NOTE: YEARS DISPLAYED AS FY ARE THE YEAR IN WHICH THE FINANCIAL YEAR ENDS (IE FY2025 COVERS APR 2024 - MAR 2025)

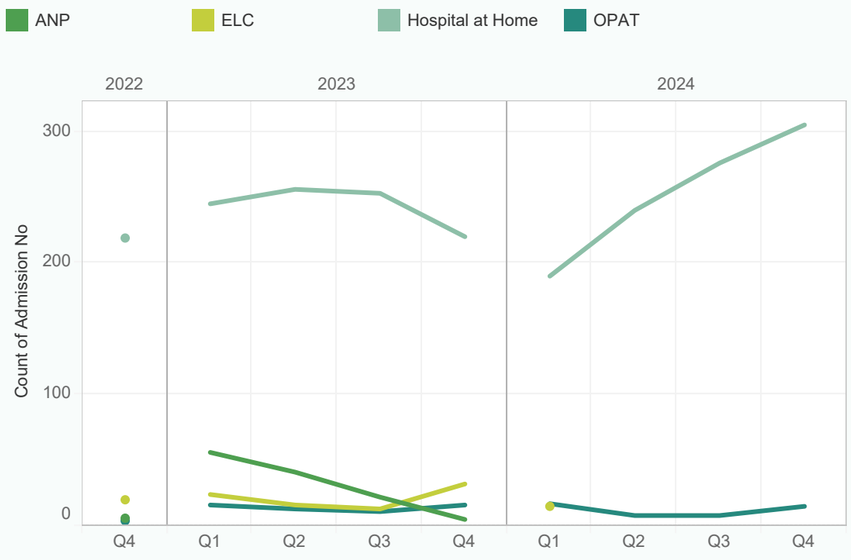
ACHSCP - DELIVERY PLAN YEAR 3 PERFORMANCE REPORTING

DATA SUPPLIED FOR MANAGEMENT INFORMATION PURPOSES ONLY

FLEXIBLE BED BASE

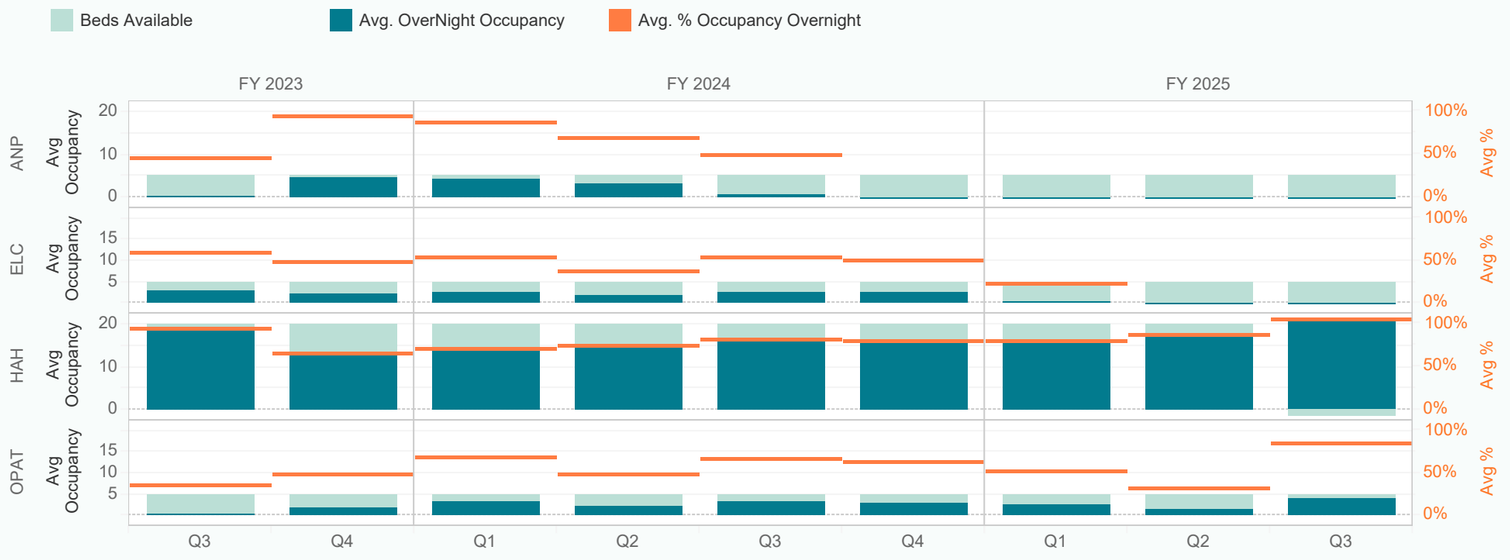
Hospital at Home Admissions (Ward Starts)

	FY 2022 Q4	FY 2025 Q3
Hospital at Home	187	305
		▲ 118
Hospital at Home - ELC	13	
		▼ -13
Hospital at Home - OPAT		15
		▲ 15



Hospital At Home Capacity and Occupancy - Latest Quarter vs Baseline

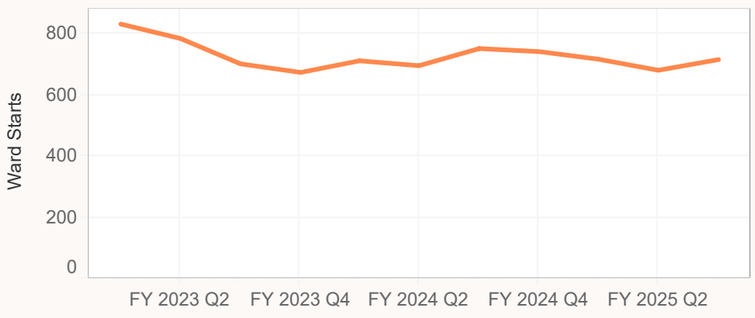
	Average Allocated Beds Available		Average Overnight Occupancy		Average % Occupancy	
	FY 2022 Q4	FY 2025 Q3	FY 2022 Q4	FY 2025 Q3	FY 2022 Q4	FY 2025 Q3
ANP		5.00	0.00	0.00		
		▲ 5.00		● 0		● 0.0%
ELC	5.00	5.00	1.63	0.00	38.2%	
		● 0		▼ -1.63		▼ -38.2%
HAH	20.00	20.00	10.51	21.26	52.6%	106.3%
		● 0		▲ 10.75		▲ 53.7%
OPAT		5.00	0.00	4.30		86.1%
		▲ 5.00		▲ 4.30		▲ 86.1%



