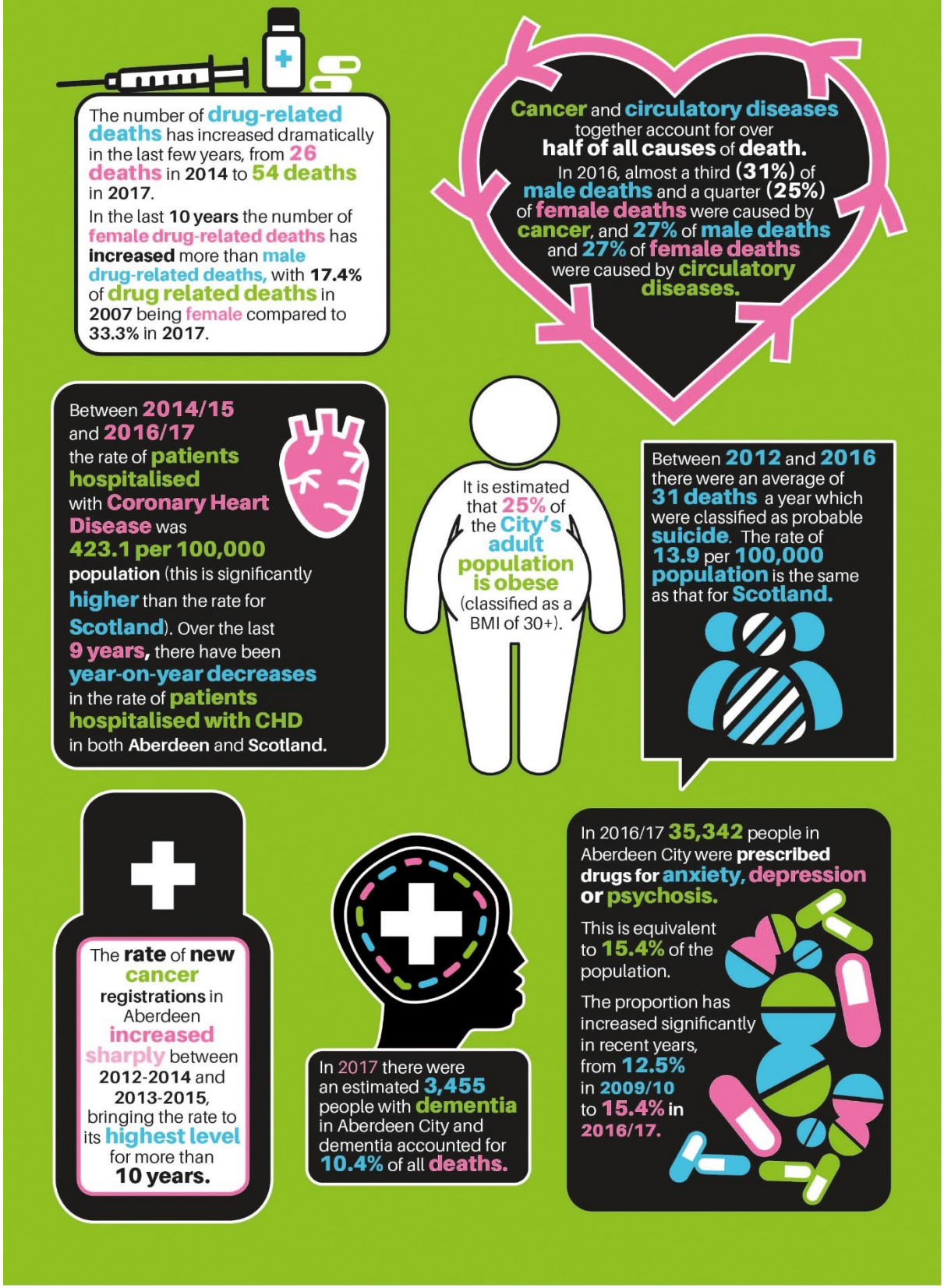
Objective	What is this?	Priorities
Prevention	We will work with our partners to achieve positive individual outcomes and lessen the need for formal supports.	Promote positive mental health and wellbeing. Address the factors that cause inequality in outcomes in and across our communities. Reduce alcohol and drug related harm.
Resilience	Supporting people and organisations 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 independent living for individuals. Value and support unpaid carers.
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.	Reshape our primary care sector. Shift the balance of care from the acute health sector to community-based services. Develop our palliative and end of life care provision.
Connections	Develop meaningful connections and relationships to promote better inclusion, health and wellbeing.	Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community**.** Counter the perception of loneliness and isolation experienced by all age groups.
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.	Implement our three-locality model. Develop a diverse and sustainable care provision.
Empowered Workforce **Principled Commissioning** **Digital Transformation** **Sustainable Finance**		

Table 1 ACHSCP Objectives and Priorities.

