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# Aberdeen City Health & Social Care Partnership

# Annual Report 2018-19

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# 1. Introduction

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

Our annual report outlines how effective the Aberdeen City Health & Social Care Partnership (ACHSCP) has been in 2018-19, the final year of the partnership's first Strategic Plan which was published on integration 'go-live' in April 2016. It describes our progress against a range of local and national performance indicators and reflects on the impact of the day-to-day delivery of our integrated health and social care services.

Our third year of operation as an integrated partnership continued the progress of previous years in improving the experiences and outcomes of the people who use our services and their carers. We recognise that our services are not yet as well co-ordinated and collaborative as we would like them to be and there is still much to do before we have truly transformed service delivery across the partnership.

We are optimistic about the capability of staff in all areas of the partnership, including our third and independent sector partners, not only to ensure that a good-quality, person-centred service is being delivered on a day-to-day basis but also to offer their professional insights about what we could be doing differently. Our aim remains to become known and respected as a high-performing partnership that has a reputation for its compassion, quality, innovation and effectiveness.

The partnership's second Strategic Plan was approved by the Integration Joint Board (IJB) in March 2019 following comprehensive engagement and consultation with the people who use our services, their carers, communities and other appropriate stakeholders.

The IJB continues to exercise good governance and oversight of the partnership's activities. It has made clear its expectations about the implementation of our strategic plan, the delivery of the expected benefits of our transformation programme and the desired positive impact on the health and wellbeing of our local population, including our wider partnership workforce.

We are committed to the integration of health and social care services and working collaboratively with our partners to achieve desired outcomes. We would like to thank all our staff and volunteers in every partnership service for striving on a daily basis to make a difference. It is hugely appreciated, and their hard work and commitment does not go unrecognised.

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## 2. Analysis and Commentary on Indicators of Note

In relation to the statistics in Appendix A, the available information enables us to compare the partnership's performance in the past year with the previous year, to compare against the country's performance as a whole and to show its position relative to the other partnerships in Scotland for each indicator. Aberdeen City sits in the country's top 20 partnerships for 15 of the 19 reported indicators. We know we can do better and our expectation is to improve our performance across all indicators year after year.

In Figure 3.1, the red line indicates the previous reporting period and the bars demonstrate our performance change.

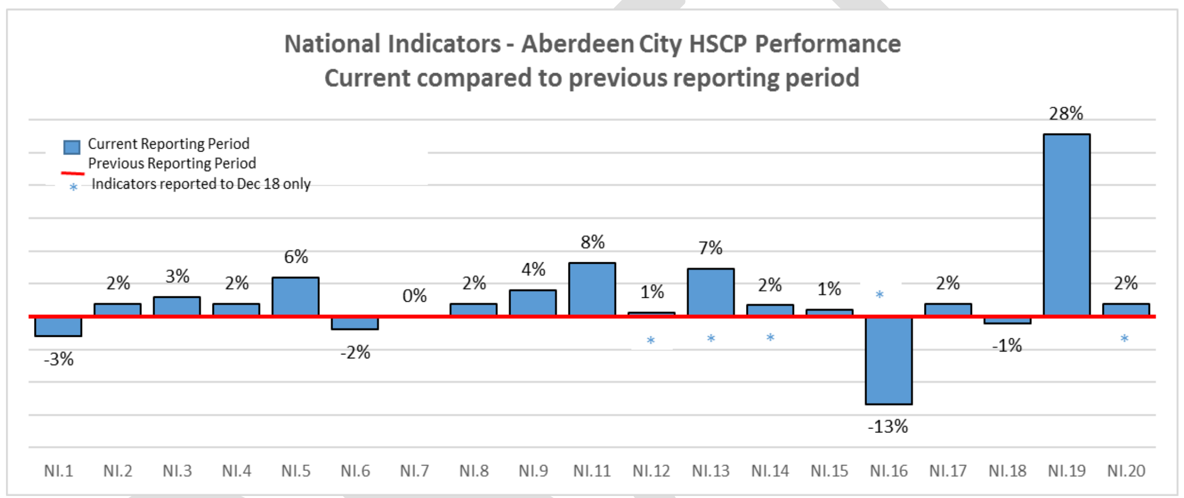


**Figure 3.1 ACHSCP Performance (National Indicators) Compared to Previous Period**

Fifteen of the 19 reported indicators have improved or stayed the same, since the previous reporting period. This is an improvement on last year where 14 indicators improved or stayed the same. Of the four indicators that performed worse than the previous period, three were on or within 3% of the previous performance except NI.16 – Falls rate per 1,000 population aged 65+ where performance had worsened by 13%, however Aberdeen City's performance remains the same as the Scotland position of 17 falls per 1,000 population aged 65+

In Figure 3.2, below the red horizontal line shows the national position and the bars for each indicator show the percentage by which the partnership differs from Scotland's performance for the current reporting period. Positive bars show where the partnership is performing better than Scotland and negative bars show where our performance is worse than Scotland's.

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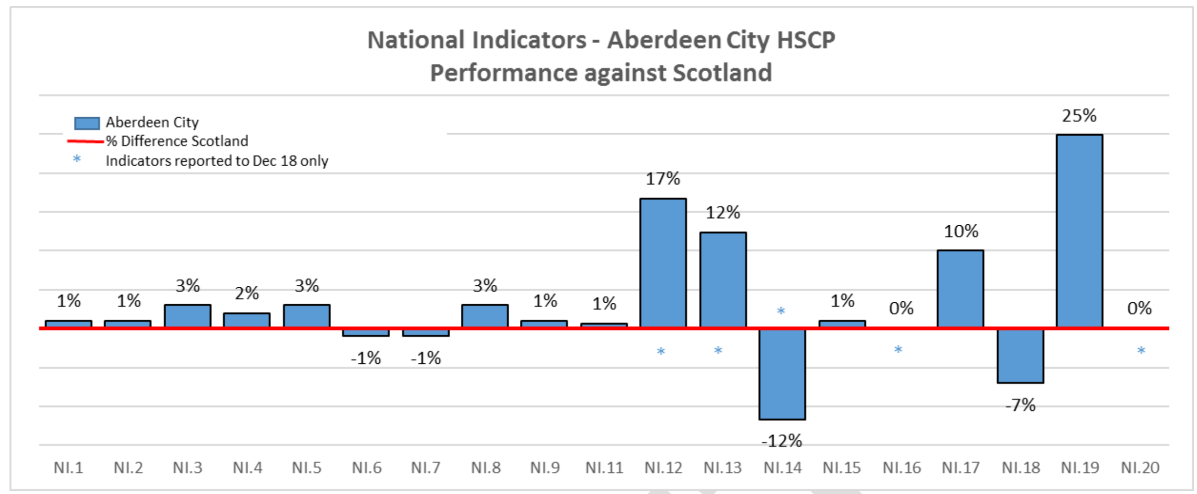


**Figure 3.2 ACHSCP Performance (National indicators) Against Scotland**

For the current reporting period the partnership performed better than Scotland for 13 of the 19 national indicators; this is an improvement from last year where we performed better in 12 of the 19 national indicators. We performed worse than Scotland in four indicators; all were within 5% of the Scotland figure with the exception of NI.14 - Readmission to hospital within 28 days (12% worse than Scotland) and NI.18 - Percentage of adults with intensive care needs receiving care at home (7% worse than Scotland).

