Aberdeen City
Health & Social Care
Partnership

A caring partnership

STRATEGIC PLAN

2025 - 2029

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FOREWORD

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

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

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

Whilst we would like to be able to have a response to every challenge highlighted in our Evidence Document our Medium-Term Financial Framework indicates that we will not have the resources to do this so in developing this Strategic Plan and more importantly the Delivery Plans that underpin the implementation of it, we have tried to be realistic in terms of what we can achieve. We are therefore prioritising our activity against two aims: -

- Modernising our approach to service delivery, which will involve making the best use of resources and implementing transformation, and
- Increasing our focus on prevention and early intervention, which will include prioritising activities that improve both physical and mental health and reduce harm

We hope that by doing this we will achieve sustainable service delivery that will mean community health and social care services will meet the care and support needs of the people of Aberdeen now and in the years to come.

Hussein Patwa
Chair – Aberdeen City Integration Joint Board

Current Service Delivery

The Aberdeen City IJB via its delivery organisation the Aberdeen City Health and Social Care Partnership (ACHSCP) provide community health and social care services including Primary Care, Adult Social Work, Adult Social Care, Community Nursing, Immunisations, and Public Health and Health Improvement which are delegated from our parent organisations NHS Grampian and Aberdeen City Council. The IJB is also responsible for the Grampian wide provision of some services including Frailty and Older People's Services, Rehabilitation, Sexual Health Services and Mental Health and Learning Disabilities Services. Aberdeen City IJB 'hosts' these services on behalf of both Aberdeenshire and Moray IJBs.

In 2023/24 8,790 people in Aberdeen City were receiving social care services/support, 58% of whom were frail/elderly.

6,000 people were supported by a Social Worker, with **5,305 receiving care at home** and 2,055 resident were in a care home

3,365 people had long term needs and **510 people required high levels of care at home** (10 hours or more).

In 2024/25 there were 1,265 patient admissions to Hospital at Home, 1,694 referrals to the Community Link Worker Service, and the City Visits Team undertook 6,216 visits

170,489 vaccinations were administered, and 170,000 appointments were available at our Community Treatment and Assessment Centres throughout the City

Our Stay Well Stay connected activities and events reached **1,777 people a massive 169% increase** on the previous year.

90% of healthcare episodes take place in Primary Care, which includes general practice, dentistry, community pharmacy and aspects of community urgent care.

There are however currently several challenges for our service delivery

- It is estimated there is a shortfall in General Practice funding of 22.8 % yet new housing development projections indicate that there will be an increase of approximately 41,964 people in Aberdeen City. Currently the maximum our practices list sizes could accommodate is 4,881
- Increasing demand and cost of care delivery in adult social care which has led to budget overspend and a need to review the way care is delivered and ensure there is a robust approach to the application of the Eligibility Criteria.
- Adult Social Care services are at capacity causing longer waits for assessment and lowering performance on Delayed Discharges. This adds pressure on Aberdeen Royal Infirmary which is also experiencing higher demand. We need to transform our service delivery to increase capacity within existing resources.
- The rising demand and need for inpatient care in Mental Health and Learning Disability services along with prolonged lengths of stay is challenging patient flow.
- Increasing instances of spikes in substance use requiring a community response.
- Pressure on Abortion Care Services requiring a review of the way the service is delivered
- Increase in prescribing costs and high volume of wastage – continued engagement with the group who are reviewing this across Grampian.

Our Vision and Values

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

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

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

We are **there** for the people of Aberdeen.

Our Key principles to Service Delivery

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Integrated Care

Integrated health and social care, delivered by multidisciplinary teams, supported by shared information.

Improving system flow

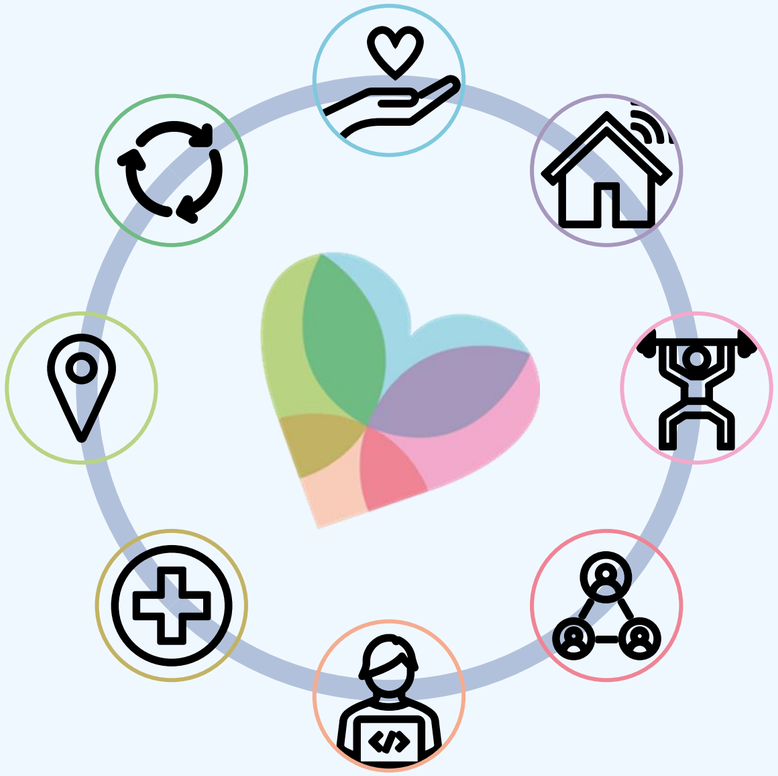
Separation of planned and unplanned care, including within primary care, front door diversion from acute services and effective discharge planning.

Single point of access

To health and care services, both step up and step down, with a focus on rapid provision of community support and easy access/ referral to all services.

Focus on prevention

Professionals and the local community working in partnership to achieve a clear focus on prevention of exacerbation of ill health.



Care closer to home

Provision of care in or near to usual place of residence, supported by skilled, empowered community teams.

Strengths based approach

Taking a strengths-based approach when assessing care needs, with the aim of maximising independence.

Assessment and Review

Regular assessment and review of care plans, completed by a skilled professional working in partnership with services users and carers.

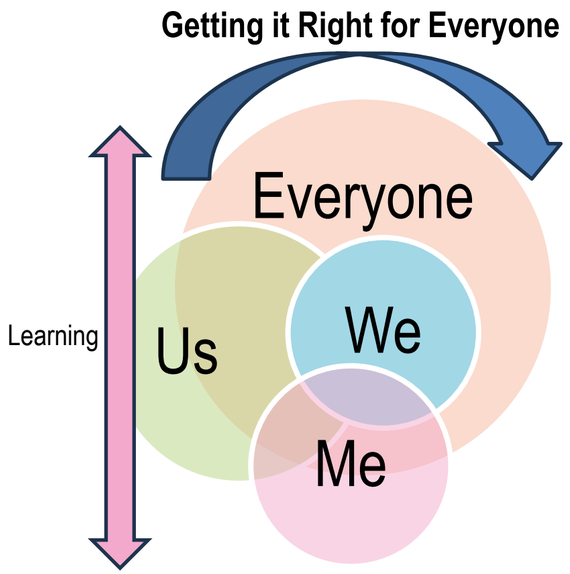
Technology based care

To support independence and improve quality of like, for example telehealth together with smart use of data and predictive case management to identify health and care needs as early as possible.

