# Strategic/Delivery Plan
## 2022 – 2025

Aberdeen City
Health & Social Care
Partnership
*A caring partnership*

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Health & Social Care
Partnership

*A caring partnership*

# Contents



# Strategic Plan on a Page

## Strategic Aims

| CARING TOGETHER | KEEPING PEOPLE SAFE AT HOME | PREVENTING ILL HEALTH | ACHIEVE FULFILLING, HEALTHY LIVES |
|---|---|---|---|
| **Strategic Priorities** | | | |
| ▸ Undertake whole pathway reviews ensuring services are more accessible and coordinated<br>▸ Empower our communities to be involved in planning and leading services locally<br>▸ Create capacity for General Practice improving patient experience<br>▸ Deliver better support to unpaid carers | ▸ Maximise independence through rehabilitation<br>▸ Reduce the impact of unscheduled care on the hospital<br>▸ Expand the choice of housing options for people requiring care<br>▸ Deliver intensive family support to keep children with their families | ▸ Tackle the top preventable risk factors for poor mental and physical health including:<br>- obesity, smoking, and use of alcohol and drugs<br>▸ Enable people to look after their own health in a way which is manageable for them | ▸ Help people access support to overcome the impact of the wider determinants of health<br>▸ Ensure services do not stigmatise people<br>▸ Improve public mental health and wellbeing<br>▸ Improve opportunities for those requiring complex care<br>▸ Remobilise services and develop plans to work towards addressing the consequences of deferred care |

## Enabling Priorities

| WORKFORCE | TECHNOLOGY | FINANCE | RELATIONSHIPS | INFRASTRUCTURE |
|---|---|---|---|---|
| ▸ Develop a Workforce Plan<br>▸ Develop and implement a volunteer protocol and pathway<br>▸ Continue to support initiatives supporting staff health and wellbeing<br>▸ Train our workforce to be Trauma informed | ▸ Support the implementation of appropriate technology-based improvements – digital records, SPOC, D365, EMAR, Morse expansion<br>▸ Expand the use of Technology Enabled Care throughout Aberdeen<br>▸ Explore ways to assist access to digital systems<br>▸ Develop and deliver Analogue to Digital Implementation Plan | ▸ Refresh our Medium-Term Financial Framework annually<br>▸ Report on financial performance on a regular basis to IJB and the Audit Risk and Performance Committee<br>▸ Monitor costings and benefits of Delivery Plan projects<br>▸ Continually seek to achieve best value in our service delivery | ▸ Transform our commissioning approach focusing on social care market stability<br>▸ Design, deliver and improve services with people around their needs<br>▸ Develop proactive communications to keep communities informed | ▸ Develop an interim and longer-term solution for Countesswells<br>▸ Review and update the Primary Care Premises Plan |

# Introduction

We are delighted to present our Strategic Plan for 2022-25 which this year comes with a detailed Delivery Plan in Appendix A.

Our key focus continues to be progressing the integration agenda by increasing access to community-based health and social care services, shifting the balance of care from hospital to more homely settings, and supporting our most vulnerable residents.

First and foremost, we need to acknowledge the impact the COVID-19 pandemic had on the health and social care system, our staff and our communities. We are grateful to our health and social care workforce and the people of Aberdeen for working with us in responding to such challenging circumstances. We were all in it together, and together, we were stronger than the sum of our parts. Our forecasting indicates that demand for health and social care services will increase over the coming years, and that, potentially, more and more people could be living with multiple, long terms conditions. If we are to achieve our policy ambition of caring for people in more homely settings, we need to increase the availability and accessibility of high-quality community-based services, particularly those for people with higher levels of need, and find more ways to keep people safe at home. Learning from the pandemic experience, we have recognised that we cannot achieve this all on our own and that we need to foster and develop the “caring together” ethos that was so evident certainly in the early stages of COVID-19.

There are four strands of Covid related legacy that will also impact on demand for services. Firstly, the pandemic has left a legacy of health debt, a consequence of deferred care. Waiting times for all diagnostic services and for cancer treatment have increased.

There are also increased referrals to mental health services. Secondly, there is Long Covid which may not always manifest in a way that can be directly linked to Covid and consequently there is very little reliable data to help plan for additional demand. Thirdly, there is the ongoing need for some level of vaccination programme and lastly there is the potential for a resurgence of the virus in either a known or variant form. These impacts require us to work as a whole system to achieve shared goals, to enable agile and flexible responses to be able to plan for the unknown as well as increasing access to community resources which support good health and wellbeing.

As well as the direct and indirect impacts of COVID-19, external influences such as climate change, housing and increasing levels of poverty caused by the cost-of-living crisis also exist. These impact on current and future health inequalities and we need to plan to address these and build resilience to prevent ill health and enable people to achieve fulfilling, healthier lives. We need to focus on recovery and renewal, building resilience for the future.

Whilst we have the challenge of this additional demand, we are aware that it is unlikely our resources will increase to match. Finances are already tight, and it continues to be very difficult to recruit and retain staff.

Audit Scotland recognised this in a briefing released in January 2022, where they noted that in December 2020, the vacancy rate for social care staff was more than two and a half times the overall vacancy rate across all establishments in Scotland. In 2019, the Scottish Parliament recognised that almost a quarter of GP practices in Scotland were reporting vacancies. We will continue to transform our services to ensure we are able to meet the challenges ahead.

The **Independent Review of Adult Social Care in Scotland** (the Feeley Report), proposed the creation of a National Care Service (NCS) and we expect a Bill to be laid before parliament in the summer. Whilst the details of these new governance arrangements are being confirmed it is imperative that we are not distracted or diverted from our strategic focus. This is one of the reasons we have developed our Delivery Plan to help ensure we stay on track. We will be mindful of the role that Aberdeen City Health and Social Care Partnership (ACHSCP) can play in shaping the NCS and will ensure we are fully engaged at a national level, influencing and assisting with the reforms proposed, using every opportunity to bring the voice, view and opinion of our local system to those important conversations. We anticipate a local transition plan being developed with local partners to enable the local implementation of the National Care Service once the Bill has received Royal Assent. This will be presented to the IJB as a separate delivery plan.

In Aberdeen, to date, we are confident that we have have maximised the levers the integration agenda affords us. Our Integration Joint Board (IJB) has made bold and brave decisions resulting in integrated services, positive relationships, and improved outcomes for local communities. It is vital we continue this journey whilst sharing our successes to show what can be achieved when the integration principles are fully embraced.

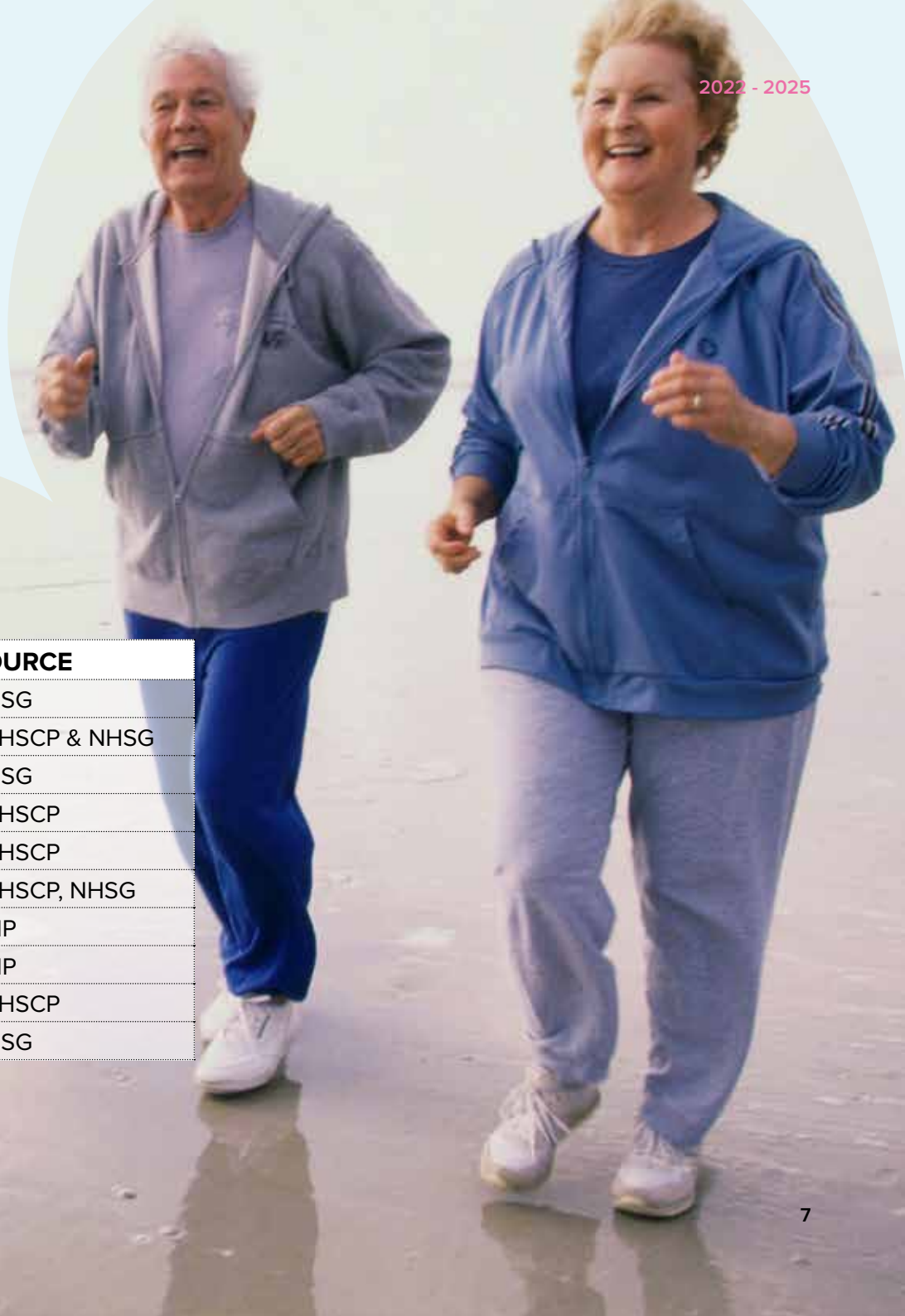
This Strategic Plan outlines where we have got to so far in realising the overall integration aims, living with and recovering from the impact of the COVID-19 pandemic, and our ambitious approach to transformation and development over the next 3 years. We plan to build on the strong foundations we have already established in terms of partnership working and strong links to both statutory and other partners.

Locally we are an engaged partner in Community Planning Aberdeen's Local Outcome Improvement Plan (LOIP) and NHS Grampian's Plan for the Future, our ambitions are completely aligned, and we will use all opportunities to work together to meet shared outcomes. Through these linkages the people of Aberdeen can be assured that we are collaborating and working together for shared objectives to make best use of the limited available resources.

**"I feel a considerable push towards prevention would benefit the population and ensure they can fulfil a healthier lifestyle."**

The first step in developing our Strategic Plan was undertaking consultation and listening to what our key stakeholders were telling us. Engagement on the Strategic Plan began with a joint exercise with the Locality Empowerment Groups on the refresh of Community Planning Aberdeen's Local Outcome Improvement Plan at the beginning of 2021. NHS Grampian subsequently undertook engagement sessions on their Plan for the Future and shared with us the overall results of these as well as analysis relating to Aberdeen City residents only. ACHSCP then undertook their own engagement. The outcome of all three engagement activities have informed the development of this plan.

| THEME | SOURCE |
|---|---|
| Prevention/Stay Well Stay Connected | NHSG |
| Access to Services | ACHSCP & NHSG |
| Quality of Services | NHSG |
| Whole System, Collaboration, Partnership Working, Relationships | ACHSCP |
| Sustainability and Recovery from Covid | ACHSCP |
| Engagement/Involvement | ACHSCP, NHSG |
| Action on Poverty | LOIP |
| Support for Mental Health (all ages) | LOIP |
| Looking After Staff | ACHSCP |
| Maximising Digital Technology | NHSG |



# Who We Are

Aberdeen City Health and Social Care Partnership (ACHSCP) delivers community health and social care services, some of which are delivered with partners in other sectors. As well as our internal services such as Social Work, Community Nursing and Allied Health Professionals, the partnership "hosts" Grampian wide services such as those for Mental Health and Learning Disabilities (MHLD), Sexual Health Services, and Specialist Older Adults and Rehabilitation Services (SOARS). The IJB for Aberdeen City governs and directs the work of the partnership.

# Our Approach

Our approach to service delivery follows the national **Integration Principles**. We aim that our services: -

- **Are joined up and easy for people to access**

  We have already redesigned our Older People's Frailty Pathway, integrating service delivery across Grampian. We will continue to deliver on this principle by reviewing further whole pathways of service delivery and creating a single point of contact (SPOC).

- **Take account of people's individual needs**

  Our services will be person-centred and data led. We have developed Our Guidance for Public Engagement, based on the Scottish Government and COSLA **Planning With People Guidance** to inform how we engage with our communities and enable people to have their say. We will ensure this approach continues to be embedded across the whole partnership whilst also making best use of data sources to target activity.

- **Take account of the particular characteristics and circumstances of different service users in different parts of the city**

  We have developed our **Equality Outcomes and Mainstreaming Framework 2021-25** which aims to make access to services more equitable, respecting and valuing the diversity of our service users in Aberdeen and ensuring they are free from discrimination.