Figure 3.3 shows the partnership's performance for each indicator ranked against all the other partnerships in Scotland. A lower number demonstrates a better position against the rest of Scotland.  Aberdeen City was in the top 50% for 13 of the 19 reported indicators for this reporting period.  This is an improvement from the last reporting period where Aberdeen City reported 11 of the 19 indicators in the top 50%.

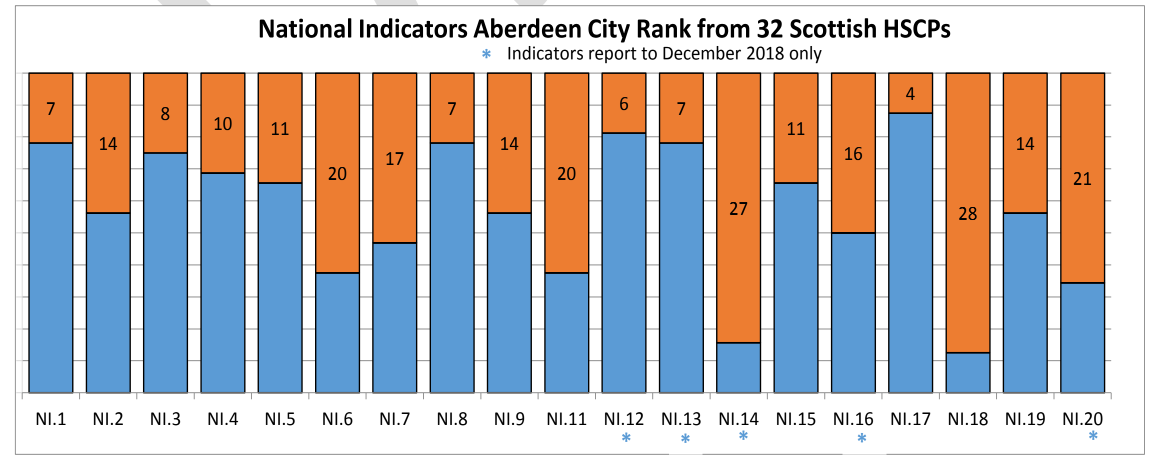


**Figure 3.3 ACHSCP Performance (National Indicators) Ranked Against Other Partnerships.**

| | |
|---|---|
| | National Indicators 1 – 9 are based on a bi-annual survey of individuals who are registered with GP practices. The recipients of the survey are randomly selected from the practice lists. There is no targeting of people who actively use health and social care services, but this is one of the first questions asked in the survey so we can identify what percentage of respondents do. Return rates are generally poor and an analysis of these, combined with those who confirmed they have used services indicate that responses are reflective of an extremely small number of service users – less than 1% in 2015/16. Whilst these figures are reported nationally, we are obliged to reflect them in our annual report; however, we will not undertake any in-depth analysis on these. In June 2019 we commissioned a local survey with a view to gathering more representative data. The questions in the local survey reflect national indicators 1 to 9 and more and we will report on the outcome of that in next year's annual report. The local survey will be repeated in two years' time in order that we can measure progress. |
| | The percentage of staff who say they would recommend their workplace as a good place to work is not reported nationally however we have taken the data in the table above from NHS Grampian's iMatter survey which includes all partnership staff including those employed by Aberdeen City Council. |
| | The premature mortality rate has decreased significantly from 464 in 2015 to 423 in 2017 and is lower than the Scottish rate of 425 in 2017. We hope this trend will continue particularly with the implementation of some of our prevention and resilience initiatives in relation to promoting healthier lifestyles and greater self-management of conditions and look forward to the publication of subsequent year's data. |
| | The emergency bed day rate has reduced significantly by almost 11% since December 2016 and is over 12% lower than the Scottish figure which is likely impacted by our improved delayed discharge activity. |
| | The readmission to hospital rate of 115, although lower than last year's figure of 117, is still higher than the previous year's figure of 104 and the Scottish figure of 103. This area is subject of ongoing investigation by our Unscheduled Care Group. |
| | The proportion of care services graded 'good' (4) or better in Care Inspectorate inspections has increased again from 86% in 2016/17, to 90% in 2017/18 and now to 92% in 2018/19, significantly higher than the Scottish average of 82%. We believe this is indicative of the improved working relationships we have developed with local providers along with our commitment to ensure the Scottish Living Wage is paid to all adult social care workers. |

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|---|---|
| | The percentage of adults with intensive care needs receiving care at home dropped last year to 54% from 55% the previous year and is significantly lower than the Scottish figure of 62%. Comparison with the Scottish figure is artificial as historical practice differs greatly between each local authority area. The local drop is concerning however and the reasons for this will be investigated and analysed. |
| | The number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) has continued to drop as a result of positive collaborative working between the Discharge Hub, colleagues in ACC Housing and commissioned providers. The figure has gone from 1,155 in 2016/17, to 838 in 2017/18, and 605 in 2018/19 – a reduction of almost 48%. Aberdeen City's 2018/19 figure is almost 25% lower than the Scottish figure of 805 |
| | Admissions from A&E have reduced by 5.5% since 2016/17 and are almost 23% lower than the Scottish figure. Can say why this is? |
| | The number of unscheduled hospital bed days for both acute and long stay specialties has reduced significantly by 20% each since 2016/17. We attribute this improvement to the work ongoing in relation to delayed discharges, improving the throughput of patients generally. |
| | A&E attendances, having dropped the previous year have increased again in 2018/19 and are above the Scottish average. We will continue to work towards diverting demand away from A&E through our Link Practitioners, Action 15 and Primary Care Improvement Plan and the introduction of our Mental Health, Dementia and Social Isolation Delivery Plans. |
| | The number of delayed discharge bed days has reduced by 33% in the last two years and is 14% lower than the Scottish figure. This is as a result of positive collaborative working between the Discharge Hub, colleagues in ACC Housing and commissioned providers. |
| | In 2018/19 ACHSCP participated in a self-evaluation exercise organised by the Ministerial Steering Group in relation to demonstrating progress on integration. Overall the partnership result was positive: -<br>45% rated at Exemplary level<br>41% rated at Established level<br>14% rated at the Part Established level<br>0% rated at the Not Yet Established level<br>Areas of improvement were identified, and an Action Plan has been developed which will be monitored by the Leadership Team with progress reported to the IJB in March 2020. It is anticipated the self-evaluation will be repeated in future years and our aim will be to achieve 100% at Exemplary level. |

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# 3. That Was the Year That Was

2018-19 was busy with many different activities, developments and initiatives. These highlighted the diversity and complexity of the partnership's delegated functions and services being progressed or completed.

Some of the highlights from the past year include:

The partnership's Learning Disability Strategy, A'thegither in Aberdeen was launched in May last year at Pittodrie Stadium. The then-chair of the IJB, Jonathan Passmore said that this was "the clearest, simplest and most accessible document the IJB had ever seen".

The strategy recognises that people with learning disabilities are valued contributors to our communities and it maps out how we can help them to flourish and achieve fulfilling, healthier lives.

The partnership's Carers Strategy, A Life Alongside Caring, was approved by the IJB in March 2018 and formally launched in Carers Week in June.

The implementation of this strategy alongside the introduction of Adult Carer Support Plans and Young Carer Statements is helping to meet many of the hopes and aspirations that carers themselves have told us about, like: treating carers as equal partners in care; treating carers holistically; improving support; building trust; planning for the future; co-ordinating the support provided to a carer, and recognising the impact of the caring role.

