

**Edinburgh** Integration Joint Board



**Annual Performance Report 2021/2022**

# Edinburgh Integration Joint Board

## Annual Performance Report 2021/22

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## Foreword

2021/22 has been another challenging year for the health and social care sector throughout Scotland and this has been felt across our services in Edinburgh.

Despite the success of the vaccine rollout, high infection rates and ongoing restrictions meant the COVID-19 pandemic has continued to affect our work during 2021/22. System pressures arising from staff shortages, increasing demand from residents with increasingly complex needs, as well as ongoing difficulties in recruitment have made for a demanding year, but our frontline staff have once again delivered exceptional services to our most vulnerable residents.

Using additional funding provided by the Scottish Government (SG) to alleviate system pressures, we have taken several measures to respond to these ongoing pressures. A programme of investment was agreed, framed to reflect the priority areas identified by the SG as well as supporting sustainability beyond the immediate crisis. This included investment in interim care beds, initiatives to increase capacity within the care at home sector, and multi-disciplinary team working.

In this Annual Performance Report for 2021/22, we outline our challenges and achievements this year as well as our progress over the last year against the six Strategic Priorities in our Strategic Plan 2019-22, and against the Scottish Government's National Health and Wellbeing Outcomes and associated indicators.

Despite the ongoing impact of the pandemic and system pressures, we continued to deliver on our Transformation programme. The Edinburgh Pact, which redefines our relationship with Edinburgh residents and will influence future policy direction through our Community Mobilisation Programme, was launched in 2021/22. The Edinburgh Wellbeing Pact's 'More Good Days' is resonating across the city, creating a catalyst for change. The rollout of Three Conversations continues, with teams in all four localities now using the approach, which recognises that people are the experts in their own lives. We also made significant progress with our redesign of bed-based services across the city, and are continuing to implement Home First, which aims to better support people to remain at home or in a homely setting rather than being admitted to hospital.

Overarching it all, our inaugural workforce strategy, '*Working Together*', was approved by the EIJB in February 2022 and aims to ensure that we have skilled and capable staff that can deliver our vision of 'a caring, healthier and safer Edinburgh'.

Trend comparison of our performance remains difficult because of the extraordinary impact of the pandemic but we continued to perform well in some areas of the national indicators (NI) and faced challenges in relation to others. Of the 18 national indicators reported, we are in line with or compare favourably to the Scottish average in ten indicators and are closing the gap in a further four of the indicators. The main area of difference with the Scottish average is for delayed discharges (NI19), which have been affected by the significant issues with social care capacity felt across the country, but particularly acutely in Edinburgh due to the demographics of the city. There was, however, a 12% drop in the rate of emergency readmissions to hospital

within 28 days to below 2019/20 levels; and in line with our Home First approach, more adults with intensive care needs received care at home.

As ever, our thanks go to all our staff and partners for their dedication and hard work during the year, and to the unpaid carers that provide vital care and support to our most vulnerable citizens.

Having decided not to stand for re-election at the Council elections in May, Councillor Ricky Henderson was succeeded as Chair of the Integration Joint Board by Councillor Tim Pogson. We thank Ricky for his work as Chair and look forward to working with Tim over the next two years.



Councillor Tim Pogson, Chair  
Edinburgh Integration Joint Board



Judith Proctor, Chief Officer  
Edinburgh Integration Joint Board

## Overview

### Introduction

The Edinburgh Integration Joint Board (EIJB) was established in 2016 to bring together the planning and operational oversight for a range of NHS and Local Authority services. This was intended to improve overall health and wellbeing through the delivery of more efficient and effective health and social care services.

The Edinburgh Health and Social Care Partnership (EHSCP) is responsible for providing integrated services through the operational delivery of the EIJB's strategic plan. Its workforce is made up of staff employed by both the City of Edinburgh Council and NHS Lothian, and our Chief Officer is accountable to the Chief Executives of both the City of Edinburgh Council and NHS Lothian.

This performance report sets out our progress against the strategic priorities and transformation plans within the EIJB Strategic Plan 2019-22, which is available [online](#). The content in this report covers the financial year April 2021 to March 2022 unless otherwise stated.

### About Edinburgh

Edinburgh is one of the largest health and social care partnerships in Scotland, with a population of 526,470 as of July 2021. 81,277 residents were aged 65 or over, with this age group projected to increase the most over the coming years.

Edinburgh is also the wealthiest city in Scotland, with 74.8% of the working age population in employment. 40.8% of the economically inactive population within the city are students.

However, 15% of the population, and as many as 20% of children, live in relative poverty. This poverty is spread throughout the city, with two thirds of those living in poverty not living in areas described as deprived. The majority of those in poverty are in employment. Our [joint strategic needs assessment \(JSNA\)](#) provides more detail on the population and demographics of Edinburgh.

### Our Localities

We organise our community health and social care services in Edinburgh around four localities: South East, South West, North East and North West. The management of most community health and social care services is carried out in these localities, including assessment and care management, home care, day centres for older people and care homes in Edinburgh.

This allows us to plan and tailor services to the communities we are supporting. Each locality has a hub team that responds to new and urgent work and two cluster care management teams that arrange and review ongoing support. There is also a mental health and substance misuse team in each locality.

## North East

- 123,328 people live in the North East locality<sup>1</sup>
- 50.8% are female and 49.2% are male
- 15.2% are aged under 18, 71.4% are 18-64 and 13.5% are over 65
- 16.5% of the population reside within the 20% most deprived areas of Scotland<sup>1</sup>
- Life expectancy at birth is 80.7 years for women and 76 for men<sup>2</sup>
- 34,536 average home care hours per week between January and March 2022
- 1,409 people receive home care service
- 18 GP practices<sup>3</sup>

## North West

- 148,576 people live in the North West locality<sup>1</sup>
- 51.8% are female and 48.2% are male
- 19.9% are aged under 18, 62.7% are 18-64 and 17.3% are over 65
- 9.0% of the population reside within the 20% most deprived areas of Scotland<sup>1</sup>
- Life expectancy at birth is 83.5 years for women and 79.6 for men<sup>2</sup>
- 25,888 average home care hours per week between January and March 2022
- 1,310 people receive home care service
- 18 GP practices<sup>3</sup>

## South East

- 141,041 people live in the South East locality<sup>1</sup>
- 52.1% are female and 47.9% are male
- 13.8% are aged under 18, 72.3% are 18-64 and 13.9% are over 65
- 9.4% of the population reside within the 20% most deprived areas of Scotland<sup>1</sup>
- Life expectancy at birth is 82.3 years for women and 78.1 for men<sup>2</sup>
- 25,420 average home care hours per week between January and March 2022
- 1,173 people receive home care service
- 19 GP practices<sup>3</sup>

## South West

- 114,675 people live in the South West locality<sup>1</sup>
- 49.8% are female and 50.2% are male
- 17.3% are aged under 18, 67.3% are 18-64 and 15.4% are over 65
- 12.6% of the population reside within the 20% most deprived areas of Scotland<sup>1</sup>
- Life expectancy at birth is 83.3 years for women and 79 for men<sup>2</sup>
- 31,141 average home care hours per week between January and March 2022
- 1,224 people receive home care service
- 16 GP practices<sup>3</sup>

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<sup>1</sup> [Edinburgh Joint Strategic Needs Assessment](#)

<sup>2</sup> [The Scottish Public Health Observatory \(ScotPHO\)](#)

<sup>3</sup> National Primary Care Clinicians Database (NPCCD), Public Health Scotland

## Key messages from the year

### Continuing pressures felt across Health and Social Care

#### Background to system pressures

2021/22 continued to be a challenging year for the health and social care system as restrictions eased but COVID-19 cases remained high. This resulted in staff shortages, increasing demand from residents with increasingly complex needs, and ongoing difficulties in recruitment. These system pressures were also reflected nationally, and many of these pressures are not new although they have been exacerbated by the EU exit and the COVID-19 pandemic.

Since March 2021, we have seen both an increase in referrals for social care support and an increasing number of people being assessed as requiring a service. This increase in demand resulted from people being de-conditioned (ie frailer, less confident) following periods of lockdown; family/unpaid carers who are exhausted having cared for people during the pandemic returning to work following furlough; and a general build-up of demand emerging as messaging about services being 'open as usual' was released.

Coupled with this increasing demand for services, we were also faced with a decrease in care capacity available to support people, compounding an already challenging position. Decreasing capacity to deliver services resulted from:

- Loss of staff – to other industries and because of the exit from the EU
- Staff sickness absence and COVID-19-related absences
- Long-term challenges with recruitment to the social care sector

Capacity within community care at home remained fragile. Many providers focused their limited resources on the delivery of essential visits only, working with families and carers to ensure that people's care needs were met, yet several providers were unable to cope with their existing care commitments, and alternative care providers were sought. These factors impacted on our ability to meet demand, with increasing waitlists for social care assessment and provision, and an increase in people delayed while awaiting discharge from hospital.

As a result of these pressures being felt across the country, in early November 2021 the Scottish Government (SG) allocated additional funding across Scotland. Using our share of this funding, the EIJB agreed a programme of investment, framed to reflect the priority areas identified by the SG as well as supporting sustainability beyond the immediate crisis.

#### System pressures initiatives

##### *Interim Care*

We were able to reduce delayed discharges by purchasing interim care home beds across Edinburgh for people in hospital waiting for a package of care or a permanent care home place. With informed consent and appropriate support in place this

allowed people to be discharged from hospital to a suitable alternative placement until their longer-term care needs could be met.

There were 121 people moved into a placement by 31 March 2022 and 71 of these had already ended their placement, a 59% turnover. In total, this initiative saved 6,239 bed days in hospital by the end of the financial year and reduced the number of daily delayed discharges by 61 delays at the peak.

Forty-five people submitted feedback surveys on their experience. 96% agreed the transition from hospital to interim care placement was organised and comfortable; 96% felt settled in their placement and that their needs were met; and 82% felt they were kept informed about the progress of a match for their package of care for going home.

### *Enhancing care at home capacity*

We undertook recruitment for our internal homecare service before and after Christmas and will continue to advertise on an ongoing basis to address current vacancies and increase our package of care capacity to meet service demand. Recruitment in this area has proved challenging, particularly as we seek to ensure that our internal recruitment is balanced with the recruitment and retention needs of our external providers.

Additionally, students studying Social Care at Edinburgh College were encouraged to register to work in social care through a student bank service, with five students already engaged in this process. This is a longer-term initiative which should gain traction with time, as it gives students real-life work experience in their chosen field alongside their studies.

Alongside supporting recruitment efforts, we used our One Edinburgh approach to optimise the provision of existing packages of care. A command centre was established and dashboards developed which use regularly updated data to inform service provision improvements. We also reviewed all current provision and unmet need across the city to identify where providers could work collaboratively to achieve greater efficiency in provision, following consultation with service users. A further part of our work to optimise current capacity is through the creation of a dedicated team to review existing packages of care and look for alternative means of providing the support people require to maintain their independence, for example through the support of local community partners or the provision of telecare/community equipment.

### *Multi-disciplinary Team (MDT) Working*

Through working collaboratively with partners, we supported the expansion of a Hospice at Home service by St Columba's, which helped an additional 47 people who require this type of complex care and prevented presentation at acute sites.

The creation of our nurse-led Hospital to Home team also enabled people to be discharged from hospital while waiting for a package of care to start.

