Edinburgh Integration Joint Board





ANNUAL PERFORMANCE REPORT

2018/2019

Working together for a caring, healthier, safer Edinburgh

NHS Lothian · EDINBVRGH · THE CITY OF EDINBURGH COUNCIL

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Foreword

The Annual Performance Report for 2018/19 captures areas of progress that the Edinburgh Integration Joint Board (EIJB) and the Edinburgh Health and Social Care Partnership (EHSCP) have made over the last financial year. The report measures our performance against our six strategic priorities as set out in the Strategic Plan 2016-19 and against the national health and wellbeing outcomes.

Although this has been a period where we have encountered challenges, we can also evidence gradual and prolonged improvements in performance across a range of areas. In the area of delayed discharge, a longstanding aspect of poor performance, we have driven the numbers down consistently against our planned trajectory. There has also been sustained improvement in the number of people waiting for assessment and waiting for packages of care. In primary care, we have seen positive improvements with a further 6,000 new citizens registered with our general practitioners, and a new, multi-disciplinary workforce beginning to be introduced into our primary care teams. Notably, pharmacists and mental health nurses have begun to make an impact and our Link Worker Network - supporting practices in areas of economic deprivation - is being augmented with a strengthened welfare rights capacity through our third sector partners. Whilst we welcome these improvements there is much still to do and we are not complacent. As integration in health and social care evolves, we continue to strive to provide the best level of care for the citizens of Edinburgh.

The EIJB began working with the Good Governance Institute (GGI) at the beginning of 2019 in a determined effort to strengthen its governance, decision making and in setting directions. Our work with the GGI will continue throughout the next reporting period. We continue to seek to find ways to improve outcomes for people and be innovative in our approaches against a backdrop of a rising population, changing patterns of health and care need and ongoing, significant financial pressure. It is still taking longer than we would wish for some of our citizens to be assessed and in receipt of the care they require but we are steadily improving. Fewer people are now delayed in an acute hospital when ready to go home, and those that are delayed, are delayed for a shorter time than previously. There is also much still to be done to support unpaid carers through our forthcoming Carers’ Strategy and improve integration in our workforce. These workstreams will maximise our resources and support our valued and hard-working staff. We will continue to focus on these areas in the coming year.

Angus McCann
EIJB Chair

Judith Proctor
EIJB Chief Officer

Introduction

The Edinburgh Integration Joint Board (EIJB) set out the vision and strategic aims in its Strategic Plan 2016-2019. The purpose of this Annual Performance Report is to show progress against the six priorities in the EIJB's Strategic Plan for the previous of its operation – 2018/19.

The Scottish Government passed the Public Bodies (Joint Working) (Scotland) Act (2014) (the Act), which brought together the planning and operational oversight for a range of NHS and local authority services for adults under a single body. The purpose of the legislation is to improve the overall health and wellbeing of the population of Scotland by jointly delivering efficient and effective health and social care services.

Since April 2016, the EIJB has been responsible for the strategic planning, governance oversight, scrutiny and performance management of most of adult health and social care services delegated to it, including some hospital-based services.

The majority of services for which the Board is responsible are delivered by the Health and Social Care Partnership (EHSCP), which is responsible for the operational elements of delivery. The Partnership brings together staff employed by the City of Edinburgh Council (the Council) and NHS Lothian to provide integrated services under the leadership of a single Chief Officer. The Chief Officer is accountable to the EIJB and to both the Council and NHS Lothian via their Chief Executives.

In March 2016, as required by the Act, the EIJB published its first Strategic Plan, setting out the strategic vision for community health and adult and social care services in the city over the next three years to 2019. In that Plan, we set out six linked key priorities that the EIJB believed was important to work towards to improve the health and wellbeing of the citizens of Edinburgh, by meeting the current need for services and managing future demand.

The six priorities are:

Prevention and early intervention
Preventing poor health and having wellbeing outcomes.

Tackling inequalities
Working with our partners to address the root causes, as well as supporting those groups whose health is at greatest risk from current levels of inequality.

Person-centred care
Practicing person centred care by placing good conversations at the centre of our engagement with citizens.

Managing our resources effectively
Making the best use of our shared resources to deliver high quality, integrated and personalised services, that improve the health and wellbeing of citizens whilst managing the financial challenge.

Making the best use of capacity across the system
Developing and making best use of the capacity available within the city to deliver timely and appropriate care and support to people with health and social care needs.

Right care, right place, right time
Delivering the right care in the right place at the right time for each individual.

National Indicators 2018/19

More detail on performance in respect to these indicators is provided throughout the Annual Performance Report. The national indicators are reported in relation to the six strategic priorities described in Table 2 which shows the association between the national outcomes, national indicators and the six EHSCP strategic priorities.

Qualitative Indicators (NI-1 to NI-10)

The qualitative indicators which form part of the National Core Data Set for health and social care are derived from a national survey called Scottish Government Health and Care experience (HACE), which is undertaken every two years.

Quantitative Indicators (NI-11 to NI-23)

The quantitative indicators aim to show shift in the balance of care from institutional services to community-based services. The data is sourced from ISD Scotland and the Care Inspectorate.

N/A – Not Available Data

Please note that for NI-1 to NI- 9, HACE survey is undertaken every two years therefore information is not available for 2018/19.

Our annual report sets out the progress we believe that we have made in working towards these priorities and those set for us by the Scottish Government. The relationship between the Edinburgh health and social care priorities, the national health and wellbeing outcomes and the national core performance measures are shown in Table 1 in the following page.

Table 1 – The relationship between EHSCP Priorities, the National Health and Wellbeing Outcomes & National Indicators

Local Priorities	Outcomes	National Indicators
Priority 1: Prevention & early intervention	1. People are able to look after and improve their own health and wellbeing and live in good health for longer 4. Health & social care services are centred on helping to maintain or improve the quality of life of people who use those services	**NI-1** Percentage of adults able to look after their health very well or quite well **NI-12** Rate of emergency admissions for adults (per 100,000) **NI-16** Falls rate per 1,000 population aged 65+
Priority 2: Tackling inequalities	5. Health & social care services contribute to reducing health inequalities	**NI-11** Premature mortality rate (per 100,000)
Priority 3: Person centred care	3. People who use health & social care services have positive experiences of those services, and have their dignity respected 7. People who use health and social care services are safe from harm	**NI-3** Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided **NI-4** Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated **NI-5** Total percentage of adults receiving any care or support who rated it as excellent or good **NI-6** Percentage of people with a positive experience of the care provided by their GP practice **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-9** Percentage of adults supported at home who agreed they felt safe **NI-15** Proportion of last 6 months of life spent at home or in community setting **NI-17** Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections
Priority 4: Managing resources effectively	8. People who work in health & social care services feel engaged with the work they do and are supported to continuously improve information, support, care and treatment they provide 9. Resources are used effectively and efficiently in the provision of health and social care services	**NI-14** Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges) **NI-19** Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) **NI-20** Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency
Priority 5: Making best use of capacity across system	6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	**NI-8** Total combined % carers who feel supported to continue in their caring role
Priority 6: Right Care, right place, right time	2. People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	**NI-2** Percentage of adults supported at home who agree that they are supported to live as independently as possible **NI-13** Rate of emergency bed days for adults (per 100,000) **NI-18** Percentage of adults with intensive care needs receiving care at home

Edinburgh Summary Performance

Performance at a glance

94% — **1. Adults are able to look after their health very well or quite well**

	14/15	15/16	16/17	17/18	18/19
Edinburgh	N/A	96%	N/A	94%	N/A
Scotland	N/A	95%	N/A	93%	N/A

79% — **2. Adults supported at home agreed that they are supported to live as independently as possible**

	14/15	15/16	16/17	17/18	18/19
Edinburgh	N/A	81%	N/A	79%	N/A
Scotland	N/A	83%	N/A	81%	N/A

74% — **3. Adults supported at home agreed they had a say in how their help care or support was provided**

	14/15	15/16	16/17	17/18	18/19
Edinburgh	N/A	77%	N/A	74%	N/A
Scotland	N/A	79%	N/A	76%	N/A

67% — **4. Adults supported at home agreed that their health and social care services seemed to be well coordinated**

	14/15	15/16	16/17	17/18	18/19
Edinburgh	N/A	71%	N/A	67%	N/A
Scotland	N/A	75%	N/A	74%	N/A

80% — **5. Adults receiving any care or support rated it as excellent or good**

	14/15	15/16	16/17	17/18	18/19
Edinburgh	N/A	78%	N/A	80%	N/A
Scotland	N/A	81%	N/A	80%	N/A

84% — **6. Adults had a positive experience of the care provided by their GP practice**

	14/15	15/16	16/17	17/18	18/19
Edinburgh	N/A	87%	N/A	84%	N/A
Scotland	N/A	85%	N/A	83%	N/A

79% — **7. Adults supported at home agreed their services and support had an impact on improving or maintaining their quality of life**

	14/15	15/16	16/17	17/18	18/19
Edinburgh	N/A	83%	N/A	79%	N/A
Scotland	N/A	83%	N/A	80%	N/A

35% — **8. Carers feel supported to continue in their caring role**

	14/15	15/16	16/17	17/18	18/19
Edinburgh	N/A	37%	N/A	35%	N/A
Scotland	N/A	40%	N/A	37%	N/A

77% — **9. Adults supported at home agreed they felt safe**

	14/15	15/16	16/17	17/18	18/19
Edinburgh	N/A	82%	N/A	77%	N/A
Scotland	N/A	83%	N/A	83%	N/A

**For NI-1 to NI- 9, Scottish Government Health and Care experience (HACE) survey is undertaken every two years therefore information is not available for 2018/19.*

386 per 100,000	11. Premature mortality rate		2014	2015	2016	2017	2018
		Edinburgh	377	406	399	380	386
		Scotland	423	441	440	425	432

8,511 per 100,000	12. Emergency admission rate		14/15	15/16	16/17	17/18	18/19
		Edinburgh	8,832	8,869	8,470	8,631	8,511
		Scotland	12,026	12,281	12,215	12,192	N/A

100,122 per 100,000	13. Emergency bed day rate		14/15	15/16	16/17	17/18	18/19
		Edinburgh	119,311	124,725	120,053	112,747	100,122
		Scotland	128,596	128,630	126,945	123,160	N/A

107 per 1,000	14. Readmission rate to hospital within 28 days		14/15	15/16	16/17	17/18	18/19
		Edinburgh	108	108	110	112	107
		Scotland	97	98	101	103	N/A

87%	15. Of the last 6 months of life is spent at home or in a community setting		14/15	15/16	16/17	17/18	18/19
		Edinburgh	83%	84%	85%	86%	87%
		Scotland	86%	87%	87%	88%	89%

22 per 1,000	16. Falls rate (65+)		14/15	15/16	16/17	17/18	18/19
		Edinburgh	23	23	22	23	22
		Scotland	21	22	22	23	N/A

84%	17. Care services graded GOOD (4) or better in Care Inspectorate inspections		14/15	15/16	16/17	17/18	18/19
		Edinburgh	83%	80%	84%	88%	84%
		Scotland	81%	83%	84%	85%	82%

61%	18. Adults with intensive care needs are receiving care at home		2014	2015	2016	2017	2018
		Edinburgh	60%	62%	62%	61%	N/A
		Scotland	61%	61%	62%	61%	N/A

1,630 per 1,000	19. The number of days people aged 75+ spend in hospital when they are ready to be discharged		14/15	15/16	16/17	17/18	18/19
		Edinburgh	1,861	1,679	1,395	1,502	1,630
		Scotland	1,044	915	841	762	805

23%	20. Health and care resource spent on hospital stays where patient was admitted as an emergency		14/15	15/16	16/17	17/18	18/19
		Edinburgh	24%	24%	24%	25%	23%
		Scotland	24%	24%	24%	25%	N/A

Table 2 - Edinburgh's Ranked Performance for national indicators

Indicator Title		Edinburgh score 2015/16	Scotland score 2015/16	Edinburgh score 2017/18	Scotland score 2017/18	Edinburgh Current Rank (Scotland-wide comparison)	Edinburgh performance against previous year	Scotland performance against previous year
NI - 1	Percentage of adults able to look after their health very well or quite well	96%	95%	94%	93%	16th	⇩	⇩
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	81%	83%	79%	81%	26th	⇩	⇩
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided	77%	79%	74%	76%	23rd	⇩	⇩
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	71%	75%	67%	74%	29th	⇩	⇩
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	78%	81%	80%	80%	19th	⇩	⇩
NI - 6	Percentage or people with positive experience of the care provided by their GP	87%	85%	84%	83%	16th	⇩	⇩
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	83%	83%	79%	80%	19th	⇩	⇩
NI - 8	Total combined % of carers who feel supported to continue in their caring role	37%	40%	35%	37%	26th	⇩	⇩
NI - 9	Percentage of adults supported at home who agreed they felt safe	82%	83%	77%	83%	31st	⇩	⇨

Indicator Title		Edinburgh score 2016/17	Scotland score 2016/17	Edinburgh score 2017/18	Scotland score 2017/18	Edinburgh score 2018/19	Scotland score 2018/19	Edinburgh Current Rank (Scotland-wide comparison)	Edinburgh performance against previous year	Scotland performance against previous year
NI - 11	Premature mortality rate per 100,000 persons	399 (Calendar year 2016)	440 (Calendar year 2016)	380 (Calendar year 2017)	425 (Calendar year 2017)	386 (Calendar year 2018)	432 (Calendar year 2018)	12th	⇩	⇩
NI - 12	Rate of emergency admissions for adults (per 100,000 population)	8,470	12,215	8,631	12,192	8,511	N/A	2nd	⇧	⇧
NI - 13	Rate of emergency bed days for adults (per 100,000 population)	120,053	126,945	112,747	123,160	100,122	N/A	13th	⇧	⇧
NI - 14	Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges)	109.5	101.0	111.5	102.6	107.0	N/A	23rd	⇧	⇩
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	84.8	87.1	85.7	87.9	86.5	88.8	31st	⇧	⇧
NI - 16	Falls rate per 1,000 population aged 65+	22	22	23	23	22	N/A	20th	⇧	⇩
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	84%	84%	88%	85%	84%	82%	17th	⇩	⇩
NI - 18	Percentage of adults with intensive care needs receiving care at home	62.3% (Calendar year 2016)	61.6% (Calendar year 2016)	61.0% (Calendar year 2017)	60.6% (Calendar year 2017)	N/A	N/A	23rd	⇩	⇩
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	1,395	841	1,502	762	1,630	805	31st	⇩	⇩
NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	24.3%	24.3%	24.9%	25.1%	22.9%	N/A	22nd	⇧	⇩

Edinburgh 2018/19

Our Facts by Numbers

How **data** can paint a picture of a **diverse** city

A Growing Population:

Home to **518,500** residents

That's over **5,250 new residents** from last year.

Room for more - visit and learn:

Over **4.5 M tourists*** visited and **56,910 students.**

*Last available data 2017

An Ageing Population

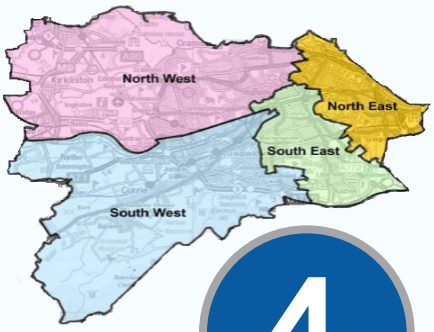
Home to:

78,060
Residents over 65+

995
Older people increase from last year

89,194
Older people expected by 2025

An increase of
14%



4
Localities

70
GP Surgeries
provided
3 Million consultations/ treatments
last year

5 Million
Hours of Homecare

109,506
A&E Visits

13.5%* of residents are carers

*Last available data 2011

“A cycle of deprivation and low aspiration has been allowed to persist because preventative measures have not been prioritised. It is estimated that as much as 40 per cent of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach”

- Christie Commission

Priority 1

Prevention and early intervention

Investing in approaches that prevent problems occurring or stop them getting worse is a key part of our strategy for improving the health and well being of the citizens of Edinburgh and managing future demand for services.