Strategic Approaches

In addition to our key principles to service delivery shown above we are also committed to the following strategic approaches to everything we do: -

- Considering the **whole system** and the impact of our activities on others
- Changing **public expectations and behaviours** towards acceptance of alternative care and support and where possible taking responsibility for their health
- **Collaborating** with our partners which may include co-location, combined pathway design, and sharing data,
- **Communicating and engaging** with our stakeholders and communities, ensuring we keep them informed and that they are involved in decisions regarding service planning and delivery
- Adopting the **Grampian Hope** which unifies GIRFE, Putting People First, Trauma Informed, Human Learning System, Self Directed Support and Realistic Medicine to consistently provide support to help people live their best lives.



The Grampian Hope Approach – unifying GIRFE, Putting People First, Trauma Informed, Human Learning System, Self Directed Support and Realistic Medicine to consistently provide support to help people live their best lives

Me (and mine)

I am part of a wider community (family, friends, community.

I will gain the information I need to make decisions about my life.

I am the expert in my own life, and I will know what is right for me.

I know that I can be clear about what matters to me.

I am supported to make the choices.

I am trusted to know what is right for me.

I understand that I will be treated with kindness, respect and dignity.

We (People who support me)

The people who support me take the time to listen and understand me, considering my while life when making decisions.

We focus on strengths, not problems, to do what's right for each person and their unique situation.

We actively listen understand a person's needs and what resources are available.

We will discuss options and agree together what would support me best.

We will work together to empower you to take charge of your own life.

We will build trust through meaningful conversations in a place that feels safe to you.

Being heard is a powerful support that can lead to positive changes in thinking and behaviours.

Us (Community)

My family, friends and community play the biggest role in helping me live well.

Building relationships within my family and community helps support me, keep me well, and makes me feel part of the community.

How do all the services/local groups who support me work together to ensure I am getting the support I need.

Everyone (How we work)

Each person should have a chance to feedback to improve services and systems.

Services, community support, and peer groups are connected to help people find the best resources to achieve their goals.

The people I would with share information in an accessible way to support my wellbeing.

Strategic Plan Development

The development of this strategic plan began with an assessment of current situation which involved consideration of the national context in which we work, our statutory responsibilities, our local context and local priorities, our performance against national indicators and information provided in the Population Needs Assessment (PNA). This resulted in the production of an Evidence Document which is published alongside this Strategic Plan and available for review.

The first stage of this assessment was a review of the latest data in relation to population health in Aberdeen City (from PNA): -

Physical Health

- Life Expectancy had been increasing since the early 1980s but has now remained virtually unchanged since 2012-14.
- The latest figures for Healthy Life Expectancy indicate that males can expect to have a period of 16.7 years and females a period of 19.6 years with health problems.

- In 2023, cancer and circulatory diseases (such as coronary heart disease and stroke) together accounted for half (50.4%) of all causes of death.
- In 2023, the most prevalent disease overall was hypertension, at an incidence of 11.1 patients per 100 population.

- The incidence of Chronic Obstructive Pulmonary Disease (COPD) at 200 (3-year average number) has increased.
- Data from the Scottish Health Survey estimates that in 2019-23, 18% of people had doctor-diagnosed asthma, up from 16% in 2018-22

Mental Health

- In 2023, Dementia and Alzheimer's disease were the leading cause of death for females (13.4% of all female deaths) and the second most common cause of death for males (7% of all male deaths).
- In 2023 there were 29 probable suicides (24 male and 5 female).

- In 2019-2023, an estimated 18% of people were deemed to have a potential psychiatric disorder.
- Depression was reported as the second most prevalent condition at 7.3 patients per 100 population.

Health Behaviours

- In 2019-2023 23%of adults were drinking alcohol above the guideline recommendations which is an increase on the previous period.
- In 2023 there were 54 drug related deaths an increase from 42 in 2022.
- Over half of the deaths in Aberdeen City in 2023 were associated with cancers and circulatory diseases, for which smoking, obesity, and physical inactivity are risks.

- Smoking during pregnancy can have significant consequences for mother and baby, and increases the risk of stillbirth, miscarriage and preterm birth. Around 9% of pregnancies booked are current smokers.
- In 2022 and 2023, 5.6% of 13–18-year-olds reported that they were vaping regularly which could lead to smoking in later life.

- Obesity rates in 2023 were 32%, a significant increase from 23% in 2016-19.
- In the latest 2020-2022 reporting period, bowel cancer screening uptake were 67.8%.
- The latest data for the three-year rolling period 2020-2023 indicates an uptake rate of 80.3% for breast cancer screening.
- The NHS Grampian cervical cancer screening uptake rate for females aged 25-49 in 2021/22 was 67.3%

- During 2022-23, 56,564 Influenza vaccines were administered to eligible groups which equates to and uptake rate of 50.8%.

Strategic Plan Development

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There are obvious challenges in relation to the physical and mental health of the population of Aberdeen as well as to influencing health related behaviours in order to improve population health and help reduce the harm and negative impacts of some of the health behaviours.

Health Indicator	Least Deprived	Most Deprived
Life Expectancy Males	81.1	71.7
Life Expectancy Females	84.8	76.4
Healthy Life Expectancy (Scotland)		26 years lower
Alcohol related hospital admissions (per 100,000)	300.7	1,044.2
Alcohol related deaths (per 100,000)	10.5	40.4
Drug related hospital admissions (per 100,000)	39.9	532
Drug related deaths (per 100,000)	5.2	57.3
Psychiatric patient hospital admissions (per 100,000)	144	343
Prescriptions for anxiety, depression and psychosis	12.5%	23.8%
Cancer registrations (per 100,000)	571.2	768.9
Early deaths from cancer (per 100,000)	98	249
Hospitalisations for coronary heart disease (per 100,000)	256.2	443.1
Early death from coronary heart disease (per 100,000)	25	95.9
Hospitalisations for COPD (per 100,000)	65.4	402.9
Incidences of smoking in pregnancy	2.8%	25%
Disposable income required to be spent on healthy diet	11%	50%

Impact of Deprivation

There is a strong association between deprivation and health outcomes as indicated by the table below. According to an analysis of the Scottish Index of Multiple Deprivation (SIMD) in 2020,19.3% of Aberdeen City's population are in the three most health deprived data zones. This is higher than Edinburgh (16.2%) but considerably lower than both Dundee (48.4%) and Glasgow (54.4%). The neighbourhoods in the 20% most deprived data zones (Quintile 1) include Torry, Woodside, Seaton, Northfield, Middlefield, Tillydrone, Mastrick, Sheddocksley and George Street.

Reducing the impact of inequality and influencing the wider determinants of health will be a focus of the IJB.

Demographics and Burden of Disease

By 2028 the number of 65–74-year-olds will increase by 14.4% and the number of 75+ will increase by 16.1% - that represents an additional 4,000 people who will potentially require health and social care. Interestingly in the 75+ age category the increase in the male population is expected to be 26.2%. In addition, 28% of people report they are living with limiting, long term conditions whilst 11% report living with non-limiting conditions.

The Scottish Burden of Disease study forecasts a 21% increase in the annual disease burden in Scotland over the next 20 years. Applied to the local context this would mean potentially an additional 6% reporting limiting, long term conditions.

Over half of single occupancy households are associated with people over 50 which increases the risk of limited access to informal carers should the need arise.

All of the above have the potential to increase future demand for health and social care services.

