Aberdeen City
Health & Social Care
Partnership

A caring partnership

Aberdeen City Health & Social Care Partnership

ANNUAL REPORT 2017-18

ABERDEEN CITY COUNCIL

NHS Grampian

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Foreword

IJB Chair Foreword

I warmly welcome the publication of this Annual Report which sets out how we have performed in our second year of operation as a Health and Social Care Partnership and how we are continuing to work towards fulfilling the ambitions and priorities outlined in our Strategic Plan.

I am delighted that we have not only continued to build on the positive foundations achieved last year but also significantly increased the ongoing transformation of our health and care services. There is, however, still much to do and my aim for the remainder of my time as IJB Chair is to continue supporting the progress achieved and to drive our ambitions of delivering even better experiences and outcomes for the people who use our services and their carers.

Our aim remains for us to be recognised as one of the top performing partnerships in Scotland across all sectors and services and one which attracts the best people to work with us. I am pleased to chair an Integration Joint Board that has so many committed and capable members and which provides the right balance of support and scrutiny to the Executive Team as we strive to make continued progress in the face of challenging demographic and financial projections.

And finally, I acknowledge the work undertaken by our former Chief Officer Judith Proctor and Head of Operations Tom Cowan who have moved on to other roles with the Edinburgh Health and Social Care Partnership, and our Head of Strategy & Transformation and Interim Chief Officer Sally Shaw who is taking up the post of Chief Officer for Orkney Health and Social Care Partnership. On balance I believe we should take it as a positive sign that our leadership is in demand elsewhere.

I wish them well and look forward to working with our new Chief Officer, Sandra Ross, when she commences in post.

Jonathan Passmore
MBE, Chair

Chief Officer Foreword

I wish to begin by saying how privileged I feel to be fulfilling the role of Interim Chief Officer for the Aberdeen City Health & Social Care Partnership. In the short time that I have been with the partnership I have recognised its strong desire to deliver person-centred health and care services that are used and appreciated by the citizens of Aberdeen and their carers. My own previous career experiences have shown me that good quality compassionate care is a fundamental expectation of the work that we do and that we are all capable, no matter what role we fulfil, of making positive, significant contributions towards this.

There is much to read and reflect upon in this report. There are many identified areas where we are doing well and some areas where we could do better. We can, for example, be pleased with our continued progress in tackling the whole-system challenges of emergency admissions and delayed discharges but recognise that there is still much to be done in reducing the number of readmissions within 28 days. Overall though, this is a good and positive summary of our work in, what is remember, only the second year of the partnership's operation.

We would not have attained such progress in the past year were it not for the hard work and dedication of all our staff and volunteers who work across the health, social care, third, independent and housing sectors. Their commitment to the wellbeing of the people who use their services is very much evident and it is only right that they are recognised and applauded for this.

There is, however, still much to do and I am confident that this next year will see our transformation activities deliver more effective and in some cases truly innovative services that offer improved experiences and outcomes for everyone.

Sally Shaw
Interim Chief Officer

1 Introduction

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

This annual report outlines how effective the Aberdeen City Health & Social Care Partnership (ACHSCP) has been in 2017-18, its second year of operation. 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.

It was acknowledged last year that the smooth delegation of local health and social care functions and services on 1st April 2016 ('Go Live' day) had given the partnership a good and solid platform from which to operate. Our first annual report outlined the integrated building blocks we had put in place and the initial change activities that were beginning to emerge. This report highlights the continued progress we are making in embedding health and social care integration and the ongoing transformation of our services.
Our key ambition is to be recognised as a high-performing partnership that has a deserved reputation for its compassion, quality, innovation and effectiveness.
The Integration Joint Board (IJB) has fulfilled an effective leadership role and relationships within it are positive and supportive of good decision-making. We have continued to develop the governance of the delegated functions and services with a focus on enabling the IJB's decision-making authority in relation to its partner organisations, Aberdeen City Council and NHS Grampian.
The IJB has previously agreed the partnership's strategic ambitions and priorities and continues to emphasize its expectations about the scale and pace of our transformation programme and the delivery of its anticipated benefits. The drive for high quality of care, effective performance and improved experiences and outcomes is at the heart of everything we do to achieve and maintain good health and wellbeing.

Our Strategic Plan 2016-19 sets out our strategic ambitions and priorities for the delegated health and social care services in the face of future demographic and financial challenges.
Our current priorities are:

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

Work has commenced on reviewing and refreshing this plan and there will be many opportunities in the weeks and months ahead for our citizens and communities to shape this. A revised Strategic Plan and Housing Contribution Statement will be presented to the IJB in March 2019.

This Annual Report shows how successful we have been in working towards our ambitions and priorities and fulfilling the national health and wellbeing outcomes. We are reasonably satisfied with the progress made to date and look forward to seeing the ongoing transformation of our integrated health and care services deliver even better experiences and outcomes for the individuals who use our services and their carers.

Did You Know?

Adult Support and Protection (ASP) is a significant responsibility for all health, social care, third, independent and housing sectors agencies across the partnership.

The Adult Protection Unit (APU) ensures the support and protection of adults at risk of harm by working in partnership with a range of organisations. Its role is also to empower and enable professionals to discharge their duties under the Adult Support and Protection (Scotland) Act 2007. It is the central point for ASP reporting forms and Police Concern Reports to be logged.

A previous Joint Inspection of Older Adult Services had highlighted that there was a small number of cases that were of concern in relation to our procedures and processes that were then in place. In response to this, the Chief Officer commissioned an internal review to provide assurance of how ASP is delivered within the partnership.

That review made twelve recommendations which now form the basis of our ASP Improvement Plan. It is developing a culture of learning and improvement across the partnership, ensuring staff receive effective support, good direction and strong leadership and ultimately offer better protection to adults in our city who are at risk of harm.

Our shared vision remains:

Aberdeen City Health & Social Care Partnership is committed to ensuring an effective, responsive and inclusive approach to the support and protection of adults at risk of harm"

For further advice and guidance, the APU can be contacted on 01224 264085 or AdultProtection@aberdeencity.gcsx.gov.uk .

2. Our Approach

The partnership is committed to a three-part, seamless approach which supports and co-ordinates the continuing quality and consistency of our day-to-day service delivery, a measured roll-out of our locality model and associated service structures and a pro-active emphasis on the opportunities to innovate and transform.

2.1 Our Localities

Pivotal to all our ambitions and priorities is having a locality model that connects us to our communities and which underpins the delivery of our integrated health and social care services.

We are taking a measured approach to the implementation of our locality model to minimise the disruption to those who, for whatever reason, depend upon our services. We have also been mindful that some individuals who need services do not fit neatly into the geography we have defined. Our commitment is that the design and development of our integrated health and care services will not be to the detriment of the continuity of care and support for anyone.

We acknowledge that we must ensure that our citizens and communities are at the heart of the design and delivery of those services which support them. Our Locality Leadership Groups (LLGs) have played a key role in informing and influencing the development of their respective Locality Plans.

We have developed profiles of each of the areas outlining the health and wellbeing of the local population. This baseline information has been shaped by contributions from members of the local communities and has been very helpful in determining locality-specific priorities in our Locality Plans for the LLGs to progress.

The IJB approved the publication of the four Locality Plans in December 2017.

We are now exploring those particular initiatives and activities which we believe will have the greatest positive impact on the health and wellbeing of our local population. We are mindful of the great work that is being done across the city on a day-to-day basis across all sectors and services. Significant engagement activity is being undertaken to establish new relationships and develop long-standing ones. We are determined to ensure that where appropriate, our locality activities will be co-produced and are developing focus groups of interested citizens, community representatives and staff to help us with this.