Building Resilient Communities

The Edinburgh Wellbeing Public Social Partnership (PSP) between statutory and third sector organisations in each locality in the city is delivering a wide range of service and support for people experiencing mental distress and illness. Partners are delivering crisis support, peer support and physical activities – all focussed on mental health, wellbeing and recovery. The current Wellbeing PSP will be extended into 2020 and this will enable longer term planning for this model and, potentially eight year agreements in place This is a significant outcome for the Edinburgh Wellbeing PSP.

A Sense of Belonging Arts programme (ASOB)
ASOB programme supported the fifth annual "Out of Sight Out of Mind" Arts exhibition at Summerhall, October 2018 which attracted over 3,000 visitors over a three week exhibition period with 500 curated exhibition pieces produced by people with lived experience of mental health problems.

Thrive Edinburgh

A series of engagement and coproduction events with stakeholders across the city led to the development of Thrive Edinburgh. Thrive is a response to addressing the mental health and wellbeing needs of all our citizens and is underpinned by four Thrive Edinburgh has four guiding principles:

Change the Conversation. Change the Culture 'mental health is everybody's business'.

**Using and creating evidence and data to drive change - **drawing on a wide range of evidence and creating an inquiring culture which builds evidence from practice.

Partnering with communities - listening and learning from each other, making the invisible visible, focusing on social networks, connectivity and relationships with kindness respect and love through active coproduction.

Act early - focusing on how we capitalise on our opportunities to build resilience and protective factors at all life stages in a range of settings.

Thrive Edinburgh has four objectives:

- Identify and address root causes
- Focus on those who are at highest risk
- Provide treatment that is easy to access and makes difference
- Building resilience and enhancing support for people to live well and meet their potential.

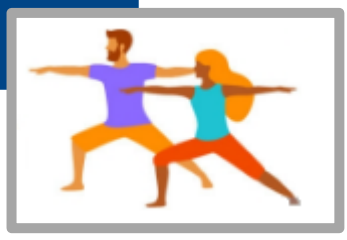
Thrive Edinburgh will include a number of new initiatives and events which will provide robust infrastructure and partnership support. Plans for two of the city's key partnerships – Health and Social Care and the Children's Partnership are being developed. Each of these commissioning plans has six workstreams underpinned by the guiding principles and objectives, informed by the Thrive Edinburgh vision.

Building Resilient Communities
Get Help When Needed
Rights in Mind
A Place to Live
Closing the Inequalities Gap
Meeting Treatment Gaps

GameChanger is an exciting and innovative Public Social Partnership led by EHSCP, Hibernian Football Club and the Hibernian Community Foundation. The aim is to unlock the power and passion associated with football and to make greater use of all Hibernian's physical, cultural and professional assets, to deliver a better, healthier future for the most vulnerable, disenfranchised or disadvantaged in our communities.

GameChanger has a wide-ranging reach across health domains and age groups. It has spearheaded the development of Edinburgh Cheer an annual Christmas campaign to make Edinburgh the kindest city to be at Christmas time. This has also involved working with Heart of Midlothian FC, Big Hearts Community Foundation, Tesco and Network Rail, Lothian Buses, City Taxis and approximately 10 private and 25 third sector agencies across the city, benefiting thousands of people who may struggle during this time of year.

65
People attend the "Fit for Live" free weekly physical activity



50
People meet for a lunch chat every week at "Community Connecting"

Primary Care

Primary Care in Edinburgh is delivered to our growing population through 70 GP Practices (our Primary Care Teams), embedded in their local communities.

On average, each practice sees each patient 5-6 times per year, with approximately 70% of all people living in Edinburgh seeing their local Primary Care Team at least once per year. Frequency of attendance varies with age - children under 5 years and adults over 60 years attend much more often. Over 6 million face to face contacts occur each year with Edinburgh Primary Care. GPs issue prescriptions which result in over 6 million items per year to be dispensed from community pharmacists. Our expenditure per person across Edinburgh is low by all available comparisons, and we are always looking for ways to improve the quality of our prescribing to ensure everyone receives the medicines they need and from which they will benefit.

Accomplishments

Primary Care across the UK has come under increasing pressure to meet demand over the last few years. Edinburgh is no different and the challenge has been amplified by the steady increase in our population by 59,980 over the last 10 years. A New General Medical Services (GMS) contract was agreed between the Government and the British Medical Association in early 2018, and the Edinburgh HSCP was tasked with agreeing a Primary Care Improvement Plan (PCIP) to deliver the benefits of the new investments which came with the new contract.

So far, the Edinburgh Primary Care Support Team has worked alongside GPs to deliver a new workforce to be introduced in primary care. By the end of 2018/19 we had about a third of this new workforce in place:

- Pharmacists supplying additional sessions of support to 60 of our practices
- Mental Health Nurses working as part of 20 primary care teams and improving the support available through local services
- Link Workers working with 19 of our Primary care Teams
- A number of smaller scale developments where we are assessing where professionals such as physiotherapists can assist with the direct delivery of primary care

In addition, we supported most Edinburgh practices with investments in practical application of technology, with training of staff to have some ‘clinical admin’ tasks able to be taken away from medical staff, to ensure Practice Management expertise was effectively harnessed and to agree how to ‘fairly’ allocate the resource available amongst all practices.

As a result, Edinburgh was able to absorb around 6,000 additional people on to GP lists this year and to prevent any further individual practices being unable to continue. We expect to consolidate and extend this approach during 2019/20 in anticipation of a more substantial investment from April 2020.

Challenges

Primary care throughout the UK has faced unprecedented difficulties over the last few years. A combination of factors has contributed to:

- Fewer medical graduates choosing Primary Care due to excessive workloads and falling remuneration
- Existing doctors choosing to work less due to pension disincentives and workload/risk of burnout/risks of mental fatigue
- Increasing demands of secondary care for often routine requests
- Expectations of patients for immediate access or response – not related to health status
- Poor investment in premises and IT systems
- Difficulty in accessing other health and social care systems for patients with immediate requirements, resulting in the burden of responsibility resting with Primary Care
- Aging population with increased health needs and increasing medical intervention potential across all age groups

All of the above reflects the poor level of investment in the sector, which the Scottish Government has now addressed with a new (General Medical Services) contract.

> “After building up a good rapport with Anna and earning her trust, we attended the link up centre together. Seeing her thrive just shows how much of a meaningful impact we can have in changing people’s lives with our work.”

Case Study

When meeting Anna, her link worker noted that she was initially hard to engage with very limited eye contact and quite angry at ‘systems’. With her children currently in care, she had ongoing meetings with social work which caused her a lot of stress - she struggled to understand the situation and what was happening.

Anna’s mood was very low, but not suicidal. She struggled to take care of herself - she felt unmotivated to get up in the morning, rarely ate or washed. Other than social workers, she didn’t have any other form of social interactions as her partner lives in Pakistan. She struggled financially and was unaware of her eligibility for any other benefits.

Her link worker had also noticed that Anna was struggling to see certain things.

Her link worker connected Anna with Advocard, Granton info centre for help with Personal Independence Payments (PIP) forms. She also arranged and supported Anna to go to the opticians.

After working up to it, Anna attended the women’s link up project with her link worker and she now attends their weekly drop in sessions to interact with people every week.

Anna feels less stressed now when she attends her social worker meetings. She now benefits from regular PIP benefits which helped her financial position. Her optician also provided her with glasses. With all this is place, everything looks a bit clearer.

Long Term Conditions Programme

In Edinburgh we estimate that 23% of people have at least one long term condition and 37% of these people have two or more long term conditions[1], known as multimorbidity. Much of the health service is designed to care for each condition in isolation. People with multiple long-term conditions often experience disjointed services and have a high 'burden of treatment' from the various professionals who support them to manage their conditions.

As people get older, they develop more long-term conditions and their use of health and social care services increases and becomes more expensive. People with long term conditions are twice as likely to be admitted to hospital, stay in hospital disproportionately longer and account for over 60% of hospital bed days[2]. People with multimorbidity account for 78% of consultations in primary care[3].

Falls can have a significant impact on an older person's independence and quality of life and are amongst the most common and most serious problems experienced by older people. Approximately 30% of people over the age of 65 experience a fall each year, which rises to 50% over 80.

The Long-Term Conditions Programme provides support to health and social care teams to improve care for people living with long-term health conditions and those who are at risk of falls. Care is improved through supporting practitioners to translate the principles defined in the *Quality Strategy* into practice, by:

- seeing the whole person rather than each individual condition;
- engaging the whole team involved in the person's care, including third sector partners; and
- improving the way that care and support is planned across the whole system.

We have developed a multi-agency Community Respiratory Hub to support people with Chronic Obstructive Pulmonary Disease (COPD) who are at high risk of hospital admission. The hub aims to improve how people experience care when they are unwell by:

- Increasing the number of people that are safely cared for at home – avoiding unnecessary admissions to hospital.
- Increasing the number of people who can confidently self-manage their condition.
- Supporting people with their physical, mental health and the wider issues that matter to people.

[1] Lothian Integrated Resource Framework 2012/13

[2] https://www2.gov.scot/Topics/Health/Services/Long-Term-Conditions

[3] Salisbury C et al. Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study. Br J Gen Pract 2011;61: e12-21.

Between April 2018–March 2019, 574 people who were at immediate high risk of hospital admission were assessed by the Community Respiratory Team within the hub. **91% (520) of these people were able to be safely cared for at home, avoiding hospital admission.** There been a 17% reduction in the number of days people who are unwell with COPD spend in hospital.

"In addition to my ability there has been a positive improvement in my mental awareness and attitude. I always feel better after the sessions."

Annie, 86 yrs, Fit for Health Participant

Falls

By proactively identifying people at risk of falls and fractures at an early stage and ensuring they are able to access the right support at the right time, we aim to reduce the number of falls related hospital attendances and increase the number of people who are assessed for risk of falls.

Compared to 2017, the number of **falls related A&E attendances in Edinburgh has reduced by 9%** from 384 attendances to 347. Over the same period, we have increased the number of falls assessments by 22%.

We know that care home residents are three times more likely to fall than older people living in the community. By working with care home staff, we aim to improve the understanding and management of falls and reduce related hospital attendances. Between August 2018 and March 2019, we have supported four care homes across Edinburgh. Falls related A&E attendances in these care homes has reduced, from an average of 23.7 per 100 beds to 2.2 per 100 beds within 6 months, resulting in an **average improvement rate of 91%.** Unplanned hospital admissions also significantly reduced from 20.1 per care home bed pre intervention, to 0.5 per care home bed within project engagement resulting in an **improvement rate of unplanned admissions of 97.5%.**

Hosted by Edinburgh Leisure, *Steady Steps* offers people who are at risk of falls to participate in a 16 week exercise programme that can help improve their strength, balance and confidence. Over the next year, we aim to test this approach in care homes.

Physical activity is a key contributor to improve self-management of long-term conditions and can have a positive effect on quality of life and reduce or maintain symptoms experienced with these conditions. Regular physical activity has also been evidenced to help prevent over 40 chronic diseases.
Working in partnership with Edinburgh Leisure *Fit for Health* 16 week physical activity programme supports people living with long term conditions to be more active and live healthier lives. *Fit for Health* encourages and supports individuals to care for their own health, providing information and physical activity options that support self-management.

Between April 2018 – March 2019, **749 people with long term conditions were referred to participate in *Fit for Health* – an increase of 21%** on the previous year.

Digital Support

Digital support can empower people with long term conditions to better manage their health and wellbeing, support independent living and gain access to services through digital means.

31% of adult UK population have raised Blood Pressure (BP). In Scotland, 1.2 million primary care appointments are made to annually check BP. Poorly controlled BP leads to an estimated 62,000 unnecessary deaths from stroke and heart attacks per year in the UK.

We know that home monitored BP is a better predictor of cardiovascular risk than GP surgery measured BP. We provide support to GP practice teams to engage people to monitor their own blood pressure at home through the *Scale Up BP* project. During the period April 2018 – March 2019 **49 GP practices and 1,590 patients were engaged**.

Anticipatory Care Planning (ACP)

ACP is a person-centred, proactive, 'thinking ahead' approach, with services and health and care professionals working with individuals, carers and their families to make informed choices about their care and support.

During the last year, we have built on the success of an earlier test of change to develop ACP pathways for people in care homes. Since April 2018, we have worked with a further 20 care homes and their aligned GP practices with the shared aim of supporting residents to think ahead about what matters to them, ensuring they have greater choice and control over their care and treatment should their condition deteriorate.

Outcomes:

- **reduced the number of (care home residents) avoidable admissions to hospital by 56%**
- created 183 ACP Key Information Summaries for care homes residents and reviewed a further 276, ensuring important information is shared across the wider health system.
- delivered 63 ACP training sessions to 404 staff across care homes, health, and health and social care teams
- held four road shows at hospitals across Edinburgh to raise public awareness of ACP and held an ACP learning event attended by over 140 delegates from across Edinburgh.

Our performance in relation to the National Health and Wellbeing Outcomes in this Priority

National Health and Wellbeing Outcome 1
People are able to look after and improve their own health and wellbeing and live in good health for longer
National Health and Wellbeing Outcome 4
Health & social care services are centred on helping to maintain or improve the quality of life of people who use those services

National Indicator (NI)		Edinburgh 2018/19	Compared to last year
NI-1	Percentage of adults able to look after their health very well or quite well *	N/A*	N/A*
NI-12	Rate of emergency admissions for adults (per 100,000) ^	8,511	- 120
NI-16	Falls rate per 1,000 population aged 65+ ^	22	-1

**Source: HACE, which is undertaken every two years therefore information is not available for 2018/19.*

^Source: ISD Scotland.

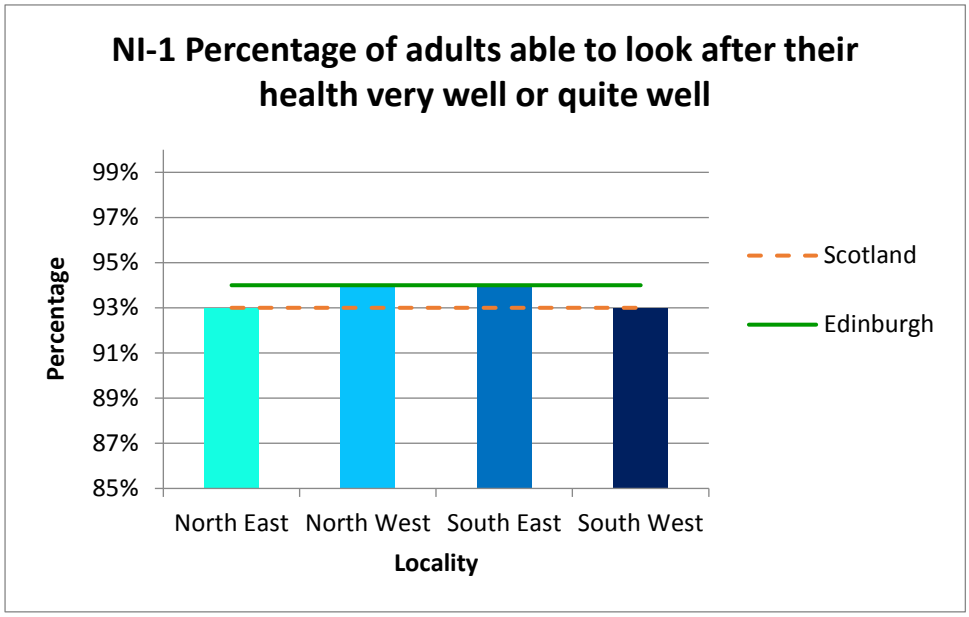
These indicators tell us about how well our services support prevention, early intervention and people being better able to be independent.