1.5 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. Given our future demographic and financial challenges it is unlikely that the partnership will be able to satisfy an increased demand for our services with fewer resources available. Doing more of the same is not a sustainable option for us and so we will need to have honest conversations with the local population about their expectations and how we can enable them to keep well and where appropriate, support them to manage their conditions. We accept that we will have to reshape and, in some cases, transform how and where we deliver our services.

We remain ambitious to be recognised as an innovative and high-performing partnership. With the support of the people of Aberdeen and our many valued partners we are confident that we will achieve this and other shared, desired outcomes.

2. Some background information


The number of drug-related deaths has increased dramatically in the last few years, from 26 deaths in 2014 to 54 deaths in 2017.
In the last 10 years the number of female drug-related deaths has increased more than male drug-related deaths, with 17.4% of drug related deaths in 2007 being female compared to 33.3% in 2017.
Cancer and circulatory diseases together account for over half of all causes of death.
In 2016, almost a third (31%) of male deaths and a quarter (25%) of female deaths were caused by cancer, and 27% of male deaths and 27% of female deaths were caused by circulatory diseases.
Between 2014/15 and 2016/17 the rate of patients hospitalised with Coronary Heart Disease was 423.1 per 100,000 population (this is significantly higher than the rate for Scotland). Over the last 9 years, there have been year-on-year decreases in the rate of patients hospitalised with CHD in both Aberdeen and Scotland.
It is estimated that 25% of the City's adult population is obese (classified as a BMI of 30+).
Between 2012 and 2016 there were an average of 31 deaths a year which were classified as probable suicide. The rate of 13.9 per 100,000 population is the same as that for Scotland.
The rate of new cancer registrations in Aberdeen increased sharply between 2012-2014 and 2013-2015, bringing the rate to its highest level for more than 10 years.
In 2017 there were an estimated 3,455 people with dementia in Aberdeen City and dementia accounted for 10.4% of all deaths.
In 2016/17 35,342 people in Aberdeen City were prescribed drugs for anxiety, depression or psychosis.
This is equivalent to 15.4% of the population.
The proportion has increased significantly in recent years, from 12.5% in 2009/10 to 15.4% in 2016/17.

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

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.

2.2. Scotland's **public health priorities**[2] have strongly influenced the development of this plan. Their stated aim for people to thrive and be as healthy as possible is set within a broader desire to reshape our attitudes towards health and well-being.

- **a Scotland where we live in vibrant, healthy and safe places and communities**
- **a Scotland where we flourish in our early years**
- **a Scotland where we have good mental well-being**
- **a Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs**
- **a Scotland where we have a sustainable, inclusive economy with equality of outcomes for all**
- **a Scotland where we eat well, have a healthy weight and are physically active**

These priorities provide a substantial foundation for our own ambitions and priorities and a very useful reference for us to use when we reflect upon the impact of our activities and initiatives. Another key national document with which this plan has a strong alignment is the Scottish Government's **Health and Social Care Delivery Plan 2016**[3] and its focus on:

- **better care**
- **better health**
- **better value**

Working towards our own objectives will clearly be of positive value to these national priorities also.

[1] http://www.aberdeencityhscp.scot/contentassets/47a823b8be3c4f26830d11200cb644a1/aberdeen-city--integration-scheme.pdf
[2] https://www.gov.scot/publications/scotlands-public-health-priorities/
[3] https://www.gov.scot/Resource/0051/00511950.pdf

2.3 A critical factor in the success of our ambitions and priorities will be the positive, supportive relationships that we continue to develop with our key 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 **Community Planning Aberdeen (CPA) Local Outcome Improvement Plan**[4] sets out a coherent, multi-agency vision to make Aberdeen a better place to live and work in. The partnership is a member of the CPA and as such, recognises the value of positive collaborations and consensual decisions to address our common challenges. 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 priority areas (Prevention, Self-Management, Planned Care, Unscheduled Care) set out in **NHS Grampian's Clinical Strategy (2016-2021)**[5] 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 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.

2.4 We have developed a significant strategic portfolio (Figure 2) since integration 'Go Live' in 2016 to ensure that we have a consistent and coherent overview of the health and wellbeing of our local population and the needs of the different client groups.

All of these documents are important in their own way but the **Strategic Commissioning Implementation Plan**[6]**,** our **Transformation Plan** and **Locality Plans**[7] have a particular significance because of what they say about our future commissioning intentions, our continuing transformation of what we do and how we do it and our locality-specific activities and initiatives to address evident differences in health and wellbeing across our city's communities.

Following the publication of this revised Strategic Plan we will take the opportunity to refresh this portfolio to ensure there is a continuing alignment with the ambitions and priorities set out in this overarching plan.