## Winter Vaccination Programme 2021

The Edinburgh Winter Vaccination campaign ran from the end of September 2021, with the intense period of delivery lasting until the end of January 2022. Significant progress was also made towards transforming it into a year-round programme.

The initial Edinburgh target population for the Winter Vaccination campaign was 259,820, with the flu uptake target set at 90% for over 65s and 80% for the 50-64 cohort and 'at risk' groups. This resulted in an initial expected uptake of 202,515.

However, the continued growth of the programme for the COVID-19 booster/third dose saw more and more cohorts being invited to receive their vaccination. Pop-up vaccination centres having already emerged across Edinburgh and the Lothians, the opening of the Royal Highland Centre (RHC) and the re-opening of the Edinburgh International Conference Centre (EICC) as a vaccination site in December significantly increased capacity in the system; the RHC alone was able to deliver up to 20,000 vaccinations per week. This increased demand, and the subsequent de-prioritisation of flu vaccination, resulted in the total number of vaccinations administered by the end of January differing hugely from the original target. A total of 504,415 vaccinations were administered at Edinburgh sites in four months; approximately 90% of Edinburgh residents aged 60 years+ took the COVID-19 vaccination, and around 85% of residents aged 70 years+ received the flu vaccination. Vaccinations were also provided across 14 smaller local access clinics at weekends, and first dose COVID-19 vaccinations for 5 - 11 year olds were delivered across the city, at separate venues from the adult campaign.

After the pre-Christmas surge, early 2022 saw a deceleration of the vaccination campaign. By March the programme moved towards a focus on smaller sites; as restrictions lifted, the closure of mass vaccination centres enabled commercial businesses like the EICC to return to business as usual.

The vaccination programme will continue in a business-as-usual capacity; mass vaccination centres have closed, but a workforce of 40 WTE HSCP staff has been recruited to continue the delivery of vaccinations which were previously administered by medical practices. A staff training programme has begun, with support from NHS Lothian Education team, for vaccinators to support Community Treatment and Care (CTAC) services across the city. During periods of reduced demand outwith the spring and winter programmes, registered nurses will also undertake tasks such as phlebotomy and wound management.

## Case Study: David, Volunteer Vaccinator

*'When I saw the job in March 2021 looking for people to join the vaccinator programme, I thought "I could never do that". I still applied, wanting to do something to give back. I was really surprised to get an interview. Even more so to be accepted onto the first cohort of new recruits to train as a vaccinator.*

*I didn't have a clue what I was doing there and thought there was no chance I'd pass the probation and training. But the training was so good, and everyone (trainers, clinicians, colleagues) was incredibly supportive. I was hooked. Learning all about how to vaccinate. Learning about exactly what's in the vaccine. Understanding how disease works in the body, and the innovations of the last few decades that have got us to where we are now in vaccine development. It was all new to me and incredibly fascinating.*

*In May, I found out that I had passed. I felt accomplished and really proud of what we all had achieved. By the time I first put a needle in someone's arm, it didn't feel weird. I remember thinking 'I'm meant to be here. This is what I should be doing'.*

## Transformation progress

Our transformation programme continued into 2021/22. Our transformation programme is a wide-ranging and ambitious programme of change and innovation, aiming to deliver high-quality and sustainable health and social care services for our citizens. The programme has been structured around the Three Conversations model, with three main programmes of work aligned to conversation stages and a further element delivering cross-cutting, enabling change.

The key projects within the transformation programme progressed in 2021-22 are discussed under the most relevant strategic priority:

- Edinburgh Pact and Community Mobilisation – Prevention and early intervention
- Three Conversations – Person-centred care
- Bed-Based Review – Managing our resources effectively
- Home Based Care – Making the best use of the capacity across the system
- Workforce Strategy – Making the best use of the capacity across the system
- Home First – Right care, right place, right time

## Strategic Priorities

### Priority 1: Prevention and early intervention

Investing in prevention and early intervention services is a key part of our strategy. By identifying those people most at risk of poor outcomes and providing effective early support we can prevent problems occurring or minimise the impact on the individual's health and wellbeing.

#### The Edinburgh Wellbeing Pact and Community Mobilisation

The Edinburgh Wellbeing Pact is one of the key elements of the existing Edinburgh Integration Joint Board (EIJB) strategic plan. In April 2021, following a period of extensive dialogue with staff, residents, stakeholders and partners across Edinburgh, we successfully made seven recommendations to the EIJB relating to the Edinburgh Wellbeing Pact and how this could be enacted. The Edinburgh Wellbeing Pact is framed around the principles of mutuality and reciprocity, and these remain central to all the enactment activities which have been initiated to date.

As part of our Community Mobilisation project, we are developing a new way to engage and fund the third sector, with emphasis on community collaboration and assets. The work to further develop and accelerate solutions has been taken forward through eight stakeholder events with over 700 people engaged in the process. The Community Mobilisation Plan continues to be an iterative and dynamic process as it needs to reflect current and future context and policy direction. Projects which have received funding under the programme to date include: the Edinburgh Community Resilience Programme; Op Ready; The Community Taskforce Volunteer Programme; The Fit and Active Programme for People with Learning Disabilities; The Enliven Edinburgh – Addressing Loneliness and Isolation Campaign; and the Neighbourhood Recruitment Programme.

#### *Building capacity to collaborate*

In January 2022 organisations were invited to build Capacity to Collaborate; 52 applications were received, which were assessed by a multi-organisation panel focusing on increasing capacity to collaborate, rather than following the more traditional, transactional relationship of being a service provider. The funding available for the proposals was a maximum of £350,000 per annum; the panel recommended that 22 proposals, ranging from £2,075 to £24,075 with a total value of £482,994 over a three year period, should receive funding. These awards will be part of the 'More Good Days' Public Social Partnership which will be further developed in the coming year.

#### Long-term Conditions Programme

Our 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. There is a [Long-Term Conditions Section](#) on our website with information for people living with long term conditions, their families and carers.

## *Supporting people at risk of falls*

During the pandemic, many people became less active, leading to an increased risk of falls. Preventative input is of particular importance as reports highlight the significant increase in falls risk due to this reduced activity and associated deconditioning ([Public Health England Report 2021](#)).

We have improved and clarified ways people can:

- access urgent assistance following a fall if uninjured but unable to get up
- participate in an assessment to help identify their risk factors of falling
- access rehabilitation to help maintain or regain their confidence and physical ability following a fall

Many referral routes are now via centralised contact centres which, with the additional increase in the use of technology, have improved efficiency.

We have ensured that consistent information is available across various mediums for the public and health and social care staff to access, including a tool with rapidly available links to assessments, cross-sector referral options and signposting. Care home falls prevention and management documents and guides are being updated to facilitate improved practice, data gathering and training. Training for health and social care practitioners and third sector organisations on falls and available resources has been developed and provided as required.

In partnership with the Red Cross, the Staying Active project is now under way in Leith, aiming to better understand how we identify risks of falls and frailty early, and to offer optimal support with a view to keeping people active and changing future outcomes.

These improvements have enabled more people to access and receive the support they require to manage an acute fall, and to reduce their risk of future falls by addressing preventable risk factors and promoting improvements in physical function and strength.

## *Anticipatory Care Planning*

A high-quality Anticipatory Care Plan (ACP) shared on a Key Information Summary (KIS) is the most effective way of making sure that the voices of individuals are heard when decisions are being made about their care and treatment. We have taken innovative approaches to ensure everyone involved in a person's care can have a role in discussing future care and treatment preferences and contribute to creating a shared plan. The ACP community bundle and the [7 steps to ACP for care homes](#) are recognised best-practice models, developed by Edinburgh practitioners to deliver an integrated approach to improving outcomes through ACP. We have provided ACP training and improvement support to a range of health and social care teams, and continue to see an upwards trend in the number of ACP-KISs for citizens in Edinburgh, with a 23% increase during 2021/22. During 2021/22, 58,751 ACP-KISs were created and in March 2022 a total of 279,177 active ACP-KISs were shared across the integrated system.

## *Supporting Self-Management: 'I don't live with my condition, it lives with me.'*

Supporting Self-Management describes the ways in which we aim to support, empower and enable people living with long term conditions to manage their health and wellbeing and live well. The Self-Management Support Worker Service, hosted with [Lothian Centre for Inclusive Living \(LCiL\)](#), has adapted to the challenges of COVID-19 by re-designing the referral and service pathway to increase access for people in most need of support.

Responding to 'what matters to you' conversations with people and their families, the Self-Management Service designed and facilitated two Self-Management workshops. The first, 'Easing Out of Lockdown', helped people develop their own resilience and coping mechanisms to live their lives as fully as possible during the pandemic. The second, 'Understanding Pain & Managing Symptoms', helped participants develop a greater understanding of their pain, how it impacts them and what they might be able to do themselves to help manage their pain.

The Self-Management section of our website includes a new page hosting the [Connect Here community resources](#), which provides information and contact details for over 1,400 services, groups and activities to help people find the support that is right for them, connecting with their community and improving their health and wellbeing.

### Case Study: Active Steps

Jamie had a range of health conditions due to his size, and he contacted Active Steps as he wanted to lose weight and become more physically active to improve his overall wellbeing, mobility, and confidence.

Jamie had a 1:1 session with an in-depth discussion about his wants and needs and what would be the best path for him. He agreed to attend the online 8 week *Make a Change* course, designed to encourage people to lead a healthier, more active lifestyle by providing them with practical tips and information to encourage them to make the changes they want.

He also agreed to attend weekly supported gym visits at Engage, and after four months his wellbeing had improved in a number of ways. As well as now being in diabetic remission, his general mobility had improved; his pain levels had reduced; his confidence had increased; his mental health had improved; and he felt better able to carry out his role as a carer. The boost that these improvements have given him have also made him more receptive to the counselling he has been receiving.

Although Jamie knows he has a long journey ahead to get to where he ideally would like to be in terms of his weight, he feels he is on the right road and has the right tools to reach his overall destination.

His mother has been so inspired that she too has enrolled in the Active Steps programme and now attends the chair-based exercise class while he attends the gym.

## Digital Support

We have been scaling up the use of remote monitoring to manage blood pressure in line with the Scottish Government priority for 2020-23. Patient recruitment to the Scale Up BP programme, which supports diagnosis and self-care of hypertension, increased between April 2021 and March 2022: over 2000 new patients across 60 Edinburgh GP practices have used Remote Health Pathways to manage their hypertension.

### Case Study: Phonelink

Alec was referred to Phonelink in June 2020 following discharge from hospital. He has a dementia diagnosis, and the year after he had a stroke he was re-admitted to hospital: the post-stroke fatigue caused confusion and he was not medicating correctly. Phonelink offered Alec two calls per day to help him get back on track.

The fatigue also meant he tended to stay at home, but after a few months of calls and taking his medicine correctly, Alec's mood was much improved, and he started getting out in the community on a daily basis. He reported that the calls changed his life for the better and has recently cancelled them; he no longer requires a prompt now his life and routine are back on track, and he knows he can ask for help again should his needs change in the future.

## Prevention of harm

We have a responsibility for adult protection and our Chief Officer sits on the multi-agency Chief Officers Group for Public Protection that is responsible for all areas of public protection across Edinburgh. This group is supported by the Adult Protection Committee.

