Edinburgh Integration Joint Board

Annual Performance Report 2019-2020

Edinburgh **Health and Social Care** Partnership

Thank you to everyone who helped us produce this Annual Performance Report, particularly the people and organisations who shared case studies with us. Your input, help and contributions are much appreciated.

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Foreword

The Annual Performance Report for 2019/20 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 year. The report, as in previous years, measures our performance against the six strategic priorities set out in the EIJB Strategic Plan and against national indicators.

Due to the impact of the COVID-19 pandemic, the publication of the Heath and Care Experience Survey results has been delayed, as have some other data sets which we need to complete the annual performance report over the previous financial year. As a result, the performance data represented in this report, is mostly based on 2019 calendar year data. This approach has been approved nationally.

The EIJB approved its Strategic Plan for 2019-2022 in August 2019. At its heart, the new Strategic Plan sets out an ambitious transformation programme for the city over a three-year planning cycle, setting the conditions for longer term, sustainable change. Despite the impact of the COVID-19 pandemic, our preparations for the transformation programme are well advanced and we have made steady progress in the roll out of the Three Conversations approach in the city and in testing the concept of our Home First Edinburgh model.

We will continue to find ways to improve outcomes for people in Edinburgh and be innovative in our approaches against a challenging backdrop of a rising population, changing patterns of health and care need and ongoing financial pressures. Against this backdrop, our overall performance this year has remained for the most part in line with national averages, with encouraging signs of improvement in many areas.

Edinburgh is performing well in respect of national indicator 12 - rate of emergency admissions - ranking third across Scotland. Edinburgh's rate of emergency admissions has been consistently lower than the Scottish average since 2013/14. Likewise, we have seen strong performance against the measure of rate of emergency bed days for adults (national indicator 13). Edinburgh is currently ranked ninth and has seen significant improvement in this area since 2015/16. We are not performing as strongly as we would like in the rate of emergency readmissions to hospital within 28 days of discharge. We will focus on this alongside our continuing work to reduce the number of days people spend in hospital when they are ready to be discharged. The recent success of the Home First Edinburgh model during the COVID-19 pandemic has tested and proven the concept.

We would like to take this opportunity to thank our dedicated staff for their professionalism and fortitude and the many unpaid carers that provide vital care and support to the most vulnerable in our society. The EIJB and EHSCP are determined to enhance our performance further in the year ahead and beyond to bring about real and sustainable change for health and social care in Edinburgh.

Angus McCann, Chair
Edinburgh Integration Joint Board

Judith Proctor, Chief Officer
Edinburgh Health and Social Care

Introduction

Background and context

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

You can read the EIJB's current Strategic Plan 2019-22. This performance report sets out the EIJB's progress against the strategic priorities and transformation plans within the Strategic Plan.

COVID-19 impact and response

The emergence of a new coronavirus, COVID-19, declaration of a pandemic and resulting restrictions has had a significant impact on our operational service delivery. The EHSCP has had to respond swiftly to protect and find new ways of delivering services to our most vulnerable citizens within a rapidly-changing landscape.

For example, as part the COVID-19 response, the EHSCP developed a mobilisation plan setting out the wide range of actions we were putting in place in response to the pandemic to ensure the health and care system was prepared for the impact of the virus. Our main focus was on creating and maintaining acute hospital bed capacity for the anticipated increase of admissions to hospital, and on supporting those people delayed in hospital back home or to a homely setting. The mobilisation plan was approved by the EIJB and by Scottish Government and operated across the pandemic. We have set out our renewal and recovery work to return to the 'new normal' of providing health and social care as we react to the Scottish Government route map through and out of the pandemic and in the EHSCP's contribution to NHS Lothian's Remobilisation Plan.

At the time of writing this report, services have had to adapt with many having to change their focus to meet emerging frontline needs and priorities. This has impacted on the availability of data in some service areas, with evaluations being delayed or resources shifted to support the frontline. This report presents the best data available, acknowledging there may be some gaps. Likewise, the full impact of the COVID-19 pandemic on finance and resources is not yet known.

Performance data and narrative

In this report we are following the recommendations made by Public Health Scotland (PHS), and using the most recent reporting period available, which is calendar year 2019. This ensures that these indicators are based on the most complete and robust data currently

available. We do not expect these numbers to differ greatly to 2019/20 financial year figures, once available, and so should not affect any conclusions that have been drawn.

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. Underneath the nine wellbeing outcomes sits a core suite of integration indicators, which all HSCPs report their performance against. These national indicators underpin the nine wellbeing outcome measures and have been developed from national data sources to ensure consistency in measurement. We have presented performance from financial year 2013/14, to the most recent year available, with comparisons made to the Scottish average.

We have included performance summary information under a separate section; which includes trend data and Edinburgh's ranking against the Scottish average. You can find more detail on individual indicators, including locality information where available, under individual priorities. In addition, PHS published annual rates for the core suite of integration indicators for each integration authority area and Scotland in July 2020. This is the first time this information has been released in a single publication which you can find on the ISD Scotland site.

The **narrative content** in this report (case studies, project updates, updates on transformation priorities, financial information) covers the financial year April 2019 to March 2020 unless otherwise shown. We have changed all names and removed any identifying details in our case studies to protect anonymity.

Performance against national indicators

National indicators NI-1 to NI-9 are reported in the Scottish Health and Care Experience Survey (HACE) commissioned by the Scottish Government. Data relating to these indicators for 2019/20 was originally due to be published in April 2020, but due to staff redeployment during the COVID-19 pandemic, the publication was delayed and so the most recent survey results were not available for inclusion within this report. The latest data available is from the 2017/18 survey. We have made comparisons to the 2015/16 survey. This survey is sent randomly to around 5% of the Scottish population every two years. In 2017/18, the survey was sent to 47,949 people in Edinburgh with 10,327 responses which shows a response rate of 22%. The response rate across Scotland was also 22%.

The primary source of data for national indicators NI-11 to NI-20 are Scottish Morbidity Records (SMRs) which are nationally collected discharge-based hospital records. In accordance with recommendations made by PHS and communicated to all HSCPs, the most recent reporting period available is calendar year 2019; this ensures that these indicators are based on the most complete and robust data currently available. We do not expect these numbers will differ greatly to 2019/20 financial year figures, once available, and so should not affect any conclusions that have been drawn.

Ministerial Strategic Group for Health and Community Care and Audit Scotland Integration reviews

The EIJB reports a range of 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.

Partnerships were asked to set objectives, targets and trajectories for each performance indicator to provide management information on the progress in the integration of health and social care systems. The performance indicators are largely based on hospital sector data due to routine availability of national data. A summary of the MSG measures and targets for the EHSCP in 2019/20 is shown in the table below.

Indicator	Baseline Year	Baseline Total	2019/20 Target Change	2019/20 Target Figure	2019/20 Achieved Figure *	Performance
A&E Attendances	2017/18	103,986	1.5% increase	105,546	107,289	
Unplanned Admissions+	2017/18	35,597	1% decrease	32,241	39,196 +*	
Emergency Occupied Bed Days:						
Acute	2017/18	330,759	3% decrease	320,836	312,416 *	
Mental Health	2017/18	122,841	7% decrease	114,242	125,840 *	
Geriatric Long Stay	2017/18	22,324	7% decrease	20,761	14,935 *	
Delayed Discharges	2017/18	76,933	5% decrease	73,086	62,120	
Last 6 months of life spent in a community setting	2017/18	85.7%	1.1% increase	86.8%	86.6% *	
Balance of Care	2017/18	95.6%	0.2% increase	95.8%	95.7% *	

*Data for unplanned admissions, emergency occupied bed days and last six months of life are shown for calendar year 2019. Data for the balance of care indicator is shown for financial year 2018/19. Please note that this data is provisional. There are also SMR data completeness issues for geriatric long stay unscheduled occupied bed days.

+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.

Red, Amber and Green (RAG) Key for Edinburgh Performance

- Performance fell by 5% or more
- Performance fell but within 1% and 4.99%
- Target met or performance is within threshold

The EIJB received an update on progress towards the recommendations arising from both the Ministerial Strategic Group and Audit Scotland reviews of integration at its meeting held in February 2020.

Care Inspectorate gradings

You will see a summary of the Care Inspectorate reviews of EHSCP and the City of Edinburgh Council services which took place during financial year 2019/20 in the section on ‘person-centred care’. The data for NI-17 comes from the Care Inspectorate and covers all registered services, not just those run by the City of Edinburgh Council on behalf of the EHSCP.

Overview and transformation priorities

About Edinburgh – key facts and figures

Population

Edinburgh is home to 524,930 residents (as of June 2019). This is an increase of 1.2% from 518,500 in 2018. In the ten years to 2018 Edinburgh's population grew by 13.1% from 459,000 to 519,000 people. In the same time period, Scotland's population grew by 4.5%. Edinburgh's population growth from 2008 to 2018 was almost five times higher than past decade population changes.

Edinburgh is home to 79,335 residents aged over 65. Population projections show the number of over 75s in Edinburgh is expected to increase by 76% from 2018 to 2041.

Employment and the economy

Edinburgh has a higher percentage (77.8%) of the working age population in employment than any other major UK city. The large student population in the city accounts for 31.7% of the economically inactive population within the city.

Around 50,000 people in Edinburgh are employed in the health sector. This industry sector makes up 15% of all jobs in Edinburgh (Edinburgh by Numbers 2019).

Tourism is a key part of Edinburgh's economy. According to Visit Scotland there were around 16.9 million visitor nights in Edinburgh in 2018.

Poverty and inequalities

Poverty rates in Edinburgh vary considerably between different areas of the city, from as low as 5% in some areas to as high as 27% in others. Every locality has at least one area of significant poverty.

The Scottish Index of Multiple Deprivation 2020 indicated that of the 20% most deprived data zones in Scotland, 5.0% (70 data zones) are in Edinburgh. The most deprived data zone in Edinburgh is in Leith ward/North East locality.

Our achievements and challenges

The vision to deliver 'a caring, healthier and safer Edinburgh' underpins the EIJB and EHSCP.

The EIJB has set out an ambitious transformation programme within the Strategic Plan for 2019-22. This details our priorities for delivering sustainable, person-centred, flexible and quality services. The four key elements of our approach are:

- further development of the Three Conversations approach
- embedding the Home First model

- developing the Edinburgh Pact
- a wide-ranging transformation programme.

Here is a summary of progress in each of these areas.

Three Conversations

Three Conversations is a strength-based partnership approach developed by Partners4Change (P4C) which recognises that people are the experts in understanding their own circumstances and needs. It replaces the traditional model of 'assessment for services', avoiding a process-driven service that results in people on waiting lists and unnecessary bureaucracy.

Three Conversations is structured around three tiers or levels of intervention.

- Conversation 1: listen and connect.

  Listening to and understanding what people need and finding ways to build upon their strengths and connect them to family, community and others.

- Conversation 2: work intensively with people in crisis.

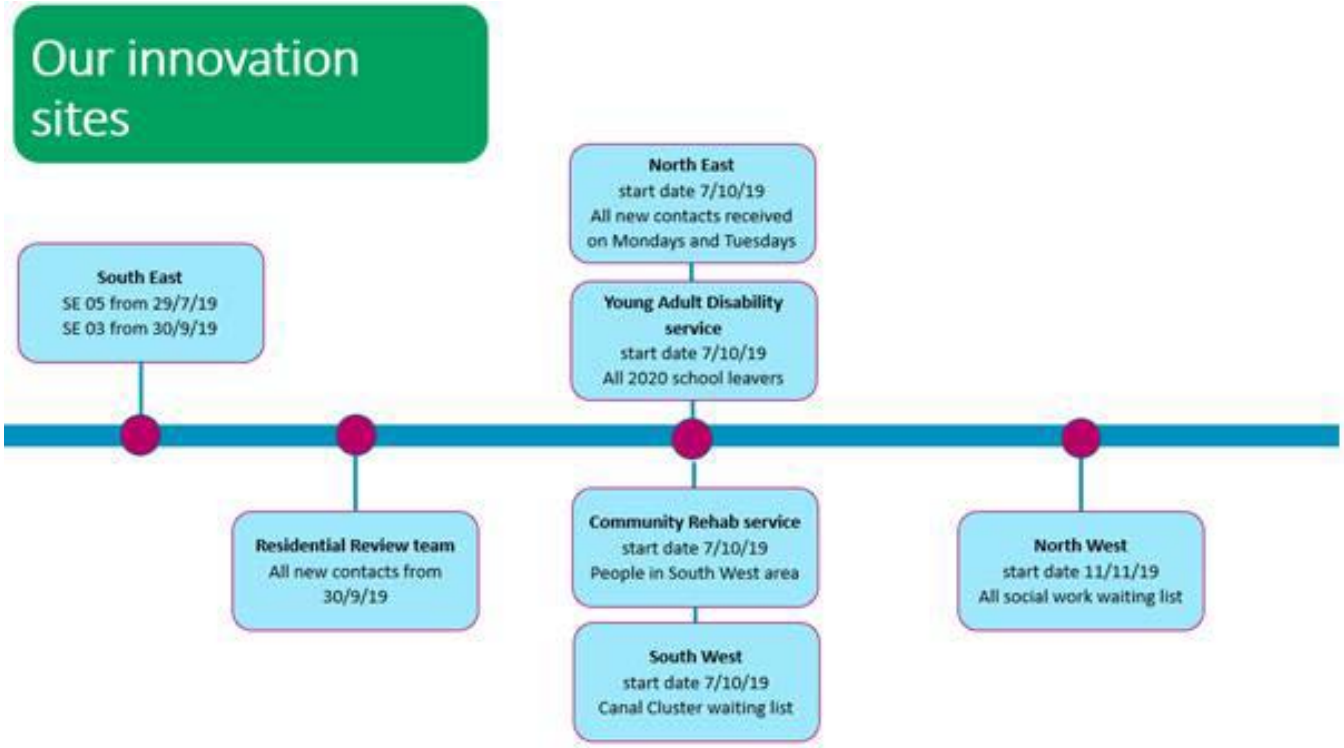
  Working out what is needed to help someone to regain control of their life or reach a point of stability and then ensuring that the emergency plan is delivered.

- Conversation 3: build a good life.

  This focuses on long-term planning.

Edinburgh is the first partnership in Scotland to adopt this new approach. During 2019/20 the programme focused on establishing innovation sites across the city and across service areas to test the approach and evaluate the lessons learned from phase one.

We now have seven innovation sites active in the city.



As part of the evaluation of the innovation sites, we collected data between July 2019 and March 2020 on the number of conversations completed, the type of conversations, how long it took for people to be connected with a worker, and the need for long-term paid for support as a result. Where possible, we compared data against approximate baseline figures from outwith the innovation sites.

The evaluation of phase one has shown:

- We held a total 1,609 conversations across the seven innovation sites, and we worked with 853 people.
- The majority of all conversations were conversation 1. Most people were supported at that point and did not need to have a further conversation. Only a minority of people required long-term support.
- We were able to respond to people's requests for support much more quickly. Prior to introducing the Three Conversations approach, the average waiting time for an assessment was 40 days, excluding the time from contact to screening and the time following allocation to a worker and start of the assessment. Within the innovation sites, the average wait to see a worker has dropped to 3.8 days.

The next stage of the Three Conversations approach will focus on scaling up and rolling out the approach. A challenge will be embedding the key principles in all areas of practice in EHSCP, as large-scale culture change of this type takes time.

Case study – Three Conversations

Agnes is a 94-year-old woman who lived with her daughter but wanted to return to her own home after a period of being unwell. Initially a package of care support was requested to help Agnes with meal preparation and dressing. However, through discussion, we found that Agnes felt she would be able to manage with some aids and adaptations to her home which support independent living. The care worker was able to link quickly with occupational therapy and got the equipment in swiftly and supported Agnes in its use. Agnes is now back in her own home, managing well and does not need any ongoing formal care or support. Both she and her family know to contact the service again should the situation change.

The Transformation programme

The EIJB ringfenced £2 million to support transformation in February 2019. The EIJB Strategic Plan 2019-22 sets out the detail of the two-year programme design, scope and intent.

The transformation programme is structured around the Three Conversations themes (listen and connect, work intensively with people in crisis, and build a good life) as well as focusing on cross-cutting enablers such as digital transformation and infrastructure.

