

# Aberdeen City Health and Social Care Partnership Strategic Plan 2016-19.



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



## Foreword.



I warmly welcome the publication of the Aberdeen City Health and Social Care Partnership's first Strategic Plan showing how we will develop and deliver integrated health and social care services for the benefit of the citizens of Aberdeen and other residents in Grampian also.

The publication of this Strategic Plan marks the 'Go Live' date for the integration of our health and social care services in Aberdeen. Many colleagues from across the health, care, third, independent and housing sectors have been working closely over the past few years to ensure the success of our integration transition. This Strategic Plan reflects their collective endeavours and I would like to thank them for their respective contribution.

We strongly believe that working with our citizens and their communities to develop their resilience and increased capacity for self-management will greatly contribute to their health and wellbeing as will the development of person centred, integrated, locality based services.

We recognise the demographic and financial challenges that we face and we recognise that we will have to do things differently however we are confident that proposals outlined will help improve the health and wellbeing of our local population and reduce the health inequalities that still exist in our city.

These are exciting times and I look forward to sharing with you news of our future developments and achievements.

A handwritten signature in black ink that reads "Len Ironside". The script is fluid and cursive, with the first letters of "Len" and "Ironside" being capitalized and prominent.

Cllr. Len Ironside, CBE (Chair)

Aberdeen City Health and Social Care Partnership Integration Joint Board

## **Integration Principles.**

The Health and Social Care Partnership is required by the Scottish Government to take into account the national integration principles when preparing both the Integration Scheme and the Strategic Plan.\*

These principles, stated below, clearly state that the main purpose of integrated services is to improve the wellbeing of our citizens and these services should be provided in a way in which, so far as possible:

- Is integrated from the point of view of recipients
- Takes account of the particular needs of different recipients
- Takes account of the particular needs of recipients from different parts of the area in which the service is being provided
- Takes account of the particular characteristics and circumstances of different service users
- Respects the rights of service users
- Takes account of the dignity of service users
- Takes account of the participation by service users in the community in which service users live
- Protects and improves the safety of service users
- Improves the quality of the service
- Is planned and led locally in a way which is engaged with the community (including in particular service users, those who look after service users and those who are involved in the provision of health or social care)
- Best anticipates needs and prevents them arising
- Makes the best use of the available facilities, people and other resources

\* The Integration Scheme is the legal agreement between Aberdeen City Council and NHS Grampian to establish the Aberdeen City Health and Social Care Partnership and the arrangements for delegating certain adult health and social care functions to the partnership. The Strategic Plan outlines how these delegated functions will be set out to meet the national health and wellbeing outcomes.

i) The planning and delivery of good quality health and social care in the city of Aberdeen embraces the principle of equal opportunities, as set out in the respective partners' Equalities Schemes.

This means that the partners will strive to encourage equal opportunities and diversity, responding to the different needs and service requirements of people regardless of sex, race, colour, disability, age, creed, marital status, ethnic origin, sexual orientation or gender re-assignment.

An Equality Impact Assessment has been undertaken and is detailed in Appendix 1.

ii) To ensure the effectiveness and fairness of the decisions that we will make we have completed a Health Inequalities Impact Assessment to help us think about how this plan and its ambitions might affect the people of Aberdeen.

A Health Inequalities Impact Assessment has been undertaken and is detailed in Appendix 2.

iii) Health and social care language can often be complex and unfamiliar. We have attempted to minimise the use of jargon in order to make this document as accessible and understandable as possible.

A Glossary of key words and phrases is set out in Appendix 4.

**If you require further information about any aspect of this Strategy please contact:**

Aberdeen City Health and Social Care Partnership  
Community Health and Care Village  
50 Frederick Street  
Aberdeen  
AB24 5HY

Website: <https://aberdeencityhscp.scot>

Twitter: <https://twitter.com/HSCAberdeen>

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

Please contact the Aberdeen City Health & Social Care Partnership on 01224 625729

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

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

---

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

---

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

---

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

---

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

---

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

---

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

## **Contents**

### **1. Introduction.**

- 1.1. This Strategic Plan.
- 1.2. Our Vision and Values.
- 1.3. Our Strategic Priorities.

### **2. Our Caring Partnership.**

- 2.1. Our Aberdeen.
- 2.2. Our Partnership.
- 2.3. Our Carers.
- 2.4. Our Resources.
- 2.5. Our Strategic Connections.

### **3. Working Together with Our City Communities.**

- 3.1. Our Localities.
- 3.2. Our Communities and Localities.
- 3.3. Locality Planning.
- 3.4. Developing a Community and Locality Based Approach.
- 3.5. Helping People Stay at Home and Prevent Unnecessary Admission.

### **4. To Enable People.**

- 4.1. Our Personalised Approach.
- 4.2. Our Self-Management Principles and Supports.
- 4.3. Our Improvement Principles and Ambitions.
- 4.4. Whose Risk Is It Anyway?

### **5. To Achieve Healthier and Fulfilling Lives and Wellbeing.**

- 5.1. Our Intentions.

### **6. How Will We Know We Are Making A Difference?**

- 6.1. Our Performance Framework.
- 6.2. Where Do We Want To Be in 2019?

### **Appendices.**

- 1. Equality Impact Assessment.
- 2. Health Inequalities Impact Assessment.
- 3. Housing Contribution Statement.
- 4. Glossary.

# 1. Introduction

## 1.1 This Strategic Plan.

This Strategic Plan outlines our ambitions for those adult health and social care functions and services which will be delegated by Aberdeen City Council and NHS Grampian to the Aberdeen City Health and Social Care Partnership.

It reflects the many conversations we have had with the people of Aberdeen and our professional colleagues across all sectors and services about what health and social care integration will mean to them and the services that they value highly.

We strongly believe that integration will offer us many different opportunities to reflect on what we currently do and to think about what we could and should be doing to benefit the local citizens and the communities in which they live.

We cannot afford to be complacent. As part of our consultation on the draft strategic plan we asked the City Voice forum to indicate whether they were satisfied or dissatisfied with their recent experiences of using our health and/or social care services. More than half of respondents **(59%)** indicated they were satisfied with this experience but 1 in 7 **(15%)** reported being dissatisfied. We want to be part of a partnership that the citizens of Aberdeen and our professional colleagues are proud to identify with and be a part of.

There are fundamental themes throughout this strategic plan that can be read as the Integration Joint Board's statement of intent and which are applicable to all our current activities and our future intentions. They include:

Our focus will always be on improving, where possible, the health and wellbeing of our citizens and seeking to reduce the health inequalities that exist in our city.

### What is integration?

The Scottish Parliament passed the Public Bodies (Joint Working) (Scotland) Act in 2014. It requires local authorities and health boards to work together and integrate certain adult health and social care services and to set these out in a legal agreement called an Integration Scheme.

Our integration authority is called the **Aberdeen City Health and Social Care Partnership** and it is responsible for the planning and delivery of those integrated services from 1<sup>st</sup> April 2016. We are committed to improving the health and wellbeing of the local population, delivering quality services and becoming recognised as one of the highest performing partnerships in Scotland.

We will be challenged however by the increasing demand for our services and the likelihood of decreasing financial resources so we must accept that we will have to configure and deliver our services differently. Delivering our services as we have traditionally done so will be ineffective in meeting that increasing demand. However we do want to reassure that desirable service change should not in itself mean service disruption.

As citizens, we must all take greater responsibility for our own health and wellbeing and in doing so be a part of the new solutions that we seek to develop. We will develop a stronger preventative emphasis to our activities and interventions to minimise the cumulative impact of an increasing population with a number of long term conditions.

We will also support and develop our communities and localities so that they can help shape priorities and implement their own solutions within the framework of this strategic plan. We want to see innovation flourish in our localities.

Improving the quality of all our services will underpin everything we do. We are committed to improving the personal experiences of everyone who uses our health and social care services and improving their personal outcomes.

The primary purpose of health and social care integration is not to save money. Integration in itself will not result in cost savings but we do anticipate that efficiencies will be achieved through identifying duplication of services and resources and eradicating these.

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

We are ambitious to be seen as an employer of choice and one of the leading and innovative health and social care partnerships in Scotland.

Given the impending demographic and financial challenges, delivering our health and care services as we have previously done is not an option for us. To achieve the required improvement in our health and wellbeing, improvement in our experiences of using services, and our personal outcomes, will require us all to take greater responsibility and interest in our own lives and wellbeing by improving our lifestyles, and where appropriate, managing our long term conditions better.

Our plan will demonstrate the strength of our commitment to improving the personal experiences of our local citizens when they use our health and care services, and our



commitment to improving their personal outcomes. We will show how we hope to develop our community connections and activities to complement the care and support that is offered, as locally as possible to enable people to live at home, or in a homely environment, for as long as is reasonably possible.

We will deliver integrated health and care services that support the people of Aberdeen to remain as well as possible for as long as possible. We will seek to ensure that people are only admitted to hospital when that is the best place for them to be, and that they stay in hospital for only the minimum time that is clinically required.

The integration of our health and care services will offer us significant opportunities to shift the balance of care towards preventative, locality based services that work in partnership with individuals, families, and communities. We are very aware though, that we must continue to deliver existing services on a day to day basis until such time as we are ready to implement our plans and support this transformation to happen. Service change will not mean service disruption.



Our Strategic Plan will outline and support the transformation of our integrated services. It presents a three-year vision for our adult health and social care services and:

- Provides an overview of the health and social care system in Aberdeen City and seeks to establish a shared understanding of our challenges and priorities.
- Provides the strategic framework for the future development of the local health and social care system so that needs and demands can be met more effectively within available resources.

- Sets out high level actions on how these issues and priorities will be addressed by the joint partners, and shows how progress will be monitored, and impact evaluated.

## **1.2 Our Vision and Values.**

Our strategic vision outlines our ambitions and is a pivotal reference point that helps frame all our discussions and suggested developments. The vision has been developed through integration conversations and workshops involving staff from the health, social care, third, independent and housing sectors and members of the shadow Integration Joint Board.

Our vision is:

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

There is a strong civic pride in Aberdeen. People are proud to identify themselves with the city and these bonds of association will be very helpful in developing our common purpose that good health and wellbeing is everybody’s business. This is something that cannot be sustained in isolation, as it needs our social connections and wider participatory activities to flourish. Our caring partnership is a mix of family, friends, neighbours and our colleagues from across the health, social care, third, independent and housing sectors working together to shape the activities and the interventions that matter to us.

Our values are the pillars that shape the identity of the partnership and help explain why we do the things we do; they underpin all our intentions and are evident in all our activities.

- **Caring**
- **Person centred**
- **Enabling**

Our values shape the development of our relationships with one another. Promoting responsibility and choice will be key factors in encouraging our citizens and our colleagues to feel that the development of the partnership and the role that it plays in our lives is not just for those periods of ill health and need, but is instead a more enduring relationship.

## **1.3 Our Strategic Priorities.**

The population of Aberdeen is, like the rest of the country, living longer. Increasing life expectancy is a good thing but it can be associated with greater demands for health and

social care. Our overall health profile is better than the Scottish national average however we know that within the city, there are significant differences in health and wellbeing, with some communities reporting greater levels of health problems than others.

People having multiple long term conditions (also known as multi morbidity) is increasingly prevalent and it is affected by wider social factors, in that it is more common and occurs at a younger age as social and economic deprivation increases. We also know that increasing multi morbidity can have a significant impact on the number of unplanned admissions, length of stay and potential for delayed discharge in our hospital services.

To address these challenges and achieve our desired outcomes, our strategic priorities for the next three years are:

- **Develop a consistent person centred approach that promotes and protects the human rights of every individual and which enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.**
- **Support and improve the health, wellbeing and quality of life of our local population.**
- **Promote and support self-management and independence for individuals for as long as reasonably possible.**
- **Value and support those who are unpaid carers to become equal partners in the planning and delivery of services, to look after their own health and to have a quality of life outside the caring role if so desired.**
- **Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing.**
- **Strengthen existing community assets and resources that can help local people with their needs as they perceive them and make it easier for people to contribute to helping others in their communities.**
- **Support our staff to deliver high quality services that have a positive impact on personal experiences and outcomes**

We are very aware that these are high level priorities but they do capture very well our intentions to work closely with our citizens, the communities they live, work and socialise in, our carers and our workforce to improve our individual and collective health and

wellbeing.

Our consultation on these proposed priorities in our draft strategic plan showed some significant variation in ranking of these priorities primarily in relation to respondent age and gender.

- Working age respondents and particularly those aged less than 35 years were more likely than those aged older than 65 years, to highlight the importance of reducing health and wider social inequalities that affect health and wellbeing.
- Older respondents were generally more likely to highlight the importance of promoting self-management and independence, and supporting unpaid carers.
- In relation to gender, males were more likely to highlight the importance of improving the health and wellbeing of our local population, while females were more likely to highlight the value of developing person-centred services.

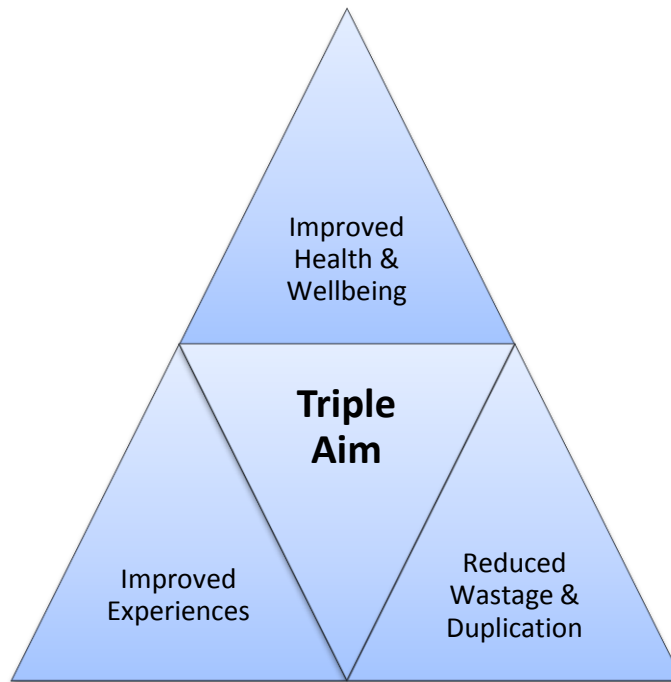
Our emphasis will be on the health and wellbeing of the individual, the resilience and capacity of communities to engage with and support its residents, investment in our carers, focus on prevention, working collaboratively with all our partner organisations, developing flexible, high quality services and achieving positive outcomes.