The Autism Strategy and Action Plan 2019-2022 was approved by the IJB in December.

This whole-life strategy has been created in partnership with autistic people, families, professionals and organisations and reflects the revised Scottish Government outcomes and priorities.

It outlines the underpinning strategic vision and the actions across 13 focus areas that will deliver improved outcomes and experiences for the local autistic population.

Audit Scotland published its Health and social care: update on progress report in November, which assessed the success of health and social care integration in Scotland so far.

The report highlighted leadership, information-sharing and governance as key strengths of the Aberdeen City Health & Social Care Partnership.

"We have seen examples of good collaborative and whole-system leadership, including in Aberdeen City, where relationships have been built across the Partnership. Although differences of opinion still exist and there is healthy debate, Aberdeen City is now better placed to implement widespread changes to improve outcomes.

2018-19 saw the departure of our interim Chief Officer, Sally Shaw, who was successful in obtaining the Chief Officer post in the Orkney Islands.

Sandra Ross was appointed by the IJB to be its Chief Officer in August.

IJB Chair Jonathan Passmore said: "We are delighted to welcome Sandra into Aberdeen City Health & Social Care Partnership. She brings a wealth of experience of front-line service, which will be of great value to the organisation.

"Having worked for a range of organisations, Sandra has extensive knowledge of operational management, and will bring strong leadership skills to the organisation as we continue to reshape and transform adult health and social care in the city."

A successful recovery operation was implemented in December last year when a care-at-home provider notified the partnership of their intention to shortly cease operations.

A working group was quickly established to oversee the safe and swift transfer of care and discussions commenced with our other providers about their capacity and willingness to support this.

A fair re-allocation of the care packages was agreed and the importance of quickly and efficiently transferring staff from the previous provider was also emphasized. Affected individuals and families were all contacted and briefed on the partnership's intentions given the quickly developing circumstances.

101 of the original 111 packages of care, consisting of over 1,000 hours of weekly support, were transferred to local providers. The remainder were allocated to Bon Accord Care. This was a complex challenge within a short timescale but we believe that the agreed actions were in the best interests of the individuals and minimized the risk of any disruption to their care and support.

The **Acute Care at Home (AC@H)** service seeks to provide comprehensive assessment and care to frail elderly people in their own homes during an acute phase of illness where it is safe and appropriate to do so. The service pathway supports both Admission Avoidance (GP referrals initially) and Active Recovery, for those patients who have received assessment, diagnostics and acute treatment. The service went live in June.

The evaluation of the first six months of operation completed in April 2018 shows that the service appears "no less safe than usual care" and satisfactory to patients, unpaid carers, staff and interacting organisations.

In this period there were a total of 84 admissions to the service, most of which were from the Geriatric Assessment Unit (GAU) using the early discharge model (67%) and consisted of older adults with frailty requiring support following hospital discharge.

In comparison to a GAU admission, 2.5% more patients were living at home 90 days following AC@H discharge and 6.8% lower mortality rates were reported.

The **HEART Awards** – 'Having Exceptional Achievement Recognised Together' – was designed to celebrate the outstanding work of colleagues in ACHSCP and its partner organisations. Our third HEART Awards ceremony was held at the Beach Ballroom in March 2019 and the occasion drew some 350 colleagues for an evening of home-grown entertainment and accolades. The award winners were: Photos available!

| | |
|---|---|
| **The Hearing Others Award:** | **Anne Carmichael and Peter Stephen** |
| **The Empowering People Award:** | **Dr Susan Brechin** |
| **The Team Aberdeen Award:** | **Capital & Services Team** |
| **The Rising Star Award:** | **Katharine Paton** |
| **The Beating Heart Award:** | **Dr Alasdair Jamieson** |
| **The Staff Choice Award:** | **Mark Craig** |
| **Special Commendation:** | **Dr Claire Wilkie** |

The Aberdeen Links Programme went live in September 2018 with the recruitment of the first cohort of Primary Care Link Practitioners by our commissioned partner, the Scottish Association for Mental Health (SAMH). This initially covered two thirds of the practice population with a second and final cohort commencing the following year.

The aim of the programme is to support people to live well through strengthening connections between community resources, third sector organisations and primary care and to enhance social prescribing activities in Aberdeen. The programme recognises the demand for GP and other primary care services and introduces an opportunity to integrate a different skill-set into the practice team.

Link Practitioners are providing a person-centred service that is responsive to the needs and interests of the practice population by supporting patients to identify issues that affect their ability to live well and help them to address these. Photos available! More data from Calum post 13/8.

Dr Caroline Howarth MBChB FRCGP was appointed as the new **Clinical Director** for Aberdeen City Health & Social Care Partnership in January 2019.

Caroline became cluster lead for the Central South GP Cluster in 2013 and went on to became one of the deputy clinical leads for the partnership in 2016. She has been involved in many projects across the city, including the recent and very successful West Visits Unscheduled Care initiative. She is currently leading on implementing the Primary Care Improvement Plan across Aberdeen.

Integration Joint Board Chair Councillor Sarah Duncan said: "I am delighted that Caroline is joining the partnership's Leadership Team. She has a wealth of experience in the delivery of primary care services for the people of Aberdeen and has already demonstrated her strong leadership skills through her prominent role with professional GP bodies and in key partnership initiatives."

The Care Inspectorate, in conjunction with Health Improvement Scotland, published in September, a joint follow-up report to their original inspection of the partnership's services for older people in 2015-16.

Their overall conclusion was that the partnership had made good progress in relation to five of the original eight recommendations, reasonable progress in relation to two and limited progress in relation to one. The report concluded:

"Our original inspection identified some strengths in the delivery of services for older people in Aberdeen. These included a strong commitment to engaging with and involving local communities in planning how to meet the health and social care needs of the older population. However, we also identified a number of significant weaknesses and we made eight recommendations for improvement in relation to these.

"The partnership had responded well to our recommendations. It had made good progress in addressing delayed discharges, carers assessments, joint training and its process for allocating money from the integrated care fund. It had made good progress supporting the frontline staff who carried out adult support and protection work. It had made limited progress developing locality teams."

The **West Unscheduled Visiting** pilot scheme to help GP practices deliver an afternoon home-visiting service has proved a big success.

All the locality's seven GP practices and Grampian Medical Emergency Department (G-MED) took part in the initiative, which involves an Advanced Nurse Practitioner (ANP) visiting patients who ask for an unscheduled home visit that would usually have been undertaken by a GP.

GPs were very satisfied with the service, giving it an average score of 90%. They reported reduced workloads, allowing them to spend more time with patients in the practice, a high-quality service for patients, and decreased stress for other practice staff. ANPs felt they provided holistic care to patients and were providing the practices with a good service.

Patients who returned questionnaires at the end of the evaluation period also reacted positively, with 100% of respondents rating their ANP as "very good" for their compassion and respectfulness. Respondents also gave the scheme full marks in terms of their overall satisfaction. One patient told the evaluation team: "The home visit was excellent – the nurse was very good and patient with me. I wish we could get someone like her all the time." The findings have been published in the Journal of Research in Nursing, available at: https://journals.sagepub.com/doi/full/10.1177/1744987119852380.