Additional specialist staff with key project management skills were recruited during late 2019 and early 2020 and the programme was formally launched in February 2020. Work has already started on some transformational workstreams including Three Conversations, Home First Edinburgh, re-designing how people access our services and a bed-base review.

Home First Edinburgh

The Home First Edinburgh approach is critical to our ability to tackle delayed discharge and ensure that people are cared for in the right place at the right time. Home First supports people who are ready to return home after a hospital stay but need short term health and social care services to manage their discharge safely. Home First Edinburgh was initially tested in the Western General Hospital, with a further test at the Royal Infirmary of Edinburgh in late February and is being gradually expanded across other acute hospital sites.

Key to the delivery of Home First Edinburgh is Discharge to Assess and the creation of Home First community navigator posts. Discharge to Assess will have 16 therapists to deliver 80-100 discharges from hospital by supporting assessment at home. As of February 2020, a team of 8 therapists covering the north of the city have supported over 200 discharges over 16 weeks. Discharge to Assess has now been successfully rolled-out to south Edinburgh and increased the number of people supported to leave hospital.

The potential of Home First Edinburgh has already had a positive impact on the whole system with an overall improvement in both delayed discharge numbers and occupied bed days between April 2018 and December 2019. This facilitated the EIJB's decommissioning of 26 beds (ward 71) in the Western General Hospital by the end of October 2019. We also decommissioned ward 120 by the end of March 2020. The decommissioning of these acute wards supports a transfer of resource toward community models of care and also created an additional 15 intermediate care beds in the community within the same timescale. It is also worth noting that we completed the roll out of Edinburgh's Hospital at Home service across the city in December 2019 and the service will undergo further review as part of the transformation programme.

As well as facilitating timely discharge, another objective of Home First Edinburgh is to prevent unnecessary hospital admission. As part of winter planning, there was investment in the flow centre to support care as an alternative to admission. Early data suggests that as a result of the work of the winter prevention team and Home First navigator, 48 people have been prevented from being admitted to hospital. This represents a saving of 388 bed days over 16 weeks. You can find more information about Home First Edinburgh in the EIJB report from 22 October 2019.

The Edinburgh Pact

The Edinburgh Pact will set out a new relationship between service providers and citizens. We will engage and collaborate to understand people's views of how statutory services should support people with health and social care needs. We have started the initial planning as part of the transformation programme and will develop the Pact over the next two years. As part of the Pact, we will carry out quantitative and qualitative research in the early stages involving senior leaders, staff and the public. It will also form a continuing dialogue between the EIJB and the public from the second half of 2020 and beyond.

Improving governance

During 2019/20, the EIJB has focused on strengthening its governance arrangements. The Good Governance Institute (GGI) carried out a review of governance in 2018 and the EIJB has now implemented most of the recommendations arising from this review. As part of this, we established a new committee structure including Strategic Planning Group, Performance and Delivery, Audit and Assurance, Clinical Care Governance, and Futures.

The EIJB approved a new Directions Policy in August 2019. The policy was developed to address the risk of non-delivery of directions by NHS Lothian and the City of Edinburgh Council which had been highlighted as a significant risk for the EIJB. The policy follows Scottish Government best practice guidance and increases transparency and accountability between the EIJB and its partner organisations; NHS Lothian and the City of Edinburgh Council. We plan to keep our Directions Policy under constant review and will monitor, review and amend the policy to meet Scottish Government guidance and approved best practise.

Initially, the EIJB developed and approved nine directions linked to the Strategic Plan in October 2019. The EIJB has since developed and approved more directions in-year to account for service change and redesign. We have also conducted an annual review of directions.

Performance summary

Performance at a Glance

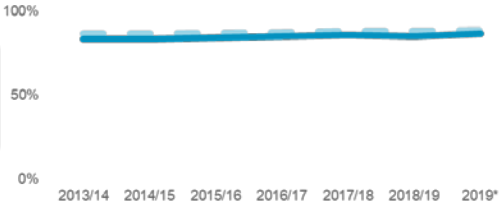
The infographic below summarises EHSCP's progress against National Indicators 11-20 as new data is available for these indicators following from the 2018/19 report. The Scottish average has been included for benchmarking purposes. The infographic shows the following information:

- The latest available figure for each indicator is shown in a circle on the left hand side of the infographic.
- A brief narrative on Edinburgh's performance over the last two years, along with the latest Scottish average is shown in the middle text box.
- The charts on the right hand side show time trends for both Edinburgh and Scotland for the past seven years.

87%
In 2019*

15. Of the last 6 months of life is spent at home or in a community setting

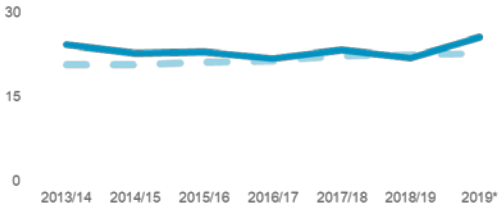
Performance improved by 2% from 85% in 2018/19
Scotland rate is 89% in 2019*



26
In 2019*

16. Falls rate (65+) per 1,000 population

Performance fell by 18% from 22 falls per 1,000 population in 2018/19
Scotland rate is 23 in 2019*



82%
In 2019/20

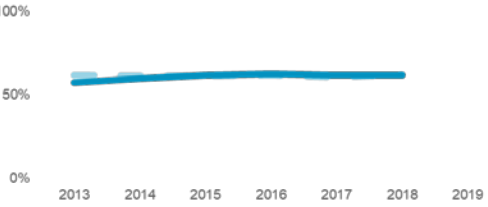
17. Care services graded GOOD (4) or better in Care Inspectorate inspections

Performance fell by 2% from 84% in 2018/19
Scotland rate is 82% in 2019/20

62%
In 2018

18. Adults with intensive care needs are receiving care at home

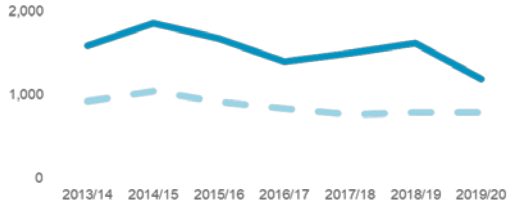
Performance remained at 62% in 2017
Scotland rate is 62% in 2018



1,191
In 2019/20

19. The number of days people aged 75+ spend in hospital when they are ready to be discharged

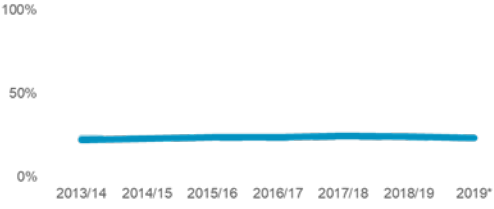
Performance improved by 27% from 1,621 rate in 2018/19
Scotland rate is 793 in 2019/20



23%
In 2019*

20. Health and care resource spent on hospital stays where patient was admitted as an emergency

The percentage fell by 1% from 24% in 2018/19
Scotland rate is 23% in 2019*



The table below compares the results for Edinburgh and Scotland from the last two Health and Care Surveys, which were published in 2015/16 and 2017/18. Please note that no data has been published for 2019/20 as the Scottish Government delayed the publication of the latest survey due to the pandemic.

1. Adults are able to look after their health very well or quite well

	15/16	16/17	17/18	18/19	19/20
Edinburgh	96%	N/A	94%	N/A	N/A
Scotland	95%	N/A	93%	N/A	N/A

2. Adults supported at home agreed that they are supported to live as independently as possible

	15/16	16/17	17/18	18/19	19/20
Edinburgh	81%	N/A	79%	N/A	N/A
Scotland	83%	N/A	81%	N/A	N/A

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

	15/16	16/17	17/18	18/19	19/20
Edinburgh	77%	N/A	74%	N/A	N/A
Scotland	79%	N/A	76%	N/A	N/A

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

	15/16	16/17	17/18	18/19	19/20
Edinburgh	71%	N/A	67%	N/A	N/A
Scotland	75%	N/A	74%	N/A	N/A

5. Adults receiving any care or support rated it as excellent or good

	15/16	16/17	17/18	18/19	19/20
Edinburgh	78%	N/A	80%	N/A	N/A
Scotland	81%	N/A	80%	N/A	N/A

6. Adults had a positive experience of the care provided by their GP practice

	15/16	16/17	17/18	18/19	19/20
Edinburgh	87%	N/A	84%	N/A	N/A
Scotland	85%	N/A	83%	N/A	N/A

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

	15/16	16/17	17/18	18/19	19/20
Edinburgh	83%	N/A	79%	N/A	N/A
Scotland	83%	N/A	80%	N/A	N/A

8. Carers feel supported to continue in their caring role

	15/16	16/17	17/18	18/19	19/20
Edinburgh	37%	N/A	35%	N/A	N/A
Scotland	40%	N/A	37%	N/A	N/A

9. Adults supported at home agreed they felt safe

	15/16	16/17	17/18	18/19	19/20
Edinburgh	82%	N/A	77%	N/A	N/A
Scotland	83%	N/A	83%	N/A	N/A

Performance against national indicators

The summary table below gives details of Edinburgh's performance against the national indicators over the last two years of the most recent available data (see the introduction section for more detail as COVID-19 has delayed the HACE 2019/20 survey results). Edinburgh's performance has been benchmarked against the Scottish average for national indicators 11 through to 20. We have shown the result as a RAG status in the final column. Green indicates that Edinburgh's performance, compared to last year, has improved. Amber signifies that Edinburgh's performance has decreased but is not behind the Scottish average. Red denotes that Edinburgh's performance has decreased and is also behind the Scottish average.

Indicator		2015/16		2017/18		2019/20	
Number	Description	Edinburgh	Scotland	Edinburgh	Scotland	Edinburgh	Scotland
NI - 1	Percentage of adults able to look after their health very well or quite well	**96%**	*95%*	**94%**	*93%*	**N/A**	*N/A*
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**81%**	*83%*	**79%**	*81%*	**N/A**	*N/A*
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%*	**N/A**	*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	**71%**	*75%*	**67%**	*74%*	**N/A**	*N/A*

NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	**78%**	*81%*	**80%**	*80%*	**N/A**	*N/A*
NI - 6	Percentage or people with positive experience of the care provided by their GP	**87%**	*85%*	**84%**	*83%*	**N/A**	*N/A*
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**83%**	*83%*	**79%**	*80%*	**N/A**	*N/A*
NI - 8	Total combined % of carers who feel supported to continue in their caring role	**37%**	*40%*	**35%**	*37%*	**N/A**	*N/A*
NI - 9	Percentage of adults supported at home who agreed they felt safe	**82%**	*83%*	**77%**	*83%*	**N/A**	*N/A*

Indicator		2018/19		2019*		How Edinburgh compared against Scotland^
Number	Description	Edinburgh	Scotland	Edinburgh	Scotland	
NI-11	Premature mortality rate per 100,000 persons (calendar year)	**386 *(2018)***	*432 (2018)*	**360 *(2019)***	*426 (2019)*	
NI-12	Rate of emergency admissions for adults (per 100,000 population)	**8,558**	*12,275*	**9,464**	*12,602*	
NI-13	Rate of emergency bed days for adults (per 100,000 population)	**112,108**	*120,177*	**104,707**	*117,478*	
NI-14	Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges)	**112**	*103*	**118**	*104*	
NI-15	Proportion of last 6 months of life spent at home or in a community setting	**85%**	*88%*	**87%**	*89%*	
NI-16	Falls rate per 1,000 population aged 65+	**21. 9**	*22. 5*	**25. 5**	*22. 7*	
NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	**84%**	*82%*	**82% (2019/20)**	*82% (2019/20)*	

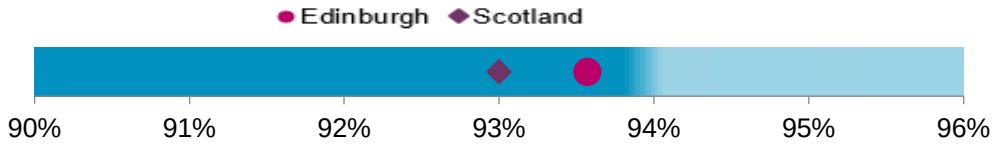
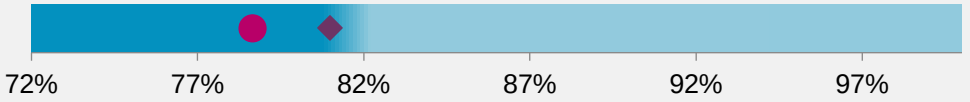
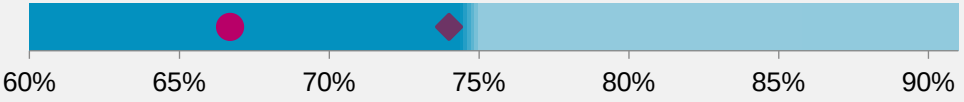
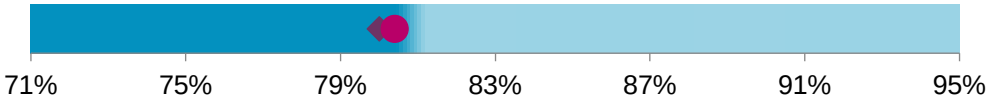
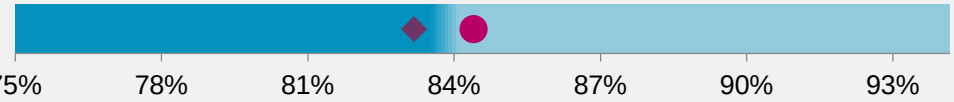
NI-18	Percentage of adults with intensive care needs receiving care at home (Calendar Year)	**62% (2018)**	*62% (2018)*	**N/A**	*N/A*	*N/A*
NI-19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**1,621**	*793*	**1,191 (2019/20)**	*793 (2019/20)*	●
NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	**24%**	*24%*	**23%**	*23%*	●

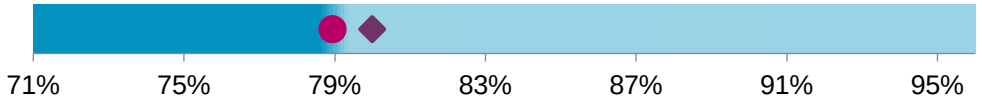
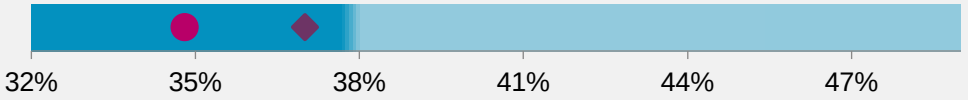
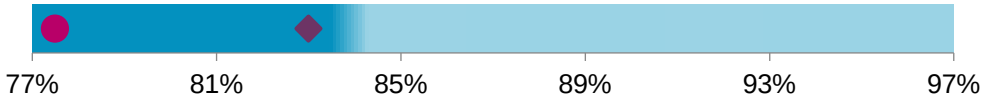
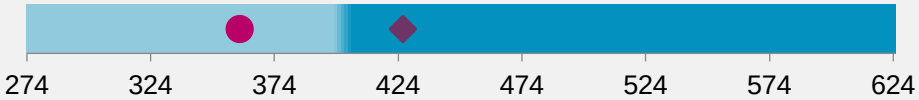
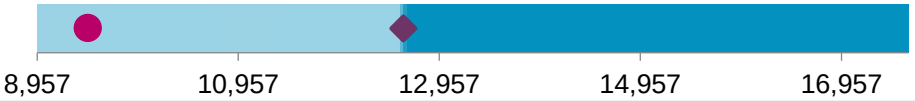
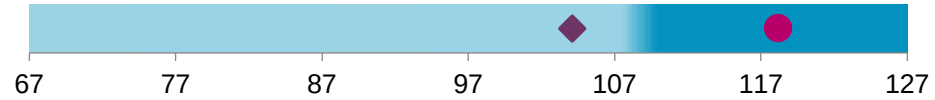
* The most recent reporting period available is calendar year 2019