To fulfil our vision and our strategic priorities, we must develop integrated services that have individuals, families and communities at the centre of all their activities. We want everyone to have seamless and enhanced positive experiences of using our services, no matter what these are and what sector they are from.

We recognise that the best health and care systems are proactive in maintaining and improving health and wellbeing, not only reactive to problems once they have occurred. We want to deliver locally based services that have a positive impact on the health and wellbeing of all individuals, families, and communities.

Addressing our strategic priorities will offer us the opportunity of fulfilling the interdependent “Triple Aim” that improves our experiences of using health and social care services, improves our health and wellbeing, and reduces wastage and duplication in the costs of care and treatment.

**Figure 1.1 The Triple Aim.**



Our vision, values and priorities will be pivotal in helping us realise all these ambitions and get the desired outcomes from all of our activities.

**What does this mean for the residents of Aberdeen?**

Our strategic vision, values and priorities will underpin all our relationships and activities.

We have a strong and shared sense of commitment and motivation to work closely with the citizens and communities of Aberdeen to develop flexible health and social care services that will address current and future demographic and financial challenges.

Our continual aim is to deliver **Better Health, Better Care and Better Value** and to do that we want to hear what matters to you and your personal experiences, good or bad, of using our health and care services on a continual basis.

## 2. Our Caring Partnership.

### 2.1 Our Aberdeen.

Aberdeen is a significant regional and national business centre and is a popular place for people to live, work and socialise. The city's geography, cultural activities, two universities and regional college combine to form a proud identity and a mostly positive and enduring quality of life.

The 2014 Good Growth for Cities index, by Price Waterhouse Cooper, (PWC) named Aberdeen as the best city in Scotland in which to live and work, and the second top city in the UK.

It is a city that projects an image that it is at ease with itself and the rest of the world however we know that Aberdeen's affluence is not uniformly distributed across the city and that where you live has an impact on your health and wellbeing.

Aberdeen City and Aberdeenshire is the most economically productive region in the UK, outside Inner London. It is however, heavily reliant on the oil and gas sector, and as such the current downturn is having a significant impact.

- Aberdeen City has historically had one of the lowest unemployment rates in Scotland, but the number of out-of-work benefit claimants has risen sharply over recent months, and in November 2015 was 58% higher than in November 2014.
- The average annual gross wage in the city is around £5,700 more than the Scottish average (£33,408 in Aberdeen City, £27,710 in Scotland).
- Aberdeen City has one of the most unequal pay structures in the UK, fuelled predominantly by the oil and gas industry. The high wages paid in the industry have increased the divide between high and low earners.

### Integration Joint Board (IJB).

From the 1<sup>st</sup> April 2016, the IJB is responsible for the planning and delivery of adult health and care services in Aberdeen.

The IJB consists of four local councillors and four members of NHS Grampian health board and also the Chief Social Work Officer, a GP, consultant, nurse, staff representatives, third sector representation and individuals representing people who use our services and their carers.

Our Chief Officer is accountable to the IJB for the effective delivery of our integrated services in line with the 9 national health and wellbeing outcomes.

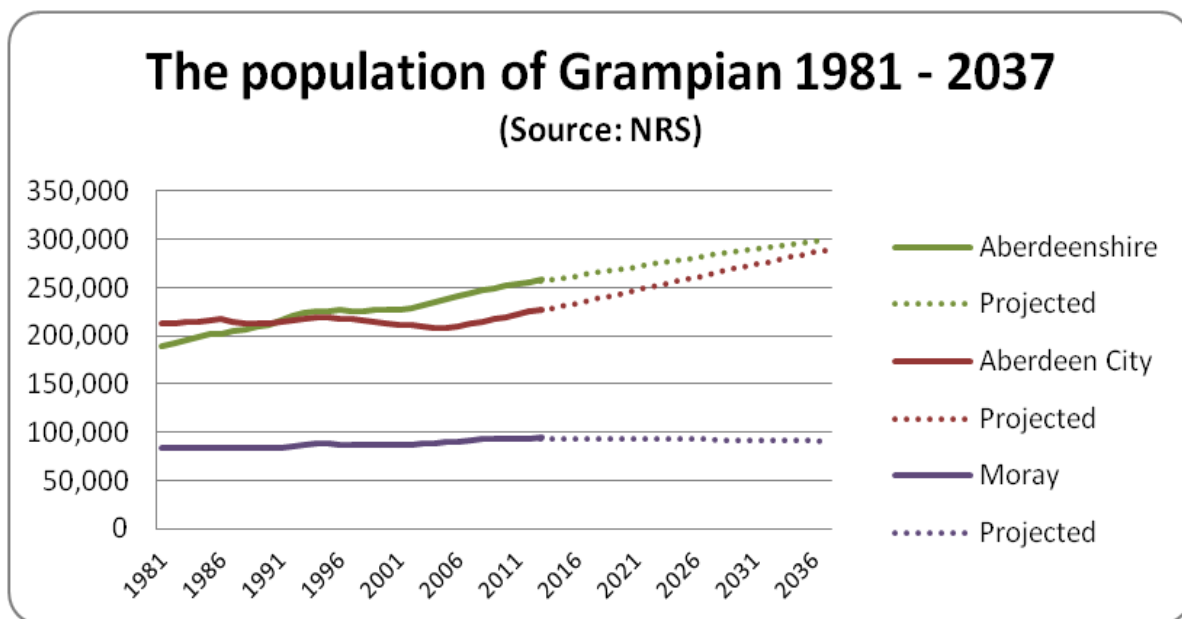
- There is a significant gender pay imbalance in Aberdeen City, with male full-time workers earning, on average, around 13% more per hour than female full-time workers.

There is a shortage of affordable housing in the City. House prices are high, and private rents in the city are the highest of all major Scottish cities. The lack of affordable housing makes the recruitment and retention of key workers, such as teachers, social workers, emergency services and health professionals, difficult. The downturn has not, as yet, improved this.

Aberdeen's booming economy in recent years has placed the city's infrastructure under significant pressure and that infrastructure is now struggling to keep pace. This has increased the cost and ease of doing business in the city. Significant investment, such as the recently agreed City Region Deal is required to improve the infrastructure to ensure that the city remains an attractive and competitive place to do business.

Aberdeen's population is rising and expected to reach almost 289,000 by 2037. The growth in the under 64s (**21%**) is mainly in the 0-15 age group, but the biggest growth is predicted in the over 65s (**49%**).

**Figure 2.1 Grampian Population 1981-2037.**



Source: NRS

Table 2.1 shows us that the age group that is projected to increase the most in size is the 75+ age group.

**Table 2.1 Aberdeen City Population 2012-2037 by Age Group.**

Age Group	0-15	16-29	30-49	50-64	65-74	75+
<b>2012</b>	32,903	56,693	62,660	39,548	17,152	16,014
<b>2037</b>	47,640	58,160	82,786	48,671	24,204	27,327
<b>% Increase (2012-2037)</b>	<b>44.78</b>	<b>2.50</b>	<b>32.11</b>	<b>23.06</b>	<b>41.11</b>	<b>70.6</b>

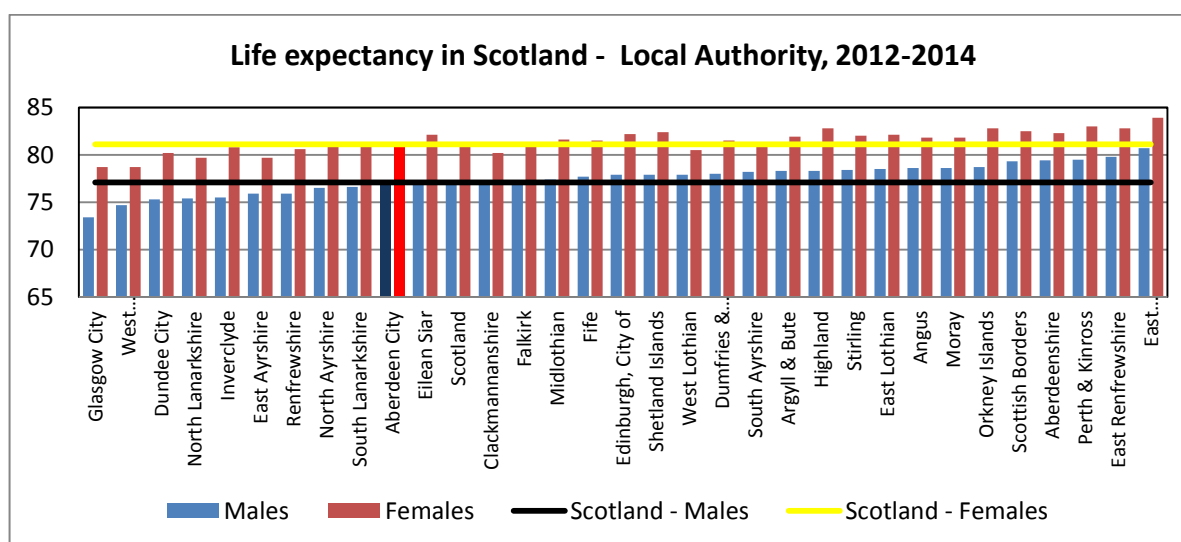
Source: NRS

The growth in the younger population will bring opportunities in terms of our potential future workforce but it also poses a risk in that if we do not change our lifestyle behaviours or transform our services, then it is difficult to see how our integrated services could cope with the anticipated demand for them that would arise.

Life expectancy for our citizens has increased over the past 10 years for both men and women, although the increase has been higher for men (3 years) than women (1.4 years). Women have a higher life expectancy than men, 81.4 years compared to 77.1 years. This is slightly above the respective Scottish figures of 81.0 years and 76.9 years.

Life expectancy in the city is broadly similar to the national picture, but there is significant variation across the city, with males in the Woodside area expected to live for 16.7 years less than those in the Braeside, Mannofield, Broomhill and Seafield North area.

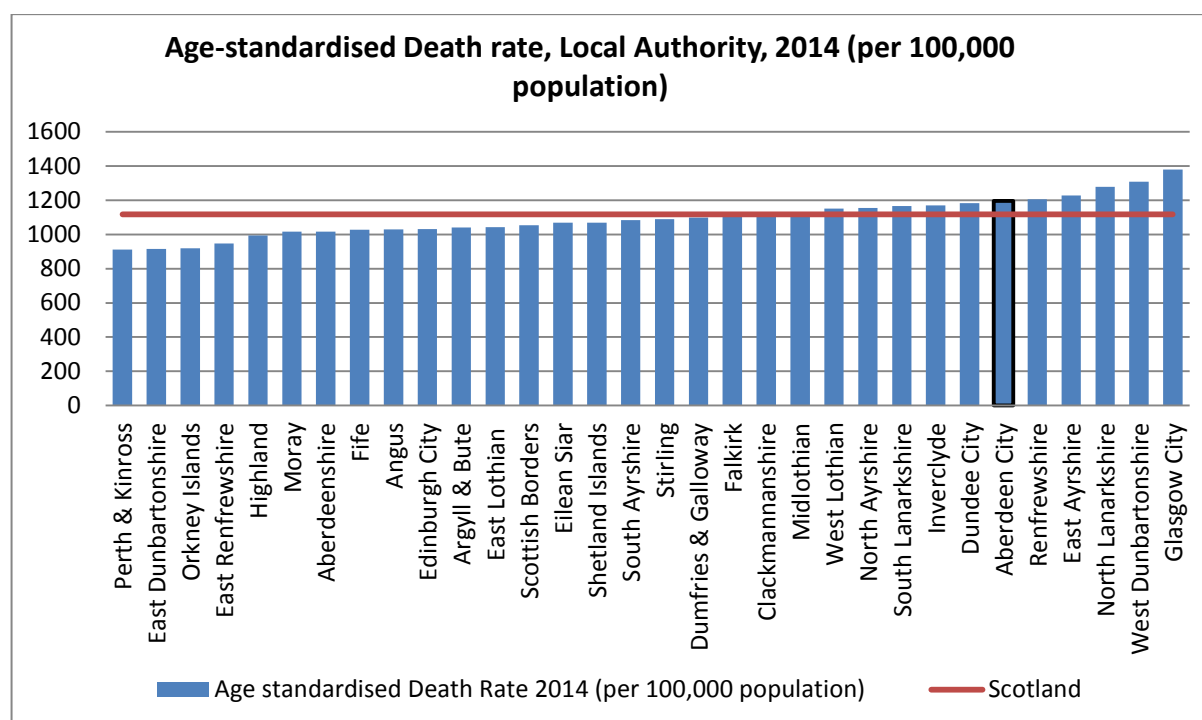
**Figure 2.1: Life Expectancy in Scotland – Local Authority, 2012-2014.**





The death rate (age standardised) for all ages in Aberdeen City is considerably higher than the national rate (Aberdeen City – 1197.2 deaths per 100,000 population; Scotland – 1117.0 deaths per 100,000 population). The premature death rate (under 75s) is also higher than the national average.

**Figure 2.2 Age-Standardised Death Rate, local Authority, 2014 (per 100,000)**



The main causes of premature death in Aberdeen are cancer and circulatory diseases (e.g. coronary heart disease and stroke) and together they account for over half of all causes of death. In **2013**, **30.3%** of male deaths and **24.6%** of female deaths were caused by cancer, and **28.8%** of male deaths and **30.6%** of female deaths were caused by circulatory diseases.

There is a correlation between deprivation levels and the number of premature deaths from cancer. Those living in the most deprived areas of the City are three times as likely to die prematurely from cancer as people from less deprived areas.

The rate of strokes recorded in the City has increased over the past decade. Older people are more likely to suffer a stroke, and a stroke is the most common cause of severe disability. Survivors of stroke will often be left with complex and multiple care needs.

There are approximately 90,000 people in Scotland living with dementia and of this number it is estimated that there are approximately 3,200 under the age of 65. There are approximately 3,300 people (all ages) living with dementia in Aberdeen City.

Whilst Aberdeen tends to have an overall health profile that is better than the Scottish average, the health experience amongst the population varies. For example, people living in the most deprived parts of Aberdeen have a 100% increased risk of being admitted to hospital with angina or heart attack, and a 590% increased risk of being admitted as an emergency for chronic obstructive airways disease.