Between April 2021 and March 2022, there were 1,901 adult protection contacts across the city. 38.8% of these referrals were made by Police Scotland. Around 23% of the contacts were made by other organisations (care homes, care agencies, etc) and 18.3% were initiated by different departments of the City of Edinburgh Council. NHS Lothian was the source for 8.35% of the referrals. Of the 1,901 referrals received during the year, further action was taken in nine out of ten cases. Half of them required social work involvement other than Adult Protection.

Just over a quarter of referrals (481) progressed to investigation in the period. Infirmary due to old age was the most common client group for those whose case was being investigated (29.5%), followed by mental health (23.9%). The cases that resulted in an investigation were principally due to neglect (23.9%) and physical harm (23.1%). Of the 481 investigations, seven out of ten resulted in further action.

There were also 797 adult protection case conferences in the year, of which 28% were initial case conferences.

## Priority 2: Tackling inequalities

We have a key role to play in addressing inequality, in particular the health inequalities that represent thousands of unnecessary premature deaths every year in Scotland. The fundamental causes of health inequalities are an unequal distribution of income, power and wealth which can lead to poverty and the marginalisation of individuals and groups. These fundamental causes also influence the distribution of wider social determinants of health, such as the availability of good-quality affordable housing; green space; work, education and learning opportunities; access to services; and social and cultural opportunities. These also have strong links to mental and physical health.

### EIJB Grant Programme 2021/22

2021/22 saw the third year of operation of the EIJB Grant Programme 2019-22 (annual budget of £4.7m) which helps realise two key priorities of the IJB's Strategic Plan - to **tackle inequalities** and promote **prevention and early intervention**.

The ongoing easing and tightening of COVID-19 pandemic restrictions, often at short notice, made it challenging and frustrating for organisations to move forward with their programmes, particularly in relation to re-convening groupwork sessions.

Organisations were however able to build on their experience and learnings from 2020/21 and worked well with the changing restrictions to continue to provide a wide and varied range of much needed services, whilst ensuring a safe and supporting environment.

In general, the return to normality is progressing well with many organisations redesigning their services to incorporate lessons learnt from the pandemic and develop new ways to deliver services to a wider group of service users. The stability and agility of third sector organisations during the pandemic has shown the important contribution the voluntary sector has in sustaining strong and resilient communities across the city. Staff, volunteers and participants have been delighted to see the return of face-to-face classes and activities, although there is recognition that remote working has its place, and a blended mix of support will continue.

The EIJB Innovation Fund, which is part of wider grant programme, has also progressed well during 2021/22 in what have been very difficult circumstances, with five of the eight pilot projects now complete. These projects have provided important learning for tackling old problems with new collaborative approaches, and have ranged from addressing new ways to support people with dementia to remain safely within community-based settings, to establishing new effective collaborative partnerships between GPs and third sector organisations to address long-term conditions such as chronic pain.

The current grant programme has now been extended by three years to March 2025 to allow third sector organisations to consolidate their services following the pandemic.

## Case Study: Space & Broom Hub

Stewart, 86, has dementia and relies on support from his wife Karen, 75.

During the pandemic, pressures facing care providers resulted in Stewart's care package being reduced to one morning visit. While Karen enjoys supporting her husband, the reduction in support left her feeling depressed, lonely and overwhelmed.

Stewart began attending the centre and Karen was given information about some carer services that were available for her. He settled into the club very quickly and as lockdown restrictions eased, was able to attend morning and afternoon sessions, where he made new friends and took part in a range of activities. Karen was pleased that Stewart enjoyed the club so much, and she found the break invaluable:

*'Those regular few hours to myself each week meant that I could plan time for me, something that I have not been able to do for ever such a long time. I could book some pampering sessions for myself; hair and nails, catch up with my friends for walks and coffee and even lunch. Having that short break to myself has been absolutely fantastic for my mental health and something I have absolutely looked forward to every week; I feel so much better because of it.'*

## Mental Health and Wellbeing (Thrive Edinburgh)

Our mental health and wellbeing strategy, Thrive Edinburgh, sets out the links between underlying societal inequalities and mental health, and our roadmap for improving the support on offer in Edinburgh to promote good mental health and wellbeing for all. Our strategy is built on four pillars: Change the Conversation, Change the Culture; Partner with Communities; Act Early; and Use Data and Evidence to Drive Change.

The *A Place to Live* commissioning process was completed and a Framework Agreement, worth an estimated £11m per annum, is now in place. This is an integrated approach to addressing the need to secure long-term community based supported accommodation for an identified group of people with ongoing complex support needs and who are transitioning from long-term stays in hospital. The new framework will be responsive to the process of bed reduction as rehabilitation beds at the Royal Edinburgh see a reduction from 60 to 36 beds. The whole system commissioning approach will result in responsive, local, and collaborative decision making that crosses over organisational boundaries, allowing for innovative practice and a more dynamic way of working. The new contracts bring current provision under a more structured contractual arrangement linked to a common specification and standard terms and conditions.

We are contributing to the Scott Review of mental health law and incapacity legislation, and with the help of people with lived experiences are rolling out our human rights education to our frontline workforce.

At the 2021/22 GO Awards Scotland ceremony for excellence in public procurement, our Thrive Collective procurement process won in two categories: Continuous Improvement, and Health and Wellbeing Recognition.

In early 2022 we began working with the wider workforce, including allied health professionals, art therapists and peer workers, to improve the life opportunities of people diagnosed with a personality disorder. An improvement plan is being developed with input from carers and people with lived experience, which will support skills, training, reflective practice, and supervision opportunities.

We have begun our city (e)scaping workstream with key partners, aiming to turn brown space into greenspace and create therapeutic, safe spaces for people to enjoy and participate in. New developments under the City (E)Scaping programme include Access Place, Linburn Walled Garden and Gracemount Community Garden. Part of the Building Resilient Communities Workstream, this work began in March and will continue over the next three years.

Partnership funding has been secured for two additional Thrive Edinburgh PhDs, focusing on poverty and mental health and urban mental health. Following a presentation on Thrive Edinburgh we have now been invited to join the iCircle Cities Urban Mental Health Network, a member group of the International Mental Health Leadership programme.

Our current Thrive Edinburgh adult health and social care commissioning plan is now coming to an end, and this has given us the opportunity to Renew, Refresh and Reimagine our strategic priorities for 2023-26. An event was held in October 2021 to begin the process, and there will be further dialogue around key priority areas over the coming year.

## Priority 3: Person-centred care

Being person-centred is about focusing care on the needs of the person rather than the needs of the service, and working with people to develop appropriate solutions instead of making decisions for them. Key to this is working with people using health and social care services as equal partners in planning, developing, and monitoring care to make sure it meets their needs and achieves positive outcomes.

### Three Conversations

The rollout of Three Conversations has continued over the last year. This approach focuses on what matters to a person and on working collaboratively with them as experts in their own lives, with staff considering a person's strengths and community networks to achieve positive outcomes. Due to the ongoing pandemic and capacity pressures across the system, rollout timescales have been extended; however, all four localities now have assessment and care management teams using the Three Conversations approach and the rollout to the remaining teams will progress this year. In addition to this, wider services within the partnership, such as Assistive Technology Enabled Care 24 (ATEC-24), have adopted the approach within the last year.

During 2021/22, teams using Three Conversations have had conversations with over 4,900 people. 35% of those who contacted us benefitted from personalised short-term support such as building community connections and providing equipment, advice or information, rather than formal long-term care services being required or increased. In the same period, it has taken on average 11 days from someone contacting Social Care Direct to their conversation starting; a significant reduction from our baseline of 37.3 days for those working in the traditional assessment model during 2018. Recent feedback from staff and people they worked with in the four teams using Three Conversations has been positive, with it being viewed as a very person-centred approach.

#### Case Study: Community Navigator

Beth had been referred by a Community Care Assistant to the Community Navigator for additional support with social isolation and loneliness. Beth is 64, lives with a number of long term physical and mental health conditions, and has very limited mobility. She lives alone in a ground floor flat, but her bathroom is not adapted to her needs and she struggles to navigate the steps to the main staircase.

During a home visit, where the unsuitability of her flat became apparent, it was also discovered that her low income caused her to struggle with her living costs, and that she would need support to access health care services.

As a result of work with Beth and a number of professionals over several months the following outcomes were achieved:

- Applications for welfare benefits and charitable grants were successful, leading to income maximisation, more sustainable money management and financial security
- Beth was made Gold Priority for social housing and is looking to move to a sheltered flat more suited to her needs
- Health services were accessed, including hospital consultations
- Daily phone calls from local voluntary organisation were set up to provide medication prompts and welfare checks; meals are delivered weekly by Cyrenians
- Increased confidence and motivation led to Beth reconnecting with family members, who now provide emotional and occasionally practical support

As a result of this collaboration, Beth has avoided further deterioration of her health conditions and can now remain living independently in the community.

## Care Inspectorate Reviews

We deliver 33 registered adult care services that are subject to inspection by the Care Inspectorate. Due to the impact of the COVID-19 pandemic, inspections are still being carried out less frequently.

The Care Inspectorate developed a new assessment question to meet the duties placed on the Care Inspectorate by the Coronavirus (Scotland) (No. 2) Act, and subsequent guidance that they must evaluate infection prevention and control, and staffing.

Inspection results are graded on a scale from 1 'unsatisfactory' (urgent remedial action required) to 6 'excellent' (outstanding or sector leading), with the grades 3 and 4 being assessed as 'adequate' and 'good' respectively.

During 2021/22, two COVID-19-focused inspections took place. The grade evaluations can be summarised as follows:

Service Name	Date of Inspection	How good is our care and support during the COVID-19 pandemic?	Requirements (COVID-19)	Areas for improvement (COVID-19)
Inch View	11-May-21	4	0	0
Royston Court	8-Feb-22	4	0	0

## Quality Improvement and Assurance in Care Homes

During the course of the year it was agreed that the Care Home Transformation Group would be disbanded, however a structured work programme for the coming year has been developed, including a plan to standardise the care documentation across the care homes, and the development of person-centred care plans.

Improvement work is ongoing at Royston Court Care Home with continued focus on processes and the sustainability of the implemented changes.

The nursing model will be implemented iteratively in the newer 60 bed care homes, with nursing staff initially recruited to Royston Care Home, followed by Inch View and then Marionville Court. Work is being carried out with staff at all levels to create conditions for change and look at ways in which they will work with registered nurses as part of the team.

An assurance tool has been created and is being used for visits to all our internal homes, which should not only provide assurance but also identify areas for improvement.

Complaints training has been delivered to our care home managers, and a system put in place to monitor all care home complaints, ensuring all actions are followed up and lessons learned are reviewed and shared.

### **Older People's Services Joint Inspection**

During 2021/22, we continued to engage with the Care Inspectorate and Healthcare Improvement Scotland (HIS) (known as the Joint Inspectors), to demonstrate the improvements we have made since the Older People's Services Joint Inspection (May 2017) and Progress review (June 2018).

Following a successful programme of collaborative meetings between staff and inspectors throughout early 2021, we pulled together a self-evaluation statement, setting out the considerable work done to address the 17 recommendations of the original report. Improvements evidenced related to both key strategic transformation projects and business-as-usual services.