FRAILTY

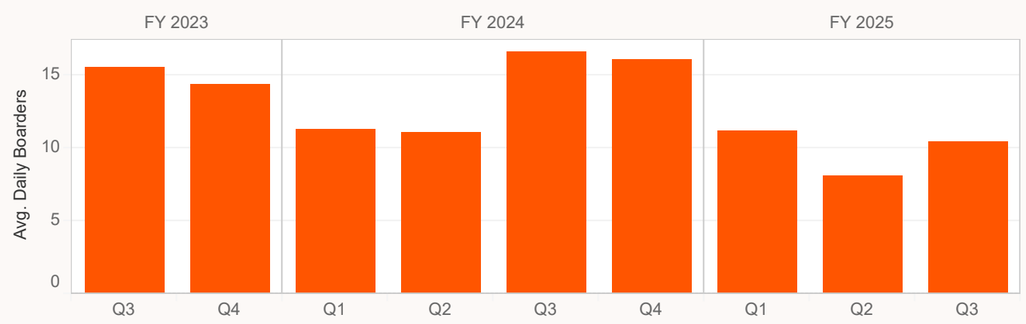
Ward 102 Ward Starts (Admissions)

	FY 2022 Q4	FY 2025 Q3
Ward 102, ARI	816	716
		▼ -100



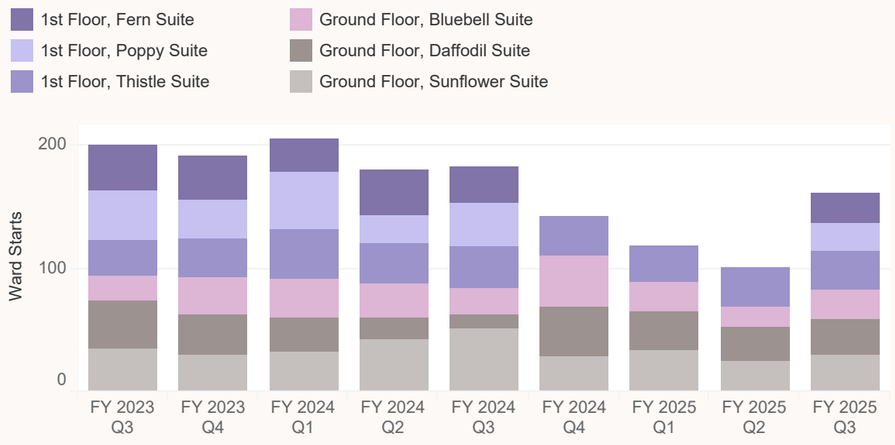
Ward 102 Average Daily Boarders

FY 2022 Q4	FY 2025 Q3
15.7	10.4
	▼ -5.3



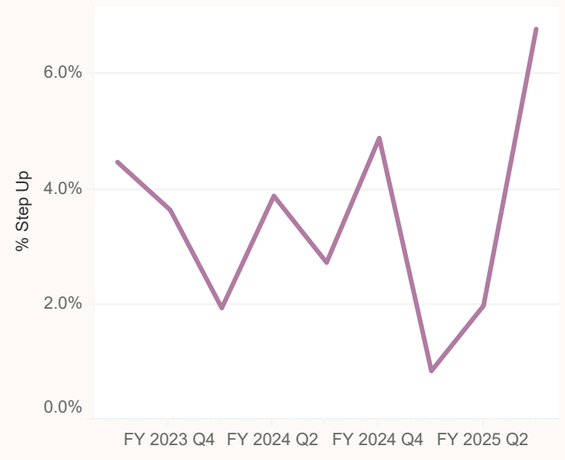
Rosewell House Ward Starts

	FY 2022 Q4	FY 2025 Q3
1st Floor, Fern Suite	26	24
		▼ -2
1st Floor, Poppy Suite	42	23
		▼ -19
1st Floor, Thistle Suite	39	32
		▼ -7
Ground Floor, Bluebell Suite	17	24
		▲ 7
Ground Floor, Daffodil Suite	18	29
		▲ 11
Ground Floor, Sunflower Suite	35	30
		▼ -5



Rosewell House % Step Up (Based on IsFirstWard=1 or Previous Ward Desc-'Hospital at Home' derived from Trakcare for each Admission)

	FY 2022 Q4	FY 2025 Q3
1st Floor, Fern Suite	7.69%	8.33%
		▲ 0.64%
1st Floor, Poppy Suite	7.14%	0.00%
		▼ -7.14%
1st Floor, Thistle Suite	5.13%	12.50%
		▲ 7.37%
Ground Floor, Bluebell Suite	5.88%	0.00%
		▼ -5.88%
Ground Floor, Daffodil Suite	16.67%	10.34%
		▼ -6.32%
Ground Floor, Sunflower Suite	0.00%	6.67%
		▲ 6.67%

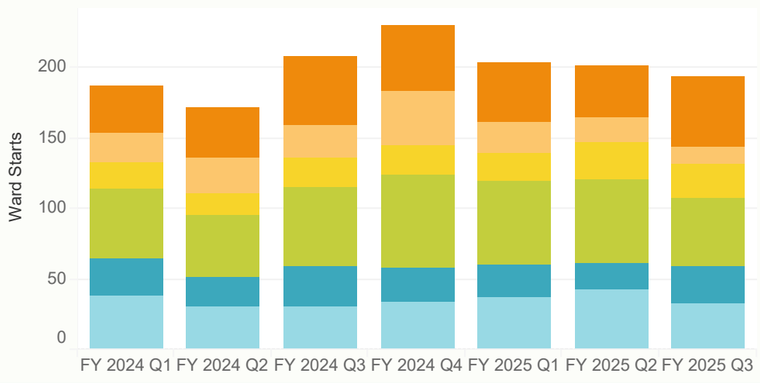


REHABILITATION REVIEW

Links Unit · Morningfield House · Neuro Rehab Unit · Orthopaedic Rehab Unit · Stroke Unit East · Stroke Unit West