Socio-economic inequalities affect health outcomes in that those who are best off financially do best on health outcomes, with the converse true for the poorest. It is known locally, but perhaps not so nationally, that our city has a mix of both significantly deprived and significantly affluent neighbourhoods. Just under one third of the Aberdeen population live in areas that are amongst the 40% **most** deprived in Scotland, whereas just over half of our population live amongst the 40% **least** deprived areas in Scotland.

Three-quarters of Aberdeen's population report that they are in 'good' or 'very good' health, but there is a negative correlation with deprivation and with age. Those from more deprived backgrounds and older people are less likely to perceive that their general health is 'good' or 'very good'. Generally, people living in more deprived areas are more likely to suffer a premature death.

Generally, people from more deprived areas of the City are more likely to attend Accident & Emergency. The more disadvantaged members of our community are the most likely to be admitted to hospital as an emergency, and are more likely to have repeat emergency admissions. The over 65 population group account for more than a third of emergency admissions to hospital in Aberdeen City.

Long term physical illness is often associated with accompanying psychological strains and this combination of physical and mental ill health has a strong association with health inequalities and poor outcomes for individuals and their families.

Almost 15% of the City's population are prescribed drugs for a mental health condition (anxiety, depression or psychosis) and this has been increasing over the past 5 years. The recent economic downturn, and the resultant job losses and instability, will likely have a detrimental effect on the health and wellbeing of those affected, particularly middle-aged men and young people and single parents with no family support networks. A lack of accessible and suitable support groups and decent housing will challenge any continuity of care.

Alcohol and drug misuse is a significant concern that not only impacts on the individual's health and wellbeing but also that of their families and communities. This is reflected in indicators such as emergency hospital admissions and criminal justice statistics. In 2014, there were 35 probable suicides in the City. Men in their 40s and 50s are the most likely group to commit suicide, and the most common method used is hanging.

Aberdeen City has a consistently higher rate of pregnancy terminations than the national rate, and has been one of the worst performing areas in Scotland over the past decade. There is a link between deprivation and termination rates. There is also an association between deprivation levels and breastfeeding, with children born into the most deprived communities the least likely to benefit from being breastfed. Women living in Northfield, Cummings Park, Torry and Mastrick are the least likely to breastfeed.

There is an obesity crisis in the Grampian area, as indeed there is in Scotland. and again the link with deprivation is evident as people from more deprived communities are less likely to eat a health balanced diet than those from less deprived areas. A range of inter-related interventions that reflect the complexity of this issue such as access to healthy food options, practical cooking skills and licensing of food outlets is required to address the situation.

Physical activity can help in the fight against obesity, but again those from more deprived areas are the least likely to achieve recommended activity levels with a relatively low awareness of what these even are. Better communication of the importance of a good diet and regular physical activity will not necessarily in itself result in improved health and wellbeing; targeted support to particular population groups will however be more appreciated and beneficial. Physical activity can help individuals across all ages and client groups to reduce stress, improve wellbeing and positively impact on those with long term conditions.

At the time of the 2011 Census, 75% of Aberdeen's population reported Scotland as their country of birth and 15.9% was born outside the UK. More than 60% of those born outside the UK had been living in the UK for less than 5 years, compared to 40% in Aberdeenshire and 44% in Scotland.

In Aberdeen city, approximately 0.1% of the population recorded 'Gypsy Traveller' as their ethnic grouping, this equates to approximately 223 individuals<sup>1</sup>. Within this community there is a belief that poor health and pain must be tolerated. Another feature is a fatalistic attitude to health ('what will be, will be'), resulting in a view that illness is inevitable, and therefore seeking treatment is pointless. Fear of certain illnesses, including cancer and other terminal illnesses, combined with this fatalism, mean that many Gypsy/Travellers may avoid health screening. Our system wide service design and provision may sometimes lack the required cultural awareness and accessibility to improve matters, leading to a reliance on a particular service in a particular area.

The 'Scotpho' profiles ([www.scotpho.org.uk](http://www.scotpho.org.uk)) contain information on 56 associated topics that can be used to inform our investment in improving the health and wellbeing of the

---

<sup>1</sup> Figure 3: White ethnic groups by council area, Scotland, 2011. [www.scotlandscensus.gov.uk](http://www.scotlandscensus.gov.uk)

local population and reducing health inequalities. Aberdeen's profile shows that we are statistically worse than the national average in relation to:

- alcohol related hospital stays
- drug related hospital stays
- patients hospitalised with Chronic Obstructive Pulmonary Disorder (COPD)
- patients hospitalised with coronary heart disease
- road traffic casualties
- people aged 65 and over with high levels of care need who are cared for at home
- crime rate
- domestic abuse
- drug crimes recorded
- population within 500 m of a derelict site
- child dental health in p7
- immunisation uptake at 24 months (5 in 1)
- immunisation uptake at 24 months (MMR)

We also recognise the significant detrimental effects on our health and wellbeing that is directly caused by isolation and loneliness. The increasing impact on the demand for our pressured services caused by this modern public health concern is preventable through a cohesive, early intervention and prevention approach that says challenging loneliness is everyone's business.

We need to have a cultural shift that looks not only at the adult population in its entirety but also our families, so that our children in turn become healthier adults. We need to focus our policy on disengaged groups and ask why is it that our health and care services are not working for them as well as we might wish. The life course issues that we need to be mindful of include: alcohol and smoking related diseases, unemployment, domestic abuse, higher accident rates, mental health issues and substance misuse issues. It is often the case that the vulnerability of individuals within these groups is heightened by a lack of appropriate support networks so additional, enhanced support is not just beneficial, but necessary.

## **2.2 Our Partnership.**

The scope of our partnership's activities has been formally outlined in our Integration Scheme<sup>2</sup> and consists of services from the health, social care, third, independent and housing sectors which are all committed to providing high quality integrated services to our citizens.

---

2

<http://www.aberdeencityhscp.scot/contentassets/47a823b8be3c4f26830d11200cb644a1/aberdeen-city--integration-scheme.pdf>

These sectors provide valuable care, support and treatment to adults of whatever age, who may have a physical health difficulty or disability, dementia, a mental health difficulty, autism, a learning disability, a substance misuse problem or any combination thereof.

Our partnership will host the Older People and Rehabilitation hospital-based services at Woodend Hospital and the Links Unit of behalf of Aberdeenshire and Moray IJBs. These services include:

- Inpatient services for people at Woodend Hospital which are part of the Grampian Specialist Rehabilitation service for elderly people.
- Stroke rehabilitation.
- Neurology rehabilitation.
- Horizons – ‘one stop shop’ for health and social care service provision for community based clients across Grampian with complex neuro disability.
- Craig Court – transitional community based neuro rehabilitation for acquired brain injury; complex stroke and spinal cord injuries.
- Mobility and Rehabilitation Service (MARS) - includes Wheelchair, prosthetics and orthotics services.

We will continue to host, within Aberdeen City, the Sexual Health Services based at the Community Health and Care Village.

It is proposed that each IJB will take responsibility for the planning and delivery of healthcare within the police custody suites situated within their respective areas. Aberdeen City IJB will take the lead responsibility for the planning and delivery of Forensic Medical services across Grampian as well as the overall strategic leadership for all Police health matters.

Further discussions will take place during the course of 2016 about the hosting of in patient mental health and learning disability services based at Royal Cornhill.

Children’s services are not within the scope of this Strategic plan as they are not being delegated by the local authority and health board to the integration joint board, but even so it is very important that we are mindful of the health and wellbeing of children and our interactions with them. Strong collaboration with the Integrated Children’s Services will be critical to our longer term strategy if we are truly going to transform our activities and provision to a more preventative and anticipatory model.



**2.2.1** A defining feature of our partnership will be the involvement of all partners in the planning, design and delivery of services, and we will seek to strengthen the trust between all partners and support the development of collective confidence in all partnership activities. We recognise that partner involvement must include individuals, families and communities also.

A significant number of integration conversations have taken place across these sectors, discussing the potential benefits and challenges that may arise from the integration of our health and care services. We recognise that there is a desire to understand structures and processes and where we all fit into those, but we will place greater value on the relationships that exist across all sectors and how these can always be used in the best interests of the individuals who use our services, their carers and their communities.

We want to be judged not only on what we do but how we do it, and so we will seek to demonstrate through our attitudes and our behaviours, that we are a caring partnership that shows compassion to the individuals who use our services, their carers and family, and our workforce. We will be very visible in our local communities and will work with our residents to plan and deliver services that make best use of the assets and resources that are available in our local communities.

A significant proportion of our services are delivered by our partners in the third, independent and housing sectors. We recognise the positive relationships that many organisations in these sectors have with the people who use their services and their carers, and the wider connections that they have with our local communities. We

recognise that further work is needed so that organisations in these sectors truly believe that they are seen and valued as our partners in delivering on our ambitions.

The Housing Contribution Statement (see Appendix Three) sets out the role of social housing providers in Aberdeen City to achieve outcomes for health and social care. The provision of good quality housing to support a range of needs will play a key role in achieving outcomes in relation to supporting people to be able to live, as far as is reasonably practicable, independently and at home:

- Increase housing supply to meet housing need and demand.
- Improve housing conditions in both the public and private sector.
- Ensure continued supply and access to affordable housing.
- Continue to provide information and advice to improve housing conditions in the private housing sector.
- Ensure there is a supply of particular needs housing of the right type to meet future requirements.
- Improve energy efficiency in both the public and private housing sectors and alleviate fuel poverty.

## **2.3 Our Carers.**

Anyone looking after a person with an illness or disability, whatever their circumstances and living arrangements, is considered a carer. Carers look after someone without pay or financial reward. They are sometimes known as 'informal' carers or more frequently as 'unpaid' carers.

The "formal" health and social care services provided a range of different sectors can be readily "counted": we have a good idea of who is doing what and how much it costs. In contrast however, much of the "unpaid" care provided by people in our communities can go unrecognised, although one report, 'Valuing Carers' suggests that in 2015 in Aberdeen £326m worth of care per annum was being delivered by unpaid carers.<sup>3</sup>

According to the 2011 census there are self-identified 15,571 carers in Aberdeen but in reality there are probably as much as 10% of the local population, roughly 25,000 people who are fulfilling this role in one way or another. It is important that we have a greater certainty about how many unpaid carers are providing care and support to their family member, friend or neighbour, and perhaps reducing the need for them to currently access "formal" health and care services. The circumstances of the cared for individual or carer can change at any time causing services to be urgently required and delivered, possibly at a higher level of intervention than would otherwise be the case.

---

<sup>3</sup> Valuing Carers 2015, The Rising Value of Carers' Support; Carers UK.

It is a good thing to recognise and support the vital role that “unpaid” carers fulfil: they are, in many respects the experts. One test of a caring society is the readiness with which we agree to be an unpaid carer should the circumstances of our relative, friend or neighbour require this. It may be that we need to reposition our attitudes to the unpaid caring role.

Given that our health and care services could not function as well as they do were it not for the contribution of our unpaid carers, we will ensure that the support offered to all carers is targeted at their specific and individual outcomes, as well as the specific and individual outcomes of those being cared for. We recognise that there are a variety of outcomes which are unique to carers such as the need for time to themselves and for relief from challenging circumstances,. We are also very aware that carers typically may not be aware of what is available to them. We need to rectify this and at the same time, promote across all our sectors and services, with high expectations regarding carer engagement.

### **Case Study:**

Kate is 55yrs old. She works part time at the City Centre Branch of the Royal Bank of Scotland. She has a son and a daughter. Her daughter is married with two children and lives several miles away. Her son lives at home and since losing his job, has suffered from depression and anxiety making it difficult for him to leave the house. Kates’ elderly parents live in sheltered housing some distance from her, on the other side of the City. Her father has recently been diagnosed with dementia and her mother has mobility problems since suffering a stroke a few years ago.

Kate does what she can to support her family but is finding it increasingly difficult to keep asking for time off work to attend hospital/GP appointments with her son and parents, and give the practical/emotional support they rely on her to provide. Kate enjoys her job but feels that she might have to give this up as her family responsibilities increase. If asked the question, Kate would not describe herself as a carer.

We anticipate that our integrated approach will benefit Kate in the following ways:

- Kate and other carers and the essential role that they fulfil will be identified on first contact with partners or as soon after as possible.
- Kate and other carers will be given advice about their rights. The partnership will promote awareness about carers’ rights at every opportunity.
- Carers typically may not be aware of what is available to them. We will ensure that our staff receive Carer Awareness Training. When undertaking Adult Carer Support Planning our staff will have the knowledge of local sources of support where carers can find further help to meet their needs. Better joint working will bring a greater understanding of the role that Kate fulfils.



- We will ensure that Kate and other carers are fully included and supported when the person they care for has need of Health and Social Care Services.
- By encouraging partnership working with Carers at all levels of care from the individual to overall service planning.
- Our staff will recognise Kate as expert in the care of her son and parents.
- We will ensure that a range of Carer Support services is available to Kate and other carers.
- We will ensure that the support offered to all carers is targeted at their specific and individual outcomes.
- We recognise that there is a need for Kate and other carers to have time to themselves and for relief from challenging circumstances.
- We will improve access to more flexible support and short breaks.

## **2.4 Our Resources.**

**2.4.1** Our staff groups across the health, social care, third, independent and housing sectors will be pivotal to the success of our integration endeavours. We know that our health and care workforce is getting older putting additional pressures on our recruitment and retention activities and costs across all sectors. It is a legitimate question to ask of ourselves 'What do we have to do to recruit our future generations of social workers, GPs, nurses, care managers and other professionals?'

There was a clear message from our consultation on the lack of staff in certain sectors and service because of low wages and lack of affordable housing, and how this impacted on the quality of service provision. Concerns were expressed that even when staff were available they are not given enough time to do what is needed and so have a task focussed instead of person centred approach to their relationship with the individual who is receiving the service. We recognise that providing individuals with a good quality of care needs, amongst other things, continuity and consistency of staffing.

We are very aware that the integration of health and social care services is a complex undertaking and that we need to consider many cultural issues relating to all our partner organisations and professions. This journey will not be risk free and not all benefits will be immediately apparent however, we believe that being part of something new that delivers improved personal outcomes and experiences will appeal to all colleagues across all sectors.