[4] https://communityplanningaberdeen.org.uk/aberdeen-city-local-outcome-improvement-plan-2016-26/
[5] http://foi.nhsgrampian.org/globalassets/foidocument/dispublicdocuments---all-documents/Grampian_Clinical_Strategy_2016-2021_Full_Version.pdf
[6] https://www.aberdeencityhscp.scot/globalassets/strategic-commissioning-implementation-plan.pdf
[7] https://www.aberdeencityhscp.scot/our-delivery/

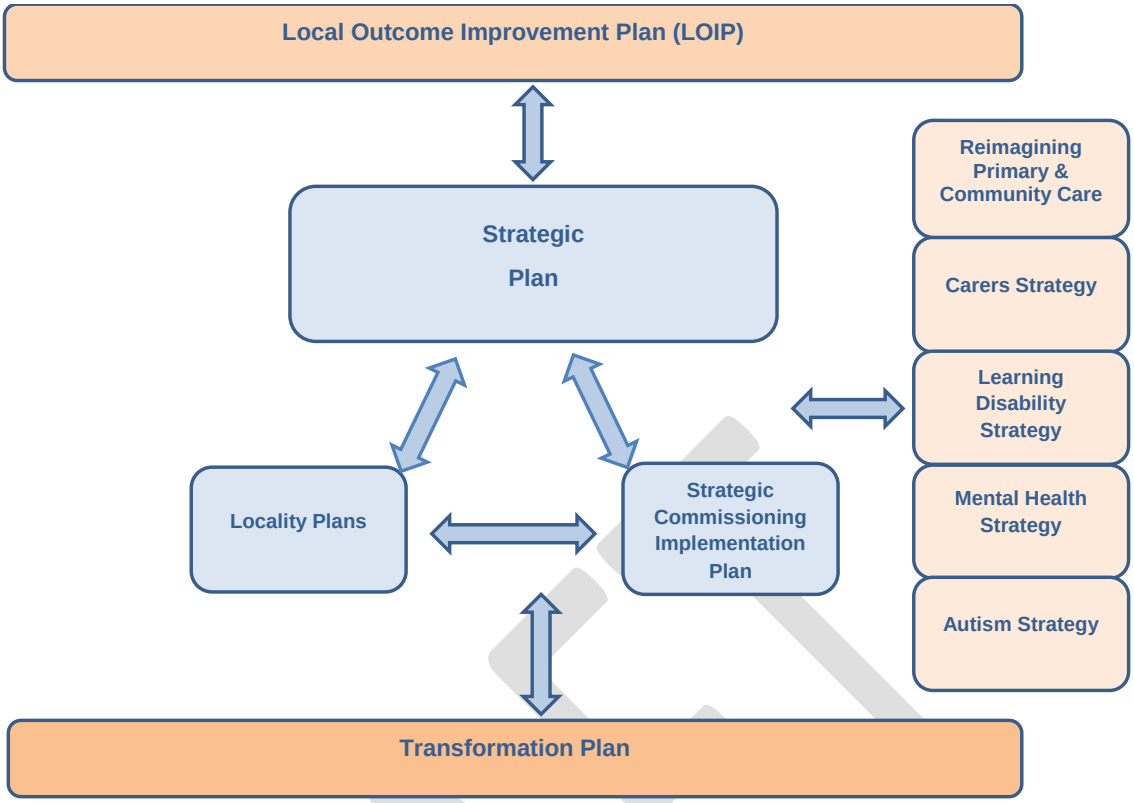


Figure 2 ACHSCP Strategic Portfolio

2.5 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).

Hosted services are those health services which have a wider Grampian provision but are assigned to 'lead' IJBs for strategic planning and operational management purposes. This Strategic Plan applies to our hosted services as we need to ensure that their model of care contributes appropriately towards our city-specific objectives and priorities. We are mindful though that the other Grampian IJBs also need that reassurance from their perspective and so we will work with NHS Grampian and the other IJBs to develop a governance structure that is as robust as the governance for the fully delegated functions and services.

Our longer-term strategic intent is to limit the scope of hosted services to an absolute minimum and to only host those services where remaining hosted offers clear advantages to our local population and the partnership itself.

Similarly, strategic planning at an IJB level of those acute sector services is desirable because of the significant proportion of unscheduled care/emergency admissions that these services experience and the positive difference that partnerships can make towards this. It is fair to suggest that we have not undertaken as much of this planning to-date as we would have wished. We will do better.

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

Table 2 ACHSCP Strategic Planning (Hosted/Acute) Responsibilities.

2.6 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 however some children-specific health services (Health Visiting, School Nursing) are operationally devolved to the partnership's Chief Officer. Better outcomes for the children and young people of this city will be achieved by working more collaboratively with children's services and aligning our respective activities where possible, more fully.