Strategic Plan Development

Budget

A report to the IJB on 18th March 2025 confirmed that the final outturn position for 2024/25 indicated that there is a recurring overspend of £16.786m. This was resolved using a combination of funding from partners and available reserves however there are no remaining uncommitted reserves with which to balance financial risks for 2025/26 onwards. The City IJB position reflects the common position across Scotland.
The future of Health and Social Care is marked by considerable financial uncertainty, driven by rising demand, inflationary pressures and the need for systematic reform. The 2025 spending review highlighted a critical funding gap for all IJB's in Scotland with all required to make savings, Aberdeen City is no different.
The revised Medium Term Financial Framework reports the following in terms of areas of budget pressure over the four years of this Strategic Plan.

Estimated Budget Pressures	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000
Pay	4,122	4,127	4,233	4,360
Non pay inflation	606	646	666	686
Primary Care Prescribing	2,524	2,000	2,000	2,000
Commissioned Services	9,344	3,847	3,962	4,081
Additional service demand	1,485	1,997	2,082	2,169
Recurring deficit	16,786			
eNIC pressure	2,050			
	36,918	**12,617**	**12,943**	**13,296**

It is crucial that budget savings are achieved on a recurring basis for the IJB to remain in financial balance and enable the continued provision of health and social care. This will require the IJB to take action to offset these pressures, either by reducing forecasted demand, reducing costs, or both, in order to achieve a balanced budget in future years. The Routemap contained at Appendix A of this plan gives an indication of the tough decisions that need to be made.

The main area of forecasted budget pressure is Commissioned Services. The reason for this is a combination of increasing demand for social care caused by an ageing population and the anticipated increase in the burden of disease along with the increasing cost of delivery of services. A recent Audit Scotland report confirmed that there has been a 19% rise in the hourly cost of providing care at home between 2016/17 and 2022/23. The actions the IJB need to take must cover both reducing the forecasted demand and reducing the cost of delivering services.

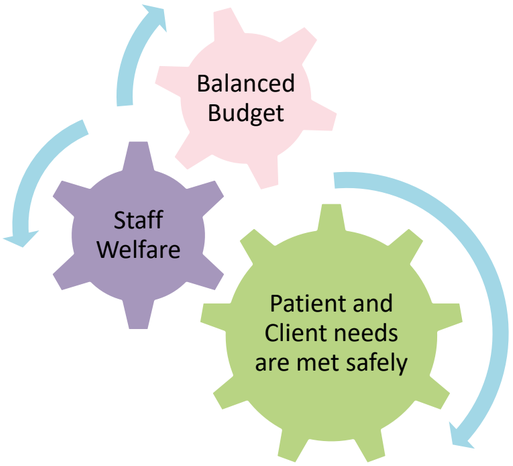
The other main cost pressure comes from payroll costs. The IJB are currently looking to manage these costs by robust vacancy management which includes a process for considering alternative ways that the service could be delivered. We need to maximise the opportunities that integration and technology bring in order to ensure efficiency and value for money.

There is a Grampian Group looking at reducing prescribing costs through reviewing what is being prescribed where and also seeking to reduce the level of waste and it is hoped that work will at least mitigate some of the cost pressures on prescribing.

In terms of non-pay costs the IJB will continue to implement our policy of 'essential spend only' in relation to non-pay spend, certainly in the first two years of this Strategic Plan. The IJB do not own assets, and asset costs are only 1% of the IJB budget, however we will continue to seek ways to consolidate our use of premises including collaborating with our partners to maximise the use of resources across the city of Aberdeen and to identify other non-pay costs where savings could be made.

Assuming savings can be achieved over the short-term, 2025/26 and 2026/27, there still remains a small deficit in future years that will require to be addressed. Whilst the IJB need to deliver within budget they are committed to protecting service delivery to the most vulnerable citizens of Aberdeen and to achieving balance between available budget, meeting client and patient needs safely, and staff welfare.

Achieving Balance



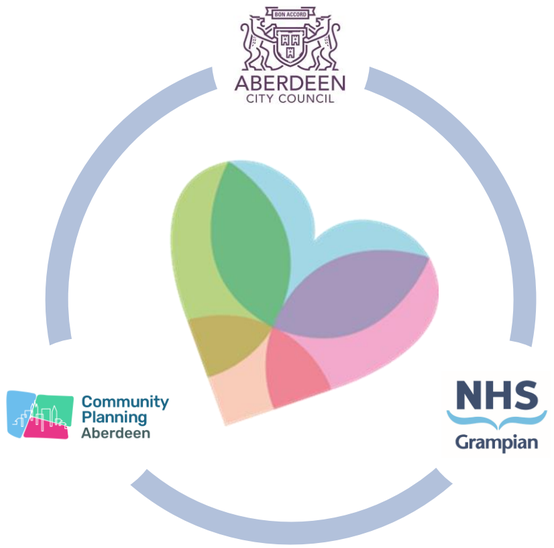
Alignment with partners

The next stage of assessment took a whole system approach and considered what Community Planning Aberdeen (CPA); Aberdeen City Council (ACC) and NHS Grampian (NHSG) were doing with their planning.

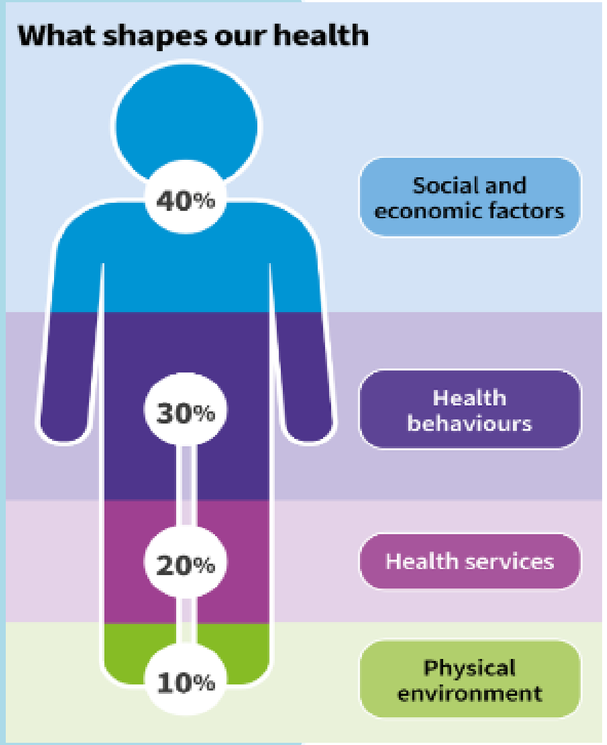
This led to the inclusion of some of the Local Outcome Improvement Plan activities in our Delivery Plan, a joint approach with ACC on consideration of the wider determinants of health and the use of case studies based on real life service users to bring our response to their needs alive.

It also led to the joint public consultation exercise undertaken using the 14 themes of the Scottish Place Standard Tool the outcome of which informed development of both the Strategic and the Delivery Plan.

Finally, it prompted the use of a Logic Model tool to inform our theory of change (see figure on page18).



Wider Social Determinants of Health



Health outcomes in Aberdeen are shaped by social and economic factors, health behaviours, access to health services and the physical environment.

In terms of **children and young people**, challenges exist during the period from before birth to the start of school, including maternal drug and alcohol use, and smoking at the beginning of pregnancy. Inequities in education, particularly in early life contribute to long term health disparities impacting things like the development of early speech and language skills, the uptake of childhood immunisations, and the mental health and wellbeing of children and young people.