The Joint Inspection Team issued its response in November 2021, noting that overall positive progress has been made. The report acknowledges that, since the progress review of 2018, senior leaders in the partnership have driven forward the change agenda and invested resources to progress strategic planning, which had previously lacked vision, direction, and pace. A positive shift has been noted, from a reactionary to a more planned and structured approach.

The Inspection Team noted particular areas of progress, including:

- Significant investment in improving the approach to engagement and consultation with stakeholders
- Developing new approaches to early intervention and prevention
- Developing and implementing the Carer Strategy (2019-2022)
- Improving access to diagnosis of dementia and post-diagnostic support
- Updating the Joint Strategic Needs Assessment, consulting on and implementing the Strategic Plan (2019-2022), and progressing with and investing in the Transformation Programme
- Implementing new approaches to assessment and care management, strengthening support to practitioners, and reducing waiting times for assessment and access to services

The Progress Report of November 2021 marks the end of formal scrutiny in relation to the original inspection and reflects the hard work and commitment of all our staff.

## Priority 4: Managing our resources effectively

In a climate of increasing need for services and continuing pressures on budgets, it is vital that we make best use of available resources.

### Financial management and performance

Financial information is a key element of our governance framework. Each year we produce a financial plan which sets out how we ensure our limited resources are targeted to support delivery of our strategic plan. Our [financial plan for 2021/22](#) was agreed by the board in March 2021.

Regular updates on financial performance against this plan were provided to the Performance and Delivery Committee as well as to the EIJB itself. Included in these reports were details of the financial impact of the pandemic and progress with the savings and recovery programme.

Budget monitoring of delegated functions is carried out by the finance teams in the City of Edinburgh Council and NHS Lothian, reflecting the EIJB's role as a strategic planning body which does not directly deliver services, employ staff or hold cash. However, the board 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.

You will find a comparison of costs against the budget for the year summarised in the table below:

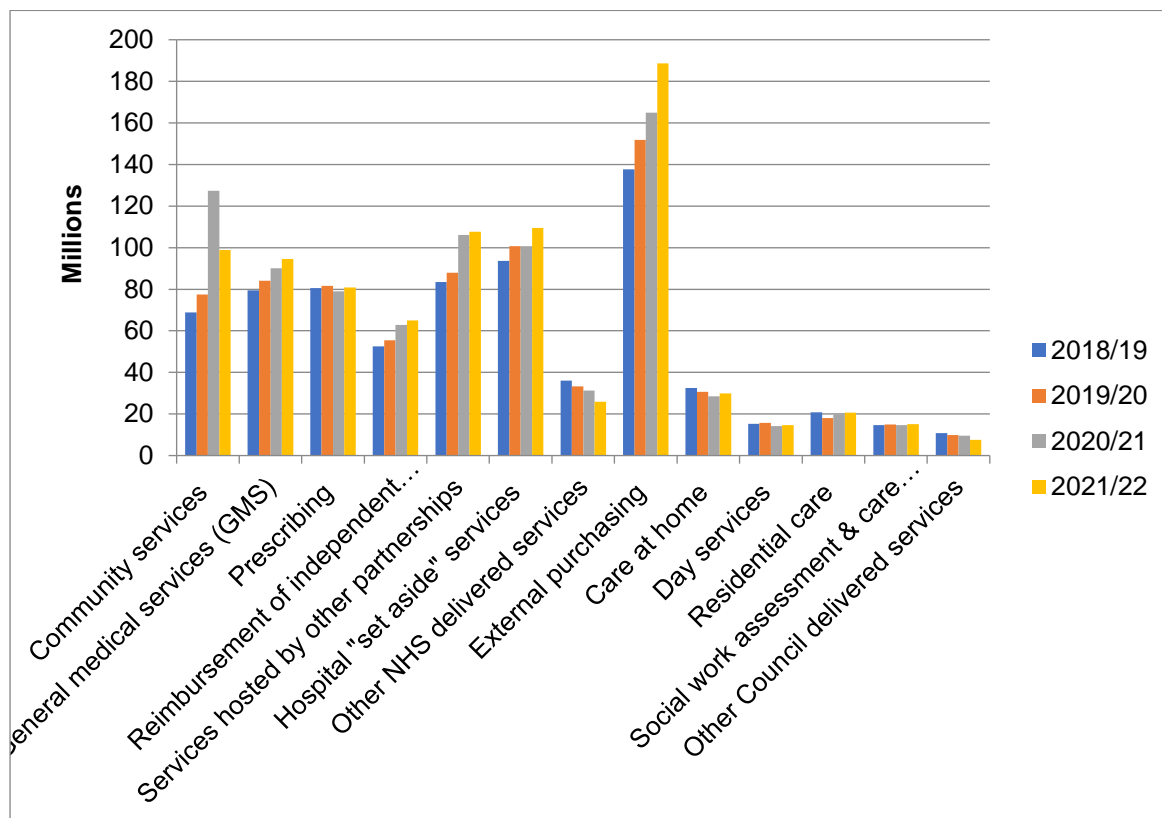
Service	Budget £m	Actual £m	Variance £m
<b>NHS DELIVERED SERVICES</b>			
Community services	101	99	2
General medical services	94	95	(1)
Prescribing	80	81	(1)
Reimbursement of independent contractors	65	65	0
Services hosted by other partnerships/NHS Lothian	109	108	2
Hospital 'set aside' services	109	110	(1)
Other	28	26	2
<b>Sub total NHS</b>	<b>586</b>	<b>582</b>	<b>3</b>
<b>CITY OF EDINBURGH DELIVERED SERVICES</b>			
External purchasing	183	189	(6)
Care at home	31	30	1
Day services	17	15	2
Residential care	22	21	1
Social work assessment and care management	16	15	1
Other	8	8	1
<b>Sub total Council</b>	<b>277</b>	<b>276</b>	<b>0</b>
<b>Net position</b>	<b>862</b>	<b>859</b>	<b>3</b>

Whilst there is no doubt that we will continue to face significant financial pressures, we saw our previous improvements in financial planning and performance sustained during 2021/22 as we delivered a surplus of £3m against the budget for the year. These funds have been transferred to our reserves and will be carried forward to 2022/23 for prioritisation by the board. Interpreting the financial results during a pandemic is not straightforward but it is evident from the table above that we continue to experience pressure in our purchasing budget. In the main this can be attributed to spot purchasing, predominantly care at home/care and support, residential services and direct payments.

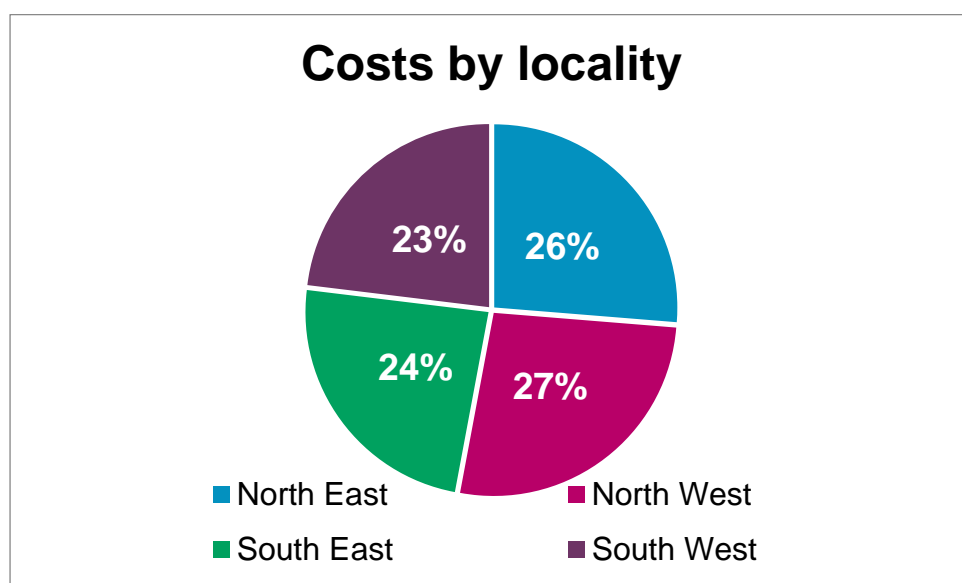
The pandemic clearly had an impact on our finances, and this was closely monitored during the year. We incurred net additional costs of £42m as a direct result of COVID-19. The main categories of associated expenditure being: sustainability payments made to support providers during the pandemic; purchase of additional capacity; additional staffing and reimbursement of independent contractors; increased prescribing costs; delivery of the vaccination programmes and slippage in the delivery of the savings and recovery programme. In line with their commitment, these costs were met in full by the Scottish Government and are summarised below:

NHS	FHS contractor costs	1,822
	Hosted and set aside service costs	3,224
	Other costs	166
	Prescribing	2,008
	Staff costs	2,710
	Vaccination programme	981
	<b>Sub total NHS</b>	<b>10,910</b>
Council	Additional community capacity	1,807
	Loss of income	1,733
	Net unmet savings	10,824
	Other costs	371
	PPE	314
	Safehaven beds	1,127
	Staff costs	598
	Sustainability payments	14,688
	<b>Sub total Council</b>	<b>31,462</b>
<b>Total net additional COVID-19 costs</b>		<b>42,372</b>

The chart below shows costs in key areas for the last four financial years:



Although many of the delegated services are delivered directly in localities, a significant proportion are run on a city-wide basis. Showing how the associated costs are incurred within each locality requires a degree of estimation and assumption. This exercise shows that the cost of services is relatively consistent across the four localities, as shown in the diagram below.



## Bed-Based Review

The bed-based review is continuing to redesign bed-based services across the city, taking into consideration demand and capacity to ensure provision of sustainable services. The project covers a range of bed-based services including medically led beds in hospital settings, and beds located in the community led by social care staff.

A phased approach has been adopted to the project activities, with the implementation of Phase 1 under way. Work is progressing to implement the agreed Phase 1 changes, which will see an increase in intermediate care capacity, a streamlined Hospital Based Complex Clinical Care (HBCCC) service, and the introduction of nursing staff into our internally managed Care Homes. These changes will enable us to leave the Liberton Hospital site, freeing it up for redevelopment. Work is also ongoing in specialist inpatient rehabilitation and palliative / end of life care.

In September 2021 the EIJB agreed to undertake a consultation on the future provision of older people's services in Edinburgh. We have been working with the Consultation Institute to plan and develop the consultation activity, and it will be published in the latter part of 2022. The outcome from the consultation will inform the options for the delivery of bed-based services in Edinburgh.

## **Priority 5: Making best use of capacity across the system**

It is important to ensure that capacity within the system is utilised in a balanced and progressive way to deliver the best outcomes for the people of Edinburgh. We continue to work with our partners in the third and independent sectors to ensure that the services we offer can meet increasing needs and demands within the continuing challenging financial climate.

### **Workforce Strategy**

Through our transformation programme, we have been developing our inaugural workforce strategy, 'Working Together', to ensure that we have skilled and capable staff that can deliver our vision of 'a caring, healthier and safer Edinburgh'. The strategy focuses on our own workforce across the City of Edinburgh Council and NHS Lothian, as well as recognising the invaluable contributions of those we work with, such as unpaid carers, volunteers and those in the third and independent sectors.

'Working Together' was developed through workshops, staff surveys and focus group activity, which in turn helped to identify key themes, commitments and actions necessary for the successful delivery of our workforce strategy. 'Working Together' is also informed by demographic and projected demand information which highlights the need for short-term as well as mid-term and long-term goals to be achieved to meet the challenges we face.