We are mindful 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 recognise that the first few years of pre-school life is critical to a child's later development and that appropriate interventions at this stage are crucially important in addressing inequalities. We will collaborate 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.

2.7 Adaptations and garden maintenance are the only housing functions which are formally delegated to the IJB. We acknowledge though, that the provision of good quality housing and housing related services plays a key role in enabling people to be able to live independently at home for as long as is reasonably practicable.

The **Aberdeen City Council Local Housing Strategy (LHS) 2018-2023**[8] covers all types and tenures of housing including social rented, private rented and owner-occupied accommodation. It sets out how local need and demand will be addressed and how this contributes to the national housing priorities. The strategy aims to deliver six strategic outcomes:

1. There is an adequate supply of housing across all tenures and homes are the right size, type and location that people want to live in with access to suitable services and facilities.
2. Homelessness is prevented and alleviated.
3. People are supported to live, as far as is reasonably practicable, independently at home or in a homely setting in their community.
4. Consumer knowledge, management standards and property condition are improved in the private rented sector.
5. Fuel poverty is reduced which contributes to meeting climate change targets.
6. The quality of housing of all tenures is improved across the city.

We are committed to working with our housing colleagues to deliver the delegated housing functions as effectively as possible and support the fulfilment of the above outcomes.

The Housing Contribution Statement (see Appendix One) shows the contributions that this LHS and its Joint Delivery Action Plan makes to the wellbeing of our residents and the broader objectives and priorities set out in this plan.

2.8 The alignment of the partnership's objectives and priorities with all these other strategic points of reference will be a crucial factor in ensuring the effectiveness of our proposed actions and initiatives and the fulfilment of personal, organisational and national outcomes.

[8] https://www.aberdeencity.gov.uk/sites/default/files/2018-09/Local%20Housing%20Strategy%202018-2023.pdf

3. Achieving healthier, fulfilling lives

Figure 3 Aberdeen in 2030 (Source: ACHSCP Public Health).

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 the partnership's significant potential across all sectors to transform itself.

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 their lived experiences and have a relentless focus on improved outcomes.

3.1 Prevention. Most people remain relatively healthy and active without the need for formal supports and services in their lives. Although health problems generally increase with age, ill health and disability should not be an inevitable consequence of growing older in
Aberdeen City.

We will seek to improve our understanding of what preventative interventions will have the greatest impact on the health and wellbeing of different population groups within the city and support the effective implementation of these. We want to strengthen our early, preventative interventions and focus on the promotion of good, positive physical and mental health and wellbeing for all people across all age-groups and client groups.

Priorities:

3.1.1 Promote positive mental health and wellbeing.

3.1.2 Address the factors that cause inequality in outcomes in and across our communities.

3.1.3 Reduce alcohol and drug-related harm.

3.1.1 Poor mental health is a significant public health challenge which many of us will either personally experience or see a family member or friend cope with the challenges it brings or be a support to others in a professional capacity. Most of these are mild to moderate mental health problems but for some people it can be a more serious long-term illness and can impact on an individual's ability to function and live independently.

We aim to provide help from the right person, in the right place and at the right time. This means developing appropriate services which are more quickly accessible and available locally for all levels of mental health problems. We continue to move away from hospital-based services as the main mental health provision to develop community-based care and treatment resources where there is a significant emphasis on prevention and supported self-management.

We will seek to ensure that our citizens enjoy the best possible mental health and wellbeing and that when anyone begins to experience poor mental health, appropriate asset-based supports are available in their communities for them to access. We are very aware that each person's recovery journey is unique to them. We are keen to work with and alongside them by delivering services that promote a "rights" based model which is focused on their personal recovery and enduring quality of life.

The national **Mental Health strategy 2017-2027**[9] has prevention and early intervention as one of its five themes and outlines key action points associated with this. This national strategy will inform and influence the development of the partnership's own mental health strategy.

[9] https://www.gov.scot/publications/mental-health-strategy-2017-2027/

COMMITMENT: We will produce a Mental Health strategy and Action Plan showing how we will promote positive mental health and wellbeing and support those who are on a recovery journey.

3.1.2 Health inequalities are unfair and avoidable differences in health outcomes across the city's population. They are a key theme that underpins everything that we understand about the health and wellbeing of our local population and the activities and interventions which we propose to implement to improve this.

Deprivation is a key driver of poor health and embedded inequalities in and across our communities and we welcome the local authority's anti-poverty strategy **'Towards a Fairer Aberdeen That Prospers For All 2017-2020'** as a significant statement of intent to remedy such matters.

We recognise that we need to understand the health impact of our activities and interventions better. Tackling the underlying causes of health inequalities needs a whole system approach that seeks to change cultures and behaviours. A bucket list of singular interventions, no matter how well intentioned will not change matters sufficiently well enough.