Did You Know?

In April 2017, Scottish Care received funding from ACHSCP to establish an engagement team in Aberdeen City with a remit to work with independent sector care homes, care at home and housing support providers.

A consultation exercise* with its members who operate care homes in the city was undertaken. 50% of care homes canvassed had some knowledge of ACHSCP; 30% regularly receive emails and 20% of managers attended partnership events.

Key challenges identified included: funding, care management, communication with health services, staff training, inspection/regulation, recruitment and community health.

Suggested opportunities include:
Scottish Care concluded that it was committed to building on the relationship between ACHSCP and the independent sector through the following:

- ensure active participation and leadership from the independent sector in developing and delivering change;
- contribute to the reshaping of market provision;
- ensure broad input from the independent sector in Aberdeen City in developing and testing new models of integrated care and support;
- develop effective partnerships across Aberdeen City.

Watch out for more Scottish Care inspired activities and developments.

*'Voices from Independent Sector Care Homes' (Scottish Care, 2017)

2.2 Our Ongoing Transformation

Our IJB expects us to deliver significant transformational change at pace, to improve the personal experiences and outcomes for individuals who use our services now and for those who will use them in the future.

Our Transformation Plan outlines the six 'big ticket' items (Figure 2.2) that the IJB wishes to see progressed. We have increased the capacity of our transformation team to drive an ambitious programme of change activity that will deliver the desired improvements and required efficiencies.

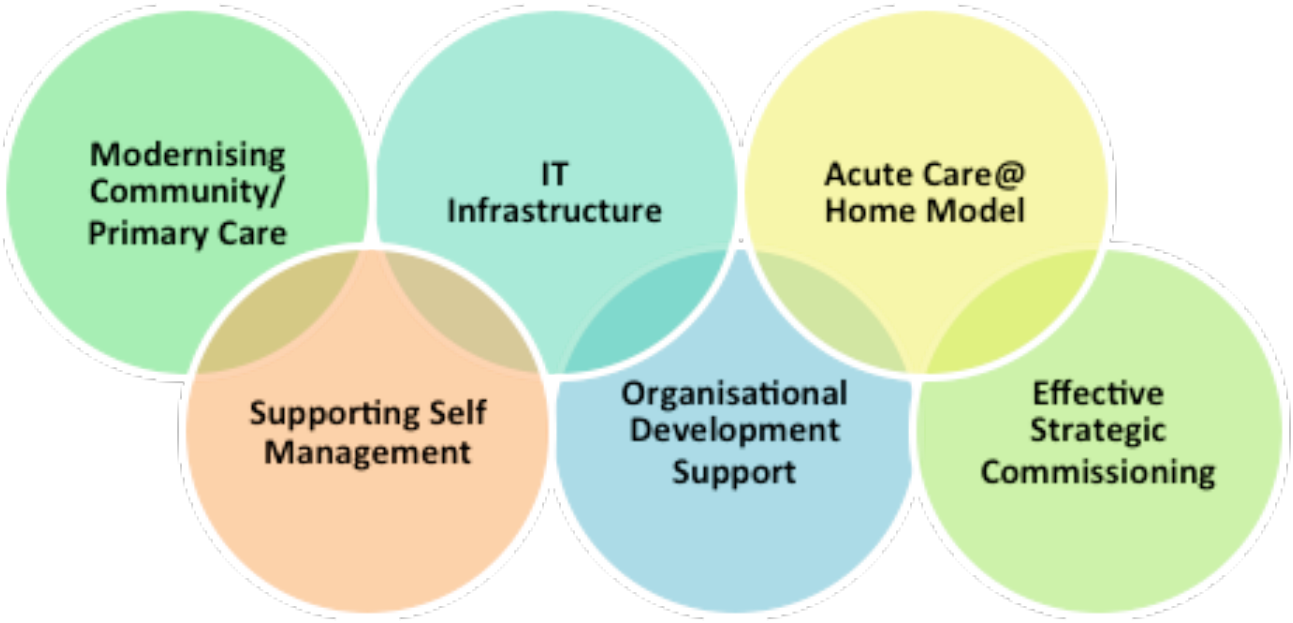

Figure 2.1 ACHSCP 'Big Ticket' Items

2.2.1 Modernising Primary & Community Care

We are confident that collaborative working in locality hubs will help to reduce admissions to hospital and prescribing costs and provide more sustainable health and social care services.

- We have implemented an INCA (Integrated Neighbourhood Care Aberdeen) pilot by bringing together care at home and nursing staff to operate in particular areas of the city. These self-managing teams (based on Buurtzorg principles) provide flexible, responsive support without the narrow time and task focus that defines other models of care.

Initial analysis of patient experience suggests that this model of delivering integrated care is highly acceptable. For example, 88% of respondents to the service evaluation questionnaire "strongly agreed" to being satisfied with the care they received, with the same proportion also strongly agreeing that they would recommend the service to others. One such individual said:

"I could never have made the progress I have without the help and encouragement of the INCA team" (Patient 3, Peterculter)

A full report describing the first six months of implementation will be published in autumn 2018.

- We have established a new home-visiting approach (West Unscheduled Care) for all GP practices in our West Locality. In this new daytime visiting service, after an initial screening by a GP, an Advanced Nurse Practitioner (ANP) visits those individuals who, because of their health and wellbeing, have requested a GP home visit.

In the first six months, there have been 241 referrals to the service, with 239 being accepted. Practice staff have given the initial implementation an average satisfaction score of 90%, with reported benefits to include improving GP capacity, faster access to care for patients and reducing the stress on wider practice staff. The skillsets of the ANPs have been highly praised with one GP saying:

"They're incredible. So, if I was unwell, I might be looking to see an ANP rather than a GP … they're good all-round practitioners and they're good at assessing things." (GP, Practice 5)

The full evaluation report of the first six months of implementation is available on request.

- The primary care Psychological Therapies service has now been fully recruited to and is now delivering this across all practices in the city. To date there have been 2075 referrals received and 1106 patients have been seen for assessment and/or treatment.

- An 'Alcohol Hub' test-of-change project is running with two GP practices to run weekly drop-in clinics for clients with substance misuse issues. This gives access to GPs, community mental health nurses and social workers. The project aims to work in a holistic way with individuals and work preventatively with them, encouraging the self-management of their conditions and circumstances.

2.2.2 Supporting Self-Management of Long-Term Conditions and Building Community Capacity

We are ambitious to improve the health and wellbeing of our local population and minimise health inequalities, but we recognise that pressures on mainstream primary and social care services cannot be addressed through a 'more of the same' approach. We endorse the value of each of us feeling able to take greater responsibility for our own health and wellbeing and letting innovation flourish in our localities.

- By introducing link practitioners into all practices within the city, we aim to provide a person-centred service that is responsive to the needs and interests of the practice population. Their initial focus is on alleviating demand pressures in GP practices and countering health inequalities by supporting people to live well through strengthening connections between primary care and community resources.

In January 2018 we commissioned SAMH (Scottish Association of Mental Health) to deliver this service and links practitioners will be placed in GP surgeries from August 2018.

- We worked in collaboration with the Active Aberdeen Partnership to continue to support the delivery of the Golden Games Festival to raise the profile of active ageing in the city. The festival of sport and physical activity provided an opportunity for 465 older adults to try 58 different activities at several venues based within our localities.

- We have supported the adoption of collaborative Care and Support Planning (House of Care) within three practices in the city. We have delivered training using an evidence-based approach to meeting the needs of people living with long-term conditions.