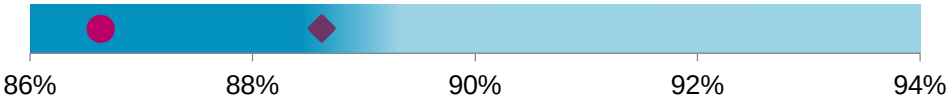
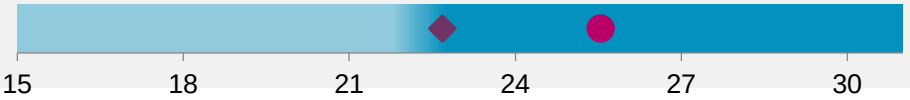
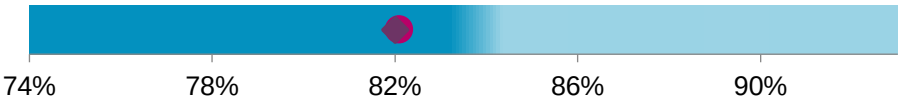
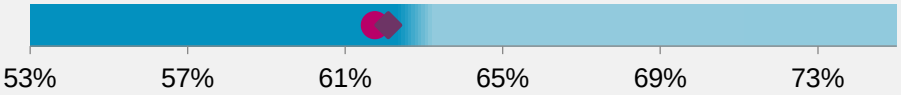
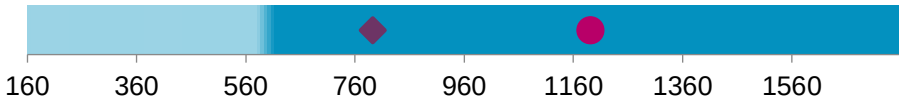
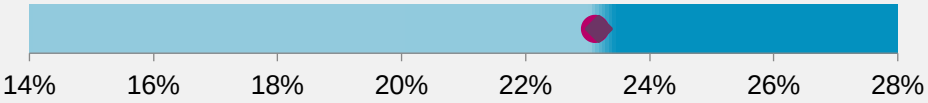
^ RAG Key

● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

Edinburgh's ranking against Scotland

Indicator Number	Indicator Description	Edinburgh City Current Rank (Scotland-wide comparison)	
		Rank	
NI-1	Percentage of adults able to look after their health very well or quite well	16th	
NI-2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	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	22nd	
NI-4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	28th	
NI-5	Total % of adults receiving any care or support who rated it as excellent or good	19th	
NI-6	Percentage or people with positive experience of the care provided by their GP	15th	

		Rank	Edinburgh ◆Scotland
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	**19th**	
NI-8	Total combined % of carers who feel supported to continue in their caring role	**25th**	
NI-9	Percentage of adults supported at home who agreed they felt safe	**30th**	
NI-11	Premature mortality rate per 100,000 persons	**11th^**	
NI-12	Rate of emergency admissions for adults (per 100,000 population)	**3rd^**	
NI-13	Rate of emergency bed days for adults (per 100,000 population)	**9th^**	
NI-14	Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges)	**28th^**	

NI-15	Proportion of last 6 months of life spent at home or in a community setting	**28th**	
NI-16	Falls rate per 1,000 population aged 65+	**26th^**	
NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	**22nd**	
NI-18	Percentage of adults with intensive care needs receiving care at home	**20th**	
NI-19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**27th^**	
NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	**17th^**	

- *Latest data available is used for each indicator: 2017/18 – NI-1 to NI-9; 2018 – NI-18; 2019 – NI-11 to NI-16 and NI-20; 2019/20 for NI-17 and NI-19*.
- *The ranking charts displays a visual of Edinburgh's position relative to the Scottish average. The minimum and maximum value in each chart is a proximate value of the lowest and highest quartile. The gradient of the colour within each bar changes where the value lies.*
- *The light blue colour indicates good performance (equal to or above the middle ranking partnership) and the dark blue colour indicates lower performance below the middle ranking partnership. Some rates show good performance for a higher rate, whilst others show good performance as a lower rate.*
- ^ *This symbol indicates where a low rate equates to good performance.*

Locality profiles

Localities working

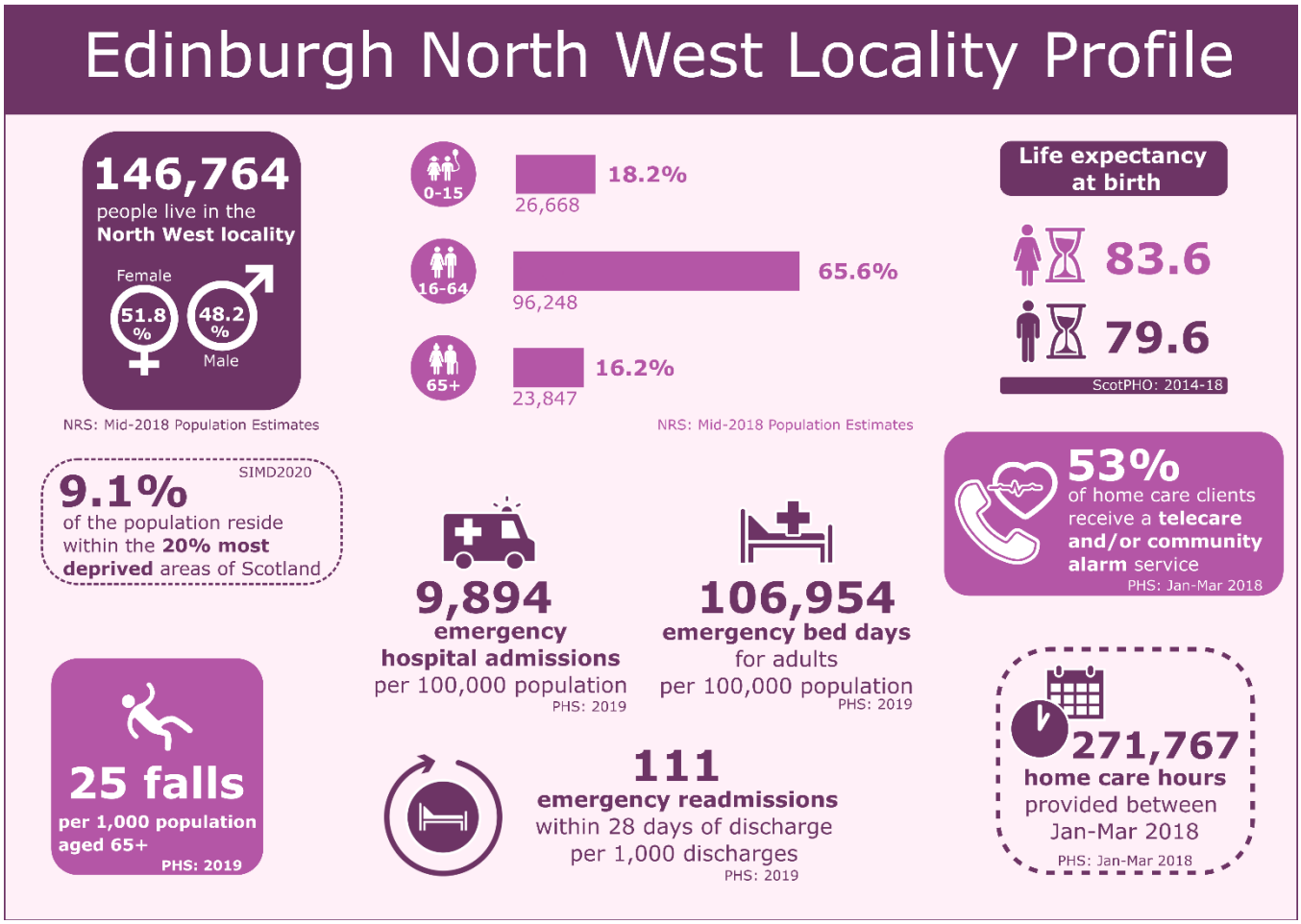
We organise our community health and social care services in Edinburgh around four localities where the management of most community health and social care services, including assessment and care management, home care, day centres for older people and care homes in Edinburgh is carried out. The four localities are grouped under: South East, South West, North East and North West. 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. A number of specialist services are managed on a city-wide basis.

Much has already been done to ensure that key services are organised and delivered locally. There remains more to do to embed the localities approach, to listen and respond effectively to the needs of communities and to ensure that strategic vision drives developments within localities. Key to this will be developing locality operational plans which support and implement the EIJB Strategic Plan. To help in developing this 'golden thread' of strategy, to plans, to implementation, we have established a Partnership Strategy and Operations Planning Forum.

You will see a summary of health and social care data for each locality in our four infographics. There is a lot of variation across, and within, the four localities with areas of high and low deprivation found in each. The North West is the largest locality and has the highest proportion of young people and older people. It also has the highest life expectancy at birth for both females and males. The North East is the locality with the highest proportion of the population living in the most deprived areas of the country and has the lowest rate of emergency bed days (the number of bed days occupied when the patient is admitted as an emergency). The South East has the lowest rate of emergency hospital admissions and the lowest rate of falls for older people is in the South West.

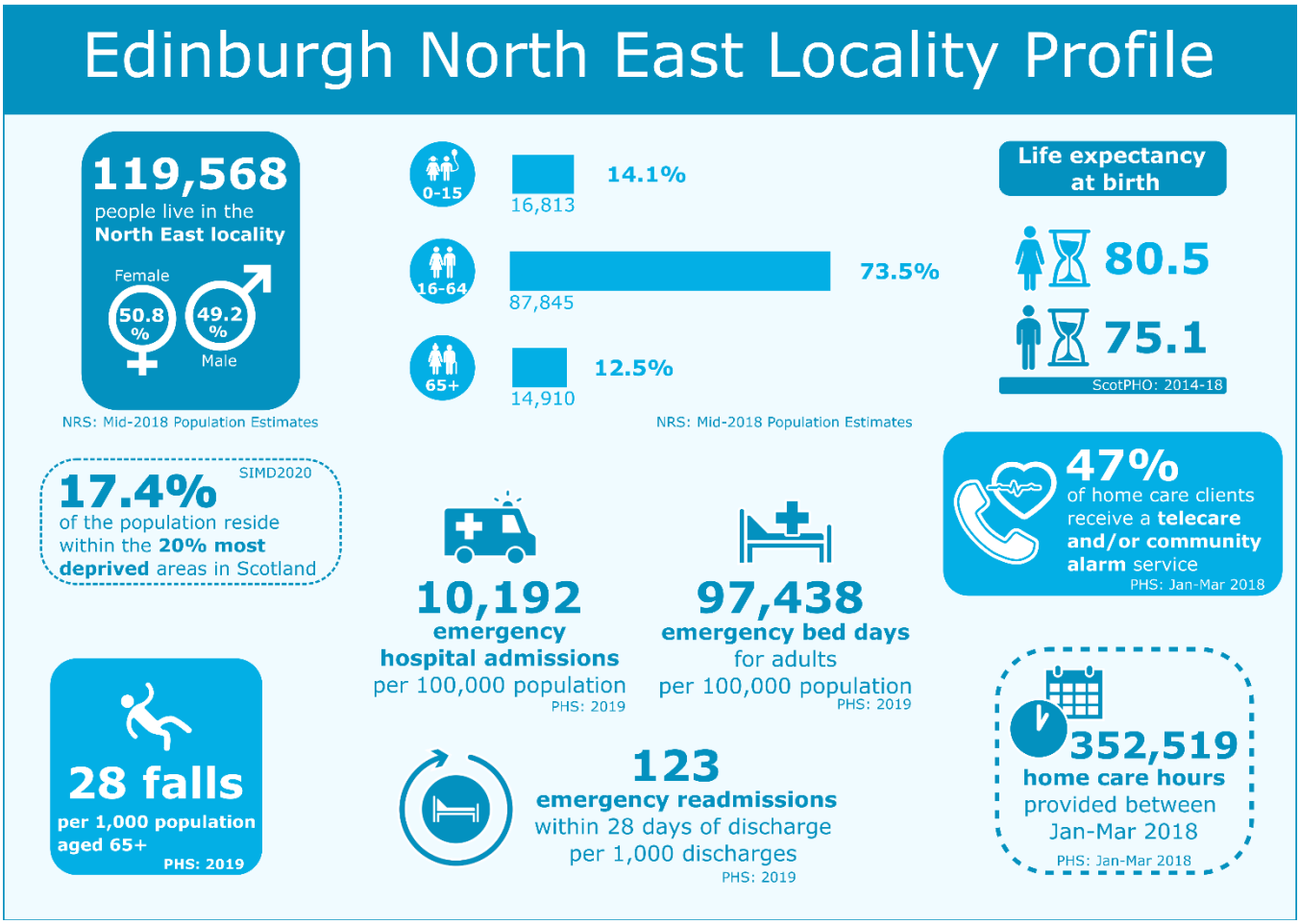
Sources:

- National Records of Scotland, City of Edinburgh Council area profile
- Edinburgh by numbers 2019, the City of Edinburgh Council
- Scottish Index of Multiple Deprivation 2020, Scottish Government
- Edinburgh Poverty Commission



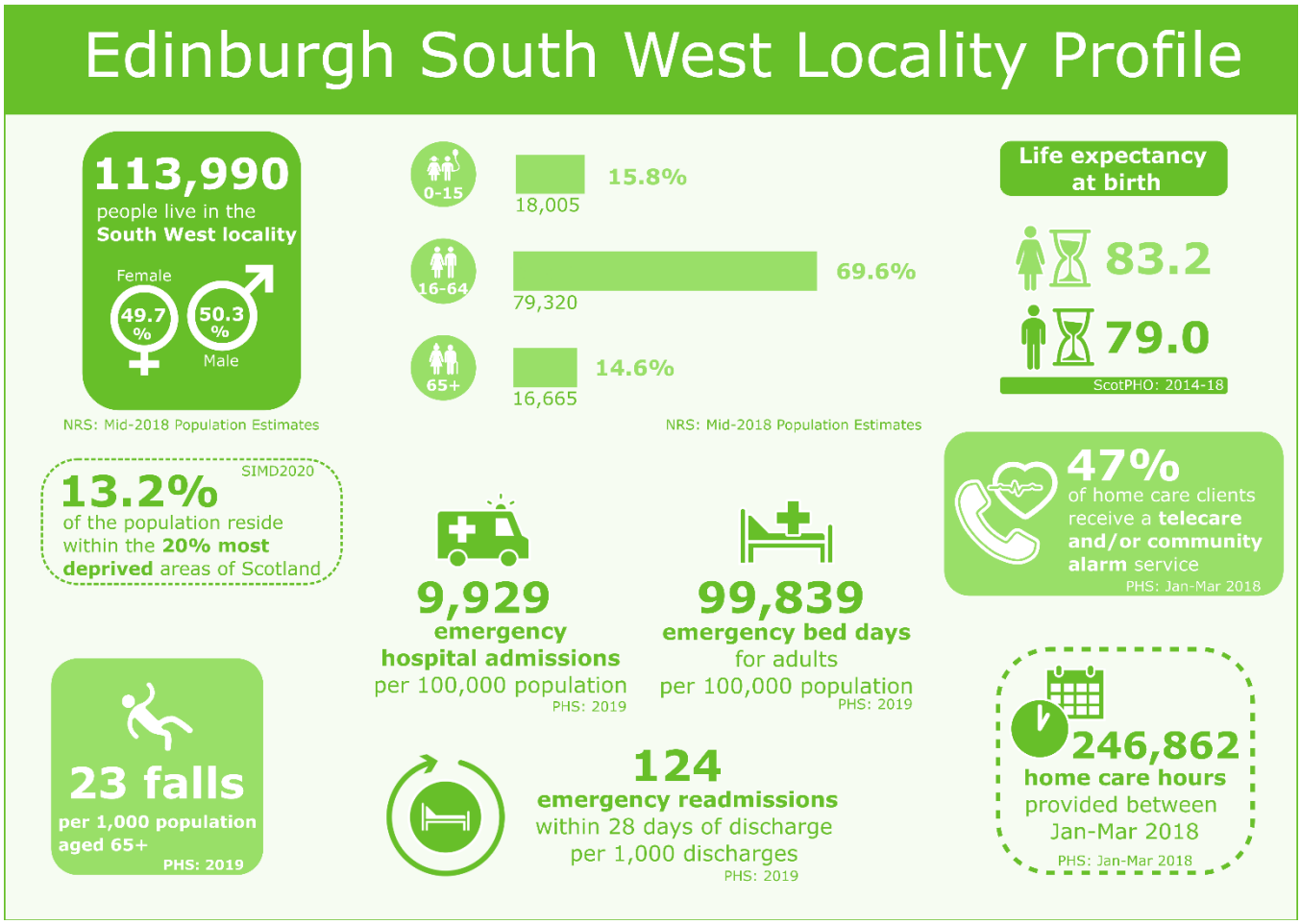
Key demographic information:

- 146,764 people live in the North West locality
- 51.8% are female and 48.2% are male
- 18.2% are aged under 16 and 16.2% are over 65
- 9.1% of the population reside within the 20% most deprived areas of Scotland
- life expectancy at birth is 83.6 years for women and 79.6 for men.



