NHS Grampian

ABERDEEN CITY COUNCIL

Aberdeen City Health & Social Care Partnership

A caring partnership

Strategic Plan 2019-2022

Aberdeen City
Health & Social Care
Partnership
A caring partnership

If you require further information about any aspect of this document, please contact:

Aberdeen City Health & Social Care Partnership
Business Hub 8, 1st Floor North
Marischal College
Broad Street
Aberdeen
AB10 1AB

01224 523237
ACHSCPEnquiries@aberdeencity.gov.uk
aberdeencityhscp.scot
twitter.com/HSCAberdeen

Contents

Aberdeen City
Health & Social Care
Partnership

A caring partnership

This document is also available in large print, other formats and other languages on request.

Please contact Aberdeen City Health and Social Care Partnership on 01224 523237 or ACHSCPEnquiries@aberdeencity.gov.uk

For help with language / interpreting and other formats of communication support, please contact 01224 522856 / 522047

ভাষা/ইন্টারপ্রেটিং এবং অন্যান্য ফরমেটের যোগাযোগ সাহায্যের জন্য দয়া করে :01224 523 542 নম্বরে যোগাযোগ করবেন।

如果需要語言/傳譯及其他形式的傳訊支援服務，請聯絡:01224 523 542。

Если требуется помощь при выборе языка /переводчика или других способов общения, звоните по телефону : 01224 523 542

للحصول على مساعدة بخصوص اللغة/الترجمة و وسائط الاتصال الأخرى، الرجاء الاتصال بالرقم التالي:01224 523 542

Lai saņemtu palīdzību sakarā ar valodu/tulkošanu un citiem iespējamiem komunikāciju atbalsta formātiem, lūdzu zvanīt 01224 523 542

Jei jus turite sunkumu su kalba/ vertimu ar kitomis bendravimo formomis, skambinkite 01224 523 542.

Jeśli potrzebujesz pomocy **językowej / tłumacza** lub innej pomocy w porozumiewaniu się, proszę zadzwonić pod numer: 01224 523 542

Strategic Plan on a Page

OUR VISION:

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

OUR VALUES:

- Caring
- Person Centred
- Enabling

OUR AIMS

Prevention	Resilience	Personalisation	Connections	Communities
Working with our partners to achieve positive health out-comes for people and address the preventable causes of ill-health in our population	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 reduce 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 DELIVERY PLANS

- Mental Health
- Action 15
- Suicide Prevention
- Learning Disabilities
- Autism
- Tobacco
- Oral Health
- Carers
- Primary Care Improvement Plan
- Locality Plans
- Alcohol
- Drugs
- Criminal Justice

OUR ENABLING PLANS

- Medium Term Financial Strategy
- Workforce
- Commissioning
- Infrastructure

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL

- Reduced Attendances at A&E
- Lower Premature Mortality Rate
- Reduction in emergency admission rate
- Increase % of people living independently in the community
- Improved Health Literacy
- Improved Healthy Life Expectancy
- Improved Vaccination Uptake
- Reduced levels of social isolation reported
- Increase in % of adults who report they are in housing most suitable for their needs
- Increase in % of carers who report they are supported to have a life alongside caring
- Increase in % of adults able to look after their health very well or quite well
- Increase in physical activity and healthy weight
- Increase in % of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life
- Increase in % of adults supported at home who agreed that their health and social care services seemed to be well coordinated
- Increase in % of adults receiving any care or support who rated it as excellent or good
- Increase in number of people with positive experience of care provided by their GP practice,

Foreword

Aberdeen City Health & Social Care Partnership and its governance body, the Integration Joint Board, have now been operating for almost three years – and during this time, real progress has been made to integrate the health and social care services delegated from our partners, Aberdeen City Council and NHS Grampian.

This vital work will now continue over the period of our new Strategic Plan 2019–22.

This is a time of challenge and change. Demand for our services is rising as people live longer but often with complex needs. We also face rising costs, reduced finances, and recruitment challenges.

But we must not diminish the quality of service we provide. To rise to the challenges ahead, we must transform the landscape of this complex and sensitive sector of public service to bring about an ever-deeper integration of our health and social care services.

Our new Strategic Plan sets out the aims, commitments and priorities, which underpin this process of change – importantly, in alignment with Community Planning Aberdeen's Local Outcome Improvement Plan, NHS Grampian's Clinical Strategy and Aberdeen City Council's Local Housing Strategy.

We must change at pace and we must transform in step with all of our partners because none of us alone can deliver improvement.

Our Strategic Plan shows how we will help to build more resilient and better-connected communities. It demonstrates how we will encourage and enable supported self-management and our prevention agenda to help manage future demand for services. And it sets out how must modernise how we do things, building in collaboration and co-operation within our own workforce and the public – to support our citizens to take more control over and responsibility for their own health and wellbeing.

We must do things better and smarter so that our funding delivers ever-more joined-up, locality-based models of health and social care – models which fully involve our citizens in planning and delivery, in a culture of transparency and trust.

Our new Strategic Plan maps out what we will do to achieve all this and how we will measure our success.
This is our plan – but it is also your plan. Because only by working as partners can we transform to thrive.

Sarah Duncan
IJB Chair Councillor

Sandra Ross
ACHSCP Chief Officer

1. 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). The Partnership's first Strategic Plan was published in April 2016 and had a lifespan of 3 years. This latest version of the Strategic Plan covers the next 3 years.