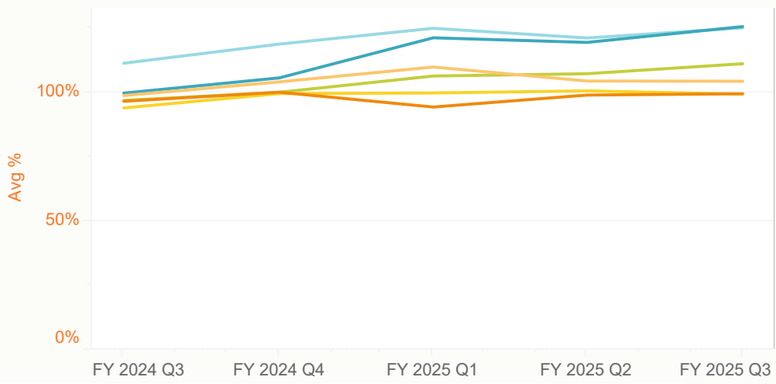
SOARS Ward Starts (Admissions)

	FY 2022 Q4	FY 2025 Q3
Links Unit	53	50
		▼ -3
Morningfield House	41	12
		▼ -29
Neuro Rehab Unit	23	24
		▲ 1
Orthopaedic Rehab Unit	52	49
		▼ -3
Stroke Unit East	34	26
		▼ -8
Stroke Unit West	27	33
		▲ 6



SOARS Average Occupancy

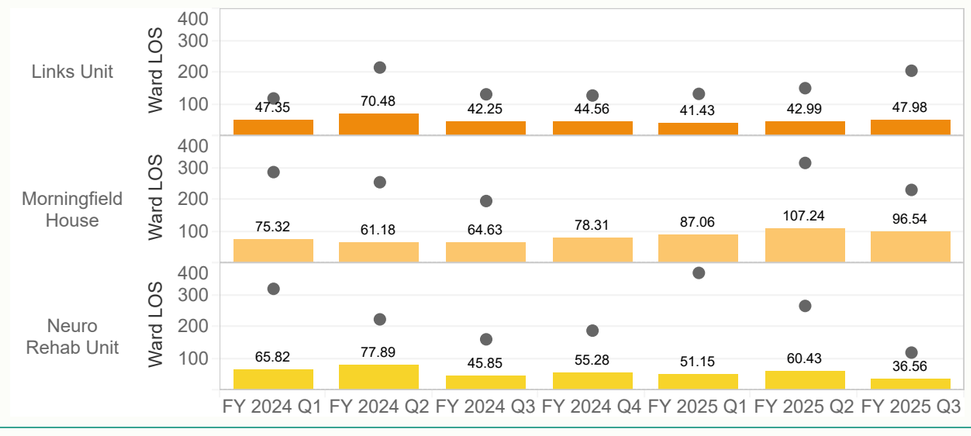
	FY 2022 Q4	FY 2025 Q3
Links Unit	101.3%	99.4%
		▼ -1.9%
Morningfield House	96.8%	104.3%
		▲ 7.5%
Neuro Rehab Unit	107.6%	99.3%
		▼ -8.4%
Orthopaedic Rehab Unit	86.5%	111.1%
		▲ 24.6%
Stroke Unit East	79.1%	125.5%
		▲ 46.3%
Stroke Unit West	99.5%	125.0%
		▲ 25.5%



SOARS Average LOS

	FY 2022 Q4	FY 2025 Q3
Links Unit	39.52	47.98
		▲ 8.5
Morningfield House	26.29	96.54
		▲ 70.3
Neuro Rehab Unit	17.02	36.56
		▲ 19.5
Orthopaedic Rehab Unit	28.43	34.59
		▲ 6.2
Stroke Unit East	39.76	74.40
		▲ 34.6
Stroke Unit West	40.67	47.93
		▲ 7.3

Denotes Max LOS

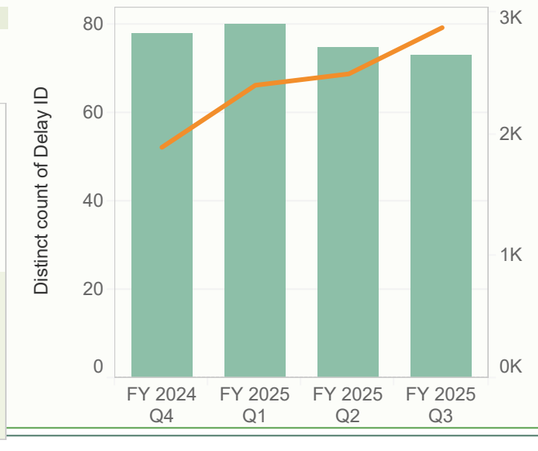


Denotes Max LOS

Delayed Discharges - SOARs Ward Codes at Snapshot (Note Ward102 delays not included)

Bed Days Monthly · Distinct Count of Delay

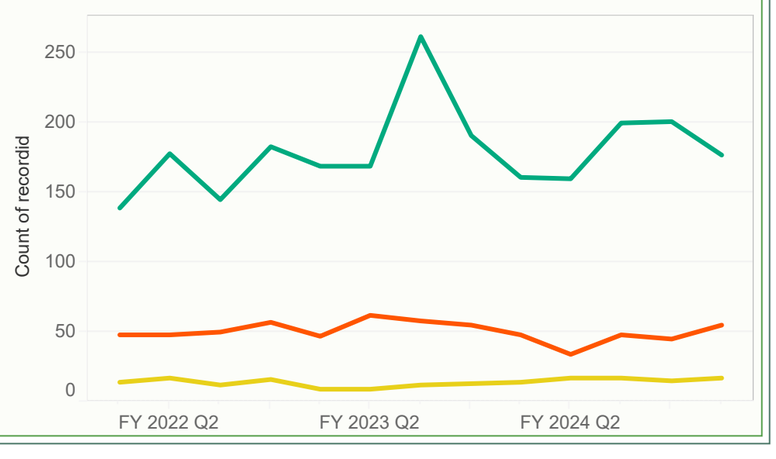
Delays			Bed Days Monthly		
	FY 2022 Q3	FY 2025 Q3		FY 2022 Q3	FY 2025 Q3
Woodend General Hospital	50	73	Woodend General Hospital	928	2,880
		▲ 23			▲ 1,952



Datix Falls (All Falls Indcidents Categorised to ABCITY Orgainisation)