We aim to:

- **Continue to maintain and improve the percentage of people who can look after their own health very, or quite well;**
- **Continue improving the rate of emergency admissions per 100,000 of the population**
- **Reduce further the falls rate of those aged over 65**

Locality breakdown: NI-1 Percentage of adults able to look after their health very well or quite well.

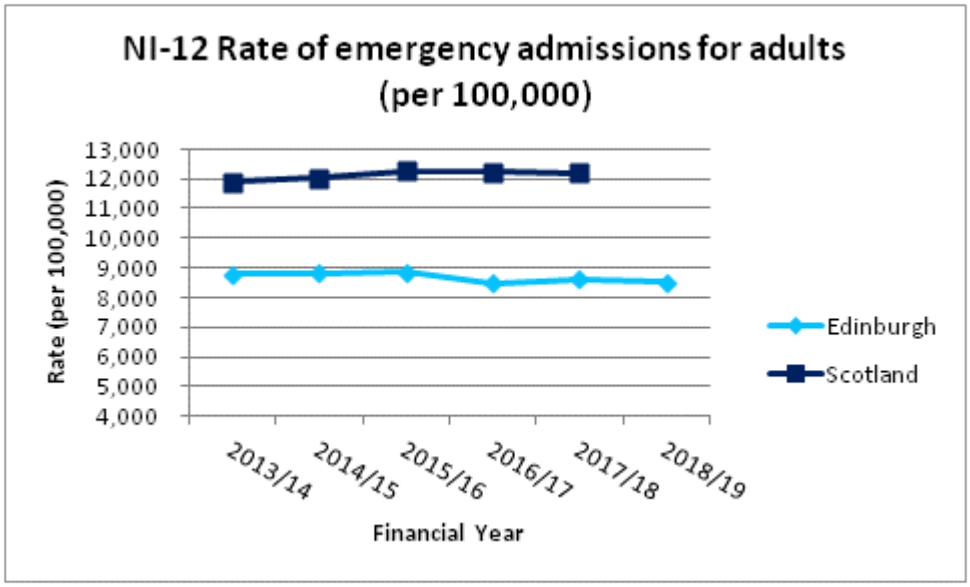
	Percentage
Scotland	93%
Edinburgh	94%
North East	93%
North West	94%
South East	94%
South West	93%



Source: *Scottish Government HACE survey 2017/18.*

NI-12: Rate of emergency admissions for adults (per 100,000)

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Edinburgh	8,775	8,832	8,869	8,470	8,631	8,511
Scotland	11,892	12,026	12,281	12,215	12,192	N/A*

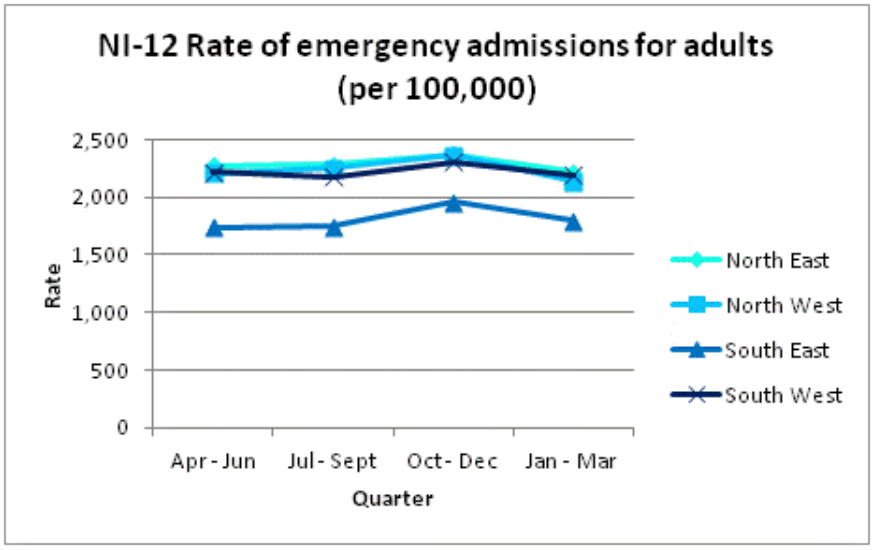


Source*: ISD Scotland.*

** No Scotland data available for full year.*

Locality breakdown: **NI-12** Rate of emergency admissions for adults (per 100,000)

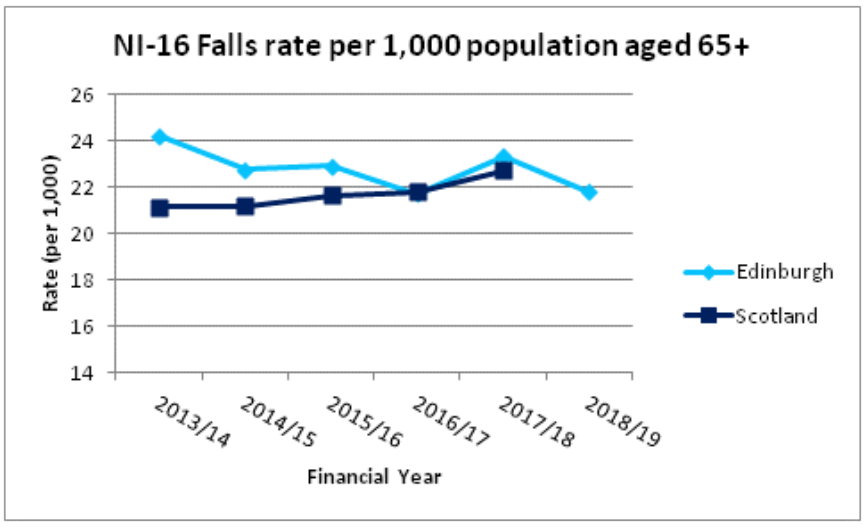
	2018/19			
	Apr - Jun	Jul - Sept	Oct - Dec	Jan - Mar
North East	2,271	2,282	2,374	2,215
North West	2,207	2,252	2,361	2,133
South East	1,739	1,743	1,954	1,799
South West	2,221	2,177	2,307	2,194



***Source**: ISD Scotland.*

NI-16: Falls rate per 1,000 population aged 65+

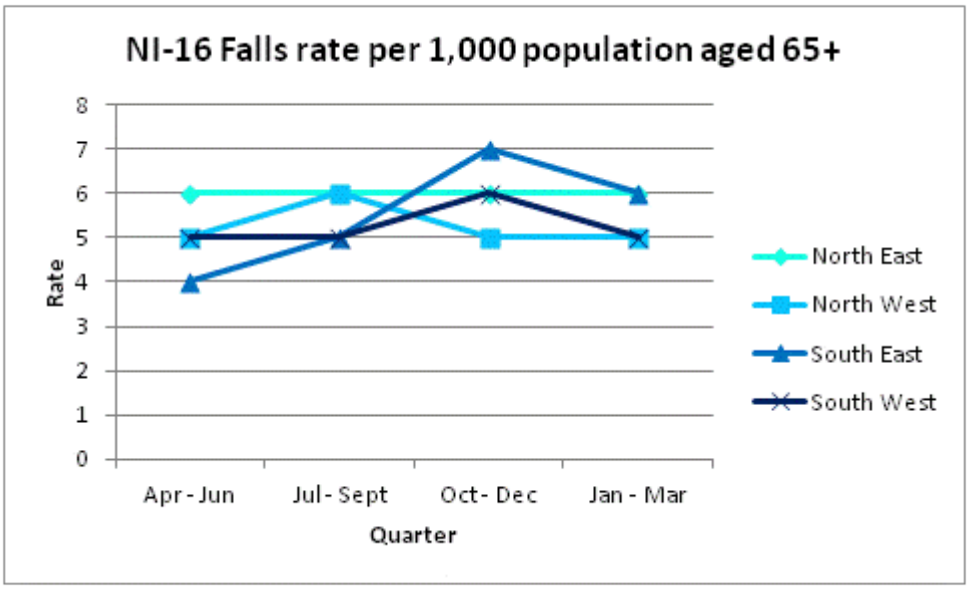
	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19^
Edinburgh	24	23	23	22	23	22
Scotland	21	21	22	22	23	N/A*



***Source**: ISD Scotland.*
** No Scotland data available for full year.*

Locality breakdown: NI-16 Falls rate per 1,000 population aged 65+

	2018/19			
	Apr - Jun	Jul - Sept	Oct - Dec	Jan - Mar
North East	6	6	6	6
North West	5	6	5	5
South East	4	5	7	6
South West	5	5	6	5



***Source**: ISD Scotland.*

^ Data completeness for Jan – Mar is 97% therefore there is missing data.

“ Tackling the root causes of current levels of inequalities will help us to both improve outcomes for citizens and address the increasing demand for health and social care services.”

Priority 2

Tackling inequalities

We know that people living in poverty and those who are part of specific social groups experience poorer life changes (e.g. unemployment and illness), reduced health and wellbeing and shorter life expectancy. Analysis of poverty income inequality in Edinburgh shows that it is an affluent city, with median household incomes estimated at 27% above the Scottish average. Despite this, the proportion of all households below the poverty line in Edinburgh is estimated at 15% (three-year average 2015-18). {source: Scottish Government)

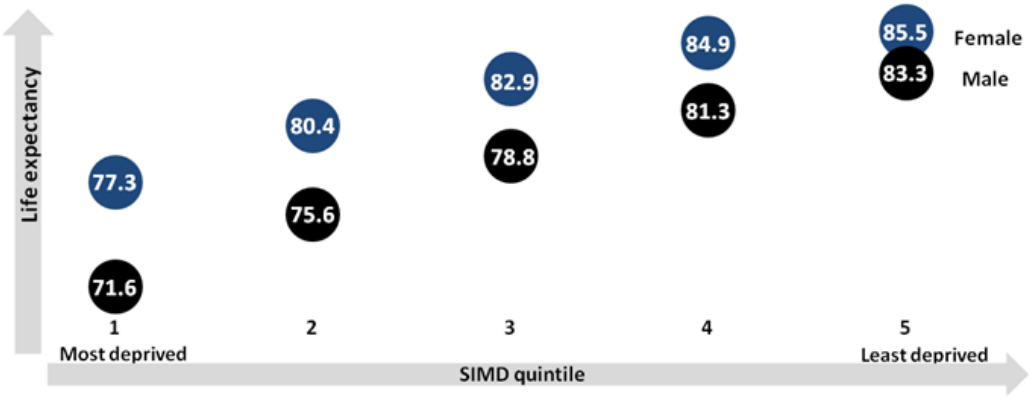
20%

of pensioner households live below the poverty line in Edinburgh

Premature mortality

Health inequalities contribute thousands of unnecessary premature deaths every year in Scotland. We also know that significant proportion of those experiencing ill health do not live in the areas that classified as being the most deprived (using the Scottish Index of Multiple Deprivation (SIMD)). The picture in Edinburgh is very mixed, with areas of affluence and areas of significant poverty existing side-by-side in all four of the localities.

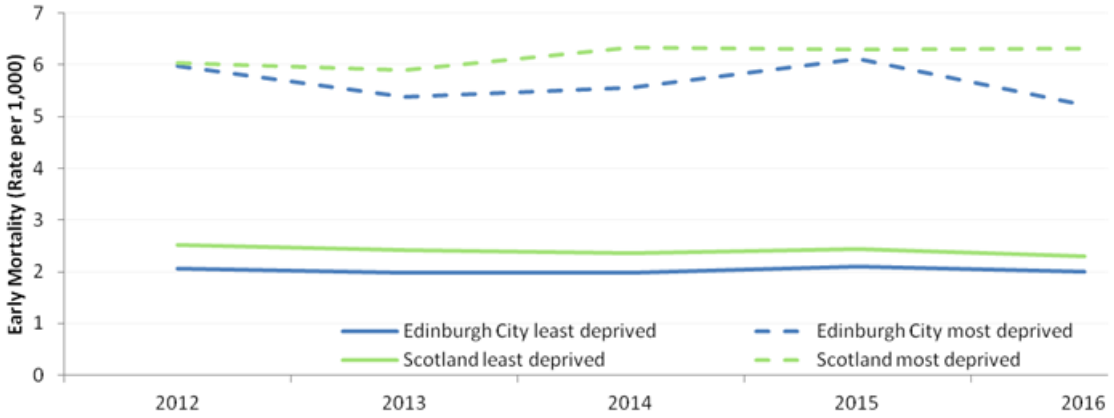
The graphic below shows the estimated average life expectancy (for males and females) at birth in years. Life expectancy at birth for an area is the number of years that a newborn baby would live if they experienced the age-specific mortality rates for that area, for the time period used, throughout their life. It is a theoretical measure which reflects recent mortality rates throughout life, rather than a true prediction of the life expectancy of the local population.



Life expectancy by sex and deprivation in Edinburgh
Source: National Records of Scotland

The wider environment in which people live and work shapes their individual experiences in terms of low income, poor housing, discrimination and access to health services. This results in the unequal and unfair distribution of health, ill health (morbidity) and death (mortality). This has implications beyond health inequalities.

It can take a number of years to effect change in levels of inequality. There has been a decline in premature mortality in Edinburgh for its most deprived citizens. Possible reasons for this decline could be attributed to national schemes that have been introduced in the last 10 years (e.g. smoke free environment and minimum alcohol pricing).



rate of early mortality by SIMD per 1,000 population (0-74)
Edinburgh City compared to Scotland

Homelessness

- People who are homeless experience some of the poorest health and wellbeing outcomes, worse than the general population. The Inclusive Edinburgh Homeless service works to provide health, housing and social work support to homeless people who have complex needs. Currently the service is implementing a *Housing First* model of supported accommodation which was initially developed in New York in the early nineties. The approach stemmed from initiatives to meet the needs of the substantial population of chronically street homeless people with multiple and complex needs. The *Housing First* model operates by taking account of two key principles: housing is a basic human right, not a reward for clinical success; and once the chaos of homelessness is eliminated from a person's life, clinical and social stabilisation occur faster and are more enduring.

This is such a great example of bringing communities together, creating employment opportunities for people and using local suppliers for healthy eating options. It also gives us a model that we can build upon for our sites and venues

Case Study – The Prep Table Café

The commitment to improving health outcomes for people by addressing the social determinates of ill health related to employment, meaningful activities poor diet, and income, coupled with the commitment to socially sustainable procurement led to a proposal to develop a social enterprise cafe in the NHS Lothian Education Centre at Comely Bank in the west of the city. The key delivery partner is Prep Table who believe that everyone is entitled to good fresh quality food; choice and variety; a place to sit with their loved ones; and enjoy themselves.