Our Strategic Plan outlines how we plan to deliver improvements to our existing services which will have a positive impact on the health and wellbeing outcomes for people living and working in Aberdeen City. This plan is mainly for them, but it is also for our staff and partners without whom we could not deliver. The services we deliver aim to meet a wide variety of needs. In developing the Strategic Plan, we reviewed our performance against our existing priorities, considered the emerging risks (mainly in terms of increasing demographics, reduced finances, and difficulties in recruiting and retaining staff) and consulted with our customers, our partners and our staff. This helped us to clarify our strategic aims, commitments and priority areas that are detailed in this plan.

The overarching aim of ACHSCP is to provide integrated services which improve people's health and wellbeing. In considering our strategic direction for the next 3 years, we have taken into account the national integration principles so we will ensure our 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 Vision

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

Our Values

- Caring
- Person centred
- Enabling

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

Our Strategic Intent

We face demographic and financial challenges now and in the future. Doing more of the same is not a sustainable option for us. We need to have honest conversations with our customers, our staff and our partners about their expectations and their contributions. We will work together to enable people to keep as well as they can in a way that suits them. We accept that we will have to reshape and transform how and where we deliver services as well as focus our effort on addressing preventable factors. 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 we will achieve this.

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

Everyone is as healthy as can be, has the knowledge, understanding and skills to look after themselves, their families and their communities

Businesses work closely with communities and volunteers

Positive mental health and wellbeing is shared by all

The healthiest choice is the easiest and preferred option

People know who to turn to by being able to easily access health information

Health status is shared across the City – health inequalities are uncommon

People are safe, healthy, wealthy and happy

People of Aberdeen are socially and digitally connected

The City is safe to live, work and play

Citizens of Aberdeen are physically connected – it is easy to get in, out and around the City

People take responsibility for their own health and participate in preventative and anticipatory care

There is a sense of pride and passion in Aberdeen

Equal opportunities are enjoyed by all

There is a strong sense of independence, resilience, confidence, self-esteem and aspiration within our communities

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

	Strategic aim	What does this mean?
1.	Prevention	Working with our partners to achieve positive health outcomes for people and address the preventable causes of ill-health in our population.
2.	Resilience	Supporting people and organisations so they can cope with, and where possible overcome, the health and wellbeing challenges they might face.
3.	Personalisation	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 reduce 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 will make specific commitments against each of these aims and identify priorities.

As a Partnership we already have a number of delivery plans in place and in development for example for Carers, people with Learning Disabilities, Autism and Mental Health. In addition, we have a role to play in helping our partners deliver on their plans and as such, where relevant, we have identified a commitment we have made in particular partner plans for example the Local Outcome Improvement Plan and NHS Grampian's Clinical Strategy.

Not all delivery plans are service or condition specific. Some are "enabling" plans i.e. they support us to deliver our services. Examples of enabling plans are our Medium-Term Financial Strategy and our Workforce Plan.

Our Strategic Plan is the high level, overarching plan that sits above all of these plans and we do not intend to duplicate the detail that is contained in these plans here. The aims, commitments and priorities are all pitched at a strategic level. Whilst some of our existing plans will need to be refreshed in light of the new aims, commitments and priorities in this new Strategic Plan, we hope our staff and our partners recognise their contributions to our Strategic Plan and likewise the role we have to play in helping them deliver on their plans.

We have also identified the performance measures that will help us identify whether we are achieving what we set out to do. Our Performance Framework is mapped to the aims, commitments and priorities and we will collect and share data that helps us to have the conversations around what is working well and what needs to change.

Our strategy will play an important role in ensuring that people's experiences match or exceed their expectations when they use our services. When designing and delivering our services it is fundamental that local community voices are heard.

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

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

Scotland's **Public Health Priorities** have strongly influenced the development of this plan.

These are: -

- **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**

Their stated aim is for people to be as healthy as they can be, and this is set within a broader desire to reshape our attitudes towards health and wellbeing.

In its **Health and Social Care Delivery Plan 2016**[3] , the Scottish Government encourages us to focus on:

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

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. ACHSCP 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.

The **Community Empowerment (Scotland) Act 2015** empowered community organisations by strengthening their voices in decisions about public services. Community Planning Aberdeen's **Engagement, Participation and Empowerment Strategy** sets out a vision of collaboration & empowerment and offers a positive way of working with communities. Its objectives are ones which ACHSCP has adopted i.e.

- **communities' inherent strengths and assets – their people, their energy, their connections, sense of purpose and resources, and their abilities to self-organise and exercise autonomy – will be valued as a fundamental building block of a healthy society**
- **every community will be equally heard and listened to**
- **participation will be the norm rather than the exception**
- **staff will be empowered to work in collaborative and empowering ways**
- **people will be able to see the difference that involvement has made**

A close alignment with the priorities (Prevention, Self-Management, Planned Care, Unscheduled Care) set out in **NHS Grampian's Clinical Strategy (2016-2021)** will ensure improved experiences and outcomes for the people who use our services and their carers. This is related to the NHS Scotland Clinical Strategy and the principles of realistic medicine in the related reports from the Chief Medical officer *(Realistic Medicine and Realising Realistic medicine).* People often want to be more involved in decisions about their care, but they may not know what questions to ask. We need to support shared decision making and empower people to be confident to ask questions about their care and to help us manage demand in the most appropriate way, including supporting self-management.

The Aberdeen City Council **Local Housing Strategy (LHS) 2018-2023** sets out how local housing need and demand will be addressed and how this contributes to the national housing priorities. The LHS 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.**

Aberdeen City Health & Social Care Partnership
A caring partnership

ACHSCP will work closely with ACC Housing colleagues to deliver the positive outcomes identified in the LHS Joint Delivery Action Plan.