  Part of these arrangements is undertaking a Health Inequality Impact Assessment in conjunction with people with the relevant protected characteristics when we are planning significant changes to service provision. We will ensure the framework is delivered and that planning to revise the framework by 2025 is undertaken timeously.

- **Respect the rights and dignity of service users**

  The Equality Outcomes and Mainstreaming Framework considers the rights and dignity of service users. We will ensure our service delivery takes a **Trauma-Informed** and **Human Rights** based approach by training our staff and encouraging more to become equality ambassadors, i.e. DiversCity Officers.

- **Take account of the participation by service users in the community in which service users live**

  We have developed a joint approach to community engagement and participation along with Community Planning Aberdeen. Each of our three localities has a Locality Empowerment Group and each Priority Neighbourhood has a Priority Neighbourhood Partnership. Each locality has developed a Locality Plan informed by, and delivered with, people living in these communities. We will report on the progress of these plans by August 2022 and will ensure our focus is on continued delivery.

- **Protect and improve the safety of service users**

  Over the last few years, we have developed robust arrangements to deliver our legal duty around **Adult Support and Protection** including a new structure for the team within Adult Social Work. We will continue to develop and enhance these arrangements ensuring vulnerable residents of Aberdeen are protected and kept safe. In most instances, the source of a child's vulnerability lies in the family circumstances or the needs or past trauma of their parents. To effect change we need to consider how services delivered to adults, children and families can come together to better consider the needs of the whole family in an early and preventative manner.

- **Improves the quality of the service**

  In 2021 we took out a partnership wide subscription to **Care Opinion** which is an online tool for patients, clients, and their carers to leave comments on the services they receive. The system is already well established in health settings. We will continue to promote the use of this tool, as an additional feedback mechanism, expanding it into social care settings ensuring the feedback informs service improvements made through our transformation activity detailed in our Delivery Plan.

- **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**

  The aim of our Locality Empowerment Groups is to ensure our services are planned and led locally. One of the aims of our Carers Strategy is that unpaid carers are listened to and involved in planning the services and support which the person they care for receives.

  Our Providers Network ensures third sector and independent providers delivering care commissioned by ACHSCP are involved in service planning and our in-house staff have opportunities through regular team meetings to influence the way services are delivered. We will ensure these approaches are further developed to enable our service planning and delivery to continue to be led by our communities.

- **Anticipate people's needs and prevent them arising**

  We are aware of the conditions that can impact on people's long-term health. Our **Stay Well Stay Connected** initiative is a programme of holistic community health interventions which is part of our prevention agenda and is designed to anticipate health issues in certain cohorts of the population. The programme puts in place support and intervention that either prevents conditions developing in the first place or minimises the impact of conditions already present.

- **Make the best use of facilities, people and resources**

  We have identified a number of enablers to this Strategic Plan – Workforce, Technology, Finance, Relationships and Infrastructure – along with a set of priorities for each of these. We will ensure we deliver on these priorities, making the best use of facilities, people and resources.

# Review of the last 3 years

Our previous Strategic Plan covered the three-year period from April 2019 to March 2022. The COVID-19 pandemic was a major focus of service delivery for two of these years however, as well as distracting us from some of our planned work, the pandemic also brought opportunities to accelerate some planned innovations and also to identify other new ways of working that will improve our service delivery and our efficiency in the future. In line with our statutory obligations, we publish an Annual Performance Report (APR). Previous reports relevant to our last Strategic Plan can be found here. These will provide enhanced detail in relation to our performance and our APR for 2021/22 will be published in the same location following approval by the IJB at the end of August 2022. In this section we report on just some of the key initiatives that we have implemented in the previous three years.

## Learning from Covid

During the pandemic we were able to break the normal rules and avoid the usual bureaucracy, ***empowering our staff*** to just get on and do the job in hand. In addition, many staff whose normal roles were paused, undertook training, and supported our care homes and other areas who were struggling to maintain service delivery due to staff shortages.

The dedication and flexibility of our staff was invaluable and going forward we plan to have a pool of fully trained volunteers to be able to step in during times of high demand to support and assist the existing workforce.

Pandemic restrictions also accelerated the city-wide adoption of ***new technology*** such as Near Me, an online consulting tool, and eConsult, an electronic triage system. These technologies assisted GPs and clinicians to continue to see patients during lockdown, and to manage increased demand once restrictions lifted. Not all of our patients are able or want to use new technology, however others welcome it as a flexible option that fits well with busy lives. We will work with our communities and our services to ensure people are supported to be able to use digital technology making options available that mean no-one is disadvantaged.

Public perception of social care began to change during the COVID-19 pandemic. Initially only the NHS was the focus of respect and gratitude for the work they were doing. Gradually, however, the public became more and more aware of the part that social care and carers were playing and social care staff received similar respect and gratitude with the weekly clap for carers and positive articles in the press and media. The momentum created needs to be built on, to ensure social care staff gain ***parity of esteem*** with their NHS colleagues.

Similarly, the public's perception of residential care was altered potentially as a result of the media reports on the impact of the COVID-19 pandemic on care homes. We have seen a reduction in demand for care home places and a resultant reduction in occupancy rates. This may return to normal in future but either way it supports one of our key policies i.e. ***shifting the balance of care*** more towards a person's own home or a homely setting. Whilst Care Homes are deemed to be homely settings, and there will always be individuals who either need or choose the care and support these can offer, there is no substitute for a person's own home if that is where they would prefer to be.

The importance of real time ***data*** influencing decision making was key throughout the pandemic response. Particularly with the pressure of high demand in the hospital and many care homes being closed due to outbreaks, it became imperative that there was an accurate picture of both demand and capacity across the whole system. A dataset was established which was utilised at the Daily System Connect meetings. Within the partnership we developed a "Surge and Flow" dashboard which captured information in relation to occupancy levels of our various care services as well as the anticipated demand. In addition, a daily Situation Report on staffing availability was made available in order that decisions could be made around equalising staff across the system and prioritising areas for support.

## Whole System Collaboration

The whole system approach that was already established pre-pandemic across Grampian really gained traction during the pandemic. The challenges COVID-19 brought impacted on every part of the health and social care system in Grampian. We were all dealing with the same issues and managers and staff regularly came together to discuss these and develop common solutions ensuring that one action in one part of the system did not have a negative unintended consequence on another.

We worked with our colleagues in Aberdeen City Council (ACC) and wider community partners to identify and provide relevant support for those who were shielding or isolating during the pandemic. Food and medical supplies were delivered to their doors with often some much needed social contact by means of even just a brief, physically distanced chat. The approach was termed ***'Aberdeen Together'*** and the learning from that was also used in the delivery model for the mass COVID-19 vaccinations with colleagues with relevant expertise from the Council helping to arrange appointments and clinics and delivering the local contact centre. We will use learning from this to help deliver our wider immunisation agenda going forward.

A good example of a collaborative approach which began prior to the pandemic is the development of ***Rosewell House*** into an integrated intermediate care facility providing much needed step-up and step-down care in a more homely setting, for patients with higher levels of acuity. The facility offers an alternative to hospital admission and helps to accelerate discharge where relevant. The 60 beds which were previously run solely by Bon Accord Care (BAC) (an Arm's Length External Organisation wholly owned by Aberdeen City Council) for residential care, are now managed by the NHS but care is delivered in partnership with BAC staff.

In December 2020, Aberdeen City IJB and Community Planning Aberdeen agreed to integrate their ***locality planning arrangements***, broadening the scope of the Locality Empowerment Groups (LEGs) to focus not only on health outcomes but also on the full set of stretch outcomes in the Local Outcome Improvement Plan (LOIP) encompassing community planning's Priority Neighbourhoods. Following significant engagement with the community using a "simulator" approach, teams from ACHSCP and Aberdeen City Council worked together with the LEGs to develop the Locality Plans. Progress against these is due to be reported annually to both the Community Planning Board and the IJB.

In April 2021, NHS Grampian adopted an interim ***Portfolio Management Approach*** which was designed to facilitate further integration between the community, primary and secondary health and social care system across defined patient pathways. The Chief Officer of ACHSCP assumed responsibility for the Medicine and Unscheduled Care departments of Aberdeen Royal Infirmary. The approach affords the Chief Officer of ACHSCP far greater influence over the whole system of health and social care enabling greater impact not only in terms of delivering services but also on the quality of that service provision. The arrangement also ensures greater involvement with the strategic planning for hospital services as delegated to the Chief Officer under the Integration Scheme. One impact of these new arrangements was the adoption of the ***Navigator Project*** in Grampian in August 2021. This support service, embedded within the Emergency Department aims to help reduce the underlying causes of potential admission / re-admission of people with complex needs (such as those who self-harm, those who experience emotional distress, domestic abuse, use alcohol or drugs to excess, are violent or are rough sleepers) by following up with them in the community and linking them into appropriate services. Many people presenting in this way will have underpinning stressors of social isolation, housing issues, deprivation, financial issues, and relationships. For many, deep rooted trauma will be a key underlying factor. The Navigator model of using professionals and people with Lived Experience creates a potential pathway for people in recovery into volunteering and employment. It sees recovery as an asset rather than a deficit. The project also links to the LOIP around enhanced early intervention and preventions for those at greatest risk of harm from drugs and alcohol.

## The things we've done differently

In December 2020 the partnership published a Market Position Statement which confirmed the strategic ambition for Day Care and Day Activities as "to work with you, your carers and our partners to ensure that there is sufficient choice of activity, local to your community (people or place) to support you and your carer to realise your outcomes." The ***Stay Well Stay Connected*** model adopts a whole population approach, with a strong focus on outcomes, whilst at the same time, embracing early intervention and prevention. The scope of the model is our adult population, but there is an enhanced focus on achieving outcomes for people living with disabilities and long-term conditions, people who, for one reason or another have started to "lose their connection" to their community, and adult carers. The detailed implementation plan outlined several key markers - the provision of planned respite, including residential respite; the testing of alternative models of support for individuals, reflecting personal choice and the achievement of outcomes; and strengthening the opportunity for the early identification of people at the cusp of losing their physical and emotional resilience and making a shift to early intervention and prevention by growing community connection within our localities. ACHSCP continues to work with providers to develop solutions for this vital service provision.

Throughout 2019 and 2020 extensive review and consultation was undertaken in relation to the delivery of care at home and supported living. This led to a commitment to move towards a ***commissioning for outcomes*** model with the establishment of clear outcomes to be achieved through the commissioning process. The four outcomes were – market stability, efficient and effective delivery, financial sustainability, and social value and cohesion with communities.

Following an options appraisal, the IJB agreed to progress with moving towards a three-locality primary provider contract for care at home and a transition to the same arrangements for supported living providers using a block funded contract that gave the provider freedom to manage the total budget in a way that delivered the specified outcomes. Although promoted for some time as the preferred future of commissioning, this move away from the traditional time and task model of payment for services delivered was ground-breaking and relatively unique across Scotland. The collaborative co-design and co-production approach taken in relation to care at home led to another innovative solution in the form of the ***Granite Care Consortium***. Rather than compete against each other for contracts to provide care at home services, eleven third and independent social care providers came together in a consortium arrangement to bid collectively for the city-wide service.

The award of this contract and the challenging transition from the previous arrangements represented significant transformational change and the successful implementation of the new contract is testament to the positive relationships, collaborative working, and innovative vision of everyone involved. One of the keys to success of the new care at home arrangements arose from the considerable work undertaken since the inception of ACHSCP to build relationships and trust with third and independent sector care providers. We have worked with umbrella organisations such as Scottish Care and Aberdeen Council for Voluntary Organisations (ACVO) to develop strong relationships with providers organisations. The Aberdeen City Provider Network has been in operation since early 2020 and this proved to be a strong foundation that continued throughout the COVID-19 pandemic. From this we developed our ***Care Home Support Team*** which is a multi-disciplinary team including nursing and care management staff.

The team work in collaboration with the Health Protection Team to ensure standards are adhered to. The team supported Care Homes throughout the pandemic and is now a permanent feature providing advice and guidance, sharing best practice and helping to find solutions to common problems. This collaborative approach raises the standards of care and improves outcomes for residents. In August 2021 the IJB approved a new service delivery model for ***Vaccination Services***. The model was designed using learning from the mass COVID-19 vaccination programme. Whilst a central venue helped deliver vaccinations to a large volume of people, it also highlighted the need to deliver services locally and engage with local communities to ensure easier access for diverse and seldom reached groups. The new model uses a combination of a central hub and fixed clinics delivered by locality-based teams as well as more dynamic options such as pop-up clinics and a mobile vaccination unit.