- The partnership delivered a 'Living and Ageing Well' conference in December 2017, which provided an opportunity for partners to consider the outcome of recent commissioned research. Discussion has subsequently begun in relation to the development of a Living and Ageing Well framework for the city.

- We have been working to improve mental health and wellbeing for individuals in our communities. In collaboration with others, we launched our "Choose Life" app, aimed at preventing suicides in the North East. This app has been accessed extensively and may be a contributing factor in the reduced number of suicides in Aberdeen and Grampian during 2016, in contrast with increases seen across Scotland.

- We have gone live with our Interim Housing pilot project for people with low-level support needs. These fully furnished properties will enable people to leave hospital and wait in appropriate housing until adaptations are put in place or an alternative longer-term housing solution is agreed.

2.2.3 Acute Care @ Home

The development of such a service fits with our ambition for our initiatives and developments to have a greater preventative impact, especially since we know that prolonged length of stay for the frail elderly and those with long-term conditions can lead to a higher risk of acquired infection and other complications such as loss of confidence, function and social networks.

- This service provides, for a limited period, active clinical treatment by appropriate professionals, in the individual's home, for a condition that would otherwise require acute hospital in-patient care.

  There are two complementary elements. The alternative to admission part includes a rapid assessment element which will allow GPs to refer patients for a consultant-led assessment and treatment review in their own home.

  The early supported discharge / active recovery part of this initiative will allow patients to be discharged from hospital sooner than they would otherwise have been. The team will review and deliver the final few days of the hospital treatment plan in the patient's own home.

  Recruitment of key posts within the multi-disciplinary team has commenced and when the service goes live, its initial focus will be in the Central Locality, which has a significant proportion of unscheduled emergency admissions.

2.2.4 Strategic Commissioning

A coherent commissioning approach across all our sectors and services is essential to ensure the consistency and quality of care that will result in the improved personal experiences and outcomes that we seek to provide.

- Our Strategic Commissioning Implementation Plan outlines those key areas where we will focus our attention to reshape the services that we deliver. A Market Facilitation Statement is included in the plan, showing how we will work collaboratively with the third, independent and housing sectors to increase the capacity and sustainability of our local care provision.

  The IJB approved the Strategic Commissioning Implementation Plan in January 2018.

- The Carers (Scotland) Act 2016 extends and enhances the rights of unpaid carers, of which there are reckoned to be as many as 38,000 in Aberdeen. The Act seeks to help improve the health and wellbeing of all carers so that they can continue to care to the best of their abilities and, if they so wish, have a life alongside caring.

  The IJB approved our Carers Strategy in March 2018 in advance of the Act taking effect from 1st April 2018.

- We have developed our Learning Disability Strategy outlining a collective vision and priorities for improving the health, wellbeing and quality of lives of those individuals with a learning disability.

  This strategy was endorsed by the IJB in March 2018.

2.2.5 Organisational Development & Cultural Change

In its broadest sense, our partnership includes colleagues who work for Aberdeen City Council and NHS Grampian as well as those colleagues who work across the third, housing and independent sectors, our unpaid carers and volunteers.

We recognise that everyone has a role to play in delivering our integration and transformation ambitions. Positive engagement across all sectors and sections of our workforce is central to achieving the partnership's vision and essential to providing improved experiences and outcomes for the people who use our services.

- The HEART Awards – 'Having Exceptional Achievement Recognised Together' – was designed to celebrate the outstanding work of colleagues in ACHSCP and its partner organisations. Our second HEART Awards ceremony was held at the Beach Ballroom in February and the occasion drew some 350 colleagues for an evening of home-grown entertainment and accolades.

  More than 60 nominations for teams and individuals were gathered in the seven award categories. The seven winners, listed below, and all the finalists each received a commemorative HEART Awards plaque.

The Communication and Inclusion Award:	Balnagask Supported Living Learning Disability Service
The Empowering People Award:	North East Sensory Services Team
The Community's Award:	Alcohol and Drugs Action
The Rising Star Award:	Kenny O'Brien
The Integrated Working Award:	The Equal Partners in Care (EPIC Group)
The Beating Heart Award:	Marywell Homeless Practice
The Staff Choice Award:	Hazel McAllan and Christina Geddes

- Our Organisational Development facilitators have worked hard to ensure actions have been taken as a result of feedback received from many different sources. These include facilitating 'From the Ground Up' workshops to increase senior leadership visibility and to enable staff to participate in Q&A sessions with them and the creation of an Ideas Hub where all partners can put in improvement ideas and suggestions.

2.2.6 IT, Infrastructure and Data Sharing

We recognise that our ambitions to innovate and transform will be hampered if there is a continued reliance on current, single-service systems.

During the past year the following initiatives have been undertaken:

- recruited additional capacity to support the delivery of our IT workstream;
- developed an IT Road Map to enable the partnership's future IT strategy to be outlined;
- supported a pan-Grampian data-sharing governance structure with an established city sub-group;
- commenced a pilot launch of Microsoft Office 365.

We launched our redesigned ACHSCP website (https://www.aberdeencityhscp.scot/) in February 2018 and already our website page views have more than doubled from the previous year. The next implementation phase will co-locate information from our partners' Aberdeen City Council and NHS Grampian public websites.

Did You Know?

The diverse range of services within the partnership also includes some housing functions that are formally delegated by Aberdeen City Council to the IJB.

This may be a surprise to some but, without doubt, the availability of appropriate good quality housing and housing services is an important contribution to improving health and wellbeing outcomes and to the success of integrated health and social care.

More specifically, it is the functions relating to aids and adaptations which is delegated, that is:

"any alteration or addition to the structure, access, layout or fixtures of accommodation, and any equipment or fittings installed or provided for use in accommodation, for the purpose of allowing a person to occupy, or to continue to occupy, the accommodation as their sole or main residence."

In practical terms this means the partnership has responsibility for the planning and delivery of a service from the point of assessment through to the provision of the required aids and adaptations in council and private sector housing. This includes the advice and assistance that is given to Registered Social Landlords (housing associations) in respect of the aids and adaptations that they provide (funded directly by the Scottish Government).

There was significant demand in 2017-18 for these resources. **349 minor and 301 major adaptations were undertaken in 462 local authority properties at a cost of £735,059.41. Bon Accord Care provided aids and minor adaptations to 500 people in private sector housing at a cost of £176,081. There were also 137 private sector grant applications which resulted in additional spend of £728,360.53.**

These delegated functions and resources are of significant importance in helping people maximise their independence and remain living safely at home for as long as is reasonably possible.

3. How Well Have We Done?

3.1 Our Performance Framework

Our overall performance governance framework has five themes (Figure 3.1) that are applicable across every part of the diverse range of services in the partnership. These themes are integral to every conversation we have about how well we are doing and give us a baseline for improving the experiences and outcomes of the people who use our services and their carers.

Figure 3.1 Performance Governance Framework Themes

Within each of the themes is a range of locally agreed operationally focused measures which we use to assess how well we are doing and to identify areas where we need to act to improve matters from both an operational and a strategic perspective.

1 Ensuring our services keep people safe and protected from avoidable harm.

safe

Complaints and how quickly we respond
Referrals to initial investigation under adult protection
Community payback orders
Criminal justice social work reports to court
Proportion of adult services posts vacant

Staff vacancy levels, sickness absence, complaints and adverse events all help us to understand how well we are delivering and ensuring safe care and treatment and these are monitored regularly through our Audit and Performance Committee.