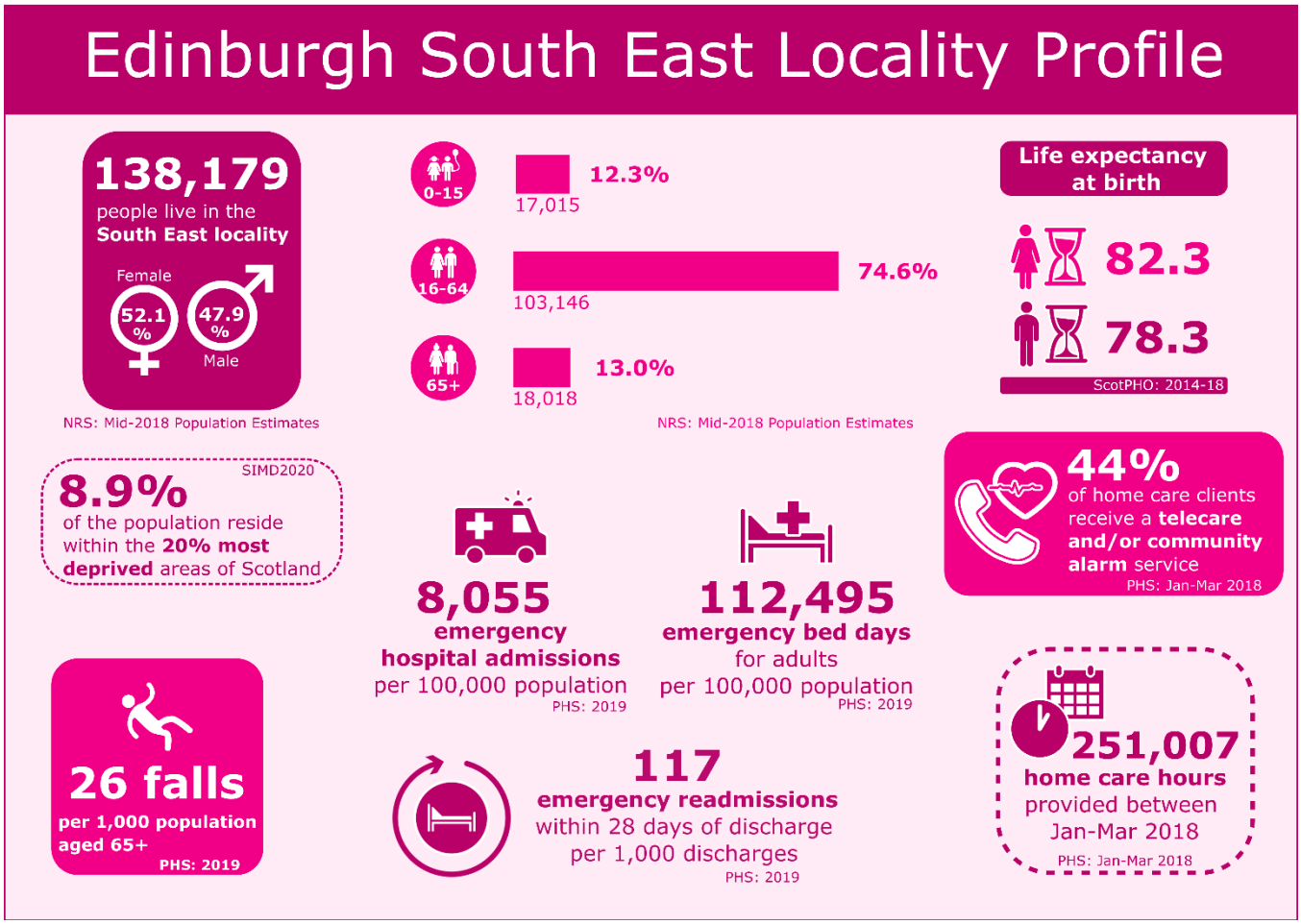
Key demographic information:

- 119,568 people live in the North East locality
- 50.8% are female and 49.2% are male
- 14.1% are aged under 16 and 12.5% are over 65
- 17.4% of the population reside within the 20% most deprived areas of Scotland
- life expectancy at birth is 80.5 years for women and 75.1 for men.



Key demographic information:

- 113,990 people live in the South West locality
- 49.7% are female and 50.3% are male
- 15.8% are aged under 16 and 14.6% are over 65
- 13.2% of the population reside within the 20% most deprived areas of Scotland
- life expectancy at birth is 83.2 years for women and 79.0 for men.



Key demographic information:

- 138,179 people live in the South East locality
- 52.1% are female and 47.9% are male
- 12.3% are aged under 16 and 13.0% are over 65
- 8.9% of the population reside within the 20% most deprived areas of Scotland
- life expectancy at birth is 82. 3 years for women and 78. 3 for men.

Priority 1
Prevention and early intervention

Context

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 individual's health and wellbeing.

The EHSCP funds or directly provides a range of services all designed to support health and wellbeing through prevention or early intervention approaches. Some of these services are highlighted below.

EIJB grants programme

Following extensive co-production, the various EIJB grant processes were combined and redesigned into a single, three-year grant programme to enable better progress towards our strategic aims of preventing poor health and wellbeing and reducing health inequalities.

In year one (2019/20) of the three-year programme, £4.6 million was awarded to 67 projects. The funding helped provide activities and services aligned to the seven funding priorities:

- reducing social isolation
- promoting healthy lifestyles
- improving mental wellbeing
- supported self-management
- information and advice
- reducing digital exclusion
- and building communities.

We have received annual monitoring returns, which included service user surveys and case studies, and these show how the activities have helped support and encourage people to:

- achieve their full potential, stay resilient and take more responsibility for their own health and wellbeing
- make choices that increase their chances of staying healthy for as long as possible
- utilise recovery and self-management approaches if they do experience ill health.

By both supporting those whose health is at greatest risk from inequality and by tackling the root causes of health inequalities, the projects helped:

- support individuals to maximise their capabilities and have control over their lives; and
- create healthy and sustainable communities that can resist the effects of inequality on health and wellbeing.

We have not yet finalised the comprehensive set of quantitative data we gather through the organisations' annual returns as delays have been inevitable due to the coronavirus pandemic and government restrictions, although we have received case studies. Many of the case studies contained in this report are from projects funded through the EIJB grant programme namely Steady Steps, South Edinburgh Lunch Club, Venture Scotland and Fresh Start.

Case study – Fresh Start

Joanne is in her 40s and lives alone. She had an eating disorder when she initially got involved with Fresh Start in 2017 after receiving information about their services from her occupational therapist. She took part in a Fresh Start cooking course but then her health deteriorated, and she couldn't continue.

Two years later she felt she was well enough to come back to Fresh Start. She had felt positive about the earlier experience even though she could not carry on. In 2019 Joanne completed a four-week cooking class where she worked in a small group with a volunteer learning to cook and then eat together. Joanne then felt confident enough to join in the eight-week Cook Club. The Cook Club uses produce donated from Fareshare, from Fresh Start gardens (in season) and purchased supplies for the group to come together to cook up to six meals. These are then shared out between everyone to take home for the week ahead/store in their freezer. The groups are led by experienced volunteers who create a relaxed, friendly and sociable environment for everyone attending, providing lots of individual support to enable people to participate.

Attending the cooking courses helped Joanne socially and she is now cooking more in her home. She no longer relies on microwave meals and is back to cooking at least part of her meal from scratch which makes her feel better.

Mental health

Thrive Edinburgh is committed to using the knowledge and skills of our communities, whether they are communities of interest or geographical communities, to mobilise change programmes which will promote mental health and wellbeing, address issues such as discrimination, stigma, loneliness and isolation, and make sure that Edinburgh's rich cultural assets are accessible to all.

Some examples of this are:

- GameChanger – our partnership with Hibernian Football Club is delivering lunch clubs, exercise classes, a venue for community groups and a new young person's programme which builds on their hopes and aspirations.
- A Sense of Belonging arts programme - this year-long programme offers numerous opportunities for people to explore the arts either as a participant or as an artist, recognising the important role that the arts have in keeping us connected, stimulated and inspired.
- LGBT Mind Matters programme – a programme of activities to support the mental health and wellbeing of the LGBTQIA communities and to provide training to agencies to ensure our services are inclusive to all.

Prevention of harm

The EHSCP has a responsibility for adult protection and the EIJB's Chief Officer sits on the multi-agency Chief Officers Group for Public Protection that is responsible for all areas of public protection across Edinburgh.

Between April 2019 and March 2020, there was a total of 1,954 adult protection contacts city-wide and 429 case conferences (both initial and review) were held.

Long-term conditions programme

As people get older, they develop more long-term conditions and their use of health and social care services increases. People with long-term conditions are twice as likely to be admitted to hospital, stay in hospital for a longer period, accounting for over 60% of hospital bed days.

The long-term conditions programme supports health and social care teams to improve care for people living with long-term health conditions and those who are at risk of falls. Our vision is for care and support for people with long-term conditions to be improved by:

- seeing the whole person rather than each individual condition

- engaging the whole team involved in the person's care, including third sector partners
- improving the way that care and support is planned across the whole system.

Our approach is in line with the national Health & Social Care Delivery Plan with delivery areas focusing on prevention and early intervention, anticipation and self-management.

Edinburgh's community respiratory hub supports people living with chronic obstructive pulmonary disease (COPD) who are at high risk of hospital admission. The percentage of people of living with COPD in Edinburgh has increased from 1.41% in 2014 to 1.68% in 2019 (rate per 100 patients). In December 2019 there was estimated to be 9,442 people living in Edinburgh with COPD. During the last year, the community respiratory team assessed 704 people with COPD, who were at immediate high risk of hospital admission because of an acute exacerbation of their COPD. Following assessment, the Community Respiratory Team supported 90% (634) of these people to be safely cared for at home, avoiding hospital admission.

By adopting a collaborative, partnership approach with the third sector, EHSCP is improving support for people to self-manage their conditions by building connections and support within local communities. Utilising digital health and care to support self-management is an important part of the approach. During 2019/20, EHSCP has scaled-up its home and mobile health monitoring resulting in 2,500 people from 50 GP practices being better able to self-manage their health conditions. Feedback from both GPs and patients has been positive. Four GP practices have introduced digital pods within their surgeries to enable patients to provide health information (for example, blood pressure, weight, smoking status) before their consultation.

Physical activity has been shown to help with the management of symptoms associated with many long-term conditions and improve quality of life. Working in partnership with Edinburgh Leisure, the 'Fit for Health' physical activity programme supports people living with long-term conditions to be more active. Between April 2019 and March 2020, 1,219 people were referred to Fit for Health with approximately 74% of those referred due to complete the full 16-week programme (the programme was disrupted because of the impact of COVID-19 restrictions).

National statistics show that falls are a common and serious health issue for older people, with around a third of all people aged 65 and over falling each year, increasing to half of those aged 80 and over. In around 5% of cases a fall leads to fracture and hospitalisation.

By proactively identifying people at risk of falls and fractures at an early stage and ensuring they access the right support at the right time, EHSCP aims to reduce the number of falls-related hospital attendances. Specialised staff support those at risk by carrying out home-based assessment leading to an individual falls plan. In addition, during 2019/20, over 200 staff from EHSCP and the third sector have attended a targeted falls prevention training

programme. The numbers of people attending A&E for a falls-related reason has reduced from an average of 380 people per month in 2018/19 to 360 people per month in 2019/20.

Care home residents are three times more likely to fall than older people living in the community, and ten times more likely to sustain an injury. In 2019, care home residents comprised 20% of the trauma orthopaedic hospital admissions despite only 4.6% of over 65s living in a care home. We put in place targeted support for care home staff to improve their knowledge of falls prevention and management, with the aim of reducing falls-related A&E attendances and unplanned hospital admissions. By October 2019, the first four care homes completed their training programme. For these care homes, falls-related A&E attendances reduced by 62% and falls-related unplanned admissions reduced 70% compared to the pre-intervention period.

Care home residents who use walking aids are known to be at an even greater falls risk. During winter 2019, seven care homes took part in a short improvement programme where 164 walking aids were assessed by trained physiotherapy assistants to check for safety. 11% were repaired and 15% were replaced.

Case study – Steady Steps

Bett, who is in her 90s, was referred to Steady Steps after she had a bad fall which resulted in a stay in hospital. Prior to attending Steady Steps, Bett struggled to walk and this impacted on her day-to-day life. She couldn't do very much around the house and leaving the house to go to the shops or run errands was impossible. She described herself as 'housebound' and felt isolated as a result.

When her physiotherapist suggested a referral to Steady Steps, Bett wasn't sure what to expect but was willing to give anything a go. On arriving at her first class Bett felt reassured as the instructor took time to talk to her about everything that was going to happen and suggest alternatives to the exercises Bett couldn't do.

Bett is now able to walk more easily and has regained her independence. Prior to COVID-19, she was able to get buses and do all her own shopping. The friends she has made through attending the classes have been as important as the physical gains.

Anticipatory care planning (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 provided ACP improvement support to 66 teams across health and social care, and the third sector. Practitioners engage people they support in ACP conversations, helping people to understand what living with long-term conditions means for them now and how care and treatment options may change or fluctuate in the future. People's wishes, preferences and decisions about their care and treatment are shared with professionals through ACP key

information summaries. This ensures people have greater choice and control over their care and treatment should their condition deteriorate.

During 2019/20:

- 19,532 ACP key information summaries were created – an increase of 53% since the end of March 2019
- 37 ACP training sessions were delivered to 157 staff
- Edinburgh care homes and GP practices were supported to create or update ACP information to detail COVID-19 care and treatment options and preferences.

Our performance

The national health and wellbeing performance outcomes linked to this priority are:

- People are able to look after and improve their own health and wellbeing and live in good health for longer (HWB-1).
- Health and social care services are centred on helping to maintain or improve quality of life (HWB-4).