We accept that reconciling these different cultures will require different professions and staff groups to understand each other's roles, responsibilities and perspectives more fully. We are not taking anything for granted but we think that empowering our staff to do the right thing from a person centred perspective, ('what we permit, we promote') will be advantageous for everyone.

We want our staff to be very clear about what is expected of them so that they can play a full part in encouraging people to engage with this plan's ambitions. Our emphasis on providing support at home or in a homely environment will require us to work more closely with our communities and to work in partnership with individuals especially with regards to those with long term conditions.

New working practices will be needed as we move towards preventative and re-ablement approaches with all staff responsible for identifying issues affecting health and wellbeing recording and acting upon the information received. Cherry picking behaviours and disabling models are not compatible with the quality of service that will be the hallmark of our partnership.

We know that there is a strong relationship between people's experiences of using our health and social care services and the experiences of staff who deliver those services and that positive outcomes are unlikely to happen to one without the other. We recognise that we cannot keep asking our staff to deliver more in shorter timescales without any extra resources, so we will work towards improved experiences being recognised as an essential outcome of our integrated activities.

We recognise that engaging with staff at all levels particularly our front line practitioners, is important. Knowing what matters to them and what works will be necessary to convince all our colleagues across all organisations and sectors of the credibility and feasibility of our intentions and activities. We will support our staff and provide them with the education and training necessary to provide high quality services. We will answer whatever queries they may have and listen to their concerns. We will respect existing staff support structures and mechanisms. We will recognise individual and service achievements and celebrate our successes together however we will never forget the responsibilities and the personal and professional accountabilities that we must always fulfil.

## **Case Study:**

Current circumstances:

- You are employed by Aberdeen City Council as a Care Manager within the Older People's Service
- You are on an ACC salary grade, terms and conditions of employment and work to ACC policies.
- You are based at Marischal College working primarily with ACC colleagues.
- You have regular contact and liaison with a range of professionals, stakeholders, supported people and their carers/families.

- You report into a Service Manager responsible for Older People's Services, who is also based at Marischal College.

Future circumstances:

- You are employed by Aberdeen City Council as a Care Manager
- You continue to be on an ACC salary grade, terms and conditions of employment and work to ACC policies.
- You are based within a locality 'Hub'.
- You are co-located with a range of colleagues both ACC and NHS Grampian undertaking a range of health and social care / work roles to form a multi-disciplinary team within the locality.
- Care staff from the Third and Independent sectors have access to a 'touch down' desk within your workplace.
- You report into an Operations Manager responsible for providing a range of health and social care services (including social care) within your locality.
- Your line manager is an NHS Grampian employee, on NHS terms and conditions of employment.
- Your line manager does not have a social work or social care background but is from a nursing background.
- You will have regular 1 to 1 meetings with your line manager on your workload.
- You will also receive professional leadership from a Social Care Service Manager at regular supervision sessions.

#### **2.4.2 Our Integrated Budget.**

The total Health and Social Care partnership budget is derived from the budgets delegated to it by Aberdeen City Council for Adult Social Care and by NHS Grampian for Community Health services.

In 2015/16 the cost of social care and NHS services in our scope of integration totalled approximately £250m. It will be an ongoing and significant challenge for us to ensure that we manage all these resources appropriately and that it gives us the necessary sound platform for future investment in line with this plan's ambitions.

Increases in health and social care costs are strongly associated with increasing age and it is widely projected that the care of the very old will account for an increasing proportion of our health and social care budgets in the future. We need to respond to the population and social changes ahead by doing things differently or we will face projected increases in both scheduled and unscheduled hospital admissions as well as admissions for care

home places that will significantly impact upon people's quality of life. This is neither desirable nor affordable.

We recognise that time is not on our side to make the changes that we need to make to meet the future anticipated demand for our services. In order to produce effective and transformational change in the coming years we will require our financial management processes to support a shift in resources towards our preventative locality-based services. Only by doing this will our changes be enduring and sustainable.

The City Council revenue budget for 2016/17 was set at its meeting on 25 February 2016, and on 2 March the Full Council meeting agreed the total budgets to be delegated to the Integration Joint Board of £88.2 million.

The Scottish Government's Local Government Finance Settlement provided Local Authorities with details of their revenue and capital funding for 2016/17 only. Previous settlement details have included indicative figures for future years, but this information is unlikely to be available until the Comprehensive Spending Review is provided, probably in Autumn 2016.

Likewise, the NHS funding settlement only covers 2016/17. On 3 March 2016 the NHS Grampian Board agreed the total budgets to be delegated to the Integration Joint Board of £163.5 million. At this stage the NHS Grampian Board figures do not reflect budget uplifts for 2016/17 for pay awards, national insurance and GP Prescribing, nor an allocation for out of area referrals. They also exclude non-recurring funding sources which have yet to be notified by the Scottish Government.

Table 2.2 shows the approved budgets for the delegated services in 2015/16 and indicative budgets for each of 2016/17, 2017/18 and 2018/19 subject to the caveats outlined above.

**Table 2.2 Aberdeen City IJB Budget**

Aberdeen City IJB Budget	2015/16 Budget aligned to Integration services £m	2016/17 Indicative Budget £m	2017/18 Indicative Budget £m	2018/19 Indicative Budget £m
Community Health Services	36.999	33.885	34.495	35.116
Learning Disabilities	28.368	28.868	27.793	26.483
Mental Health & Addictions	17.849	17.783	17.733	17.435
Older People & Physical and Sensory Disabilities	70.809	72.417	72.522	70.577
ACC Administration & Management & Criminal Justice	0.200	0.794	0.936	0.998
Primary Care Prescribing	38.302	38.334	39.024	39.726
Primary Care	35.110	33.476	33.811	34.149
Additional Capacity Funding	5.729	9.625	9.884	10.147
Provision for NHS pay & price increases 2016/17	0.000	5.800	5.904	6.010
<b>Hosted Services</b>				
Intermediate Care	8.620	8.553	8.707	8.864
Sexual Health Services	0.828	0.822	0.837	0.852
Marie Curie Nursing	0.289	0.289	0.294	0.299
Heart Failure Service	0.116	0.108	0.110	0.112
Continence Service	0.273	0.273	0.278	0.283
Diabetes MCN	0.367	0.367	0.374	0.380
Chronic Oedema Service	0.092	0.092	0.094	0.095
HMP Grampian	1.022	0.934	0.951	0.968
Police Forensic Examiners	0.271	0.271	0.276	0.281
Primary Care Contracts Team	0.248	0.282	0.287	0.292
Other Hosted Primary Care Budgets	1.037	1.037	1.056	1.075
GMED	3.618	3.489	3.552	3.616
<b>Total</b>	<b>250.147</b>	<b>257.499</b>	<b>258.916</b>	<b>257.758</b>

The Integration Joint Board will also have strategic planning influence over the budget for Large Hospital services. The set-aside budget for 2016/17 totals £46.7m.

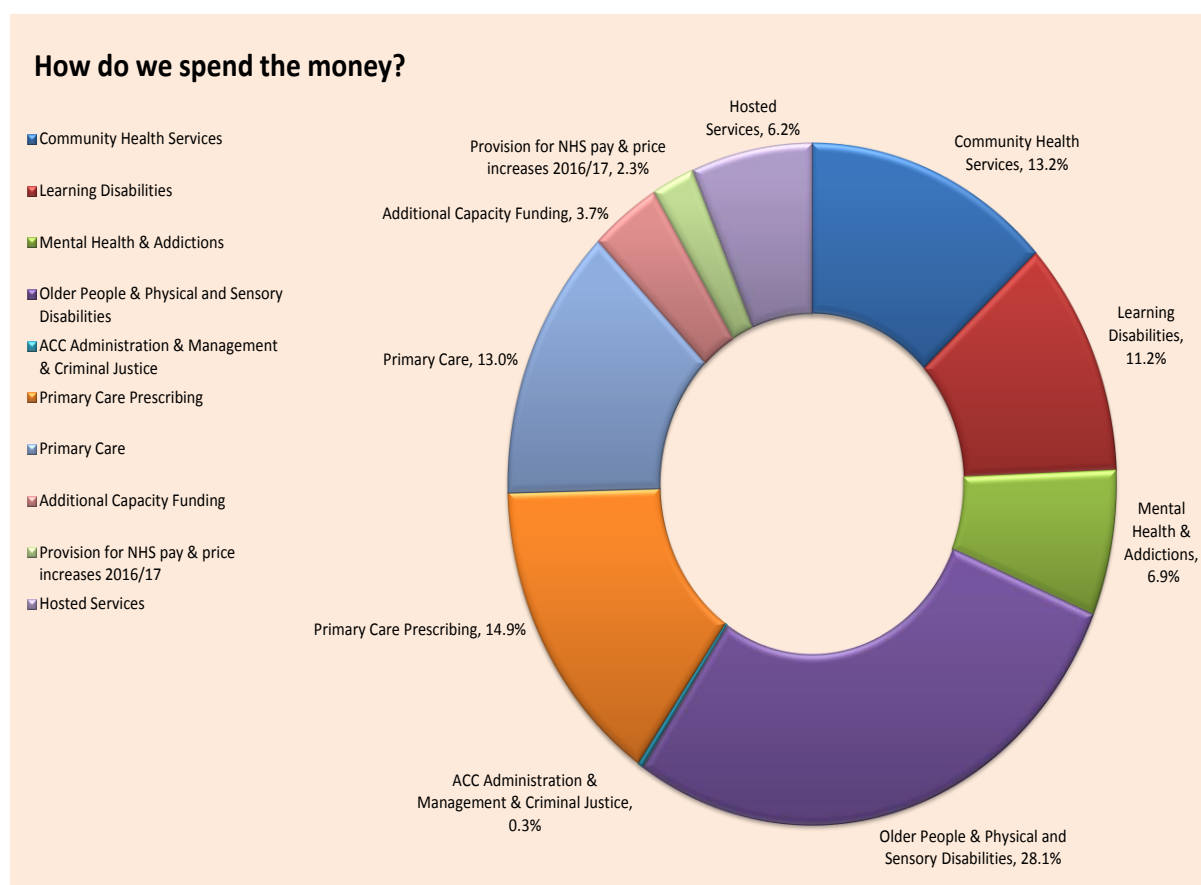
In order to provide an estimate of the budgets that will be delegated to the IJB for each of the 3 years covered by this Strategic Plan a range of assumptions have been made as follows:

- An estimate of budget uplifts for 2016/17 for pay awards, national insurance and GP Prescribing.
- An estimate of growth in future year's budgets to allow for the effects of staff pay awards and contractual obligations, price inflation on contractual arrangements and implementation of the Scottish Government commitment to paying the living wage.
- Ongoing impact of service options and budget savings agreed to achieve a balanced budget in 2016/17.

- A share of the estimated efficiency savings that the City Council and NHS Grampian are likely to be required to identify in order to achieve a balanced budget in 2017/18 and 2018/19.

Budgets for 2017/18 and 2018/19 will be confirmed in accordance with the processes outlined in the Integration Scheme.

**Figure 2.3 How Do We Spend The Money?**



**2.4.3** A common theme discussed in our integration conversations is the desire to harness IT solutions to improve the planning and delivery of our integrated services.

The people who use our health and care services believe that we already share appropriate information between professionals and are often very surprised to hear, when things go awry that, for different reasons, this is not the case. For these individuals to be true partners in their care we will need significant investment in shared IT systems that can be accessed across health, social care and home settings. Valuable staff time is being lost managing the cumbersome systems, some of which are still paper based, that are currently in place.

Effective person centred delivery of our integrated services will need integrated IT

solutions across our health and social care sectors. We need to be clear about what we want our integrated services to do and then look to the IT solutions that can support this. We recognise that there is already an enthusiasm to discuss how we can share assessments, client/patient records and anticipatory care plans (ACPs). We need to be clearer about the opportunities for individuals, families and communities that can be realised through the greater use of technology.

## 2.5 Our Strategic Connections.

**2.5.1** We recognise the importance of many different client group policies and plans to the respective partner agencies. The vision and aspirations set out in this Strategic Plan are consistent with those policies and plans to ensure a continuing quality of experience and satisfaction for the individuals who use our services and their carers.

The national transformation of public services shares many common themes with our thoughts about what needs to be done to make integration successful at an individual, service, and organisational level. Key themes include:

- Outcomes focussed, that is, what actually needs to happen from the individual's point of view.
- Person centred and co-produced in order to ensure that people and communities are fully involved in the design and delivery of services.
- Assets and strengths based, building on the strengths of individuals and communities, and developing their resilience.
- Focussed on prevention and early intervention.
- Evidence led to support performance improvement and innovation.
- Empowering staff to work in partnership and in innovative ways

The Christie Commission<sup>4</sup> identified the need to redesign public services and in response to the Commission's recommendations, the Scottish Government emphasized the four pillars of public service reform as:

- A decisive shift towards **prevention**.
- A greater focus on '**place**' to drive **better partnership**, collaboration and local delivery.
- Investing in **people** who deliver services through enhanced workforce development and effective leadership.
- A more transparent public service culture which improves standards of **performance**

---

<sup>4</sup> <http://www.gov.scot/About/Review/publicservicescommission>

These pillars will underpin the transformational change of our services and in doing provide a first level response to the question ‘What are we going to do’? We recognise that in order to maintain trust and confidence levels there needs to be a strategic cohesion between our ambitions and actions so that we can explain, in a straightforward manner, what we are proposing to do, including why and what we hope to achieve.

**2.5.2** Two national strategies underpin the ambitions and priorities of this Strategic Plan. The ‘**Social Services in Scotland: a shared vision and strategy 2015-2020**’<sup>5</sup> outlines its vision as:

‘a socially just Scotland with excellent social services delivered by a skilled and valued workforce which works with others to empower, support and protect people, with a focus on prevention, early intervention and enablement’.

Similarly, the **2020 healthcare vision**<sup>6</sup> is that

‘everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self-management
- If hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- There will be a focus on making sure that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission’

These strategies recognise the complexity of the transformational change that will accompany the integration of our health and social care services. They will no doubt challenge our workforce but are both very clear about their desired impact on the people who use our services and their carers.

**2.5.3** The ‘**Concordat**’ (2007)<sup>7</sup> between local and national government emphasises the central role of community planning and single outcome agreements in delivering valued services and tangible benefits to our communities.