As well as sharing food, Prep Table also seeks to ensure that organisations can share food donations, good will, funding and surplus food resulting in effective food distribution within Edinburgh for all. This offers affordable, healthy and locally sourced food for staff and community members, cooked and served by paid employees and volunteers who have an opportunity to gain new skills and experiences within a supportive working environment. It presents a prime opportunity to meet wider health gain aspirations for people who are experiencing significant inequalities, whether staff and local community members.

Prep Table is committed to working with agencies that are committed to improving the life chances of people experiencing hardships, distress and marginalisation.

Health Inequalities Grant Programme

Both the Edinburgh Partnership and the Edinburgh Integration Joint Board (IJB) recognise the importance of reducing health inequalities and enabling prevention and early intervention. Two of the key priorities identified in the IJB's Strategic Plan are to:

Tackle inequalities: take action to identify those experiencing poorer health outcomes and address the barriers they face which will in turn help manage the increasing demand for health and social care services.

Consolidate the approach to prevention and early intervention: establish links with community resources and assets to ensure people have the opportunity to access preventative opportunities which will help them keep themselves as fit and healthy as possible.

In order to help realise these priorities, an overall investment of £1.8m was made through the Health Inequalities Grant Programme in 2018/19.

The grants criteria comprises the four strategic objectives together with 10 priority outcomes. The priority outcomes are designed to cover the broad range of issues which impact on the health inequality objectives and have been developed over time through a co-production process with a range of stakeholders.

Health Inequalities Grant Programme Priority Outcomes	**Percentage of participants surveyed who agreed or strongly agreed that the service had the intended positive impact on them**
Increased social capital	89%
Increased Community Capacity	85%
More people live in healthy environments and use greenspace	86%
Increased participation in physical activity	88%
Increased number of people eat healthily	94%
Reduced misuse of alcohol and drugs	64%
Reduced levels of anxiety and depression	80%
Reduced damage to physical and mental health from all forms of abuse and violence	85%
Increased income	84%

Bill's story shows that the positive impact in his life had a "ripple effect" on others. His journey and his renewed enthusiasm for giving back to the community by becoming a volunteer to help others is inspiring – the wider impact is important.

Case Study

Bill was referred to Carr Gomm, a local 3rd sector organisation, because he was socially isolated, and had poor confidence and self-esteem. Bill received one-to-one support sessions, an accompanied visit to a local community gym and visits to local organisations

Through meaningful time with Carr Gomm's worker, anxiety was identified as a problem and creator of his self-isolation. As a result, Bill was supported to attend an anxiety management workshop, run by the Thistle Foundation to improve his self-management. The workshop gave him his first experience of peer support which he found invaluable in terms of his recovery and gave him the confidence to access a local gym.

In addition to the Thistle Anxiety workshop and gym, Bill was supported to access the Volunteer Edinburgh website and Mental Health Conversation Café.

Bill has now secured a volunteering position in local Charity shop and has become a great advocate for regular exercise improving your health.

Our performance in relation to the National Health and Wellbeing Outcomes in this Priority

National Health and Wellbeing Outcome 5
Health & social care services contribute to reducing health inequalities

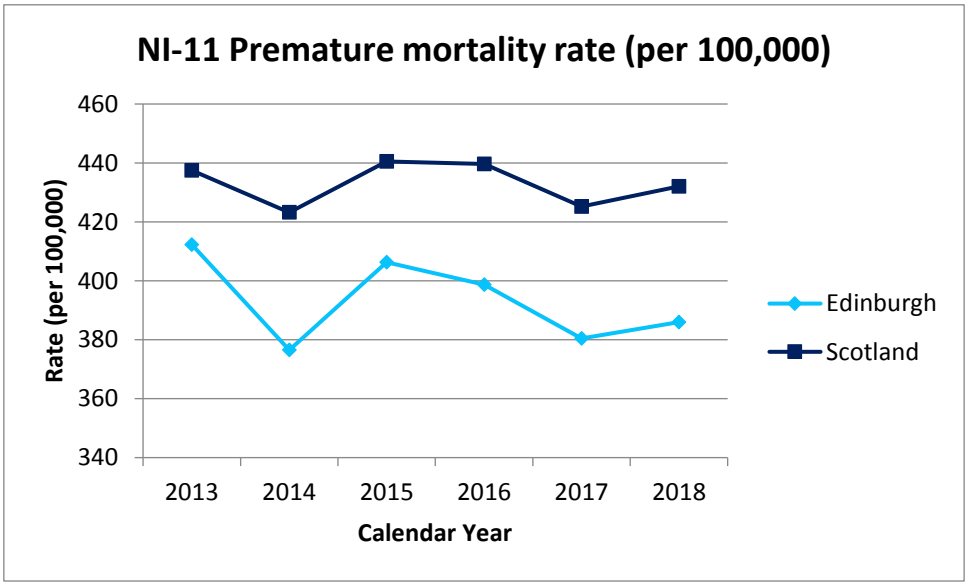
National Indicator (NI)		Edinburgh 2018	Compared to last year
NI-11	Premature mortality rate (per 100,000)	386	380

***Source**: National Records of Scotland (NRS).*

NI-11: Premature mortality rate (per 100,000)

	2013	2014	2015	2016	2017	2018
Edinburgh	412	377	406	399	380	386
Scotland	438	423	441	440	425	432

The Premature Mortality rate helps us understand improvements or deteriorations in health inequalities in the population. With our partner agencies we want to see further improvement over time.



***Source**: National Records of Scotland (NRS).*

“ putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome.”

Priority 3

Person-centred care

Care should not be experienced as a 'one size fits all' model to people but shaped around what individuals think would help them to live as independently and happily as possible.

The Edinburgh Integration Joint Board is committed to supporting citizens to live as independently as possible and exercise more choice and control over the way in which their health and care needs are met. We endorse the principles of *Collaboration, Dignity, Informed Choice, Innovation, Involvement, Participation, Responsibility and Risk enablement* that underpin the Social Care (Self-directed Support) (Scotland) Act 2013. In last year's Annual Performance Report, we recognised that we had not made the necessary progress we needed in respect of this strategic priority.

Edinburgh Carer Support Team

The Edinburgh Carer Support Team (ECST) consists of a Hospital Discharge Carer Support Service (HDCSS) and a Community Carer Support Service delivered in partnership with third sector partners. The aim of our service is to provide an easy, internal pathway for front line staff to use when they identify a citizen with a caring role. We aim to identify carers early in their caring role, having a good conversation to identify their personal needs and desired outcomes enabling us to support them in a person-centred way.

"Your approach and generosity with time and patience is still being felt as I now support my mother and sister. The work that you and your team do is invaluable."

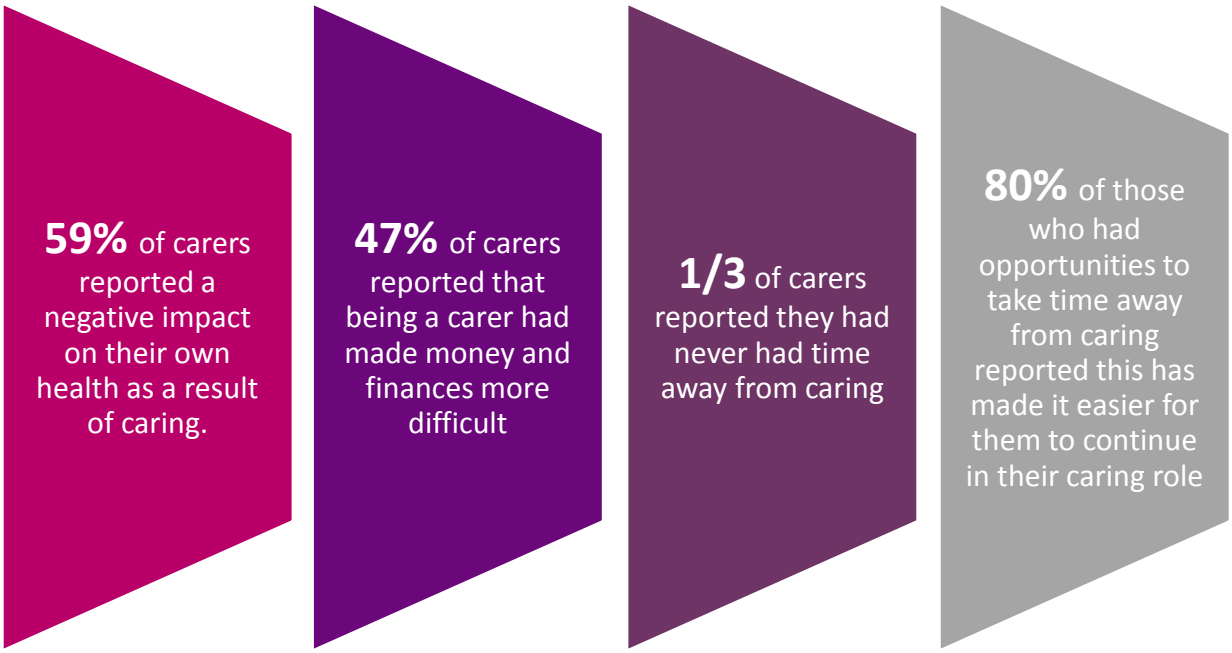
Accomplishments

- The HDCSS received 907 referrals and completed 335 Adult Carer Support Plans
- The Community Carer Support Service received 406 referrals for carer support
- The HDCSS participated in the pilot phase of using the new Adult Carer Support Plan (ACSP) in North West Edinburgh and have rolled this out to the rest of the HDCSS
- Two new Carer Support Worker posts were established
- We piloted a new process to support carers to complete Anticipatory Care Plan
- We worked in partnership with carer organisations across the city to provide support to both adult and young carers including carer information and support; carer advocacy and carer training, learning, and peer support opportunities.

Challenges

- We experienced challenges in managing the increased numbers of referrals due to demand. Our current waiting time for an ACSP to be carried out by the HDCSS is approximately eight weeks. This is an improvement for citizens in the length of wait they experienced in previous years before the HDCSS was in place, but we would like to improve this.

- Rolling out the new ACSP process has meant both cultural and process system changes. Although this has been a challenge, positive progress has been made and moving into 2019 will be in rolling out this to wider teams both in the EHSCP and with third sector organisations.



Priority areas from VOCAL's carer survey March 2018

Right in Mind

- **The Peer Collaborative** brings together people who experience mental health challenges in order to aid recovery and understanding. The Peer Collaborative share information, learn together and increase capacity for peer support in Edinburgh. New initiatives introduced include opportunities for all mental health staff to learn how to use their own recovery experience to support others, workshops for peer workers and a new 5 day Peer Work course.

- **A Rights Based Care** programme hosted by Advocard and the Royal Edinburgh Hospital Patients Council is being established. This will be a user-led, collective advocacy project which will aim to promote rights-based care to train and raise awareness of rights-based care practice across professionals who work with people using mental health services in the City. This will encompass and further develop the "A&E | All and Equal" and focus on embedding measures compliant with the United Nations Convention on the Rights of People with Disabilities.

Good Conversations

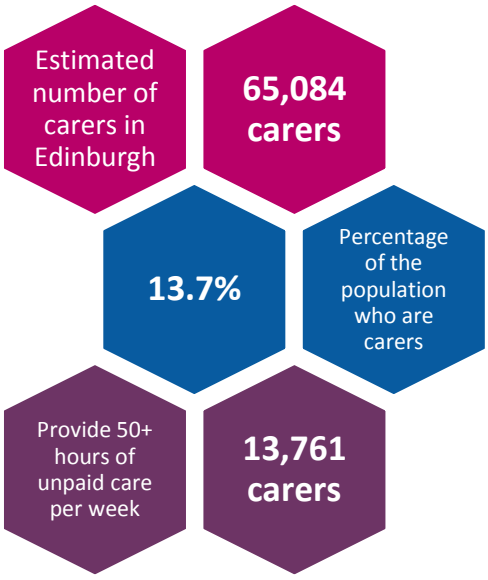
Since November 2017 the Edinburgh Health and Social Care Partnership has been working alongside the Thistle Foundation to deliver Good Conversations training to a total of 171 practitioners. Good conversations start with what matters to the person and explore how to make the most of strengths and resources the person already has, before exploring how the partnership might support them. Feedback from the training has been positive, with a key aspect of the programme being the inclusion of facilitated reflective practice sessions.

> *"My experience so far is the new assessment seems to elicit more conversation from the client regarding their situation and it feels more inclusive as it shows what they can do themselves to improve their situation as well as any input from others."*

Each cohort of practitioners has been supported to generate ideas about how to improve their own and team approach, taking an outcome focused and strengths-based approach to working with people, communities, and each other. Many of the challenges identified by practitioners were around current systems and ways of working, as well as how they will be supported to sustain change.

Several innovations have developed from the training including:

- Locality based reflective practice sessions, where practitioners supported each other to change their approach
- Changing initial conversations with people to focus on their best hopes from working with the partnership
- Co-producing and testing an alternative assessment tool, the Good Conversation Record, with staff and supported people.



Edinburgh's Carers -
Scottish Household Survey 2011

Who are Edinburgh's carers?

The Scottish Health Survey 2016[4] estimated that there are 788,000 people caring for a relative, friend or neighbour in Scotland, 44,000 (5.6%), of these people are under the age of 18. It also indicated that a third of carers have reported that caring has a negative impact on their health. The Scottish Household Survey (2011) estimates there are 65,084 carers living in Edinburgh, this is 13.7% of the population.

"Thank you for listening to me. I really appreciate that you have taken this time to listen to me and to know that someone is there. You have made me feel better because I have been able to talk to someone"

Case Study

A referral was received from an Occupational Therapist for a Carer who provides personal care, emotional and physical support and assistance with medication for their spouse who has a progressive neurological disorder. They also manage the running of the household including finances and medical appointments. The Carer has their own health issues which affects their mobility. A package of care (POC) is in place once a day from Monday to Friday for fifteen minutes and on a Tuesday the cared for person attends a day centre. An Adult Carer Support Plan (ACSP) was carried out by a dedicated Carer Support Worker (CSW) who offered the carer an opportunity to have a good conversation about their individual circumstances looking at their own personal needs and outcomes. Through this, the significant impact on the carers physical and mental health became apparent and they expressed how socially isolated and emotionally drained they felt with guilt and worry. The Carer was extremely stressed, had no time for themselves and didn't want to ask for help but felt they desperately needed it.

A plan was completed, and the carer was eligible for support in a number of ways; firstly through a carers payment to fund adult swimming lessons in order to support the carer to improve their physical and mental health, their self-confidence and reduce isolation. The Carer also accessed a Carers Emergency Card; was supported to complete an Anticipatory Care Plan to reduce further stress; referred onto a specialist neurological CSW to carry out a Carer's Emergency Plan and offer ongoing support. The CSW also requested on behalf of the cared for person; a second day at the day centre; an overnight respite package; an increase to the POC to 7 days per week; and referred them for a befriender. These supports will give the Carer a break from their caring role, allow them to improve their own health and decrease their stress levels.

