



Aberdeen City
Health & Social Care
Partnership

A caring partnership

Strategic Plan
2019-2022

Contents






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Strategic Plan on a Page

OUR VALUES:

- Caring
- Person Centred
- Enabling

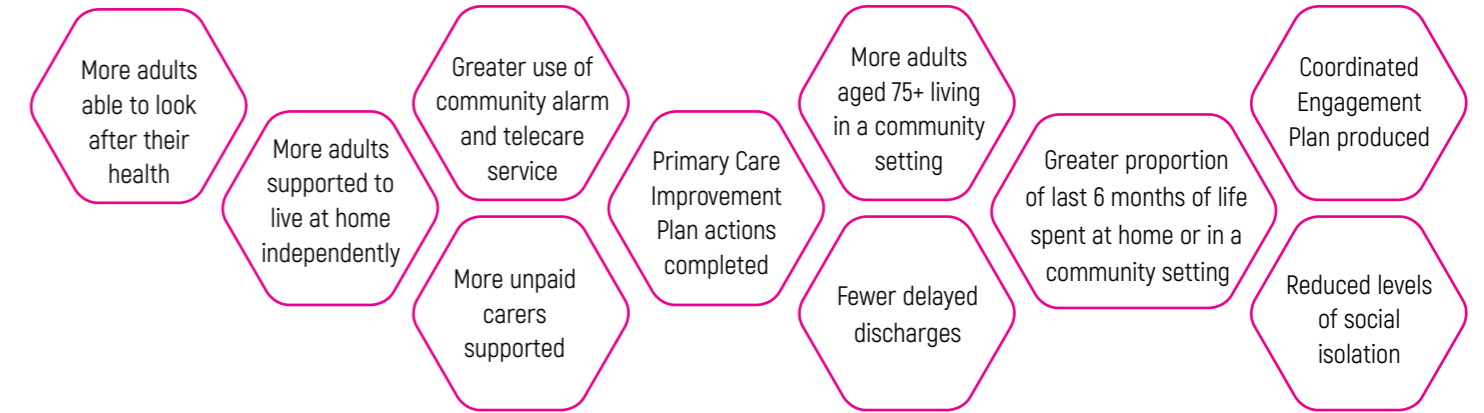
OUR VISION:

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

Prevention	Resilience	Enabling	Connections	Communities	
Working with our partners to achieve positive outcomes for people and lessen the need for formal support	Working with our partners to support people so that they can cope with, and where possible, overcome the health and wellbeing challenges they may face.	Ensuring that the right care is provided in the right place and at the right time when people are in need. Ensuring that our systems are as simple and efficient as possible.	Develop meaningful community connections and relationships with people to promote better inclusion, health and wellbeing and combat social isolation	Working with our communities, recognising the valuable role that people have in supporting themselves to stay well and supporting each other when care is needed.	OUR AIMS

Mental Health Strategy Implementation Plan	Action 15 Plan	Market Facilitation Plan	Primary Care Improvement Plan	Learning Disability Implementation Plan	Carers Strategy Implementation Plan	Resilient, Supported and Included Plan	Autism Implementation Plan		OUR IMPLEMENTATION PLANS
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Workforce Plan	TEC Framework	Digital Strategy	Locality Plans	Transformation Plan	Reimagining Primary & Community Care	Medium Term Financial Plan	Engagement, Empowerment & Participation Strategy		OUR ENABLING PLANS
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HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL

IJB Chair Foreword

To be inserted

Chief Officer Foreword

To be inserted

2. Introduction

Aberdeen City Council (ACC) and NHS Grampian (NHSG) delegate a wide range of adult health and social care services to Aberdeen City Health & Social Care Partnership (ACHSCP).

Our Strategic Plan outlines how we plan to deliver these. This plan belongs to everyone living and working in Aberdeen. In developing it, we met with many people – individuals and professional bodies - across the city to help us understand how they want services to look and feel, what is important to them, and what we should focus on.

This gave us lots of information about what is going well, what needs to be improved and what we need to concentrate on. It also highlighted that there are many and varied needs in relation to health and social care services and we have worked to shape our strategic plan to meet these.