Health and social care partnerships have a duty under the Fairer Scotland Duty to contribute to reducing health inequalities. We will always seek to understand better the health and wellbeing of our local population and what factors are contributing to different health outcomes. We will, with our community planning partners, use this information to identify and implement appropriate actions to reduce the health inequalities that exist in our city. We are mindful that our workforce will need appropriate support to recognise what works and to make this shift of emphasis succeed.

COMMITMENT: We will actively contribute to reducing known health inequalities in the health and wellbeing of our local population.

3.1.3 Alcohol and drug use significantly contribute to poorer health and wellbeing across all parts of our city. Much of the harm caused by substance use can be prevented through joined up health and social care services undertaking evidenced-based early intervention. There can be many personal challenges to overcome but we need to make a person's recovery journey easier by removing the stigma associated with seeking help.

We will seek innovative ways of tackling substance use in all its forms and we will provide accessible, high quality services for people who require more intensive support and treatment. We will support our local Alcohol and Drugs Partnership to

deliver the national strategy ***"Rights, respect and recovery: alcohol and drug treatment strategy"***[10]

COMMITMENT: We will support the Alcohol and Drug Partnership in delivering actions to reduce substance related harm.

3.2 Resilience. Resilience can be understood to be the adaptability of individuals and organisations to circumstances that may be less than stable or positive. It is not a new concept, but it is one that can significantly influence our attitudes and behaviours to life's day-to-day challenges.

Priorities:

3.2.1 Promote and support self-management and independent living for individuals.

3.2.2 Value and support unpaid carers.

3.2.1 Supported 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. For this shift to be effective, individuals need to have opportunities to develop their knowledge, skills and confidence to make informed decisions and adapt their health-related behaviours. They also need to have access to the necessary expertise to support them in overcoming barriers and achieving their goals.

Supported self-management is not just about us taking greater responsibility for our own health and wellbeing. Many people with long term conditions already make appropriate decisions and manage a broad range of factors that contribute to their health and wellbeing on a day-to-day basis. Instead, we need to accept that there are wider considerations and explanations in relation to the lives that we lead and our current health and wellbeing.

There is no shortage of health improvement messages including keeping physically active, minimising our alcohol intake and eating five portions of vegetables a day for us to acknowledge and adopt; what is needed is an approach that recognises our experiences of the complexity and cumulative impact of our health condition(s), an understanding of what may work for each and every individual and our desired personal outcomes.

COMMITMENT: We will continue to invest in our 'Promoting self-management

[10] https://www.gov.scot/publications/rights-respect-recovery/

and building community capacity' transformation portfolio.

3.2.2 It is a good thing to recognise and support the vital role that "unpaid" carers fulfil as they are, in many respects, the experts in relation to the health and wellbeing of the person they care for. The **Scottish Health and Care Experience Survey**[11] however shows that we can do so much better as only 40% of the respondents who identified as carers feel supported to continue in their caring role and only 49% feel they have a say in the services provided for the person they look after.

Being an unpaid carer is a very individual experience that depends on the needs of the cared for person. There are some common issues but the mother of a young adult daughter with mental health difficulties for example will have a different perspective of the carer role from the partner of an older person with dementia.

Carers are a significant partnership stakeholder and our health and social 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, irrespective of who they are, is targeted at their particular individual outcomes and, of course, the personal outcomes of those being cared for.

Our **Carers Strategy 2018-2021**[12] sets out key actions that will support our many unpaid carers with the challenges that they experience regularly to enable them to have a life out with caring if they so choose.

COMMITMENT: We will support our unpaid carers to identify as carers, to manage their caring role, to be involved in the planning of services for the cared-for person and to have a life alongside caring if they so choose.

3.3 Right Care in the Right Place at the Right Time. This approach means services are tailored to the requirements of the individual so that people have access to the right care, support or treatment when they need them, in ways which are personalised, empowering and effective. It means that there are no in-built premature assumptions of what someone needs or a uniform 'one size fits all' provision but there are instead appropriate diversions to other resources and services as and when appropriate for each individual.

[11] https://www2.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey
[12] https://www.aberdeencityhscp.scot/globalassets/carers-strategy---march-2018.pdf

Priorities:

3.3.1 Reshape our primary care sector.

3.3.2 Shift the balance of care from the acute health sector to community-based services.

3.3.3 Develop our palliative and end of life care provision

3.3.1 Primary care is an important area of operation within the partnership providing appropriate advice and treatment for physical and mental health illnesses and conditions across all ages.

It is the first point of healthcare contact for many people and the gateway to other health services. It provides the reassurance of long-term continuity as well as more immediate, single episodes of advice and treatment when required.