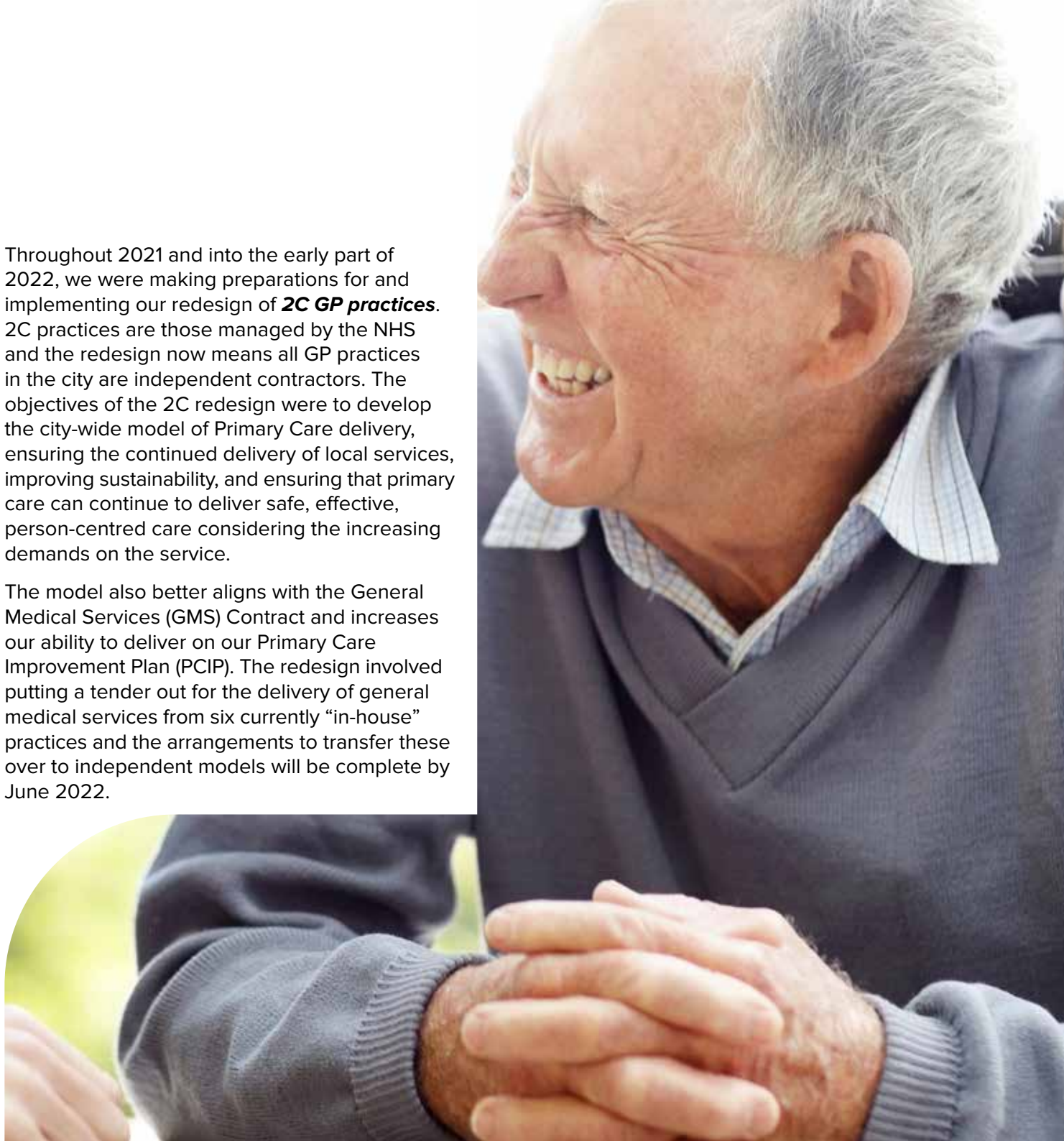
## The modernisation of our services which we have achieved

The adoption of various ***digital solutions*** over the last few years is helping to modernise service delivery within ACHSCP. Our social care case management system which also manages payments for commissioned services and statutory reporting requirements is being replaced by a system called Dynamics 365 (D365). ***D365*** is a set of intelligent business applications used to deliver greater results through predictive, Artificial Intelligence (AI) driven insights, across services. For staff, it will transform the way we record, access and share information across the business and with our service users. For service users, it will give them more involvement, more interaction and greater transparency in the service they receive, and for managers it will mean they can better use data to make decisions, allocate resources and deliver services to best meet the needs of the most vulnerable, moving towards predictive rather than reactive care.

The system has been in development since early 2020 and we eagerly await its implementation in July 2022. In September 2019, the IJB approved the procurement and implementation of the ***Morse*** System for the Health Visiting Service. This enabled the digitisation of the way Health Visitors worked allowing them to access and update records whilst being mobile. A project evaluation was completed in May 2021 which indicated substantial efficiencies have been achieved as a direct result due to a reduction in duplication and an increase in face-to-face contact time. Based on the positive experience of the Health Visiting Service, the Hospital at Home team received funding from Healthcare Improvement Scotland to implement Morse in their service for one year. In May 2021, further approval was given to enter into a three-year enterprise license agreement which allows for the whole of community nursing to benefit from this digitisation. In advance of the expiry of the license agreement an evaluation will be undertaken of the D365 system to understand whether it could offer the same benefits. If not, further market analysis will be undertaken, and the system will either be recommissioned, or the licence renewed.

Throughout 2021 and into the early part of 2022, we were making preparations for and implementing our redesign of ***2C GP practices***. 2C practices are those managed by the NHS and the redesign now means all GP practices in the city are independent contractors. The objectives of the 2C redesign were to develop the city-wide model of Primary Care delivery, ensuring the continued delivery of local services, improving sustainability, and ensuring that primary care can continue to deliver safe, effective, person-centred care considering the increasing demands on the service.

The model also better aligns with the General Medical Services (GMS) Contract and increases our ability to deliver on our Primary Care Improvement Plan (PCIP). The redesign involved putting a tender out for the delivery of general medical services from six currently “in-house” practices and the arrangements to transfer these over to independent models will be complete by June 2022.



## Key learning points to take forward from our review of the last 3 years

- **Take account of the participation by service users in the community in which service users live.**
- **Over the last three years we really put into practice our stated strategic intentions to work together with our communities and partners and focus on outcomes. The Rosewell House model, the new Care at Home contract delivered by the Granite Care Consortium, the development of the Locality Empowerment Groups and the close working relationships we have with our two statutory partners Aberdeen City Council and NHS Grampian are testament to that.**
- **Although the proposed National Care Service may alter our governance arrangements, it is our intention to continue building on these solid foundations and further develop the relationships we have with our key stakeholders to improve our overall service delivery which will ultimately have a positive impact on outcomes for the people we serve.**
- **Our resources, our infrastructure, and the way we do business are other key areas of strength that we will build on over the coming years.**
- **Our staff have always been critical to our achievements, and they were tested to the limit throughout the pandemic. We will repay their service by ensuring that we develop a Workforce Plan that recognises their professionalism, provides flexible yet robust career opportunities, considers their health and wellbeing and seeks parity of esteem for the social care workforce.**
- **We acknowledge the benefits of new technology, in service delivery, in supporting our staff to be able to do their job well, and in improving outcomes for the people of Aberdeen. We will maximise the use of technology where appropriate, and where necessary we will plan to support those who, for whatever reason, do not have equity of access.**
- **During the pandemic our decision making was strengthened because it was based on data. Whilst accessing and sharing accurate and current data remains a challenge we will build on the systems and processes introduced in the last two years and seek to improve the availability of data, ensuring this is used safely and securely, for the benefit of patients, clients, and staff.**

# Our Progress Against National Indicators

| National Indicator | Title | Performance | RAG Status |
|---|---|---|---|
| 1 | Percentage of adults able to look after their health very well or quite well | Consistent high scoring at 94% which is slightly above Scottish average of 93% | |
| 2 | Percentage of adults supported at home who agreed that they are supported to live as independently as possible | Consistent at 82%, slightly above Scottish average of 81% | |
| 3 | Percentage of adults supported at home who agreed they had a say in how their help, care or support was provided | Slight downward trend, down to 78% from 79% the previous year, although above the Scottish average of 75% | |
| 4 | Percentage of adults supported at home who agreed that their health and social care services seemed to be well coordinated | Stable performance at 76% and above the Scottish average of 73% | |
| 5 | Total percentage of adults receiving any care or support who rated it as excellent or good | Downward trend, down to 79% from 83% the previous year, and lower than the Scottish average of 80% | |
| 6 | Percentage of people with positive experience of the care provided by their GP practice | Downward trend to 77% from 82% and lower than the Scottish average of 79% | |
| 7 | Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life | Improving picture at 84%, up from 79% the previous year and above the Scottish average of 80% | |
| 8 | Total combined percentage of carers who feel supported to continue in their caring role | Lower than we would like it to be at 34%, and down from 40% the previous year, although 34% is on a par with Scottish average. | |
| 9 | Percentage of adults supported at home who agreed they felt safe | Improving picture at 85%, up from 84% the previous year, and above Scottish average of 83% | |
| 11 | Premature mortality rate per 100,000 | Rate reducing but higher than the Scottish average | |
| 12 | Emergency Admission rate per 100,000 | Rate reducing and lower than the Scottish average | |
| 13 | Emergency Bed Day Rate per 100,000 population | Rate reducing and lower than the Scottish average | |
| 14 | Readmission to hospital within 28 days (per 1,000 population) | Rate increasing and higher than the Scottish average | |

| National Indicator | Title | Performance | RAG Status |
|---|---|---|---|
| 15 | Proportion of last 6 months of life spent at home or in a community setting | Rate increasing and higher than the Scottish average | |
| 16 | Falls rate per 1,000 population aged 65+ | Rate reducing but higher than the Scottish average | |
| 17 | Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections | Rate has stayed the same but is higher than the Scottish average | |
| 18 | Percentage of adults with intensive care needs receiving care at home | Although the rate has increased it is still lower than we would want it to be and 10% lower than the Scottish average | |
| 19 | Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) | Rate has reduced significantly and is also significantly lower than Scottish average | |
| 20 | Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency | Rate has decreased but is slightly higher than Scottish average | |

The data above is based on the latest published data available, the most recent of which is 2019/20 i.e., pre Covid. NB: there is no data available for National Indicator 10 or 21 – 23. Red, Amber, Green (RAG) status is based on a combination of the trend pattern of the indicator and how Aberdeen City compares to the Scottish average.

More detailed information on our progress against National and Ministerial Steering Group Indicators is published in our Annual Performance Reports, available here. Actions in this Strategic Plan will seek to improve our performance on all of these indicators but particularly those that are amber and red i.e., ***improving the quality of care and support, enabling people to have their say in how their help, care or support is provided, supporting unpaid carers to continue in their caring role, premature mortality rate, readmission to hospital after 28 days, falls rate, percentage of adults with intensive care needs receiving care at home and percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.***

# Our Strategic Context

## Key Themes from our Strategic Context

Key themes from our strategic context to take into our Strategic Plan are: -

- **The need to focus on recovering from COVID-19**
- **The need to address the wider determinants of health which impact on inequity of access to health and social care services such as housing / homelessness, climate change, and cost of living concerns**
- **The need to ensure service delivery takes a rights-based approach for both adults and children**
- **The need to focus on shifting the paradigm of social care**
- **The need to maximise the use of new technologies and use data to inform our planning**

When integration of health and social care was first legislated for under the Public Bodies (Joint Working) (Scotland) Act 2014, the aim was to improve the quality and consistency of outcomes whilst allowing for local approaches to service delivery. Another aim was for health and social care services to focus on the needs of the individual, to promote health and wellbeing, and to enable people to live healthier lives in their community. Key to achieving this aim is that people's experiences of health and social care are positive and that they are able to shape the care and support they receive.

There are nine National Health and Wellbeing Outcomes which apply to integrated health and social care. These are shown below and everything in this Strategic Plan is aimed at achieving these.

1. **People are able to look after and improve their own health and wellbeing and live in good health for longer.**
2. **People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.**
3. **People who use health and social care services have positive experiences of those services, and have their dignity respected.**
4. **Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**
5. **Health and social care services contribute to reducing health inequalities.**
6. **People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.**
7. **People who use health and social care services are safe from harm.**
8. **People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**
9. **Resources are used effectively and efficiently in the provision of health and social care services.**

As part of striving to achieve these outcomes, we link our development work to current national and local strategies, plans and policies.

Scotland's Public Health Priorities, which inform our areas of focus are –

1. **COVID-19 Response, Recovery and Renewal**
2. **Mental Health**
3. **Communities and Place**
4. **Poverty and Children**

Good quality, affordable homes which are inexpensive to keep warm and are at the heart of communities is the aim of the Housing to 2040 strategy. There are commitments that all new homes delivered by Registered Social Landlords and Local Authorities will be zero emissions by 2026. This will involve fitting zero emission heating systems ahead of new regulations coming into force in 2024. There is also a stated aim to work with social housing providers to deliver digital connections in new social homes. New building standards will be introduced from 2025/26 to underpin the new Scottish Accessible Homes Standards to future proof new homes for lifelong accessibility. These measures will help our most vulnerable residents mitigate the impact of inequality, ensuring they can afford to heat their homes, maximise the use of new technologies and be able to continue living in their own home despite physical disability or mobility challenges. We will work alongside colleagues in ACC Housing to monitor the delivery of these aims and ensure they benefit those who need them most. Aberdeen City Council has its own Local Housing Strategy, chapter 5 of which is dedicated to independent living and specialist provision. The local strategy recognises that housing is at the heart of independent living and that good quality housing and support services can significantly improve people's lives, particularly older people and those with complex needs.

ACHSCP continues to work alongside colleagues in ACC Housing to ensure the housing needs of those most vulnerable are met. Our Disabled Adaptations Group (DAG) takes a cross sector view of adaptations in the city, planning for people to have housing that best suits their needs and allows them to have independence. The group is currently considering a response to the consultation on Providing Community Equipment and Housing Adaptations.

The Scottish Government is currently consulting on proposals to introduce a statutory duty to prevent homelessness through a housing bill expected in 2023. The proposals include changing existing homelessness legislation to ensure homelessness is prevented at an earlier stage.