The transition from children's to adult social care services particularly for children with a learning disability is often challenging and there is a need to ensure this is more effective and does not adversely impact outcomes for these children.

Aberdeen City Council have developed the Family Support Model which is a new approach to support families with complex and multi-faceted challenges to shift the focus from reactive and risk-based services to upstream and preventative approaches and this will help address inequality in these areas. ACHSCP services will work as part of that model to provide relevant health and care to those families.

A healthy **economy** is inextricably linked to the health and wellbeing of a population. People who experience economic inequality can experience poorer health and wellbeing. ACHSCP can help people maintain or improve their health and wellbeing in order that they can fulfil their role in the workplace, maintain their income, provide a sense of purpose and contribute to a healthy economy.

Having **housing** which is affordable, warm, and secure is an essential part of wellbeing. The availability, location, type, and quality of housing is also important. Some households experience fuel poverty and some residents require specialist provision housing as a result of ill-health or disability. For a range of reasons, others are without a secure place to live. The Aberdeen City IJB is responsible for disabled adaptations, and we will work with housing providers and other partners across the city to support the provision of adaptations enabling people to live independently in their own homes for as long as possible. We will share information on predicted need to enable housing colleagues to plan for future housing requirements. We will also continue to provide bespoke health and care services to the homeless population.

The **natural environment** and access to green and blue space is vital to health and wellbeing. Climate change poses risks to physical health associated with excess heat or cold, and the impact of air pollution. It also poses risks to mental health in relation to the impact of loss or damage from extreme weather events.

Case Studies & Lived Experience

As part of the joint approach a number of case studies have been prepared. Below are a sample of these along with a description of how the IJB Strategic plan could support each.
NB: whilst the case studies are an amalgamation of scenarios relating to real people the names are fictional, and the photos are stock images.

Name: Amara
Frail Person

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

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

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

To support Amara…
Our Stay Well Stay Connected programme (working alongside the Aberdeen City Council Future Libraries Model) helps to address the social isolation Amara feels and also has programmes to support those who are digitally excluded. We know we need to improve information about the health and social care services and community groups available and how to access them so people like Amara can be more proactive and self-sufficient in meeting their own needs.

Name: Frank
Complex Mental Health

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

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

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

For Frank…

Our principle of 'care closer to home' will help meet Frank's needs and our strategic approach of Grampian Hope should ensure he has wrap around care from a consistent and known team. Support from community based commissioned substance use services should help Frank on his road to recovery.

Case Studies & Lived Experience

Name: Sarah
Unpaid Carer

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

What does Sarah need?
- To maintain her flexible working hours and income.
- To ensure her daughter's health and wellbeing and development support her independent living skills.
- To undertake the guardianship process for her daughter and make decision on her behalf as she transition in adulthood.
- To find supportive groups for her daughter and improve her daughter's community abilities.
- To secure alternative care for her daughter and develop a contingency plan for emergencies.
- To increase her savings for a suitable vehicle.

What is Sarah feeling?
- Concern that the support network provided by her mother and sister will be reduced.
- Concern that she may now be required to support her mother should she be diagnosed with dementia.
- Frustration at the lack of support for single parents whose children have additional support needs.
- Frustration at the lack of continuity in the people providing paid-for care.
- Frustration at the complex nature of health and guardianship processes
- Anxiety about everything she must having in place for the care of her daughter.

Supporting Sarah…

Sarah can be supported by the Aberdeen City Adult Carers Support Service who will help her to develop and Adult Carers Support Plan which will detail her specific needs in relation to maintaining her caring role and having a life alongside caring. They can also signpost her to groups and services that can help her navigate the care system for her daughter and help access to transport.

Public Consultation

There was strong support for the priorities we specifically mentioned in the Place Standard Tool - refreshing our Primary Care Improvement Plan (93.6%), a focus on community and home-based services allowing people to live independently (93.4%), deliver and promote a range of opportunities to increase social interaction and improve physical and mental health and wellbeing (93.1%) and continue our inclusive approach when designing and delivering services (91.9%). In addition, the following comments were made: -

Feedback	What we have done
Access to healthcare services, particularly GPs and dental services is a concern	Included commitment to implementing and reviewing our Primary Care Improvement Plan in our Delivery Plan
There is a lack of support for those with mental health issues and substance abuse.	Included specific actions in our Delivery Plan around support for people with complex needs and substance use as well as specifically reducing the harm from drugs and alcohol use.
More community involvement and better transparency, communication and collaboration	Included commitment to this in the 'Our Strategic Approach' section
Use different methods to reach out involving disabled and visually impaired individuals in consultations	Included commitment to this in the 'Our Strategic Approach' section although note that we will include all sensory impairments.
Information Dissemination and Community Engagement need to improve	Included commitment to this in the 'Our Strategic Approach' section
Listen to our concerns and act on them, keep us informed on what is happening and how our feedback is being used	Included commitment to this in the 'Our Strategic Approach' section
Identify areas of health inequality and focus, increase resources to those	Augmented the section on inequality to increase focus however at this point we cannot increase resources although that will remain an ambition for the future.
People need to take responsibility for their health, with the recognition that some people need support and education to do this.	Included commitment to this in the 'Our Strategic Approach' section
Keen on lifestyle prescribing (e.g. nature walks)	Included reference to alternative care in the 'Our Strategic Approach' section
Be realistic in relation to funding (i.e. only commit to actions in the Strategic plan that can be delivered within reducing budgets)	Considered as part of Strategic Plan development and added as part of Chair of IJB Foreword

Our Challenge and Response

The assessment of our current performance in relation to both service delivery and financial performance and the current and predicted health of the population in Aberdeen and the predicted growth of the older population and burden of disease has led to the creation of the following key challenge and response statements.

Our Key Challenge

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

Our Response

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

Strategic Aims and Priorities

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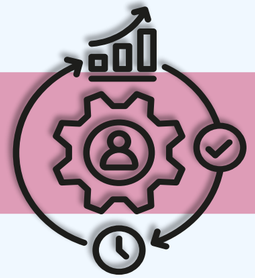
This in turn has led to the creation of the following aims and priorities – more detail on the activities we will undertake to deliver these is contained in our Delivery Plan.

Aims	Priority	Outcome	Measure
 MODERNISE OUR APPROACH TO SERVICE DELIVERY	Make Best use of Resources	Financial Balance	Budget Performance
	Implementing Transformation	Sustainable service provision that can meet future demand.	Service measures around numbers of patients and clients supported, waiting times, unmet need etc. System measures around Delayed Discharges, Emergency Department Attendance, Performance and Admission.
 SHIFT OUR FOCUS TOWARDS PREVENTION AND EARLY INTERVENTION	Improve Physical and Mental Health	Improved population health	National Health and Wellbeing indicators
	Reduce Harm	Reduction in health care need	Level of service demand.

Note that we can't address everything at once and must prioritise/be realistic about what we can do in relation to funding.

Logic Model

Situation

Delivery of community health and social care service to the people of Aberdeen at time of increasing demand and restricted resources

Inputs

Financial Budget
£439 Millon

2,164
Staff Workforce

Activities
What we do

Primary Care Services

Community Nursing

Adult Social Work/ Social Care

Frailty and Older People's Services

Rehabilitation

Public Health/ Health Improvement

Mental Health and Learning Disabilities Services

Sexual Health Services

Substance Use Services

Immunisations

Who we reach

All people in Aberdeen City who require care and support and meet the Eligibility Criteria.