This Strategic Plan contributes to the following national single outcome agreement outcomes:

---

<sup>5</sup> <http://www.gov.scot/Resource/0047/00473374.pdf>

<sup>6</sup> <http://www.gov.scot/Topics/Health/Policy/2020-Vision>

<sup>7</sup> <http://www.gov.scot/Publications/2007/11/13092240/concordat>



- We live longer, healthier lives.
- We have tackled the significant inequalities in Scottish society.
- We live in well-designed, sustainable places where we are able to access the amenities and services we need.
- Our public services are high quality, continually improving, efficient and responsive to local people's needs respectively.
- Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it.

Our Integration Joint Board will be a statutory partner in the city's Community Planning Partnership and will seek to exert a strong influence on its conversations that impact on the health and wellbeing of the local population. Effective community planning arrangements will support our integration activities and increase our focus on prevention and continuous improvement in order to achieve better services and better outcomes for our citizens and communities.

The **Aberdeen City Single Outcome Agreement** will set out our coherent, multi-agency ambitions to make Aberdeen a better place to live and work in. It will be a significant influence on the implementation of this strategic plan and our progress towards fulfilling the national health and wellbeing outcomes.

#### **2.5.4 Strategic Planning for Acute Services.**

Strategic planning of the acute sector services below is being delegated to IJBs because of the significant proportion of unplanned admissions that they experience.

- Accident and Emergency services provided in a hospital.
- Inpatient hospital services:
  - General medicine
  - Geriatric medicine
  - Rehabilitation medicine
  - Respiratory medicine
  - Palliative care
  - Mental health
  - Psychiatry of learning disability

It is proposed that Aberdeenshire IJB will take the overall lead in hosting the strategic planning of these services on behalf of Aberdeen City and Moray IJBs. This will include taking lead responsibility for the strategic planning process associated with the services and working with NHS Grampian to ensure that there is a consistent and comprehensive planning process for all acute services.

A series of workshops have been held to understand our strategic planning requirements in the context of the pathway of care overseen by each service. A number of common themes emerged including:

- Healthier populations who are independent for longer – prevention, self-care/management and managing expectations
- Individualised care with positive risk taking
- ‘One Team Approach’ – better co-ordinated care with a key contact for patients/carers
- Integrated planning at locality level based on population needs and available resources
- Rapid access to services and decision making as and when it is required
- Supporting carers needs
- Education accessible and where appropriate joined-up for all appropriate professionals
- Reducing avoidable admissions – right care in the right place and at the right time
- Improving communication – accessible electronic records to support professional to professional communication but also requirement to consider how we improve professional/patient communication

These themes have been factored into the development of this strategic plan and will also feature heavily in the service specific planning process within the acute sector and also the development of the Grampian Clinical Services Strategy.

### **What does this mean for the residents of Aberdeen?**

A new organisation, the Aberdeen City Health and Social Care Partnership will have responsibility for the planning and delivery of adult health and social care services as of 1<sup>st</sup> April 2016.

Social Workers, Community Nurses, Allied Health Professionals, GPs and colleagues from other services in the health, care, third, independent and housing sectors will all be working more closely together to offer an improved 'seamless' service to individuals and their carers.

“Unpaid” carers are an integral part of our Partnership. We could not do what we do without their contribution and support.

### 3. Working Together with Our Communities.

Our Strategic Plan recognises the value of an asset based approach to developing effective and sustainable models of care that focus on health and wellbeing and maximise the assets of both individuals and communities.

We want to move away from traditional 'Deficit' models that focus on identified problems which require professional interventions to resolve them, and which do not support the active involvement of local residents and communities. We recognise though, that moving away from these models will be a challenge as they are commonly used as the basis of our statutory interventions, but this will be necessary if we are to be successful in empowering and promoting independence, rather than continuing to reinforce dependence.

In practical terms, this will mean moving away from a point of view that statutory authorities should commission services for all the needs of a community to one that encourages and supports individuals and communities to take more responsibility for their own health and wellbeing.

We want to promote and develop the resilience of our communities by increasing opportunities for the people who live in these communities to shape their own lives and take part in local decision making. This means that we:

- Start with the assets and resources in our communities and identify opportunities and strengths.
- See people as having something valuable to contribute and support them to develop their potential in adding social value to their communities.
- Focus on communities encouraging and adding social value at every opportunity

This will not be without its challenges. The single person household will likely be the most common household type in years to come and that living without the immediate

#### What is co-production?

Co-production has been defined as:

"Delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and communities.

Where activities are co-produced in this way, both services and communities become far more effective agents of change."

A co-production approach includes the following key characteristics:

Recognising people as assets.

Building on people's existing capabilities.

Promoting mutuality and reciprocity.

Developing peer support networks.

Breaking down barriers between citizens, professionals and services.

Facilitating rather than delivering.

Co-production will be a key

support of family members, combined with the increasing prevalence of chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease, heart failure, arthritis and dementia, will challenge our vision of a healthy, resilient interconnected community.

### **3.1 Our Localities.**

The Public Bodies (Joint Working) (Scotland) Act 2014 requires us to divide Aberdeen's geographical area into at least two localities to enable the effective planning and delivery of our integrated services.

Localities should be large enough to offer sufficient scope for service improvement but small enough to feel local and real for those people who live there. The main purposes of localities are to assess need, prioritise and plan how all resources are used in pursuit of delivering the outcomes of the strategic plan in the locality. The partnership is also required to involve representatives of a locality in any decisions or planned changes that are likely to significantly affect service provision in that locality. Our intended locality approach will be wholly in line with these integration principles below:

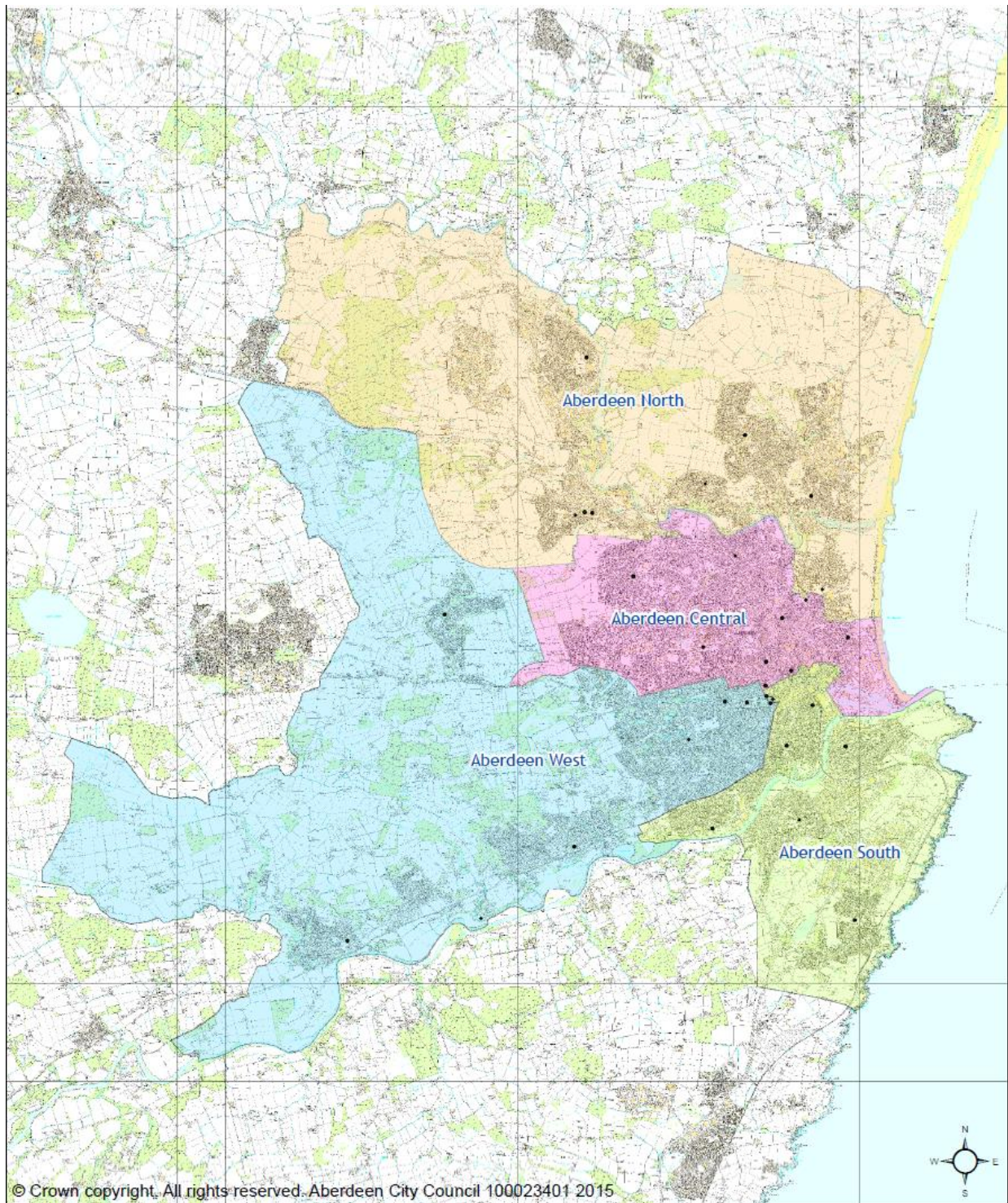
- integrated from the point of view of recipients
- takes account of the particular needs of different recipients, and from different parts of the area in which the service is being provided
- takes account of the participation by service users in the community in which service users live
- makes the best use of available facilities, people and other resources
- and is planned and led locally in a way which is engaged with the community (including in particular service users, those who look after service users and those who are involved in the provision of health or social care.)

We are proposing to base our localities on the four existing GP cluster areas that have existed for a number of years so that we can take advantage of established relationships and activities. Our localities will be:

- **Aberdeen North**
- **Aberdeen Central**
- **Aberdeen West**
- **Aberdeen South.**



**Figure 3.2 Our Localities.**



We are very aware that drawing lines on a map should not define the experiences and activities of the local population. They will however, provide us with a definable set of areas from which to administer local delivery and evidence the impact of our integrated activities.

Localities must be well organised, with sufficient structure to co-ordinate their input to strategic planning. Each locality is required to have a locality lead, and this position will be identified formally through the ongoing reorganisation of the partnership.

We will develop an integrated management structure that will give sufficient balance to, and support the delivery of our strategic and operational responsibilities. Our senior managers in their new roles will lead discussions and consultations on what functions and services should be aligned to the locality model. We will then work with appropriate Organisational Development colleagues to develop and support integrated, multi-disciplinary teams across the localities.

As the partnership matures we anticipate that the identities of the localities will become more visible and robust and their activities more effective. Even so, we are very clear that co-operation not competition will define the operation of our localities especially since, for example, we know that some individuals will live in one part of the city but be registered with a GP practice in another. Information, good practice and access to activities and/or services will all continue to be shared across locality boundaries. We will not remove professional or service silos only to see them emerge in another form in another part of the partnership's operations.

It is important not to underestimate the significance of the role of localities in our partnership model. They are intended to be the engine room of integration, bringing together individuals, carers and professionals from the health, social care and housing sectors to plan and help redesign services. If this approach is to be successful, localities and their leadership teams must have the information they need about the nature of the communities they serve and must be empowered by the partnership to make the appropriate decisions that will deliver the desired outcomes.

### **3.2 Localities and communities.**

We all have different thoughts and different answers when asked 'What are the things that make life meaningful, provide a sense of wellbeing, and keep us healthy?' Very few of us live, work and socialise solely in one part of Aberdeen. Work patterns, leisure interests, shopping habits and technological advances mean that our connections and relationships across different areas of the city (and beyond) can be mapped in a way that makes perfect sense to each individual.

Our development of localities will therefore reflect that citizens will naturally associate themselves with communities rather than necessarily by the "locality" within which they geographically reside, the boundaries of which are set for administrative purposes rather than necessarily being meaningful to local residents.

"Natural Communities" refer to the communities of place that people call their own. People form associations and local groups around natural communities, but will also



relate to larger geographical areas. For example, someone living in Torry will associate themselves with that area and form associations and groups (for example, a parent may associate with other parents of children attending the same school.) The person living in Torry may also associate themselves with the wider Aberdeen City geographical area, and identify that they live in the South of Aberdeen.

Our citizens are very clear about what their lives would be like were it not for the informal activities they participate in or support as volunteers. Each and every community has different connections and relationships and it is through these that we will tackle head on the scourge of loneliness and isolation which is the root cause of much of the increasing demand for our services.



### 3.3 Locality Planning.

Localities will be critically important from a planning perspective as they will enable us to understand the health and wellbeing of the populations in these areas. We will seek to use these localities to develop local solutions within a cohesive framework. We will start small by testing our proposals, understand the impact of their implementation and then, where appropriate, seek to develop them further on a sustainable basis .

Some communities in Aberdeen already have established networks or planning groups, and where these are in place it is intended to seek to utilise this existing community asset infrastructure. Examples of this would be the Tillydrone network, and the Northfield Total Place Board and wider Stakeholder Engagement Group. In communities where there are limited or disparate networks, we will work with these communities to grow appropriate networks and build community assets. A bottom up approach will be taken rather than placing a community or neighbourhood structure down onto a community in order to increase the likelihood for sustainability.

We are supporting the creation of new Locality Leadership Groups – in the South area, the Cluster Integration Group has agreed that they will develop and diversify membership to become the Leadership Group for the South Locality. Discussions are planned with the North and other Cluster Integration Groups.

We will liaise with all our Community Planning colleagues to ensure that there is a strong strategic coherence in terms of the engagement that we undertake with our citizens and communities, developing our understanding of our local communities and populations and agreeing our joined up actions.

It is our intention that the four localities should plan and develop services on the basis of what we know about the health and wellbeing of the local population and what assets and resources are available locally. We are mindful though that this locality planning in itself should not increase health and social inequalities and create a postcode lottery of access to services.

All our activities will be co-ordinated through the partnership in line with this strategic plan but we recognise that localities may want to pursue some different approaches given their identified priorities. Mature and trusting relationships in and between the localities and the partnership as a whole will help ensure that these local emphases are within the parameters of this strategic plan.

We do not have all the answers as to how locality planning will work across all client groups, patient pathways and service models but it will always be the basis of our discussions that are seeking to improve our health and wellbeing, our personal experiences and our personal outcomes.