There are known workforce recruitment challenges to overcome but even so, this sector has shown a continuing ability to introduce new practice models and adopt evidence-based interventions. It has a key role to play in promoting people's health and wellbeing and maintaining their independence at home in the community.

Our **Primary Care Improvement Plan**[13] outlines our proposed initiatives to address this sector's significant operating challenges.

COMMITMENT: We will implement fully our Primary Care Improvement Plan

3.3.2 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.

Shifting the balance of care from the acute health sector to primary care and community care is seen as a good and desirable thing to do. Most adults are relatively healthy and have little or no contact with our health and social care services, but we are aware that there are a small number of individuals who have a disproportionately high usage of health services. It is envisaged that effective integrated service provision in our communities and localities will, over time, reduce this.

[13] https://www.aberdeencityhscp.scot/globalassets/primarycareimprovementplan.pdf

We are mindful though, of those who, for whatever reason are viewed as being 'furthest from the point of care' not in a geographical context but because of their substance misuse, poor mental health, complexity of ill-health, disability or vulnerability. Their numbers may be small compared to some other population groups but the impact of getting it right for them may well be proportionately greater. This objective is not just about better and more effective use of what we currently have but actively redesigning to deliver improved experiences and outcomes.

COMMITMENT: We will support and implement as appropriate the local Unscheduled Care Essential Actions Plan developed with our partner agencies.

3.3.3 Palliative care is an approach that seeks to improve the quality of life of individuals who have a terminal illness or life-limiting conditions. End of life care is that part of palliative care which seeks to ensure that an individual dies as peacefully and with as much dignity as possible.

Palliative and end of life care involves a variety of general and specialist services across primary care; care at home; residential/nursing care homes; acute hospitals and hospices. Good communication, collaboration and continuity of care across all sectors is essential to ensure our care and support at these times is recognised as being caring, compassionate and person-centred.

We recognise the need to be responsive to the changing preferences and priorities of people with advanced illness and their carers. The choices that are expressed after diagnosis may well change later, for example, most people when asked, initially express a preference for dying at home but in fact, most die in hospital. There are different reasons that explain this, but sensitive anticipatory planning conversations will help ensure that the holistic care that is put in place meets the needs and wishes of the individual and, where appropriate, their carer.

The national **Strategic Framework for Action on Palliative and End of Life Care** says that by 2021 everyone who needs palliative care will have access to it.

Commitment: We will review our current palliative and end of life care provision and develop an action plan to fulfil the strategic framework vision.

3.4 Connections. We will seek to make open and ongoing engagement with our local population a defining feature of who we are as a partnership. We will continue to engage with our localities, develop better relationships with their residents and

work together to support a quality of life that is as good, positive and active as possible.

Priorities:

3.4.1 Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.

3.4.2 Reduce the perception of loneliness and isolation experienced by individuals across age and client groups.

3.4.1 We want to promote and develop the wellbeing of our communities by increasing opportunities for the people who live in these areas 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 strongly believe that those living, working and volunteering locally are best placed to identify local issues and needs; to suggest how these needs might be addressed; to prioritise the needs based on what is most important to the local community; and reflect all of these within an agreed action plan for the community.

It is because people are healthier when they feel connected to things that matter to them that the IJB has previously endorsed Community Planning Aberdeen's **'Engagement, Participation and Empowerment' Strategy[14].** Working with our citizens to co-produce the outcomes that matter to them is an important principle for us.

The IJB does not have a formal responsibility for transport connections and resources but we recognise that for many people an ambition of feeling 'better connected' will be unrealised if transport challenges are not addressed.

COMMITMENT: We will develop a co-ordinated engagement plan for all the partnership's activities and initiatives with our client and patient groups, communities and localities.

[14] https://communityplanningaberdeen.org.uk/wp-content/uploads/2017/08/Engagement-participation-empowerment-strategy.pdf

3.4.2 Perceptions of loneliness and isolation can differ across client groups and age groups. Some experiences can include those of an older person whose only social contact is with those who are formally contracted to deliver homecare support; the younger adult with mental health difficulties who believes that they don't have anyone in their life that they can turn to and confide in about their wellbeing and the person on a substance misuse recovery journey who has been shunned by everyone he once knew: family, friends, former workmates and peers who are in a different part of their own journey.

People's perception of how lonely they are and the impact of this can be associated with an increased risk of poor health, increased attendance at GP surgeries and A&E Depts and in some instances, premature mortality. Offering different opportunities depending on who we are and where we are can help address these challenges. See for example, the partnership's **Learning Disability strategy 'A'thegither in Aberdeen 2018-2023**[15] which has as its first outcome "people feel connected to their communities".

We wish to develop those resources and connections, sometimes known as 'social capital' across all sectors of the partnership so that different individuals in different circumstances can experience the benefits of accessing them.

COMMITMENT: We will develop the social capital of our partnership across all sectors and services.