Local Development Plan - Future Demand and Growth" - the Aberdeen City and Aberdeenshire Strategic Development Plan (SDP) 2014 sets out a target of building 31,500 new houses by 2035, achieving an annual house building rate of 3,000 per year by 2020. Over 50% of these will be built in Aberdeen City. The greatest demand for services over the next seven years will be in the North and South Localities. There are additional housing units being developed which will require a 'rebalance' of existing General Medical Services (GMS) and the delivery of new ways of working and new professional roles to ensure patients get access to the right person, at the right place at the right time. ACHSCP will continue to work with ACC and NHSG to ensure priorities are identified for the investment in infrastructure to modernise primary and community care services. The Strategic Housing Investment Plan (SHIP) sets out the local priorities for the delivery of affordable housing, this includes a 15% target for wheelchair accessible housing.

One of the key drivers for **Aberdeen City Integrated Children's Services Plan "Children Are Our Future" 2017/20** is that children have the best start in life. We acknowledge the need to build stronger connections between children and adult services. Investment in early years/family support will enable current and future generations to enjoy improved health and wellbeing and have better life outcomes. In particular children and young people who are looked after or care experienced are at greater risk of having poorer life chances and we need to ensure we deliver on our corporate parenting responsibilities. 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.

Not least because Aberdeen City commissions almost all of its adult social care services from external organisations, these **third and independent sector providers** and their representative bodies – Aberdeen Council for Voluntary Organisations (ACVO) and Scottish Care - are key partners in our service delivery. Bon Accord Care (BAC), the Arm's Length External Organisation (ALEO) wholly owned by Aberdeen City Council and the delivery arm for older people's social care services, is also a key partner. ACHSCP will work with these partners to deliver on its strategic commissioning intentions as detailed in the Strategic Commissioning Implementation Plan. We need to foster and build good working relationships with these service providers as we cannot deliver our services without them. They are the experts in their field and we value that expertise and will work with them to co-design and co-produce the highest quality, efficient and effective services that we can within the finances available, ensuring that we deliver the best possible outcomes for the people in Aberdeen who use these services.


Local Outcome Improvement Plan
Tobacco Control Plan
Towards a Fairer Aberdeen
Unscheduled Care
Diet and Healthy Weight
Nursing 2030 Vision
Integrated Children's Services Plan
NHSG Clinical Strategy
Local Housing Strategy
Every Life Matters
Aberdeen Adapts
Public Health Priorities for Scotland
Health and Social Care Delivery Plan
Active and Independent Living Programme
ACHSCP Strategic Plan
British Sign Language
Type 2 Diabetes
See Hear Strategy
Sustainable Food Charter
Engagement Participation and Empowerment

In addition to universal health services which are available to the general public, the services provided by ACHSCP include adult social care and health services for older people and people with learning disabilities and mental health and substance misuse problems, as well as Disabled Adaptations and support for those in the criminal justice system. They also include primary and community healthcare services including Allied Health Professionals (AHPs), General Practitioners (GPs), District Nurses, community dental, ophthalmic and pharmacy services, Public Health, Health Visiting and School Nursing.

In addition to our core services, the Partnership 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.

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

Grampian-wide service we are responsible for	Hospital services we have strategic planning responsibility for

• 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

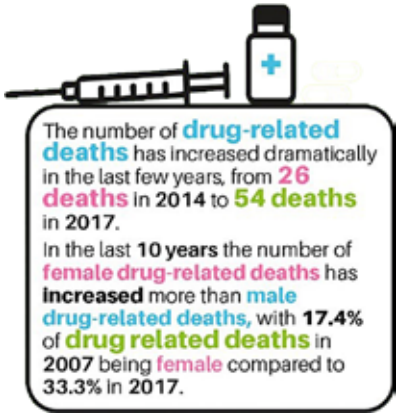
Table 2 ACHSCP Strategic Planning (Hosted/Acute) Responsibilities.

Aims	Commitments	Priorities (timescale across the lifetime of the plan unless otherwise identified)
Prevention	• Promote positive health and wellbeing • Reduce harmful impact of alcohol, drugs, tobacco, obesity and poor oral health • Address the factors that cause inequality in outcomes in and across our communities	• Develop Mental Health Strategy (Year 1) and deliver on this in future years • Deliver Action 15 Plan • Refresh our local Suicide Prevention Plan • Develop a local Dementia Plan (Year 1) • Deliver on Scotland's Public Health Priorities • Work with the Active Aberdeen Partnership to improve levels of physical activity • Deliver health improvement actions for early years, children and young people • Work with partners to address environmental factors – place planning and Aberdeen Adapts (in relation to climate change) • Work with Alcohol and Drug Partnership (ADP) to deliver Drug Strategy • Work with Alcohol and Drug Partnership (ADP) to refresh Alcohol Strategy (Year 1) • Refresh Tobacco Strategy (Year 1), • Develop local action plans on healthy diet and weight and Type 2 diabetes (Year 1) • Develop local plan for delivery of dental services (Year 1) • Develop a framework for addressing health inequality (year1) • Work with the Integrated Children's Services to identify ways to give children the best start on life • Work with the Grampian Independent Advocacy Group to review advocacy provision • Work with NESS to review delivery of the national SeeHear Strategy and with ACC to implement the British Sign Language Plan • Deliver the Action Plan for Learning Disabilities • Deliver the Action Plan for Autism • Improve levels of Health Literacy
Resilience	• Promote and support self-management and independent living for individuals • Value and Support Unpaid Carers • Develop coordinated arrangements which enable people of	• Deliver self-management transformation projects • Work closely with Housing colleagues to deliver the positive outcomes identified in the LHS Joint Delivery Action Plan. • Deliver disabled adaptions where appropriate • Develop a local plan for the delivery of rehabilitation services (Year 1) • Deliver on our Action Plan for Carers