As a Community Planning Partner, we have a responsibility to keep people and communities safe from harm. We have continued our co-ordinated efforts to raise the awareness of adult support and protection amongst the general public and those agencies and organisations which have a public protection responsibility. **In 2017-18, there were 1125 referrals (2016-17, 1203 referrals) to our Adult Support Unit, 36% of which required further adult protection action (2016-17, 34%), 22% required further non-adult protection action (2016-17, 20.5%) and 42% required no further action (2016-17, 45.5%).** The slight increase in the proportion of referrals that require some form of action is being monitored by both the Adult Protection Unit and the Adult Protection Committee.

2 Focusing on effective care for good outcomes and experience

effective

Attendances at A&E

Smoking cessation in our most deprived communities

Alcohol brief interventions

Health outcomes can be improved by reaching and supporting people at risk of poor health. We are seeing some positive signs of health improvement in terms of prevalence of obesity, smoking and dental health, however enduring health inequalities in the city remain.

Changing trends in the use of A&E is an indication of the effectiveness and responsiveness of other services. There has been a concerted effort to provide people with information to enable them to access care or support from the most appropriate person and place. **In Grampian the use of A&E services has been on a small but steady downward trend in contrast with the rest of Scotland. In addition, the number of people in Aberdeen whose A&E attendance results in emergency admission to hospital is markedly lower than the rest of Scotland.**

Smoking is a major contributor to poor health. Working to achieve national targets to reduce smoking further, 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. This is not easy as national figures show; we have, however, continued to reach similar numbers of people as in previous years. **The level of people accessing smoking cessation support in our most deprived areas has been fairly well sustained since 2015 and our smoking cessation services are among the most effective in Scotland.**

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 ABIs delivered in community settings with more success. Additionally, a specific project on reducing alcohol-related falls is showing promising results and we are evaluating its effectiveness and impact on longer-term outcomes.**

3 Caring for people with kindness, compassion, dignity and respect

caring

People having a say in how help and care is provided
People feeling safe and supported at home
People living as independently as possible
Experience of care in GP practices

There are, as yet, no locally agreed measures of how caring we are as a partnership. Instead, understanding how well we are achieving an ethos of being caring and compassionate is largely measured through the National Health and Care Experience Survey.

Across Scotland there has been a small decline in the level of positive feedback in relation to the 'integration' related indicators contained in the national survey when comparing 2017/18 with 2015/16. **This effect has been much less marked in Aberdeen, where our position relative to the other partnerships in Scotland has improved in all but two of the nine indicators. More so, we have shown improvement in several areas, in contrast with Scotland where of those people receiving care or support, more people said they had a say in how their help or care was provided and reported feeling safe whilst being supported at home. A greater proportion of people receiving care in Aberdeen rated it as good or excellent. Nonetheless, there are areas we wish to improve upon where the feedback shows either no change or a slight decline, including helping people to live as independently as possible, supporting carers, and improving the positive experience of care in GP practices.**

4 Organising services to be responsive to individual needs

responsive

Bed days spent in hospital by patients delayed
Number of people delayed in hospital
People (65+) with intensive care needs receiving care at home
Unmet need for social care
Uptake of self directed support

Improved operational processes, effective service commissioning and the focused 'Team Aberdeen' ethos have, together, improved the experience of care for many individuals and their families.

Responding to what the local indicators tell us has helped us to act to reduce unmet needs for social care, increase the proportion of people (65+) with intensive care needs who receive care at home, and increase the uptake of self-directed support. All of these efforts help to ensure we are responsive to supporting the individual needs of people in our city.

Avoiding unnecessary emergency hospital admissions is a big focus and here Aberdeen does particularly well - reported to be the 8th best of all thirty-one partnerships in Scotland. Related to this is the number of days spent in hospital following an emergency admission, where Aberdeen at 9th best of all partnerships, continues to see a drop in hospital bed-days. Alongside this positive picture however, our readmissions to hospital after 28 days of discharge is increasing and whilst these affect a small number of people, this is something that our Unscheduled Care Programme Board and Senior Leadership Team are working to understand and improve.

Minimising the number and wider effects of and for individuals delayed in their discharge from hospital is an indication of system responsiveness. We have been working hard throughout the year using available funding to continue reducing the number of older people who are delayed in hospital when they are ready to be discharged. **We have made further improvement this year and our position relative to other partnerships has changed from being 26th in 2016 to 20th in 2017.**

5 Well led organisation enabling quality care, innovation and a positive culture

well led

Sickness absence
Innovation tools and uptake
iMatter feedback and learning
Engagement events and feedback

A workforce that feels valued and supported is a crucial element of improving the experiences and outcomes of the individuals who use our services and their carers.

Promoting trust and autonomy is a key behaviour of a modern, adaptive organisation and one which will lead to improved staff morale and welfare. Our HEART Awards, the annual conference, the 'Our Ideas' tool and iMatter are all great examples of the partnership's commitment to engage, motivate and inspire staff to do their very best each and every day.

Appendix Two Shows all of these ACHSCP Local Indicators by Theme.

Did You Know?

The IJB requires a mechanism with which to action its strategic plan and this takes the form of a formal instruction, known as a Direction, from the IJB to one or both of its partner organisations NHS Grampian and Aberdeen City Council to undertake a particular task or activity.

A Direction must clearly identify which of the delegated health and social care functions they relate to and the budget associated with the required change. The exercise of each function can be described in terms of the service delivery it relates to, the outcomes desired from its implementation or by reference to the Strategic Plan.

Prospective Directions are set out in a report to the IJB who will be asked, in the report's recommendations to approve the Direction. IJB papers are available online in advance of scheduled meetings.

Once a Direction is approved by the IJB, a letter is sent by the partnership's Chief Officer to the relevant Chief Executive advising them of its particular requirements. A Direction will continue to apply unless it is time limited or superseded by a subsequent instruction from the IJB.

During 2017-18, the IJB agreed to send 22 Directions to ACC (19) and NHSG (3). Of these, two Directions have now expired and one Direction has been superseded by a revised Direction.

3.2 National Health and Wellbeing Outcomes

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

3.2.1 Performance Comparisons

The available information enables us to compare the partnership's performance in the past year with the previous reporting year, to compare against the national performance and to show its position relative to the other partnerships in Scotland for each indicator.

The national indicators are currently:

NI - 1	Percentage of adults able to look after their health very well or quite well	NI - 13	Emergency bed-day rate (per 100,000 population).
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	Ni - 14	Readmission to hospital within 28 days (per 1,000 population)
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	Ni - 15	Proportion of last 6 months of life spent at home or in a community setting
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	NI - 16	Falls rate per 1,000 population aged 65+
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	NI - 18	Percentage of adults with intensive care needs receiving care at home
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	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)
NI - 8	Total combined % carers who feel supported to continue in their caring role	NI -20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency
NI - 9	Percentage of adults supported at home who agreed they felt safe	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready
NI - 11	Premature mortality rate per 100,000 persons (European age-standardised mortality rate per 100,000 for people aged under 75)	NI - 23	Expenditure on end of life care, cost in last 6 months per death
NI - 12	Emergency admission rate (per 100,000 population)		

In Figure 3.2 the red line indicates the previous reporting period and the bars demonstrate our performance change. **14 of the 19 reported indicators have improved or stayed the same. Most notable improvements are evident in the rate of emergency bed-days for adults reducing by 9% (N13) and the number of days people spend in hospital when they are ready to be discharged reducing by 27% (N19). Of the 5 indicators that had performed worse than the previous period, 4 indicators were within 3% of the previous periods performance except readmission to hospital within 28 days at 10% (N14).**

National Indicators - Aberdeen City HSCP Performance
Current compared to previous reporting period