HARM · NMISS · NOHARM

	FY 2022 Q4	FY 2025 Q3
HARM	57	55
		▼ -2
NMISS	16	16
		● 0
NOHARM	183	178
		▼ -5



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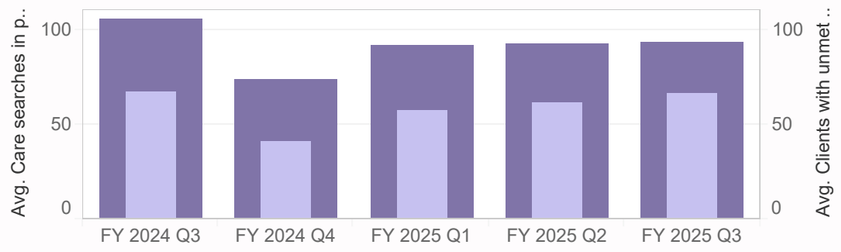
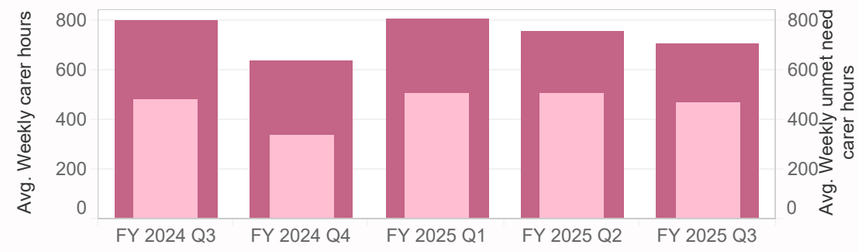
SOCIAL CARE PATHWAYS

OPEN CASES AND UNMET NEED (14+ DAYS OPEN)

	FY 2022 Q4	FY 2025 Q3
Avg. Care searches in place	283.3	93.8
		▼ -189
Avg. Clients with unmet needs	152.5	66.5
		▼ -86.1

	FY 2022 Q4	FY 2025 Q3
Avg. Weekly carer hours	2,756	707
		▼ -2,048.2
Avg. Weekly unmet need carer hours	1,225	467
		▼ -758.1



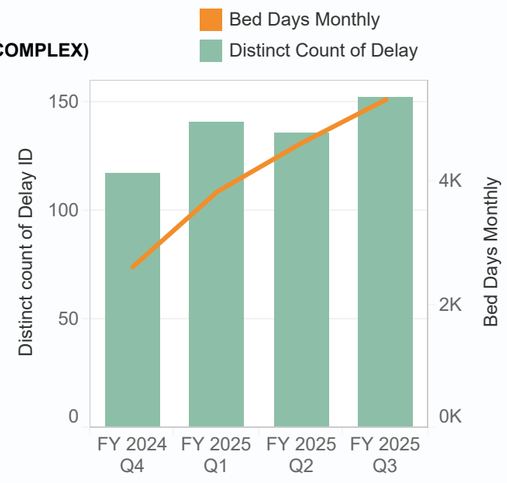


HOME PATHWAYS

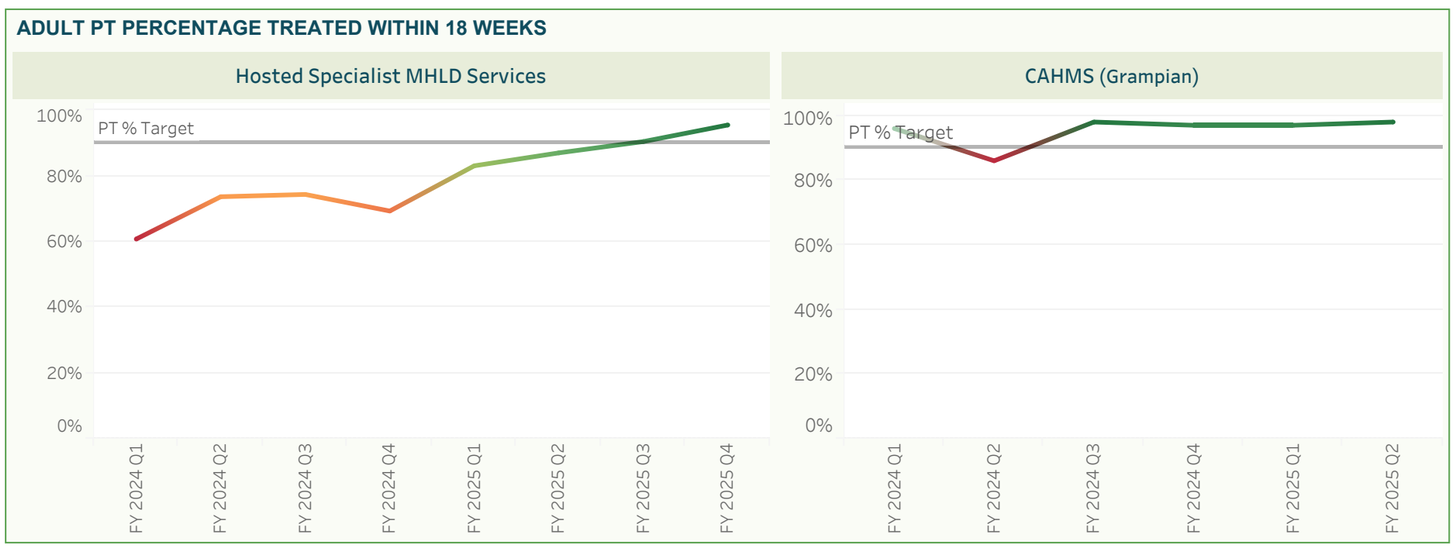
DELAYED DISCHARGES (STANDARD AND COMPLEX)

	FY 2022 Q3	FY 2025 Q3
Standard	91	138
		▲ 47
Complex-Code 9	11	17
		▲ 6

	FY 2022 Q3	FY 2025 Q3
Standard	1,258	4,478
		▲ 3,220
Complex-Code 9	367	871
		▲ 504



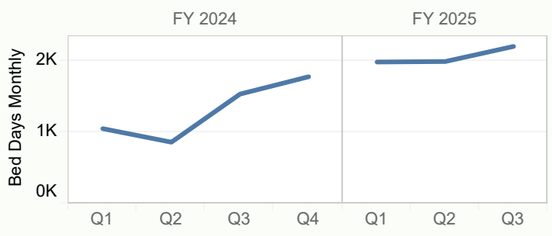
ADULT PT PERCENTAGE TREATED WITHIN 18 WEEKS