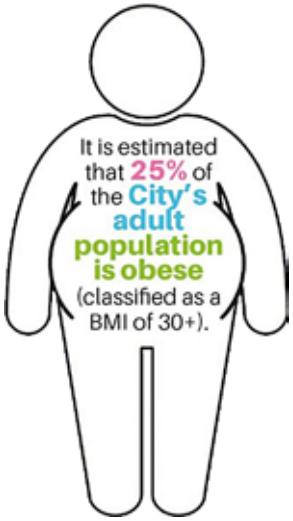
Aims	Commitments	Priorities (timescale across the lifetime of the plan unless otherwise identified)
Resilience	all ages with complex physical disabilities to maintain their health and avoid unnecessary complications	
Personalisation	• Provide the right care, in the right place, at the right time • Reshape our community and primary care Sectors • Develop our palliative and end of life care provision	• Deliver on the Unscheduled Care 6 Essential Actions • Continue to improve delayed discharge experience • Develop a plan for transitions at all stages starting with children with disabilities transitioning to Adult Learning Disability Services in Year 1 • Deliver on our Primary Care Improvement Plan • Modernise infrastructure to support the delivery of primary and community care services • Continue to deliver initiatives related to Shifting the Balance of Care to the community • Continue to deliver initiatives related to preventing admission to hospital • Work with regional colleagues to develop strategies related to cancer and palliative care
Connections	• Enable our citizens to have opportunities to maintain their well-being and take a full and active role in their local community • Reduce the level to which people of all ages feel lonely and isolated	• Continue to deliver the Link Worker Project • Develop the Silver City Surfers project • Develop a local Dementia Plan (Year 1) • Deliver on our Action Plan for Carers • Develop a plan to reduce social isolation (Year 2)
Communities	• Enable our communities to utilise their energy, strengths, people and assets to self-organise and exercise autonomy • Develop a diverse and sustainable care provision	• Promote community engagement, participation and empowerment • Implement the new locality model • Promote an asset- based approach • Encourage co-design and co-production of services • Work with our partners in Community Planning to deliver on the LOIP • Work on delivering our Medium-Term Financial Framework • Review our Commissioning Plan (Year 1) • Develop a Market Facilitation Plan (Year 2) • Develop a Risk Management and Business Continuity Plan • Work with the Sustainable Food City Partnership Aberdeen to deliver the Sustainable Food Charter

6.1 Prevention

We recognise that if we want to improve the health and wellbeing of our citizens, we must identify and over-come any barriers to change. We strongly believe that compassionate and inclusive leadership can help to unlock the potential to transform services and we will work with citizens, communities and partners to promote change. 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.



This includes working with our partners in Children's Services to ensure current and future generations live well. If we can keep people as healthy and as well as possible, we can keep them out of hospital and away from GP practices unless and until it is appropriate for them to be there. We will work with our partners to ensure we "make every opportunity count". Colleagues who are already visiting clients' homes for other reasons (fire safety, crime detection or prevention) can alert us to health and social care needs that could benefit from early intervention.



There is no shortage of health improvement messages, including keeping physically active, eating healthily, minimising our alcohol intake, avoiding non-prescription drugs, quitting smoking and good oral health. What is also needed is an approach that recognises our experiences of the complexity and cumulative impact of health conditions, and an understanding of what may work for each individual and their desired personal outcomes. We need to make healthy choices the easy choices. 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 seen as a predictable consequence of growing older in Aberdeen.

Tobacco use, obesity and oral ill-health can all have harmful impacts on health. Obesity is one of the contributing factors to the development of type 2 diabetes which can lead to other negative impacts on a person's health. Promoting a healthy diet and weight and increasing opportunities for physical activity will go some way to off-setting these effects. We also need to understand the impact food poverty and household food insecurity have on families' ability to make healthy food choices. The right kind of support that can help address this. As well as raising the awareness of the effects, we need to provide information and opportunities so people can understand the impact of the choices they make on their health and wellbeing.

If people are to become more active, then they need access to open/green space. We will work with our partners to influence the provision of these. We also need to better understand the impact climate change will have on the future health of the population and include this within our awareness-raising and education.

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.**

Poor mental health is 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. We want our citizens to enjoy the best possible mental health and wellbeing. When anyone begins to experience poor mental health, appropriate supports should be available in their communities for them to access. The national Mental Health Strategy 2017-2027 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.

No death by suicide should be regarded as either acceptable or inevitable. Suicide is preventable. We want to ensure that help and support is available to anyone contemplating suicide and to those who have lost loved ones to suicide.

Health inequalities across the city are unfair and avoidable. Reducing and overcoming such inequalities are part of our Fairer Scotland Duty and will be our focus. Alcohol and drug use significantly contribute to poorer health and wellbeing across all parts of our city. 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".