The partnership is now extending the service – with the longer-term aim of scaling up the model to cover half of the city by the end of this year.

At its meeting in March, the IJB agreed to move from four to three **localities** – to help Aberdeen City Health & Social Care Partnership (ACHSP) provide services tailored to the needs of local communities.

Each of the three new ACHSCP localities will include within its defined area an Aberdeen Community Planning Partnership priority locality – and the three localities will be aligned with existing city neighbourhoods.

During a comprehensive consultation on the proposal to move to three localities, respondents were overall in favour of the change and overwhelmingly agreed that more joined-up locality planning arrangements would bring big benefits. The new arrangements will be brought in over a period of time and the approach will be very much based on working closely with interested people, groups and communities.

The Capital and Services Team were worthy winners of this year's 'Team Aberdeen' HEART award. They are currently progressing a number of live projects which are aligned to key investment priorities in the NHS Grampian (NHSG) Primary Care Premises Plan 2019-2020, including:

Denburn / Aurora Project: An Outline Business Case has been approved to secure £8.1M investment to accommodate the Denburn/Aurora Medical Practice in a new Community Treatment and Care Centre.

Danestone: Work is ongoing to secure investment for the replacement of the Danestone Medical Practice to better support new models of care and introduce new professional roles across the North Locality.

The North Corridor: The Aberdeen City and Aberdeenshire IJBs, together with NHSG, are progressing an Outline Business Case to secure £19M to deliver an integrated Community Treatment and Care Centre for 13,000+ patients.

Countesswells: The IJB together with NHSG and ACC are exploring opportunities for the co-location of health and care services with Education, Community Learning and other community planning partners in a wider community campus model in the emerging Countesswells community.

The Team are also working with colleagues to develop an Infrastructure Plan by January 2020. This plan will set out strategic priorities to invest in buildings, ICT, equipment and transportation links to ensure a modern, flexible, accessible and connected estate.

The partnership undertook an evaluation of our **INCA** pilot to show how well our two teams of community nursing and care at home staff in Cove and Peterculter had fulfilled key Buurtzorg principles, namely – keeping the person at the centre, drawing on and building informal networks to support them, working in small self-managing, neighbourhood-based teams, collaborating with formal networks as required, and using an enabling approach rather than a narrow focus on time and task.

Our evaluation of this pilot showed that:

• people receiving their support from INCA greatly valued the service (mean satisfaction score 98%)

• staff retention was challenging, particularly regarding self-management, resolving conflict and a predominantly social-care caseload (due to the team's double-running with existing community nursing teams)

• a real positive was the ability to rapidly provide step-up or step-down support according to a person's individual and changing needs.

We are sure that our learning will improve our provision of flexible, person-centred and enabling care and influence the development of a multidisciplinary team approach to the rapid stepping up and down of support in localities.

The INCA evaluation, referenced above, was used as the basis for a research article by the partnership's Research and Evaluation Manager, Dr Calum Leask, in conjunction with a colleague, Andrea Gilmartin from NHS Grampian.

This article was published in a peer-reviewed and internationally read journal, AIMS Public Health. It is the first peer-reviewed piece of research that the partnership has produced and as such is hugely significant for emphasizing to a global readership the partnership's outcome-focused ambitions and priorities.

In January 2019, Independent Sector Leads from Scottish Care's Aberdeen City team met with managers from 18 out of 20 independent sector care homes in the city. The aim was to:

- scope current communication and involvement with ACHSCP
- learn about local independent care homes workforce and practice development
- gather information regarding the relationships between care homes and external organisations
- identify any next steps.

A report, "Voices from the Independent Sector Care Homes" (Link), was produced in March 2019 and this has identified areas where the partnership can work together with the independent sector to improve working relationships and ultimately positively impact outcomes for our clients, resident in care homes.

One of the Enablers in our new Strategic Plan is an Empowered Workforce. In March 2019 our IJB approved our Workforce Plan, which was co-produced with a wide variety of stakeholders and staff groups. The plan seeks to ensure a sustainable workforce with the right skills and behaviours. It acknowledges that in order to achieve the identified objectives, there is a need to:

- fundamentally change what is done, the way it is done and with whom to fully integrate services
- increase engagement of the workforce, in its widest sense, by making them feel more valued
- support staff's well-being (physical & mental)
- make work a joyful thing and increase trust with colleagues and partners

In developing the plan, we considered some of the key challenges such as an ageing population; an ageing workforce; increasing complexity; and lack of digitalisation. These challenges point to a need to engage in the potential of younger people, in order to have appropriate succession planning in place. The need to retain and train people to support the transformation of the way support is delivered is also required. Underpinning the delivery of the workforce plan is an action plan based upon four themes; Right People, Right Skills, Right Roles, and Sustainability.

During 2018-19, 73 initiatives were funded through the **Health Improvement Fund** to improve health and wellbeing in communities across Aberdeen. Projects funded have ranged from developing a woodland walk to be more accessible for the whole community; to raised beds at sheltered housing; to creating a sensory garden within a local primary school.

A celebration event was held for the first time in November 2018 as an opportunity for projects to share learning and network. Eleven projects attended to showcase their work with approximately 80 staff and community members attending. The learning from this has been used to shape further showcasing opportunities.

The Health Improvement Fund has continued to evolve by continuing to grow the decision-making process involving more frontline staff and community members. The fund has also undergone an options appraisal process to inform the future direction of the fund. A report was presented to the IJB in March 2019 sharing the journey of the fund from 2016-19. https://www.aberdeencityhscp.scot/our-news/new-report-highlights-heath-improvement-fund-successes/

**Co-production** aims to draw on the knowledge, ability and resources of people along with professionals to improve outcomes. Aberdeen City Health and Social Care Partnership decided to test out co-production approaches and worked with Governance International where staff and community members were familiarised with the Co-production Star toolkit. Locality-based projects were developed, including a focus on diabetes peer support in the South and falls prevention in the North.

The approaches supported the development of 'Stepping Forward Together' to help people self-manage their falls risk. As a result of listening to stories from service users the concept of 'falls ambassadors' emerged, their role being to visit community groups to share personal experiences, talk about ways to prevent falls and demonstrate strength and balance exercises. The ambassadors working with Occupational Therapy staff tested out this approach on a number of groups and following positive feedback applied for Health Improvement Funding to develop a model that would become sustainable.

A peer support group meeting eight-weekly at Robert Gordon University (RGU) for people living with Type 2 diabetes is another initiative that has been co-produced with the community and various partners. The Health Improvement Fund has played a key role by starting a series of development and training activities. These were identified by members of the community to develop their confidence as Peer Supporters and to sustain the peer support model in their neighbourhoods and across networks.

During 2018/19 we progressed a number of **digital initiatives** to enhance the way we work. 'Connect', the partnership's dedicated intranet, was launched in January 2019 providing a space for a range of news and information of interest to staff, from copies of the 'Partnership Matters' newsletter, to guidance documents, to social spaces and how staff can have their say. Links to Connect are also available on the NHS Grampian Intranet and Aberdeen City Councils Intranet the Zone. Connect Banner graphic available.

The GOVRoam project which gives secure wifi access across ACC and NHSG premises has been made live. This means NHS staff will have network access in places such as Marischal College and ACC staff in all NHS premises. This is part of a much wider project across Scotland so that eventually staff will have access to secure WIFI in any publicly owned building right across Scotland irrespective of the sector of local government or NHS staff work in.