MHLD TRANSFORMATION

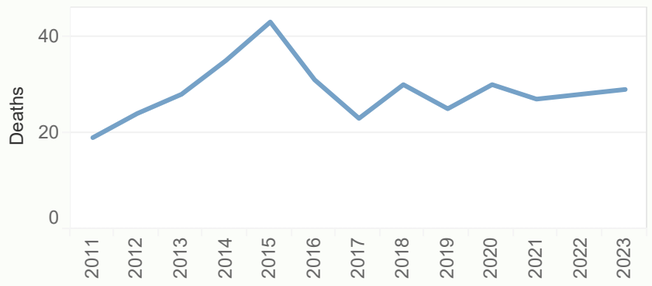
MHLD DELAYED BED DAYS (RCH, GREAT WESTERN LODGE & POLMUIR REHAB)

	FY 2022 Q4	FY 2025 Q3
Code 9 reasons	70	1,340
		▲ 1,270
Health and social care reasons	233	870
		▲ 637



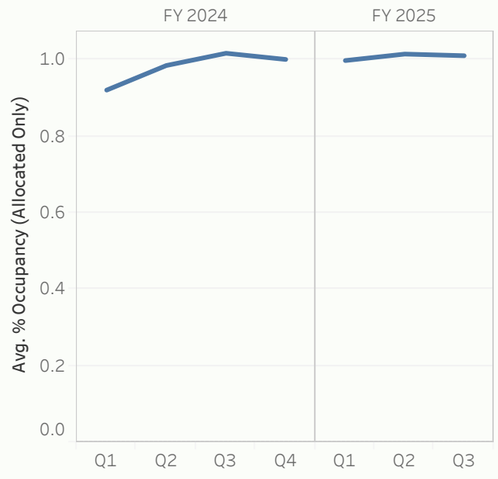
PROBABLE SUIICIDES

2022	2023
28	29
	▲ 1



MH AVERAGE OVERNIGHT OCCUPANCY (LISTED WARDS ONLY)

	FY 2022 Q4	FY 2025 Q3
Avg. % Occupancy (Allocated Only)	78.5%	98.6%
Difference		▲ 20.1%



	FY 2022 Q4	FY 2025 Q3
Brodie Ward, RCH	76.9%	97.8%
		▲ 20.9%
Corgarff Ward, RCH	75.5%	95.7%
		▲ 20.2%
Davan Ward, RCH	0.0%	109.3%
		▲ 109.3%
Dunnottar Ward, RCH	95.7%	104.5%
		▲ 8.8%
Eden Ward, RCH	65.6%	72.7%
		▲ 7.2%
Forensic Acute, RCH	111.7%	97.7%
		▼ -14.0%
Forensic Rehab Ward, RCH	99.5%	107.1%
		▲ 7.6%

	FY 2022 Q4	FY 2025 Q3
Fraser Ward, RCH	97.6%	108.5%
		▲ 10.9%
Fyvie Ward, RCH	93.7%	108.7%
		▲ 15.0%
Huntly Ward, RCH	90.1%	112.4%
		▲ 22.4%
IPCU, RCH	74.3%	84.5%
		▲ 10.2%
Loirston Ward, RCH	99.3%	122.6%
		▲ 23.3%
Muick Ward, RCH	0.0%	107.4%
		▲ 107.4%
Skene Ward, RCH	96.5%	102.6%
		▲ 6.1%
Strathbeg Ward, RCH	78.8%	85.6%
		▲ 6.8%

	FY 2022 Q4	FY 2025 Q3
Great Western Lodge	100.0%	99.2%
		▼ -0.8%
Polmuir Rehab	59.1%	74.8%
		▲ 15.7%

STRATEGY

SUITABLE HOMES

	Major Adaptations	Minor Adaptations
2019/20	410	654
2020/21	63	295
2021/22	156	610
2023/24	184	1,234

* 2024/25 latest available figures as of Sept 2024, other years are as at end of March

	Community Alarm & Telecare package	Very Sheltered Housing
2018/19	2,803	2,382
2019/20	3,105	2,382
2020/21	2,543	2,382
2021/22	2,607	2,382
2022/23	2,607	2,382
2024/25 (*p)	2,818	

ADULT CARERS SUPPORTED

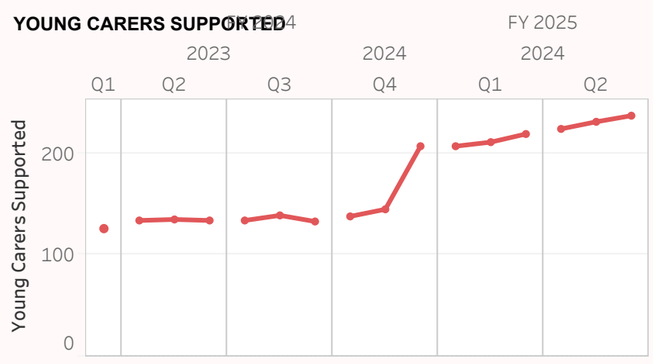
Jan-Mar Figures for given year

2021/22	2022/23	2023/24
594	1018	1435

2024/25 Latest (Jul-Sept)