3.5 Communities. 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. We will seek to build on the existing assets and strengths within our communities and strive to ensure that our citizens and communities are fully involved in the design and delivery of services.

Priorities:

3.5.1 Implement our three-locality model.

3.5.2 Develop a diverse and sustainable care provision.

3.5.1 Localities are intended to be the engine room of integration, bringing together our citizens, unpaid carers and professionals from the health, social care, third, independent and housing sectors to reshape our services based on informed practice and local insights.

[15] https://www.aberdeencityhscp.scot/globalassets/athegither-in-aberdeen-strategy.pdf

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 the time.

Our proposed three-locality model (Figure 3.1) will result in a closer alignment with community planning structures and activities, better partner collaborations, less public confusion and an enhanced focus on areas where people experience poorer outcomes. These three localities (North, Central and South) again cover the whole geography of the city as the legislation[16] obliges and, crucially, the three community planning localities can be wholly located within their respective integration localities.

Figure 3.1 Proposed 3-Locality Model.

A recent consultation on this proposed 3-locality model produced a favourable response.

COMMITMENT: We will implement a three-locality model and in doing so, align our activities more fully with those of the Community Planning Aberdeen locality model.

[16] http://www.legislation.gov.uk/asp/2014/9/contents/enacted

3.5.2 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-supported and well-resourced care provision will be better placed to make a significant contribution towards a more stable health and care environment and the development of enhanced models of care. **Our Market Facilitation Statement**[17] shows how we will seek to develop the sustainability of our valued providers.

COMMITMENT: We will refresh our Market Facilitation Statement and develop an Action Plan showing how we will support our local care provision.

[17] https://www.aberdeencityhscp.scot/globalassets/strategic-commissioning-implementation-plan.pdf

4. Our Enablers

Our enablers are those fundamental elements which we require to support the development of, in order to facilitate the attainment of our strategic objectives.

- **empowered staff**
- **principled commissioning**
- **digital transformation and**
- **sustainable finance**

It is a good and positive thing to develop these in their own right as well as because of the positive contribution that they make to our portfolio of activities.

4.1 Empowered staff. Our staff groups across the health, social care, third, independent and housing sectors are pivotal to our aspirations. 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.

Valuing our staff and empowering them all to work as positively and collaboratively as possible will be crucial to our desire to deliver safe, caring, responsive and effective health and social care services. Collaborative leadership will provide the supports that our staff need to flourish but for this to be evident we will increase opportunities for integrated leadership development to help our leaders work more collaboratively

Recruitment and retention of staff is a real challenge in different parts of the partnership and it is likely that new roles and new working practices will be needed as we move towards more anticipatory and preventative approaches. We have significant opportunities to work collaboratively with our local regional college and universities to be truly innovative in how we recruit, develop and retain our staff across all sectors and job roles.

We are mindful 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 have many partner organisations in the city 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. Positive engagement with professional and regulatory bodies and trade union representatives will be of value to our workforce ambitions.

We strongly believe that fair work is work that offers effective voice, opportunity, security, fulfilment and respect to our workforce across all sectors. Balancing the rights and responsibilities of our employer organisations and workers will generate

benefits at an individual and organisational level and also more widely across our communities. The IJB has previously endorsed the Ethical Care Charter[18] and incorporating this charter in the commissioning of our care at home services will make a significant contribution to addressing particular challenges in the delivery of care experienced by that workforce. We recognise that we need to offer similar supports to other elements of our workforce.

COMMITMENT: We will promote a culture of compassionate and collaborative 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.

4.2 Principled Commissioning. Our approach to commissioning is one which views it as collaborative decision-making that generates a broader and more innovative range of options about how to achieve shared outcomes.

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 intended users, families, communities and other agencies that have an interest in the continued wellbeing of our local population.

- 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

Figure 3.2 Commissioning Principles.

Self-directed support (SDS) options will continue to be a key element of our personalised approach given that it enables people to have more informed choice and flexibility over their care and support. We are very aware that having more

[18] http://www.unison-scotland.org/unisons-ethical-care-charter/

people commissioning and controlling their own care through the use of individual budgets or direct payments will require consistent and accurate information that clearly, without the use of jargon, explains the options and opportunities that are available to them.

All our commissioning will be done in a way that is respectful of the appropriate legislation, mindful of known best practice such as the **Ethical Care Charter[19],** and sensitive to the needs of our local care provision. 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.

COMMITMENT: Each and every commissioning decision that we make will be capable of being explained in the context of the strategic objectives and priorities set out in this Strategic Plan.

4.3 Digital Transformation. 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.

COMMITMENT: 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.

4.4 Sustainable finance. 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.

[19] http://www.unison-scotland.org/unisons-ethical-care-charter/

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 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.