[4] The Scottish Health Survey (2016) https://www.gov.scot/publications/scottish-health-survey-2016-volume-1-main-report/pages/60/

Our performance in relation to the National Health and Wellbeing Outcomes in this Priority

National Health and Wellbeing Outcome 3
People who use health & social care services have positive experiences of those services, and have their dignity respected
National Health and Wellbeing Outcome 7
People who use health and social care services are safe from harm

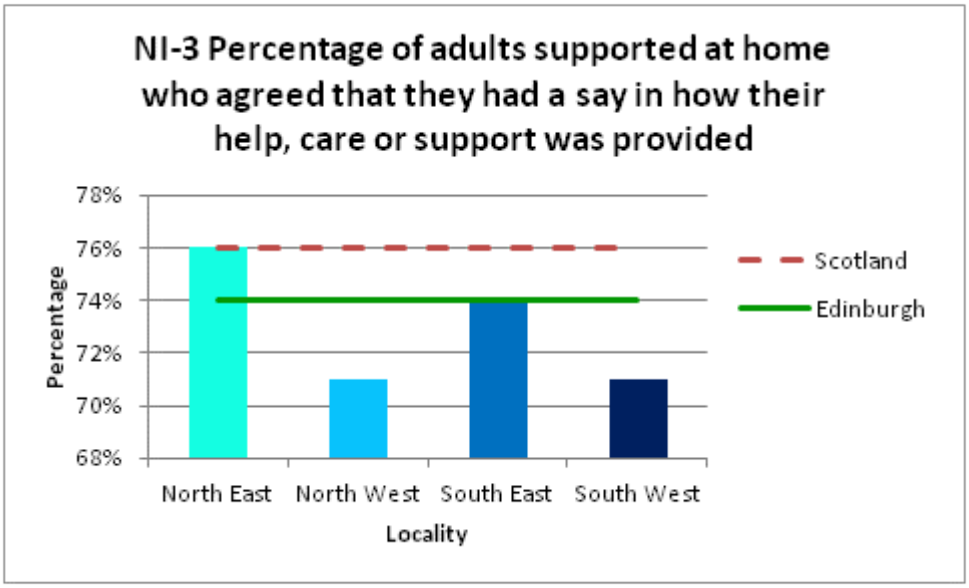
National Indicator (NI)		**Edinburgh 2018/19**	**Compared to last year**
NI-3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. *	N/A	
NI-4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated. *		
NI-5	Total percentage of adults receiving any care or support who rated it as excellent or good. *		
NI-6	Percentage of people with a positive experience of the care provided by their GP practice. *		
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-9	Percentage of adults supported at home who agreed they felt safe. *		
NI-15	Proportion of last 6 months of life spent at home or in community setting ^	87%	1%
NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections +	84%	- 4%

**Source: HACE, which is undertaken every two years therefore information is not available for 2018/19.*
^Source: ISD Scotland.
+Source: Care Inspectorate.

We aim to improve people's experience of care and support – in supporting them being independent as possible at home, or in a homely setting. Our performance against these indicators tell us that generally the majority of people have a positive experience of the care and support they receive. However there are some areas, such as in care co-ordination, where we need further improvement.

Locality breakdown: NI-3 Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.

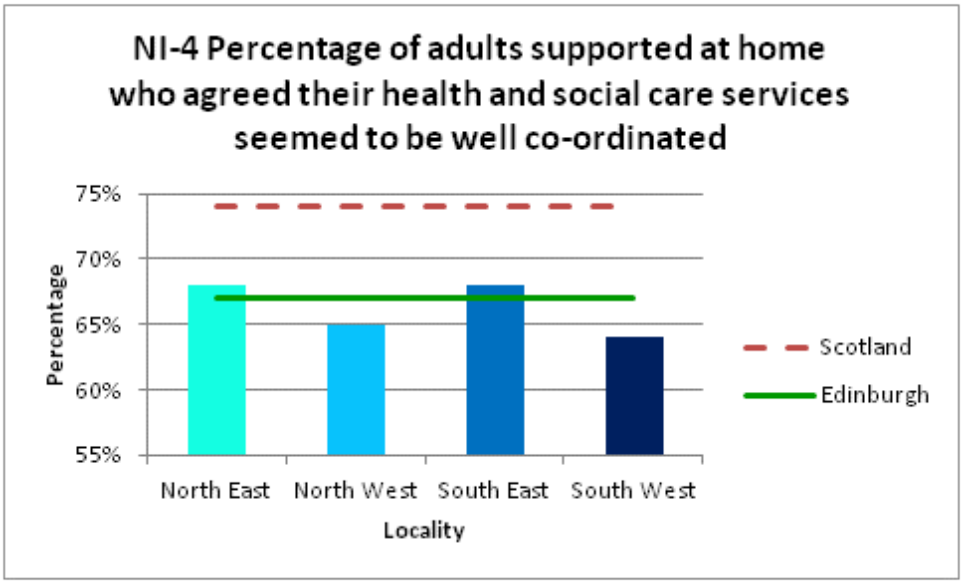
	Percentage
Scotland	76%
Edinburgh	74%
North East	76%
North West	71%
South East	74%
South West	71%



Source: *Scottish Government HACE survey 2017/18.*

Locality breakdown: NI-4 Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated.

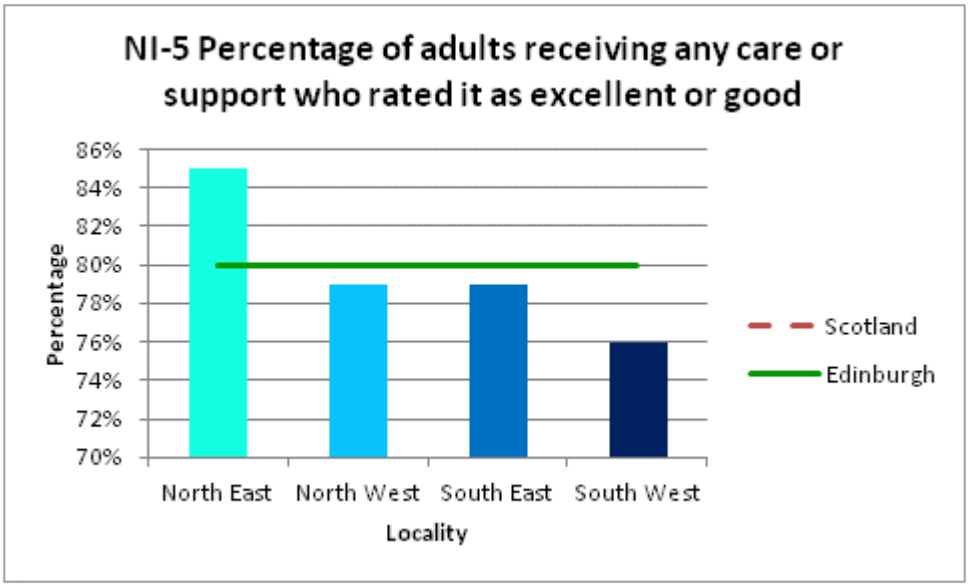
	Percentage
Scotland	74%
Edinburgh	67%
North East	68%
North West	65%
South East	68%
South West	64%



Source: *Scottish Government HACE survey 2017/18.*

Locality breakdown: NI-5 Total percentage of adults receiving any care or support who rated it as excellent or good.

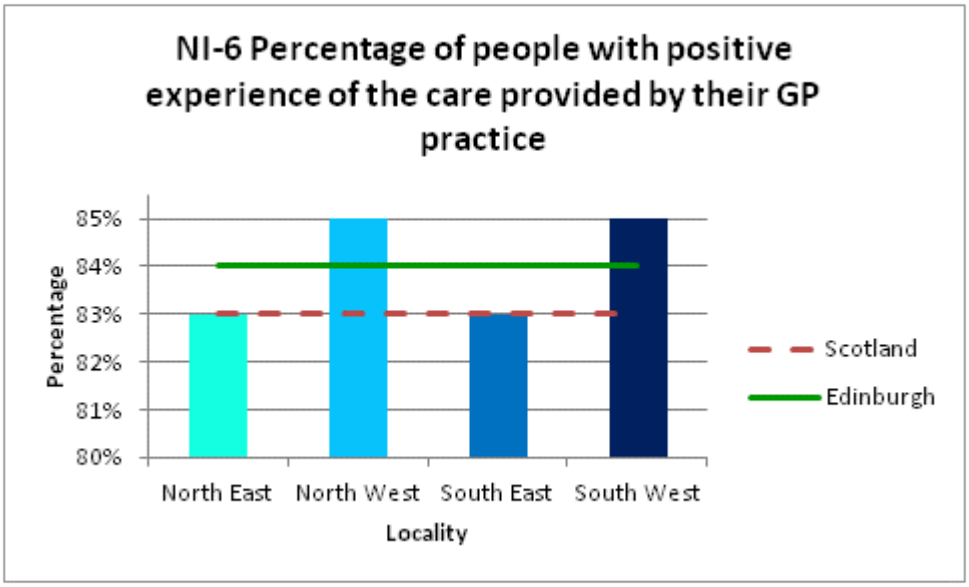
	Percentage
Scotland	80%
Edinburgh	80%
North East	85%
North West	79%
South East	79%
South West	76%



Source: *Scottish Government HACE survey 2017/18.*

Locality breakdown: NI-6 Percentage of people with a positive experience of the care provided by their GP practice.

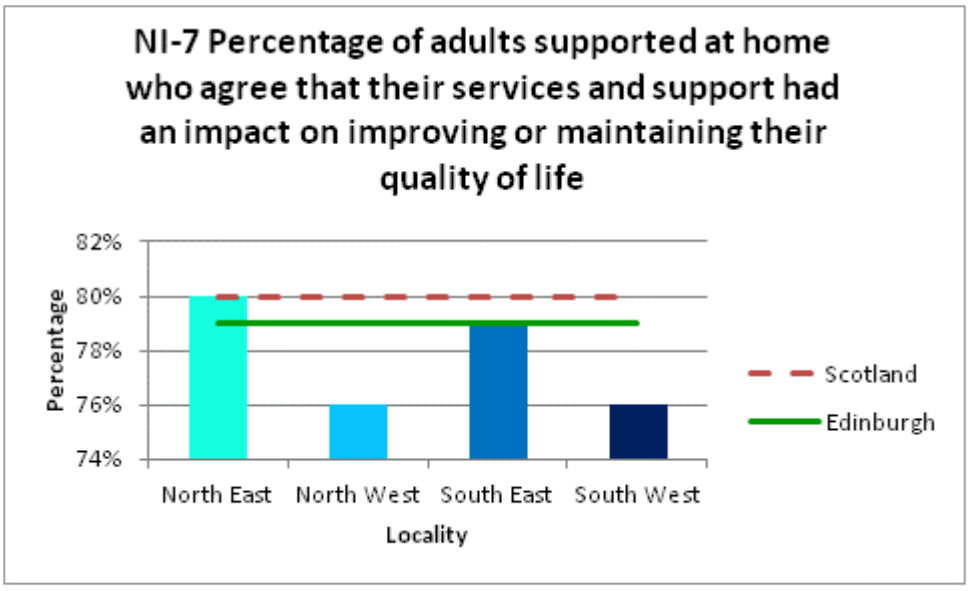
	Percentage
Scotland	83%
Edinburgh	84%
North East	83%
North West	85%
South East	83%
South West	85%



Source: *Scottish Government HACE survey 2017/18.*

Locality breakdown: 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.

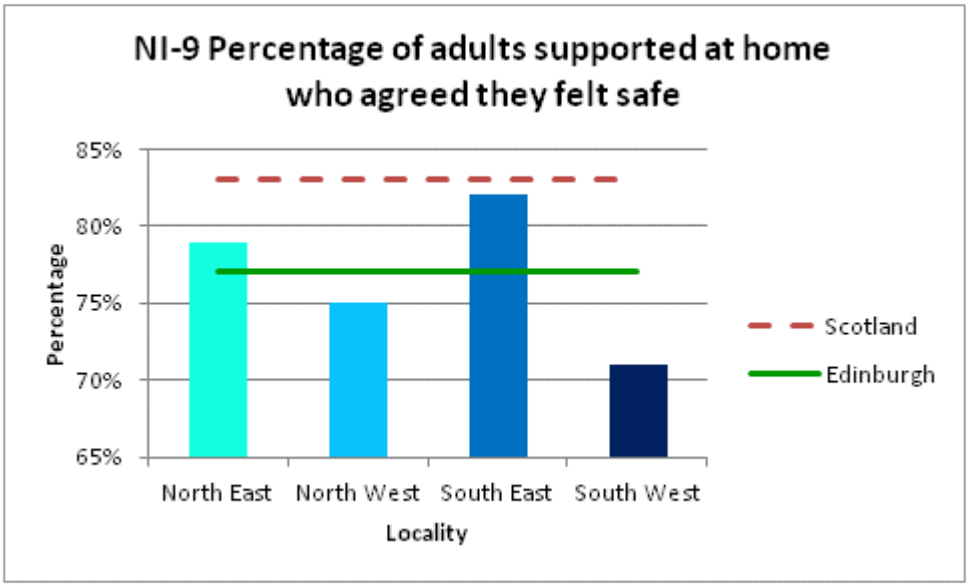
	Percentage
Scotland	80%
Edinburgh	79%
North East	80%
North West	76%
South East	79%
South West	76%



Source: *Scottish Government HACE survey 2017/18.*

Locality breakdown: NI-9 Percentage of adults supported at home who agreed they felt safe.

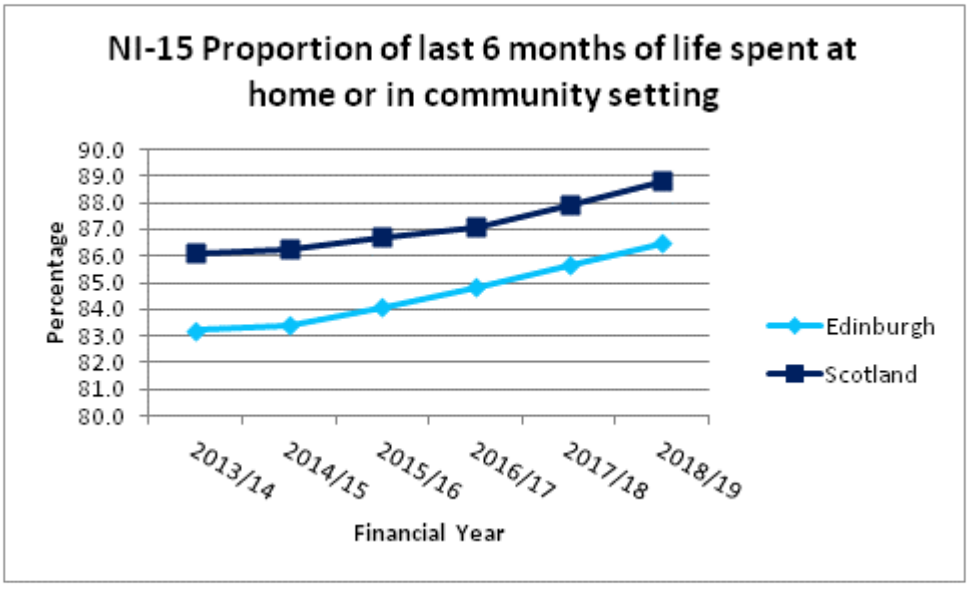
	Percentage
Scotland	83%
Edinburgh	77%
North East	79%
North West	75%
South East	82%
South West	71%



Source: *Scottish Government HACE survey 2017/18.*

NI-15: Proportion of last 6 months of life spent at home or in a community setting