Outcomes

Short

Continuing to meet population need whilst implementing efficiencies and innovations and delivering a balanced budget.

Identifying future transformation and modernisation opportunities and laying the groundwork for these.

Medium

Continuing to meet population need in a slightly different way using more technology and maximising multi agency person led approaches.

Undertaking transformation and modernisation to improve patient and client experience and outcomes

Collaborating more with partners providing more joined up services

Long

Meeting patient and client need in very different ways.

Services are more integrated, accessible, sustainable and person led

Budget is balanced and reserves are being built up for future investment.

Assumptions and Influences

- Demand will continue to grow
- Resources will continue to be constrained

Measures

- Number of patients and clients being supported
- Activity, Waiting Times, and Unmet Need
- ED Attendance, ED Admission and Delayed Discharge

Enablers to Delivery

Finance

Each year we update our Medium-Term Financial Framework (MTFF). This sets out the projected budget available to us over the medium term to support the delivery of our strategic priorities. We anticipate significant financial challenges over the next four years of our Strategy and anticipate a need to stop services or reduce service levels to balance our budget.

To support the development and delivery of our MTFF, we follow a Budget Protocol. This makes provision for consultation with the public on our proposed budget options to address anticipated budget deficits in future years. We will continue to refine and monitor our approach to budget setting to help ensure we evidence an even greater shift to preventative and early intervention activities.

Data

Data is vital to having the relevant information both to plan service delivery in the future (population growth, demographics, burden of disease, impact of deprivation etc.) and to monitor our performance in relation to current activity. Unfortunately, not all of the data that is available is easily accessed or real time and we have only recently clarified our data needs. Data sharing is an issue with information governance arrangements improved data sets and sharing

Infrastructure

Although more and more service delivery will be provided in people's homes many of our services will continue to be buildings based. It is vital that the buildings we use are accessible and fit for purpose. The IJB does not own buildings itself but operates from buildings owned by partners or rented from private landlords. We are currently reviewing our use of premises with a view to maximising space usage and minimising costs. We are also preparing an Infrastructure Plan that dovetails with those of our partners.

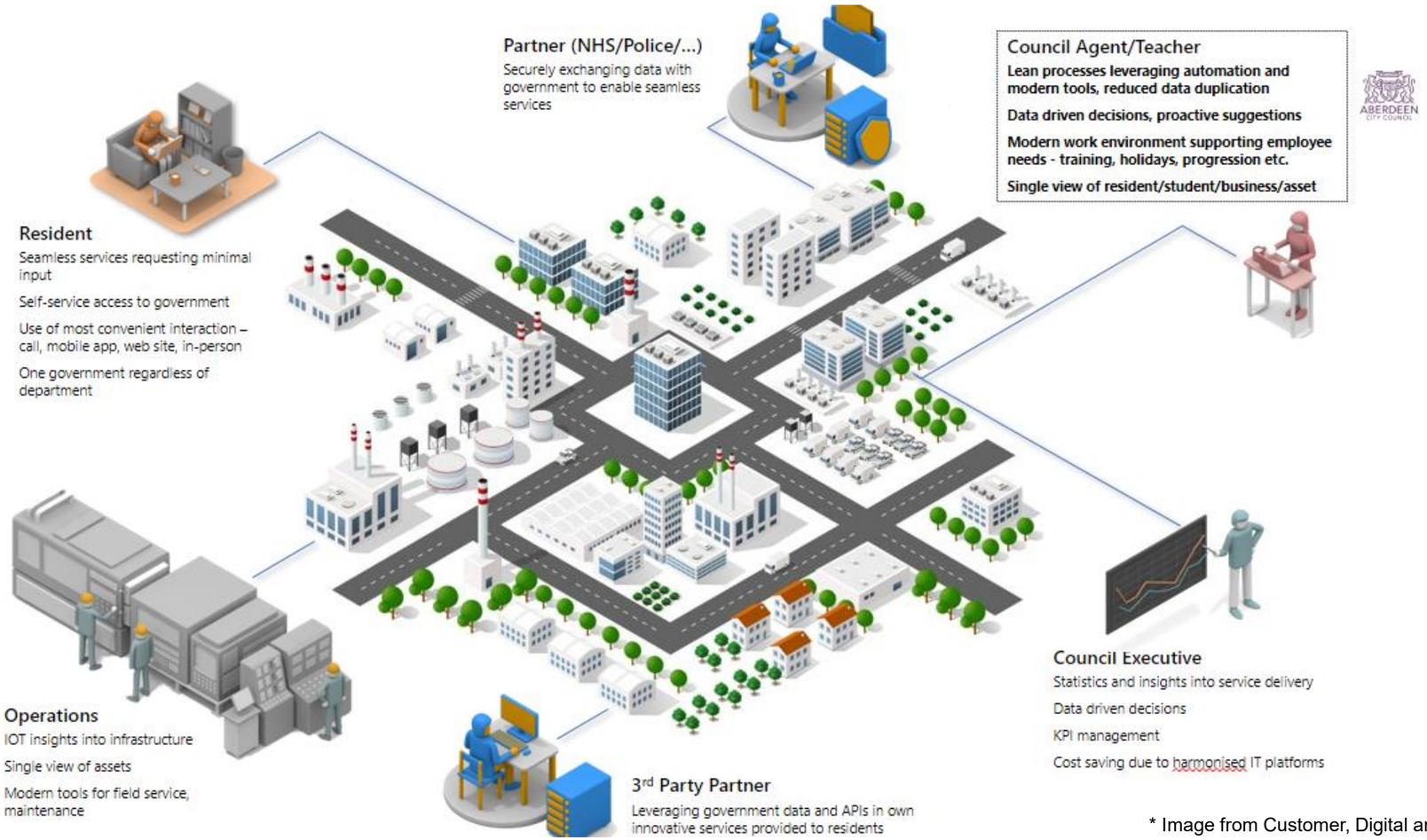
Workforce

It is essential we have the right capability and capacity to meet the future needs of Aberdeen. We will update our Workforce Plan to support the delivery of this Strategy. The challenge of recruitment and retention of staff continues, particularly within clinical and social care settings. However, it is also unlikely that we will be able to afford the same level of staffing in future years. We will look to increase the integration of community teams and maximise the use of digital service delivery whilst ensuring that staff are supported to adapt their skills to this new way of working.

Enablers to Delivery

Technology

This enabler covers both the use of Technology Enabled Care for service users and to digital applications and solutions for staff to modernise service delivery. Undoubtably the introduction of technology will deliver efficiencies in the medium to long term, but it requires investment in the short to medium term. The IJB has been fortunate to secure some initial pump priming external funding to deliver a couple of bespoke initiatives and we will continue to maximise any further similar opportunities. We are aware that not everyone will be able to access and use some of the technology we are seeking to introduce, and we will develop a Digital Inclusion Plan as part of the implementation plan.



* Image from Customer, Digital and Data Strategy (ACC)

Strategic Risks

Our Strategic Risk Register (SRR) contains eight risks. These are listed below along with a narrative of how this strategic plan is designed to mitigate each.