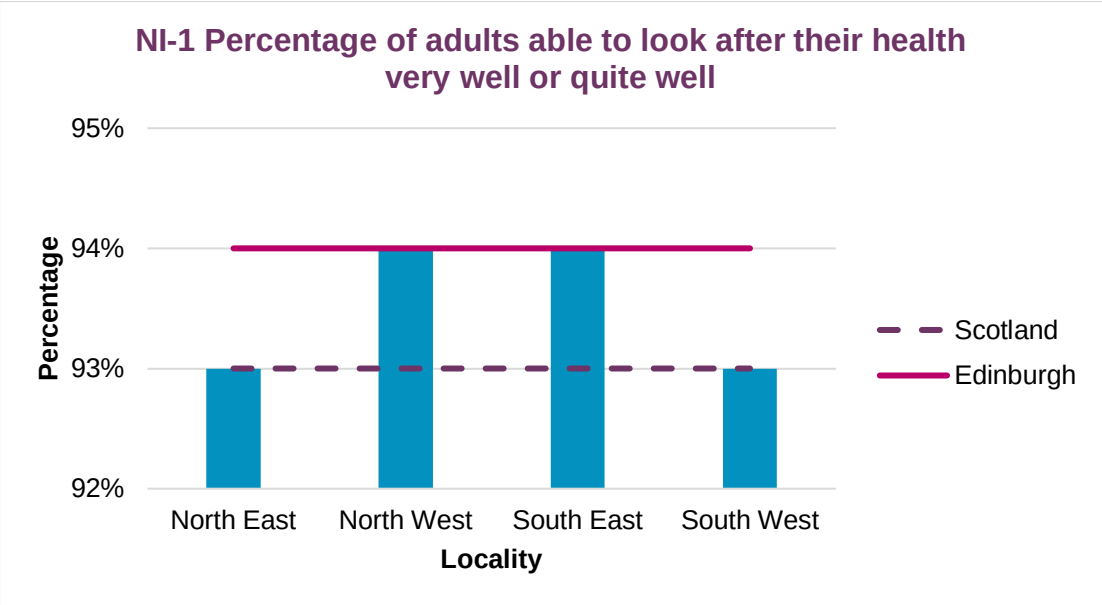
National Indicator (NI)		Edinburgh 2018/19	Edinburgh 2019	Difference	Performance
NI-1	Percentage of adults able to look after their health very well or quite well	No Health and Care Experience survey data is available for 2018/19, as the survey is conducted on a bi-annual basis. The publication of the 2019/20 survey was delayed by the Scottish Government due to the COVID-19 pandemic.			
NI-12	Rate of emergency admissions for adults (per 100,000)	8,558	9,464	+906	●
NI-16	Falls rate per 1,000 population aged 65+	21.9	25.5	+3.6	●

RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

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

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

	2017/18
Scotland	93%
Edinburgh	94%
North East	93%
North West	94%
South East	94%
South West	93%



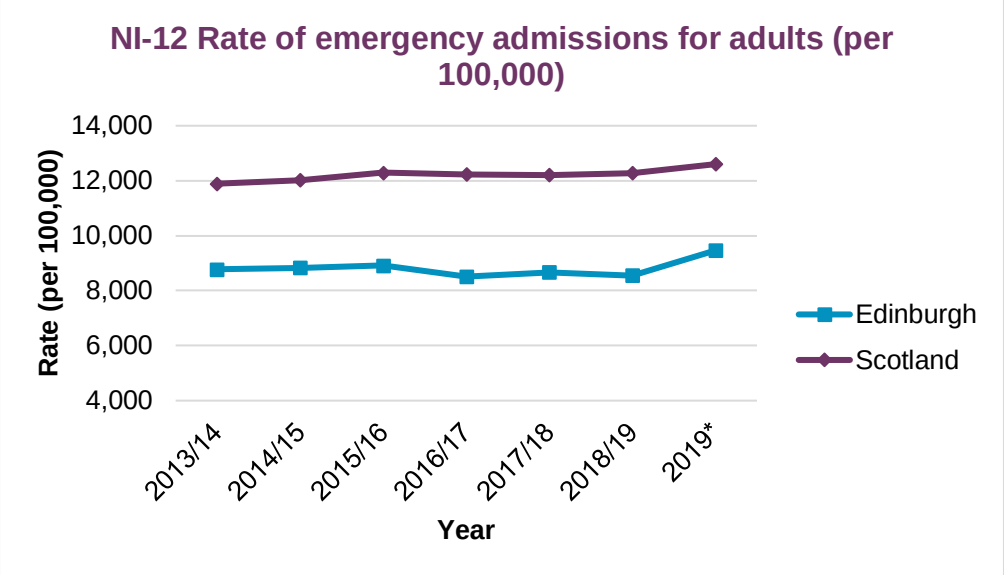
Source: Scottish Government HACE survey 2017/18

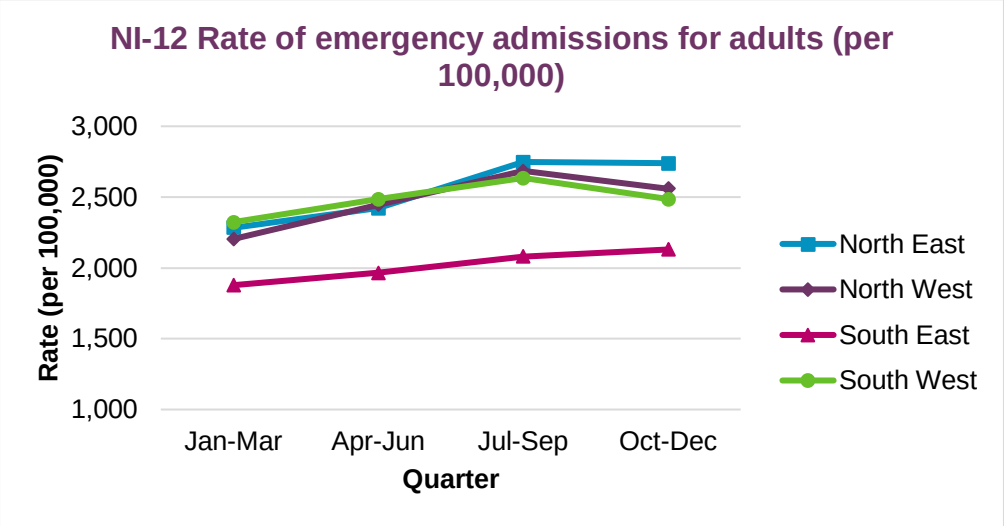
Based on the 2017/18 HACE survey, 94% of respondents stated that that they were able to look after their health very well or quite well which is very encouraging. This is higher than the Scottish average of 93%. There is a small amount of variation between the localities with North East and South West both responding with 94%, and North East and South West localities reporting only 1% less.

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

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019*
Edinburgh	8,775	8,832	8,914	8,512	8,670	8,558	9,464
Scotland	11,892	12,026	12,295	12,229	12,210	12,275	12,602

	2019			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
North East	2,283	2,423	2,748	2,738
North West	2,204	2,446	2,685	2,559
South East	1,878	1,966	2,081	2,130
South West	2,323	2,486	2,635	2,485





Source: Public Health Scotland

The rate of emergency admissions had been fluctuating between 8,000 and 9,000 from 2013/14 until 2018/19. The rate had started to reduce in 2015/16 but increased to 9,464 in 2019.

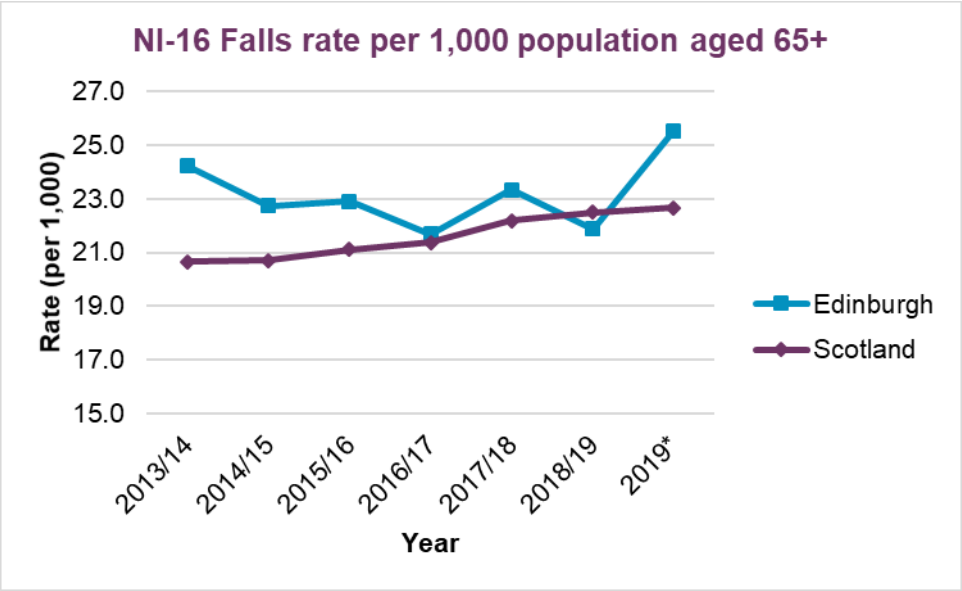
The increase in the emergency admission rate is due to a service change at the A&E at the Royal Infirmary Edinburgh in April 2019. Patients who are waiting on test results are admitted as an emergency inpatient to the Acute Assessment Unit. A large majority of these patients are discharged home on the same day as arrival, with a small number being admitted into a downstream acute ward. This change has artificially increased the number of emergency admissions.

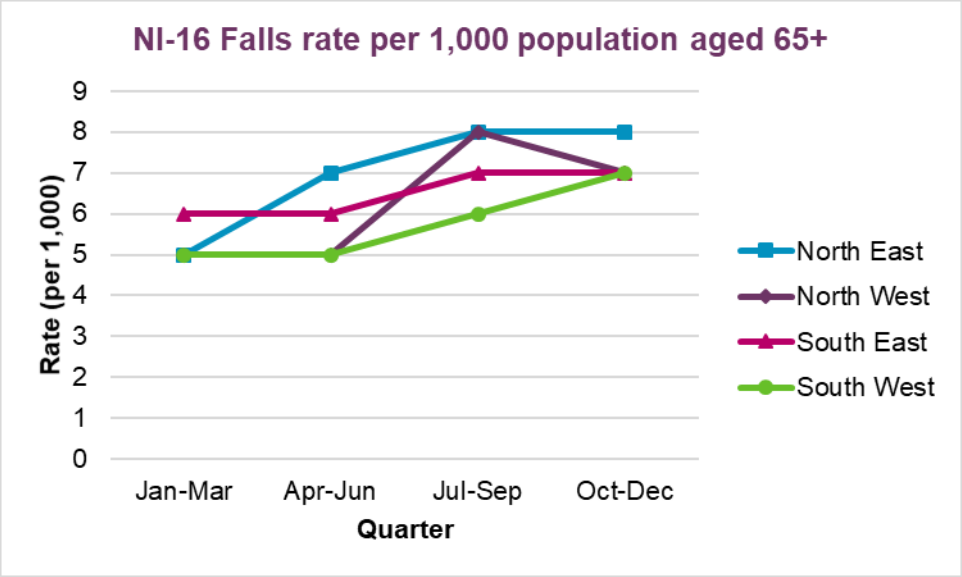
When breaking the figures down by locality, South East has the lowest rate of emergency admissions which is due to a younger population living within the locality.

NI-16 Falls rate per 1,000 population in over 65s

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019*
Edinburgh	24.2	22.7	22.9	21.7	23.4	21.9	25.5
Scotland	20.7	20.7	21.1	21.4	22.2	22.5	22.7

	2019			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
North East	5	7	8	8
North West	5	5	8	7
South East	6	6	7	7
South West	5	5	6	7





Source: Public Health Scotland

The long-term trend for the falls rate was steadily decreasing from 24 falls in 2013/14, to 22 falls in 2018/19. However, in 2019 the rate has increased to 25.5 which is higher than the Scottish rate of 22.7 falls per 1,000 people aged 65 and over.

Priority 2
Tackling inequalities

Context

The Edinburgh Poverty Commission was set up in 2019 to explore the extent and nature of poverty in Edinburgh. The Commission has found that poverty is not a marginal issue in the Edinburgh. Rather it affects a sizeable proportion of the population (some 80,000 people) and with much evidence to suggest its scale and impacts are growing larger over time. The emerging picture is one in which the majority of people in poverty in Edinburgh are of working age, probably in employment, probably living in rental accommodation in a family with children and do not always live in those areas traditionally considered as 'poor' or 'deprived'. You can find more information about the Poverty Commission on their website.

The EIJB is a member of the Edinburgh Partnership, the body responsible for community planning in the city. The Partnership's vision is that 'Edinburgh is a thriving, connected, inspired and fair city, where all forms of poverty and inequality are reduced' and the Community Plan sets out the priorities for delivering this vision. The plan focuses on prevention and early intervention, recognising the role of social disadvantage and poverty in creating inequalities for individuals and communities in the city, and identifies three priorities:

- to ensure that citizens have enough money to live on
- have access to work, learning and training opportunities
- and have access to an affordable, well designed, safe and inclusive place to live.

The EIJB has a key role to play in addressing inequality, in particular, health inequalities. Some of the workstreams we have to reduce inequalities are outlined below.

EIJB grant programme

As noted earlier, a key focus for the EIJB grant programme is supporting those whose health is at greatest risk from inequality. Funded projects include:

- Health All Round which covers South West and central Edinburgh
- the Health Agency which works mostly in Wester Hailes
- South Edinburgh Healthy Lifestyles run by the Edinburgh & Lothians Greenspace Trust
- the Ripple Project working in the North East locality

- Be Healthy Together, a community-led project in south west Edinburgh
- LGBT Health and Wellbeing Centre which works Edinburgh-wide.

Case Study – Venture Scotland

John had been living a chaotic lifestyle with very little structure before he came to Venture Scotland (VS). He was trying to deal both with his own issues and family problems and felt trapped. John ended up spending his time drinking so he didn't have to think about his problems or how to change anything in his life.

John was angry, depressed, isolated and felt 'broken'. Eventually he reached crisis point and tried to kill himself. He ended up in hospital and went through various mental health programmes before being introduced to Venture Scotland by his link worker.

The structured programme has four different group stages: challenge, discover, explore and leadership. All parts of the programme offer opportunities to take part in outdoor activities such as rock climbing and coasteering as well as group wilderness residentials.

The discover element introduced learning about mental health and involved a five-day stay at the VS bothy (an old shepherd's cottage in Glen Etive in the Scottish Highlands). John found 'discover' much more intense than the first trip as it meant confronting more serious issues in some sessions and sharing things about himself with the group. After taking part in 'discover' John realised that he needed to apply what he was learning at VS to his life, rather than just turning up to distract himself from his life and then expecting things to change by magic. In the final stage of the course 'leadership', the group has a lot more independence and input, planning two expeditions. Group members learned new skills including first aid and navigation.

At the end of the programme, John said 'Aside from the various activities, Venture Scotland has helped me get from some of the absolute worst pits of despair that I have ever been in, to feeling like I'm a person again, like I'm an actual member of society.'

Income maximisation services

Income maximisation services are funded as part of the EIJB's current grants programme alongside funding from partner agencies. We established an income maximisation consortium in March 2019 to lead on the development of modern, flexible, fit-for-purpose services across the city. The new model which has been developed through collaboration with the advice service providers, delivers a more targeted approach to improve access to income maximisation for the most vulnerable clients. This approach is guided by Scottish Government recommendations within the report A Review of Publicly Funded Advice Services in Scotland published in February 2018. The new service has been designed to be flexible and better able

to respond to changing patterns of need and is underpinned by the principles of co-location of services in other settings, collaboration and co-operation between providers and a focus on quality standards.

Income maximisation services include:

- checking entitlement to benefits and other sources of income
- helping with benefit claims and appeals
- carrying out 'better off' calculations
- help with managing problem levels of debt.

The new model makes provision for:

- welfare advice in GP practices delivered by 8 whole time equivalent (WTE) advice workers, offering 4,160 appointments a year with an estimated patient income gain £2 million a year
- welfare advice in drug and alcohol recovery Hubs – 2 WTE advice workers in four locality hubs, with 720 appointments and an estimated client gain £450,000 a year
- welfare advice in mental health hubs/Thrive centres – 2 WTE advice workers in four locality hubs, delivering 720 appointments reaching 300 individuals, estimated client gain £450,000 a year
- Locality-based provision – 13. 5 WTE advice workers, reaching 3,510 individuals per year, with an estimated client gain of £3.4 million a year.

Case study – advice workers in health settings

Julie is a 27 year old single parent, living in temporary supported accommodation following incidents of domestic violence. She suffers from post-traumatic stress, agoraphobia, anxiety and depression. She attended the service along with her support worker to get advice in relation to her PIP application.

Because of her mental health issues, Julie found the interview itself very challenging and she needed additional measures to be taken to make sure that the environment was safe and accessible for her to engage in the session. The adviser was sensitive to her needs and took time to understand how best to engage with her and the role the support worker could provide. Julie had been in receipt of DLA for many years. As well as providing income to support her care needs, this also included a mobility component for a bus pass, which is essential in supporting Julie to feel safe when travelling. Despite her long-standing and evidenced disabilities, Julie was turned down in transition to PIP and so was supported to complete an application for a mandatory reconsideration.

The impact of this decision has been significant for Julie and added to her levels of distress and anxiety. This also placed Julie and her child in financial hardship. As a result of the accessibility of our services and the breadth of knowledge and

expertise of the adviser Julie received the time, support and negotiation she needed to deal with these issues and successfully appeal the decision.

GP link workers

The community link workers (CLWs) programme was set up to address the finding that 5% of patients use 20% of GP resources. Additionally, approximately 45% of primary care support requests are classed as non-clinical in nature.