1682

YOUNG CARERS SUPPORTED

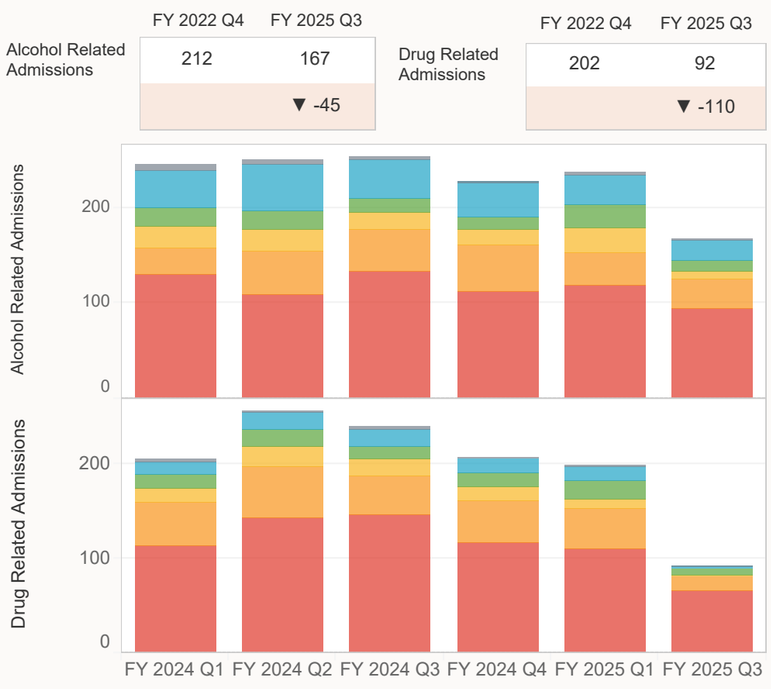


PREVENTION

ALCOHOL AND DRUG RELATED ADMISSIONS

	FY 2022 Q4	FY 2025 Q3
Alcohol Related Admissions	212	167
		▼ -45

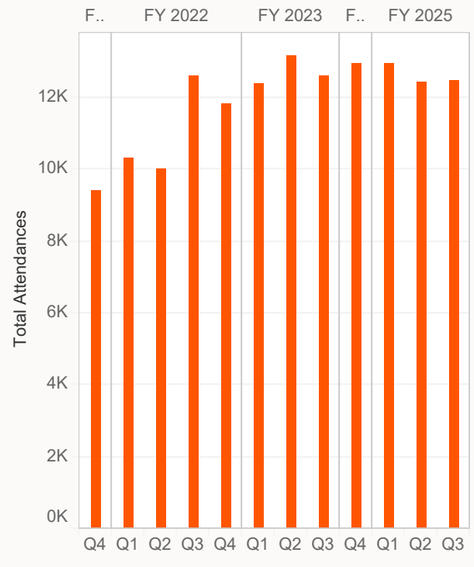
	FY 2022 Q4	FY 2025 Q3
Drug Related Admissions	202	92
		▼ -110



SEXUAL HEALTH - TOTAL CLINIC ATTENDANCES

(inc Phone, Virtual & F2F)

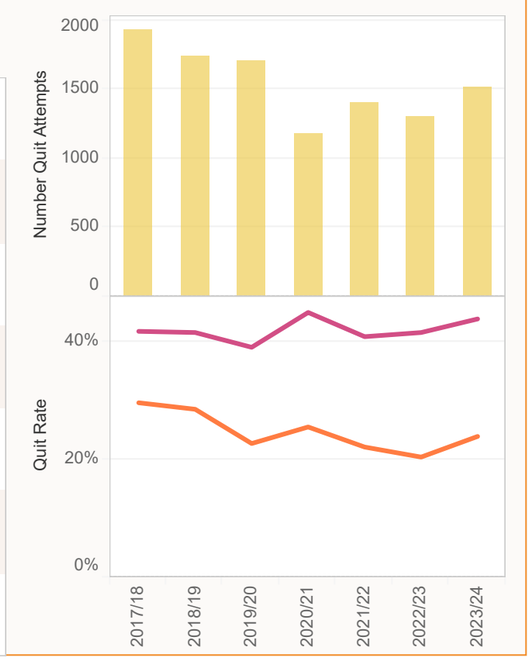
FY 2022 Q4	FY 2025 Q3
11,805	12,454
	▲ 649



SMOKING CESSATION

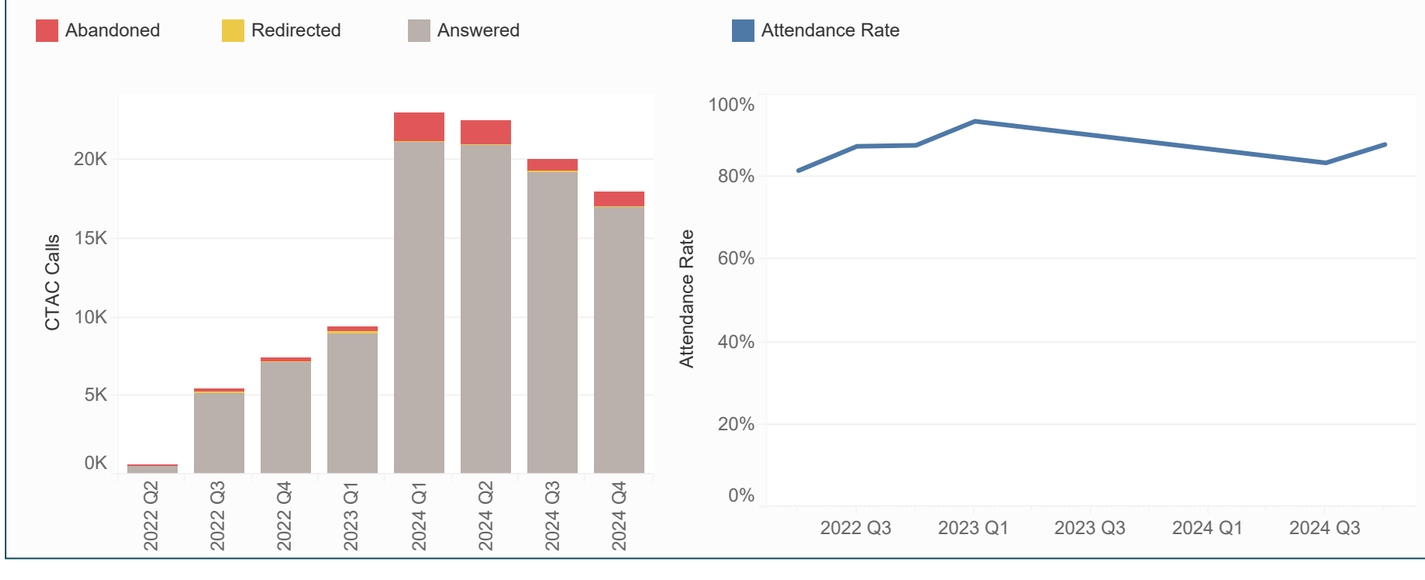
Four Week Quit Rate Twelve Week Quit Rate

	Number Quit Attempts	Four Week Quit Rate	Twelve Week Quit Rate
2023/24	1,517	43.8%	23.9%
2022/23	1,302	41.5%	20.4%
2021/22	1,401	40.8%	22.1%
2020/21	1,175	44.9%	25.5%
2019/20	1,712	39.0%	22.7%
2018/19	1,740	41.5%	28.5%
2017/18	1,936	41.7%	29.6%