Risk	Event	Strategic Plan Mitigation
Commissioned Services (including General Practice)	Potential failure of commissioned services to deliver on their contract within available budget	The GP Vision work and the transformation projects focused on commissioned social care services will both help to achieve sustainable service delivery in these areas.
Financial Sustainability	A risk that the IJB exceeds its allocated funding	Current and future transformation and budget savings projects along with enhanced monitoring arrangements will help to achieve financial balance.
Delivery of Hosted Services	A risk that these do not deliver expected outcomes	There isn't a specific activity in the Strategic or Delivery Plans but an ongoing business as usual activity is the delivery of the recommendations from the Internal Audit on Hosted Services
Performance	A risk that services fail to meet national, regulatory, and local standards	Prevention and Early Intervention activity to manage demand Service modernisation and transformation to maximise performance Improved datasets and data sharing to enhance performance monitoring and continuous improvement
Transformation	A risk that people do not receive the best health and social care outcomes	Service modernisation and transformation to maximise the potential to improve outcomes
Involvement of lived experience	A risk that services are not tailored to meet individual needs	Inclusion of a 'strategic approach' of communicating and engaging with our stakeholders and communities, ensuring they are well informed and involved in decisions
Workforce	Failure to manage staffing budgets within forecasted predictions	Commitment to refresh the Workforce Plan
Premises	A risk that buildings across the city, operated by, or overseen by, the IJB/ACHSCP are not being used to maximum efficiency and are not in line with statutory/regulatory requirements.	Current Premises Review Commitment to develop an Infrastructure Plan

Implementation and Governance

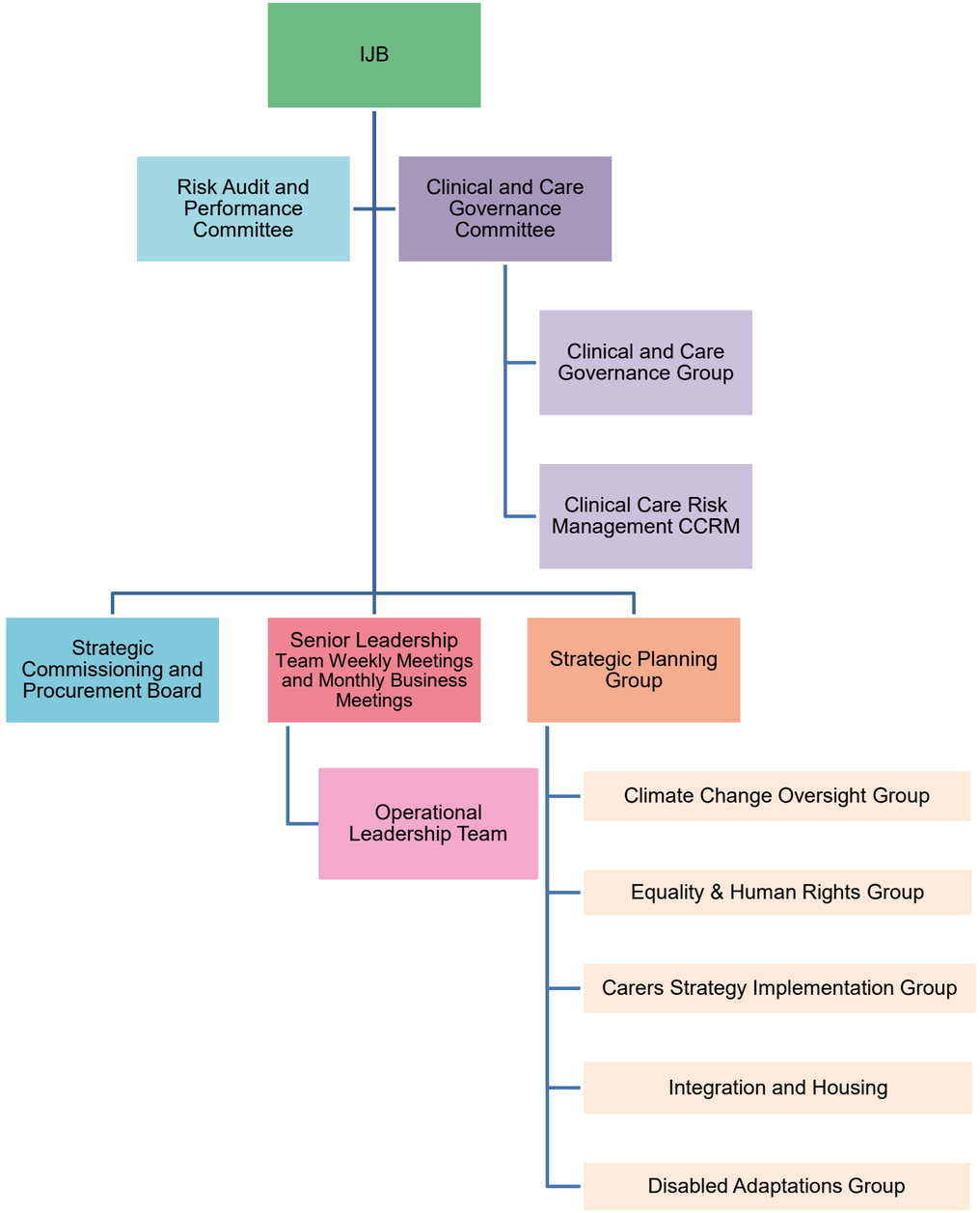
The implementation of this four-year Strategic Plan will be achieved through the successful delivery of four Annual Delivery Plans. These will contain details of the projects and activities we plan to undertake along with timelines and measures. The Routemap attached as Appendix A gives a high-level overview of the activity, we plan to undertake over the four-year lifespan of the Strategic Plan although it should be noted that this is our intention at this time. Every year a review of progress and emerging priorities will be undertaken, and the subsequent year's Delivery Plan will be developed which will continue to be aligned to both the Medium-Term Financial Framework and the Strategic Risk Register.

We will continue to use a programme and project management approach to delivering our Strategic and Delivery Plans. Each project or activity is allocated a member of the Senior Leadership Team to lead on its delivery and a timescale within which it will be started and delivered. A project team will undertake agreed tasks to contribute to the overall successful delivery and milestones and performance measures will be agreed. The availability of resource to deliver will form part of the consideration process when determining what we can commit to in the Delivery Plans. The projects or activities vary in size and complexity. Some of the more complex transformational projects will be subject to formal evaluation, the outcome of which will inform future transformational activity.

As part of our normal approach to service change, we will co-design and coproduce solutions through engagement and consultation with our communities. Each significant service change will be impact assessed using our 'Assessing our Impact' process, details of which can be found on the Aberdeen City Health and Social Care website here.

Progress on the Delivery Plan will be reported monthly to our Senior Leadership Team, and quarterly to both the Risk Audit and Performance Committee (RAPC) and the Chief Executives of Aberdeen City Council and NHS Grampian. Progress will be determined using both project/activity update narrative referring to performance against the project plan and relevant milestones, and data collated in relation to Key Performance Indicators as agreed for each.

Progress against our Strategic Plan including data in relation to National and Ministerial Strategic Group (MSG) Performance Indicators will be reported annually to the IJB, the Scottish Government, and other stakeholders including the public, through the publication of our Annual Performance Report (APR) final-achscp-annual-performance-report-2023-2024-5.pdf).



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Routemap to Delivery of the Strategic Plan 2025-29

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Appendix A

The IJB's Strategic Plan 2025-29 will be delivered over four years. As the environment we are currently operating in is uncertain and constantly changing, we have only developed a detailed Delivery Plan for 2025-26. This is already in progress and is underpinned by project implementation plans which will be monitored via the governance process detailed in the Strategic Plan. Detailed Delivery Plans will be developed for subsequent years, and these will be informed by the progress made during the previous year and by any emerging priorities or risks. The actions or projects in these plans may continue or build on work that was started in 2025/26 and/or they may contain new actions as a result of annual review or appropriate timing or readiness.