Community link workers are best defined as generalist social practitioners based in GP practices, serving the local community using a patient-centred model of care. They are not support workers or sign-posters but work with people to help them make informed choices about the services they use.

Link workers cover three main areas:

- as part of the national programme focusing on health inequalities, 13.5 WTE CLWs work across 21 practices serving an overall estimated patient population of 147,000 of which 46,000 are from the most deprived communities
- There is a specific ‘test of change’ focusing on older people, in particular those who are frail, have dementia or are experiencing social isolation, with 3.5 WTE CLWs deployed across nine practices
- a second ‘test of change’ focuses on issues of mental health, chronic pain and social isolation within the mainstream population. This covers three practices and employs 2 WTE CLWs.

Initial evaluation data from the project has shown:

- there were approximately 8,000 booked appointments across all CLW services. ‘Did not attend’ rates were 2% for the specific older people’s service but much higher for those experiencing general health inequalities (around 20%)
- a broad range of issues including mental health, trauma and abuse, social isolation, housing, family and caring concerns, welfare and employability
- indications of improved mental wellbeing amongst service users over the period interacting with their CLW (measured using the short Warwick Edinburgh Mental Wellbeing Scale)
- indications of a decrease in some GP consultation and/or a more clinically-focussed consultation with the GP or nurse

A more in-depth evaluation of impact is currently underway. Next steps already identified include building referrals to the service and exploring and addressing the reasons for non-attendance.

“We have had a link worker at the practice for some time now and we are extremely happy with the service - they act as a link between the practice and the wider community. Most importantly, they help support our patients with complex social problems and mental health issues, thus freeing up GP time. They also provide us with up-to-date information about activities and events in the area.”

Edinburgh GP

Case study - GP link worker

I received a referral from a practice receptionist for Halima, a 34 year old Sudanese woman. Halima had arrived in Edinburgh only a month before and had mentioned in her practice registration form that she had already begun to feel isolated. Knowing the health effects that isolation and loneliness can have the receptionist quickly referred Halima on to me, the community link worker.

When I met with Halima, she told me she had not left her new home since arriving a month earlier, with her baby son. She was very keen to improve her English and meet new people and hoped this in turn would help her to become more independent.

I talked through a range of options available to her locally and she was keen to get involved. Halima did not feel confident enough to use the bus on her own, so I accompanied her on the bus, explained bus numbers, routes, costs, timings etc and we went along together to register for an English class. After being on the bus together Halima felt confident enough to start using the bus service on her own.

Halima was keen to meet other mums and for her son to have the opportunity to play with other young children. I accompanied Halima along to a local mother and toddlers’ group to meet the group leaders. Halima told me she felt she wouldn't have attended if she hadn't met the group leaders first and visited the venue but felt happy to start attending the groups the following week herself.

Halima is now regularly attending English classes and has established a small local friendship group through attending the mother and toddler group. She feels her confidence has grown and that she has become more independent. Her hopes for the future are to find employment and learn to drive.

Inclusive Edinburgh

The average age of death for people experiencing rough sleeping is 43 compared to 77 for the general population. People rough sleeping are 17 times more likely to experience a violent attack, and nine times more likely to commit suicide (Inclusive Edinburgh EIJB report, June 2019). Homeless people experience some of the worst health outcomes and tend to be amongst the highest users of urgent and emergency care, with four times the usage of hospital services and eight times the cost of inpatient services compared to the general population.

The Inclusive Edinburgh Board, (made up of members from health, social work, police, housing, third sector and the university sector) is contributing to reducing inequalities and improving the health and wellbeing of homeless people through inter-agency collaboration.

A specific priority has been delivering more integration between the Edinburgh Access Practice (primary care) and The Access Point (housing and social work) to provide wrap-around care and support that considers the person's physical, mental health, housing, and social care needs. Third sector partners work alongside statutory services in delivering this support. The model is focused on keeping the ambitions and support needs of the person at the centre within a single point of access. Work is well underway to relocate this integrated service at new premises within the Cowgate area of the city.

Alcohol and drug misuse services

The EIJB has delegated authority for adult social work and community health services including adult alcohol and drug services, and some hospital-based services including those relating to an addiction. Two voting members of the EIJB currently sit on the Edinburgh Alcohol and Drugs Partnership which has responsibility for all elements of drug and alcohol strategy as within the national strategy 'Rights, Respect and Responsibility'.

During 2019/20 the EIJB agreed to support the aims of the national strategy and improve health by preventing and reducing alcohol and drug use, harm and related deaths, through the delivery of services outlined in investment plans for 'Seek, Keep and Treat' (SKT) funding (EIJB report, June 2019 and EIJB report, December 2019).

As of March 2020, implementation of the SKT investment plans has delivered:

- employment of nurses, healthcare assistants, data analysts, and voluntary sector staff to carry out assertive outreach and rapid access prescribing for those identified as being at the highest risk of drug-related death
- increasing senior clinical staffing to respond to those with the most complex needs.

Our performance

The national health and wellbeing performance outcome linked to this priority is:

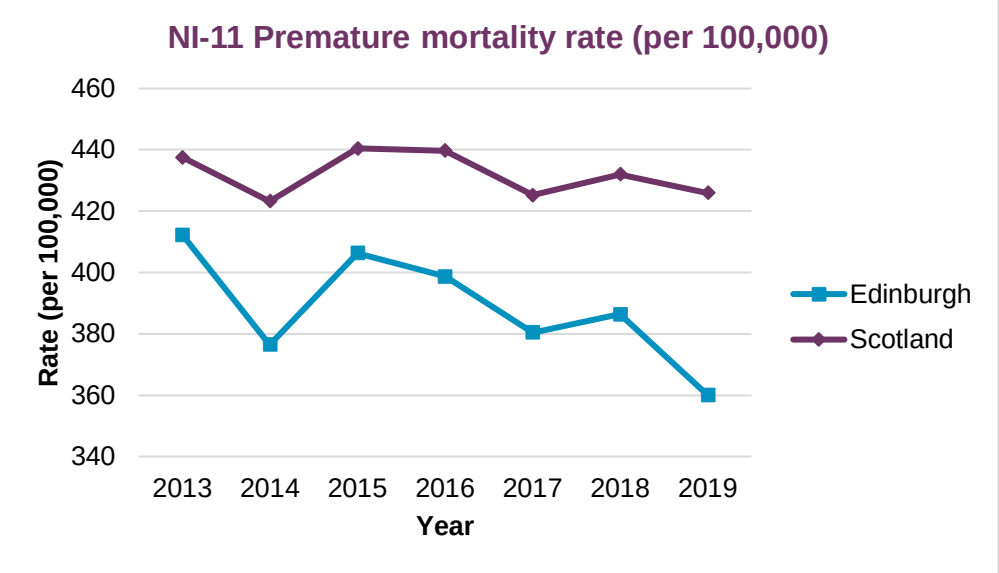
- Health and Social Care services contribute to reducing health inequalities (HWB-5).

National Indicator (NI)		Edinburgh 2018	Edinburgh 2019	Difference	Performance
NI-11	Premature mortality rate (per 100,000)	386	360	-26	●

RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

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

	2013	2014	2015	2016	2017	2018	2019
Edinburgh	412	377	406	399	380	386	360
Scotland	438	423	441	440	425	432	426



Source: Public Health Scotland

Edinburgh's premature mortality rate continues to show positive progress and has remained consistently below the Scottish average since 2013. In 2019, the premature mortality rate reduced to its lowest level of 360 deaths per 100,000 population aged 75 and over. The Scottish average in 2019 also decreased from 432 deaths in 2018 to 426.

Priority 3
Person-centred care

Context

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, rather than making decisions for them. Key to this is viewing people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs and by putting people and their families at the heart of decision-making to achieve positive outcomes.

Developing the Three Conversations approach is a significant part of Edinburgh's approach to person-centred care and this is described more fully under the 'Overview' section. Our efforts to shift the balance of care and address delayed discharge are outlined under 'Priority 6 – Right care, right place, right time. '

There are, however, other examples of how the EHSCP delivers person-centred care and these are described more fully below.

Locality working

Local health and social care responsibilities are mainly managed through our four localities: North East, North West, South East and South West. This fulfils the legislative requirement to work at locality level and enables EHSCP to shape services to be more responsive to the different characteristics and needs of our distinct Edinburgh communities which benefits residents.

The four localities provide a front-door access point for health and social care services, and act as the co-ordination point for long-term support. The Three Conversations methodology underpins the locality approach and ensures person-centred planning and care.

Each locality is based around a hub and cluster model. The hub is an integrated, responsive and proactive team that offers short term input to prevent unnecessary admission and promote independence. Hubs work closely with hospital sites to deliver a Home First approach,

supporting people to return to home or a homely setting at the time that is right for them. Staff and teams included within the hub are social work, occupational therapy, physiotherapy and reablement. Hub staff work closely with people to identify what their needs are and liaise with a range of community supports across the NHS, local authority, third sector and community to meet their needs.

Clusters support people who need ongoing care, including those with ongoing clinical and/or care home needs. Each cluster offers a range of services: care homes, social work, occupational therapy, community nursing (including district nursing, community learning disability and older people's mental health) and home care and support. There are also designated clinical leads for general practice within each locality. Again, these integrated teams also work closely with community supports across the NHS, the City of Edinburgh Council, third sector and community to ensure people's needs are met.

Disability services

Providing person-centred services that promote independence for people with disabilities is key to our vision. The EHSCP provides a range of services for people with physical disabilities, learning disabilities and autism. These include: providing care and support to enable people to live at home with their families, enabling people to live independently by providing housing with support, local area co-ordination, and short breaks services. You can find more information on our approach to disability services within the EIJB's Strategic Plan.

Case Study - Firrhill short breaks service

Firrhill short breaks service offers residential respite care for up to eight adults with a learning disability and some physical disabilities. The periods of respite are negotiated and agreed in advance with people and their families/carers.

People are encouraged to make personal choices, establish relationships, and maintain independent living skills (or develop new skills if appropriate) during their short break. Key is understanding that people will have different preferences: some like to come and relax, whilst others like their stay to be active and full of fun. Some people choose to have a complete break, whilst others wish to continue with their daily routine, for example by attending day services.

The Care Inspectorate conducted an unannounced inspection in February 2020 and the service received two 'excellent' grades (grade 6) for the quality of care and support and quality of staffing, while the quality of management and leadership was classed as 'very good' (grade 5).

You can download the full report from the Care Inspectorate's website.

Older people's services

The EHSCP delivers and commissions a wide range of services for older people. These include support at home, technology-enabled care, providing adaptions and equipment, community-based services (for example day services and lunch clubs), and early intervention and prevention activities (for example exercise programmes and falls prevention).

Responding to the Older People's Services Joint Inspection (May 2017) and Progress review (June 2018) continued in 2019/20. We developed a revised improvement action plan including the Three Conversations approach, and progress was reported to the EIJB in December 2019 (Update on Progress – Older People Joint Improvement Plan). The monitoring report that went with the report showed the majority of recommendations and associated actions had been either achieved or were on track to be delivered within agreed timescales. We identified issues in two specific areas – developing workforce strategy and supporting a sustainable volunteer model – which has meant that progress has been limited. You will find more detail about how the EHSCP is addressing workforce issues n the next section of this performance report – making best use of our resources.

Case study – South Edinburgh lunch club

Stephen lives by himself and was struggling with loneliness and isolation. Stephen's social worker referred him to the South Edinburgh lunch club.

The lunch club put things in place to enable Stephen to attend. At the start staff gave him a welfare call on the days he was attending to make sure he was up and ready for the transport to the club. They also paired Stephen with other people who had similar interests so that he felt welcome and included.

It took Stephen a while to integrate into the group. However, he spoke more each week, then started to take on more of a leadership role. He started helping a volunteer with activities and became a mentor for new members coming into the service. Stephen also started taking part in the exercise activities, despite his initial reluctance, as staff gave him a lot of encouragement and took it at his pace.

Stephen's personal outcomes were to get into more of a routine and to find ways to manage his anxiety. As a result of attending the club, Stephen has been able to introduce routines at home to help him better manage his medication and meal planning. He also is coping better with his anxiety.

Around 8,000 people are living with dementia in Edinburgh. This includes just under 300 people under the age of 65 years. During 2019, 119 people with a dementia diagnosis were reported missing (3.5% of all missing people). Only 12 of the missing people returned to their

current home address independently, the others were located elsewhere mostly having been traced by the police.

The Herbert Protocol was launched in Edinburgh during April 2019 as a joint initiative between EHSCP, Police Scotland, Alzheimer Scotland and Scottish Care. The Herbert Protocol has been designed to aid efforts to find people with dementia who go missing. By encouraging family members to record key information about a person's interests and significant places, it can help to speed up the tracing people with dementia who go missing.

Mental health services

Since September 2018, the Partnership has been co-designing the Thrive open-access model. We have collaborated with the voluntary and public sector, people with lived experience, and carers. We are currently prototyping this model across localities and we will use the learning from this work to inform any changes prior to the formal start in October 2020.

A Thrive welcome team is the access point for mental health support in each locality. It is a multi-disciplinary and multi-agency team that works with people to find the right help when needed (including social, therapeutic and medical support) through guided conversations. Thrive collective services are commissioned directly through this process and include statutory mental health services. There will be a range of services, programmes and activities which give interconnected social, practical, emotional, medical and clinical support which people need to improve their lives. The Thrive network relates to the wider range of services and support that exist across Edinburgh including primary care practices, welfare advice and income maximisation services, and support for people with drug and alcohol problems.

Thrive procurement activity started in September 2019. This builds on the partnership working of Edinburgh Wellbeing Public Social Partnership and will deliver a range of services and programmes to support the delivery of the Thrive welcome team and the Thrive collective. This work is on track with new contracts set to start on 1 October 2020.

Care Inspectorate reviews

There are 36 individual, registered, in-house services under the auspices of the EIJB. Inspection regimens for these services vary between care at home services, support at home services and care homes but all graded within a framework comprising a suite of national standards.

These categories are:

- how well do we support people's wellbeing?
- how good is our leadership?
- how good is our staff team?
- how good is our setting?
- how well care and support are planned?

These key questions are underpinned by a set of six principles.

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 2019/20, 24 inspections took place. Here is a summary of the gradings awarded:

Service type	Number of services	Frequency of inspection	Inspections undertaken	Lowest grade	Highest grade	% with grades good or above
Adult placement	1	Yearly	0 *			
Care home service - older people	9	Yearly	9 **	1	5	55%
Combined housing support/care support	16	Yearly	13 *	4	5	100%
Support service – other than care at home	6	Every 3 years	0			
Housing support	2	Every 2 years	0 *			
Care home service - adults	2	Yearly	2	4	6	100%
* indicates service areas where the Care Inspectorate did not conduct all its planned inspections because of the COVID-19 pandemic						
** The COVID -19 inspection undertaken in two care homes for older people consisted of a review the intelligence held by the Care Inspectorate (CI), risk factors identified by the CI and a letter to the Registered Manager asking for an assurance statement regarding the quality of service delivered. The outcome of which was to be no change to the grades awarded at the end of the 2018/19 inspection visit.						

We have established two care home improvement oversight groups: one in December 2019 and one in February 2020. One oversight group was set up because of Care Inspectorate enforcement action in the form of an improvement notice and the other in response to the award of grades of 2.

Each oversight group is chaired by the relevant locality manager and is supported by officers from across EHSCP and the City of Edinburgh Council to develop and implement actions which show improvements which deliver better life outcomes for people using the service.

Our performance

The national health and wellbeing performance outcomes linked to this priority are:

- people who use health and social care services have positive experiences of those services, and have their dignity respected (HWB-3)
- people who use health and social care services are safe from harm (HWB-7).