We want all members of our communities to have the same opportunities and experiences. Our citizens with learning difficulties, autism, a sensory impairment or those that have been through the criminal justice system, can all experience inequality in outcomes. We have developed plans to try to redress the balance and delivery of these will be an area of focus over the next three years. We will identify and work closely with those undertaking caring roles who can speak on behalf of cared-for people and ensure that appropriate advocacy services are in place for those who have difficulty making their own voice heard.

Health literacy, i.e. the degree to which people have the capacity to understand the information they need to make appropriate health decisions is not equal across all of our communities. We will ensure that health information is provided in an easy-read format and that the use of techniques such as "Teachback" are used as widely as possible to improve the levels of health literacy.

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).

6.2 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 ownership of 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. We have implemented a number of transformation projects such as the introduction of Community Link Practitioners in all GP practices, the implementation of a "House of Care" model which involves the individual in planning conversations with their healthcare professional(s), and the development of a services directory which people can use to find support that best suits their needs. We will continue to embed these initiatives over the lifetime of the Strategic Plan to build resilience in the community.

Good quality housing and related services such as the use of the community alarm or telecare equipment play a key role in enabling people to live independently and safely at home for as long as is reasonably practicable. We will work with our colleagues in Aberdeen City Council Housing and Registered Social Landlords to ensure that people have housing that is right for their needs including arranging adaptations to their existing homes, if relevant, rather than compounding a disabling condition by having to move to a new house. The approach to adaptations should be tenure-neutral i.e. there should be equivalency regardless of the type of property an individual lives in. In addition to this we plan to map review specialist housing provision across all client groups, mapping the existing stock and developing a strategic approach to delivery of new accommodation models.

Stable, sustainable employment is an important foundation for people's health and wellbeing. Employers play a critical role in supporting positive health and wellbeing outcomes by promoting active physical and mental health initiatives and sustaining people with health conditions in work. ACHSCP will look to be a public health partner with the city's employers.

Many people of all ages live with complex physical disabilities that can often bring unnecessary complications such as additional injuries as a result of falling in the home. We will develop coordinated arrangements through rehabilitation and reablement which enable them to better manage their conditions and maintain their best health.

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 2018-2021 Action Plan sets out key actions that will support unpaid carers in Aberdeen to overcome the impact their caring role may have on their life and enable them to have a life alongside caring if they so choose.

6.3 Personalisation

This approach is where 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 instead there is appropriate signposting to other resources and services as and when appropriate for each individual. This identification of the right care needs to start early and follow through with the individual as they transition through the various stages in their life. We are developing a Transitions Plan that will identify actions to help ensure this happens.

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 types of care. We continue to shift the balance of care away from residential and hospital settings into the community and are actively seeking to prevent hospital attendance and admission so that conditions can be treated and supported in the community. Our service provision has a significant emphasis on prevention and supported self-management.

Primary care is a crucial area of operation, 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. Our Primary Care Improvement Plan outlines our proposed initiatives to address this sector's significant operating challenges. Our community care services can also benefit from review.

We are embarking on a programme of improvement projects that will support the reshaping of both the primary and community care sectors. This includes a modernisation programme of the infrastructure that supports the service delivery. Most of our social care services are provided by our partners in the third and independent sectors. We know that we all have workforce recruitment challenges to overcome but even so, all partners have shown a continuing ability to introduce new ways of delivering health and social care.

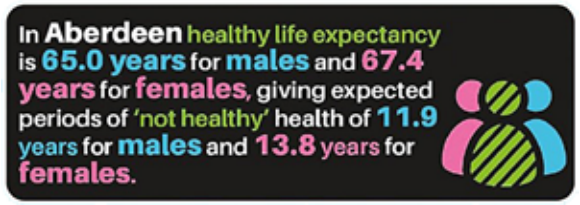
Palliative care seeks to improve the quality of life of people who have a terminal illness or life-limiting conditions including cancer. End-of-life care is that part of palliative care which seeks to ensure that a person dies as peacefully and with as much dignity as possible. We recognise the need to be responsive to the changing preferences and priorities of people with advanced illness and those of their carers. Although the choices that are expressed after diagnosis may well change later, sensitive anticipatory planning will help ensure that care meets the needs and wishes of the individual and, where appropriate, their carer.

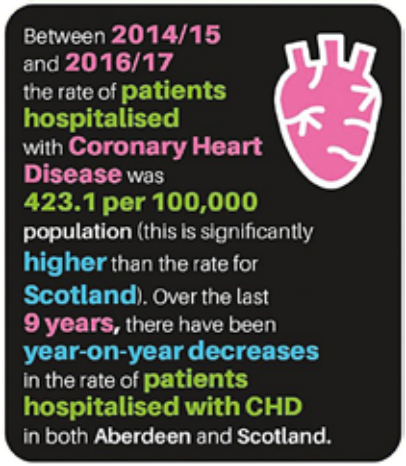
People are healthier when they feel connected to things that matter to them. We want our citizens to feel connected to their community and have opportunities to make connections across their community, depending on their need. Some may be living with dementia or undertaking a caring role and may wish to seek support from individuals or groups of people in a similar situation. Others may need help getting to grips with technology and could benefit from others with expertise in that area.

There is a wealth of knowledge, expertise, and willingness in the community and we want to help connect those who need with those who can support. Some people may not even realise they can help or believe that they have anything to offer. We want to foster the environment which creates the ability for everyone to make the connection they need.

ACHSCP 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. ACSHSCP has a specific transformation project around community transport and will work with partners to ensure this is delivered with improved transport outcomes for our communities.

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 and in some instances, early death. Offering different opportunities, depending on who we are and where we are, can help address these challenges. We will develop a plan to address social isolation and help promote the positive power of connections.





