Aberdeen City Health and Social Care Partnership – MSG Improvement Indicators 2018/19

Aberdeen City HSCP	Unplanned Admissions	Unplanned Bed Days	A&E Attendances & seen within 4 hours	Delayed Discharge Bed Days	Last 6 months of life spent in community	Balance of Care (resident in non-hospital setting)
Baseline	Number of emergency admissions (Acute Specialties) Baseline 2015/16 21,777, 2016/ 21,269, 2017/18 (to Sep 17) 10,519 ▪ 2% reduction in emergency admission from 2015/16 to 2016/17 ▪ 4% reduction in A&E attendances admitted as an emergency from 2015/16 to 2016/17. ▪ 23% of A&E attendances were subsequently admitted as an emergency in 2015/16 (based on12 monthly average) and 22% in 2016/17. ▪ In 2015/16 49% of emergency admissions were from A&E, this reduced to 48% in 2016/17 and 46% in 2017/18 (to Sep 17).	Number of unscheduled hospital bed days for Acute Specialties, excluding Geriatric Long Stay and Mental Health, Baseline 2015/16 158,323, 2016/17 147,719, 2017/18 (to Sep 17) 58,060. ▪ 7% decrease in number of unscheduled hospital bed days from 2015/16 to 2016/17. Number of Mental Health unscheduled hospital bed days Baseline 2015/16 63,936, 2016/17 60,154, 2017/18 (to Sep 17) 29,637 ▪ 6% reduction in number of unscheduled bed days from 2015/16 to 2016/17 Number of Geriatric Long Stay unscheduled hospital bed days Baseline 2015/16 7,525,	Number of A&E attendances Baseline 2015/16 46,435, 2016/17 45,459, 2017/18 (to Sep 17) 23,447. ▪ 2% reduction in number of A&E attendances from 2015/16 to 2016/17 ▪ Percentage of attendances seen within 4 hours has remained constant at 95% in 2015/16, 94% in 2016/17 & 94% in 2017/18 (to Sep 17).	Number of Delayed Discharge bed days (all delays standard and code 9's) Baseline 2015/16 43,944, 2016/17 27,353, 2017/18 (to Sep 17) 10,046. ▪ 61% reduction in number of bed days occupied by delayed discharges 2015/16 to 2016/17. ▪ 83% reduction in number of bed days occupied by Code 9 delayed discharges from 2015/16 to 2016/17. ▪ In 2015/16 16% of bed days occupied by delayed discharges were occupied by code 9's, this decreased to 14% in 2016/17 and increased again to 16% in 2017/18 (to Sep 17).	Percentage of last 6 months of life spent in the community Baseline 2015/16 88%, 2016/17 89%. ▪ A higher percentage of individuals spend their last 6 months of life in a community setting, with 88% in 2013/14, 2014/15 and 2015/16, and 89% in 2016/17.	Balance of care – Percentage of population in community or institutional settings. Percentage of population aged 75+ in community setting (including care home) Baseline 2013/14 98.2%, 2014/15 98.1%, 2015/16 98.3%. In 2015/16 83.3% aged 75+ were at Home (Unsupported), 8.2% at Home (Supported), 6.8% in a Care Home, 0.03% in a Hospice/Palliative Care Unit, 0.02% in a Community Hospital and 1.65% in a Large Hospital. This compares to 2013/14 where 83.5% were at Home (Unsupported), 8.4% at Home (Supported), 6.4% in a

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		2016/17 7,321, 2017/18 (to Sep 17) 1,530 ▪ 3% reduction in number of unscheduled bed days from 2015/16 to 2016/17				Care Home, 0.04% in a Hospice/Palliative Care Unit, 0.1% in a Community Hospital and 1.64% in a Large Hospital.
Objective	Projecting that 2017/18 will outturn at a 0.8% decrease on 2016/17 figure i.e. to 21,099, the objective will be to return to achieving a reduction on the 2017/18 figure closer to that of the reduction achieved from 2015/16 to 2016/17 i.e. 2%, achieving an annual figure of 20,677 by the end of 2018/19.	Projecting that 2017/18 will outturn at almost a 30% decrease on the 2016/17 figure i.e. to 104,142 the objective would be to maintain a steadier rate of decline in 2018/19 to a level of 5% below the 2017/18 figure i.e. an annual total of 98,921	Projecting that 2017/18 will outturn at a 0.08% increase on 2016/17 figures i.e. to 45,495 the objective would be to achieve a reduction on the 2017/18 figure closer to that achieved from 2015/16 to 2016/17 i.e. 2% achieving an annual total of 44.585. Additionally, the objective will be to improve the attendances seen within 4 hours to the 2016/17 rate of 95%.	Projecting that 2017/18 will outturn at a 35% decrease on 2016/17 figures i.e. to 17,780 and given that we feel much of the quick win improvements have already been achieved , the objective would be to maintain this reduction at a more stable rate of 5% on the 2017/18 rate i.e. to an annual total of 16,891.	The objective will be to achieve a 1% increase on the 2016/17 figure to achieve 90% by the end of 2018/19	The objective will be to achieve a 0.2% increase on the 2016/17 figure to achieve 98.5% by the end of 2018/19.