If the proposals are implemented as they stand, all public sector staff including ACHSCP staff would have a duty to prevent homelessness, particularly by asking and acting on a risk of homelessness. There would also be responsibilities relating to strategic and joint planning. Homelessness can have a negative impact on both physical and mental health and wellbeing and can cause inequity of access to health and social care services. By being alert to the potential of homelessness and taking early action it is hoped that these impacts would be avoided.

The update to the Climate Change Plan 2018-2032 acknowledges that the challenge of meeting statutory targets for Net Zero emissions has become more difficult following the COVID-19 pandemic. This has had an impact on every aspect of life, with job losses, businesses struggling, and a fundamental shift in how people live and work in local communities. The plan recognises climate change as a human rights issue and the transition to net zero as an opportunity to tackle inequalities. ACHSCP must do all that it can to support, particularly vulnerable people through these challenges as well as making every effort to reduce its own carbon footprint and meet its statutory targets on Net Zero emissions.

The principles of **Scotland's Digital Strategy** include being collaborative, inclusive, ethical and user focused, data driven, and technology enabled. One of the aims is that no one is left behind by ensuring we tackle digital exclusion and reduce inequality. As part of this ACHSCP will use digital technology to transform people's lives where possible. A major barrier to the effective use of data is the inability to share information easily between the various agencies. We appreciate the importance of data security and building trust with our patients and clients, but we will continue to lobby to make data sharing easier.

**The Promise**, Scotland's independent care review for children, outlines that wherever safe to do so, Scotland will make sure children stay with their families and families will be actively supported to stay together. The wider structural and social inequalities that impact families' abilities to stay together and to thrive will be tackled so that no child or family in Scotland is left behind. It will be essential for ACHSCP to continue to work together with partners on these key areas of reform. This is reflected in our whole-system approach to working with partners for the benefit of all people living and working in Aberdeen and ACC's Family Support Model that we are working alongside colleagues to deliver.

The Scottish Government is planning to incorporate the **United Nations Convention on the Rights of the Child** (UNCRC) into law, having published a Bill. The UNCRC is the 'gold standard' across the world for children's rights. It covers all aspects of a child's life and sets out the civil, political, economic, social and cultural rights that all children everywhere are entitled to. It also explains how adults and governments must work together to make sure all children can enjoy all their rights. Incorporation will mean that ACHSCP must take steps to respect children's rights in their decisions and actions. It will also mean that children, young people and their representatives will be able to use courts in Scotland to enforce their rights.

In February 2021, Derek Feeley delivered a report on an **Independent Review of Adult Social Care in Scotland**. The report describes a need to shift the paradigm in relation to social care towards it being seen as an investment rather than a burden, to it being consistent and fair, enabling rights and capabilities, a vehicle for supporting independent living, being preventative and anticipatory, and as a result of collaboration and relationships.

ACHSCP have already begun making some progress on some of these areas particularly supporting independent living, having a focus on prevention, building relationships and working collaboratively, but there is still more to do. The key themes of the report are around access and design of services, planning and commissioning services, workforce, unpaid carers, and equality, as well as key recommendations around a human rights-based approach and redesigning models of care. Again, ACHSCP have made some progress on these. This Strategic Plan details the actions we will take to continue with our delivery of Feeley's vision for social care services.

Last year, the Scottish Government and CoSLA published a statement of intent to progress aspects of the Feeley report which don't require legislative solutions. The statement covers charging for social care services, ethical commissioning ensuring an approach to social care support that is based on human rights and needs; ensuring the voices of those with lived experience are at the heart of policy development, service design and service delivery; and ensuring that unpaid carers are fully supported to have a life alongside caring, in order to protect their health and wellbeing and better sustain caring roles.

Another consideration for the delivery of health and social care services is the level of funding available. Currently there is no clarity on the distribution of funding as a result of the recent increase in National Insurance or whether adult social care is to be provided free at the point of delivery in the same way as health. Due to restricted funding, Eligibility Criteria for social care is set very high which means meaningful support is only available when people are acutely unwell or in crisis.

This is against a backdrop of the increasing cost of living because of fuel and food price increases, which will have a greater impact on the most vulnerable and deprived in our society who are most likely in need of social care services.

# Our Data

Our data indicates four key areas that require our focus over the next three years. The data comes from a variety of published sources including Aberdeen City's **Population Needs Assessment**. Development of locality level data was interrupted by the COVID-19 pandemic however the **Locality Plans** for each of our three localities are based on locality specific information and contain priorities based on what the local community told us.

| **DEMAND FOR SERVICES WILL INCREASE** | | |
|---|---|---|
|  | The number of people **aged 75 and over** living in Aberdeen City will increase by 28.2% by 2033. | Demand for health and social care services is increasing. People are living longer, and over the next decade there will be a significant increase in the population aged over 75.<br>This will result in an increased requirement for support from services such as rehabilitation (from an expected increase in falls, periods of immobility etc) and dementia management. Current capacity in these areas is already stretched and we will need to continue our transformation of these services to meet this need.<br>The projected 25% increase in the prevalence of long-term conditions and rise in multi morbidity will lead to our services supporting patients and clients with more complex needs. This will require the review of current arrangements and planning to ensure future service delivery and staff skill sets are in place to match this demand. |
| | It is estimated that almost half of people over 80 will experience a **fall** at least once a year, with most falls happening in people's own homes. | |
| | **Unmet need** for social care has increased by 75% between April 2021 and April 2022. | |
| | There has been a 25% increase in people living with **Long Term Conditions**, by 2035 it is estimated that 66% of adults over 65 will be living with multi-morbidity. | |
| | There was an average of 3.6% of **operations cancelled** in NHS Grampian in 2021 | The pandemic caused the deferment of care. Operations were cancelled, cancer treatment delayed, and there was reduced access to diagnostic services. The consequence of this is a 'health debt' which adds to the pressure on the health and social care system and this will need to be factored into our capacity planning.<br>We will have a particular focus on Lung Cancer due to the significant increase in referral rates (see below). In addition, we will provide additional support for those diagnosed with Chronic, Obstructive, Pulmonary Disease (COPD) by developing a COPD hotline to enable people to receive support in their own homes. |
| | **Waiting times for cancer treatment** increased from 42 days in July to September 2020, to 49 days for the same period in 2021 which is the latest data available. | |
| | The percentage of people waiting within 6 weeks for **diagnostics** increased from 39.6% in January 2021 to 51.9% in December 2021. | |
| | It is estimated that somewhere between 0.7% and 2% of the population are projected to experience **Long Covid** (symptoms for 12 weeks or more after their first suspected COVID-19 infection). These figures equate to between 1,603 and 4,581 people in Aberdeen City. | Although the long-term impact of COVID-19 on health and social care services is unknown, even the lower projections of the incidence of Long Covid represents a potential significant additional demand. In addition, we need to be prepared for the resurgence of Covid whether in a known form or a variant. We will take this into account when considering transformation to improve capacity. |

| PARTICULAR FOCUS | | |
|---|---|---|
|  | The number of **unpaid carers** feeling supported in their caring role whilst on par with the Scottish average, at 34%, has decreased for Aberdeen City. | Our data also indicates that we need to have a particular focus on outcomes in certain service areas, particularly support for unpaid carers, substance misuse and mental health.<br><br>Providing support for unpaid carers was recognised as vital to the health and social care system with the introduction of the Carers (Scotland) Act 2016. Aberdeen City developed their Carers Strategy – A Life Alongside Caring in April 2018 just as the Act was implemented. The COVID-19 pandemic has impacted unpaid carers in Aberdeen City and the full delivery of the strategy and the revision of this were also delayed as a result of the response to the pandemic however this will now be taken forward as part of this strategy.<br><br>The incidence of drug misuse is on the increase, and colleagues in Aberdeen City Alcohol and Drugs Partnership are working to reduce the use and harm from alcohol and other drugs through their Delivery Framework.<br><br>Whilst demand for Mental Health services was already on the increase, the impact of the COVID-19 pandemic appears to have exacerbated the rate of this increase over the last two years. We are undertaking a Grampian wide transformation programme in relation to Mental Health and Learning Disability Services which will encompass transformation activity to address these areas.<br><br>Complex care needs are increasing and although we have made significant progress in reducing delayed discharges overall, those with complex care needs are more likely to experience delays in hospital. Plans have been put in place in conjunction with our care providers set out within the Market Position Statement 2021 – 2026, to adapt and change to the increase demand across the city for Mental Health and Learning Disability Residential services. |
| | In 2019/20 **Alcohol Related Admissions** (per 100,000) from the Central locality were 62% higher than the Scottish Average and were 31% higher in 2020/21. | |
| | **Drug related hospital admissions** increased by 8.7% between 2018 and 2020 with 'overdose' being the most common presentation of Frequent Attenders at the Emergency Department in ARI in 2021. | |
| | In 2019/20 16.6% of Aberdeen's population were prescribed drugs for anxiety, depression, or psychosis. | |
| | Referrals of Aberdeen City residents to **Mental Health Services** in Grampian increased by 43% from 2019 to 2022. | |
| | In 2019 there were 25 **probable suicides** and in 2020 there were 30 probable suicides. | |
| | Significant progress has been made in reducing our **Delayed Discharges** by 52.8% however we have not made the corresponding improvement to those relating to patients requiring more complex care with an increase of 38% in 2020/21 and another 17.6% increase in 2021/22. | |
| | **Complex care** needs are increasing, current residential and supported living providers claim that 12% of services were not currently suitable and that 40% of services would not be suitable in 5 years' time. | |

| **MORE NEEDS TO BE DONE IN TERMS OF PREVENTION** | | |
|---|---|---|
|  | **Emergency Attendances** at Aberdeen Royal Infirmary increased by 39% between January 2021 and January 2022. | One of the key ambitions of the integration of community health and social care services is to enable people to keep as well as possible, which has the positive consequence of avoiding unnecessary admissions to hospital.<br>Having sufficient and appropriate health and social care services in the community also means those who are ready to be discharged from hospital can be so promptly, to the most appropriate care setting for them, whether that be an intermediate care facility or straight home with the necessary adaptations, rehabilitation, care, or support in place.<br>We need to understand future demand for each of the different types of services to help us plan to better manage our capacity going forward. We already know that Rosewell House is working well as an integrated, intermediate care facility, and we will assess what other services and support may be required in addition to this. Our Hospital at Home service has also been hugely successful both in keeping people at home and allowing them to return home from hospital sooner and we will look to increase that capacity. |
| | There has been a 14% increase in **Unscheduled Bed Days** between January 2021 and January 2022. | |
| | **Healthy life expectancy** is reducing for both males and females in Aberdeen. | The reduction in healthy life expectancy in both male and females in Aberdeen is potentially due to the increase in incidence of multi morbidity. Whilst some people are genetically predisposed to a health condition, there are many diseases and long-term conditions that are either preventable or, if they already exist, their impact can be reduced or reversed, by adopting self-care or self-management techniques. An example is Type 2 Diabetes, a major cause of which is obesity combined with a sedentary lifestyle. Without preventative interventions such diseases will create additional demands on the health and social care system in future, so it is important that we do everything we can to help inform people of the risks they may be taking with their health and support them to make healthy life choices. We will do this in a person-centred way taking into account individual and social determinants of health. |
| | In the period 2016-19 it was estimated that 23% of the City's adult population was **obese**. Fruit and vegetable portion intake was consistently around 3 which is below recommended 5. | |
| | In the period 2016-19 it was estimated that 70% of adult's **physical activity** met the recommended guidelines. | |
| | Referrals to clinical and medical oncology for **Lung Cancers** have increased by 171% and 81% respectively between 2019 to present. Smoking prevalence in the 16 to 64 age group increased by 9% between 2018 and 2019 and smoking during pregnancy was almost ten times higher for expectant mothers living in the most deprived areas than those in the least deprived between 2018/19 and 2020/21. | The top four causes of death in Aberdeen in 2020 were heart disease, lung cancer, Alzheimer's/ Dementia, and respiratory conditions. Whilst the incidence of most of these has remained stable from 2019, the incidence of lung cancer has significantly increased. The primary cause of Lung Cancer is cigarette smoking. We will continue to contribute to the NHS Grampian Tobacco Strategic Plan for the North East of Scotland particularly in relation to encouraging the uptake of Smoking Cessation services. |

| THERE IS A WORRYING TREND OF INCREASING DEPRIVATION IN ABERDEEN CITY | | |
|---|---|---|
|  | In 2016 Aberdeen City's local share of data zones in the 20% most deprived was 8%. In 2020 that had risen to 10.25% | The upward trend of deprivation within the City is a cause for concern, particularly as the latest statistics available are for 2020 which means this is prior to any impact of the pandemic or the recent cost of living crisis.<br>A loss of employment tends to mean reduced income which may lead to a deterioration of living conditions (possibly even homelessness), an inability to heat the home, having to make a choice between heating or eating, reduced nutrition, reduced opportunity to maintain a healthy active lifestyle and potential impact on education of children and young people within the family. All of this can impact negatively on both mental and physical wellbeing. We are already aware that the Alcohol Admission Rate (per 100,000) differs across the City, with the Central Locality in 2019/20 and 2020/21 having admissions double that of the South locality, these differences, likely due to inequalities and lifestyle, will continue to become more marked without effective intervention.<br>Although ACHSCP cannot resolve an individual's financial situation, we can be alert to it, particularly the risk of homelessness as a result of the forthcoming new duty and help them find ways to mitigate the impact. |
|  | It is estimated that 800,000 people in Scotland lost employment as a result of the pandemic (as of April 21). Using a rough extrapolation from population estimates this could equate to 2,680 people in Aberdeen | |

# Our Vision

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

## Our Values

Honesty
Empathy
Equity
Respect
Transparency

## Our Enablers

Workforce
Technology
Finance
Relationships
Infrastructure

# Our Vision Values and Strategic Aims

Our vision remains unchanged since the inception of ACHSCP in 2016. It is that we are a caring partnership working in and with our communities to enable all people to achieve fulfilling, healthy lives.