6.4 Connections

People are healthier when they feel connected to things that matter to them. We want our citizens to feel connected to their community and have opportunities to make connections across their community, depending on their need. Some may be living with dementia or undertaking a caring role and may wish to seek support from individuals or groups of people in a similar situation. Others may need help getting to grips with technology and could benefit from others with expertise in that area.

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.

There is a wealth of knowledge, expertise, and willingness in the community and we want to help connect those who need with those who can support. Some people may not even realise they can help or believe that they have anything to offer. We want to foster the environment which creates the ability for everyone to make the connection they need.

ACHSCP 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.

ACSHSCP has a specific transformation project around community transport and will work with partners to ensure this is delivered with improved transport outcomes for our communities.

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 and in some instances, early death. Offering different opportunities, depending on who we are and where we are, can help address these challenges.

We will develop a plan to address social isolation and help promote the positive power of connections.

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%).

6.5 Communities

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 ensure communities are involve in the planning, design and delivery of our services.

Localities are intended to be the engine room of integration, bringing together our citizens, unpaid carers and professionals from the public, third, independent and housing sectors to reshape our services based on informed practice and local insights. The decision to implement a four-locality model in Aberdeen 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 legislation obliges and, crucially, the three community planning localities would be wholly within their respective ACHSCP localities.

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. This is why the IJB has previously endorsed Community Planning Aberdeen's 'Engagement, Participation and Empowerment' Strategy. 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:

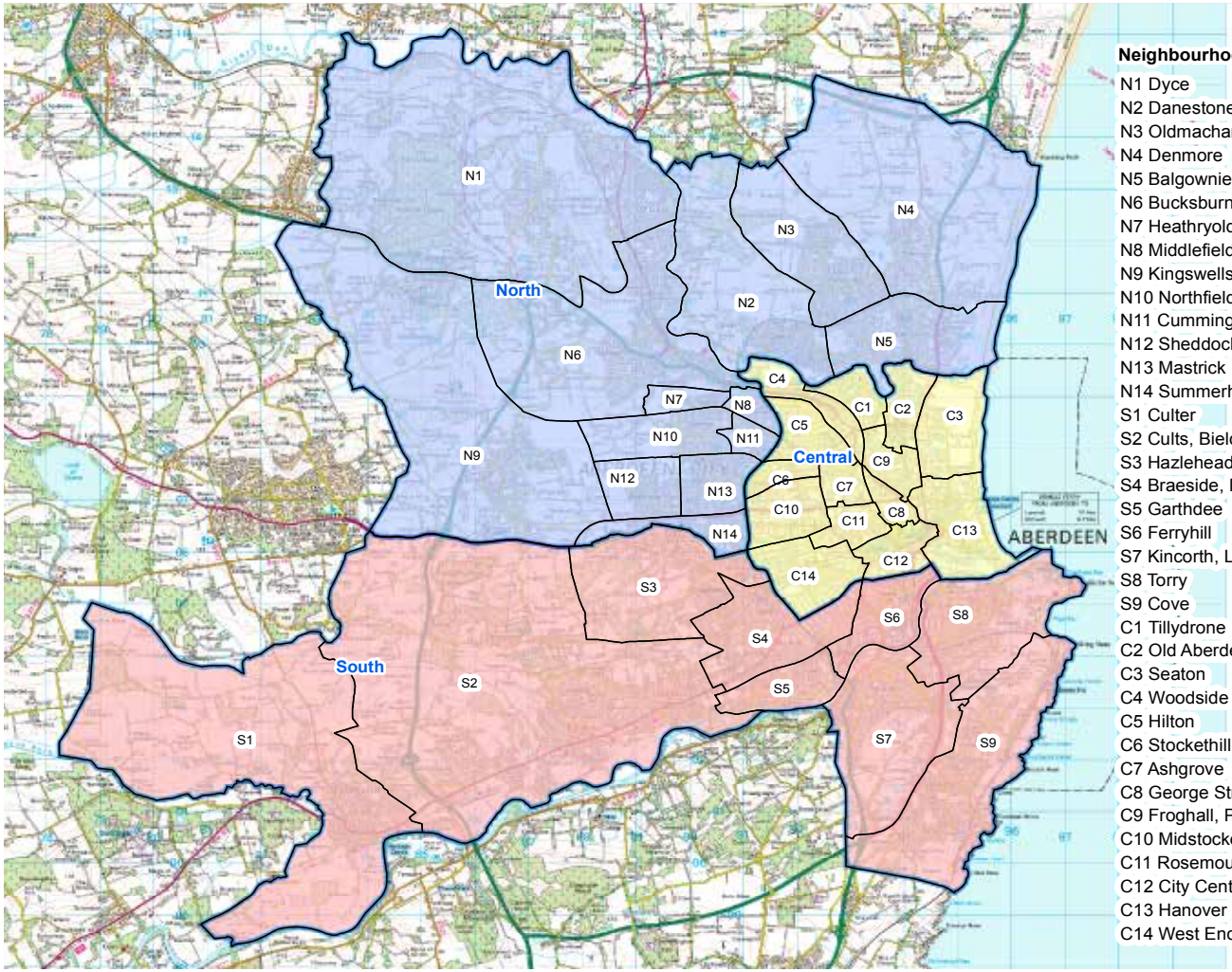
- start with the assets and resources in our communities and identify opportunities and strengths;
- see people as having something valuable to contribute and support them to develop their potential in adding social value to their communities;
- focus on community organisations, encouraging and adding social value and social cohesion at every opportunity.