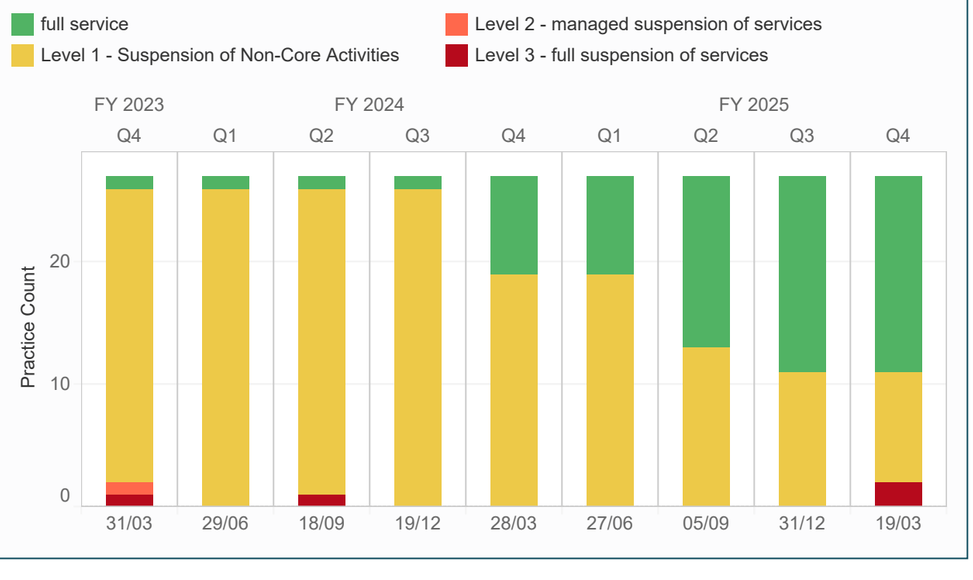


PRIMARY CARE

COMMUNITY TREATMENT AND CARE- (CTAC)



PRIMARY CARE STABILTY LEVELS (Non-standard update frequency, Snapshot of last update each quarter)



DEFINITIONS

METRICS USED

Datix	**Falls**	This is taken from DATIX as all falls listed under the ABCITY organisation where the incident result is provided as HARM/NO HARM/NEAR MISS.
Delayed Discharges	**Complex Delays**	A delay meeting the definition for delayed discharge for which the reason for delay is considerd a 'Complex' reason (full delay reason codes available via PHS). These are typically delays where the HSCP has less control (i.e. Adults with Incapacity, Guardianship, Specialist Facility requirements).
	Delayed Discharges	A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge, and who continues to occupy the bed beyond the ready for discharge date and 48 hours after social work has been contacted. It is very important that, while the clinician in charge has ultimate responsibility for the decision to discharge, the decision must be made as part of a multi-disciplinary process and focuses on the needs of the individual patient.
	Monthly Bed Days	The total number of bed days in a month occupied by a delayed discharge. Note this is not the total length of delay.
	Standard Delays	A delay meeting the definition for delayed discharge for which the reason for delay is considerd a 'Standard' reason (full delay reason codes available via PHS).
Hospital at Home	**Allocated Beds Available**	Allocated beds is pulled directly from the applicable field in Trakcare for that ward.
	Average % Occupancy	Calculated using the overnight occupancy for a given ward or group of wards divided by the allocated beds available for the applicable ward(s), given as a percentage.
	Hospital at Home Admissions	Admission to Hospital at Home wards from anywhere in the system at any point during a patients stay, including transfers from any other ward/locations as well as first ward admissions for the given date range. Individuals who have multiple movements into the ward in a date range are counted for both movements.
	Overnight Occupancy	The total number of occupied beds at midnight for The given date.
Mental Health	**Probable Suicides**	'Probable suicides' refers to deaths from intentional self-harm and events of undetermined intent. The latter category includes cases where it is not clear whether the death is a suicide. Data used for this chart is from published data.
	PT Percentage Treated within 18 Weeks	The percentage of patients who were treated within the 18 week treatment time target for the listed service teams. Hosted Specialist Services: Community Perinatal, Commmunity Rehab, Eating Disorders, Eden, Forensic Services, LD, Liason Psychiatry, Maternity., Neonatal, Perinatal & Rehabilitation. CAHMS: Child and Adolescent Mental Health Services
	RCH Average Overnight Occupancy	Calculated using the overnight occupancy for a given ward or group of wards divided by the allocated beds available for the applicable ward(s), given as a percentage.
Prevention	**Alcohol and Drug Related Admissions**	These are admissions which have ICD10 codes given below. Note that this figure can vary and lag as diagnosis is determined and amended on Trakcare - this can take a few months to appear within the data. Recent data should be considered as changable. Alcohol Related– F10 codes. Drug Related – F11 – F19 codes.
	Sexual Health Clinic Activity	Provided by ACHSCP for the dashboard and include face to face and phone/virtual visits.
Primary Care	**CTAC calls and attendance**	Provided by ACHSCP. Community Treatment and Care services appointments booked and attended. Call numbers and results also included.
	Primary Care Stability Levels	Supplied by the Primary Care Contracts Team. Practices contact the team with their current 'Level' which can range from full services to full suspension of services.
Rosewell House	**% Step Up (RWH) -**	There are beds which are allocated for people who are presenting as unwell but not requiring an admission to an acute hospital setting. These beds may prevent the person from an avoidable admission to hospital or a crisis driven avoidable admission to a mainstream care home. For the dashboard these are identified using the IsFirstWard flag.
	Ward Starts (RWH) -	Admission to Rosewell House wards from anywhere in the system at any point during a patients stay, including transfers from any other ward/locations as well as first ward admissions for the given date range. Individuals who have multiple movements into the ward in a date range are counted for both movements.
SOARS	**Average LOS**	Calculated as the number of hours between the ward start and the end date divided by 24 to give a decimal day value. This value is expressed as an average for all ward end dates (discharges and transfers) during the given date range.
	Average Occupancy % -	Calculated using the overnight occupancy for a given ward or group of wards divided by the allocated beds available for the applicable ward(s), given as a percentage.
	Max LOS	As above however, only the maximum LOS value for a discharge that has occurred in the given date range.
	Ward Starts -	Admission to SOARS wards from anywhere in the system at any point during a patients stay, including transfers from any other ward/locations as well as first ward admissions for the given date range. Individuals who have multiple movements into the ward in a date range are counted for both movements.
Social Care	**Care Searches in Place**	Provided by ACHSCP. The total number of cases which remain open and awaiting care (a single client can have multiple cases).
	Clients with Unmet Needs	Provided by ACHSCP. The number of clients who have been waiting over 14 days for one or more open cases for social care.
	Weekly Carer Hours	Provided by ACHSCP. The total number of hours required to satisy the care requirements for all open cases.
	Weekly Unmet Needs Carer Hours	Provided by ACHSCP. The total number of hours required to satisy the care requirements for all open cases that have been open for 14+ days.
Strategy	**Adapations**	Provided by ACHSCP. Adaptations completed split by major/minor.
	Carers Supported (Young & Adult)	The number of carers supported by the partnership, split by age
	Telecare	Provided by ACHSCP. Telecare and community alarm clients.
Ward 102	**Daily Boarders -**	A patient who is physically located on a different ward but should have been admitted to the given ward, however no bed was available to admit them. For example a patient who is under the care of Ward 102 may use a bed in another ward.
	Ward 102 Ward Starts	Admission to Ward 102 from anywhere in the system at any point during a patients stay, including transfers from any other ward/locations as well as first ward admissions for a given date range. Individuals who have multiple movements into the ward in a date range are counted for both movements.