Our next step is for the working together strategy to progress to implementation, with wider communication of our strategy and delivery groups beginning in 2022/23.

### **One Edinburgh: Home-Based Care**

'One Edinburgh' is part of our Home-Based Care and Support project within the Transformation Programme. It seeks to transform Edinburgh's approach to supporting people in their own homes, recognising that choice and control for supported people cannot happen unless there is a sustainable market of providers and services to choose from. It is supporting the development of a market position statement including the One Edinburgh Charter, co-produced with external provider partners, and takes into consideration our approach to commissioning care at home services and the function of our internal Home Care and Reablement provision.

Over 2020/21 we have begun to implement our new mobile workforce scheduling solution for our internal Home Care and Reablement provision. This will be complete by the end of 2022 and is an enabler for our internal redesign.

### **Primary Care Transformation**

The application of the Primary Care Improvement Plan (PCIP) and Transformation and Stability (T&S) funds in Edinburgh saw another constructive year in 2021/22. There is now the equivalent of 237 additional full time primary care staff funded through PCIP across the city, with a further ten to be recruited with the funding currently available.

Pharmacotherapy accounts for 30% of the PCIP funding, and we have been very successful in quickly building this expanded service. Alongside our partners we opted to employ more pharmacy technician staff to improve the skill mix within the workforce, and these staff will be able to combine to provide multi-practice support for relatively routine processing of medicine-related activity. Deployment of pharmacy teams into practices has provided both additional capacity and expertise, with approximately 200,000 interventions delivered in a year when the envisaged service is not yet fully in place.

Fifty of our 70 medical practices are currently accessing the minimum Community Treatment and Care Centres (CTAC) services, with a smaller number receiving more substantial support. CTACs take several time-consuming procedures, such as complex wound dressings, out of medical practices, and deliver vaccinations and other procedures like ear irrigation which require specialised equipment and training. Student and travel vaccinations are now being delivered through CTACs with shingles and pneumococcal vaccinations delivered from April 2022. While some patients will now need to travel further than their local surgery to receive some primary care treatment, this will free up medical practices to concentrate on the services they are best placed to provide.

## Priority 6: Right care, right place, right time

As part of making sure people receive the right care in the right place at the right time, we want to ensure people are supported to live as independently as possible. We are committed to ensuring people are supported at home and within their communities whenever possible, and are admitted to and stay in hospital only when clinically necessary. Central to our thinking is working towards the provision of care tailored to the individual, in a place which best provides this care and as close as possible to when it is required.

### Supporting Carers

Carers remain vital partners in supporting the most vulnerable people in society and while society emerges from the pandemic, carers continue to feel its effects daily.

Despite its challenges, in 2021 contracted provision under the Edinburgh Joint Carer's Strategy (EJCS) 2019-22 was rolled out to support carers across the six priority areas:

- Identifying carers
- Information and advice
- Carer health and wellbeing
- Short breaks
- Young carers
- Personalising support for carers

Short breaks and developments around Adult Carer Support Plans were affected by pandemic restrictions, however, resulting in a portion of funds being re-invested to benefit carers. Importantly, where provision was affected, carers continued to be supported in creative and dynamic ways, making the first year of the contracted provision a great success.

The Edinburgh Joint Carer's Strategy is being refreshed in 2022 and will align with the National Carer Strategy, which is currently under consultation. This shall allow recent challenges to be addressed and will ensure the six priorities continue to be delivered upon. A working group has been established and the Carers Strategic Partnership Group shall have oversight as this work progresses.

### Home First

Home First is developing services to better support people to remain at home or in a homely setting, preventing hospital admission and providing alternatives to hospital where it is clinically safe to do so. Significant progress was made in several workstreams during the year.

To support the prevention of admissions, we implemented a Single Point of Access through the Flow Centre for all urgent health and social care/therapy pathways requiring a 4-hour response. From March 2021 - February 2022, 357 referrals were received and 53% of admissions were avoided. We also expanded the social work hospital team to include Home First Navigators in Home Based Complex Clinical Care and intermediate care, and additional social workers to support the front door at the Royal Infirmary and Western General Hospital. Our Hospital@Home service also

prevents admissions. Referrals to this service have increased by 40%, with the introduction of different referral routes and virtual clinics which accept Emergency Department referrals out of hours for visits next day.

Our Home First approach also works to support timely discharge from hospital. In 2021/22, Edinburgh became the first Lothian partnership to test Planned Date of Discharge (PDD), as part of the pan-Lothian pathfinder site for the national Discharge without Delay initiative. We also enhanced our Discharge to Assess (D2A) service, which enables more people to be assessed at home, supporting 2,173 discharges or referrals since June 2021. Additionally, the Community Respiratory Team built on the success of the test of change done at the Royal Infirmary in 2021 to support the discharge of COVID-19 patients. In 2021/22 there were 20 referrals with 60 hospital bed days saved.

## Health and Wellbeing Outcomes

There are nine national health and wellbeing outcomes which have been set by the Scottish Government. Each Integration Joint Board (IJB) uses these outcomes to set their local priorities.

The table below shows how the strategic priorities from our Strategic Plan contribute to these national outcomes.

Strategic priority	National outcomes this priority contributes to	Associated national indicators
Prevention and early intervention	<p><i>Outcome 1:</i> People are able to look after and improve their own health and wellbeing and live in good health for longer</p> <p><i>Outcome 4:</i> Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services</p>	<p>Indicator 1</p> <p>Indicator 7</p> <p>Indicator 12</p> <p>Indicator 16</p>
Tackling inequalities	<p><i>Outcome 5:</i> Health and social care services contribute to reducing health inequalities</p>	<p>Indicator 11</p>
Person-centred care	<p><i>Outcome 3:</i> People who use health and social care services have positive experiences of those services, and have their dignity respected</p> <p><i>Outcome 7:</i> People who use health and social care services are safe from harm</p>	<p>Indicator 3</p> <p>Indicator 4</p> <p>Indicator 5</p> <p>Indicator 9</p> <p>Indicator 17</p>
Managing our resources effectively	<p><i>Outcome 9:</i> Resources are used effectively and efficiently in the provision of health and social care services</p>	<p>Indicator 14</p> <p>Indicator 20</p>
Making best use of capacity across the system	<p><i>Outcome 8:</i> People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide</p>	<p>Indicator 6</p>
Right care, right place, right time	<p><i>Outcome 2:</i> People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community</p> <p><i>Outcome 6:</i> 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</p>	<p>Indicator 2</p> <p>Indicator 8</p> <p>Indicator 13</p> <p>Indicator 15</p> <p>Indicator 18</p> <p>Indicator 19</p>

Underpinning the nine wellbeing outcomes sits a core suite of integration indicators, which all HSCPs report their performance against. These national indicators have been developed from national data sources to ensure consistency in measurement. There are 23 indicators but four of them (indicators 10, 21, 22 and 23) have not yet been finalised for reporting.

National indicators (NI) 1 to 9 are based on the Scottish Health and Care Experience Survey (HACE) commissioned by the Scottish Government. The primary source of data for indicators 12 through 16 are Scottish Morbidity Records (SMRs) which are nationally collected discharge-based hospital records. Following recommendations made by Public Health Scotland (PHS) and communicated to all Health and Social Care Partnerships, the most recent reporting period available is calendar year 2021; this ensures that these indicators are based on the most complete and robust data currently available. Figures presented may not fully reflect activity during 2021/22 due to the varying impact of COVID-19 at different points of the pandemic.

## Performance against National Indicators

### Health and Care Experience Survey Indicators

National indicators (NI) 1 to 9 are based on the Scottish Health and Care Experience Survey (HACE) commissioned by the Scottish Government. This survey is sent randomly to around 5% of the Scottish population every two years. The most recent survey results for inclusion in this report are from the 2021/22 survey, which was sent to 43,282 people in Edinburgh and produced 10,102 responses. This represented a response rate of 23%; a drop from the 25% response rate for the 2019/20 survey, and just under the rate of 24% for Scotland. Results for indicators 1, 6 and 8 are comparable across all years, but those for indicators 2,3,4,5,7 and 9 are comparable to 2019/20 only.

Figures for both Edinburgh and Scotland have seen reductions since 2019/20 in almost all indicators, showing a likely impact of the pandemic affecting both local and national responses. The exception to this is indicator 2 - *Percentage of adults supported at home who agree that they are supported to live as independently as possible* – where Edinburgh saw a small increase that was not seen nationally.

As can be seen in the table below, Edinburgh is above the Scottish average for 2021/22 in six of the HACE survey indicators, in line with the Scottish average in one indicator and below the Scottish average in two indicators.

The areas where we are below the Scottish average are:

3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided
4. Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated

We continue to target improvements in these areas through our roll out of Three Conversations, the Home First approach and promoting self-directed support options.

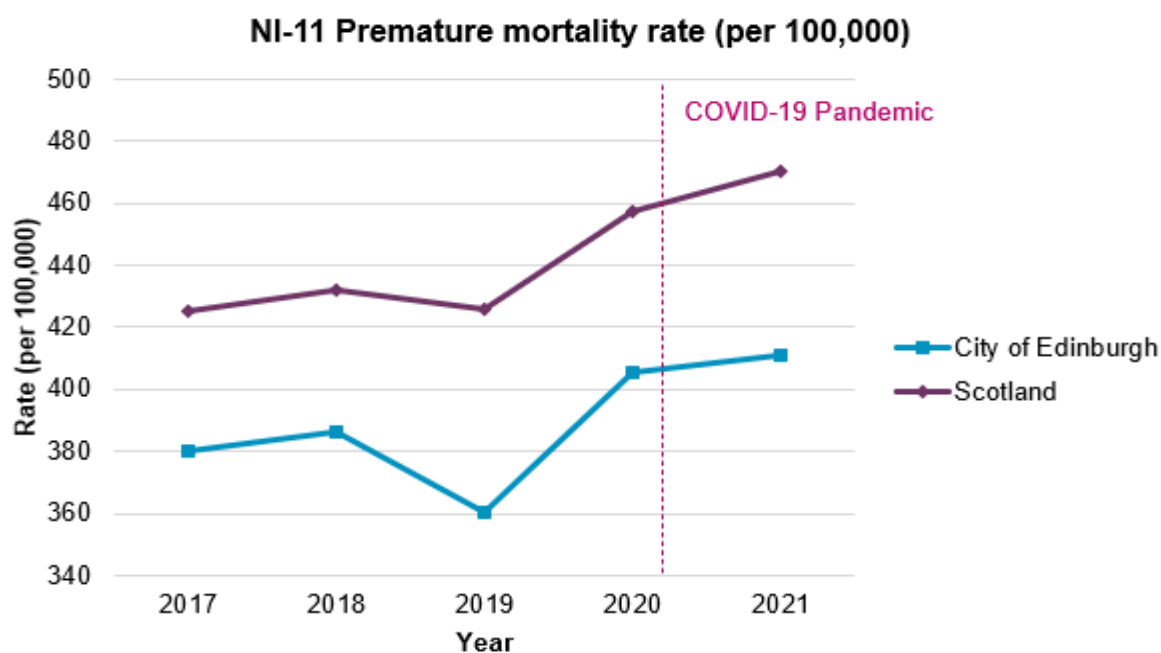
National Indicator (NI)	2021/22 Edinburgh	2021/22 Scotland	2019/20 Edinburgh	2019/20 Scotland	2017/18* Edinburgh	2017/18* Scotland	2015/16* Edinburgh	2015/16* Scotland
<i>NI-1</i> : Percentage of adults able to look after their health very well or quite well	91.6%	90.9%	93.8%	92.9%	93.6%	92.9%	96.1%	94.5%
<i>NI-2</i> : Percentage of adults supported at home who agree that they are supported to live as independently as possible	78.9%	78.8%	77.6%	80.8%				
<i>NI-3</i> : Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	68.9%	70.6%	76.7%	75.4%				
<i>NI-4</i> : Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated	64.8%	66.4%	72.6%	73.5%				
<i>NI-5</i> : Percentage of adults receiving any care or support who rated it as excellent or good	77.4%	75.3%	82.2%	80.2%				
<i>NI-6</i> : Percentage of people with a positive experience of the care provided by their GP practice	73.8%	66.5%	82.5%	78.7%	84.2%	82.6%	86.9%	85.3%
<i>NI-7</i> : Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	79.2%	78.1%	83.2%	80.0%				
<i>NI-8</i> : Percentage of carers who feel supported to continue in their caring role	30.4%	29.7%	33.0%	34.3%	34.8%	36.5%	36.6%	40.0%
<i>NI-9</i> : Percentage of adults supported at home who agreed they felt safe	79.4%	79.7%	86.5%	82.8%				