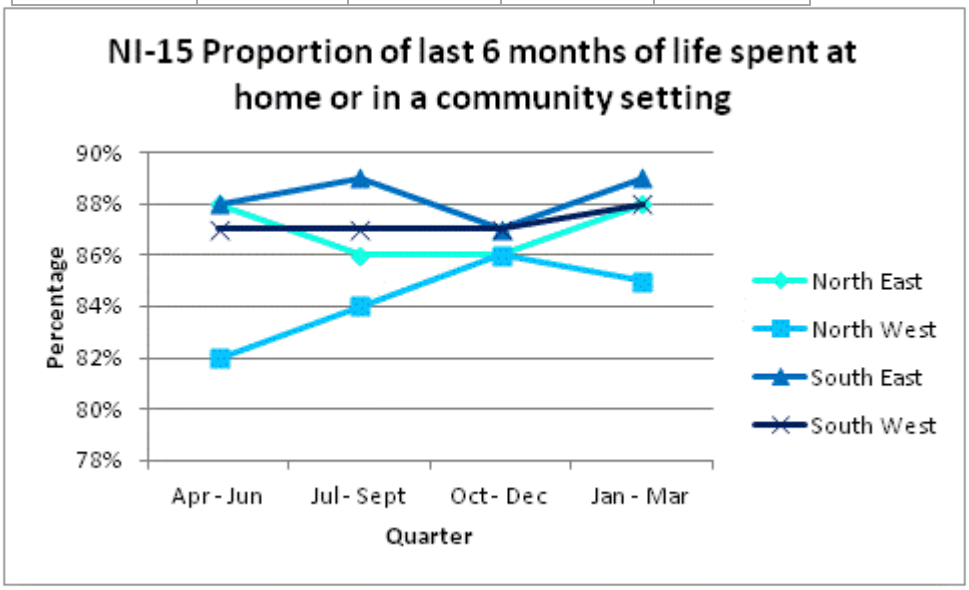
	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Edinburgh	83.2	83.4	84.1	84.8	85.7	86.5
Scotland	86.1	86.2	86.7	87.1	87.9	88.8



Source*: ISD Scotland.*

Locality breakdown: NI-15 Proportion of last 6 months of life spent at home or in a community setting

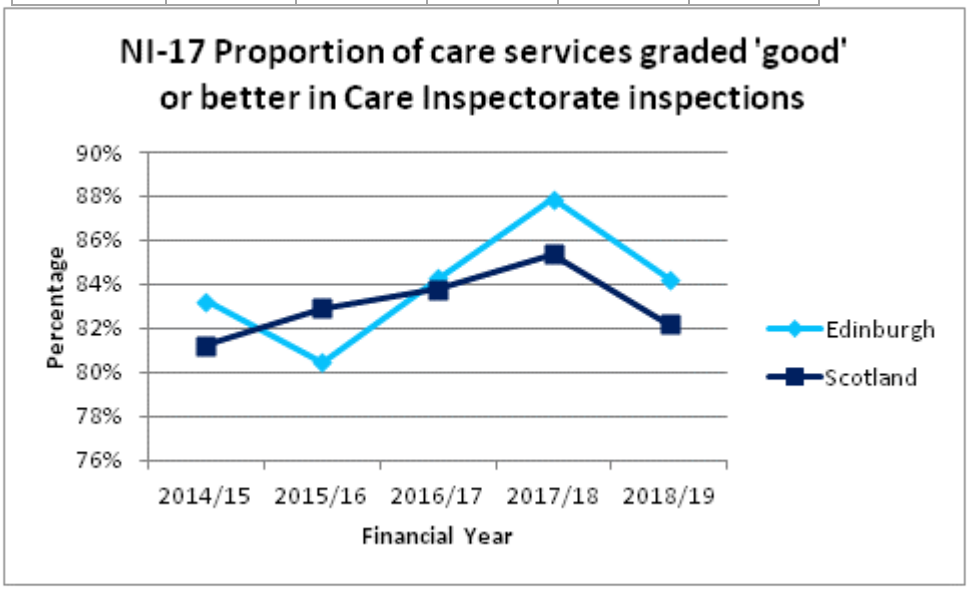
	2018/19			
	Apr - Jun	Jul - Sept	Oct - Dec	Jan - Mar
North East	88%	86%	86%	88%
North West	82%	84%	86%	85%
South East	88%	89%	87%	89%
South West	87%	87%	87%	88%



***Source**: ISD Scotland.*

NI-17: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

	2014/15	2015/16	2016/17	2017/18	2018/19
Edinburgh	83%	80%	84%	88%	84%
Scotland	81%	83%	84%	85%	82%



***Source**: Care Inspectorate.*

"When faced with increasing demands for services and limited resources with which to meet those demands, it is essential that we make every penny count."

Priority 4

Managing our resources effectively

We want to shift the balance of care toward the community so that all our resources are deployed effectively, in order to deliver on our priorities and improve the health and wellbeing of the citizens of Edinburgh.

In an environment of increasing demographic pressures and a growing financial challenge, the ability to redesign services in ways that make the best use of scarce resource will be critical. Aligned with this is the rising expectation from the public that health and social care services should be able to deliver the increased capacity required to fully meet changing needs.

The Integration Joint Board recognises the importance of maximising opportunities to share resources with our partners to deliver high quality, integrated and personalised services that improve the health and wellbeing of citizens whilst managing the financial challenges that we all face.

As the resources available to EIJB flow through the Council and NHS Lothian, the financial constraints facing our partner organisations are equally relevant for the EIJB. There is no doubt that, given the financial constraints that the Council and NHS Lothian face, both now and in the medium term, we will have a recurring financial challenge to address. In this environment, achieving financial balance will require a focus on service redesign.

Our change programme is encapsulated within the Strategic Plan, but while we think about change in the medium to longer term, and while we put in place the programme and engage with our teams and stakeholders on our plans, we also have to make savings and deliver in-year financial balance. The approach we took in 2018 was to focus in the immediate term mainly on 'grip and control' measures. In the medium to longer term, we are confident of achieving efficiencies that assist in delivering financial balance through redesign and outputs from transformation through the change programme.

Our Financial Performance

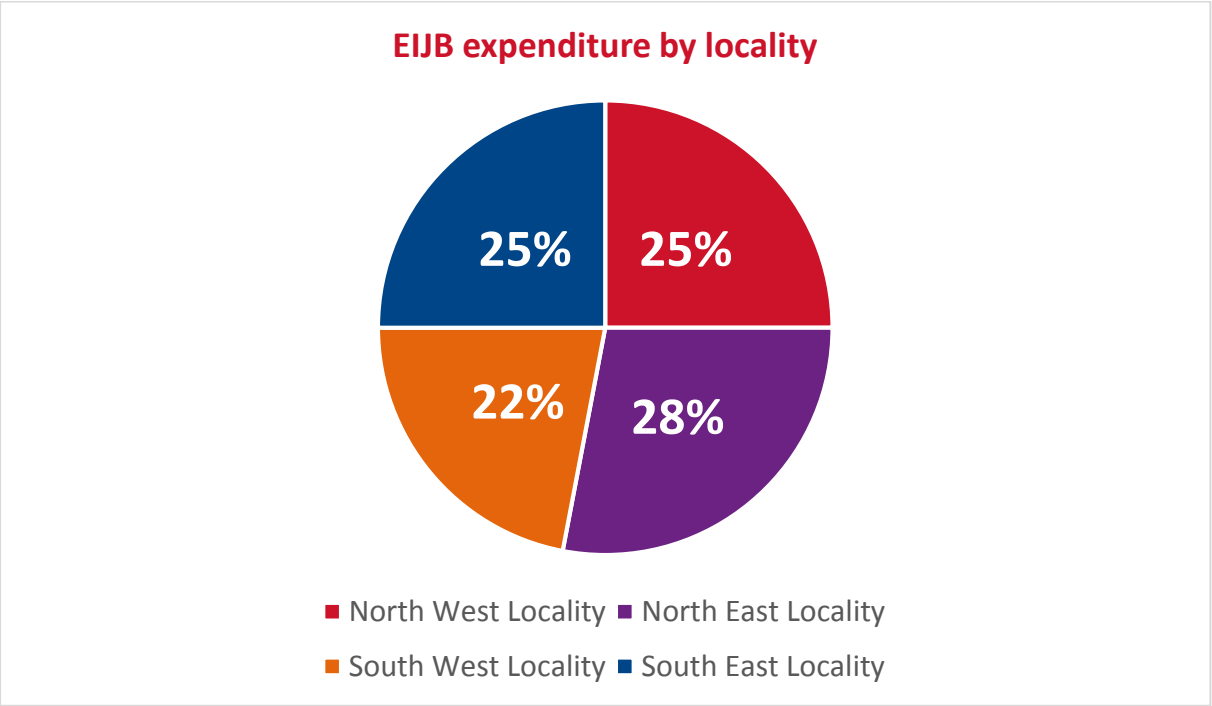
Financial information is a key element of our governance framework with financial performance for all delegated services reported at each meeting of the IJB. Budget monitoring of IJB delegated functions is undertaken by the finance teams in the City of Edinburgh Council and NHS Lothian, reflecting the IJB's role as a strategic planning body which does not directly deliver services, employ staff or hold cash. However, the IJB needs oversight of the in-year budget position as this highlights any issues that need to be accounted for when planning the future delivery of health and social care services.

The financial plan sets out how we ensure our limited resources are targeted to maximise the contribution to our objectives. For the year we are reporting a surplus of £1.3m which brings the total value of the EIJB's reserve to £9.7m. We are in the process of agreeing how these will be applied in 2019/20 recognising the need to balance existing commitments, our ambitions for supporting transformational change and the requirement to balance the in-year financial plan.

Our financial performance for the year is summarised in the following table:

	Budget	Actual Expenditure	Variance
	£k	**£k**	**£k**
NHS delivered services			
Community services	53,954	52,822	1,132
General medical services	79,454	79,472	(18)
Prescribing	80,612	80,573	39
Reimbursement of independent contractors	52,444	52,444	0
Services hosted by other partnerships	82,363	82,128	235
Hospital "set aside" services	90,969	93,577	(2,608)
Other	51,743	53,507	(1,764)
Council delivered services			
External purchasing	130,558	137,682	(7,124)
Care at home	31,406	32,540	(1,134)
Day services	15,862	15,304	558
Residential care	19,485	20,825	(1,340)
Social work assessment & care management	14,727	14,601	126
Other	12,353	10,921	1,432
Sub total	**715,930**	**726,395**	**(10,466)**
Movement in reserves	1,341		1,341
Additional contributions from partners	10,466	0	10,466
Total	**727,736**	**726,395**	**1,341**

The breakdown of these costs by locality is shown in the pie chart below.



Workforce Planning

A sustainable workforce will be a significant challenge for the Partnership and our partner organisations in both the independent and voluntary sector. Workforce development must be aligned to other planning agendas (service, financial etc) and will require us to focus on the key issues to hand that will shape the way forward and to take well-informed decisions to get the right staff in the right place at the right time.

5162
People working under the Edinburgh Health and Social Care Partnership

The Scottish Government recently published The National Health & Social Care Workforce Plan. Its purpose being to support organisations to identify develop and put in place the workforce they need to deliver safe and sustainable services.

Based on robust data and intelligence, a baseline workforce plan was developed and had the following objectives:

- To heighten the strategic importance of workforce data and planning;
- To identify gaps and potential risks (both in terms of our workforce but also in terms of sustainability of services); and
- To provide a signpost for future work.

The inaugural baseline workforce plan was agreed by the EIJB in December 2018. It highlights gaps and risks linked to sustainability and the possible implications for future service delivery and/or service redesign.

Our performance in relation to the National Health and Wellbeing Outcomes in this Priority

National Health and Wellbeing Outcome 8
People who work in health & social care services feel engaged with the work they do and are supported to continuously improve information, support, care and treatment they provide
National Health and Wellbeing Outcome 9
Resources are used effectively and efficiently in the provision of health and social care services

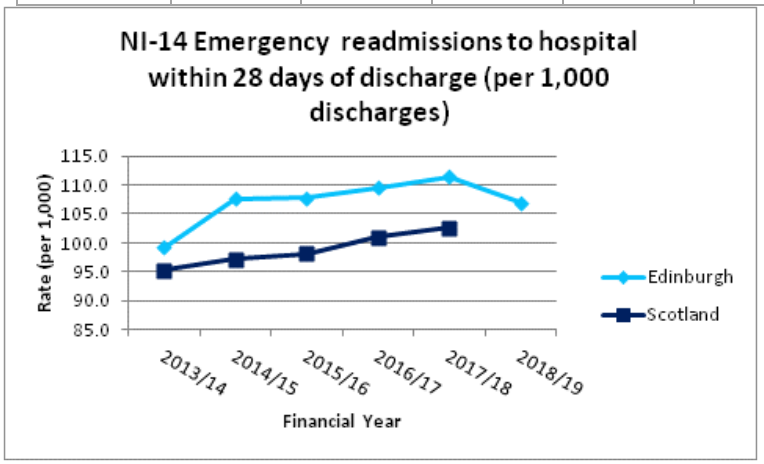
National Indicator (NI)		Edinburgh 2018/19	Compared to last year
NI-14	Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges)	107	-5
NI-19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	1,630	128
NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	22.9%	-2%

***Source**: ISD Scotland*

These indicators give us a picture of how we are using our resources effectively to support our strategic aims. For example, it is not a good use of resources for a person to remain in an acute hospital when they could be at home – nor is it good for the person. By reducing the number of days people spend in hospital when ready to go home, we ensure that acute hospital resources can be accessed by people in need of treatment. Our performance in this area shows improvement in reducing emergency admissions and the percentage of resource spent on hospital stays arising from emergency admissions. We have made significant improvement in reducing the days people over the age of 75 spend in hospital when ready to go home.

NI-14: Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges)

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Edinburgh	99.3	107.7	107.8	109.5	111.5	107.0^
Scotland	95.3	97.1	98.1	101.0	102.6	N/A*



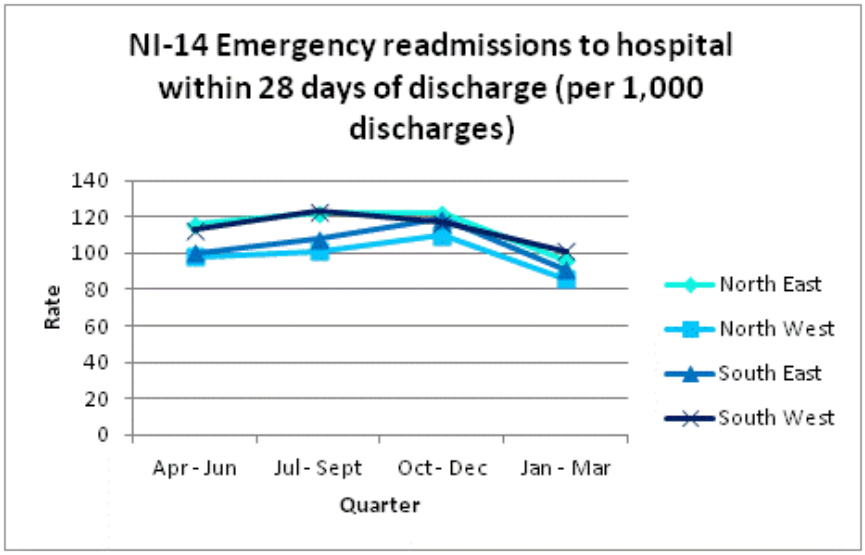
***Source**: ISD Scotland*

** No Scotland data available for full year.*

^Data completeness for Jan – Mar is 97% therefore there is missing data.