GLOSSARY OF ADDITIONAL TERMS

Creative breaks	Creative Breaks is a funding programme of the Short Breaks Fund, operated by Shared Care Scotland on behalf of the Scottish Government. The purpose of the Short Breaks Fund is to increase the range, availability, and choice of short breaks for carers and those they care for across Scotland. The Short Breaks Fund aims to make a lasting positive impact to carers and the people that they care for, to funded organisations, and to wider short breaks policy and practice. The Creative Breaks programme provides grant funding to third sector organisations to develop and deliver short breaks projects and services for carers of adults (aged 21 years), and young carers (caring for children or adults), and the people that they care for.
Criteria led discharge	This term is used to describe a discharge process which is led by certain criteria that will enable the person to be discharged safely. During the persons stay the doctors, nurses and other staff will work with them to observe and record their progress with certain "goals". The term 'goal' refers to what the healthcare team want they person to achieve for their individual health needs. Discharge from hospital happens when they are medically ready to go and their healthcare team have confirmed they have met their goals as an inpatient. Criteria Led Discharge goals may include: • Ability to transfer safely – this doesn't necessarily mean walking, but means they can safely transfer from bed to a chair etc. with any equipment assessed necessary for their needs. • that their blood pressure and temperature are within the required range. • their discharge destination is ready, safe for them to return to and they have any required care packages/equipment in place.
Delayed Discharge	A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge, and who continues to occupy the bed beyond the ready for discharge date. It is very important that, while the clinician in charge has ultimate responsibility for the decision to discharge, the decision must be made as part of a multi-disciplinary process and focuses on the needs of the individual patient
Delayed Transfer of Care	A 'delayed transfer of care' occurs when a patient is ready to leave their current bed but requires some further care in another facility or community hospital but is still occupying an acute bed. Delayed transfers – also referred to as 'DTOCs' or sometimes, often in the media, described as 'bed-blocking' – can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care, as delayed transfers reduce the number of beds available for other patients
Discharge to Assess,	Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person
Emergency discharge beds	This is provision of care in a care home setting for the care of people who are medically fit for discharge however, there is no placement in the current system able to support them with their preferred placement. They may also need a bit more nursing or support to recover completely before moving onto their selected placement. The placement may be required due to a lack of care at home care availability or a place in their preferred care home or Very Sheltered housing scheme not being available. Emergency discharge beds tend to be purchased as a result of increased pressure and demand on the system to support people to move on from the hospital and release bed capacity.
Hospital at home	Is a short-term, targeted intervention that aims to provide a level of acute hospital care in a person's own home or normal place of care that is equivalent to that provided within a hospital.
Hospital Homecoming	A two year volunteer project with nine test sites, at the time of writing, to support people up to 12 weeks after they have been discharged from hospital. Services the volunteers offer include shopping, prescription collections, transport to appointments, befriending and dog walking.
Interim placement	There will be times when a patient in hospital, or the community cannot access the service they require, be that a Care Home, alternative housing with care, or a Care at Home service and therefore a variety of interim options are required. This avoids risk or harm to patients by reducing unnecessary delays for individuals being discharged from hospital but also to avoid where possible unnecessary admissions to hospital.
Reablement	The reablement approach supports people to do things for themselves and helps people to retain or regain their skills and confidence so they can learn to manage again after a period of illness. It is usually provided in the person's own home and aims to assist people to continue to live as they wish and to enable the individual to do ordinary activities like cooking meals, washing, dressing, moving about the home and going out. Reablement may be used to support discharge from hospital, prevent readmission or enable an individual to remain living at home. (from SCIE)
Rehabilitation	Person-centred interventions designed to optimise functioning and reduce disability in individuals with health conditions in interaction with their environment. Rehabilitation may be required following an injury, surgery, disease or illness or because their functioning has declined with age. Rehabilitation can help to reduce, manage or prevent complications associated with many health conditions, such as spinal cord injury, stroke, or a fracture. Rehabilitation is provided by a multidisciplinary workforce including physiotherapists, occupational therapists, speech and language therapists, audiologists, orthotists and prosthetists, clinical psychologists, physical medicine and rehabilitation doctors, and rehabilitation nurses. It addresses underlying conditions such as pain and supports people to overcome difficulties with movement, communication, eating, thinking, seeing, hearing. It helps the person be as independent as possible in everyday activities and enables participation in education, work, recreation and meaningful roles. (WHO)
Respite	An opportunity for carers and those that they care for to have a break from their current circumstances in a residential setting such as a care home or very sheltered housing complex. Respite may be planned in advance, or unplanned where there is a sudden change in someone's situation or as a place of safety, in response to an Adult Protection situation and/or emergency response to risk allowing time to forward plan and make arrangements.
Step down beds	These are rehabilitation beds when people need a bit more time to recover after a period of time when they have been unwell or after surgery. The person is generally well but require a time of support to help them rehabilitate with input from Allied health Professions such as Occupational Therapists and Physiotherapists.
Step up beds	There are beds which are allocated for people who are presenting as unwell but not requiring an admission to an acute hospital setting. This may be in a care home for example which provide 24 hour care and support to a person who may be requiring additional care and support and in some cases nursing input. These beds may prevent the person from an avoidable admission to hospital or a crisis driven avoidable admission to a mainstream care home.