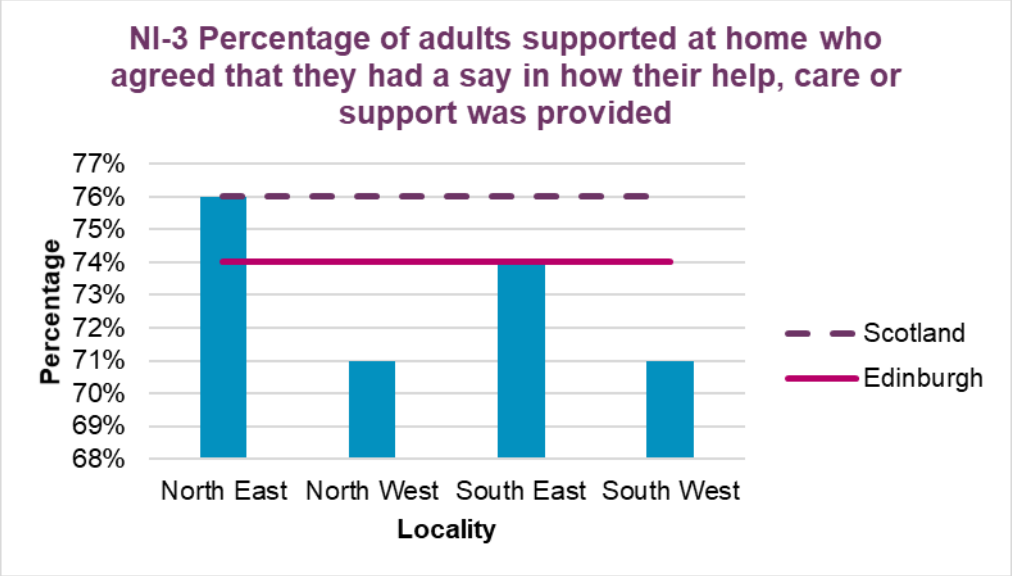
National Indicator (NI)		Edinburgh 2018/19	Edinburgh 2019	Difference	Performance
NI-3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	No Health and Care Experience survey data is available for 2018/19, as the survey is conducted on a bi-annual basis. The publication of the 2019/20 survey was delayed by the Scottish Government due to the COVID-19 pandemic.			
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-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-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	84%	82% *(2019/20)*	-2%	●

RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

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

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-3	2017/18
Scotland	76%
Edinburgh	74%
North East	76%
North West	71%
South East	74%
South West	71%



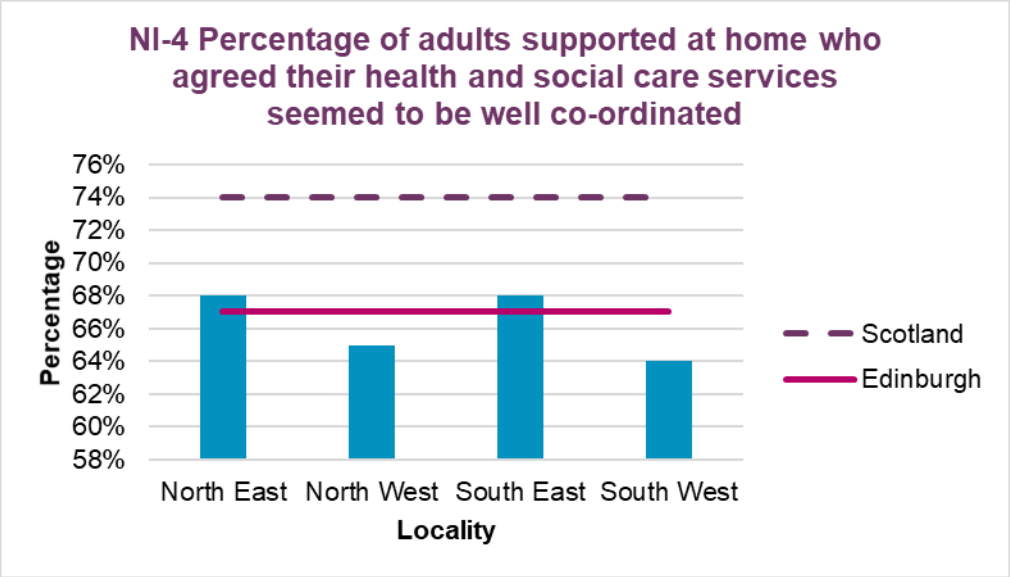
Source: Scottish Government HACE survey 2017/18

The percentage of adults supported at home agreed they had a say in how their help, care or support was provided decreased by 3% from 77% in 2015/16 to 74% in 2017/18, as we reported last year. This is lower than the Scottish average which is currently 76%. There is variation between the four localities with North East matching the Scottish average of 76%, whilst North West and South West have the lowest percentage at 71%.

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

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-4	2017/18
Scotland	74%
Edinburgh	67%
North East	68%
North West	65%
South East	68%
South West	64%



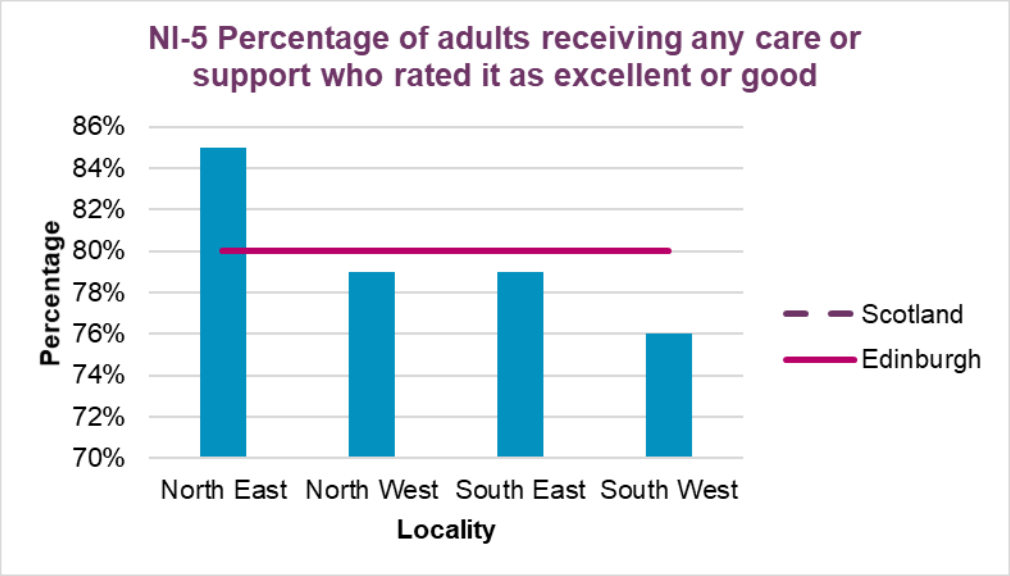
Source: Scottish Government HACE survey 2017/18

Edinburgh's performance around adults who are supported at home who agreed that their health and social care services seemed well co-ordinated decreased slightly by 4% from 71% in 2015/16, to 67% in 2017/18. The Scottish average is 74%. Both North East and South East scored 68%, whilst South West has the lowest percentage of 64% which is 10% lower than the Scottish average.

NI-5 Percentage of adults receiving any care or support who rated it as excellent or good

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-5	2017/18
Scotland	80%
Edinburgh	80%
North East	85%
North West	79%
South East	79%
South West	76%



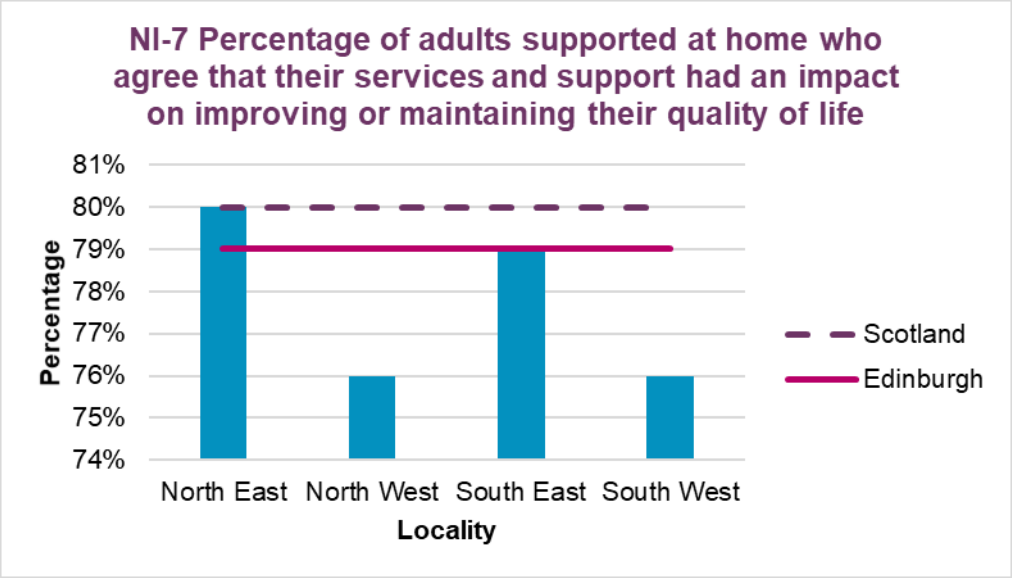
Source: Scottish Government HACE survey 2017/18

The percentage of adults receiving any care or support and rated it as excellent or good increased by 2% from 78% in 2015/16, to 80% in 2017/18. The Scottish average is also 80%. Interestingly, North East has the highest percentage of the four localities at 85%, which is higher than the Scottish average. The South West locality has the lowest score at 76%.

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

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-7	2017/18
Scotland	80%
Edinburgh	79%
North East	80%
North West	76%
South East	79%
South West	76%



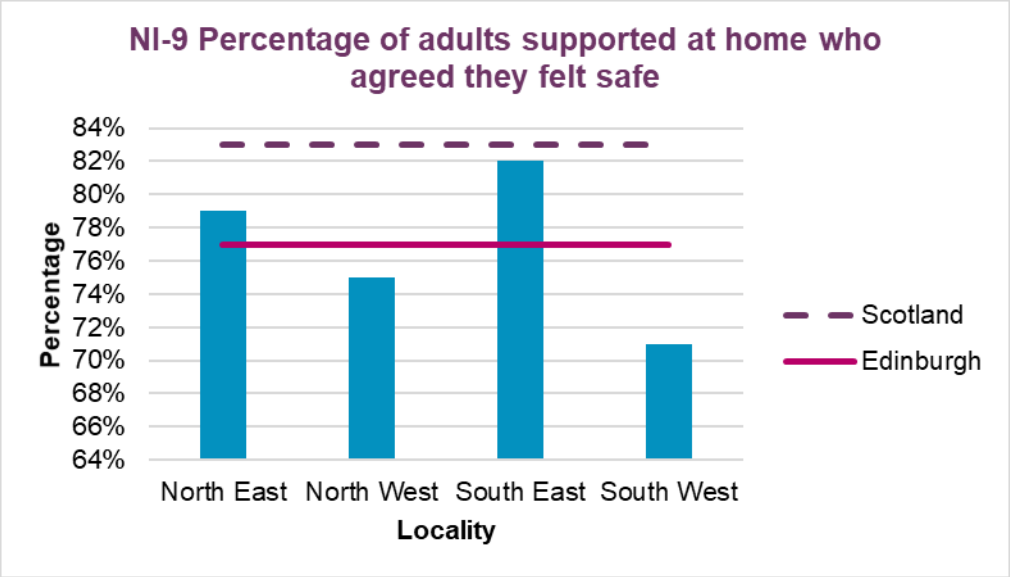
Source: Scottish Government HACE survey 2017/18

The percentage of adults supported at home who agreed that their services and support had an impact on improving or maintaining their quality of life reduced from 83% in 2015/16, to 79% in 2017/18. The Scottish average is 80%. There is very slight variation between the four localities with North East scoring the highest at 80%, which is the same as the Scottish average, with North West and South West both achieving 76%.

NI-9 Percentage of adults supported at home who agreed they felt safe

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-9	2017/18
Scotland	83%
Edinburgh	77%
North East	79%
North West	75%
South East	82%
South West	71%

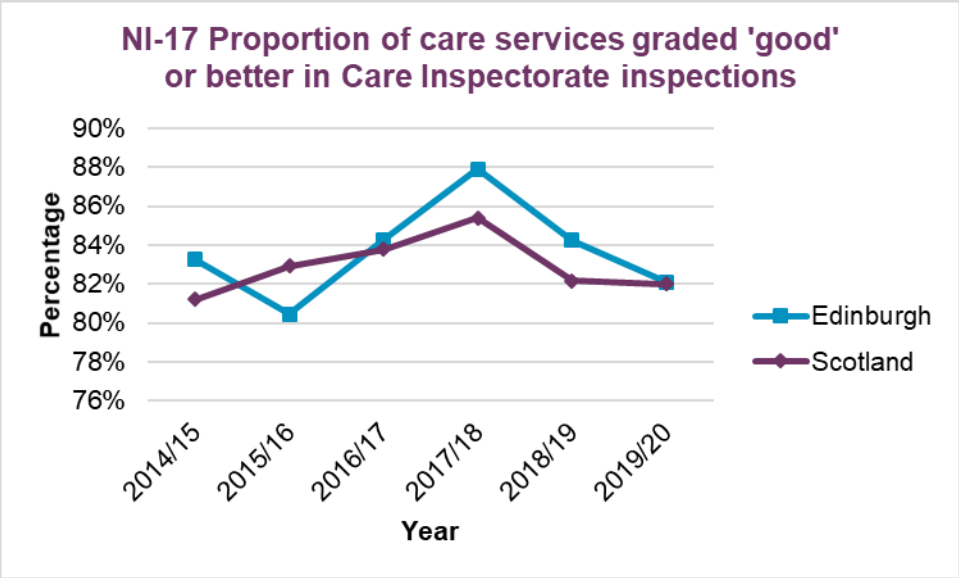


Source: Scottish Government HACE survey 2017/18

The percentage of adults supported at home who agreed that they felt safe reduced from 82% in 2015/16, to 77% in 2017/18. This is below the Scottish average of 83%. There is a large variation between the localities with the South East locality scoring close to the Scottish average with 82%. The South West locality score is the lowest at 71%.

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

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Edinburgh	83%	80%	84%	88%	84%	82%
Scotland	81%	83%	84%	85%	82%	82%



Source: Care Inspectorate

There were 339 out of 413 services within Edinburgh which were graded as ‘good’ (4) or better by the Care Inspectorate in 2019/20 which equates to 82%. This is a slight reduction of 2% compared to 2018/19. Edinburgh’s rate is the same as the Scottish average of 82%.

Priority 4
Managing our resources effectively

Context

In a climate of increasing need for services and continuing pressures on budgets, it is vital that the EIJB makes best use of its available resources.

Workforce planning

Our workforce is made up of approximately 5,000 staff, with 56% employed by the City of Edinburgh Council and 44% by NHS Lothian. Ensuring a sustainable workforce continues to be a significant challenge for the EHSCP. Our workforce is ageing, with the three largest cohorts falling within the following age ranges: age 50-54 (18.5% of total workforce); age 55-59 (15.8%) and age 45-49 (14.45%). Less than 9% of our workforce is under the age of 30.

The EIJB considered an initial baseline workforce plan in December 2018. This set out the specific risks and issues for EHSCP and the potential implications for future service delivery. A core workforce group is now developing a workforce strategy with a whole-systems approach which aligns to strategic and financial planning priorities. Part of this approach will be taking forward strategies relating to learning and development, recruitment and retention, as well as the opportunities afforded through new digital and technological advancements.

During 2019/20, following the Scottish Government's national recruitment drive, the EHSCP has been working to resolve capacity imbalances within care home settings. Work has also taken place within localities to analyse their own workforce profile and to implement local approaches to workforce planning challenges. This will continue in 2020-21. The impact of the COVID-19 pandemic will also shape our future workforce plans going forward.

Staff feedback

The iMatter survey was introduced to all EHSCP staff across health and social work services in 2019. The response rate for this year's return was 55% and the directorate's Employee Engagement Index (EEI) score was 77.

Overall, 24 of the 28 questions fall within the highest 'strive and celebrate' category: the remaining four need monitoring to 'further improve'. All teams have been asked to discuss individual report findings, identify areas for improvement and develop an action plan.

Contracts and commissioning

We have had a renewed focus on strengthening our approach to contracts and commissioning during 2019/20. Part of this work has included developing a draft market facilitation framework. The draft framework sets out the EHSCP approach to commissioning and contracting services and will be subject to sector-wide consultation and engagement later in 2020.

We are committed to moving away from the transactional behaviours and processes of traditional market management and encouraging greater partnership working, believing that effective relationship-building rests on:

- transparent decision-making
- good collaborative structures
- cross-sector leadership
- a focus on sustainability.