A project, which was initially aimed at giving the Link Practitioners internet access at GP practices, was further widened to all NHS buildings in Aberdeen city so that staff from any of our third sector partners can have internet access while carrying out duties at NHS buildings throughout the city.

NB: need to group these together under theme headings and display better – perhaps in speech bubbles and using pictures/graphics?

# 4. Our Local Framework

The local performance management framework we had in place under our previous Strategic Plan had five themes (Safe, Effective, Responsive, Caring and Well-Led), each with its own set of locally agreed operationally focused measures. The framework gave us a baseline for improving the experiences and outcomes of the people who use our services and their carers and this chapter of our Annual Report provides the final update against this format.

With the development of our new Strategic Plan we have devised a new performance framework with a number of measures allocated across each of the five Strategic Aims – Prevention, Resilience, Personalisation, Connections, and Communities. The measures are noted in the final section of our Strategic Plan. Future Annual Reports will contain detail on our progress against these but in the meantime here are some of the highlights from the final year of our prevision strategic plan.

## SAFE: How well do our services protect people from abuse and avoidable harm?

The partnership recognises its responsibilities to keep people and communities safe from harm. Link to Biennial Report. Referrals to Adult Support and Protection and the number of complaints received are good indicators as to how well we are doing in this regard.

| **Adult Support and Protection** | **2016-17** | **2017-18** | **2018-19** |
|---|---|---|---|
| Referrals to Adult Support Unit | 1203 | 1125 | 1367 |
| Referrals requiring further adult protection action | 34% | 36% | 34% |
| Referrals requiring further non-adult protection action | 20.5% | 22% | 27% |
| Referrals requiring no further action | 45.5% | 42% | 28% |
| **Note, 153 outcomes are still as yet unknown.** | | | |
| The increase in referrals is seen as a positive in that more people are aware of Adult Support and Protection legislation and are willing to come forward with any concerns they may have. Those referrals requiring further adult protection action decreased last year and it is positive to note that an increase in referrals resulted in further non adult protection related action meaning that this process is helping us to identify and meet the needs of our vulnerable clients whatever these may be. | | | |

| **Complaints** | **2017-18** | **2018-19** |
|---|---|---|
| Stage 2 Total Received | 108 | 93 |
| Stage 2 responded to within timescale | 68% | 72% |
| NB: due to anomalies with recording we are only able to report complaints received for the last two years. The number of complaints have decreased which indicates and increase in satisfaction levels whilst the rate responded to within timescale has increased which demonstrates how seriously we take poor individual experiences and outcomes. | | |

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## Effective: How well does our care, support and treatment achieve good outcomes for individuals?

Smoking is a major contributor to poor health. Our efforts have been to provide effective care by reaching people in parts of Aberdeen where smoking is still prevalent and support them to quit.

Alcohol Brief Intervention (ABI) is a preventative approach to support a healthier relationship with alcohol. In previous years, efforts have been focused on providing ABIs in healthcare settings and government targets are set in this way. We have, however, been increasing the volume of ABIs delivered in community settings

| | 2017-18 | 2018-19 |
|---|---|---|
| Smoking Cessation (most deprived areas) | 389 | 337 |
| Number of ABIs delivered | 4043 | 4471 |
| There has been a decrease in smoking cessation in our most deprived areas. Changing priorities and the needs of a more complex 'hard to reach' client base has meant a shift of focus away from the community to more acute settings which has disrupted service provision. In line with national trends, there are also less smokers presenting to the service. It is thought this is due to the rise of the use of e-cigarettes as a quitting aid as well as again the hardest to reach client group not accessing services.<br><br>There has been a significant (more than 10%) rise in the number of ABIs delivered. A reduction in the harmful impact of alcohol, tobacco, drugs, obesity and poor oral health is a commitment we have made in our revised Strategic Plan. | | |

## Responsive: How well are services organised to meet individual needs?

Being responsive to individual needs is a critical influence on people's experiences of using our integrated health and social care services. As reported earlier, there has been a decrease in the number of delayed discharges and a significant decrease in the number of bed days occupied by those whose discharge has been delayed.

One of the strategic aims in our revised Strategic Plan is Personalisation, which is about delivering the right care, in the right place at the right time and the performance measures identified will help us demonstrate this more effectively in future.



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## Caring: How well, with respect to dignity, compassion and kindness, do we treat people?

The recently commissioned local survey aims to evaluate the impact of our deliverables within our strategic plan. Within this we also seek to understand people's satisfaction with health and social care services that we provide and whether we do so with dignity, care and respect. The results of the first survey which will be completed by Autumn 2019 will provide us with a baseline for improvement for when the survey is repeated in 2022.

## Well-Led: How well do we encourage learning, innovation and an open culture?

A workforce that feels valued and supported is a crucial piece of the jigsaw of how we improve the experiences and outcomes of the individuals who use our services and their carers. In short, high employee satisfaction contributes to improved user experiences and outcomes.

Promoting trust and autonomy is a key behaviour of a modern, adaptive organisation and one which will lead to improved staff morale and welfare. In March 2019 our IJB approved our Workforce Plan which was co-produced with a wide variety of stakeholders and staff groups. The plan seeks to ensure a sustainable workforce with the right skills and behaviours.

Our HEART Awards, our annual conference, the iMatter tool and the Chief Officer's regular 'Open Forum/'Meet the staff' focus groups and the development and launch of our new 'Connect" intranet site for staff in January 2019 are all great examples of the partnership's commitment to engage, motivate and inspire staff to do their very best each and every day.

2018/19 saw changes in our senior management structure. Our new Chief Officer, Sandra Ross started in September 2018 and implemented a flatter structure within the Leadership Team also adopting a self-managing approach. Additional supports were implemented including team development sessions, a professional link, one to one coaching, and group Action Learning Sets, all to support the Leadership Team to manage their challenging roles in a supported and positive way.

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# 5. National Health and Wellbeing Outcomes

The nine national health and wellbeing outcomes are high-level statements of what we are trying to achieve as an integrated partnership. A core set of indicators are aligned with each of the outcomes (some indicators are aligned with more than one outcome) and help show us the progress we are making in delivering high-quality, person-centred integrated services.

## How well are people in our city population looking after their own health and wellbeing?

According to the most recent statistics available for 2017, the Aberdeen City male and female life expectancies were 76.90 and 81.05 years at birth respectively, compared to 77.02 and 81.08 in Scotland. This slowdown in life expectancy improvement has affected the most deprived Scottish areas particularly, exacerbating the already very wide health inequalities.