Principles of the Strategic Plan

Our Strategic Plan will set the focus and direction for the next three years, based on clear principles and priorities. The partnership also has to take into account the national integration principles when preparing our plan.

Our guiding principles is to provide integrated services which improve people's health and wellbeing. These services will be provided in ways which:

- ✓ Are joined up and easy for people to access
- ✓ Take account of people's individual needs
- ✓ Take account of the particular characteristics and circumstances of different service users in different parts of the city
- ✓ Respect the rights and dignity of service users
- ✓ Take account of the participation by service users in the community in which service users live
- ✓ Protect and improve the safety of service users
- ✓ Improves the quality of the service
- ✓ Are planned and led locally for the benefit of service users, people who look after service users and the people who provide health or social care services)
- ✓ Anticipate people's needs and prevent them arising
- ✓ Make the best use of facilities, people and resources

A key challenge is for these principles to be part and parcel of our day-to-day practice.

It is important to us as a partnership that our actions meet the expectations that are placed on us.

Our principles are underpinned by our vision:

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

We will achieve this by being:

- ✓ Caring
- ✓ Person centred
- ✓ Enabling

Our Strategic Plan is based on

- ✓ conversations with people
- ✓ integration principles
- ✓ consideration of local and national strategies
- ✓ our vision
- ✓ our values



“ Our vision and values underpin all of our activities and define who we are and what is important to us. ”

Our Strategic Plan seeks to establish a shared understanding of our challenges and priorities.

We face demographic and financial challenges now and in the future. Satisfying the increasing demand for our services will be a significant challenge 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 people to keep well and, where appropriate, support them to manage their conditions.

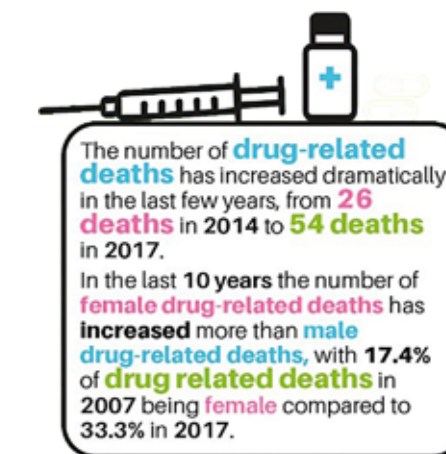
We will deliver on our Strategic Plan under five broad strategic aims:

Strategic aim	What does this mean?
1. Prevention	We will work with our partners to achieve positive individual outcomes and lessen the need for formal support.
2. Resilience	Supporting people and organisations so they can cope with, and where possible overcome, the health and wellbeing challenges they might face.
3. Enabling	Ensuring that the right care is provided in the right place and at the right time when people are in need.
4. Connections	Develop meaningful community connections and relationships with people to promote better inclusion, health and wellbeing and to combat social isolation.
5. Communities	Working with our communities, recognising the valuable role that people have in supporting themselves to stay well and supporting each other when care is needed.

We accept that we will have to reshape and 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.



Our Strategic Plan is about working in partnership

Our strategy will play an important role in ensuring that people's experiences match or exceed their expectations when they use our services.

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.

We recognise that working collaboratively with all our community planning partners is a positive and productive thing to do and we will seek to co-ordinate our activities so that they work seamlessly together.

Our plan has been strongly influenced by

1. 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 wellbeing
- 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

2. The Scottish Government's **Health and Social Care Delivery Plan 2016**³ and its focus on:

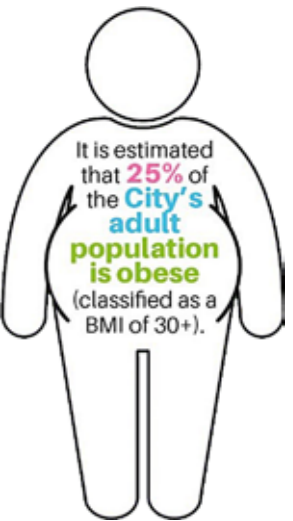
- better care
- better health
- better value

3. Effective community planning arrangements will help us to deliver better services and achieve better outcomes for our citizens and communities. The **Community Planning Aberdeen (CPA) Local Outcome Improvement Plan (LOIP)**⁴ sets out a multi-agency approach to make Aberdeen a better place to live and work in. The partnership is a member of the CPA and recognises the value of all partners working together 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.