\*Figures for 2019/20 onwards are not always directly comparable to previous years due to changes in methodology

Source: Scottish Government HACE surveys

### Indicator 11: Premature mortality rate

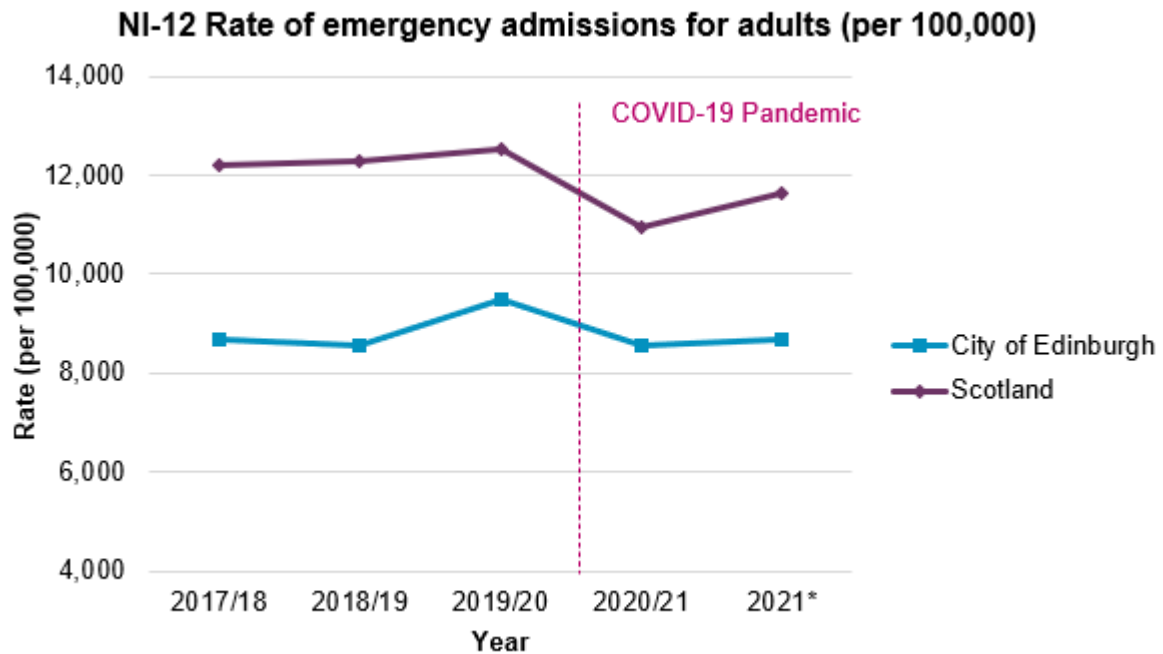
Our performance in terms of premature mortality shows a slight decline but continues to be better than the Scottish average and we rank 12<sup>th</sup> overall.



	2017	2018	2019	2020	2021
<b>City of Edinburgh</b>	380	386	360.3	405	411
<b>Scotland</b>	425	432	425.8	457	471

### Indicator 12: Rate of emergency admissions for adults

We continue to have a much lower rate for emergency admissions than the Scottish average and the second lowest rate in Scotland. The ongoing impact of the pandemic may have continued to affect the numbers of people attending hospital A&E departments in 2021. Our Home First Project also continues to look for ways to treat patients at home or in the community where appropriate, including through a redesign of unscheduled care pathways.

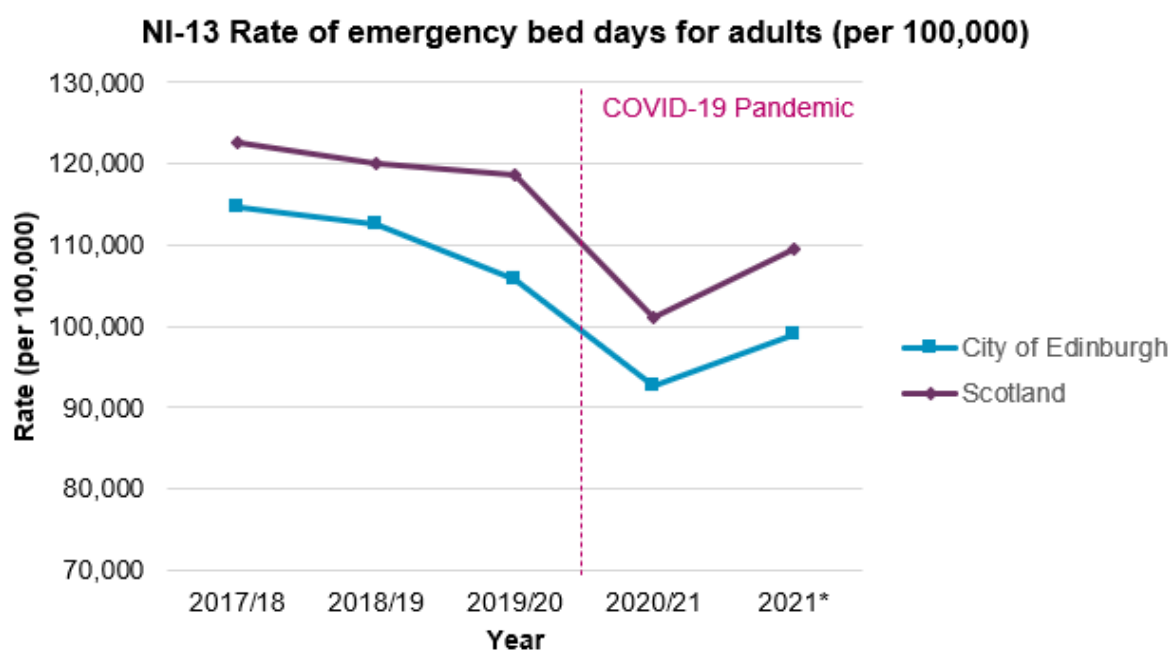


The rate of emergency admissions varies across our localities, as per the table below.

	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021*
<b>City of Edinburgh</b>	8,671	8,565	9,486	8,543	8,688
<b>Scotland</b>	12,211	12,280	12,525	10,952	11,636
<b>North East</b>	9,047	9,060	9,977	9,096	9,205
<b>North West</b>	9,473	9,126	10,222	9,274	9,456
<b>South East</b>	7,496	7,307	8,002	7,067	7,263
<b>South West</b>	8,754	8,963	9,962	8,913	8,985

#### Indicator 13: Rate of emergency bed days for adults

This indicator was also affected by the impact of the pandemic and the reduced numbers of people attending hospitals for emergency treatment. In 2021, figures for this indicator increased slightly, but we are substantially below the Scottish average and the figures achieved in the three years prior to the pandemic. Edinburgh has the ninth lowest rate in Scotland for this indicator.



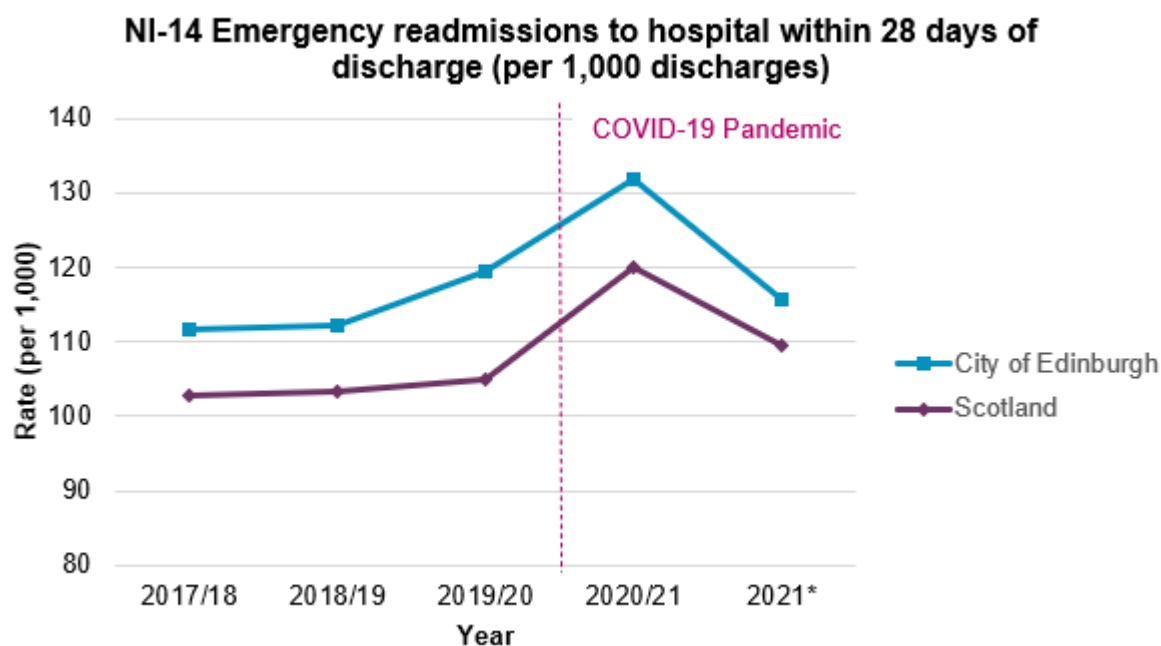
As with emergency hospital admissions, performance varies across our localities depending on demographics:

	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021*
<b>City of Edinburgh</b>	114,716	112,447	105,677	92,759	98,984
<b>Scotland</b>	122,571	120,007	118,574	101,115	109,429
<b>North East</b>	105,964	108,073	103,800	86,632	92,510
<b>North West</b>	120,956	114,775	106,906	93,400	103,285
<b>South East</b>	126,886	118,618	110,554	103,997	104,145
<b>South West</b>	100,941	106,411	100,286	84,255	94,081

#### Indicator 14: Readmissions to hospital within 28 days of discharge

2021 saw a marked improvement in this indicator compared to the previous two years, with the 2021 rate dropping below pre-pandemic levels. This follows an increase in 2020/21 when the reduced number of people in hospital meant that those who were admitted were likely to have had more complex issues, which would in turn have made readmission a greater possibility. This trend can be seen in the national as well as Edinburgh data. Edinburgh was ranked 22<sup>nd</sup> out of 31 partnerships in 2021, an improvement from 26<sup>th</sup> in 2020.