Our **values** indicate what is important to us and set the standard for our behaviour. These have been amended after reflecting on the Planning With People Guidance and the Independent Review of Adult Social Care in Scotland. Above all we will be **honest** in everything we do; we will aim to **empathise** with the residents of Aberdeen understanding their needs, listening to their views and involving them in decision making. Providing services that have **equity** of access for all is important to us and we will make every effort to reduce the negative impact of inequality. We will **respect** the views and the rights of the people of Aberdeen and will be **transparent** in our dealings with them.

For 2022-25 we have identified four **strategic aims**. These build on the acceleration of some of the delivery commitments made within the last strategic plan as a result of the two years of the pandemic. We have retained our emphasis on prevention, personalisation and resilience but have refocused our connections and communities aims into a wider encompassing 'Caring Together' aim.

### CARING TOGETHER

Together with our communities, ensure that health and social care services are high quality, accessible, safe, and sustainable; that people have their rights, dignity and diversity respected; and that they have a say in how services are designed and delivered both for themselves and for the people they care for, ensuring they can access the right care, at the right time, in a way that suits them.

### KEEPING PEOPLE SAFE AT HOME

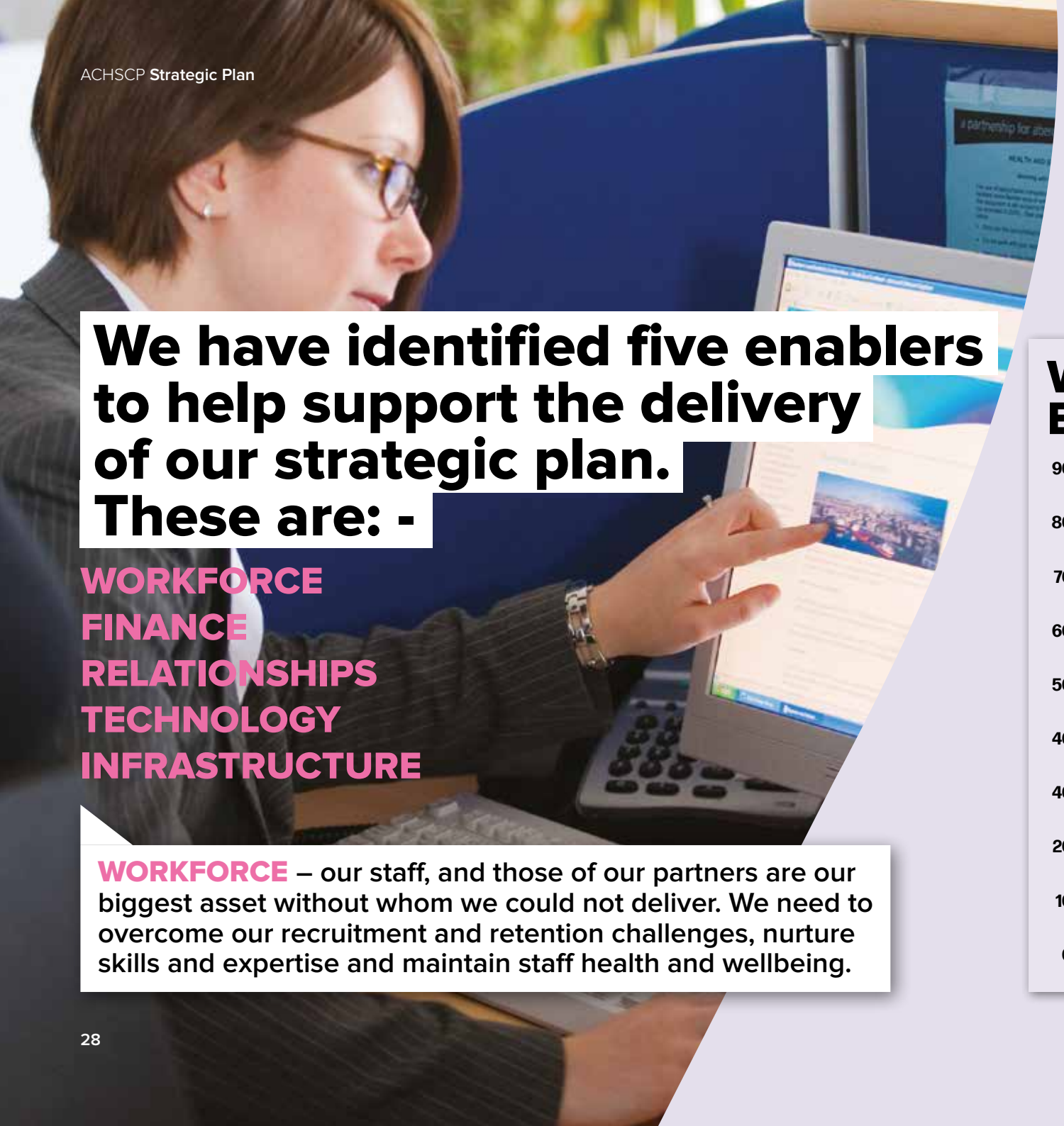
When they need it, people can be cared for safely in their own home or in a homely setting, reducing the number of times they need to be admitted to hospital or reducing the length of stay where admission is unavoidable. This includes a continued focus on improving the circumstances of adults at risk of harm.

### PREVENTING ILL HEALTH

Help communities to achieve positive mental and physical health outcomes by providing advice and designing suitable support (which may include utilising existing local assets), to help address the preventable causes of ill-health, ensuring this starts at as early an age as possible.

### ACHIEVING FULFILLING, HEALTHY LIVES

Support people to help overcome the health and wellbeing challenges they may face, particularly in relation to inequality, recovering from COVID-19, and the impact of an unpaid caring role, enabling them to live the life they want, at every stage.

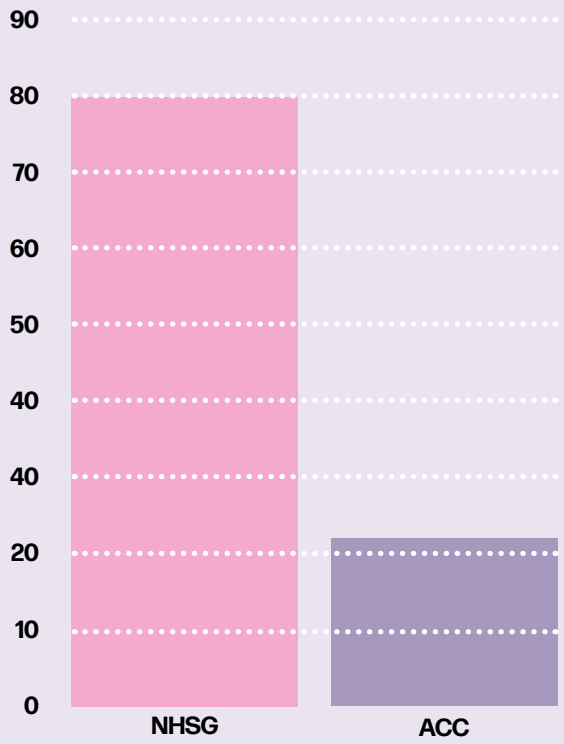


# We have identified five enablers to help support the delivery of our strategic plan. These are: -

**WORKFORCE**
**FINANCE**
**RELATIONSHIPS**
**TECHNOLOGY**
**INFRASTRUCTURE**

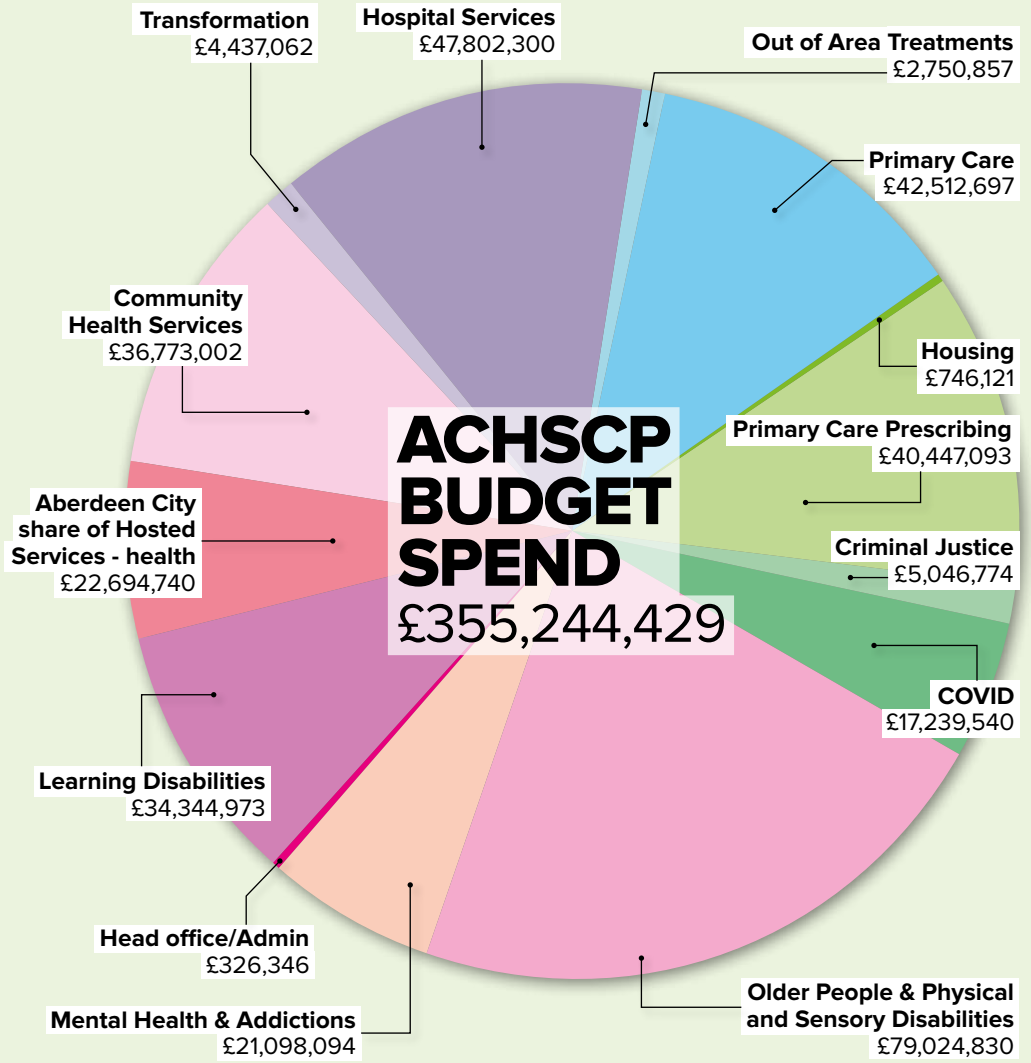
**WORKFORCE** – our staff, and those of our partners are our biggest asset without whom we could not deliver. We need to overcome our recruitment and retention challenges, nurture skills and expertise and maintain staff health and wellbeing.

## Workforce Budget (£m)



**FINANCE** – service delivery requires funding. With the breadth of services provided and increasing demand we need to ensure service delivery is as efficient as possible to make the best use of the funding we have. How we use our current annual funding is shown right: -

**RELATIONSHIPS** – developing and maintaining positive relationships with our partners and our communities is crucial to the successful delivery of this Strategic Plan. One of the key ways we utilise positive relationships to transform community health and social care services is through our approach to Commissioning. Commissioning is the process used to understand, plan, and deliver services. We will also continue to collaborate with people with lived experience, hearing their voices, and designing, delivering, and improving services around their needs and personal goals (known as outcomes) based on what they say.



| **RELATIONSHIPS** Our Commissioning Principles |
|---|
| • 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 |

**TECHNOLOGY** – Data and digital technologies are transforming every element of our lives. They are radically redefining relationships between all organisations and their clients and customers. To most effectively improve outcomes, and to prevent and reduce demand, services and data need to be integrated and have the individual person and their unique circumstances at their core. Delivering our strategic aims relies on the effective use of data and digital technologies to connect people; to understand and meet their needs; to build on the strengths of individuals and communities; and support their independence and resilience. Data and digital services can empower residents and ensure limited resources are targeted to support and protect the most vulnerable in our city. They can also transform how services are designed, broadening and deepening client, patient, and community engagement; and improving outcomes with proactive and preventative decision making.

**INFRASTRUCTURE** – the physical assets we use for service delivery need to be fit for purpose and not unnecessarily increase our carbon footprint. The built environment impacts on our service delivery with new housing developments increasing demand for services within the communities where they are situated. Transport is also a key enabler for patients and clients to access services.

# Our Strategic Priorities for 2022-25

Against each of the Strategic Aims and Enablers we have identified a number of priorities which we will deliver over the three-year lifecycle of the Strategic Plan. Ultimately these are the means by which we aim to deliver on our Strategic Plan, and on the National Health and Wellbeing Outcomes.