4. Similarly, a close alignment with the priorities (Prevention, Self-Management, Planned Care, Unscheduled Care) set out in **NHS Grampian's Clinical Strategy (2016-2021)**⁵ will ensure improved experiences and outcomes for the people who use our services and their carers.

We have been working hard since we started as a partnership in spring 2016 to lay out our ambitions and directions in documents which can help guide and shape how we deliver all of our different health and social care services.

Following the publication of this new Strategic Plan, we will take the opportunity to take a fresh look at our delivery plans to ensure they continue to reflect the ambitions and priorities set out in this overarching plan.



¹ <http://www.aberdeencityhsc.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>

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

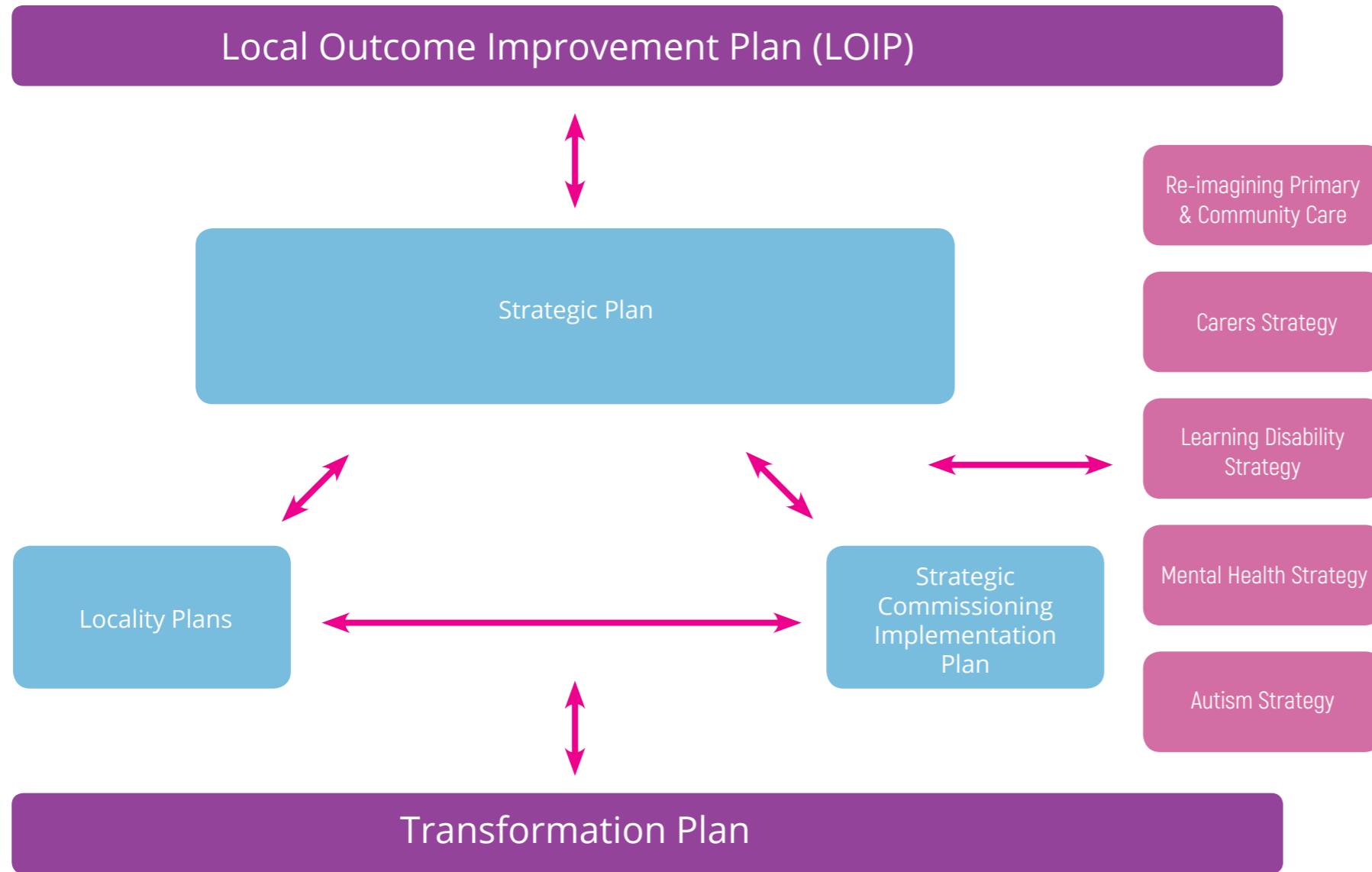


Figure 2 ACHSCP Strategic Portfolio

The IJB also has a strategic planning responsibility for some specific services which cover the whole Grampian area and some services which are delivered in acute hospital settings. (Table 2).

Our Strategic Plan applies to these services too, as we need to make sure that the ways in which they are delivered, match our objectives and priorities.



Grampian-wide service we are responsible for	Hospital services we are responsible for
<ul style="list-style-type: none"> Intermediate Care of the Elderly and Specialist Rehabilitation Sexual Health Acute Mental Health and Learning Disability (decision pending) 	<ul style="list-style-type: none"> Accident and Emergency Inpatient hospital services <ul style="list-style-type: none"> General medicine Geriatric medicine Rehabilitation medicine Respiratory medicine Palliative care Mental health Learning disability

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

The partnership's Chief Officer also has operational responsibility for School Nursing and Health Visiting. Better outcomes for the children and young people in Aberdeen will be achieved by working more collaboratively with children's services and aligning our respective activities more fully. Working together with our wider partners, we aim to ensure that transitions between children's and adult services are as smooth as possible for those who require care and their carers.

We know that many adults in poor physical and mental health – who may have housing difficulties, substance misuse challenges and challenging family relationships – can trace their current experiences back to adverse events in childhood. We recognise that the first few years are critical to a child's development and that positive interventions at this stage can be crucially important