Our service delivery can only be successful if we have sufficient finances and workforce both in-house and with our partners. There are many challenges to our service delivery, and we need to ensure we are aware of the risks and have mitigations and contingencies in place to enable us to develop a diverse and sustainable care provision. This includes a commitment to sustainable food provision. We will refresh our commissioning plan and develop a market facilitation plan which puts our partners at the centre of designing and delivering services both now and in the future.

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.

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%).



Neighbourhood

- N1 Dyce
- N2 Danestone
- N3 Oldmachar
- N4 Denmore
- N5 Balgownie & Donmouth
- N6 Bucksburn
- N7 Heathryold
- N8 Middlefield
- N9 Kingswells
- N10 Northfield
- N11 Cummings Park
- N12 Sheddocksley
- N13 Mastrick
- N14 Summerhill
- S1 Culter
- S2 Cults, Bieldside & Milltimber
- S3 Hazlehead
- S4 Braeside, Mannofield, Broomhill & Seafield
- S5 Garthdee
- S6 Ferryhill
- S7 Kincorth, Leggart & Nigg
- S8 Torry
- S9 Cove
- C1 Tillydrone
- C2 Old Aberdeen
- C3 Seaton
- C4 Woodside
- C5 Hilton
- C6 Stockethill
- C7 Ashgrove
- C8 George Street
- C9 Froghall, Powis & Sunnybank
- C10 Midstocket
- C11 Rosemount
- C12 City Centre
- C13 Hanover
- C14 West End

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.**

36

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

7. 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
- modern and adaptable infrastructure

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.

Commitment

- Value and empower all staff, both our own and our partners to work as positively and collaboratively as possible in the delivery of health and social care services
- Positively engage with professional and regulatory bodies and trade union representatives

Priorities

- Develop our Workforce Plan (Year 1)
- Work towards adopting the principles of Unison's Ethical Care Charter
- Work towards ACC and NHSG achieving the Carer Positive Award

7.1 Empowered staff

Our staff groups across the public, 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. Our staff are key to delivering positive outcomes to our patients and clients. Taking care of our staff will maximise the impact of these outcomes.

Valuing our staff and empowering them all to work as positively and collaboratively as possible is 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 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 and 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 apply the learning to other sectors and care settings. Positive engagement with professional and regulatory bodies and trade union representatives is essential 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 Partnership 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.

Our Carers Strategy identifies an action for businesses to achieve the Carer Positive Award and we will seek to achieve that and encourage others in Aberdeen to do likewise to help meet the Scottish Government's target of 30% of all businesses with this award. We need to offer similar supports to other elements of our workforce.

7.2 Principled Commissioning

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

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 individuals, families, groups, communities and other agencies that have an interest in the continued wellbeing of the people of Aberdeen.

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 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, and sensitive to the needs of our local care provision. We will not adopt a uniform one-size-fits-all commissioning approach but instead we will be sensitive to age, wellbeing and complexity of need.

Commitment

- Ensure that all commissioned services enhance the quality of life for people and their carers now and in the future
- We will give people more informed choice and flexibility over their care and support

Priorities

- Review Commissioning Plan (Year 1)
- Develop a Market Facilitation Plan (Year 2)
- Embed Self Directed Support into social care delivery. (Year 1)

- ✔ **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**

Commitment

- 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.

Priorities

- Develop and deliver our Digital Transformation Plan in conjunction with our partners.

7.3 Digital Transformation

Digital technology is key to transforming our health and social care services across ACHSCP 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. In developing our digital transformation, we are linking closely with the work that both NHS Grampian and Aberdeen City Council are undertaking to reduce duplication of effort, achieve better value for money and join up systems where appropriate.

7.4 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 Framework (MTFF) 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.

Table 3 below shows the level of budget pressure the Partnership 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 and represent just over 2% of the total budget. To offset these anticipated pressures, key 'financial saving' workstreams have been identified and provisional targets (in brackets) have been set to be delivered from these. The total savings are equivalent to approximately 1.5% of the overall budget.

	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

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 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 are aligned with the aims, commitments and priorities of our Strategic Plan. There will be times, however, when disinvestment options will be considered, particularly when the impact, alignment or value for money delivered by a service is not as strong as it could be.

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. There is a national and a local desire to see the evidence of the impact of our transformation and our evaluation framework will provide that assurance.

Commitment

- Address the significant challenge of health and social care budgets reducing in real terms while demand for services increases

Priorities

- Deliver our Medium-Term Financial Framework

Commitment

Support service redesign and provide modern buildings, equipment, new technologies and effective transport links essential to delivering successful integrated, community-based health and social care services fit for the future

Priorities

Develop and deliver an Infrastructure Plan

7.5 Modern and Adaptable Infrastructure

In these times of changing needs and service redesign, modern buildings, equipment, new technologies and effective transport links are essential to delivering successful integrated, community-based health and social care services fit for the future. The Capital and Services team support both the redesign of services and the development of robust business cases to secure the necessary investment for the related infrastructure required to support the delivery of identified new service models.

This requires collaborative working across primary and community care services to identify the priorities for ACHSCP and to feed these into the planning of our partners (ACC and NHSG) who retain ownership of buildings and lead all funding submissions to the Scottish Government Capital Programmes.

This work is undertaken in line with the NHS Grampian Asset Management Plan, the General Medical Services (GMS) Premises Plan, and the ACC Asset Management Plan. Work has recently commenced to develop an Infrastructure Plan which will support this activity.