## Caring Together

**Undertake whole pathway reviews ensuring services are more accessible and coordinated**

During the consultation process for this Strategic Plan, people told us that access to services needs to be as easy as possible and where people need support from more than one health and social care professional, that should be as co-ordinated and as seamless as possible. In line with the shift to a rights-based service delivery model we need to ensure that those who need it have access to independent advocacy. People also told us that transitioning between services, particularly for children moving into adult services should be managed in a planned way, well in advance of the date of transition. Collaboration and partnership working was also a theme from consultation, so coordination should extend to working jointly with other services that impact on the holistic needs of an individual including housing, education, employment, transport, and place planning. This should include improved data sharing and early identification of preventative interventions. We will undertake a series of pathway reviews to ensure our services are as accessible and as joined up as possible.

**Empower our communities to be involved in planning and leading services locally**

In order for people to be able to make informed choices about their care they need to have detailed information of the services available to them, what support these services can offer, and how to access these. When we refer to services this includes those available from both statutory and non-statutory providers including community groups. For funded service provision, the information provided should include the promotion of the four Self-directed Support (SDS) options and the flexibility available within these, offering our residents choice and control over the way they receive their care. We are committed to creating a culture of doing with our service users, rather than doing to them. The Locality Empowerment Groups (LEGs) are our key links to our communities, and we intend to build on the work undertaken to create these, growing the membership and particularly developing the diversity of the make-up. The LEGs are not our only link with our communities, however, and we will seek ways to increase our reach into communities through both existing and potential users of our services utilising existing networks and channels.

People told us they want to be involved in decisions about the care that both they and their loved ones receive. We are therefore committed to co-designing and co-producing services with our communities, particularly those people within the community with lived experience of the services we deliver.

We want to ensure that people's voices are heard and that they are able to have their say in the types of services made available, and how, where, and when these are delivered. We believe this will not only improve our service delivery, but it will also enhance the experience of our service users and their carers.

**Create Capacity for General Practice improving patient experience**

A key 'frontline' service in health and social care is General Medical Services (GMS) provided by General Practitioners (GPs) and the range of multi-disciplinary teams that surround them to deliver effective care to the communities they serve. In recent years the service has experienced the combined challenges of increasing workload and issues with recruitment and retention. A number of GP practices have closed, and future sustainability is a concern. An important transformational tool for creating capacity and improving patient experience of GP services is the Primary Care Improvement Plan (PCIP) which seeks to add additional capacity in the form of alternative professional roles to support GPs as well as delivering some services in a different way, improving access for patients and improving outcomes.

**Deliver better support to unpaid carers**

Unpaid carers have told us that they feel undervalued and that the Covid-19 pandemic impacted them significantly. We will listen to the voices of unpaid cares and make sure that all unpaid carers (whether they recognise themselves as such or not) are made aware of their rights, are consulted on the type of support they need, and help co-design it and that they are made aware of the support available to them and how to access it.
We will ensure that unpaid carers are able to identify any barriers they may encounter in accessing the services they need and are supported to overcome these. This feedback will be used to inform the development and implementation of our revised Carers Strategy.

## Keeping People Safe at Home

The strategic responsibility of the IJB is to shift the balance of care from hospital to be delivered in primary, community, and social care settings so that a patient is seen closer to home. We aim to enable people to remain living independently at home by choice thereby improving outcomes. This means expanding our community health and social care services including those provided in community hubs, Intermediate Care facilities and Hospital at Home services. In line with this agenda, we need to consider whether it remains appropriate for people to receive short periods of rehabilitation within a hospital setting or whether that can be safely delivered along with other support in their own home, reducing the need for bed-based services.

**Maximise Independence through Rehabilitation**

It is estimated that half of people over 80 will experience a fall at least once a year, with most falls happening in people's own homes. Many experiencing a fall may fracture a bone and require hospitalisation. This can have a life altering affect and most need specialist support to help them recover the strength, mobility, and confidence to return home and look after themselves. Any lengthy stay in hospital for whatever reason, and indeed any period of inactivity can lead to deconditioning which in turn has a range of negative health impacts, including falls, depression, Type 2 diabetes, cardiovascular disease, and musculoskeletal problems.

We will seek to find innovative ways to increase strength and balance activity among those who have been most affected by deconditioning, maximising their independence and reducing their risk of falls. We will focus particularly on those living with multi-morbidity or dementia, those living in social care settings, and people from more deprived backgrounds.

**Reduce the impact of Unscheduled Care on the Hospital**

Shifting the balance of care is also important for unplanned or unscheduled care, reducing the burden on acute hospital-based services. On a daily basis, colleagues in the Grampian health and care system identify patients who are receiving care in a setting that is not necessarily the best place for their particular condition or circumstance. The COVID-19 pandemic saw reduced services for screening/diagnostic services, outpatient follow up appointments and planned surgery. We have accrued a health debt as a result of that deferred care that will require maximum usage and efficiency of the hospital bed base for planned interventions such as surgery and oncology. We need to do all that we can in the community to minimise the impact on the remobilisation of these services of unplanned and emergency attendances and admissions. We will build on the work undertaken prior to, and during, the pandemic, working at pace, to upscale the tests of change and agility that COVID-19 brought us. There is a strong need to work across organisational and professional boundaries to bring about the necessary transformation and modernisation. Delivery models in both primary and secondary care will be blended to share knowledge and expertise to meet identified needs in the most appropriate way.

**Expand the choice of housing options for people requiring care**

A person's own home is a crucial part of the health and social care system and contributes positively or negatively to their health. We need to do all that we can to ensure people requiring care can, if appropriate, continue to live in their own home safely and independently, whilst receiving the care that they need. We will work with ACC as a planning authority to help shape the housing market, working with the city's social landlords and developers in terms of matching need with supply. A person's home includes a residential care, or nursing home, very sheltered or sheltered housing, extra care housing, supported living accommodation or their own home, specially built or adapted to suit their needs.

Adaptations to make properties suitable for people with care needs to live in, can range from widening doors to enable wheelchair access and providing level access showers to installing grab rails, ramps, and handrails. The use of Telecare can also enable people to live in their own homes for longer.

**Deliver intensive family support to keep children with their families**

Aberdeen City Integrated Children's Services are driving forward the development of a multi-agency Family Support Model that will ensure a data led approach to commissioning services to deliver more effective early and preventative support to families. There are four groups for whom this approach will apply - Children with a disability; Children in conflict with the law; Children who are exposed to the risk of Trauma; and Children on the edge of care. In most instances the reasons for escalating vulnerability/need relates to a child's family circumstances or the needs and past trauma of their parents.

Consequently, to truly effect change we need to consider how services delivered to adults, children and families can come together to better consider the needs of the whole family in an early and preventative manner. This has strong alignment to Scottish Government policy in relation to Whole Family Support for those with addictions and mental health needs.

## Preventing Ill Health

Tackle the top preventable risk factors for poor physical and mental health including obesity, smoking and use of alcohol and drugs

Whilst some people are genetically predisposed to a health condition, there are many diseases and long-term conditions that are either preventable or, if they already exist, their impact can be reduced or reversed, by adopting self-care or self-management techniques. An example is Type 2 Diabetes, a major cause of which is obesity combined with a sedentary lifestyle. Encouraging people to increase their activity levels and maintain a healthy weight can, not only reduce the incidence of Type 2 Diabetes, but also reduce the health impacts on those already with the condition. Investment in addiction services and smoking cessation programmes can have similar impacts on levels of alcohol, drugs, and tobacco use. Our aim is to give people the knowledge, support and tools, they need to make choices to stay as well as they are able for as long as possible. In this way we hope to support our residents to make informed choices and overcome barriers to prevent the preventable.

**Enable people to look after their own health in a way which is manageable for them**

Immunisation is one of the most effective public health interventions in the world for saving lives and promoting good health. Immunisation helps protect against serious diseases and once we have been immunised, our bodies are better able to fight these diseases if we encounter them. We have experienced the benefits of immunisations (or vaccinations) during the COVID-19 pandemic. Most vaccinations are normally given in childhood and help protect our health throughout our lives. It is important, however that parents bring their children forward for vaccinations when they are eligible.

In August 2021 Aberdeen City Integration Joint Board approved an Immunisation Blueprint which details a hub and spoke model for the delivery of immunisations is the city ensuring easy, local access for those who need them.

ACHSCP host Grampian-wide Sexual Health Services. An individual's sexual health can impact on their physical and mental health and wellbeing. In January 2022 Healthcare Improvement Scotland (HIS) published Sexual Health Standards covering leadership and governance; shared and supported decision-making; education and training; access to sexual health care; sexual wellbeing; prevention detection and management of sexually transmitted diseases and bloodborne viruses; services for young people; reducing sexual health inequalities; reducing unintended pregnancies; and abortion care. We will develop an action plan to deliver on these standards.

## Achieve Fulfilling Healthy Lives

**Help people access support to overcome the impact of the wider determinants of health**

Health and wellbeing are impacted by so much more than physical conditions. Where people are born, their childhood experiences, the quality of home they live in, the standard of education they receive, their family income, their employment status etc. can all impact.

ACHSCP cannot address all of these wider determinants of health on our own, but we can work with partners to try to influence positive changes. We can also ensure our staff have an awareness of these factors, and deliver services in a person-centred way, targeted to the specific needs of patients and clients, depending on their individual circumstances. Collaborative working with partners can help ensure people are supported to get the help they need.

Access to open spaces helps to encourage activity and improve health and we will work will partners to promote the inclusion of such spaces in new developments. How people get around the city also has an impact on both their health and the environment. Transport needs to be available and accessible in order for people to be able to get to health-related appointments, but we would also encourage active travel as far as possible to provide opportunities for people to improve their health as they move around the city. We will work with ACC and NESTRANS as the transport authority for the city to achieve these ambitions.Infrastructure has an impact on the environment. Considering the impact of climate change, we need to aim to reduce our carbon footprint in every decision we make.

**Ensure services do not stigmatise people**

Some of our residents, including our staff, experience inequality, stigma or discrimination due to their age, sex, disability, sexual orientation, gender reassignment, marital status, pregnancy or maternity status, race, religion, or belief. We will ensure service design, delivery and development takes account of the needs of those who are inappropriately stigmatised by ensuring these are considered in the planning process with mitigating adjustments put in place. In May 2021, Aberdeen City IJB updated their Equality Outcomes and Mainstreaming Framework (EOMF) with seven equality related outcomes covering all patients, clients, service users and their carers having access to, and confidence in the services we deliver as well as those delivering services having compassion and respecting the dignity of individuals and involving people in the way those services are delivered. A group of DiversCity officers is being created to champion our equality agenda and drive the delivery of the EOMF. The Equality and Human Rights Sub Group of the Strategic Planning Group comprising of representatives of people and communities with protected characteristics will provide constructive challenge to the DiversCity Officers and monitor progress of delivery of the framework.

Part of the arrangements we put in place for our approach to inequality was to adopt a robust process for undertaking Health Inequality Impact Assessments (HIIA) for every major change to service provisions. The process includes an initial assessment checklist to determine whether an HIIA is required and, if one is, a recording proforma to capture who was involved, what feedback they gave and what impact this had on the decision-making process.

**Improve public mental health and wellbeing**

The pandemic had an additional negative impact on people's mental health and wellbeing. There was widespread concern over the impact of COVID-19 on people's health, or that of their loved ones, coupled with lockdown restrictions removing the opportunities for social interaction and activities that, under normal circumstances, help support positive mental health and wellbeing. In addition, many people experienced life events such as bereavement or loss of employment. Bereavement will normally impact negatively on mental health and wellbeing, but, during the heights of the pandemic, there was the added impact of people not being able to hold the usual funeral arrangements, or to seek comfort from friends and family in the normal way. Losing a job at any time can be stressful, but the pandemic brought greater uncertainty about the future of entire industries brining additional concern over the prospects of returning to certain professions in the future. All of this continues to bring additional demand to our mental health services, in particular those community-based ones aimed at initial intervention. Providing support at an early stage is key to avoiding lengthy or more intense episodes of poor mental health.

**Improve opportunities for those requiring complex care**

We know the reason for people being delayed the longest in hospital is the lack of facilities in the community, not only locally, but nationally, for those requiring complex care. Complex care is often required for people with chronic or long-term health conditions for example, learning disabilities, physical disabilities or those experiencing significant concerns with their mental health, who require extra assistance to manage their symptoms and daily activities to enable the best possible quality of life.

Within Aberdeen City we have limited complex care facilities meaning people often have to be looked after out-of-area, which is not only detrimental to their wellbeing, but it is also a loss to the local economy and can come at significant cost, not only for ACHSCP but for friends and family visiting.

To date we do not have the volume of demand for complex care services to create a robust service or pathway that is viable from a provider perspective. Building on the commissioning model we used which saw the birth of the Granite City Consortium (which delivers our Care at Home in Aberdeen City), we will seek to work with providers to consider a new build or adaptation which could become a complex care village offering local support for not only Aberdeen City residents but also those living in the wider north east.  Our vision would be for the village to create a positive environment where people are supported to have quality lives, within a local community, supported and engaged with their families as they choose.

**Remobilise services and develop plans to work towards addressing the consequences of deferred care.**

During the pandemic all but critical services were paused. In terms of acute services, non-urgent operations were cancelled and waiting times for diagnostic services and cancer treatment increased. In addition, it is estimated that somewhere between 0.7% and 2% of the population are projected to experience symptoms for 12 weeks or more after their first suspected COVID-19 infection.