Transition from childhood through adolescence to adulthood can be unsettling for many people. We recognise that early engagement with young adults and their families can ease anxieties and reduce the likelihood of harmful consequences to health and wellbeing .

Good quality housing and related services also play 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**⁶ 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.

⁶<https://www.aberdeencity.gov.uk/sites/default/files/2018-09/Local%20Housing%20Strategy%202018-2023.pdf>

By **2026** the **population of Aberdeen** is projected to **increase** by **3.2%** to **237,169**, with the largest projected increase in the 75+ years age group (15.5%).

We are committed to working with our housing colleagues to support the fulfilment of these outcomes. The Housing Contribution Statement at Appendix X sets out how we will work with housing colleagues to deliver the aims of this strategy,

We recognise, too, that working with all our community planning partners is a good and positive thing to do and we have actively sought to align our activities as best we can.

The **Aberdeen** median age is **36** years compared to **42** across **Scotland**.



IN 2030 ABERDEEN WILL BE ONE OF THE HEALTHIEST PLACES TO LIVE IN EUROPE BECAUSE



4.1 Prevention

We recognise that if we want to improve the health and wellbeing of our local people, we must identify and overcome any barriers to change.

We strongly believe that compassionate and inclusive leadership can help to break down ingrained attitudes and unlock the partnership's potential to transform services and we will work with our partners to enable the necessary changes to happen.

We also recognise that we need to engage with people about their experiences and focus on improved outcomes.

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

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.

Mental health issues are a significant public health challenge which many of us, our friends and our families will experience. Such issues can have an impact on a person's ability to function and live independently and can affect other people in their network of family and friends.

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 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.

Priorities

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

Commitments

We will produce a Mental Health Strategy and Action Plan

We will actively contribute to reducing known health inequalities

We will support Alcohol and Drug Partnership in delivering actions to reduce substance-related harm

Evidence

Mental Health Strategy and Action Plan in place

% adults registered with a GP and dentist

Number of people with a learning disability in further education or employment

The national **Mental Health Strategy 2017-2027**⁷ 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.