There is an opportunity in particular for our specialisms and hospital based services at ARI, Cornhill and Woodend to look at our emerging localism and see what connections can be made with these initiatives and developments to improve service delivery and individual outcomes, in a way that does not diminish their professional identity or expertise, but instead opens that to a wider audience.

### **3.4 Locality Plans.**

We will develop locality profiles that illustrate our understanding of the local communities including the health and wellbeing of the local population. These profiles will map the assets and resources and also highlight particular challenges. We will use these profiles to underpin the development of the locality plans which will detail the local services that we intend to develop.

Each locality plan is required to include:

- A list of all the services under the management of the Integration Authority of which the locality is a part;



- Identified priorities for each locality under each of the service headings
- Planned expenditure for the identified priorities showing how resources are shifting towards preventative and community-based health and care services.

Our locality plans will be credible and achievable. They will provide the commissioning detail of what integrated health and social care services will be aligned to the localities and how these will function in the best interests of the individuals who use our services, their families and communities.

### **3.5 Developing a Community and Locality Based Approach.**

We strongly believe that those living, working and volunteering locally are best placed to assess identified need in terms of issues relating to health and social care; to suggest how these needs might be addressed; to prioritise the needs on the basis of what is most important to the local community; and reflect all of these within an agreed action plan for the community. It is important to recognise again that some individuals may, at any given time, be isolated or unconnected within a community. This does not mean that they are not part of that community, but that there remains an opportunity to create and develop rich connections.

We are very aware that our colleagues from across all sectors and professional disciplines want to know what the locality model will mean for them and the way that they work. We are clear that our four locality model will not necessarily be the prescriptive delivery model for the services that we commission and deliver across all sectors however our pragmatism should not be mistaken for a lack of ambition about the improvements we intend to deliver in the best interests of the people who use our services, their carers and families and our workforce.

If we are serious about the people who use our services having an improved, seamless experience then we need better communication and improved co-ordination within the health service itself (primary care, secondary care and the acute sector) as well as with and between the social care, third, independent and housing sectors.

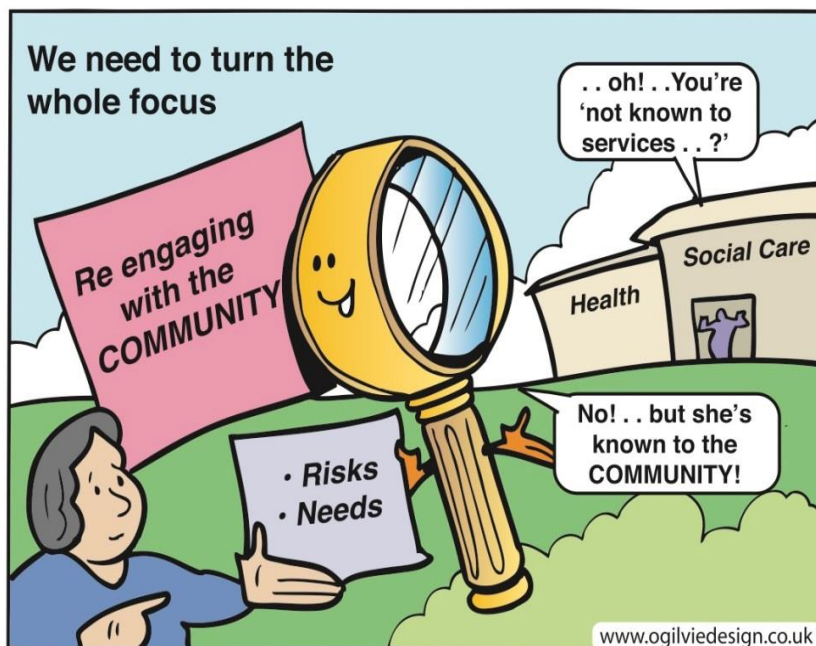
We also need real time information and good decision support provided to our front line practitioners so that other appropriate options can be sourced for individuals to reduce our 'social admissions' (admissions which are not clinically necessary but are the most practicable at that time due to the absence of other options i.e. social care).

We need to develop integrated, multi-disciplinary, community based services that will have an increased focus on early, preventative interventions and less reliance on formal support. We want the formation of these teams to result in fewer avoidable hospital admissions, A&E attendances and care home admissions, and for them to be focussed on the best interests and outcomes of individuals such as Jean whose story below is not that different from many others across the city.

### Case Study:

Jean is 78 and lives alone. She has chronic obstructive pulmonary disease, arthritis and high blood pressure. Her family live nearby and help when they can. She is not confined to the house but does struggle to walk long distances or stand for any length of time. She is scared of falling but is adamant that she wants to remain in her own home. Reshaping our services will offer Jean and her family the following:

- Better coordination of care with a single point of contact for Jean and her family
- One concise, integrated care plan that addresses all her needs and informs Jean and her family what to do if she is unwell
- Less duplication of assessment and less need to repeat information
- More community based support helping to reduce the need for hospital admissions
- Information to Jean and her family to help them understand more about her conditions and how she can manage her health to live more independently.
- More joined up service and greater continuity of care
- More advice and support for those who care for Jean.
- More linking up to community activities that support Jean being an active member of the community in areas of her own choice.



We also anticipate these professional outcomes;

- Better joint working and greater understanding of the roles of others
- Shared knowledge and ownership of issues
- Greater awareness of resources, enabling more effective choice.
- Greater shared risk management and more creative responses to need.
- Much faster access to all relevant information

- A proactive rather than a reactive service
- Better development of skills and knowledge
- Breaking down barriers and silo based working practices in the best interests of the individual

The objective of enabling Jean and others like her to remain safely in their own homes is a key policy ambition of the Public Bodies Act but we know that there are significant numbers of people, who for different reasons, are not known to services. These individuals, however, will be known to their family, friends and communities and maybe it is our services that are hard to reach. We need to change this.

### **3.5.1 Integrated Community Hubs.**

Most people want to receive their primary care services either at their local GP surgery or, if circumstances warrant, their own home and ideally at a time convenient to them given their other commitments and the perceived necessity of the treatment.

A new model of integrated care would develop our community infrastructure and focus much more on preventing ill health, supporting self-management, enhancing primary care, providing care in people's homes and the community, and increasing co-ordination between primary care teams and specialists in secondary care.

We believe that having our multi-disciplinary teams responsible for service provision in smaller geographical hubs could potentially facilitate better continuity of care as a result of local strong alignment of key professionals including GPs, Care Managers, Nurses, Allied Health Professionals, Pharmacists as well as appropriate colleagues from the third and Independent sectors.

There is also the potential for this alignment to be supplemented with significant contributions from, for example, community geriatrician consultants (and other acute sector consultants) and clinical psychologists to ensure that individuals are being seen by the right professionals with the right set of skills at the right time in the right place.

Providing appropriate support to the decisions made by other colleagues across the "Hub" will reinforce the continuity of care experienced by all individuals. We will link much better into assets within our communities to help those individuals with complex needs and there will be better links with our hospital-based services with the result that our admission and discharge planning will be better co-ordinated.

Colleagues from across this "Hub" will meet regularly to discuss those individuals who have recently been discharged from hospital, had contact with out of hours, or were screened and appropriate interventions agreed. Other conversations will explore how greater links with the community and third and independent sector groups can be

established to increase community capacity for improving the health opportunities of older people and reconnect people with their own communities.

Given this, a key question is how can we build effective teams and supporting infrastructure in our localities to help us care, support and treat individuals in their communities. This alignment of service and close collaboration across professional disciplines will enable us to explore opportunities that will benefit individuals.

- Workloads that reflect professionals' skillsets, have colleagues working to the top of their 'licence'
- Free up GP time to care for the complex patients in their own homes
- GP beds in each locality
- Increased use of technology ie Skype or email consultations
- Improved access and longer appointment times where appropriate
- Greater collaboration re home visits to decide who is the most appropriate professional to visit
- Collaboration between hubs to promote initiatives/best practice and also to provide sickness/holiday cover
- New ways of working and the training of Advanced Nurse Practitioners and Physicians Associates, Pharmacists and Links Workers to supplement teams in the community.

### **3.5.2 Helping People Stay at Home and Prevent Unnecessary Admission.**

In Aberdeen we are committed to only admitting people to hospital when they need to be there and that they stay in hospital for only the minimum time that is clinically required. Aberdeen City has had, and continues to have, a high rate of people being admitted to hospital unnecessarily and remaining in hospital too long. There are a number of reasons for this, which may include the lack of available care at home service provision and availability of suitable housing options.

Given the choice, people often say they want to remain at home, and so we will develop a hospital at home service to prevent unnecessary hospital admission by providing acute care at home. The benefits of this model include: shorter duration of hospital-equivalent treatment, fewer procedures, reduced complications, improved activities of daily living, and better satisfaction as well as providing an opportunity to assess a person's home environment. The development of this model will incorporate the following themes:

- An increase in services around prevention of admission; building on and developing existing community services to provide acute care at home at a time of crisis.
- Home to assess as the guiding principle.

- A comprehensive assessment applying a re-enablement approach to determine and reduce long-term health and social care needs.
- A consistent approach to risk management taking a more risk enabling approach.
- Consideration of what services are best delivered at city-wide, locality or at GP practice level and how we can work better together with communities and third sector partners to support people at home.
- A single point of access for health and social care to mobilise services.
- Improvement in communication and documentation, to be person centred, standardised, and shared.
- Medication management and pharmacy support embedded as part of the service model.
- Telecare and telehealth solutions embedded as part of the service model.
- Transport links that support service provision.
- Enhanced links to housing services.

A key next step is to establish what elements that already exist could be reshaped to work more effectively, and also to identify any gaps that we need to provide as part of the new model.

#### **What does this mean for the residents of Aberdeen?**

We will use the people, organisations and communities that sit within this locality model as the basis for all our engagement with our residents and communities in the city.

We will seek to use and build on the strengths and assets of our local communities in supporting and facilitating an individual's important contribution to their own community and their own health and wellbeing

We will seek to develop integrated health and care services that are aligned with the four localities and add social value to the communities in these localities.

## 4.1 Our Personalised Approach.

A strong aspiration of the partnership is for our personalised approach to be evident in all our activities and for the individuals and their carers to truly believe that they have choice and control, as far as is reasonably practicable, over the care and treatment that is offered to them.

Our approach means services are tailored to the requirements of the individual rather than a 'one size fits all' approach. It also encompasses the provision of improved information and advice, investment in preventive services to reduce or delay people's need for care and the promotion of resilience and interdependence among individuals and communities.

With improved choice and control comes responsibility and we accept that more work is needed to inform and support many people about the appropriate use of certain services, for example GP surgeries and the Accident & Emergency department, and what other alternatives may be more suitable for them given their circumstances.

An older population affects our need for healthcare services. For example, if we had tomorrow's population today, we might expect emergency admissions in the over 65s to increase from 5300 to 8100 per year.

The growth in our older age population is an opportunity as well as a challenge for the partnership. Aberdeen has, until recently been recognised as doing well in the social and economic factors that underpin good health, and we can use our vibrant neighbourhoods and communities to minimise the need for health services. Many older people are active members of the place where they live and positively contribute to the local health economy by volunteering and providing informal social care. A 5% increase in self-care could reduce demand for

### What does 'person centred' mean?

Being person centred means treating everyone with dignity, respect and compassion. It means offering personalised care, support or treatment that is tailored to the needs and aspirations of each individual, not standardised to their condition.

Being person centred means seeing individuals as assets not burdens and working with them so that they can recognise and develop their own resourcefulness and capabilities.

professional care by 25%, while a 10% decrease could increase demand for professional care by 50%.

**4.2** A key element of our personalised approach is the promotion and availability of 'self-directed support'. Self-directed support enables people to have more informed choice and flexibility over their care and support and provides the opportunity for more people to commission and control their own care through the use of individual budgets or direct payments.

The individuals who use our services and their carers will require consistent and accurate information that clearly, without the use of jargon, explains the options and opportunities that are available to them.

Personal outcomes are defined as what matters to individuals and their carers as well as the end result or impact of activities. Outcome based approaches are inherently person centred as they require meaningful engagement with individuals as an essential first step. Focusing on outcomes for individuals will challenge the partnership to move away from any tendency towards service led approaches and to think and act in a person centred way drawing on the individual's own assets, strengths and capacity.

Ensuring that personal, organisational and national outcomes are linked in a coherent manner is central to the successful implementation of an outcomes focused approach and our commissioning framework. We will ensure that review and feedback is linked through the different levels however we will always seek to emphasise the core personal outcomes underpinning all our activities.

## **4.2 Our Self-Management.**

Most adults under 65 are independent with little or no contact with our health and social care services. We mostly expect to live longer and healthier lives and to have more choice and control over the support we might need to maintain our independence as we age. For that to happen, we must plan now for new ways of providing services that deliver the outcomes for health and wellbeing that people will need and expect. However, we know that there is going to be an increasing demand for our services, and our resources are unlikely to grow at the same rate, if at all.

We need to spend less on some of the things we currently do and find different, and more efficient and effective ways of delivering services in the future. Many people with long term conditions make decisions, take actions and manage a broad range of factors that contribute to their health on a day-to-day basis. It makes sense that practitioners should support people to manage their health as effectively as possible.

Individuals are clear that their respective health conditions should not define nor dictate their lives. They do however want to understand their long term conditions, develop the

skills or attributes necessary to manage them better, and develop appropriate informal and formal support relationships.

Self-management means moving away from a model where individuals are passive recipients of care and treatment to a more collaborative relationship where they are active partners. To achieve this, it will be very beneficial for individuals to develop their knowledge, skills and confidence to make informed decisions and adapt their health-related behaviours. They need to have access to the necessary expertise to support them in making informed decisions, achieving their goals and overcoming barriers.



Achieving optimal physical, emotional and social health is an important self-management outcome. We need to be very clear about which other self-management outcomes are considered important by the individuals, their carers and families, and appropriate professionals, to guide the commissioning and design of future self-management services.

Self-management has received growing attention as an effective approach for long-term condition management. We recognise that this is not an option for every individual to pursue as there are some individuals who perhaps are not going to get better or who are always going to need some form of health and social care provision. We do not consider self-management to be a substitute for the appropriate provision of health and care services, but instead is part of the complementary range of supports and services that we wish to develop and offer.