This is known as Long Covid and although the long-term impact on health and social care services is unknown, these figures are equivalent to between 1,603 and 4,581 people in Aberdeen City which represents a potential significant additional demand. Not only do we need to do all that we can to ensure all health and social care services are remobilised as soon as they safely can be, to mitigate any ongoing health debt, but we also need to plan to provide support to the existing health debt and those experiencing ongoing health issues as a result of Long Covid. COVID-19 is here to stay, and we need to learn to live with it and any variant that comes along. Our services need to be able to continue to work as normally as possible without the significant pauses seen in the past.

# Our Enabling Priorities

## Workforce

Our workforce is our biggest asset.  During the COVID-19 pandemic we asked a lot of them, and they delivered. A priority for us is to continue to support all staff's health and wellbeing, whether they are working directly for the partnership or in one of our commissioned services or partner organisations. Recruitment and retention of staff is challenging across all sectors. We need to support training to improve skillsets (particularly in the areas of Trauma Informed Care, Complex Care and Self-directed Support) and improve the career structure, ensuring there are clear development opportunities. There is a shortage of clinical staff which is a significant risk for sustainable service delivery. We need to attract more clinicians to work locally through innovative new roles, developing a new workforce, working with NHS Grampian and nationally to improve the pipeline of trainees coming to Grampian. In Social Care we need to ensure training is standardised and that training with one organisation is portable to another. We want to see carers being paid an appropriate wage for the jobs that they do and their terms and conditions being equivalent to employees in the public sector. Not only should this reduce turnover, improve the consistency of care, and reduce absence rates but also achieve parity of esteem with health and make social work and community health and social care a more rewarding career. The National Care Workforce Strategy seeks a workforce that is well-trained and developed, healthy and supported, and sustainable and recognised. During the Pandemic we recognised the contribution of unpaid volunteers to the health and social care system, and this is something we would seek to embed as an integral part of the overall workforce. Our workforce plan will be developed taking cognisance of all of these aspects as well as against the backdrop of the Scottish Government and CoSLA Statement of Intent in relation to the Feeley Report.

## Technology

Digital Consulting software such as Near Me and eConsult have enabled GPs and clinicians to manage their capacity to cope with the increase in demand for services. These systems, however, have also brought challenges and we will continue to work with our partners in NHS Grampian to ensure they are used in a way that supports patients.

Technology Enabled Care (TEC) can help people live independently at home and, where appropriate, we would like to extend its use throughout Aberdeen being mindful of the additional associated electricity costs this may bring.  Digital devices can help detect a fall, sense movement and even prompt times for medications or meals. This can reduce the need for, potentially intrusive, in-home care provision whilst providing both the individual and their families or carers confidence and peace of mind. A major development is the switchover from analogue to digital telephone systems in 2025. This will impact those who use monitored telecare systems such as Community Alarms, and we are planning now to ensure equipment can continue to be used in a way that supports and benefits clients beyond the change.

Technology can also assist staff to improve the quality of service delivered. The digitisation of patient or client records can help multi-disciplinary teams share information and provide the details required to ensure swift and appropriate care is provided. The necessary security and data sharing protocols need to be in place. Electronic Medication Administration Record (EMAR) used mainly in Care Homes can improve the efficiency of medication administration and reduce the opportunity for errors however this is a costly system for providers to implement.

We are also building technologies that collate and analyse of system wide datasets, not only to help manage the care and support people receive but also to help plan future service transformation. Our use of personal data must be ethical and transparent. People should have greater access to and control over their health and social care information and have a say in how their data is used and shared. This is part of encouraging them to play an active role in looking after their own health and wellbeing. We will work with partners to continue to build standards, policies, systems, and a culture which supports data driven and evidence-based decision making. When gathering data we will ensure, where relevant and proportionate that we capture information on protected characteristics to help us design and deliver services that bring equity across our population.

## Finance

Whilst demand is increasing, finances are not necessarily keeping apace, so we need to ensure we make the best use of our restricted budgets through the redesign of services and doing things differently. We can do this by employing robust financial management, exploring options for improvements to systems and processes that achieve efficiencies (perhaps through better coordination of services) and ensuring we maximise any income that is available to us through Contributing to Your Care and Support, our non-residential charging policy. A key priority in managing our finances is that the costing implications and benefits of the actions in our Delivery Plan are monitored in order that our service delivery achieves best value.

## Relationships

Developing and maintaining positive relationships is central to achieving the priorities we have set out in this strategic plan. These relationships occur at a strategic level with our partners in the wider Grampian Area, NHS Grampian and Aberdeen City Council as well as on an individual level through the relationships we build with our workforce, independent and third sector partners and the people of Aberdeen. Since the redesign of our GP services all the GP practices in the city are now independent contractors which brings a new dynamic as to how these relationships are managed.

One of the key ways we are aiming to utilise positive relationships to transform community health and social care services is through our approach to the planning, commissioning, and procurement of these services. All of our commissioning work will be done taking cognisance of our commissioning principles and our focus will be on shaping the delivery of high-quality, person-centred care and support recognising the variety of needs and therefore the differing skill levels and associated costs for some areas of care such as very acute dementia, and stroke and neurological care and rehabilitation.

Aberdeen City IJB outsources almost all of its social care services, so the sustainability of our market and our providers is critical. Longer term contracts that do not require frequent re-commissioning should provide stability. This will help providers recruit and retain staff, providing greater opportunity for social care as an attractive career prospect and giving parity of esteem. We are committed to delivering on Unison's Ethical Care Charter.

Underpinning our relationship with the people of Aberdeen is the need to help them understand the challenges that we face, why we need to transform services, and what this means for them. We will develop proactive, repeated, and consistent communications to keep, particularly those who only occasionally access community health and social care, informed of our strategic direction, our service delivery and any specific changes that may impact them.

## Infrastructure

Infrastructure includes physical buildings, places and spaces. Aberdeen City IJB does not in itself own any buildings. Services are delivered from premises owned by one of our statutory partners - Aberdeen City Council or NHS Grampian – or by independent providers or landlords for commissioned services. We need to ensure that assets used to deliver health and social care services are fit for purpose, modernised where appropriate, and managed sustainably. In light of changes to the way we deliver services, we also need to determine our future requirement for building based space and maximise our use of the space available to us, particularly for as long as social distancing measures continue to be in place as a result of the COVID-19 pandemic. We need to determine what, if any, level of investment may be required to achieve aims with regards to infrastructure and identify where that may come from. New housing developments increase demand for services within the communities where they are built.

We will monitor new development activity and work with partners to ensure the relevant financial contributions from developers are used to meet these additional needs.

# Our Delivery Plan and Measuring Success

Appendix A contains our Delivery Plan which lists the actions we plan to take over the three years to deliver on the priorities within this Strategic Plan. The Delivery Plan provides detail on the programmes of work and individual projects to be undertaken in relation to each priority, who will be responsible for delivery, the timescale within which it will be delivered and the measure which will tell us how we will measure our success. These measures are a mixture of local and national indicators, qualitative and quantitative data.

The Delivery Plan is based on what we know now. It will be reviewed annually with any additional actions which are subsequently deemed to be essential to the delivery of the Strategic Plan added in years two and three following agreement from the IJB. This review will be undertaken at the time we undertake the annual updating of the Medium-Term Financial Framework to ensure the actions can be resourced appropriately.

Progress on this Strategic Plan will be monitored on an ongoing basis using our existing programme and project management and governance arrangements. A member of the Leadership Team is allocated to each priority and will be responsible for reporting to the Leadership Team Meetings on a monthly basis. Additional quarterly reporting will be undertaken via the Executive Programme Board to the Risk Audit and Performance and Clinical and Care Governance Committees. Our Annual Performance Report (APR) will be approved and published annually by the IJB as required under the Public Bodies (Joint Working) (Scotland) Act 2014.

The nine National Wellbeing Outcomes noted in Our Strategic context above are measured using an agreed core suite of 23 National Indicators. It is accepted that a degree of development is required in relation to the core suite however these are what we are measured on at the moment. In our Annual Performance Report, we are required to demonstrate how we are improving the National Health and Wellbeing Outcomes and across Scotland we have agreed that including an Appendix to the APR showing latest performance against the national indicators is currently the best and only way to do this that also allows for benchmarking across the country.

# **Strategic Delivery Plan** – Appendix A

| **Caring Together** | **Strategic Measures**<br>NI 3 - Percentage of adults supported at home who agreed they had a say in how their help, care or support was provided<br>NI 4 - Percentage of adults supported at home who agreed that their health and social care services seem to be well coordinated<br>NI 5 - Total percentage of adults receiving any care or support who rated it as excellent or good<br>NI 6 - % of people with positive experience of care at their GP practice<br>NI 8 - total combined percentage of carers who feel supported to continue in their caring role<br>Social Care Unmet Need |
|---|---|

| **Programme/Projects** | **Lead** | **Y1** | **Y2** | **Y3** | **Measures** |
|---|---|---|---|---|---|
| **Undertake Pathway Reviews** | | | | | |
| Redesign Adult Social Work enhancing the role of Care Managers in playing a guiding role in the promotion of personalised options for care | Social Work | Sep-22 | | | Redesign implemented |
| Undertake a strategic review of specific social care pathways and develop an implementation plan for improving accessibility and coordination | Social Work | Nov-22 | | | Implementation Plan |
| Map existing universal and social support and work with partners and the community to develop services to meet any identified gaps | Strategy & Transformation | | Sep-23 | | Map developed |
| Implement the recommendations from the current Adult Support and Protection inspection | Social Work | Mar-23 | | | Action Plan complete |
| Deliver the Justice Social Work Delivery Plan | Social Work | Mar-23 | Mar-24 | Dec-24 | Percentage of actions complete |
| Develop and implement a Transition Plan for those transitioning between children and adult social care services | MHLD | Mar-23 | | | Plan developed |
| Develop cross sector, easily accessible, community hubs where a range of services coalesce, all responding to local need | Primary Care/Social Work/ AHPs/Nursing | Mar-23 | | | Hubs operational |

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|---|---|---|---|---|---|
| **Community Empowerment** | | | | | |
| Develop the membership and diversity of our Locality Empowerment Groups | Strategy & Transformation | Mar-23 | | | Membership |
| Increase community involvement through existing networks and channels | Strategy & Transformation | | Mar-24 | Mar-25 | Number of cohorts/groups involved |
| Deliver our Locality Plans and report on progress | Strategy & Transformation | Aug-22 | | | Progress Report |
| Train our staff and embed the use of Our Guidance for Public Engagement | Strategy & Transformation | Mar-23 | | | Percentage of Staff Trained |
| Promote the use of Care Opinion to encourage patients, clients, carers and service users to share experiences of services, further informing choice. | Strategy & Transformation | Mar-23 | | | Number of posts on Care Opinion |
| **Primary Care** | | | | | |
| Finalise the arrangements for the closure of Carden Medical Practice and identify an alternative use of the building | Primary Care | Jun-22 | | | Report to IJB |
| Improve primary care stability by creating capacity for general practice | Primary Care | Mar-23 | | | Report to IJB |
| Deliver the strategic intent for the Primary Care Improvement Plan (PCIP) | Primary Care | Mar-23 | Mar-24 | Mar-25 | Plan report |
| **Unpaid Carers** | | | | | |
| Develop and deliver a revised Carers Strategy with unpaid carers and providers of carers support services in Aberdeen, considering the impact of Covid 19 | Strategy & Transformation | Oct-22 | | | Strategy Approved at IJB |
| Monitor and evaluate the impact of the Carers Strategy on an ongoing basis factoring in early preparations for the next revision | Strategy & Transformation | | Oct-23 | Oct-24 | Reports to Risk Audit and Performance Committee (RAPC) |

| **Keeping People Safe at Home** | **Strategic Measures**<br>NI 2 – Percentage of adults supported at home who agree that they are supported to live as independently as possible<br>NI 9 – Percentage of adults supported at home who agree they felt safe<br>NI 12 – Emergency admission rate<br>NI 13 – Emergency bed day rate<br>NI 14 – Readmission to hospital within 28 days<br>NI 15 – Proportion of last 6 months of life spent at home or in a community setting<br>NI 16 – Falls rate per 1,000 population aged 65+<br>NI 18 – Percentage of adults with intensive care needs receiving care at home<br>NI 19 – Number of days people spend in hospital when they are ready to be discharged, per 1,000 population<br>NI 20 – percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency<br>Numbers of specialist housing new build<br>Adaptation statistics<br>Telecare usage statistics |
|---|---|

| **Programme/Projects** | **Lead** | **Y1** | **Y2** | **Y3** | **Measures** |
|---|---|---|---|---|---|
| **Rehabilitation** | | | | | |
| Commence strategic review of rehabilitation services across ACHSCP\SOARS\ Portfolio and have an implementation plan in place to commence by April 2023 | AHP/Rehabilitation | Apr-23 | | | Implementation plan in place |
| Implementation of outcome of review of rehabilitation | AHP/Rehabilitation | | Apr-24 | Apr-25 | |
| Explore how other partners in sports and leisure, can assist in delivering rehabilitation across multiple areas | AHP/Rehabilitation | Sep-22 | | | Community First |
| Work with local authority partners to look at how we can coalesce rehabilitation and housing support with social care support, perhaps looking at sheltered housing accommodation as rehabilitation community hubs | AHP/Rehabilitation | | Sep-23 | | Hubs developed |
| Increase community capacity to reduce impact on secondary care and increase support for chronic heart failure | AHP/Rehabilitation | | Mar-24 | | Secondary Care Chronic Heart Failure admissions |