Health inequalities across the city are unfair and avoidable. Reducing and overcoming such inequalities 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 inequalities across our communities and we welcome Aberdeen City Council's anti-poverty strategy **'Towards a Fairer Aberdeen That Prospers For All 2017-2020'** as a significant statement of intent to remedy such matters.

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 the factors which contribute to unequal health outcomes.

We will, with our community planning partners, use this information to take appropriate actions to reduce the health inequalities in our city.

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 evidence-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 need 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"**⁸

⁷<https://www.gov.scot/publications/mental-health-strategy-2017-2027/>

⁸<https://www.gov.scot/publications/rights-respect-recovery/>

113 (40%) of the city's data zones are in the **20% least deprived** areas of Scotland. However, there are **22 (8%)** data zones in the **20% most deprived** areas of Scotland.

Females in the most deprived areas have a life expectancy of **77.7 years** compared to **84.1 years** for those in the **least deprived** quintile - a difference of **6.4 years**.

Males in the most deprived area (SIMD 2016) in Aberdeen have a life expectancy of **72.0 years** compared to **81.0 years** for those in the **least deprived** quintile - a difference of **9 years**.

It is estimated that over a fifth (**21.1%**) of adults in **Aberdeen City** smoke - lower than Scotland at **24.3%**. Those in the **most deprived areas** are **more likely** than those in the **least deprived areas** to smoke (**32%** compared to **12%**).

4.2 Resilience

Resilience can be understood to be the ways in which people and organisations adapt 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 in response to life's day-to-day challenges.

Supported self-management means moving away from a model where people are passive recipients of care and treatment towards a more collaborative relationship where they are active partners taking greater responsibility for their own health and wellbeing. Many people with long-term conditions already make appropriate decisions and manage many factors that contribute to their health and wellbeing on a day-to-day basis. For this shift to be effective, people 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.

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

Unpaid carers are significant partners and our health and social care services could not function as well as they do were it not for their contribution. We will ensure that the support offered to all carers, is targeted both at their individual outcomes and the personal outcomes of those being cared for.

Our **Carers Strategy 2018-2020**⁹ 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 outwith caring if they so choose.

⁹<https://www2.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey>

¹⁰<https://www.aberdeencityhsc.scot/globalassets/carers-strategy---march-2018.pdf>

In **2016/17** there were **1,520 alcohol-related hospital stays** in Aberdeen City. While the rate of stays has **decreased** over the past 10 years, it is still higher than that for Scotland (**705.4** compared to **680.8** per 100,000 population).

In **2013-2016**, **27%** of adults in Aberdeen City were **drinking above** the guideline recommendations of **14 units** per week.

In **2016/17** there were **45** alcohol-related **deaths** in the City. The **alcohol-related mortality rate** is now at its **highest level** since 2005-2009 and **higher** than the **average rate** for Scotland.

The **alcohol-related mortality rate** varies across the city ranging from **0.0** to **91.2** per **100,000 population**.

Priorities

Promote and support self-management and independent living for individuals

Value and support unpaid carers

Commitments

We will continue to invest in our 'Promoting self management and building community capacity' transformation portfolio

We will 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

Evidence

% of adults able to look after their health

% adults supported to live at home independently

Use of community alarm and telecare services

Number of unpaid carers supported

Feedback from unpaid carers in relation to support, involvement and having a life alongside caring

4.3 Enabling

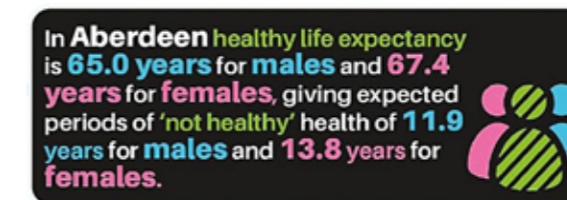
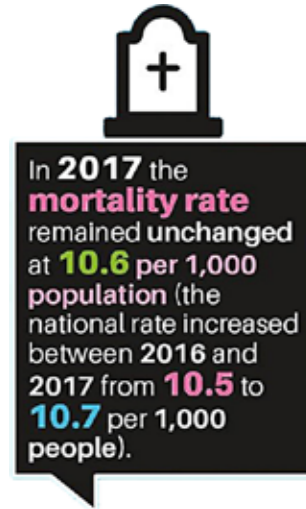
This approach means services are tailored to the needs of individual people, so that they have access to the right care, in the right place at the right time. It means that there are no in-built assumptions of what someone needs or a uniform 'one size fits all' provision but there are instead appropriate directions to other resources and services as and when appropriate for each individual.