Locality breakdown: NI-14 Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges)

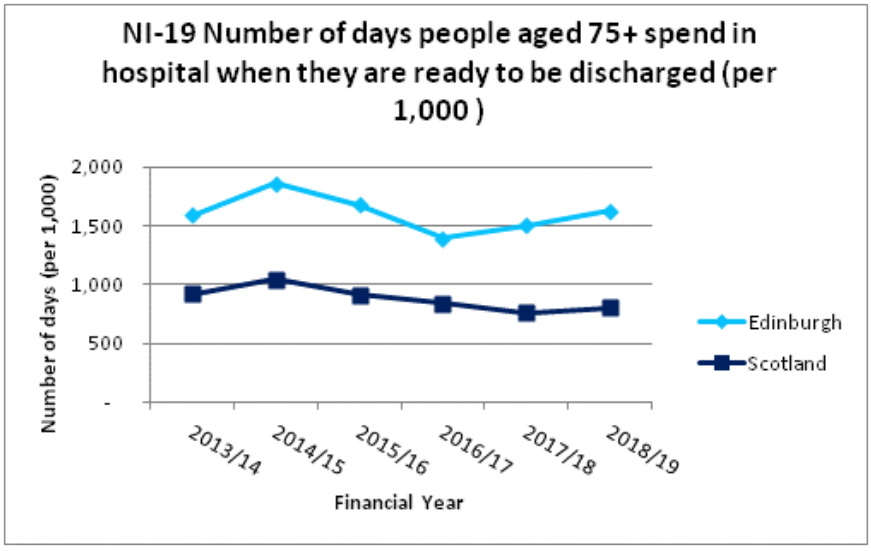
	2018/19			
	Apr - Jun	Jul - Sept	Oct - Dec	Jan - Mar
North East	116	122	122	96
North West	98	101	110	86
South East	100	108	119	91
South West	113	123	117	101



***Source**: ISD Scotland*

NI-19: Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)

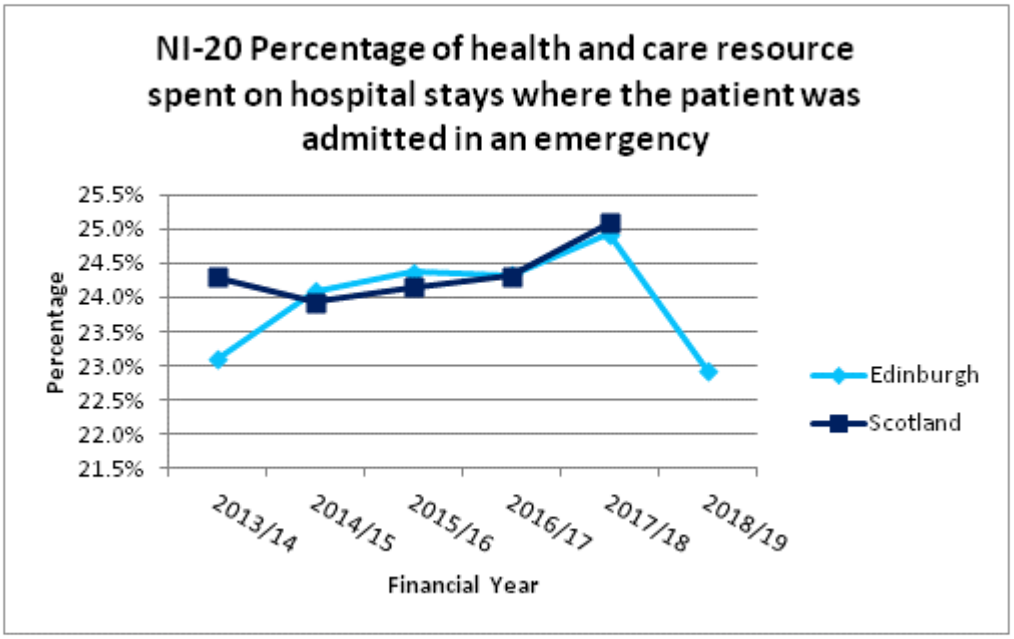
	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Edinburgh	1,592	1,861	1,679	1,395	1,502	1,630
Scotland	922	1,044	915	841	762	805



***Source**: Delayed Discharge Census, ISD Scotland*

NI-20: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Edinburgh	23.1%	24.1%	24.4%	24.3%	24.9%	22.9%
Scotland	24.3%	23.9%	24.2%	24.3%	25.1%	N/A*



***Source**: ISD Scotland*

** No Scotland data available for full year.*

“We can only deliver our priorities by working collaboratively with our partners (citizens, communities, statutory agencies, housing providers and the third and independent sector) to make the best use of all our skills and resources.”

Priority 5

Making the best use of capacity across the system

Deliver timely and appropriate care and support to people with health and social care needs.

The Edinburgh Integration Joint Board cannot tackle the twin pressures of limited resources and increased demand for services alone. At the heart of our strategic plan is changing the relationship between statutory services, citizens, communities and our partners in the independent, third and housing sectors, so that we make best use of the capacity available within the city.

In this last year, we have proactively engaged with partners from the independent, third and housing sectors as we have developed our Strategic Plan. We believe that this has assisted us in developing outcome focused and innovative plans that result in improved health and wellbeing for the citizens of Edinburgh.

Community Investment Strategy – Working with EVOC

In late 2018 a number of related but separate areas of work have individually reached the same point in our evolution toward a mature, integrated interface between third sector services and activities and the Edinburgh Health and Social Care Partnership:

- Primary Care Community Link Workers
- Third sector grant programme
- Development of the Strategic Plan
- Delivery of an integrated programme of Mental Health Support through the Action 15 investment from Scottish Government.

Work is now underway for EVOC to work in partnership with the Edinburgh Health and Social Care Partnership to start the formulation of a Community Investment Strategy which will: Strengthen community-based services to improve outcomes for Edinburgh's citizens – shifting the balance of care away from traditional institutional services, increasing access to relevant, timely information and support while also reducing delivery costs.

- Move away from our current conservative model of care which often escalates the level of support provided as the result of failure demand and risk avoidance and which increases use of acute, primary and secondary care services.
- Deliver the required investment into prevention and early intervention activity through the third sector, while allowing time for the necessary disinvestment and realignment of current service delivery which are needed to release resources to divert into delivery of the new strategy;
- Facilitate a move away from a competitive and/or 'purchaser-provider' relationship toward a relationship of mutual respect which seamlessly interfaces all partners and which shares risk and incentive; and

- Truly engage with local communities to support an asset-based expansion of local community activity.

This also recognises the excellent and invaluable collaborative work being carried out throughout the third sector to increase the impact of preventative activity.

Firhill

Recurring funding for 6 bedded residential unit (Firhill) in the south east of the city was secured following a successful test of concept. The same partnership of service providers (Carr Gomm, Penumbra, Volunteer Edinburgh, City of Edinburgh Council and NHS Lothian continue to provide this service).

Following the success of Firhill, a second 16 bedded residential service was developed using the tested model and delivery partners. This new development in the south west of the city opened in November 2018.

Both examples above demonstrate a successful shift in the balance of care from hospital to community settings resulting in £1.2 million investment in new models of care and service delivery.

Training of a range of 3rd sector staff from different 3rd sector agencies across the city in use of assessment tools which has enable systematic review of clients' care plans across the 216 community placements.

Our performance in relation to the National Health and Wellbeing Outcomes in this Priority

National Health and Wellbeing Outcome 6
People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

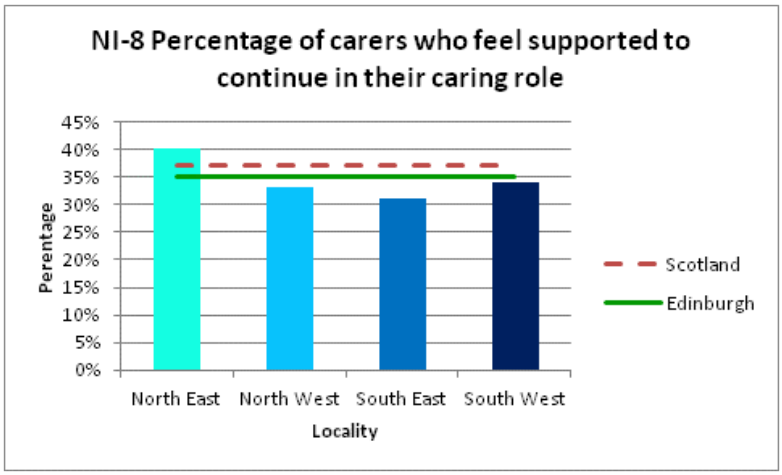
National Indicator (NI)		Edinburgh 2018/19	Compared to last year
NI-8	Total combined % carers who feel supported to continue in their caring role. *	N/A	N/A

**SourceL HACE survey is undertaken every two years therefore information is not available for 2018/19.*

While we do not have current data on this indicator, we do know from work undertaken in the preparation of our Carers' Strategy that carers report it being difficult to undertake the caring role. Our Strategy and new ways of working aim to support an improvement in the reported experience in Edinburgh.

Locality breakdown: NI-8 Total combined % carers who feel supported to continue in their caring role

	Percentage
Scotland	37%
Edinburgh	35%
North East	40%
North West	33%
South East	31%
South West	34%



Source: *Scottish Government HACE survey 2017/18.*

“We want to ensure that people are supported to live as independently as possible, in a place which best provides their care and as close as possible to when it is required.”

Priority 6

Right care, right place, right time

We want to ensure that people are supported to live as independently as possible at home or in a homely setting.

The Integration Joint Board's strategic ambition in terms of meeting current need is to deliver the right care, in the right place, at the right time, so that people:

- are assessed, treated and supported at home and within the community wherever possible and are admitted to hospital only when clinically necessary
- are discharged from hospital as soon as possible with support to recover and regain their independence at home and in the community
- experience smooth transitions between services, including from children to adults' services
- have their care and support reviewed regularly to ensure these remain appropriate
- are safe and protected.

Our progress in delivering on this ambition in 2018/19 is mixed largely due to the challenges we face in creating the capacity within the health and social care system to meet the level of demand for care and support.

Delayed Discharge

Between March 2018 and March 2019 we have seen a 48% reduction in the number of people delayed in hospital awaiting discharge (291 to 150).

Overall, the number of bed days lost due to delayed discharge for Edinburgh patients in March 2018 was 8,218 days. In March 2019 the number of lost bed days was 5,556 days. A reduction of almost a third (32%).

Comparing March 2018 and 2019, there has been a reduction in the number of people waiting for assessment from 1,544 to 1,375.

There has been a large fall in the number of people waiting for a package of care between March 2018 and 2019. This has fallen from 988 people to 480 people. The number of hours these people were waiting for has also fallen from 8,146 to 3,456 hours.

It's more than 'just right care, right place, right time' - stories [like Alfie's] mean that we are putting our people we care for first.

Case Study - Home First

Alfie came into hospital with worsening confusion thought to be a urinary tract infection. He has a background of vascular dementia. Alfie received care three times a day over seven days from the Health and Social Care Partnership to enable him to be at home. From discussions with Alfie and his family, it was clear that home was best - this was more familiar to him and he knew his carers. There was no medical reason for him to remain in hospital.

The Occupational Therapist assessed Alfie in the hospital and discussed a 'Home First' with both him and his daughter. The 'Home First' approach is a rapid response led by the Locality Hub. Face to face contact is made on the day of discharge to follow up any concerns with regards to his admission. In his case, there were concerns as to how Alfie was managing both in the short and long term.

The Home First approach is assessment focused in a person's home environment rather than an unfamiliar hospital environment. Alfie was discharged the day after admission with his care restarted. He received a contact from the Locality Hub Social worker within 24 hours to work within him and his daughter on his current and future needs with the focus on keeping him at home.

Get Help When Needed

We made a successful application to be the only Scottish partner in the UK Living Well Big Lottery to implement open access mental health centres across the city of Edinburgh. This provides funding to support coproduction, skills building and evaluation. (£100,000 p.a. for three years).

Meeting Treatment Gaps

We are actively reviewing our current pathways (Bipolar, Schizophrenia, Neuro-developmental disorders; Eating Disorders, Personality Disorder, Perinatal Mental Health and Depression) to ensure that our services are rights based, provide evidenced based clinical treatment as defined by SIGN and NICE[5], and there is a comprehensive focus on meaningful days and community connecting.

Between March 2018 and March 2019 there has been a 48% reduction in the number of people delayed in hospital awaiting discharge (291 to 150)

[5] SIGN: Scottish Intercollegiate Guidelines Network: NICE – National Institute for Health and Care Excellence

Our performance in relation to the National Health and Wellbeing Outcomes in this Priority

National Health and Wellbeing Outcome 2
People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

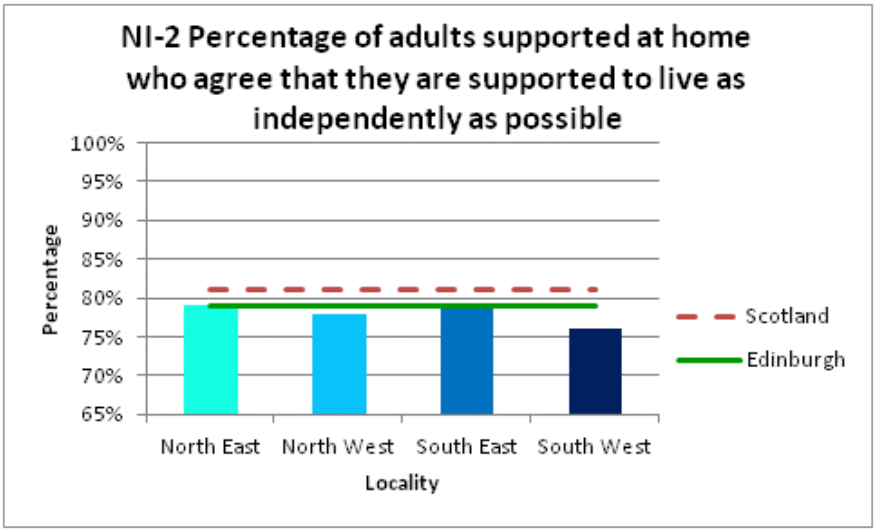
National Indicator (NI)		Edinburgh 2018/19	Compared to last year
NI-2	Percentage of adults supported at home who agree that they are supported to live as independently as possible. *	N/A	N/A
NI-13	Rate of emergency bed days for adults (per 100,000) ^	100,122	-12,625
NI-18	Percentage of adults with intensive care needs receiving care at home ^	N/A	N/A

**Source: HACE, which is undertaken every two years therefore information is not available for 2018/19.*
^Source: ISD Scotland.

We have seen significant improvement in the number of people delayed in hospital when ready to go home and in our ability as a partnership to assess people and, once assessed, provide care. We aim to improve further through our Home First approach and under our new Strategic Plan and transformation programme.