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|---|---|---|---|---|---|
| Grow and embed the COPD hotline to support people in their own home | AHP/Rehabilitation | Mar-23 | | | COPD Hotline embedded |
| Undertake a strategic review of the Neuro Rehabilitation Pathway | AHP/Rehabilitation | Oct-22 | | | Report to IJB |
| Implement findings of the Neuro Rehabilitation Pathway review | AHP/Rehabilitation | | Oct-23 | Oct-24 | Evaluation |
| Review bed-based services for rehabilitation and consider a delivery model that meets the needs and aspirations of our communities | AHP/Rehabilitation | | Mar-24 | | Model developed |
| Implement recommendations from bed-based review | AHP/Rehabilitation | | | Mar-25 | Model Implemented |

| **Unscheduled Care** | | | | | |
|---|---|---|---|---|---|
| Build on our intermediate bed-based services to create 20 step-up beds available for our primary care multi-disciplinary teams (MDTs) to access | Nursing | Sep-22 | | | 20 beds created |
| Increase our hospital at home base with an ultimate ambition of 100 beds. These will be for unscheduled, older people, respiratory and cardiac pathways | Nursing | Sep-22 | Mar-24 | Mar-25 | Number of Beds available |
| Deliver the second phase of the Frailty pathway | SOARS | Sep-22 | | | Pathway delivered |
| Review Frailty Pathway and implement any enhancements identified | SOARS | | Sep-23 | Sep-24 | Evaluation |
| Develop clear access routes for unscheduled care pathways so that people receive prompt care, from the right person, in the right place, at the right time | Social Work/Nursing | | Sep-23 | | Pathways developed |
| Develop a flexible bed base within the community that can respond, through secondary and primary care support, to surges in pressure particularly in winter, whilst ensuring that our fixed, unscheduled bed base, is protected for those where hospital treatment is the best option | Social Work/ Nursing/ Commissioning | | Sep-23 | | Flexible Bed Base Developed |
| Undertake a strategic review of the data, demographic and demand picture to understand the 'bed base' for unscheduled care across MUSC, SOARS and ACHSCP between 2023- 2030 | Strategy and Transformation | Sep-22 | | | Review the demand profile produced |

| **Expand Housing Options** | | | | | |
|---|---|---|---|---|---|
| Working with ACC as a planning authority, create incentives for investment in specialist housing influencing new builds and enabling people to have lifetime homes. | Strategy and Transformation | Mar-23 | | | Numbers of specialist housing new build |
| Help people to ensure their current homes meet their needs including enabling adaptations and encouraging the use of Telecare where appropriate | Strategy and Transformation | Mar-23 | Mar-24 | Mar-25 | Adaptation statistics, Telecare usage statistics |
| Respond to the national consultation on equipment and adaptations helping to shape future guidance in this area. | Strategy and Transformation | Jun-22 | | | Consultation submitted by deadline |
| Work with ACC Housing and RSLs to ensure energy efficient, affordable housing is made available to those who need it most | Strategy and Transformation | Mar-23 | Mar-24 | Mar-25 | Housing satisfaction results |

| **Deliver Intensive Family Support** | | | | | |
|---|---|---|---|---|---|
| Work with Integrated Children's Services to support the delivery of the Family Support Model particularly in relation to children with a disability and those who are exposed to the risk of trauma | Nursing | Mar-23 | Mar-24 | Mar-25 | Family Support Model milestones delivered |

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| **Preventing Ill Health** | **Strategic Measures**<br>NI 11 - Premature mortality rate<br>Healthy Life Expectancy<br>% Physical activity meeting national guidelines<br>% of Adult population considered obese<br>Smoking/Smoking Cessation statistics<br>Drug and Alcohol related admissions<br>Drug and Alcohol related deaths<br>Social Isolation/Connectedness<br>Immunisation Statistics<br>Sexual Health Statistics |

| Programme/Projects | Lead | Y1 | Y2 | Y3 | Measures |
|---|---|---|---|---|---|
| **Prevention** | | | | | |
| Reduce the use and harm from alcohol and other drugs | Aberdeen City Alcohol and Drugs Partnership | Mar-23 | Mar-24 | Mar-25 | Drug and Alcohol related admissions and deaths, Delivery Framework Milestones |
| Deliver actions to meet the HIS Sexual Health Standards | Sexual Health | Mar-23 | Mar-24 | Mar-25 | Progress towards meeting standards |
| Deliver our Immunisations Blueprint. | Nursing | Mar-23 | Mar-24 | Mar-25 | Immunisations Statistics |
| Continue the promotion of active lives initiatives including encouraging active travel. | Strategy and Transformation | Mar-23 | Mar-24 | Mar-25 | Percentage of population meeting Physical activity national guidelines |
| Continue to contribute to the NHS Grampian Tobacco Strategic Plan for the North East of Scotland particularly in relation to encouraging the uptake of Smoking Cessation Services | Strategy and Transformation | Mar-23 | Mar-24 | Mar-25 | Smoking/Smoking Cessation statistics |
| Continue to deliver our Stay Well Stay Connected programme of holistic community health interventions focusing on the prevention agenda around achieving a healthy weight through providing advice and support for positive nutrition and an active lifestyle. | Strategy and Transformation | Mar-23 | Mar-24 | Mar-25 | |
| Continue to contribute to the Grampian Patient Transport Plan (GPTP) and the Aberdeen Local Transport Strategy (ALTS) encouraging sustainable and active travel. | Strategy and Transformation | Mar-23 | Mar-24 | Mar-25 | ACHSCP requirements reflected GPTP and ALTS |

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| **Achieving fulfilling, healthy lives** | **Strategic Measures**<br>NI 1 – Percentage of adults able to look after their health very well or quite well<br>NI 7 – Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life<br>Percentage of Equality Outcomes and Mainstream Framework delivered<br>Number of Health Inequality Impact Assessments published<br>Complex Care Statistics |

| **Programme/Projects** | **Lead** | **Y1** | **Y2** | **Y3** | **Measures** |
|---|---|---|---|---|---|
| **Address Inequality/Wider Determinants of Health** | | | | | |
| Deliver on our Equality Outcomes and Mainstreaming Framework, report on our progress to both the IJB and the Risk, Audit and Performance Committee and plan to revise the EOMF in advance of the 2025 deadline | Strategy and Transformation | Mar-23 | Mar-24 | Mar-25 | IJB and Committee Reports |
| Undertake and publish Health Inequality Impact Assessments, where relevant, for major service change, in conjunction with people and communities with the relevant protected characteristics | Strategy and Transformation | Mar-23 | Mar-24 | Mar-25 | Number of Health Inequality Impact Assessments published |
| Make Every Opportunity Count by identifying any wider determinant issue and ensuring patients, clients and their carers are signposted to relevant services for help | Strategy and Transformation | | | | Service Directory developed |
| Embed consideration of the impact of climate change in health and social care planning and in business continuity arrangements aiming to reduce our carbon footprint and deliver on our Net Zero emissions target | Business/Strategy & Transformation | Mar-23 | Mar-24 | Mar-25 | Climate Change impacts included in Business Cases, IJB Reports and Business Continuity Plans |
| **Mental Health and Learning Disabilities** | | | | | |
| Continue to progress Mental Health and Learning Disabilities (MHLD) transformation to evidence increased community delivery across secondary and primary care with a clear plan for 2022 and 2023 in place by June 2022 | MHLD | Jun-22 | Jun-23 | Jun-24 | Plan developed, Progress Reports |
| Implement the actions in the MHLD Transformation Plan | MHLD | Jun-22 | Jun-23 | Jun-24 | Progress Reports |

| **Complex Care** | | | | | |
|---|---|---|---|---|---|
| Link in with local authority and third and independent sector providers to bring the Complex Care conversation to the fore and bring a degree of pace to achieving a solution for this area of need | MHLD | Sep-22 | Mar-24 | | Discussion instigated |
| Work with neighbouring areas to understand the scale of current service needs for complex care across Grampian | MHLD | Sep-22 | Mar-24 | | Demand identified |
| Work with Children's Social Work and health services, to predict future demand for complex care | MHLD | Sep-22 | | | Future predicted demand identified |
| Work with providers to understand the core skills required to support complex behaviours and seek to work with them and training providers to create a bespoke workforce that will achieve positive outcomes for this group of clients | MHLD | | Jun-23 | | Core Skills and training matrix developed |

| **Remobilisation** | | | | | |
|---|---|---|---|---|---|
| Explore opportunities for working with those on waiting lists to help support them while they wait, or divert them from the list | Leadership Team | Mar-23 | Mar-24 | Mar-25 | Numbers supported/diverted |
| Plan service capacity to include the impact of the consequences of deferred care and Long Covid | Leadership Team | Mar-23 | Mar-24 | Mar-25 | Unmet Need |
| Remobilise services in line with the Grampian Remobilisation Plan as soon as it is safe to do so | Leadership Team | Mar-23 | Mar-24 | Mar-25 | Percentage Remobilisation |
| Develop a plan ready to respond to increased demand due to covid variants or vaccinations | Business/ Strategy and Transformation | Sep-22 | | | Plan developed |

# Strategic Enablers

| Programme/Projects | Lead | Y1 | Y2 | Y3 | Measures |
|---|---|---|---|---|---|
| **Workforce** | | | | | |
| Develop a Workforce Plan taking cognisance of national and regional agendas | People and Organisation | Jul-22 | | | Plan developed |
| Develop and implement a volunteer protocol and pathway with a view to growing and valuing volunteering within the health and social care system | People and Organisation | | Sep-23 | | Protocol developed |
| Continue to support initiatives supporting staff health and wellbeing | People and Organisation | Mar-23 | Mar-24 | Mar-25 | Initiatives delivered |
| Train our workforce to be Trauma Informed | People and Organisation | Mar-23 | | | Percentage of workforce trained |
| **Technology** | | | | | |
| Support the implementation of digital records where possible | Strategy & Transformation | Mar-23 | Mar-24 | Mar-25 | Percentage of records digitised |
| Support the implementation of Electronic Medication Administration Recording (EMAR) in our care homes | Strategy & Transformation | | Dec-23 | | Percentage of homes where EMAR is used |
| Seek to expand the use of Technology Enabled Care (TEC) throughout Aberdeen | Social Work/ Commissioning | Mar-23 | Mar-24 | Mar-25 | TEC usage statistics |
| Support the implementation of the new D365 system which enables the recording, access and sharing of adult and children's social work information | Social Work/Strategy & Transformation | Jul-22 | | | Successful implementation and use |
| Deliver a Single Point of Contact for individuals and professionals including a repository of information on health and social care services available, eligibility criteria and ow to access | Strategy & Transformation | Sep-22 | | | Community First Programme Milestones |
| Review the future use of Morse in Community Nursing and Allied Health Professionals | Strategy & Transformation/Nursing | | May-23 | | Proposal to IJB |
| Explore ways we can help people access and use digital systems | Strategy & Transformation | Mar-23 | Mar-24 | Mar-25 | Number of people supported |
| Develop and deliver Analogue to Digital Implementation Plan | Strategy & Transformation | | | Mar-25 | Plan developed and delivered |

| **Finance** | | | | | |
|---|---|---|---|---|---|
| Monitor costing implications and benefits of Delivery Plan actions esuring Best Value is delivered | Chief Finance Officer | Mar-23 | Mar-24 | Mar-25 | Medium Term Financial Framework (MTFF) |

| **Relationships** | | | | | |
|---|---|---|---|---|---|
| Review availability of the range of independent advocacy and implement any recommendations from the review | Commissioning | | Jun-23 | Jun-24 | Report to Integrated Joint Board (IJB) /Implement |
| Develop proactive, repeated and consistent communications to keep communities informed | Business | Mar-23 | Mar-24 | Mar-25 | Number of proactive communications |
| Continue to deliver on our commissioning principle that commissioning practice includes solutions co-designed and co-produced with partners and communities | Commissioning | | | | Number of codesigned/ coproduced commissioning |
| Continue to transform our commissioning approach, building on the work we undertook with our Care at Home contract, developing positive relationships with providers, encouraging collaborative approaches and commissioning for outcomes | Commissioning | Mar-23 | Mar-24 | Mar-25 | Number of commissioning for outcomes arrangements |
| Focus on long term contracts and more creative commissioning approaches such as direct awards and alliance contracts which will provide greater stability for the social care market | Commissioning | Mar-23 | Mar-24 | Mar-25 | Number of long term and creative contracts |
| Continue to deliver ethical commissioning in relation to financial transparency and fair working conditions for social care staff as well as progressing implementation of Unisons Ethical Care Charter | Commissioning | Mar-23 | Mar-24 | Mar-25 | Number of ethical commissioning arrangements and % of Unison's Ethical Care Charter implemented |

| **Infrastructure** | | | | | |
|---|---|---|---|---|---|
| Identify interim and long term solutions for the provision of health and social care services in Countesswells | Primary Care/Strategy and Transformation | Mar-23 | | | Report to AMG/IJB |
| Continue to review and update the Primary Care Premises Plan (PCPP) on an annual basis | Primary Care/Strategy and Transformation | Mar-23 | Mar-24 | Mar-25 | PCPP revised every year |

Aberdeen City Health & Social Care Partnership

*A caring partnership*

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

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ABERDEEN CITY COUNCIL

NHS Grampian