### **4.3 End of Life Choices**

Offering a person- centred approach that respects choices is brought into sharp focus when it is an individual's end of life choices that are being contemplated. The percentage of people who die at home in Grampian has not changed in the past 20 years. Given that people say they want to die at home, we need to be better at providing and promoting the services that are required in these challenging circumstances, such as Roxburghe House.

As a partnership we need to get better at having difficult or enlightening conversations and we need to be mindful of the language that we use in those conversations. Anticipatory Care Plans have an important role in understanding the person not the condition(s) but we must make sure that they reflect the individual's current thoughts and choices. We must also make sure that those expressed choices are informed choices, as there can be difficulties in accessing appropriate services with people telling us that they don't know who to turn to. Carers will have a crucial role in supporting the cared for individual with these conversations and the choices that arise from them.

Continuing supportive care means that there is ongoing assessment and support for those people whose end of life is imminent. Their circumstances will be a test of how well we are doing in improving the co-ordination between services, how responsive our communities based services are, and whether we are actually improving individual experiences.

### **4.3 Whose Risk Is It Anyway?**

We will have a robust and transparent approach to risk management that respects individual choices and keeps people safe from harm. We recognise that individuals need to be supported to live the lives they want and not the lives we think they need however we also need to spread the word that adult support and protection is everyone's business.

We are very aware that within the health and social care sectors there are different attitudes to risk, and because of this, our workforce will need continuing support and reassurance about how best to manage expectations and support choices. Through the development of our clinical/care and staff governance structures and processes we will ensure that professional leadership and guidance continues to inform and influence our attitude to risk.

Our IJB's outlook is captured in our risk appetite statement which says:

The IJB recognises that it is both operating in, and directly shaping, a collaborative health and social care economy where safety, quality and

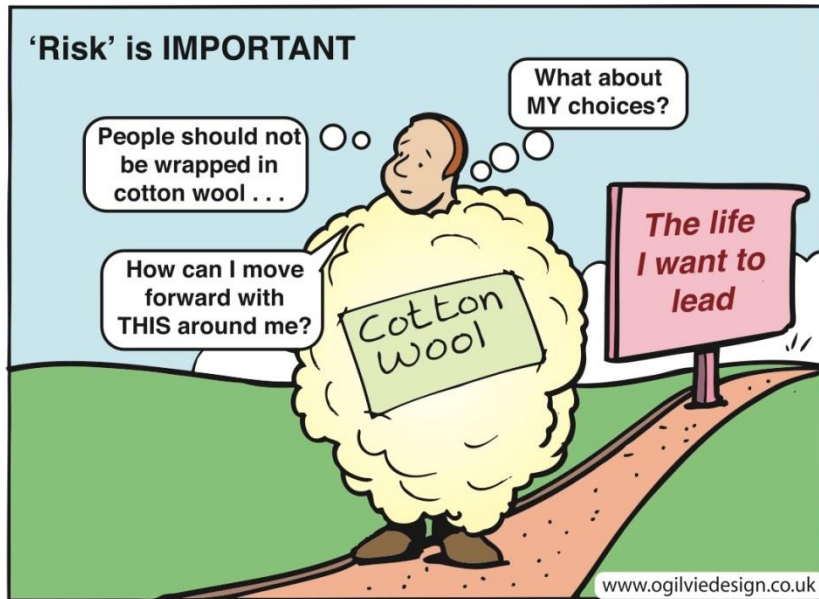
sustainability of services are of mutual benefit to local citizens, to stakeholders and to organisational stakeholders. It also recognises, as a newly-established organisation, that its appetite for risk will change over time, reflecting a longer-term aspiration to develop innovation in local service provision based on evidence of benefits and on a culture of continuing, planned engagement with the public and other stakeholders, including those involved in service delivery. As a result the IJB is working towards a mature risk appetite over time.

It recognises that achievement of its priorities will involve balancing different types of risk and that there will be a complex relationship between different risks and opportunities. The risk appetite approach is intended to be helpful to the board in decision-making and to enable members to consider the risks to organisational goals of *not* taking decisions as well as of taking them.

The board has identified several broad dimensions of risk which will affect the achievement of its strategic priorities. These are: financial risk; regulatory compliance risks; risks to quality and innovation outcomes; risk of harm to clients and staff; reputational risk.

The IJB will set a level of appetite ranging from “none” up to “significant” for these different dimensions. It will have zero tolerance of instances of fraud. It will accept no or minimal risk in relation to breaches of regulatory and statutory compliance. Similarly, it will accept no or minimal risks of harm to service users or to staff. It will accept low to moderate risk in relation to financial loss and to quality and innovation outcomes which predict clearly identifiable benefits and can be managed within statutory safeguards. It will accept moderate to high risks to reputation where the decision being proposed has significant benefits for the organisation’s strategic priorities. Higher levels of all risk types may be accepted if specific and effective controls are demonstrably in place and there are clear advantages for integration objectives.

The IJB has an appetite from its inception to take decisions which may expose the organisation to additional scrutiny and interest where there is evidence of confidence by key stakeholders, especially the public, that difficult decisions are being made for the right reasons. This is most likely to be evident in relation to innovation where there is a perceived need to challenge relationships, standards and working practices and/or where the IJB considers there are identifiable, longer-term benefits of greater integration of systems and technology.



A Risk Management Framework incorporating our risk management policy, risk appetite statement and both strategic and operational risk registers will be developed.

We will support, in the best interests of the individuals who use our health and care services and their carers, a positive culture of risk enablement that is underpinned by evidence-based decision making, based on accurate and appropriate information.

### Case Study:

Sarah is a young woman with a moderate learning disability who lives in supported accommodation. Whilst Sarah had support and access to staff within her accommodation, she also goes out to her own activities and work placement – using public transport unsupervised. This worked well for Sarah, as she had a degree of independence, alongside the ‘back up’ of her support team when she needed assistance.

Recently, however, the staff at her work placement (run by a third sector organisation) had become more concerned as Sarah appeared more withdrawn and appeared to no longer want to buy her lunch as she usually did. Sarah confided to the work placement staff that a ‘boyfriend’ was now regularly meeting her on the bus on her way to work and asking rather forcefully for ‘a loan’ via the cash machine. Sarah felt scared and didn’t want to give him the money, but also didn’t want to upset him.

The work placement reported the situation to the Adult Protection Unit who commenced an inquiry with social work staff working alongside the Police, the supported accommodation, the work placement and the local learning disability community nurses to find out what happened and make sure Sarah was safe. Working jointly, a protection plan was put in place that

supported Sarah to travel safely to her activities; protected her bank account; confronted the man targeting her; and worked with her to ensure she was able to have a better understanding of what a healthy relationship is and is not.

- The sphere of Public Protection is already one of the areas where the various organisations who work with vulnerable individuals work exceptionally closely together.
- Legislation already places duties to ensure the good cooperation of Social Work and health staff (alongside other agencies). Local multi-agency arrangements have implemented this to good effect.
- Integration will help embed and deepen these existing good links and will also further aid in the management of the most complex and detailed public protection cases.
- Integration will also further integrate the third and independent sectors into public protection frameworks via the embedding of joint referral and commissioning arrangements.

#### **4.4 Improvement Principles and Ambitions**

We are committed to improving the experiences of the individuals who use our services and their personal outcomes. We are also committed to the continuing improvement of all our services so that they are recognised as being effective, person centred and high quality.

Managing public expectations about where these services are and what they do is a critical element of our improvement agenda and will require continuous engagement and transparent decisions.

The commissioning of services will be one of the most important functions undertaken by the partnership as it seeks to ensure that all services enhance the quality of life for the individuals and their carers now and in the future. We recognise that it will be most effective if it is done in partnership with citizens, families, communities and other agencies that have an interest in the continued wellbeing of our local population.

We recognise however that not everybody has the time, energy and inclination to participate in these discussions, however, we will aim to include as many people as possible. We want the citizens of Aberdeen to value the health and care services that we are proposing to develop and in a wider context, identify with and support the broader ambitions of the partnership.

The vision and aspirations set out in this Strategic Plan are consistent with the ambitions and expectations of the National Care Standards and the NHS Quality Strategy. We will commission outcomes-focussed services that deliver high quality care and support and can evidence a positive quality of experience for the individual

and their carer. We will develop a quality-driven approach that promotes and protects human rights and seeks the appropriate involvement of people and their carers in the commissioning process. We will challenge discrimination, intended or otherwise and will ensure that we will manage and mitigate against risk appropriately.

### **What does this mean for the residents of Aberdeen?**

We will be person centred in all our activities and will always consider the best interests of the individual and the communities in which they live.

There will be more emphasis on people taking responsibility for their own health and wellbeing, self-managing their long term condition(s) and self-directing their care. We need to be realistic however, about what is expected and what can be afforded.

We will expect continuous improvement to be a defining feature of the services that we commission, and for this to be always evident to the people who use those services and their carers.

## 5. To Achieve Healthier and Fulfilling Lives and Wellbeing.

**5.1** The majority of people remain healthy and active into old age without the need for services. Although health problems generally increase with age, ill health and disability should not be an inevitable consequence of growing older in Aberdeen City. We want to focus on the promotion of health and wellbeing and strengthen early intervention and prevention.

At the same time, we want to make sure that people have access to the right treatment, care and support services when they need them, in ways which are effective, personalised and empowering. We need to recognise the essential asset of life experience and create opportunities for people to be more in control of their health and wellbeing and the management of any health problems.

To achieve our strategic objective of optimising the independence of people at home we need to look at how we manage our resources to deliver the best value for all people and their carers and their communities. In the next few years, health and social care budgets will most likely reduce in real terms while the demand for services will increase.

We are committed to making the best use of our resources to deliver best value in improving outcomes for people. We will have to make difficult decisions about future priorities and how we meet them, through the process of joint commissioning. We may however, need to stop or reduce investment in some services to release resources to commission other or different services to address our known challenges and fulfil our strategic priorities.

**5.2** The Scottish Government has identified nine national health and wellbeing outcomes that the partnership must work towards. We have taken our focus on individuals, communities and the partnership and applied it to these outcomes showing some ideas that we think will address some of the challenges that we have outlined in this plan.

### What do we mean by health and wellbeing?

The World Health Organisation (WHO) offers a positive definition of health which includes our social and personal resources as well as our physical capacities as 'a resource for everyday life, not the objective of living'.

A sense of physical, mental and emotional wellbeing is a key attribute that reflects the multi-dimensional and positive aspect of health.

WHO also make the point that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being".

## **Outcome One: People are able to look after and improve their own health and wellbeing and live in good health for longer.**

- **What does this mean for individuals?**

That people develop their resilience and interdependence so that they are able to accept responsibility for their own health and wellbeing, with support where needed and continue to contribute to their communities.

- **What does this mean for our communities?**

They are a safe place to live; residents feel that they are listened to, that their opinion 'counts' and believe that there are positive opportunities for developments that will enhance their lives and the life of their community.

- **What does this mean for the Partnership?**

Our personalised approach will promote self-directed support and self-management and support the prevention of ill health. We will support our local communities by adding social value wherever possible and seek public participation in all our activities.

- **How are we going to do this?**

- We will support and develop our Wellbeing activities that promote good health and participation in appropriate activities.
- We will invest in telecare and telehealth solutions to enable people to monitor their health and alert the appropriate services to any changes.
- We will target our interventions towards those population groups whose vulnerability, behaviours and wellbeing requires additional support for them to attain optimal health and wellbeing.
- We will put in place the necessary supports to develop high health literacy rates and self-care/self-management skills
- We will adopt a consistent 'Making Every Opportunity Count' approach to support individuals to be as independent as possible.

- **How will we know we are making a difference?**

- Percentage of adults able to look after their health very well or quite well.
- Premature mortality rate.

- Emergency Admission Rate.

**Outcome Two: People, including those with disabilities or long term conditions or who are frail are able to live as far as is reasonably practicable independently and at home or in a homely setting in their community.**

- **What does this mean for individuals?**

We should have easy access to understandable information and advice and access to ‘low level supports’ to help us continue to live independently. We should be supported to develop self-care and self-management skills and to be able to contribute to our communities in ways we value.

- **What does this mean for our communities?**

Communities will be more aware of the difficulties that people face, and increasingly will be more able to respond so that individuals feel listened to, valued and have a greater sense of belonging and connectedness that contributes to their wellbeing and the wellbeing of their community.

- **What does this mean for the Partnership?**

We will promote ability not disability and respond appropriately to what people are telling us. We will communicate with other services and providers to make sure that our delivery of service is as holistic as possible and we will provide extra help to those who struggle to navigate the system to stay in control of their care.

- **How are we going to do this?**

- We will invest more resources in early intervention and re-enablement to ensure that people have the best opportunity to remain independent
- We will promote the uptake of Anticipatory Care Plans and make sure that they always reflect the current thoughts and opinions of the individuals and their carers and that all relevant staff have access to, and take cognisance of them.
- We will always involve the people who use our services and their carers in the planning and delivery of our services.



- We will develop a hospital at home service so that appropriate individuals can receive acute hospital care at home.
- Increase use of risk tools, falls education and proactive multi-disciplinary team working to improve early intervention with frail, older individuals.
- Increase options for palliative care in localities.
- **How will we know we are making a difference?**
  - Percentage of adults supported at home who agree that they are supported to live as independently as possible.
  - Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
  - Emergency admission rate.
  - Emergency bed day rate.
  - Readmission to hospital within 28 days.
  - Proportion of last six months spent at home or in a community setting.
  - Falls rate per 100,000 population aged 65+.
  - Percentage of adults with intensive care needs receiving care at home.
  - Number of days people spend in hospital when they are ready to be discharged per 1,000 population.
  - Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.
  - Percentage of people admitted to hospital from home during the year who are discharged to a care home.
  - Percentage of people who are discharged from hospital within 72 hours of being ready.
  - Expenditure on end of life care

**Outcome Three:      People who use health and social care services have positive experiences of those services and have their dignity respected.**

- **What does this mean for individuals?**

Individuals will be treated with respect and dignity at all times and will be given the necessary information to make informed choices. They will be listened to and their views, and where appropriate, those of their carers and families will be taken into account by all colleagues who have an involvement in their life.

- **What does this mean for our communities?**

Residents have clear expectations of the range and purposes of the services and support available in the community and are clear about how to access them. They have confidence in the care and treatment that is provided to them irrespective of who is providing them.

- **What does this mean for the Partnership?**

A commitment to 'continual improvement' in leadership, governance, and organisational culture, behaviours, personalisation of service delivery, active listening and communicating, a growing confidence in multi-professional, multi-agency roles and responsibilities.