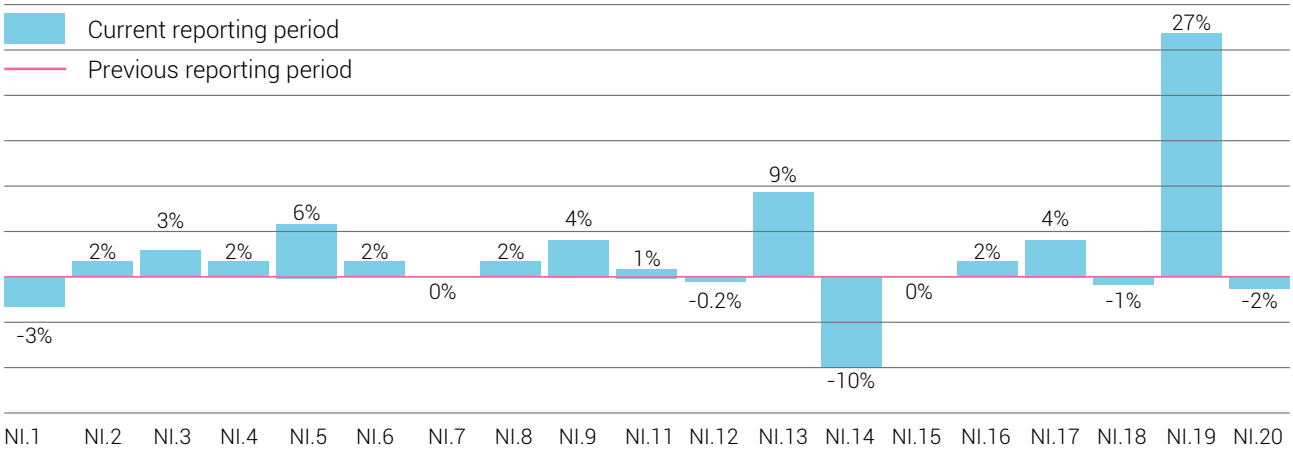

Figure 3.2 ACHSCP Performance (National Indicators) Compared to Previous Period

In Figure 3.3 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.

National Indicators - Aberdeen City HSCP
Performance against Scotland

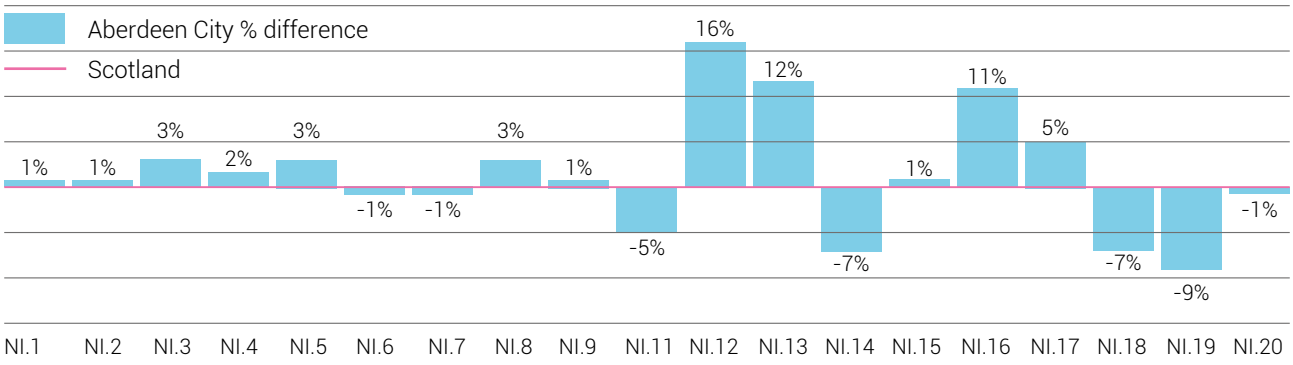

Figure 3.3 ACHSCP Performance (National indicators) Against Scotland

For the current reporting period, the partnership performed better than Scotland for 12 of the 19 indicators with particularly good comparative performance in the rate of emergency admissions at 16% better than the average (N12), the rate of emergency bed-days for adults at 12% (N13) and the falls rate per 1,000 population in over 65s at 11% (N16). We performed worse in 7 of the indicators with readmissions to hospital within 28 days of discharge worse than average by 7% (N14), the percentage of all adults with intensive needs receiving care at home worse by 7% lower (N18) and the number of days people spend in hospital when they are ready to be discharged worse by 9% (N19).

Figure 3.4 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.

National Indicators - Aberdeen City Rank from 32 Scottish HSCPs

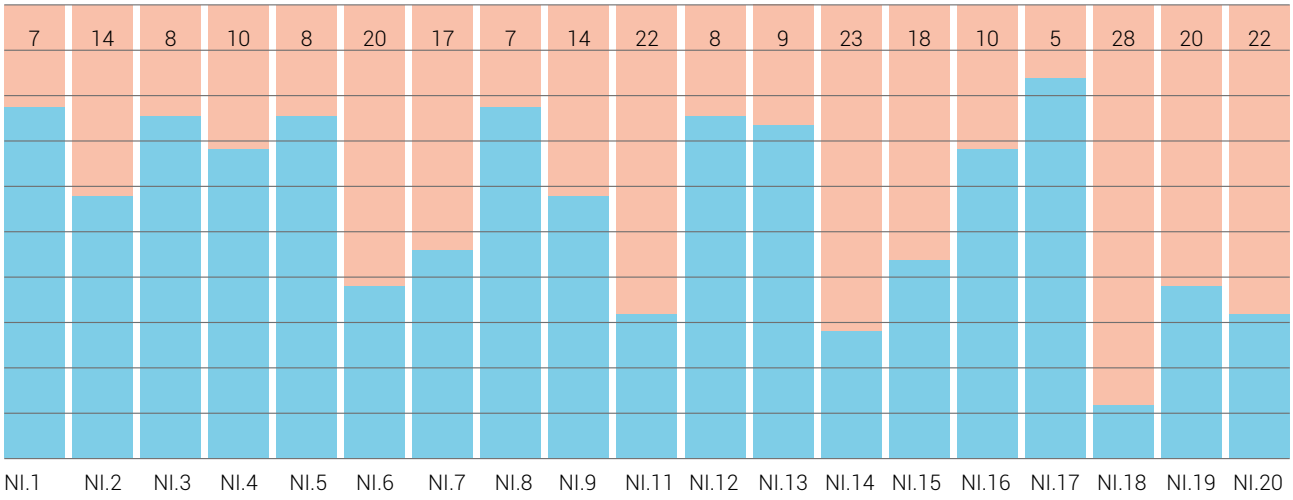

Figure 3.4 ACHSCP Performance (National Indicators) Ranked Against Other Partnerships

The partnership was in the top 50% for 11 of the 19 reported indicators for this reporting period. The most positive performance (5th) was in respect of N17 (the proportion of care services graded good (4) or better). The poorest ranking (28th) was in relation to N18 (percentage of all adults with intensive care needs receiving care at home)'..

Appendix One shows the partnership's performance in relation to the national core suite of indicators compared with the previous reporting period and also compared against the other partnerships in Scotland.