Primary care is a crucial 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 many other health services.

We know that we have workforce recruitment challenges to overcome but even so, this sector has shown a continuing ability to introduce new ways of delivering health care. 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**¹¹ outlines our proposed initiatives to address this sector's significant operating challenges.

We are mindful, though, of those who are 'furthest from the point of care' – not in a geographical sense but because of their substance use, 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 aim is not just about better and more effective use of what we currently have but actively redesigning to deliver improved experiences and outcomes.

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

We recognise the need to be responsive to the changing preferences and priorities of people with advanced illness and those of 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 conversations about sensitive anticipatory planning 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.

¹¹<https://www.aberdeencityhsc.scot/globalassets/primarycareimprovementplan.pdf>

Priorities

- 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

Commitments

- We will implement, fully, our Primary Care Improvement Plan
- We will support and implement, as appropriate, the local Unscheduled Care Essentials Action Plan developed with our partner agencies
- We will review our current palliative and end-of-life care provision and develop an action plan to fulfill the strategic framework vision

Evidence

- Primary Care Improvement Plan actions completed
- % of adults aged 75+ living in a community setting
- Number of delayed discharges
- Proportion of last 6 months of life spent at home or in a community setting

Priorities

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

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

Commitments

We will develop a coordinated engagement plan for all the partnership's activities and initiatives with our client and patient groups

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

Evidence

Coordinated Engagement Plan produced

Level of social isolation reported

4.4 Connections

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.

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.

People are healthier when they feel connected to things that matter to them. This is why the IJB has previously endorsed Community Planning Aberdeen's **'Engagement, Participation and Empowerment' Strategy**¹². Working with our citizens to co-produce the outcomes that matter to them is an important principle for us.

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.

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 not be realised if transport challenges are not addressed.

Perceptions of loneliness and isolation can differ across client groups and age groups. 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, early death.

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**¹³ which has as its first outcome "people feel connected to their communities".

¹²<https://communityplanningaberdeen.org.uk/wp-content/uploads/2017/08/Engagement-participation-empowerment-strategy.pdf>

¹³<https://www.aberdeencityhsc.scot/globalassets/athegither-in-aberdeen-strategy.pdf>

4.5 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. 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.

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.

The decision to implement a four-locality model was taken in the pre-integration shadow year.

Our proposed three-locality model (Figure 3.1) will result in a closer alignment with community planning structures and activities, better partner collaborations, more public clarity and a better focus on areas where people experience poorer outcomes. These three localities (North, Central and South) again cover the whole city as the legislation¹⁴ obliges and, crucially, the three community planning localities would be wholly within their respective ACHSCP localities.

Many of our services are delivered by our partners in the third, independent and housing sectors. Many organisations in these sectors have positive relationships with the people who use their services and their carers and have wider connections with our local communities.

The depth 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 and often depend on these services.

We strongly believe that well-supported and well-resourced care makes a significant contribution towards a more stable health and care environment and the development of enhanced models of care. **Our Market Facilitation Statement**¹⁵ shows how we will seek to develop the sustainability of our valued providers.

¹⁵<https://www.aberdeencityhsc.scot/globalassets/strategic-commissioning-implementation-plan.pdf>

Priorities

Implement our three-locality model

Develop a diverse and sustainable care provision

Commitments

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

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

Evidence

Coordinated Engagement Plan produced

Level of social isolation reported



24% of the city's **population** was **born outside the UK** (compared to **9.0%** for Scotland). Of those, it is estimated that **60%** are from **EU countries** and **40%** from **non-EU countries**.