6. How will we know we are making a difference

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 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 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.

There are six Ministerial Steering Group (MSG) indicators which are reported on a quarterly basis. These are a subset of the national indicators and have been identified as being the key ones that demonstrate progress on integration. In addition, we have a number of measures that are collecting and reporting for partner plans such as the Local Outcome Improvement Plan and a number of measures which are identified in our own delivery plans. Relevant measures have been aligned to the aims, commitments and priorities in this Strategic Plan and these will be reported over the year to relevant operational forums and to our Audit and Performance Systems and Clinical and Care Governance Committees.

Our aim is not to duplicate effort but to arrange existing performance reporting in such a way that it demonstrates achievement of our Strategic Plan.

Our Annual Performance Report is a statutory requirement. It is published on our website and shows how well we have performed as a Partnership in achieving what we set out to do. Future annual reports will be organised in line with the aims, commitments and priorities of this Strategic Plan.

PREVENTION	RESILIENCE	PERSONALISATION	CONNECTIONS	COMMUNITY
Reduction in number of A&E attendances	Reduction in Emergency Admission Rate (per 100,000 population)	Increase in % of population aged 75+ living in a community setting (including a care home)	Increase % of Community Links Practitioners in post	Increase in total of home care hours delivered
Reduction in number of alcohol-related hospital admissions	Reduction in readmission to hospital within 28 days (per 100,000 population)	Reduction in total number of delayed discharges	Increase number of clients supported by Community Links Practitioners	Reduction in social care unmet need
Reduction in number of alcohol-related deaths	Decrease in falls rate (per 100,000 population|	Increase in the proportion of the last six months on life spent at home or in a community setting	Reduce level of social isolation reported	Increase in residential care occupancy rate
Reduction in number of drug-related hospital admissions	Decrease in premature mortality rate for people aged under 75 (per 100,000 population)	Reduction in number of adverse events	Increased uptake of Silver City project	Increase in proportion of care services graded "Good" (4) or better in Care Inspectorate inspection
Reduction in number of drug-related deaths	Increase in % adults supported at home who agree they felt safe	Increase in % of population registered with a GP	Increase use of Chaplaincy listening service	Decrease in proportion of care service contractually non-compliant
Reduce % of men and women who are obese to 20% by 2021	Increase in % of adults supported at home who agree that they are supported to live as independently as possible	75% of adults should be registered with an NHS dentist by the end of 2020, 78% by the end of 2022 NB: include % participation (i.e. visited within last 2 years)	Increased uptake of Dementia Scholarship	Increase in % of adults supported at home who agreed that their health and social care services seemed to be well coordinated
Reduce suicide rates amongst men in Aberdeen to below 2016 levels (20) by 2021.	Increase in % of adults who report they are in housing most suitable for their needs	Increase in number and percentage of new-build properties developed and fully accessible for people with particular needs	Achievement of Dementia Friendly City status	Increase in total % of adults receiving any care or support who rated it as excellent or good
Reduce tobacco smoking by 5% overall by 2021.	Increase in % of home care where two or more members of staff are required	Increase in number of older people or people with a disability given housing options prior to hospital discharge or whilst in interim accommodation		Decrease in number of complaints received
Increase the number of successful 12 week quits	Increase in % of adults with intensive care needs receiving care at home	Increase in % uptake of Self-Directed Support Options		Increase in number of complaints responded to within 20 working days
Increased physical activity	Increase in number of people using a community alarm service	% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life		Increase in number of community groups convened and meeting regularly

PREVENTION	RESILIENCE	PERSONALISATION	CONNECTIONS	COMMUNITY
Increase levels of Health Literacy	Increase in number of people using telecare	Reduce offender re-conviction rate		Increase in number of community training sessions delivered
Increased uptake in vaccinations offered	Increase in number of adaptations delivered per tenure	Number of new referrals to initial investigation under Adult Support and Protection		Increase in % of staff who say they would recommend their workplace as a good place to work
Improved breastfeeding targets	Reduction in number of adaptation reinstatements agreed	Increase in % of people with positive experience of care provided by their GP practice		Decrease in total FTE posts vacant
Reduce number of deaths related to cancer	Increase in number of people provided with 12 months post-diagnostic support			Decrease in total FTE agency staff employed
Reduce number of deaths related to circulatory disease	Increase in % of adults able to look after their health very well or quite well			Decrease in sickness absence rate
Improved child dental health	Increase in number of unpaid carers supported			Decrease in staff turnover rate
Less than 5% of adults in Grampian should have no teeth remaining by 2022	Increase in % of carers who report they are supported to have a life alongside caring			
Reverse the rising incidence of oral cancer in Grampian by 2022	Increase in % of adults able to look after their health very well or quite well			
Reduce the life expectancy gap between most and least deprived areas				
Reduction in drug prescriptions for type 2 diabetes care				
Incidence of type 2 diabetes				
Reduce heart attack admission rate gap between most and least deprived areas				
Reduce cancer rate gap between most and least deprived areas				

Aberdeen City
Health & Social Care
Partnership
A caring partnership

If you require further information about any aspect of this document, please contact:

Aberdeen City Health & Social Care Partnership
Business Hub 8, 1st Floor North
Marischal College
Broad Street
Aberdeen
AB10 1AB

01224 523237
ACHSCPEnquiries@aberdeencity.gov.uk
aberdeencityhscp.scot
twitter.com/HSCAberdeen