Implementing this strategy will assist in delivering the ambitions and priorities of the partnership's Strategic Plan, maximise the use of our available resources and improve our strategic financial planning across the medium term.

Included in Table 3 below is the level of budget pressure the IJB will face after assumptions have been made in terms of the level of income likely to be received from partners. The budget pressures identified include provision for pay awards, Scottish Living Wage uplifts, demographic projections and prescribing inflation. To offset these anticipated pressures, the IJB has identified key 'financial saving' workstreams and has set provisional targets (in brackets) to be delivered from these.

	2019-20 £'000	**2020-21 £'000**	**2021-22 £'000**	**2022-23 £'000**
Budget Pressures (year on year)	6,452	6,749	6,304	6,623
Workstreams to reduce financial pressure:				
Efficiency Savings	(1,150)	(1,650)	(1,650)	(1,650)
Transformation	(1,458)	(1,487)	(1,517)	(1,547)
Medicines Management	(1,000)	(1,000)	(1,000)	(1,000)
Service Redesign	(2,844)	(2,612)	(2,137)	(2,426)
Shortfall	**0**	**0**	**0**	**0**

Table 3 ACHSCP MTFS Budget Pressures and Workstreams

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 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.

COMMITMENT: We will develop our performance reporting to show how effective our financial resource allocation has been in fulfilling desired health and wellbeing outcomes.

5. How will we know we are making a difference

5.1 We remain committed to our ambition of being recognised as one of the highest performing partnerships in Scotland for our effective performance across all sectors and services. Our service delivery will, without exception, be safe, effective, responsive, caring and well-led.

Our emphasis will always be on fulfilling outcomes. 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.

The **National Performance Framework**[20] is a single framework to which all public services are aligned. It sets out a vision of national wellbeing across a range of economic, health, social and environmental factors. The nine **National Health and Wellbeing Outcomes**[21] are high-level statements of what we are trying to achieve as a partnership. A core set of indicators are aligned with the different outcomes to show us the progress we are making in delivering person-centred, high-quality, integrated services and fulfilling the ambitions and priorities set out in our Strategic Plan.

5.2 Our Annual Performance Report shows how well we have performed as a partnership in working towards and fulfilling our operational objectives and the national outcomes. Future annual reports will also comment on how well we have fulfilled the objectives and priorities set out in this plan.

We are determined to be recognised as a partnership that works closely with our citizens, staff, unpaid carers and our partner agencies in the third, independent and housing sectors to fulfil the vision and ambitions of this strategic plan.

[20] http://nationalperformance.gov.scot/
[21] https://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes

Objectives	Priorities	Commitments	Health & Wellbeing Outcomes	National Performance Framework
Prevention	Promote positive mental health and wellbeing. Address the factors that cause inequality in outcomes in and across our communities. Reduce alcohol and drug-related harm.	We will produce a Mental Health strategy and Action Plan showing how we will promote positive mental health and wellbeing and support those who are on a recovery journey. We will actively contribute to reducing known health inequalities in the health and wellbeing of our local population. We will support the Alcohol and Drug Partnership in delivering actions to reduce substance related harm.	• people are able to look after & improve their own health & wellbeing & live in good health for longer • people are able to live, as far as reasonably practicable, independently & at home • people who use health and social care services have positive experiences of those services & have their dignity respected • health & social care services are centred on helping to maintain or improve the quality of lives of people who use those services	• 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
Resilience	Promote and support self-management and independent living for individuals. Value and support unpaid carers.	We will continue to invest in our 'Promoting self-management and building community capacity' transformation portfolio. We will support our unpaid carers to identify as carers, to manage their caring role, to be involved in the planning of services for the cared-for person and to have a life alongside		

Right Care, Right Place, Right Time	Reshape our primary care sector. Shift the balance of care from the acute health sector Develop our palliative and end of life care provision	We will implement fully our Primary Care Improvement Plan. We will support and implement as appropriate the local Unscheduled Care Essential Actions Plan developed with our partner agencies. We will review our current palliative and end of life care provision and develop an action plan to fulfil the strategic framework vision.	• health & social care services contribute to reducing health inequalities • people who provide unpaid care are supported to look after their own health & 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	• 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
Connections	Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community. Counter the perception of loneliness and isolation experienced by all age groups.	We will develop a co-ordinated engagement plan for all of the partnership's activities and initiatives with our client and patient groups, communities and localities. We will develop the social capital of our partnership across all sectors and services.		
Community	Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.	We will implement a three-locality model and in doing so, align our activities more fully with those of the Community Planning Aberdeen locality model.		

	Develop a diverse and sustainable care provision.	We will refresh our Market Facilitation Statement and develop an Action Plan showing how we will support our local care provision.		
Safe, Effective, Responsive, Caring, Well-Led				