- **How are we going to do this?**

- We will demand high levels of positive engagement between staff and the individuals who use our services.
- We will develop a single point of contact for individuals to enter our health and social care system and for their journey to be supported and co-ordinated as appropriate.
- We will record and act upon all feedback received on a continual basis to ensure ongoing improvement throughout our systems and processes. We will have robust feedback systems putting individual experience at the heart of improvement and change.

- **How will we know we are making a difference?**

- Percentage of adults supported at home who agree they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good.
- Percentage of people with positive experience of the care provided by their GP practice
- Readmission to hospital within 28 days.
- Proportion of last six months spent at home or in a community setting.
- Proportion of care services graded 'good' or better in Care Inspectorate inspections.

- Number of days people spend in hospital when they are ready to be discharged per 1,000 population.
- Percentage of people who are discharged from hospital within 72 hours of being ready.
- Expenditure on end of life care

**Outcome Four: Health and social care services are centred on helping to maintain or improve the quality of life of service users.**

- **What does this mean for individuals?**

People should feel supported and confident in maintaining independent living, feel valued and included in their community, feel they have influence in and with the services that they access and that are important to them..

- **What does this mean for our communities?**

health and social care service improvement will centre on strengthening community services supporting and seeking to add social value at every opportunity so people can find what they need close to where they live.

- **What does this mean for the Partnership?**

Our health and social care services will be locally designed and delivered in partnership with citizens and community and voluntary organisations, in order to increase people's access to the assets and resources in their local communities. We will facilitate people's access to local community assets and resources that support good health, self-care and self-management in ways which encourage a sense of belonging to the communities in which they live.

- **How are we going to do this?**

- We will develop integrated health and social care services on a locality basis.
- We will develop Integrated Community Hubs across our Localities providing significant multi-disciplinary resource so that individuals are able to be supported at the right time in the right place by the right person.

- We will develop strong, meaningful partnerships with all our partners across the third, independent and housing sectors and ensure that they are involved in the planning and delivery of services.
- **How will we know we are making a difference?**
  - Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
  - Emergency admission rate.
  - Emergency bed day rate.
  - Falls rate per 100,000 population aged 65+.
  - Number of days people spend in hospital when they are ready to be discharged per 1,000 population.
  - Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.

## **Outcome Five: Health and social care services contribute to reducing health inequalities.**

- **What does this mean for individuals?**  
People want to see improving health for themselves and their families, and believe they have a realistic prospect of achieving that.
- **What does this mean for our communities?**  
Making better use of everyone's assets to achieve better outcomes, create an integrated web of support across communities and agencies to support people to have increasing opportunities for improved outcomes.
- **What does this mean for the Partnership?**  
We will put reducing health inequalities at the heart of everything that we do and will seek to develop inequalities-sensitive practice at every level of the partnership.
- **How are we going to do this?**

- Localities will be encouraged to establish informal, desirable supports i.e. self-management groups, peer support groups, carer support groups that our citizens and communities value
  - We will support and develop our understanding and implementation of health inequality impact assessments tools.
  - We will complete a health inequality impact assessment for this Strategic Plan and will do this for all subsequent health and social care policies and strategies.
  - Locality plans will prioritise reducing health inequalities in those communities that experience the poorest levels of health and wellbeing.
- **How will we know we are making a difference?**
    - Premature mortality rate.
    - Emergency Admission Rate.
    - Readmission to hospital within 28 days.

**Outcome Six: People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing.**

- **What does this mean for individuals?**

Individuals can be reassured that the significant role of unpaid carers will be recognised, that their views will be included and respected in the development of all strategic and operational plans for themselves and the people they provide care to. The health and wellbeing of the carers themselves and the impact of their carer role is hugely valuable and appropriate support must be blended throughout all our systems.
- **What does this mean for our communities?**

Carers are a vital cog in the life of communities and barriers will be reduced to enable carers to stay active in their communities to increase their sense of belonging and developing social connections that actively support them in their role in meaningful ways.

- **What does this mean for the Partnership?**

The Partnership values the contribution that carers make and will endeavour to nurture and protect their rights, their sense of belonging and their supportive links throughout our health and social care systems will enhance the engagement with unpaid carers by all partner sectors and organisations and at all levels.

- **What are we going to do this?**

- In response to what we have been told by carers, we will continuously improve access to more flexible support and short breaks.
- We will continue to invest in the involvement of carers as equal partners in the planning and delivery of community based health and social care supports and services.
- We will implement in full the legislative requirements of the Carers Support Act 2016 and also work towards attaining the Carers Positive accreditation.

- **How will we know we are making a difference?**

- Percentage of carers who feel supported to continue in their caring role.

## **Outcome Seven:      People who use health and social care services are safe from harm.**

- **What does this mean for individuals?**

Adults at risk of harm are supported and protected by their families, communities and network of supports.

- **What does this mean for our communities?**

Communities are aware and confident that systems are in place for the identification, reporting, and prevention of harm.

- **What does this mean for the Partnership?**

We have a culture which places the safety and wellbeing of the individuals that we work with at the centre of everything we do. We are confident that our evidence-based practice, clear and robust governance arrangements, and commitment to continuous service improvement minimises the risks of harm to them.

- **What are we going to do this?**
  - We will continue to promote the key message that adult support and protection is everyone's responsibility.
  - We will develop a robust clinical and care governance framework that protects the people who use our integrated health and care services.
  - We have robust systems in place for the reporting and investigation of harm/suspected harm and we will ensure that all staff are fully aware of their professional responsibilities.
  - We will ensure through appropriate consultation that individuals and communities feel confident to use our robust protection systems and are aware of any risk in their locality that could impact on the safety of themselves their family and friends and their community and are given appropriate advice and support to tackle any concerns they might have.
  
- **How will we know we are making a difference?**
  - Percentage of adults supported at home who agree they felt safe.
  - Emergency admission rate.
  - Emergency bed day rate.
  - Falls rate per 100,000 population aged 65+.
  - Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.

**Outcome Eight: People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.**

- **What does this mean for individuals?**

People have clarity over what is expected of them and are motivated to come to work, feel supported by colleagues and management, and are valued by colleagues and people for whom they provide high quality care and support,

- **What does this mean for our communities?**

All partnership staff belong and contribute to their own communities, we will reflect this in our contractual obligation to allow one hour of volunteering per month for all staff to ensure and encourage a work life balance.

- **What does this mean for the Partnership?**

Clear recruitment and retention strategies, training provision, particularly during change implementation, clear lines of accountability and reporting, feedback mechanisms, ability to participate in decision-making, provision of necessary equipment and infrastructure to undertake roles, fair reward, adequate staffing levels and a recognition that all staff must have a work/life balance.

- **How are we going to do this?**

- Ensure staff are equipped to promote health and wellbeing as part of a targeted approach.
- We will develop the Partnership's organisational structure and behaviours and will seek to harmonise, where possible, our activities and the processes that support these so that we become a more effective, agile and efficient agency.
- We will offer the workforce appropriate opportunities to participate in robust multi-disciplinary working arrangements where good practice can be shared and skillsets developed.
- We will do our best to support our workforce at all times including when they themselves are experiencing episodes of ill health or have become a carer themselves.
- We will support our partner organisations across all sectors to work towards attaining Healthy Working Lives accreditation.
- We will seek to develop a social care campus that will provide individuals who are seeking employment in the health and care services with appropriate levels of training and (linked) affordable housing options.

- **How will we know we are making a difference?**

- Percentage of staff who say they would recommend their workplace as a good place to work.



## **Outcome Nine: Resources are used effectively in the provision of health and social care services, without waste.**

- **What does this mean for individuals?**

People will understand how health and social care organisations make their decisions, people will be confident that public funding is being used cost effectively.

- **What does this mean for our communities?**

Understanding of how health and social care organisations make decisions, confidence that public funding is being used to best effect, communities collaborate with organisations to identify where local assets can be used to help meet health and social care needs.

- **What does this mean for the Partnership?**

Decision-making processes that are consistent, fair, accountable and transparent, ensuring that the right people with the right skills and knowledge participate in decision-making groups which have timely access to up-to-date health intelligence and evidence of effectiveness and cost-effectiveness.

- **How are we going to do this?**

- We will seek to shift the balance of care to community based models that are valued by individuals and which strengthen our communities.
- We will review our bed based services with a view to developing appropriate intermediate models of care delivery such as step up or step down.
- We will improve outcomes for service users and carers by developing easier access to health and social care in the right place and at the right time.
- We will develop fully integrated teams that will work across sectors and pathways to ensure that the individuals and their carers who use our services have more positive experiences and outcomes on a continual basis.
- We will develop strong, collaborative relationships with the acute sector so that our mutual challenges can be addressed to fulfil our shared strategic objective.

- We will develop our planning function to give us a better understanding of the health and wellbeing of the local population, their unmet needs and the evidence of what works so that this can be shared more fully with our communities and localities.

- **How will we know we are making a difference?**

- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated
- Readmission to hospital within 28 days.
- Proportion of last six months spent at home or in a community setting.
- Falls rate per 100,000 population aged 65+.
- Number of days people spend in hospital when they are ready to be discharged per 1,000 population.
- Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.
- Percentage of people who are discharged from hospital within 72 hours of being ready.
- Expenditure on end of life care.

## **6. How will we know we are making a difference?**

### **6.1 Performance Framework.**

One of our key ambitions is for our partnership to be recognised at a local and national level as a high performing partnership. As such, we will show how we are improving personal experiences, improving personal outcomes and fulfilling our strategic priorities.

As can be seen in Chapter 5 there are a core suite of indicators provided by the Scottish Government that are aligned with the national outcomes. However, given what we have said about our personalized approach, the views of individuals and their carers about the quality of their experience when using our services will be an essential indicator of whether our partnership is progressing in the expected manner or not. Similarly, knowing that we have an engaged and motivated workforce across all sectors and organisations will also be an important barometer of the partnership's own health and wellbeing.

Colleagues from across the health, social care, third, independent and housing sectors will continue to work together to establish an integration platform that offers us the best opportunity to reshape our health and care services. No single activity will produce the outcomes that we desire, instead we will require planned and co-ordinated interventions across a number of areas including:

- Focus on population health and adding social value to our communities
- New improved ways of delivering our care and support
- Technological advances making people's lives easier
- Quality and efficiency improvements
- Active cost management

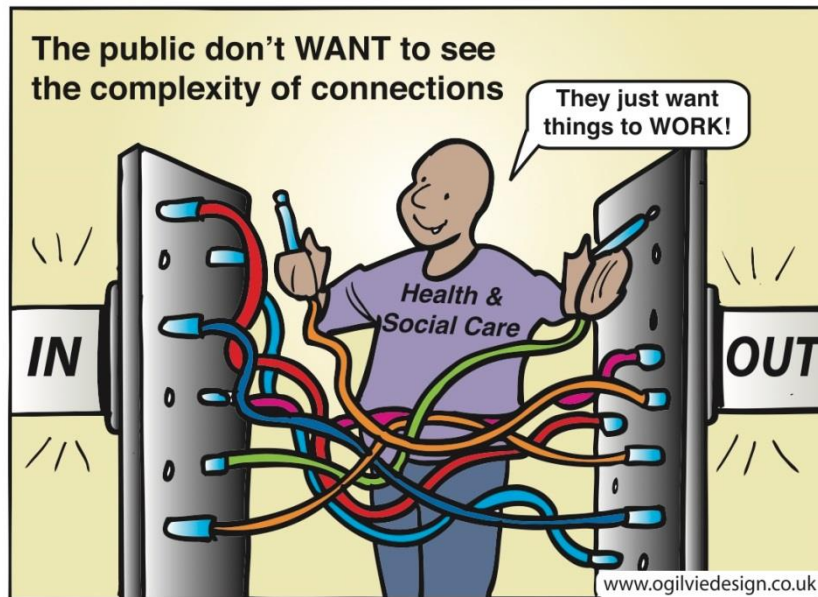
We recognise the strengths of the single system frameworks that have previously evidenced the performance of services therein. The services that are to be delegated to, or hosted by, the IJB, are highly complex. Therefore, there is a self-evident business critical need that we work collegiately with all our sector partners to develop a performance management framework that is acknowledged as being appropriate, easy to understand, and fit for all purposes.

We will be consistent in the manner in which we evaluate all our new initiatives and developments, and we will have high expectations of the engagement and consultation that will take place. Our locality based, participatory approach to the planning and delivery of services will offer different opportunities to fulfill our priorities and meet the national outcomes. Our strategic coherence will be evident in the development of all these opportunities.

## 6.2 Where do we want to be in 2019?

As part of the consultation on our draft strategic plan, we asked respondents to tell us what would integrated health and social care partnerships look like in 2019. Their answers can be summarised as:

- The integration of adult health and social care services has progressed smoothly and the partnership is established and known throughout the city.
- There are high satisfaction levels from those individuals who use our health and social care services.
- Carers feel better supported than previously was the case.
- Staff are busy (that hasn't changed) but they are engaged with our transformational activities and morale on the whole is good.
- Staff feel empowered to address the underlying issues impacting on health and wellbeing.
- Our partner organisations in the third, independent and housing sectors feel valued for the contribution they are making to the planning and delivery of services.
- IT systems are more joined up than they were previously.
- People feel empowered to look after own health in their own communities.
- Greater focus on prevention and early intervention.
- No more falling through cracks, less disengagement distress and crisis.
- The locality model is up and running across the city with there being subtle differences in how the four localities are addressing some of their own priorities
- Improved resilience in the communities
- Better connections amongst staff individuals and community resources.
- Multi-disciplinary working is accepted as the natural order of things; workers are confident, know the communities in which they work, know where to link in with wider partnerships and have clear systems and processes in place so everyone knows what is expected of them.
- People are getting more confident in knowing where to go for help/support when it is required but also confident that when they are sick or have high support needs those needs will be met for the most part in their own homes and that they will be involved in decisions about their lives.
- Improved understanding of support of range of disciplines in the community



**What does this mean for the residents of Aberdeen?**

We will be judged on the differences and improvements that we make to the health and wellbeing of the people of Aberdeen and its local communities. We will improve this.

We are very clear about the mutually supportive and consultative relationships that we want with our localities and communities.

There will be a strong and consistent partnership ethos across all professions, sectors and services.