3.2.2 Outcome Attainment

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

Using a combination of data about health behaviours, use of health services and mortality, we can see that **94% of those surveyed said they could look after their own health well (2016/17: 97%). We also know that obesity amongst adults has decreased slightly in the past 4 years, the prevalence of smoking in adults has continued to decrease in the past 3 years and dental registration in adults has increased steadily in the past 4 years.**

The use of hospital services in emergencies or unplanned situations gives us a good indication of the population's health and wellbeing. **Emergency admission rates (i.e. adjusted for population size and age) had a very minimal increase in the past year but have reduced over the past 4 years and are consistently lower than the rate seen across Scotland.**

With these lifestyle improvements and decreasing emergency admission rates we would hope to see gradual positive change in longevity; however, the picture is a mixed one. **Male life expectancy in Aberdeen has been decreasing slowly since 2012 compared to a static position across Scotland. At 76 years, it is now statistically significantly lower than the Scottish average of 77. There is a difference of 9 years in life expectancy between the least and most deprived parts of the city. Female life expectancy has also reduced from 84 to 80 years, with a difference of 8 years between the least and most deprived parts of the city.**

Premature mortality is reducing at a slower rate than across Scotland. Of concern is that these avoidable deaths are occurring in middle-aged people in the most deprived parts of Aberdeen.

Our public health colleagues are leading the exploration of these trends so that we can better understand what initiatives will have the greatest positive impact on them.

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

82% of people who took part in the national health and care survey said that they are supported to live as independently as possible (2016/17: 80%). Some measures 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. These include:

- **a general increased trend in the proportion of adults with intensive care needs receiving care at home since 2010;**
- **a lower level of hospital admission following a fall, although this has been increasing slightly since 2015;**
- **a reduction in hospital bed-day rates following emergency admission since 2013, compared to a static picture nationally;**
- **stable readmission rates to hospital after 28 days of being discharged since 2011, although with a sharp increase in 2016;**
- **dramatic reduction in the number of days patients are delayed in hospital when they are ready to be discharged since 2014.**

Aberdeen was one of five demonstrator sites that took part in the 'Adapting for Change' programme, which concluded in 2018. Our local focus was:

- person-centred service re-design;
- reducing housing-related delayed discharge;
- housing options and housing allocations;
- promoting technology enabled care;
- better design outcomes.

We have applied our learning to provide person-centred housing solutions to those people in hospital awaiting their discharge. The volumes are not especially high but the length of delay can result in poor individual experiences and a high number of bed-days lost. A co-ordinated approach that emphasizes the contribution that interim housing options can make **has significantly reduced the number of individuals from a high point of 20-plus 5 years ago to a new improved low that sees fewer than 5 people per month experiencing delayed discharge because of their housing needs.**

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. According to the national survey, **there has been an increase in:**

- **the % of adults (79%) who say they have had a say in how their care is provided (2016/17: 76%);**
- **the % of adults (76%) who agree that their care is well co-ordinated (2016/17: 74%);**
- **the % of adults (83%) receiving any care or support who rated it as excellent or good (2016/17: 77%);**
- **the proportion of the city's care and support services (90%) that were rated good (grade 4) or better following Care Inspectorate inspections (2016/17: 86%).**

There has also been, however, a local decrease (82%) in positive GP experiences (2016/17: 84%).

Overall though, these local experiences reflect well against the national trend of reducing levels of satisfaction.

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

A significant proportion of the partnership's services are delivered by the third and independent sectors. Aberdeen Council for Voluntary Organisations (ACVO) and Scottish Care (the umbrella group for many of our care home and care at home provider organisations) have both played a prominent role in the constructive discussions that have taken place about how we ensure that improved personal experiences and outcomes for the many different people who use, and rely on, our services are delivered.

Services		Number of Services with Upheld/Partially Upheld Complaints (2016-17)	Number of Services with Enforcements (2016-17)	Number of Services with Requirements (2016-17)
Adult Placement Service	1	0 (0)	0 (0)	0 (0)
Care Home Service	58	9 (7)	1 (0)	6 (7)
Housing Support Service	58	3 (3)	0 (0)	6 (6)
Nurse Agency	6	0 (0)	0 (0)	0 (0)
Support Service	57	4 (1)	0 (0)	0 (0)
Total	**180**	**16 (11)**	**1 (0)**	**12 (13)**

Table 3.1: Complaints, Enforcements & Requirements (Source: Care Inspectorate)

Of all our commissioned services, it is our care homes and support services that are responsible for an increase in the number of complaints that were either upheld or partially upheld. The slight increase in enforcement action was attributable to a care home.

Quality Themes	**Inspection Grades**					
	1	2	3	4	5	6
Care and Support	0	3 (1.66%)	7 (3.88%)	43 (23.88%)	105 (58.33%)	22 (12.22%)
Environment	0	1 (1.38%)	5 (6.94%)	19 (26.38%)	41 (56.90%)	6 (8.33%)
Staffing	0	4 (2.22%)	8 (4.44%)	36 (20.00%)	110 (61.11%)	22 (12.22%)
Management & Leadership	0	4 (2.22%)	9 (5.00%)	54 (30.00%)	95 (52.77%)	18 (10.00%)

Table 3.2: Inspection Grades 2017-18 (Source: Care Inspectorate)

90% of care services in Aberdeen are graded good or better, an increase of 4% from last year and we are now in this respect 5th highest of all partnerships in Scotland. This comment from the husband of 'N' typifies the commitment and compassionate care that is delivered daily throughout the partnership...

"You know that I have always had the highest regard for Craig Court...and your truly wonderful team. I know that I could not have come through the past four and a half years without the dedication, professionalism and simple humanity of you all. Your support...and the tremendous care you gave 'N' particularly during the last few weeks of her life is something I shall remember and treasure for the rest of my life. We are forever in your debt."

As heartening as that is to read, we are also sadly mindful of the successful interventions that were necessary last year when we were informed of a (different) failing care home by the Care Inspectorate. We will never be complacent about the quality of care that is delivered in our name as a commissioning partnership and will always intervene in the best interests of those individuals who are receiving poor or unsatisfactory care.

How well are we helping to reduce health inequalities?

There are enduring health inequalities in the city. The previous sections highlighted the stark differences in life expectancy and the increased likelihood of being admitted to hospital in an emergency.

Particularly worrying is:

- **higher than average premature mortality in the city;**
- **all-cause mortality for 15-44 year olds in the most deprived parts of Aberdeen which is four times greater than our affluent areas;**
- **patients living in the most deprived parts of our city are twice as likely to be admitted as an emergency than those living in affluent areas.**

To combat this, we are striving to increase access to some of the services most used by people from our most deprived areas:

- **99% of people start alcohol treatment within 3 weeks of referral;**
- **98% of people start drug treatment within 3 weeks of referral.**

Improving the accessibility of our services and understanding the impact of our interventions with these population groups will help us tackle health inequalities in our communities.

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.

In particular:

- **only 40% of carers feel supported to continue in their caring role;**
- **only 49% of carers feel they have a say in the services provided for the person they look after.**

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. Our Carers Strategy Implementation Group will be tasked with understanding these responses and leading on their expected improvement.

How well do we keep people safe from harm?

Many of the measures described in the earlier sections give an indication of how well we protect people from harm, including emergency admissions, readmissions, falls rate and good quality commissioned services. In addition to these, **the national survey reports an increase in the proportion of adults supported at home who agreed they felt safe from 80% (2016/17) to 84% (no change in corresponding Scotland wide figure, 83%).**

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

During the past year we introduced "iMatter", a feedback tool for staff which provides a measure of engagement, communication and motivation. Our plan for 2017/18 is to use the tool pro-actively to engage with staff and teams on ways to address and improve our sickness absence levels. This is a key area of improvement work affecting the partnership's emerging organisational culture and productivity.