· Note :- Most of the initiatives listed below are at the early stages of implementation. Whilst we anticipate that the impact they will have on people's health and wellbeing will ultimately be significant, our approach is to achieve a steady, sustainable step change. The objectives listed above will be continuously reviewed as the initiatives become embedded and evidence becomes available as to the level of impact on each of the improvement indicators.

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How will it be achieved	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly intermediate care and creative use of SDS options) · Continued geriatric support to the ED at ARI achieving diagnosis-treatment-home where clinically safe to do so. · Modernisation of Primary Care	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly intermediate care and creative use of SDS options) · Continued geriatric support to the ED at ARI achieving diagnosis-treatment-home where clinically safe to do so. · Modernisation of Primary Care · Increased use of Technology Enabled	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly intermediate care and creative use of SDS options) · Modernisation of Primary Care · Increased use of Technology Enabled Care and Responder Services · Implementing Link Workers · Increased Pharmacy Support in GP practices	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly intermediate care and creative use of SDS options) · Continued geriatric support to the ED at ARI achieving diagnosis-treatment-home where clinically safe to do so. · Modernisation of Primary Care · Increased use of Technology Enabled	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly palliative and end of life care) · Modernisation of Primary Care · Increased use of Technology Enabled Care and Responder Services · Targeted Support for Carers · Increased adoption and roll	· Focus on locality needs and solutions · Implementing the Acute Care at Home model · Implementing the Integrated Neighbourhood Care in Aberdeen (INCA) model · Increasing availability of care through strategic commissioning (particularly intermediate care and creative use of SDS options) · Focus on enablement models of care. · Modernisation of Primary Care · Increased use of Technology Enabled Care and Responder Services

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	· Increased use of Technology Enabled Care and Responder Services · Implementation of Link Workers · Increased Pharmacy Support to GP practices · Targeted Support for carers	Care and Responder Services · Implementation of Link Workers · Increased Pharmacy Support to GP practices · Targeted support for carers	· Increased GP locality collaboration – widening access to primary care	Care and Responder Services · Implementation of Link Workers · Increased Pharmacy Support to GP practices · Targeted Support for Carers · Implementation of the Delayed Discharge Action Plan	out of Anticipatory Care Plans in respect of end of life care as soon as possible in the pathway · Continued, active participation in the Palliative Care Strategy Group	· Implementation of Link Workers · Increased Pharmacy Support to GPs · Targeted Support for Carers · Increased GP locality collaboration – widening access to primary care
Progress (updated by ISD)						
Notes	ACH&SCP are 12% below the Scottish average for Emergency Admissions and very close to the 25th percentile rate (per 100,000 population).	ACH&SCP are 9% below the Scottish average for Unplanned Bed Days. We will seek to undertake further detailed analysis of unplanned bed days in relation to Geriatric Long Stay and Mental Health.	ACH&SCP has one of the lowest rates of A&E attendance of any partnership in Scotland however we are still committed to improving on this.	ACH&SCP have already achieved a 68% (3,034) reduction in DD Bed Days between Feb 15 and Sep 17 as a result of a rigorous action plan. We have moved from being the 2nd worst partnership to the 12th best.	ACH&SCP are above the Scottish average in this indicator (87%) and the highest placed City based partnership. Dying at home is a personal choice and rural partnerships have the highest percentages this indicator.	Most partnerships have a similarly high percentage for the overall number of those resident in a non-hospital setting the variance tends to be between supported and unsupported and this will be given further analysis during 2018/19.