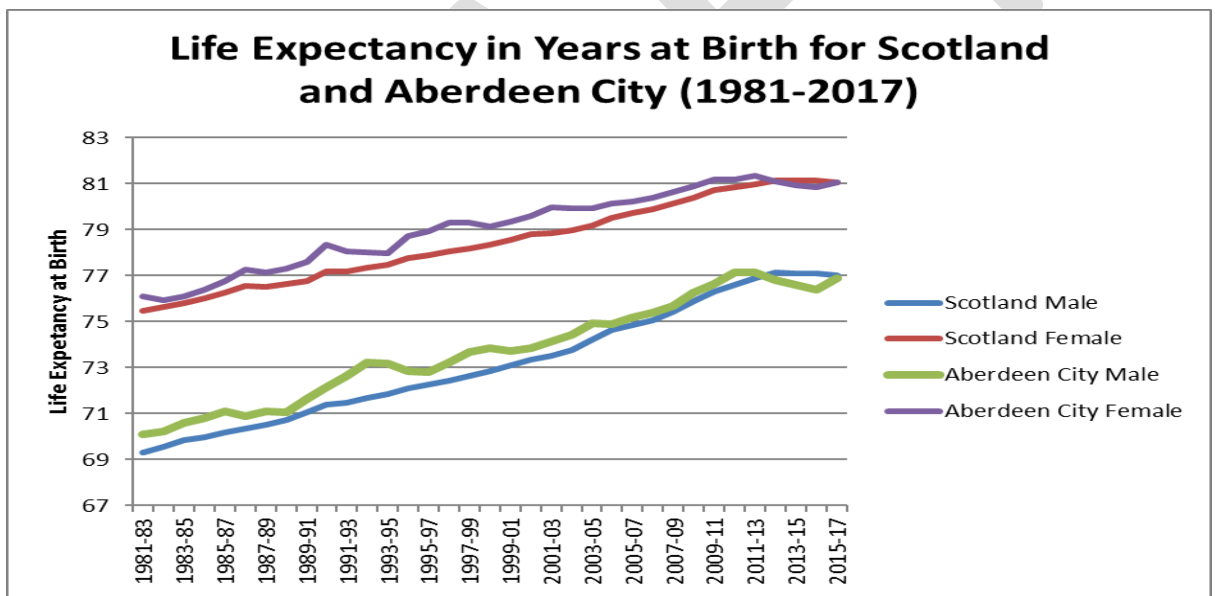


**Table 6.1 Life Expectancy in Years at birth**

Our premature mortality rate is reducing at a slower rate than the national figure. The change in national mortality trends has affected men and women, almost every age group, and almost every cause of death. It is a local concern that these avoidable deaths are mostly occurring in middle-aged people in the most deprived parts of Aberdeen. They also partially explain the worsening of life expectancy trends.

The use of hospital services in emergencies or unplanned situations gives us a good indication of the population's health and wellbeing. Our emergency admission rates per 100,000 persons have decreased and are consistently lower than the rates seen across Scotland.

## How well are vulnerable people in our city able to live independently at home or in a homely setting?

There is a basket of measures available which give us an indication about how well people with long-term conditions, frailty or disabilities cope with independent living and their reliance on formal supports and interventions. Most suggested a positive picture in this respect with only the % of adults with intensive care needs receiving care at home and the falls rate countering this impression.

- Emergency admission rates **decreased in 2018** to a level below that of the previous period.
- A **decrease** in the readmission within 28 days rate reverses to some extent the increase evident in 2017 although we are still higher than the 2016 rate.
- **Significant decrease** in the emergency bed day rate; 76,286 for 2018 compared to 82,302 for the previous reporting period.
- **Slight increase** in the proportion of last six months in home or community setting.
- **Significant decrease** in number of days people spend in hospital when they are ready to be discharged.
- **Slight decrease** in the % of health and care resource that is spent on hospital stay following emergency admission. This decrease reverses last year's increase.

However,

- **Increase** in the falls rate 65+; 17 for the 2018 period compared to 15 for the previous reporting period.
- **Slight decrease** in the % of adults with intense care needs receiving a care at home service

## How positive are the experiences of people who use health and social care services?

Improving the personal experiences of those of us who are using our integrated health and social care services is a key partnership ambition. We are making good progress in this respect given that:

- there is a **slight increase** in the proportion of last 6 months at home or in community setting
- the proportion of local care services graded good or better has **increased year-on-year**, and
- there has been a **significant decrease** in the number of days people spend in hospital when they are ready to be discharged.

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## How are services centred on improving quality of life for people?

Similarly, we believe that we are making a positive and sustained improvement to the quality of people's lives, as shown by the following:

- Emergency admission rates **decreased** in the period April – December 2018 to a level below that of the previous period.
- There was a **significant decrease** in the emergency bed day rate.
- The proportion of care services graded good, or better **has increased** year-on-year over the past three years
- There has been a **significant decrease** in the number of days people spend in hospital when they are ready to be discharged
- there has been a **slight decrease** in the % of health and care resource that is spent on hospital stay following emergency admission. This decrease reverses last year's increase.
- Increase in the falls rate 65+.

It is worth highlighting again the significant contribution that our partners in the third and independent sectors make to the quality of lives of the people who use their services and their unpaid carers. **92% of local care services being graded as 'good' or better by the Care Inspectorate is a tremendous endorsement of our commissioned provision across all client groups.**

| Quality Themes | Inspection Grades % (2017-18 %) | | | | | |
|---|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** | **6** |
| **Care and Support (wellbeing)** | **0** | **0.56** | **3.95** | **51.07** | **57.63** | **6.78** |
| **Care and Support (planning)** | **0** | **0.56** (1.66) | **4.52** (3.88) | **29.38** (23.88) | **58.76** (58.33) | **6.78** (12.22) |
| **Environment** | **0** | **1.72** (1.38) | **8.62** (6.94) | **25.86** (26.38) | **56.90** (56.90) | **6.90** (8.33) |
| **Staffing** | **0.61** (0) | **0** (2.22) | **7.36** (4.44) | **20.86** (20.00) | **60.12** (61.11) | **11.04** (12.22) |
| **Management & Leadership** | **0** | **0.62** (2.22) | **6.79** (5.00) | **30.25** (30.00) | **54.94** (52.77) | **7.41** (10.00) |

**Table 6.2 Care Inspectorate Grades (Source: Care Inspectorate)**

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This ongoing improvement is even more noteworthy when one considers that in April 2018, the Care Inspectorate launched the new Health and Social Care Standards which are significantly more rights-based, person-led and outcomes-focused than the previous standards.

There has been **a slight decrease in the past year in the number of upheld complaints and in the number of services with requirements.** More particularly, the housing support returns show a slight increase in the number of upheld complaints but a decrease in the number of services with requirements.

| Services | Number of Services with Upheld/Partially Upheld Complaints (2017-18; 2016-17) | | Number of Services with Enforcements (2017-18; 2016-17) | Number of Services with Requirements (2017-18; 2016-17) |
|---|---|---|---|---|
| Adult Placement Service | 1 | **0** (0; 0) | **0** (0; 0) | **0** (0; 0) |
| Care Home Service | 58 | **6** (8; 7) | **0** (1; 0) | **5** (5; 6) |
| Housing Support Service | 56 | **4** (3; 3) | **0** (0; 0) | **2** (5; 5) |
| Nurse Agency | 8 | **0** (0; 0) | **0** (0; 0) | **0** (0; 0) |
| Support Service | 59 | **3** (4; 1) | **0** (0; 0) | **1** (0; 0) |
| **Total** | **182** | **13 (15; 11)** | **0 (1; 0)** | **8 (10; 11)** |

**Table 6.3: Complaints, Enforcements & Requirements (Source: Care Inspectorate)**

**We are the fourth best ranked partnership in the country for the quality of our commissioned services** but we are mindful that other factors can impact on the quality and continuity of care that is delivered in our name. We have a dedicated team of Social Care Contract Managers and a robust process for contract management and coupled with our focus on improving commissioning relationships and working in a more collaborative and supportive way, and the concerted efforts of our providers and the organisations that support them such as Scottish Care and Aberdeen Council for Voluntary Organisations, we believe this impacts positively on this measure. We will never be complacent about this and will always intervene in the best interests of those individuals who are receiving care.