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

Aberdeen has a **higher proportion of working age people** and a **lower proportion of under 16 year-olds** and **people of pensionable age** than does Scotland.

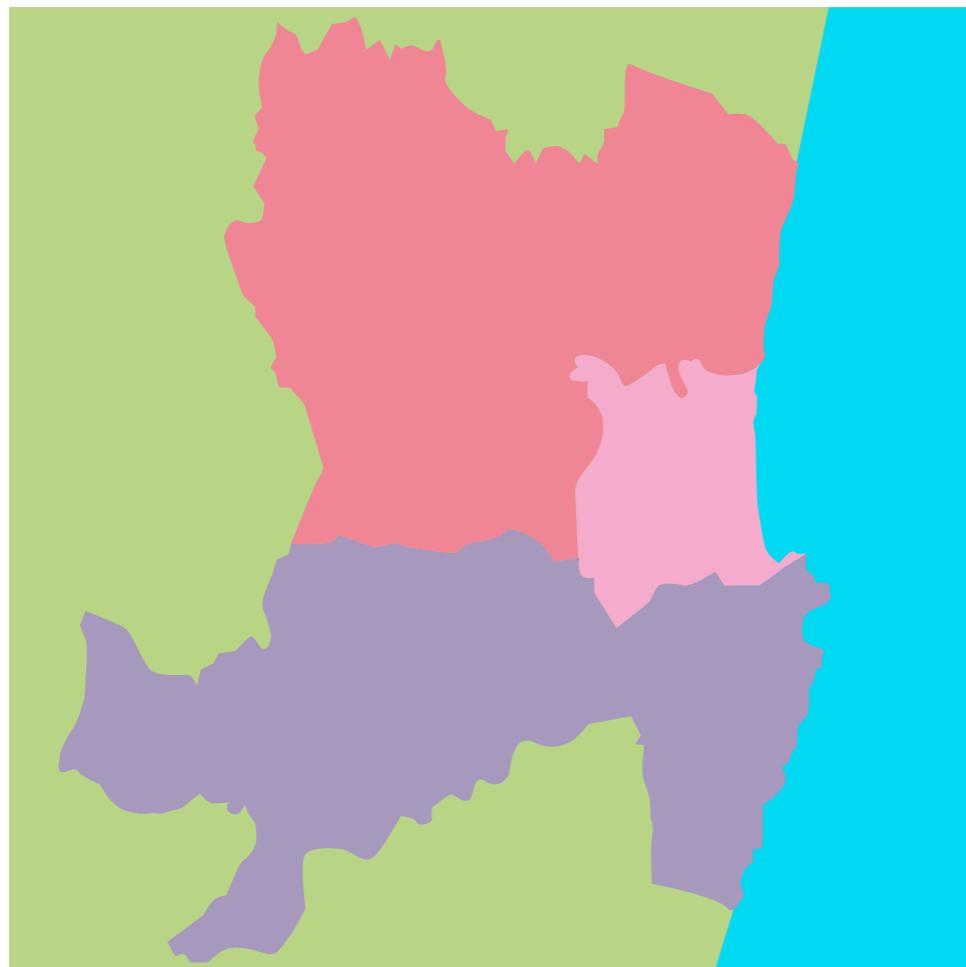


Figure 3.1 Proposed 3-Locality Model.

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

¹⁴<http://www.legislation.gov.uk/asp/2014/9/contents/enacted>

5. Our Enablers

Our enablers are those fundamental elements which we need to develop further in order to meet our strategic objectives.

- empowered staff
- principled commissioning
- digital transformation
- 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 activities.

5.1 Empowered staff

Our staff groups across the health, social care, third, independent and housing sectors are pivotal to our aspirations – and there is a strong relationship between the morale of staff and people's experiences of using our health and social care services.

Valuing our staff and empowering them all to work as positively and collaboratively as possible will be crucial to delivering 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 need to 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 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.

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

Evidence

- Staff satisfaction results from iMatters survey
- Staff absence rate
- Staff turnover rate

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 apply the learning 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 our staff an effective voice, opportunities, security, fulfilment and respect. 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 endorsed the Ethical Care Charter 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 need to offer similar supports to other elements of our workforce.