- **75% of employees completed the imatter questionnaire.**
- **80% of teams achieved the target response rate to receive a team report.**
- **78% represents how engaged all employees who completed the questionnaire felt (calculated from Qs1-28).**
- **6.94 (out of 10) employees rated working within the ACHSCP (calculated from Q29).**

Table 3.3 shows that the partnership was ranked first (75%) in Grampian by a considerable margin (Scottish average 65%) in its questionnaire response rate, a close second in the employee engagement index (78%) and a respectable third in the 'working within my organisation' score (6.94%). All of the partnership's results were higher than the corresponding figure for Scotland as a whole.

	Response Rate	Employee Engagement Index	Working within my Org
ACHSCP	75%	78%	6.94
Aberdeenshire	65%	79%	7.25
NHS Grampian	65%	77%	6.96
Scotland	63%	76%	6.77%

Table 3.3: iMatter questionnaire results 2017-18

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 at the start of the 2017/18 financial year was £302,855,462, a decrease of £7,884,785 (2.53%) from the funding given to it in 2016-17, its first year of existence.

Table 3.4 shows the respective contributions made by our partner organisations, NHS Grampian and Aberdeen City Council.

NHS Grampian £ (2016-17)	Aberdeen City Council £ (2016-17)
217,686,633 (222,584,000)	**85,168,829 (88,156,247)**

Table 3.4 Delegated funding to IJB

The IJB has previously agreed a reserves strategy and during the 2017/18 budget process agreed to hold back **£2.5 million** as earmarked reserves. The accounts show a usable reserves position of **£8,306,965 (2016-17, £10,417,474)**. This is largely due to unspent transformation funds provided by the Scottish Government to the IJB via NHS Grampian.

We have an ambitious strategic plan which seeks to transform our integrated health and social care services to improve the wellbeing of the local population and improve their experiences and outcomes. There was a significant level of spend allocated towards transformation projects during 2017-18 but the realisation of expected benefits was slower than might have been anticipated due to the complexity of having to work through the governance systems of the three organisations (NHS Grampian, Aberdeen City Council and the IJB). Following the recruitment to key project management positions in the strategy and transformation team it is expected that the pace and impact of our change activity will be demonstrably improved.

The breakdown of spend across all of our activities in 2017-18 is shown in Table 3.5.

Sector	Gross Expenditure £ (2016-17)	Variance (%) against Budget
Older People, Physical and	72,882,926 (69,719,818)	(0.55)
Sensory Impairments		
Primary Care Prescribing	41,364,343 (40,005,916)	4.07
Set Aside Services	41,344,000 (46,732,000)	-
Primary Care	37,234,075 (36,846,589)	0.6
Community Health Services	31,406,760 (31,649,313)	(0.54)
Learning Disabilities	31,269,790 (29,264,461)	1.72
ACHSCP share of Hosted Services	21,724,509 (21,207,851)	5.62
Mental Health and Substance Misuse	20,065,177 (18,304,741)	0.45
Transformation	5,011,678 (2,856,283)	-
Criminal Justice	4,658,796 (4,413,345)	(293.62)
Housing	1,860,555 (2,197,288)	0.0
Out of Area Placements	1,480,487 (1,219,506)	47.36
Head Office/Admin	(475,319) (1,007,021)	
Cost of Services	**309,827,777 (305,424,132)**	

Table 3.5 2017-18 Expenditure breakdown by sector

The Integration Scheme defines the services that have been delegated by the health board and local authority to the IJB. For some of the delegated health services it was not practical to split the services across the three IJBs in the Grampian area. These services are still delegated, but classed as 'hosted', which means the costs and budgets are shared based on estimated usage across the three IJB areas. These services are managed and led by one lead IJB on behalf of the other two boards in the area.

Our hosted services continue to experience financial pressure as the governance and financial processes between the three Grampian IJBs were not well enough developed for the 2017/18 budget process. Workshops have been held with the three IJBs during the past year to start developing and refining the governance and financial processes.

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. For the past year, **NHS Grampian has advised that the partnership's use of these services had reduced as indicated below.**

	2016-17	2017-18
Budget	£46,732,000	£41,344,000
Days Used	152,498	142,349

Table 3.6 Set Aside

This reduction can be interpreted as another indicator of our success in reducing delayed discharges and developing increased capacity in our communities and localities.

A proposed budget for 2018/19 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 27th March 2018.

The proposed balanced budget was approved.

3.3 Driving Improvement

The Ministerial Strategic Group (MSG) for Health and Community Care extended invitations to all partnerships across the country to participate in a national measurement of improvement under integration that focused on particular indicators (Table 4.7).

Indicators	2015-16	2016-17	2017-18	2018-19 Target
Number of emergency admissions (all ages)	21,745	21,289	21,628	20,677
% of emergency admissions from A&E	49%	48%	46%	
Number of unscheduled bed-days (acute)	158,187	148,558	133,879	127,185
Number of unscheduled bed-days (long-stay)				
Mental Health	65,653	62,622	57,858	
Geriatric	7,525	7,365	n/a	
Number of A&E attendances	46,435	45,459	46,272	44,525
% A&E attendances seen within 4 hours	95%	94%	92%	95%
Number of delayed discharge bed-days (all reasons)	43,944	27,353	19,202	16,891
% of delayed discharge bed-days occupied by Code 9s.	16%	14%	19%	

	2014-15	2015-16	2016-17 (prov)	2018-19 Target
% of last six months of life spent in community setting (inc care homes).	88%	88%	89%	90%
Balance of care; % of 75+ population in community settings.	98%	98%	98%	98.5%

Table 3.7 MSG Indicators

These indicators are proxy measures for how well the partnership is doing in keeping the city's adult residents safe, well and continuing to live in a homely setting. Favourable improvements can be seen in the % of emergency admissions from A&E, unscheduled bed-days, delayed discharge bed-days and the % of the last six months of life spent in a community setting. We have also seen previous improvements in emergency admissions, A&E attendances and % of A&E attendances seen within 4 hours reversed in the past year.

More specifically, there has been an increase in the number of A&E attendances but a decrease in the % of A&E attendances that are seen within 4 hours. Despite that increase in the number of A&E attendances, there is a reducing trend in the % of emergency admissions from A&E.

There has been a slight increase in the number of emergency admissions last year compared with the year before. However, over the past two years, the number of days that patients spent in hospital following an emergency admission fell by 15%. The 24,000 bed-days saved over this time is equivalent to 33 beds per annum. Our impressive record in tackling delayed discharge continued last year and, given that reduction, it is perhaps to be expected that the proportion of delayed discharge bed-days occupied by individuals with complex needs (Code 9s) has increased.

The % of last six months of life spent in community settings increased slightly whilst the balance of care showing the % of 75+ individuals living in the community remained constant.

Our continuing focus on promoting individual health and wellbeing, locality connections and innovative service design will all help people avoid unnecessary admission to hospital, lengthy stays and poor care outcomes post-discharge. We know what our targets for these indicators for 2018-19 are. We will report our progress against them in next year's annual report.

Did You Know?

The Public Bodies (Joint Working)(Scotland) Act 2014 obliges IJBs to have as non-voting members representatives (reps) of people who are using our integrated health and social care services and unpaid carers.

ACHSCP has one service user rep and two carer reps on our IJB who all commenced in their roles before 'Integration Go Live' in April 2016 and as such have been able to chart the partnership's progress since then against the expectations of the IJB.

Reflecting on the past year, the reps have been satisfied with the IJB's team spirit. All members are encouraged to have their say and are listened to resulting in, they believe, a more rounded and better-informed discussion. The involvement of the reps in the recent recruitment process for the new Chief Officer was seen as a heartening acceptance of their role and the contributions that they make not only to the IJB but to many other steering groups, committees, events and activities also.