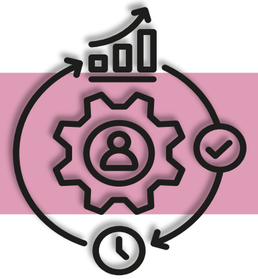
Consideration has been given to longer term planning and this Appendix contains what we have called our Routemap to Delivery over the four financial years 2025-26 through to 2028-29. The actions or projects listed under 2025-26 are all currently in progress as part of the 2025-26 Delivery Plan. These will deliver the £14.3 million target savings for 2025-26 required to achieve a balanced budget. For subsequent years the Routemap lists actions which, at this moment in time we would intend to take in these years. Confirmation or what our future intentions are for each year will come at the point the Medium-Term Financial Framework is finalised each year when we will also develop the corresponding detailed annual Delivery Plan

Work has already begun on developing implementation plans for the actions and projects currently listed under 2026-27 and we know that our budget pressures for 2026-27 are £4.1 million from pay, £1.4 million from non-pay, £3.8 million from commissioned services and £2m from additional demand. Whilst it is difficult to quantify the level of savings that can be achieved in future years, as savings are currently being achieved or planned in these areas, we have a degree of confidence that the actions and projects we are proposing for future years will balance the budget. The robust vacancy management process which has been implemented is already reducing pay costs and there are further opportunities in the integration and restructuring of teams and the introduction of digital technology to achieve efficiencies in some processes which should lead to the achievement of the saving required. The premises review has indicated a level of under-utilisation, and we are confident when we have been able to work out the logistics and identify mitigations to minimise the consequential impacts on patients and staff, that we will be able to achieve savings. Opportunities for further efficiencies in commissioned services contracts are already being identified and again should lead to the achievement of the savings required.

Research undertaken by UK national organisations further enhance the confidence we have in the actions we are proposing. The National Association of Primary Care found that the implementation of integrated neighbourhood teams resulted in a 7% reduction in the cost of care for high intensity patients whilst also reducing demand on GPs and on outpatient departments by 6% each, Emergency Department attendance by 12% and bed days used by 14%.. The Social Care Institute for Excellence found that community based reablement led to 62% of clients no longer needing a service after 6-12 weeks, compared with 5% in the control group, and that 26% had a reduced requirement for homecare hours, compared with 13% of the control group. The NHS Confederation/NHS Providers found that implementing Discharge to Assess/Discharge Without Delay led to a 37% reduction in average length of stay in community hospitals with 83% of patients being discharged with no immediate support requirements. It should be noted that these reductions and savings are not net of the cost of investment, but they do give an indication of the difference that can be achieved.

As well as reducing costs our Strategic Plan confirms that we need to reduce future demand for services. This is where our prevention and early intervention aim will have an impact however it is very difficult to predict the level of this will have as we are reliant on changing individual behaviours. Data from Public Health Scotland states that primary prevention is 3-4 times more cost effective than treatment. The return on investment for immunisations is £34 for every £1 spent and a study by the University of Wales indicated that there is an average return of £14 for every £1 invested in prevention initiatives so we have confidence that successful interventions will yield results.

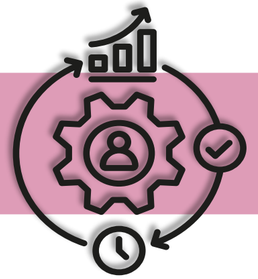
Whilst a level of confidence currently exists the process of developing detailed Delivery Plans in future years based on knowledge and experience gained and evidenced by robust implementation plans will increase confidence levels as we progress through the implementation of the Strategic Plan.



MODERNISE OUR APPROACH TO SERVICE DELIVERY

Strategic Priority – Make best use of resources

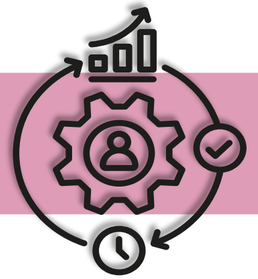
2025/26	2026/27	2027/28	2028/29
Actions to reduce non pay costs			
Undertake review of premises utilisation and make recommendations for future consolidated use	Implement recommendations of review seeking to consolidate/vacate a minimum of two premises whilst also maximising the utilisation of remaining premises. Continue to review other options for consolidated use widening the scope of the review to partner premises and making recommendations.	Implement recommendations of review seeking to consolidate/vacate a minimum of two premises whilst also maximising the utilisation of remaining premises..	Implement recommendations of review seeking to consolidate/vacate a minimum of two premises whilst also maximising the utilisation of remaining premises..
Deliver savings in Utility Costs	Deliver further savings in Utility Costs and identify other building related costs where efficiencies could be made utilising digitised processes where relevant.	Maximise use of digital tools to further reduce building related costs.	Maximise use of digital tools to further reduce building related costs.
Actions to reduce pay costs			
Deliver efficiencies from the robust management of vacancies	Continue robust management of vacancies	Continue robust management of vacancies	Continue robust management of vacancies
Reduce the number of posts in ACHSCP establishment through use of VSER and implement team restructuring through increased integration and use of technology	Continue the utilisation of VSER, integration and technology to streamline and implement team restructuring through increased integration and use of technology	Continue the utilisation of VSER, integration and technology to streamline and implement team restructuring through increased integration and use of technology	Review ACHSCP establishment in light of changes and confirm any further reduction required.



MODERNISE OUR APPROACH TO SERVICE DELIVERY

Strategic Priority – Make best use of resources

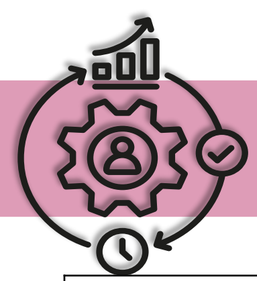
2025/26	2026/27	2027/28	2028/29
Actions to reduce cost of service delivery and/or achieve greater efficiency			
Modernise Care Delivery for Older People	Review consistent application of new guidance in relation to annual review and consideration of Eligibility Criteria	Review consistent application of new guidance in relation to annual review and consideration of Eligibility Criteria	Review consistent application of new guidance in relation to annual review and consideration of Eligibility Criteria
Review Mix of Residential Care	Monitor the mix of residential and non-residential care and ensure it is appropriate for individual needs	Monitor the mix of residential and non-residential care and ensure it is appropriate for individual needs	Monitor the mix of residential and non-residential care and ensure it is appropriate for individual needs
Modernise care delivery models for vulnerable adults including people with Learning Disabilities and Complex Needs.	Ensure implementation of contract reviews and robust application of tiered service delivery	Ensure implementation of contract reviews and robust application of tiered service delivery	Ensure implementation of contract reviews and robust application of tiered service delivery
Implement transitions process to improve service user experience and future financial planning	N/A	Evaluate implementation of Transitions process.	Implement recommendations from evaluation of Transitions process
Redesign Day Care Provision for people with Learning Disabilities	Review impact of day care redesign and seek further redesign at lower cost	Review impact of further redesign	Ensure robust review of all Day Care provision in relation to client needs
Review use and cost of Out of Area care	Identify initiatives to bring people back within area and develop business case to support implementation	Implement at least one initiative to bring people back within area	Implement at least one initiative to bring people back within area
Reduce spend and achieve value for money with key commissioned service provider	Reduce spend and achieve value for money with key commissioned service provider	Reduce spend and achieve value for money with key commissioned service provider	Reduce spend and achieve value for money with key commissioned service provider