Locality breakdown: NI-2 Percentage of adults supported at home who agree that they are supported to live as independently as possible

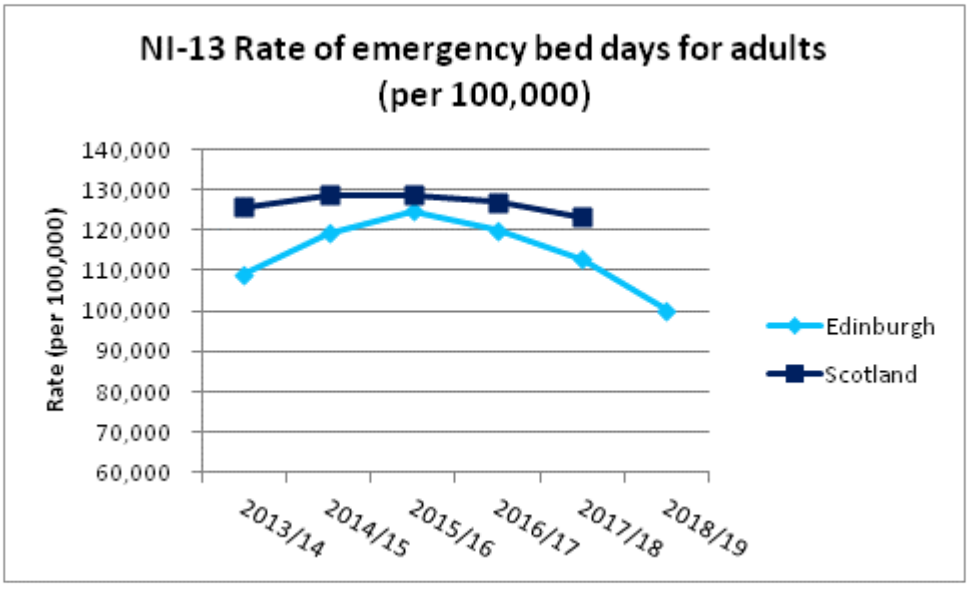
	Percentage
Scotland	81%
Edinburgh	79%
North East	79%
North West	78%
South East	79%
South West	76%



Source: *Scottish Government HACE survey 2017/18.*

NI-13: Rate of emergency bed days for adults (per 100,000)

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Edinburgh	109,231	119,311	124,725	120,053	112,747	100,122
Scotland	125,730	128,596	128,630	126,945	123,160	N/A*

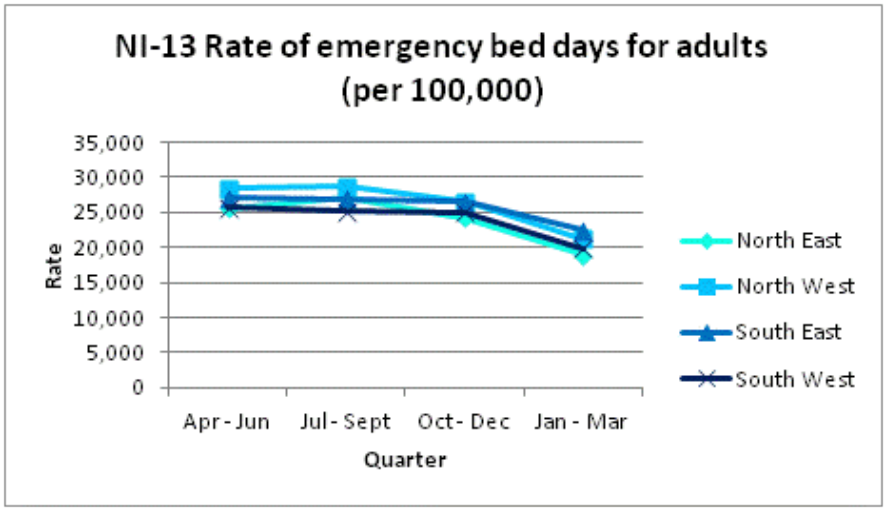


Source*: ISD Scotland.*
** No Scotland data available for full year.*

Note*: Data completeness for Jan – Mar is only 97%*

Locality breakdown: NI-13 Rate of emergency bed days for adults (per 100,000)

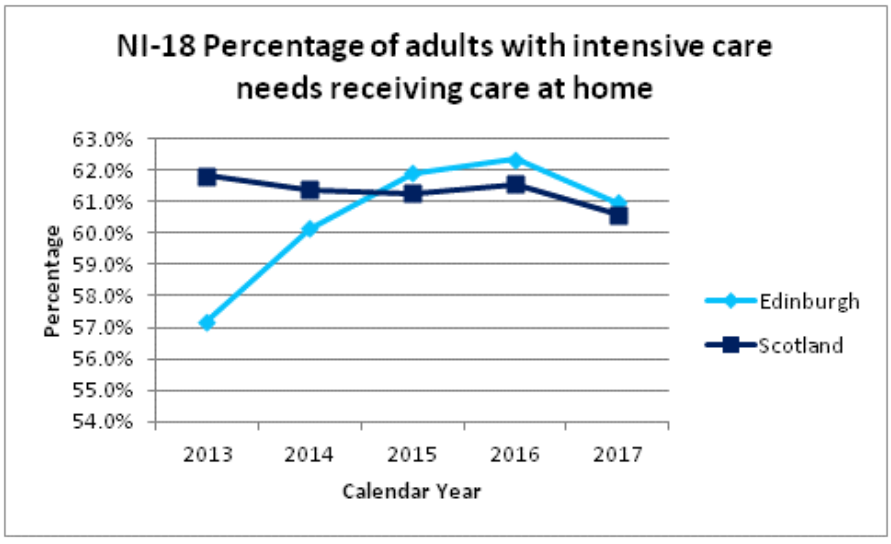
	2018/19			
	Apr - Jun	Jul - Sept	Oct - Dec	Jan - Mar
North East	25,517	27,195	24,149	18,877
North West	28,452	28,638	26,491	21,167
South East	26,970	26,865	26,524	22,477
South West	25,651	25,145	24,929	19,902



***Source**: ISD Scotland.*

NI-18: Percentage of adults with intensive care needs receiving care at home

	2013	2014	2015	2016	2017	2018
Edinburgh	57.2%	60.1%	61.9%	62.3%	61.0%	N/A
Scotland	61.8%	61.4%	61.3%	61.6%	60.6%	N/A



***Source**: ISD Scotland.*


Pentland Hills

Looking Ahead

The Strategic Plan 2019-22 sets out the strategic framework for the next 3 year planning cycle and beyond. It is an ambitious strategy which features four key elements: the Edinburgh Offer; the 3 Conversations Approach; the principle of Home First; and a comprehensive Transformation Programme.

Of note we have carried forward our six strategic priorities which underpin our direction of travel and remains at the heart of our focus on improving the health and social care outcomes and experience for the citizens of Edinburgh.

Vision: To deliver together a caring, healthier and safer Edinburgh

What means do we have?	How will we get there?	Where do we want to get to?
Scottish Government Direction	Implementation of Strategic Plan and Change Programme aligned to priorities	An affordable, sustainable and trusted health and social care system
Good Governance	Develop modern Edinburgh Offer	A clearly understood and supported 'Edinburgh Offer' which is fair, proportionate and manages expectations
Budget	Roll out Three Conversations Approach	A person centred, patient first and home first approach
Workforce	Strong Partnership with the voluntary and independent sectors	A motivated, skilled and representative workforce
Infrastructure	Shift balance of care to communities	An optimised partnership with the voluntary and independent sectors
Data and Performance Management Framework	Tackling Inequality	Care supported by the latest technology
Technology	Unity of purpose and momentum	A culture of continuous improvement
Communications and Engagement		

Principles *Home First, Integration, Engagement, Respect, Fairness, Affordable and Sustainable, Safer*

Our Values *Empowering, Inclusive, Working Together, Honest and Transparent*

Edinburgh Offer

Working with the strengths of our citizens and communities to make sure that age, disability, or health conditions are not barriers to living a safe and thriving life in Edinburgh – EIJB Strategic Plan 2019-2022

The Edinburgh Offer is essentially a pact between Edinburgh Health and Social Care Partnership and the people of Edinburgh - clearly setting out what are reasonable and mutual expectations. It is intended to be informative and promote easier access to better health and wellbeing, where we all play our part. We will make a series of commitments on what people can expect from the Partnership to help them live as well as possible in their communities.

We have significant and serious challenges facing us with increasing demands on our services, in part due to changing demographics. In Edinburgh, we have the highest population growth in Scotland - with further predictions for growth in the number of young people with disabilities turning 18, including number of those with complex needs, people living with long term conditions, and those with dementia. This sits within an environment of funding constraints. It is therefore important that we make the best use of the resources we do have and engage in different conversations which include:

- Support to self-management
- Enablement promotion
- Use of universal services
- Support of community-based resources
- Health promotion
- Support to 3rd sector organisations and Social Enterprises delivering prevention services and opportunities which support our wider priorities
- Technology Enabled Care as the primary response. We seek to be solution focussed, preventing deterioration in condition management, and promoting longer-term independence, with an emphasis on the opportunities offered by more creative use of everyday technology

When people make contact with us, it tends to be in response to a change in circumstances in which they feel they have suddenly lost some control or are in the process of losing control, and where they have identified the need for some support. We want to ensure that we respond appropriately, and people's experience is positive. We believe that people are the experts in their own lives and the way we engage with our citizens should reflect that. Our aim is to work with individuals and their carers to identify what matters to them and support them to reach their potential. We will take account of what matters to the person, their talents, interests, skills, resources, and their unique view of their own life and how they want it to be.

The work of the Partnership has an important contribution to make in supporting the establishment of a fair and just society, working in communities to tackle isolation and support the most vulnerable and disadvantaged people. Our current system, however, draws people into using statutory services rather than building independence and resilience.

If we are to continue to be able to provide essential services to those who need them, we must establish a new agreement with communities on how we will achieve this in a way which is sustainable and future ready. The Partnership wants to have open and honest conversations with people, to move away from being gatekeepers to resources to manage need, to have greater emphasis on enabling people to grow their capabilities to live healthier, more connected lives, with greater control over their circumstances.

Three Conversations Approach

The Three Conversations Approach offers three clear and precise ways of interacting with people that focuses on what matters to them – EIJB Strategic Plan 2019-2022

While we try hard to deliver effective and efficient services to the people of Edinburgh, the current health and social care systems are highly bureaucratic and process driven. They are often perceived as 'barriers' for people accessing our services and this experience is also shared by our workers. We have recognised that this no longer works well for anyone. We need a radical shift in how we work to improve the experience of both those who need and those who deliver our services. **The Three Conversations®** is a strength-based relationship approach which focusses on what really matters to people in their families and in their communities. It recognises that people are the experts in their own lives and circumstances and is intended to replace our current 'assessment for services' culture and systems.

The Edinburgh Health and Social Care Partnership have embarked on a relationship with Partners4Change who have developed the approach, and describe it below:

Three distinct conversations

At the heart of our approach are the three distinct conversations we use to understand what really matters to people and families, what needs to happen next for them, and how we can be most useful.

Conversation 1: Listen and connect

Conversation 1 is about listening hard to people and their families to understand what's important and working with them to make connections and build relationships in order to help them get on with their life independently. Conversation 1 is not about whether the person is 'eligible', but it does meet statutory requirements and obligations

Conversation 2: Work intensively with people in crisis

When we meet people who need something to happen urgently to help them regain stability and control in their life, we use Conversation 2 to understand what's causing the crisis, put together an 'emergency plan' and stick with the person to make sure that the changes happen quickly, and that the plan works for them. No long-term plans are made while in crisis but rather when greater stability is achieved

Conversation 3: Build a good life

We always exhaust Conversations 1 and/or 2 before moving on to Conversation 3 – and often we find that we don't get this far. But for some people, longer-term support in building a good life will be necessary, so Conversation 3 is about understanding what this good life looks like to them and their family and helping them to get the support organised so they can live the best life possible.

The Three Conversations® is a move away from the conventional approach of assessments that often lead to waiting lists for 'service users/patients' and excess paperwork for staff. Instead it starts with a simple conversation in which our workers ask the person to identify what it is that they need to or would like to happen. This replaces the time lost on asking lots of irrelevant questions with more time in getting to know the person and identifying solutions that will enable them to engage with their community and live a successful life.

Feedback from areas that have already implemented the approach is very positive.

> "You took me along a route with an end result - I felt like a weight had been lifted from my shoulders, things were clarified in my head. The whole experience was brilliant for me and for mum"

> "*I only had to deal with one person, who actually supported me*"

Staff who have worked in areas with this new approach have commented on the impact on their working experience:

- We're far more aware of what's happening in local communities and the sorts of events that people we know are involved with.
- We're trying to be informed, but not led, by what we already know about people, so that we 'don't write a story, before we've had a conversation'.
- This way of working doesn't feel easier for the team, but it's more interesting, more flexible, and it's about working with people.

Over the next two years we will roll out this approach through the development of 'innovation sites' where we will support workers and teams to implement 3 conversations into their day to day practice. These will then be spread and developed across all our services.

The Three Conversations® approach has been chosen for Edinburgh because it underpins and supports our intent; strategic priorities; and visions and values. The approach to delivering change through the Three Conversations® is rapid, dynamic and co-designed. Partners4Change will help us to co-design these and provide the support and mentoring to enable to deliver the changes in a sustainable and lasting way for the benefit of the people of Edinburgh.

Home First

Whenever possible, in supporting individual choice, we must do what we can to assist an individual to stay at home, or in a homely setting, for a long as possible.

The principle of Home First, an approach supported by the Scottish Government, aims to shift the balance of care from acute hospital services to home or a homely setting within the community. Led by EHSCP teams, it will be delivered through prevention of admission or early supported discharge and will inform the way we work across a person's care journey.

Home first promotes rehabilitation and recovery through a risk enabled, multi-disciplinary approach, which has the potential to prevent life changing decisions being made in a period of crisis, too often resulting in long-term acute care outcomes. Home first improves outcomes for those citizens who are able to return home and generates more capacity in acute hospitals to care for those who have acute needs that cannot be met elsewhere.

The Home First project has started and will continue to be developed through phase 1 of this planning cycle. As home first evolves, there will be opportunities to encapsulate related services that form part of the current set aside. These will be identified through the transformation programme. There are many predicted benefits of the home first principle which include:

- reduction in length of stay
- reduction in occupied bed days
- reduction in delayed discharges
- number of unscheduled admissions and readmissions
- patient experience
- staff experience

Transformation Programme

Transformation – the case for change

It is widely acknowledged that we face unprecedented challenges to the sustainability of our health and care system: resource availability cannot continue to match levels of demand; the population is ageing, and we are facing challenges in workforce supply. It is clear that our health and care system must change and must find new ways to meet these challenges.

We know we need to increase the pace and focus for our transformation and change efforts as a Health and Social Care Partnership to address some pressing areas of underperformance – delayed discharge, people waiting for care, assessment, and review. But, even more importantly we must increase our efforts as they relate to the wider change in demand, demographics and to create and build a sustainable, high quality health and care system for the future in this city.

Our Transformation Programme

We are in the process of initiating a large-scale and complex programme of change and improvement. 3 Conversations is at the heart of our ambitions and plans for transformational change and as such, we have structured our wider change programme around it and are using it as the framework for driving whole system transformation.

There are 4 distinct programmes of work – 3 of these will deliver change and improvement relating to the three distinct conversation stages, whilst the fourth will deliver a range of cross-cutting and enabling improvements.

Our Conversation 1 programme is focused on a range of projects and initiatives which will help strengthen prevention and early intervention approaches, build community capacity and resilience and transform the “front door” to our services.

Our Conversation 2 programme will focus on projects which transform our approaches to dealing with crisis management, including the implementation of a “home first” model and the redesign of the way we deal with adult support and protection issues.

Our Conversation 3 programme is focused on the transformation of services and supports for those who require longer term support to build a good life. This includes transformation of care at home options and bed-based care services.

Governance and Resourcing

The EIJB is supportive of our transformation plans and will provide the overall governance and leadership to drive it forward. Beneath this we are establishing a robust programme structure, including the formation of dedicated programme boards, with multi-disciplinary membership including partners from the third sector, to drive delivery.

For further information:

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