5.2 Principled Commissioning

Our approach to commissioning is collaborative and generates an innovative range of options to achieve shared outcomes.

The commissioning of services will be one of the partnership’s most important functions as it seeks to ensure that all services enhance the quality of life for the people and their carers now and in the future. We recognise that it will be most effective if it is done in partnership with 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-system approach
- ✓ Commissioning actively promotes solutions that enable prevention and early intervention
- ✓ Commissioning activities balance innovation and risk
- ✓ Commissioning decisions are based on a sound methodology and appraisal of options
- ✓ Commissioning practice includes solutions co-designed and co-produced with partners and communities
- ✓ 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 people commissioning and controlling their own care through individual budgets or direct payments will need consistent and accurate information that clearly, without jargon, explains the options and opportunities available.

All our commissioning will be respectful of the appropriate legislation, mindful of best practice such as the **Ethical Care Charter**¹⁷, 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.

5.3 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 part in our lives in so many other ways. There are significant opportunities to introduce digital solutions across all sectors and services. We aspire to reach a point 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 continue to engage with us.

Commitment

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

Evidence

- Commissioning Implementation Plan refreshed with clear links to Strategic Plan aims, priorities and commitments

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 to ensure a seamless, coordinated approach to this digital transformation of how we deliver our services

Evidence

- Staff satisfaction results from iMatters survey
- Staff absence rate
- Staff turnover rate

¹⁷<http://www.unison-scotland.org/unisons-ethical-care-charter/>

5.4 Sustainable Finance

Over the next few years we will have to address the significant challenge of health and social care budgets reducing in real terms while demand for services increases. To achieve our objective of improving 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 people 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 strategy establishes the estimated level of resources required by the partnership to operate its services over the next five financial years, given the demand pressures and funding constraints that we are likely to experience.

Implementing this strategy will help us to deliver the ambitions and priorities of the partnership's Strategic Plan, maximise our resources and improve our financial planning across the medium term.

Table 3 below shows the level of budget pressure the IJB will face after assumptions have been made about the level of income likely to be received from partners. The budget pressures 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	2020-21	2021-22	2022-23
	£'000	£'000	£'000	£'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 people's health and wellbeing and which are aligned with the ambitions and priorities of our Strategic Plan. There will be times, however, when disinvestment options will be considered because of ineffective impact, weak alignment and poor value for money.

Our investment/disinvestment decisions 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 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

Evidence

Performance Framework



6.1 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 Framework¹⁸ 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**¹⁹ 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.

6.2 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.





Strategic Aims	Priorities	Commitments
Prevention	<p>Promote positive mental health and wellbeing.</p> <p>Address the factors that cause inequality in outcomes in and across our communities.</p> <p>Reduce alcohol and drug-related harm.</p>	<p>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.</p> <p>We will actively contribute to reducing known health inequalities in the health and wellbeing of our local population.</p> <p>We will support the Alcohol and Drug Partnership in delivering actions to reduce substance related harm.</p>
Resilience	<p>Promote and support self-management and independent living for individuals.</p> <p>Value and support unpaid carers.</p>	<p>We will continue to invest in our 'Promoting self-management and building community capacity' transformation portfolio.</p> <p>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</p>
Enabling	<p>Reshape our primary care sector.</p> <p>Shift the balance of care from the acute health sector</p> <p>Develop our palliative and end of life care provision</p>	<p>We will implement fully our Primary Care Improvement Plan.</p> <p>We will support and implement as appropriate the local Unscheduled Care Essential Actions Plan developed with our partner agencies.</p> <p>We will review our current palliative and end of life care provision and develop an action plan to fulfil the strategic framework vision.</p>
Connections	<p>Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.</p> <p>Counter the perception of loneliness and isolation experienced by all age groups.</p>	<p>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.</p> <p>We will develop the social capital of our partnership across all sectors and services.</p>
Community	<p>Enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.</p> <p>Develop a diverse and sustainable care provision.</p>	<p>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.</p> <p>We will refresh our Market Facilitation Statement and develop an Action Plan showing how we will support our local care provision.</p>



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