MODERNISE OUR APPROACH TO SERVICE DELIVERY

Strategic Priority – Make best use of resources

2025/26	2026/27	2027/28	2028/29
Enabling Actions			
Develop Dashboards to support the planning and delivery of services	Investigate the use of analytics and predictive demand management tools	Review data needs and identify gaps	Refresh Dashboards in light of review
Refresh Workforce Plan focusing on future staffing requirements taking service transformation into account	Ensure robust implementation of Workforce Plan including delivery of support to staff to build skills and confidence in new ways of working.	Ensure robust implementation of Workforce Plan including delivery of support to staff to build skills and confidence in new ways of working.	Ensure robust implementation of Workforce Plan and begin preparations for refresh
Refresh Carers Strategy ensuring unpaid carers in Aberdeen City continue to be supported in their caring roles	Ensure robust implementation of Carers Strategy	Ensure robust implementation of Carers Strategy	Ensure robust implementation of Carers Strategy and begin preparations for refresh
Implement an Individual Budget approach to the charging of social care Ensure charges are increased at least in line with inflation.	Implement the revised Contributing to your Care policy with a view to increasing income Ensure charges are increased at least in line with inflation.	Scope additional opportunities for income across all services Ensure charges are increased at least in line with inflation.	Implement opportunities for additional income. Review the implementation of the Contributing to your Care policy Ensure charges are increased at least in line with inflation.



MODERNISE OUR APPROACH TO SERVICE DELIVERY

Strategic Priority – Implementing Transformation

2025/26	2026/27	2027/28	2028/29
Actions to reduce cost of service delivery and/or achieve greater efficiency			
Deliver city commitments in the GP Vision	Deliver city commitments in the GP Vision	Deliver city commitments in the GP Vision	Deliver city commitments in the GP Vision
Implement and review Primary Care Improvement Plan (PCIP) to identify, successful efficient delivery of services and areas of improvement	Continued implementation of PCIP	Continued implementation of PCIP	Continued implementation of PCIP
Deliver the Discharge Without Delay (DWD) Collaborative commitments	Review impact of DWD implementation and expand concept to other community services where relevant	Review impact and explore other initiatives to improve discharge, maximising additional capacity created through social care transformation	Review discharge data and target the root cause of continuing delays
Redesign model of support to Amputees to community-based provision	Maximise the benefit and efficiency of reablement in community pathways and hospital discharge	Review reablement pathways and identify improvements	Implement improvement initiatives identified in relation to reablement
Codesign alliancing work with Counselling Services	Ensure robust implementation of new contract review process and continue with scheduled review of commissioned services contracts and work with providers to reduce costs	Ensure robust implementation of new contract review process and continue with scheduled review of commissioned services contracts and work with providers to reduce costs	Ensure robust implementation of new contract review process and continue with scheduled review of commissioned services contracts and work with providers to reduce costs
Implement redesign of residential substance use service with a view to delivering a community-based support service model			
Develop an Initial Point of Contact Model (pre assessment offer) for adult social care.	Scope development of a digital front door approach	Implement a digital front door approach	Deliver a Single Point of Access
In conjunction with ACC colleagues, influence the redesign of Sheltered Housing to modernise the model of Housing Support .	Refresh our Market Position Statements to ensure clear articulation of service need	Review Housing support provision and other aspects of Housing for Varying Needs	Refresh our Market Position Statements to ensure clear articulation of service need

SHIFT OUR FOCUS TOWARDS PREVENTION AND EARLY INTERVENTION

Strategic Priority – Improve Physical and Mental Health

2025/26	2026/27	2027/28	2028/29
Actions to reduce future demand for services			
Increase the number of people who accept the invitation of cancer screening on the basis of informed consent.	Review 2025/26 performance in relation to cancer screening uptake and adjust approach to make further improvements as required	Review 2026/27 performance in relation to cancer screening uptake and adjust approach to make further improvements as required	Review 2027/28 performance in relation to cancer screening uptake and adjust approach to make further improvements as required
Improve uptake of immunisations to at least the Grampian average level by March 2027	Improve uptake of immunisations to at least the Grampian average level by March 2027	Review immunisation uptake rates and adjust approach to make further improvements as required	Review immunisation uptake rates and adjust approach to make further improvements as required
Publish an agreed multi-agency Healthy Weight Action Plan for Aberdeen City by December 2025	Implement the multi-agency Healthy Weight Action Plan for Aberdeen City	Review the implementation of the multi-agency Healthy Weight Action Plan for Aberdeen City and agree revised Action Plan	Implement the revised multi-agency Healthy Weight Action Plan for Aberdeen City
Publish an agreed multi-agency Public Mental Health action plan for Aberdeen City by March 26	Implement the multi-agency Public Mental Health Action Plan for Aberdeen City	Review the implementation of the multi-agency Public Mental Health Action Plan for Aberdeen City and agree revised Action Plan	Implement the revised multi-agency Public Mental Health Action Plan for Aberdeen City
Publish an agreed multi-agency Ageing Well action plan for Aberdeen City by April 2026	Implement the multi-agency Ageing Well Action Plan for Aberdeen City	Review the implementation of the multi-agency Ageing Well Action Plan for Aberdeen City and agree revised Action Plan	Implement the revised multi-agency Ageing Well Action Plan for Aberdeen City
N/A	Review the Stay Well Stay Connected Programme in light of the development of the three Public Health Action Plans and look to consolidate activity into a Wellbeing Strategy and Operating Model maximising the collective resources of partners in the City.	In conjunction with partners implement the Wellbeing Strategy and Operating Model	Review and evaluate the Wellbeing Strategy and Operating Model and implement improvements.

SHIFT OUR FOCUS TOWARDS PREVENTION AND EARLY INTERVENTION

Strategic Priority – Improve Physical and Mental Health

2025/26	2026/27	2027/28	2028/29
Actions to reduce future demand for services			
Decrease the number of women who are smoking during pregnancy in the 40% most deprived SIMD	Review 2025/26 performance in relation to women smoking during pregnancy in the 40% most deprived SIMDs and adjust approach to make further improvements as required. Consider other cohorts to target for smoking cessation.	Implement smoking cessation activity for other cohorts identified and review revised Population Needs Assessment to determine relevant cohorts for improvement activity for 2028/29.	Implement smoking cessation activity for other cohorts identified
Reduce the number of 13-18-year-olds in regular use of Vaping products	Increase focus on Vaping avoidance/cessation to both younger and older age groups Review data in relation to use of chewing tobacco and determine whether avoidance/cessation activity is required in this area.	Implement improvement activity as identified and review data in relation to Vaping and chewing tobacco and determine whether further avoidance/cessation activity is required in these areas.	Implement improvement activity as identified and review data in relation to Vaping, chewing tobacco or any other emerging substance and determine whether further avoidance/cessation activity is required in these areas.
Reduce harm caused by the use of drugs and alcohol	Reduce harm caused by the use of drugs and alcohol	Reduce harm caused by the use of drugs and alcohol	Reduce harm caused by the use of drugs and alcohol
Deliver & implement Action plans for Suicide & Self Harm Prevention Strategies	Deliver & implement Action plans for Suicide & Self Harm Prevention Strategies	Deliver & implement Action plans for Suicide & Self Harm Prevention Strategies	Deliver & implement Action plans for Suicide & Self Harm Prevention Strategies

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