As you might expect, the development of the partnership's Carers and Learning Disability Strategies has been seen as a high point. The huge efforts to consult widely and to ensure that the strategies reflect the lives of individuals with a learning disability and our unpaid carers has been welcomed.

Our reps recognise that much more work needs to be done to enable other users of our services and carers to have their comments and opinions channelled through the rep role. There are many diverse groups and organisations making positive contributions in their own way to the wellbeing of the local population such as CLAN for those people (individuals or carers) who are affected by cancer, Triple A's (Autism Awareness Association) a peer support organisation for those on the autistic spectrum and Our Positive Voice (Grampian) for those people who are living with HIV.

"The partnership is still in its infancy and, whilst it has achieved much, it still has far to go. We remain at the start of a journey and one which has many exciting prospects ahead."

4 Looking Forward

4.1 Conclusion

Last year's Annual Report reflected the success we had achieved in our first year of operation in putting the integration building blocks in place and beginning many inter-related transformation projects.

There is much still to do, and the mechanics of integration and its governance are complex. However, we have a solid platform from which to shape health and social care services for the future and to support us in a sustained focus on addressing long-standing and unacceptable health inequalities in our communities.

Our overall performance this past year has been good and noteworthy. The range and complexity of transformational activities that we are progressing this year has, if anything, 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 expect the scale, pace and impact of our ongoing transformation to be even more evident next year.

and finally . . .

Did You Know?

Cairns Counselling is one of the smaller organisations in the partnership. It is a grant-funded, city centre-based independent charity with over 24 years of experience in supporting adults with a range of issues including anxiety, depression, loss, relationship difficulties, low self-esteem and isolation.

In the past year, 932 requests for counselling were received (mostly from the recommendation of GPs). 5012 hours of counselling were arranged with the support of 32 volunteer counsellors and 80% of these appointments were attended.

95% of respondents to a service evaluation survey said they experienced an improvement in their wellbeing because of the counselling they received and 99% of respondents would recommend the service to others.

Some of their comments included the following:

"Slowly but surely, I began to make sense of things. I understood that I wasn't a failure; that I was worthwhile in my own right; that my identity wasn't in what I did but in who I am- the real me."

"I feel the whole outlook of my life, myself and others past, present, future, has changed incredibly for the better."

"I'm much more productive at work and more positive in looking at being able to tackle problems within relationships."

The impact of counselling is not only a benefit restricted to the individual, but one that ripples out to benefit relationships, families, employers and our wider communities.

Appendix One:

ACHSCP Performance (National Indicators) Compared Against Previous Period and Scotland

Indicator	Title	Aberdeen City		Scotland		RAG
		Previous 2015/16	Current 2017/18	Previous 2015/16	Current 2017/18	
NI - 1	Percentage of adults able to look after their health very well or quite well	97%	94%	95%	93%	A
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	80%	82%	83%	81%	G
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	76%	79%	79%	76%	G
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	74%	76%	75%	74%	G
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	77%	83%	81%	80%	G
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	84%	82%	85%	83%	A
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	79%	79%	83%	80%	G
NI - 8	Total combined % carers who feel supported to continue in their caring role	38%	40%	40%	37%	G
NI - 9	Percentage of adults supported at home who agreed they felt safe	80%	84%	83%	83%	G
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	NA	
NI - 11	Premature mortality rate per 100,000 persons (European age-standardised mortality rate per 100,000 for people aged under 75)	464 (2015/16)	460 (2016/17)	441 (2015/16)	440 (2016/17)	G
NI - 12	Emergency admission rate (per 100,000 population)	9978	9999	12297	11959	A
NI - 13	Emergency bed-day rate (per 100,000 population).	111,210	101,626	126,302	115,518	G

Indicator	Title	Aberdeen City		Scotland		RAG
		Previous 2015/16	Current 2017/18	Previous 2015/16	Current 2017/18	
Ni - 14	Readmission to hospital within 28 days (per 1,000 population)	94	103	100	97	R
Ni - 15	Proportion of last 6 months of life spent at home or in a community setting	89%	89%	87%	88%	G
NI - 16	Falls rate per 1,000 population aged 65+	20	19	21	22	G
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	86%	90%	84%	85%	G
NI - 18	Percentage of adults with intensive care needs receiving care at home	55% (2015/16)	54% (2016/17)	62% (2015/16)	61% (2016/17)	A
NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	1,156	844	842	722	G
NI -20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	25%	24%	25%	23%	G
NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	NA	
NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	NA	
NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	NA	

*All data is for 2016/17 or 2017/18 unless otherwise stated in the table

Appendix Two:

ACHSCP Local Indicators by Theme

Aberdeen City Health and Social Care Partnership: Performance at a Glance Quarter 4 (January - March 2018)

Theme	ID.	Indicator Description	Source	Performance Current Reporting Period	Target	Previous Reporting Period	Performance against Last Period	Trend Line	Trend Period	Current Period
Responsive	L01	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population	NHS - EDISON	24.0	-	24.0	S		5 Quarters	Jan-Mar 18
	L02	Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)	NHS - EDISON	44	-	49	I		5 Quarters	Jan-Mar 18
	L10	% people 65y+ with intensive care needs receiving care at home	SW	36.0%	-	37.0%	I		5 Quarters	Jan-Mar 18
	L11	Unmet need (hours) for social care	SW	720	-	753	I		5 Data	End Mar 18
	L12	Uptake of self directed support (No. & % out of eligible	SW	Opt 1. 33% (346) Opt 2. 2% (24) Opt 3. 65% (688)	-	N/A	N/A	Opt 1 Opt 2 Opt 3	1 Data Points	Apr 17-Mar 18
Effective	L03	A&E Attendance rates per 1000 population (All Ages)	NHS	49.6	-	52.5	I		5 Quarters	Jan-Mar 18
	L04	Smoking cessation in 40% most deprived after 12 weeks	NHS	81	-	102	W		5 Quarters	Oct-Dec 17
	L05	Number of Alcohol Brief Interventions being delivered	NHS	572	-	677	W		5 Quarters	Jan-Mar 18
Safe	L06A	Number of complaints received and % responded to within 20 working days - NHS	NHS	60.0% (20)	-	59.0% (22)	S		4 Quarters	Jan-Mar 18
	L06B	Number of complaints received and % responded to within 20 working days - Council	SW	83% (24)	-	100% (19)	W		5 Quarters	Jan-Mar 18
	L09	Number of new referrals to initial investigation under adult protection	SW	113	-	89	W		5 Quarters	Jan-Mar 18

Key

I Improved on previous reporting period by more than 2% S '+/- 2% on previous reporting period W Worsened on previous reporting period by more than 2%

Appendix Two:

Aberdeen City Health and Social Care Partnership: Performance at a Glance Quarter 4 (January - March 2018)

Theme	ID.	Indicator Description	Source	Performance Current Reporting Period	Target	Previous Reporting Period	Performance against Last Period	Trend Line	Trend Period	Current Period
Safe	L13	Adult Services % Posts Vacant	SW	4.9%	-	5.0%	I		4 Quarters	Oct -Dec 17
	L14	Number of new community payback orders	SW	285	-	274	W		5 Quarters	Jan-Mar 18
	L15	Number of Criminal Justice Social Work reports to court	SW	391	-	405	I		5 Quarters	Jan-Mar 18
Well Led	L07	NHS Sickness Absence % of Hours Lost	NHS	5.1%	-	5.1%	S		5 Quarters	Jan-Mar 18
	L08	Average number of days to sickness lost per employee in social care (rolling 12 months)	SW	13		11	S		5 Quarters	Jan-Mar 18

Aberdeen City
Health & Social Care
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