Edinburgh has been consistently above the Scottish average for this indicator, though we have seen the gap close in 2021. Detailed analysis of the data has revealed that there is no single reason for this higher rate of readmissions in Edinburgh, but our Home First project is continuing to look into areas where improvements can be made to reduce the rate of readmissions further.

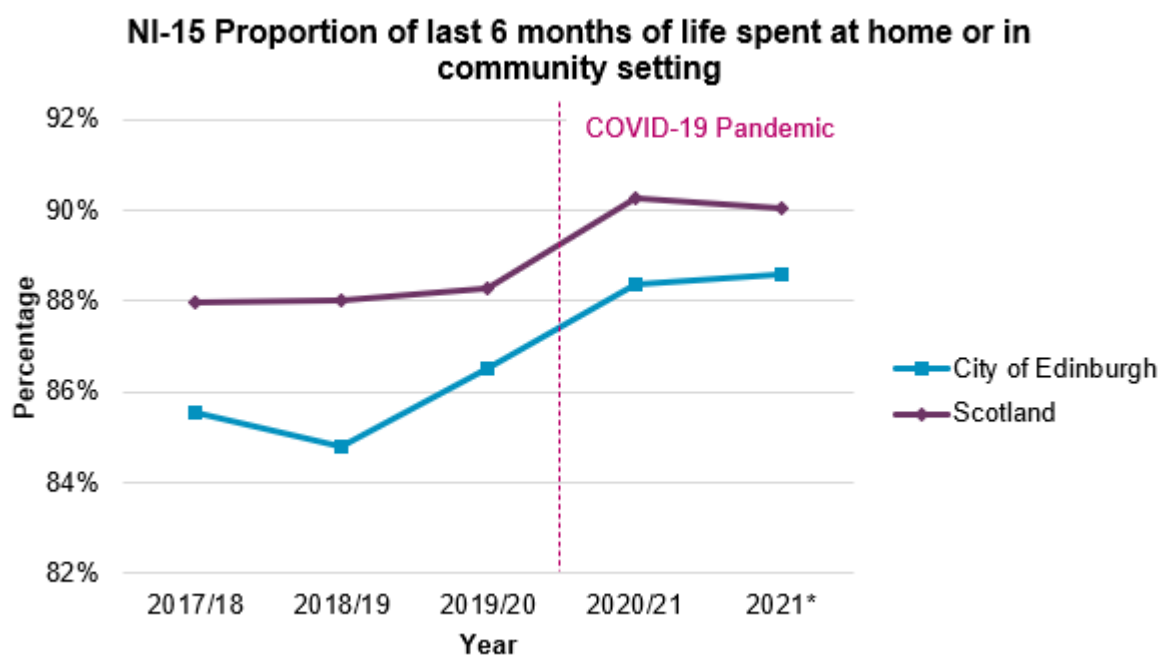


	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021*
<b>City of Edinburgh</b>	112	112	120	132	116
<b>Scotland</b>	103	103	105	120	110
<b>North East</b>	110	119	124	134	118
<b>North West</b>	106	104	112	137	116
<b>South East</b>	116	110	119	119	108
<b>South West</b>	117	119	124	135	117

#### Indicator 15: Proportion of last 6 months of life spent at home or in community setting

Our performance in this indicator has improved in 2021, continuing the increase seen in 2020/21 compared to a slight decrease seen nationally. Although still lower than the Scottish average, the difference is now only one percentage point. We are now ranked 27<sup>th</sup> out of 31 partnerships, an improvement from being ranked lowest in 2020. As this measure is based on how much time people spent in hospital during the last six months of their life, the continuing lower numbers in hospital due to the pandemic may have affected the trend.

Our Home First project continues to focus on supporting people at home or in a community setting where appropriate, including through our Hospital at Home service. Our bed-based strategy is also looking to ensure we have the right mix of beds across hospital and community settings to support a shift in the balance of care to the community.



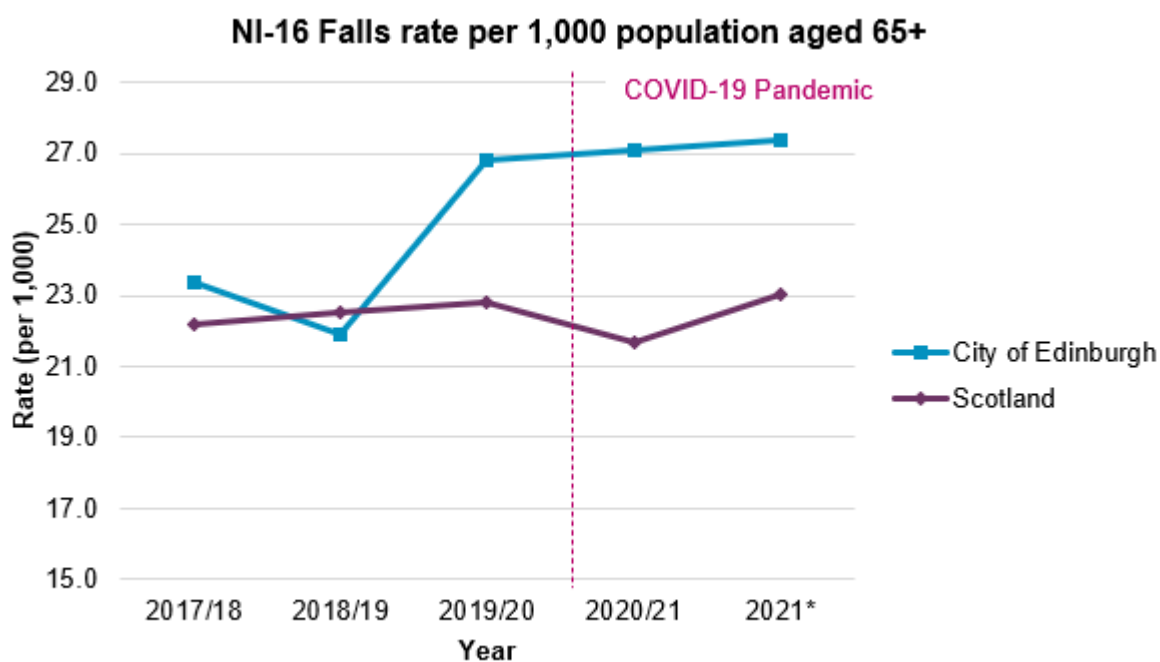
	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021*
<b>City of Edinburgh</b>	86%	85%	87%	88%	89%
<b>Scotland</b>	88%	88%	88%	90%	90%
<b>North East</b>	85%	85%	86%	88%	88%
<b>North West</b>	84%	83%	85%	88%	88%
<b>South East</b>	87%	87%	88%	89%	89%
<b>South West</b>	86%	86%	87%	89%	90%

#### Indicator 16: Falls rate per 1,000 population in over 65s

Performance in this indicator has been largely unchanged for three consecutive years, although it remains higher than the Scottish average. Edinburgh was ranked 28<sup>th</sup> out of 31 partnerships in 2021, a slight improvement from 29<sup>th</sup> in 2020.

The rate increased sharply from 2019/20 and was accompanied by a drop in the average length of stay following admission. This rate is based on the number admitted to hospital following a fall, rather than all falls in the community, and the increase in rate from 2019/20 is likely linked to a service change at A&E at the Royal Infirmary Edinburgh where more people were admitted for short periods of time from A&E.

The actions taken in our Supporting People at Risk of Falls initiative, run as part of our Long-Term Conditions programme, aim to reduce the adverse consequences and likelihood of falls; a likelihood which may have increased due to deconditioning as a result of reduced physical activity during the pandemic.



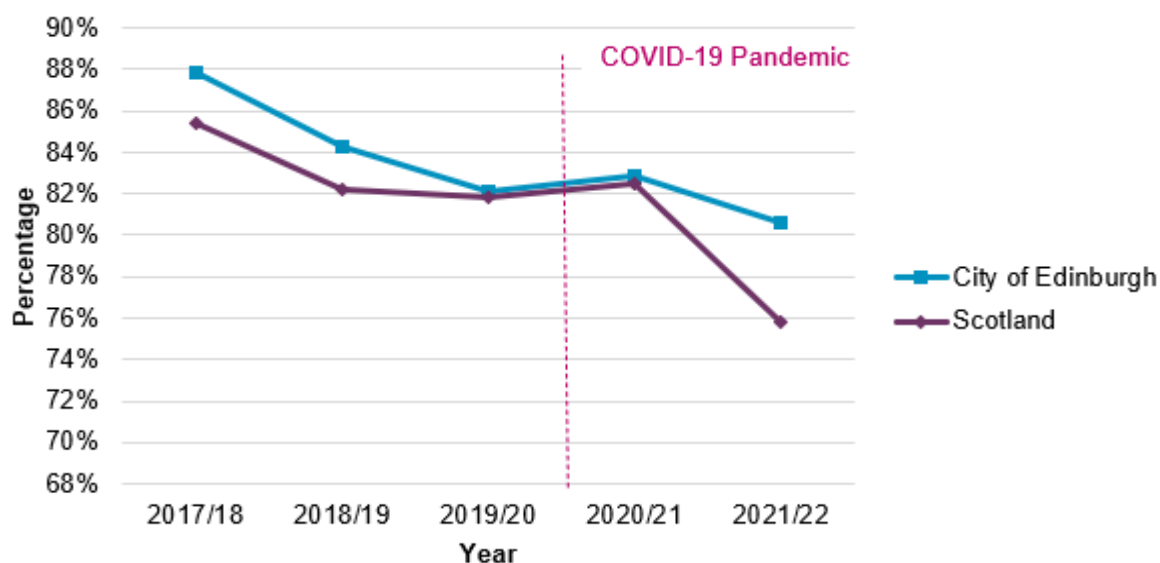
	2017/18	2018/19	2019/20	2020/21	2021*
<b>City of Edinburgh</b>	23	22	27	27	27
<b>Scotland</b>	22	23	23	22	23
<b>North East</b>	25	23	30	28	28
<b>North West</b>	24	22	27	29	28
<b>South East</b>	23	22	28	26	27
<b>South West</b>	21	21	23	24	26

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

Although performance in this indicator dipped slightly compared to 2020/21 in line with a general downward trend, the fall was less marked than that of the Scottish average. In 2021 we ranked 11<sup>th</sup> out of 31 partnerships, an improvement from 20<sup>th</sup> in 2020.

Most of the Care Inspectorate's strategic inspection work was paused between March 2020 and spring 2021. Some more inspection activity has resumed since then, but the Care Inspectorate have altered the way they carry out inspections and their areas of focus, creating a new question to establish how services were responding to the pandemic, particularly as regards infection prevention and control measures. The data for NI-17 comes from the Care Inspectorate and covers all registered services in Edinburgh, not just those that we run. The figure covers the latest inspection result for each registered service, even if the inspection took place before the referenced financial year.