## How well are we helping to reduce health inequalities?

We are aware that there are enduring health inequalities in the city. The indicators aligned with this outcome (premature mortality rate and emergency admission rate) **both show improvements from previous years and have favourable comparisons with** their equivalent national figures.

Improving the accessibility of our services and understanding the impact of our interventions with these population groups will help us tackle health inequalities and we have made addressing the factors that cause inequality in outcomes in and across our communities a specific commitment in our refreshed Strategic Plan.

## How well are carers supported?

Improving our support for unpaid carers has been a pivotal ambition of the partnership from its early days. In comparison with the extent of positive feedback from the people who use our services, carers feedback is much lower both in Aberdeen and also across Scotland as a whole.

We are confident that the implementation of our new Carers Strategy will result in better experiences and outcomes and an improved opinion of how their role is perceived and supported. During 2018/19 we commissioned a local survey of Carers which was a repeat of the exercise we undertook when we were developing our strategy. Our Carers Strategy Implementation Group is tasked with understanding the responses to the survey and leading on their expected improvement.

## How well do we keep people safe from harm?

Many of the measures described in the earlier sections also give an indication of how well we protect people from harm. The decrease in the emergency admission rate, the emergency bed day rate, readmission within 28 days rate and the % of health and care resource that is spent on hospital stay coupled with an increase in the proportion of care services graded good suggests we are moving in the right direction. We recognise however that we need to understand better why our falls rate is increasing year on year.

## How well do staff feel engaged and supported to improve the care they provide?

The “iMatter” feedback tool continues to be a key means of providing a measure of engagement, communication and motivation across the partnership.

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**The response to last year's questionnaire was 68% which is up slightly on the previous year when it was 65%. Our Employee Engagement Index score (EEI), which represents how engaged our employees are, was 78, the same as the previous year. Overall, employees rated working with the partnership as 7.05 out of 10, an increase from 6.94 the previous year.**

The partnership has a Joint Staff Forum to discuss matters of common interest and concern to staff and their representatives. It provides a platform to develop constructive working relationships to ensure that our staff are at the centre of plans for the on-going development of our organisation.

In the past year the Forum has provided an "open" communication channel on a range of transformational activity; provided IJB feedback on key strategic documents; decided HEART Award Winners in two categories and overseen adherence to Organisational Change Policy.

An open call went out to all staff to ask for volunteers to be engagement ambassadors. A few workshops were held with staff from different areas of the partnership, which, as well helping to shape the Organisational Development plan and identifying potential actions, the group also discussed ideas on how better to engage with staff in general.

## How well do we use our resources?

The IJB has a responsibility under the Public Bodies (Joint Working) (Scotland) Act 2014 to set a balanced budget. The funds for the IJB are delegated from Aberdeen City Council (ACC) and NHS Grampian (NHSG) with the purpose of delivering the IJB's Strategic Plan.

**The level of funding delegated to the IJB from its statutory partners at the start of the 2018/19 financial year was £315,156,732, an increase of £12,301,270.**

The funding contributions from the partners exclude any funding which is ring-fenced for the provision of specific services, such as that provided for Criminal Justice.

Table 4.4 shows the respective contributions made by our partner organisations, NHS Grampian and Aberdeen City Council.

| Total Partner Funding £<br>2017-18; 2016-17 | NHS Grampian £<br>2017-18; 2016-17 | Aberdeen City Council £<br>2017-18; 2016-17 |
|---|---|---|
| **315,156,732**<br>302,855,462; 310,740,247 | **228,300,813**<br>217,686,633; 222,584,000 | **86,855,919**<br>85,168,829; 88,156,247 |

**Table 6.4 Delegated funding to IJB**

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The breakdown of spend across all of our activities in 2017-18 is shown in Table 6.5.

| Sector | Gross expenditure £ 2018-19 | Gross Expenditure £ 2017-18;2016-17 |
|---|---|---|
| Older People, Physical and Sensory Impairments | 74,255,297 | 72,882,926; 69,719,818 |
| Set Aside Services | 46,416,000 | 41,344,000; 46,732,000 |
| Primary Care Prescribing | 40,316,656 | 41,364,343; 40,005,916 |
| Primary Care | 38,885,208 | 37,234,075; 36,846,589 |
| Learning Disabilities | 34,621,408 | 31,269,790; 29,264,461 |
| Community Health Services | 31,594,608 | 31,406,760; 31,649,313 |
| ACHSCP share of Hosted Services | 22,330,324 | 21,724,509; 21,207,851 |
| Mental Health and Substance Misuse | 19,992,884 | 20,065,177; 18,304,741 |
| Transformation | 5,652,732 | 5,011,678; 2,856,283 |
| Criminal Justice | 5,110,341 | 4,658,796; 4,413,345 |
| Housing | 1,860,555 | 1,860,555; 2,197,288 |
| Out of Area Placements | 1,689,920 | 1,480,487; 1,219,506 |
| Head Office/Admin | 171,352 | 475,319; 1,007,021 |
| **Cost of Services** | **322,897,286** | **309,827,777; 305,424,132** |

**Table 6.5 Expenditure breakdown by sector 2018-19**

The accounts for the year ended 31 March 2019 show a usable reserves position of £5,578,337. This is largely due to additional funding received in 2016/17 from the Scottish Government which the IJB is using on integration and change projects. A significant element of these funds has been committed and used in 2018/19. All of the recurring funding has now been allocated and the IJB had agreed through its Medium-Term Financial Framework to use these funds in 2017/18, hence the reduction.

| Total Reserves £ 2018-19 | Total Reserves £ 2017-18; 2017-16 |
|---|---|
| **5,578,337** | **8,306,965; 10,417,474** |

**Table 6.6 IJB Reserves**

The IJB has a notional budget representing the use of acute health services by the city's residents. It is envisaged that effective integrated service provision in our communities and localities will, over time, reduce the use of these acute health services. NHS Grampian has advised that for the past year, the partnership's use of these services had slightly increased as indicated below and that there had also been a budget increase due to movements in the price per bed days for the services.

| Set Aside | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|
| Budget | £46,732,000 | £41,344,000 | £46,416,000 |
| Days used | 152,498 | 142,349 | 143,055 |

**Table 6.7 Set Aside Budgets and Usage**

Further work is being undertaken to determine possible explanations for the increase in the bed usage.

A proposed budget for 2019/2019 which outlined budget pressures, budget reductions and an indicative budget position for the next five financial years was presented to a special meeting of the IJB on 12 March 2019 by the Chief Finance Officer.

The proposed balanced budget was approved.

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# 7. Looking Forward

Our overall performance this past year has been positive. We are pleased that our continuing efforts to reduce the number of delayed discharges is progressing well in the right direction. We are the fourth best ranked partnership in the country for the % of care services which are graded 'good' or better and our readmissions rate within 28 days has improved from its red status last year.

We recognise that there is still much to do. Two indicators - the percentage of adults with intensive care needs receiving care at home and the number of A&E attendances - give us cause for concern and they will be the focus of investigation and improvement activity this coming year. We will use the results of our local survey to identify areas that we would wish to target for improvement and will look for evidence of that improvement to report in future years.