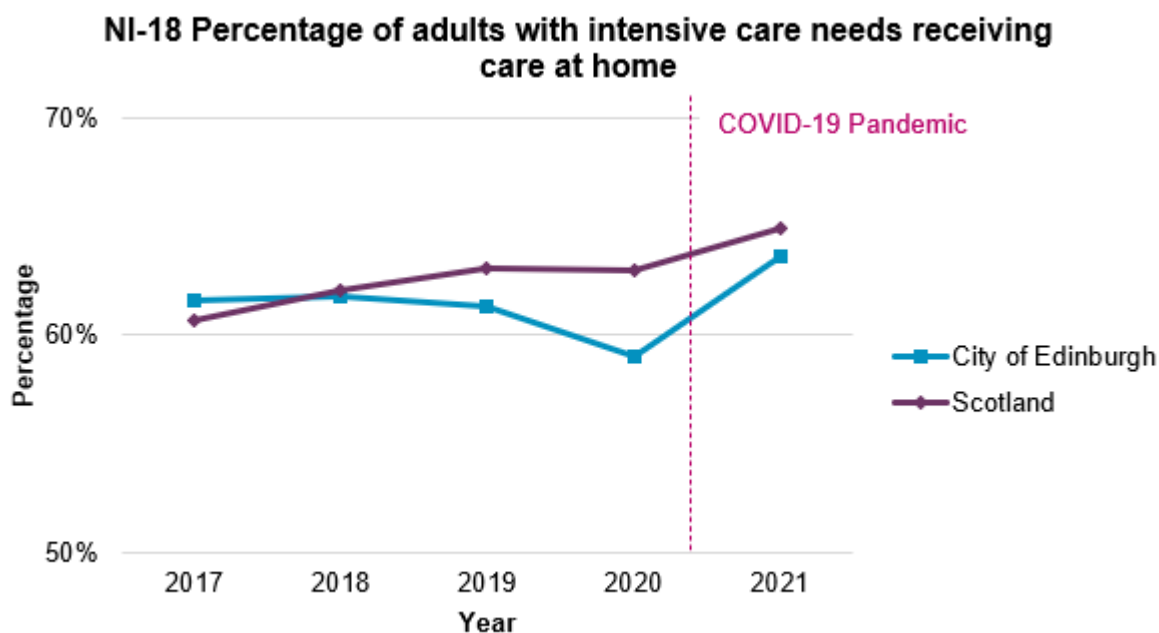
**NI-17 Proportion of care services graded 'good' or better in Care Inspectorate inspections**



	2017/18	2018/19	2019/20	2020/21	2021/22
<b>City of Edinburgh</b>	88%	84%	82%	83%	81%
<b>Scotland</b>	85%	82%	82%	82%	76%

**Indicator 18: Percentage of adults with intensive needs receiving care at home**

Our performance in this indicator has improved compared to the previous year and is now at the highest level in the last five years. While performance remains slightly below the Scottish average, the gap has been narrowed in the last year. Our ranking compared to other partnerships improved from 24<sup>th</sup> to 20<sup>th</sup> out of 31 partnerships. We continue to work to shift the balance of care from hospital settings to the community, through our bed-based review and Home First approach.



	2017	2018	2019	2020	2021
<b>City of Edinburgh</b>	61.6%	61.8%	61.4%	59.0%	63.6%
<b>Scotland</b>	60.7%	62.1%	63.0%	63.0%	64.9%

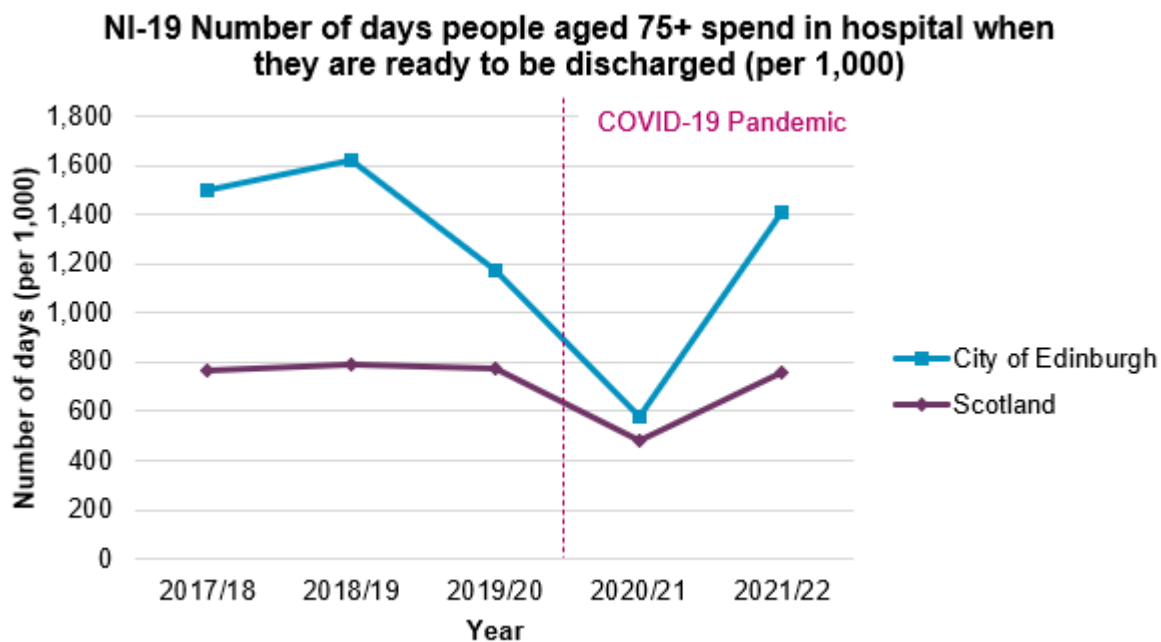
#### Indicator 19: Number of days people aged 75+ spend in hospital when they are ready to be discharged

The impact of the system pressures described earlier in this report can be seen in this indicator. As predicted in last year's Annual Performance Report, the figures for delayed discharges have increased as services remobilised and pressures on capacity increased following the removal of restrictions.

The figure for this indicator in 2021/22 saw a sharp increase, although this remains below the high rates we saw in 2017/18 and 2018/19. Our rank was the lowest in Scotland, with delay figures considerably above the Scottish average. Significant work has been undertaken to reduce the number and length of delayed discharges, including supporting 121 people into interim placements, which saved over 6,000 bed days for those who would otherwise have continued to be delayed in hospital. However, this work has been unable to offset the impact on delays from the significant capacity challenges being faced across the social care sector in Edinburgh.

Our bed-based strategy will implement changes that support increased capacity in intermediate care and a move to a nursing model within our internal care homes. Ongoing work through the Home First project on implementing a Planned Date of Discharge will also support more proactive discharge planning. Work under way

through our 'One Edinburgh' approach to home-based care will also support increased efficiency and capacity gains in this sector.



	2017/18	2018/19	2019/20	2020/21	2021/22
<b>City of Edinburgh</b>	1,502	1,621	1,175	579	1,409
<b>Scotland</b>	762	793	774	484	761

Indicator 20: Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency

NHS Boards were not able to provide detailed cost information for 2020/21 due to changes in service delivery during the pandemic. As a result, Public Health Scotland (PHS) have not provided information for indicator 20 beyond 2019/20. PHS previously published information to calendar year 2020 using costs from 2019/20 as a proxy but, given the impact of the COVID-19 pandemic on activity and expenditure, PHS no longer consider this appropriate.

## Ministerial Strategic Group Indicators

We also report performance indicators to the Scottish Government through the Ministerial Strategic Group for Health and Community Care (MSG). These performance indicators give a view of how HSCPs are progressing against a range of whole system level measures. The performance indicators are largely based on hospital sector data due to routine availability of national data. While similar to some of the core indicators, these figures are calculated in slightly different ways so are not comparable.

Since the 2017/18 baseline was set, we are moving in the desired direction for all but two of these indicators.

Indicator	2017/18 Baseline total	Desired direction of travel	Latest available figures	Achieved Direction of travel	Latest Period
A&E Attendances	103,986	↓	101,376	↓	2021/22
Unplanned Admissions <sup>+</sup>	35,597	↓	36,284 <sup>+</sup>	↑	2021
Emergency Occupied Bed Days:					
Acute	330,759	↓	292,703	↓	2021
Geriatric Long Stay <sup>^</sup>	22,324	↓	19,291 <sup>^</sup>	↓	2021/22
Mental Health	122,841	↓	125,733 <sup>p</sup>	↑	2020/21
Delayed Discharges	76,933	↓	73,719	↓	2021/22
Last 6 months of life spent in a community setting	85.7%	↑	88.4%	↑	2020/21
Balance of Care: at home <sup>#</sup>	95.5% <sup>*</sup>	↑	96.1%	↑	2020/21

Notes: No target were set for 2021/22 due to the pandemic.

<sup>+</sup>The increase in the number of unplanned admissions is due to a service change at the Royal Infirmary in Edinburgh from April 2019. Some patients who have attended A&E have been admitted as an emergency inpatient to the Acute Assessment Unit. This has increased the number of emergency admissions in 2019. Most of these patients are discharged on the same day as admission to the Acute Assessment Unit.

<sup>^</sup> Geriatric long stay unscheduled occupied bed days data is affected by SMR completeness issue.

<sup>p</sup> This data is provisional.

<sup>#</sup> This indicator is still under development and may change in future releases.

<sup>\*</sup> The Balance of Care 2017/18 baseline figure has been updated since it was last published.

## Looking ahead

Even with restrictions lifted, health and wellbeing continues to be affected by the pandemic; and with a deteriorating economic situation and a 'cost of living crisis' exacerbating existing inequalities, we will continue to support people through our services and prepare for the longer-term impact on health and wellbeing.

During 2022/23 we will be updating our Strategic Plan, with strategic objectives evolving in the light of the impact of COVID-19, the economic situation, and societal trends.

Innovation and sustainability will remain central to our thinking and underpin our desire to foster a culture of continuous improvement. We have folded our flagship transformation projects into a core innovation and sustainability programme and will seek to align all aspects of our strategic activity to make best use of our resources.

Many of our transformation projects are moving towards 'business as usual', with progress continuing in the remaining workstreams. The 'More Good Days' Public Social Partnership will be a key vehicle for delivery of our Edinburgh Community Mobilisation and Accelerate programme, which sets out to accelerate system change to create more resilient communities and a sustainable health and social care system, improving population health and tackling inequalities.

Phase 1 of the Bed-Based Review is being implemented in tandem with progression in the outstanding workstreams, which include Breaks from Caring (respite), Mental Health Beds, and Supported Accommodation. A city-wide consultation is also being planned to get public opinion on the future provision of older people's services in Edinburgh. The results, scheduled to be published in late 2022, will inform the options for the delivery of bed-based services in Edinburgh. Due to the size, scale and complexity of the project, it is anticipated that the project will continue for the next two to three years with the potential to widen the scope to other areas in the future.

While the pandemic has affected progress in our Home-Based Care project, our collaboration with providers has continued, building closer relationships through shared optimisation work. This work is supporting the development of our commissioning approach to a new contract for care at home provision. This will have an emphasis on moving away from time and task models of care provision to focus on better outcomes for the people we support.

We will also be continuing to monitor developments with the National Care Service (NCS) and carefully considering how we can support our staff and service users through continuing to provide person-centred care as these changes evolve.