We need to work with both Aberdeen City Council and NHS Grampian staff to develop a single reporting system that allows us to sensibly report on partnership complaints and compliments and staff-related data such as sickness absence and turnover. We are excited to be launching the integration level Care Opinion module which will allow users of commissioned services to feedback their experiences on-line and we look forward to being able to report on this and using it to inform future service delivery.

The range and complexity of transformational activities that we are progressing this year has grown and diversified but we recognise that many of our changes are designed for the long term and so their impact will not be readily apparent to us just yet. We hope our new Leadership Team structure supported by our Workforce Plan will equip us for this challenge.

Sustainable improvements can only be achieved by a strong and continued focus on innovation, improvement and accountability across the whole health and social care workforce. As an organisation, we are looking at what we do and how we do it in order to be more effective and efficient. We are embarking on an improvement programme known as SWIFT - Supporting Workforce Improvement for Tomorrow. Staff have been trained in Lean Six Sigma performance improvement techniques and these will be employed in improvement projects that have been identified and supported by staff themselves. We hope to be able to report on the improvements achieved in our next Annual Report.

As mentioned earlier, the IJB approved our new Strategic Plan 2019-2022 in March. This plan has five Strategic Aims (Prevention; Resilience; Personalisation; Connections and Communities) and against each a number of commitments have been made and priorities identified. These capture the range of activities and developments that we will put in place to promote the health and wellbeing of our

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local population and the services that we provide to maximise this wherever possible.

A Strategic Implementation Dashboard has been developed showing the alignment between desired activities, objectives and themes. This plan also identifies which colleague in the Leadership Team has a responsibility for implementing that activity and the timescale for this. Their progress will be monitored on a quarterly basis by the Chief Officer. Strategic Performance Indicators incorporating local and national indicators have been aligned to each of the Strategic Aims and next year's Annual Report will articulate the degree to which the Strategic Plan's year one priorities have been delivered along with progress made towards subsequent years commitments.

Finally, we will seek to make significant progress on our MSG Self-Evaluation Action Plan aiming for 100% rated at exemplary level.

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Aberdeen City Health & Social Care Partnership

*A caring partnership*

# Appendix A - Performance Summary (National Indicators)

*If Current position is the same or better than Scotland then "Green"*

*If Current position is worse than Scotland but within 5% then "Amber"*

*If Current position is worse than Scotland by more than 5% then "Red"*

| Indicator | Title | Aberdeen City | | | Scotland | RAG |
|---|---|---|---|---|---|---|
| | | % 2013-14 | % 2015-16 | % 2017-18 | % 2017-18 | |
| NI - 1 | Percentage of adults able to look after their health very well or quite well | 96 | 97 | 94 | 93 | |
| NI - 2 | Percentage of adults supported at home who agreed that they are supported to live as independently as possible | 82 | 80 | 82 | 81 | |
| NI - 3 | Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided | 86 | 76 | 79 | 76 | |
| NI - 4 | Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated | 80 | 74 | 76 | 74 | |
| NI - 5 | Total % of adults receiving any care or support who rated it as excellent or good | 83 | 77 | 83 | 80 | |
| NI - 6 | Percentage of people with positive experience of the care provided by their GP practice | 85 | 84 | 82 | 83 | |
| NI - 7 | Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life | 83 | 79 | 79 | 80 | |
| NI - 8 | Total combined % carers who feel supported to continue in their caring role | 42 | 38 | 40 | 37 | |
| NI - 9 | Percentage of adults supported at home who agreed they felt safe | 82 | 80 | 84 | 83 | |

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| Indicator | Title | Aberdeen City | | | Scotland | RAG |
|---|---|---|---|---|---|---|
| | | % 2013-14 | % 2015-16 | % 2017-18 | % 2017-18 | |
| NI - 10 | Percentage of staff who say they would recommend their workplace as a good place to work | 76% 2017 | 76% 2018 | 76% 2019 | - | |
| NI - 11 | Premature mortality rate per 100,000 persons *(European age-standardised mortality rate per 100,000 for people aged under 75)* | 464 (2015) | 460 (2016) | 423 (2017) | 425 (2017) | |
| NI - 12 | Emergency admission rate (per 100,000 population) | 7,526 (Apr-Dec 2016) | 7,672 (Apr-Dec 2017) | 7,627 (Apr-Dec 2018) | 9,154 (Apr-Dec 2018) | |
| NI - 13 | Emergency bed-day rate (per 100,000 population). | 85,564 (Apr-Dec 2016) | 82,302 (Apr-Dec 2017) | 76,286 (Apr-Dec 2018) | 87,034 (Apr-Dec 2018) | |
| Ni - 14 | Readmission to hospital within 28 days (per 1,000 population) | 104 (Apr-Dec 2016) | 117 (Apr-Dec 2017) | 115 (Apr-Dec 2018) | 103 (Apr-Dec 2018) | |
| Ni - 15 | Proportion of last 6 months of life spent at home or in a community setting | 89% (2016-17) | 89% (2017-18) | 90% (2018-19) | 89% (2018-19) | |
| NI - 16 | Falls rate per 1,000 population aged 65+ | 15 (Apr-Dec 2016) | 15 (Apr-Dec 2017) | 17 (Apr-Dec 2018) | 17 (Apr-Dec 2018) | |
| NI - 17 | Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections | 86% (2016-17) | 90% (2017-18) | 92% (2018-19) | 82% (2018-19) | |
| NI - 18 | Percentage of adults with intensive care needs receiving care at home | 53% (2015) | 55% (2016) | 54% (2017) | 61% (2017) | |
| NI - 19 | Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) | 1,155 (2016-17) | 838 (2017-18) | 605 (2018-19) | 805 (2018-19) | |
| NI -20 | Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency | 26% (Apr-Dec 2016) | 26% (Apr-Dec 2017) | 24% (Apr-Dec 2018) | 22% (Apr-Dec 2018) | |
| NI - 21 | Percentage of people admitted to hospital from home during the year, who are discharged to a care home | - | - | - | - | - |

| Indicator | Title | Aberdeen City | | | Scotland | RAG |
|---|---|---|---|---|---|---|
| | | % 2013-14 | % 2015-16 | % 2017-18 | % 2017-18 | |
| NI - 22 | Percentage of people who are discharged from hospital within 72 hours of being ready | - | - | - | - | - |
| NI - 23 | Expenditure on end of life care, cost in last 6 months per death | - | - | - | - | - |

## Appendix A - Performance Summary (MSG Indicators)

| Indicators | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2018-19 |
|---|---|---|---|---|---|
| Number of emergency admissions (18+) | 21,883 | 21,401 | 21,837 | 21,375 | |
| Number of unscheduled bed-days (acute; 18+) | 154,443 | 144,702 | 140,935 | 120,374 | |
| Number of unscheduled bed-days (mental health) | 66,559 | 63,078 | 61,031 | 56,302 | |
| Number of A&E attendances (18+) | 35,314 | 35,046 | 35,838 | 36,248 | |
| Delayed Discharge bed days (all ages) | 43,944 | 27,353 | 19,202 | 13,172 | |

| | | | | | |
|---|---|---|---|---|---|
| % of last six months of life spent in community setting (inc care homes). | 88.1% | 88.9% | 88.6% | N/K | |
| Balance of care; % of 75+ population in community settings. | 95.3% | 95.5% | 95.6% | N/K | |

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