We already know of areas where we need to improve and where we need the market to be able to support more reliable, sustainable services. These areas include:

- seasonal fluctuation – summer and winter problems need to be planned for and mitigated better
- boom and bust – when providers fail or withdraw from packages resulting in a tremendous impact on people
- the challenges associated with delivering small packages of care such as medication prompts and meal preparation
- the move towards outcomes-based commissioning and greater personalisation
- transformation of traditional models of care and better use of digital technology.

Addressing these issues will be key to our approach moving forward.

An enhanced health and social care contract management framework (CMF) was introduced and piloted with a small number of providers in December 2019 with a view to rolling out in the 2020/21 financial year. Unfortunately, we have had to delay full implementation because of the impact of COVID-19.

This enhanced CMF has been designed to:

- focus resources where they are required most
- allow for early identification and addressing of issues, concerns and risks
- collect and record more structured and consistent information across care groups
- allow autonomy for contract managers in how they conduct contract management activity
- promote more robust monitoring of financial and governance arrangements within service providers
- allow service provider monitoring to be conducted in a standardised format, with frequency determined by level of risk. A key objective of service provider monitoring is for EHSCP staff to gain insight into and understanding of the work service providers are doing on our behalf.

Financial management and performance

Financial information is a key element of our governance framework with financial performance for all delegated services reported at each meeting of the EIJB. 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.

Each year we produce a financial plan which sets out how we ensure our limited resources are targeted to support delivery of the Strategic plan. For 2019/20 our financial plan was set with a deficit of £10 million which we committed to address, in collaboration with our partners, during the year. Financial performance for the delegated services was reported throughout the year and, by the end of the year, we had bridged the £10 million gap through a combination of:

- funding confirmed by the City of Edinburgh Council after the initial budget was set
- slippage on some specific investments
- the agreed use of EIJB reserves.

This position reflected the need to balance existing commitments, our ambitions for supporting transformational change and the need to balance the in-year financial plan.

You will find financial performance for the year summarised in the table on the next page.

	19/20 budget £k	19/20 actual £k	Variance £k
NHS DELIVERED SERVICES			
Community services	77,403	77,420	(17)
General medical services (GMS)	84,173	84,024	149
Prescribing	81,181	81,690	(509)
Reimbursement of independent contractors	55,502	55,502	0
Services hosted by other partnerships	88,812	87,894	918
Hospital 'set aside' services	99,538	100,776	(1,238)
Other	33,985	33,293	692
COUNCIL DELIVERED SERVICES			
External purchasing	151,077	151,814	(737)
Care at home	29,906	30,722	(816)
Day services	17,143	15,675	1,468
Residential care	18,056	18,074	(18)
Social work assessment & care management	14,932	14,904	28
Other	9,935	9,860	75
Additional contributions from partners	5		5
Total	**761,648**	**761,648**	**0**

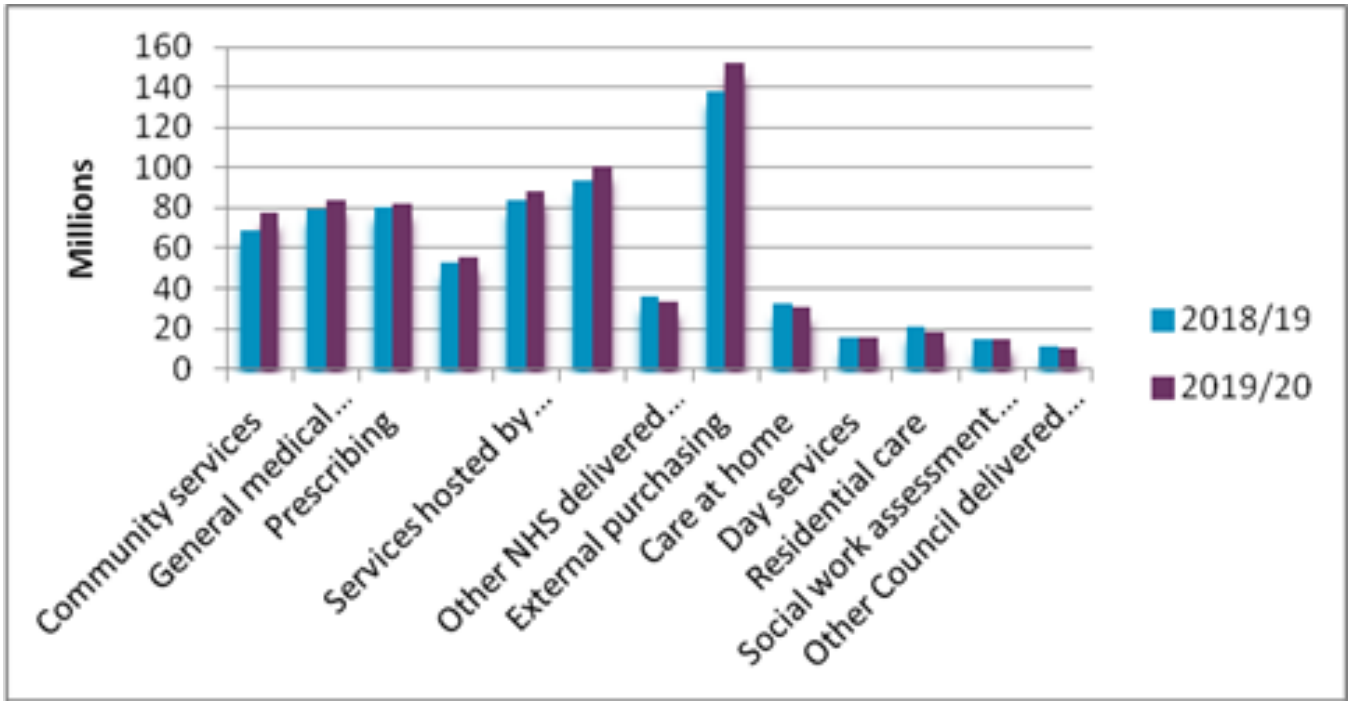
Whilst there is no doubt that we will continue to face significant financial pressures, there were some notable improvements in financial planning and performance in 2019/20. This was the first year that the EIJB has not relied on one-off contributions from our partners in the City of Edinburgh Council and NHS Lothian. Also, for the first time, we not only met but exceeded the target within our planned savings and recovery programme.

Although the positive progress with the 2019/20 savings and recovery programme marks a departure from previous non-delivery, the financial pressures facing us have not materially changed. Key pressures include:

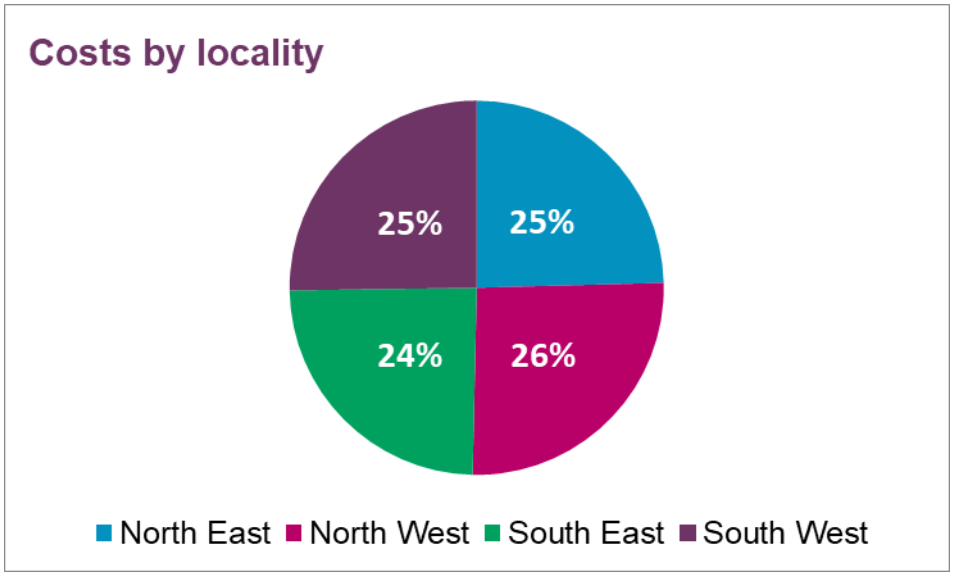
- Increasing demand and spend on externally-purchased services. Despite breaking even against budget for the first time in some years, this area of spend continues to increase year-on-year. Demographic factors continue to drive demand for these services, which is also evidenced in the continuing growth in direct payments and individual service funds. Costs rose by £14 million (or 9%) from the level of the previous year.
- Increasing prescription costs. Medicines prescribed by GPs cost almost £82 million in 2019/20, an increase of £1 million (or 1%). Although Edinburgh has one of the lowest prescribing costs per head of population, we see costs rising year-on-year as volumes increase and prices fluctuate.
- Increasing demand for equipment to enable people to live independently at home. Costs for equipment supplied continues to rise in line with increased demand.

- Continuing overall pressures in set-aside budgets. NHS Lothian set-aside budgets overspent by £1.2 million in the year. This is a focus of continuing discussions with NHS Lothian and the three other Lothian IJBs.

The table below shows how costs in key areas for financial year 2019/20 compared to those from the previous financial year (2018/19).



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 means 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.



Our performance

The national health and wellbeing performance outcomes linked to this priority are:

- people who work in health and social care services feel engaged with the work they do and are supported to improve continuously the information, support, care and treatment they provide (HWB-8)
- resources are used effectively and efficiently in the provision of health and social care services (HWB-9).

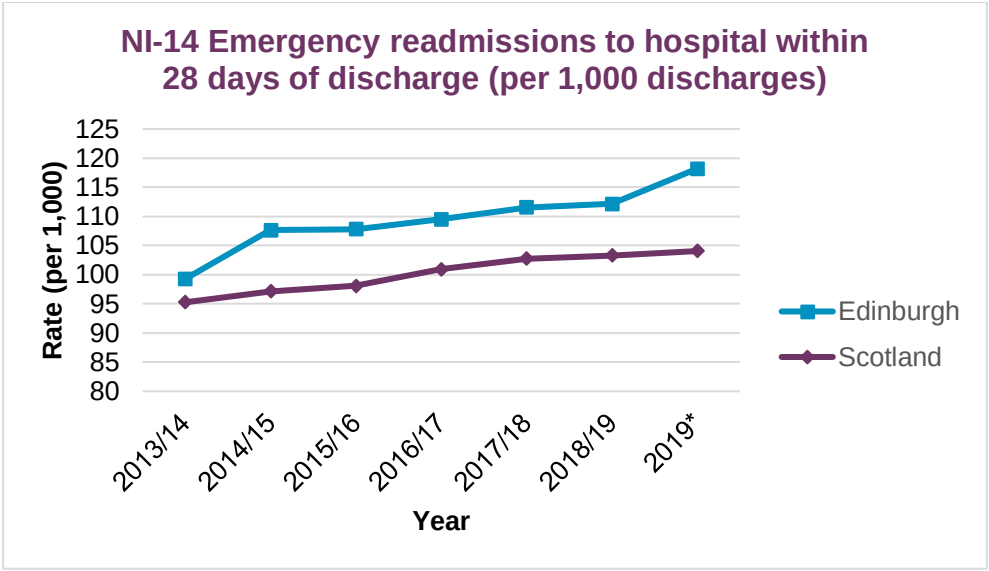
National Indicator (NI)		Edinburgh 2018/19	Edinburgh 2019	Difference	Performance
NI-14	Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges)	112	118	+6	●
NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	24%	23%	-1%	●

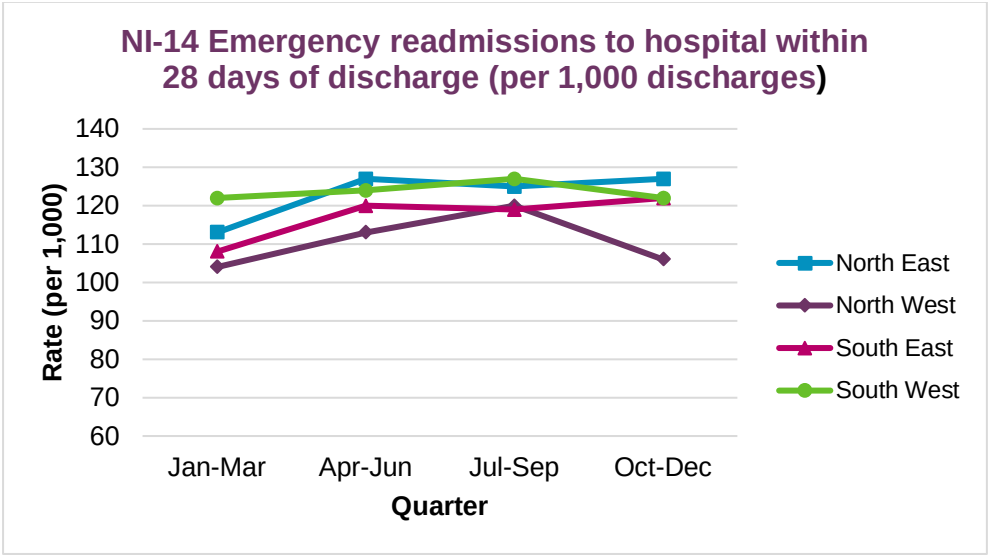
RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

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	2019*
Edinburgh	99	108	108	110	112	112	118
Scotland	95	97	98	101	103	103	104

	2019			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
North East	113	127	125	127
North West	104	113	120	106
South East	108	120	119	122
South West	122	124	127	122



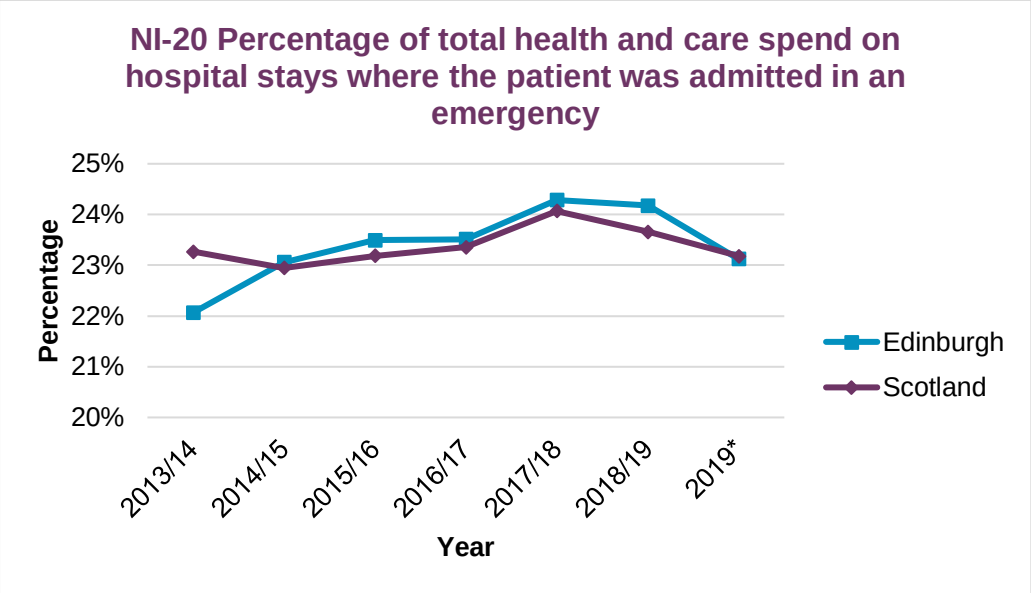


Source: Public Health Scotland

Edinburgh's readmission rate to hospital within 28 days remains higher than the Scottish average. The long-term trend has been increasing from 99 in 2013/14 to 118 in 2019. There is little variation between the four Edinburgh localities in 2019, although there was a slight decrease in the North West locality in the last quarter.

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

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019*
Edinburgh	22.1%	23.1%	23.5%	23.5%	24.3%	24.2%	23.1%
Scotland	23.3%	22.9%	23.2%	23.4%	24.1%	23.7%	23.2%



Source: Public Health Scotland

The percentage of health and care resources spent on hospital stays where the patient was an emergency admission slightly decreased from 24% to 23% in 2019.

Priority 5
Making the best use of capacity across the whole system

Context

In a climate of increased demand for services and a challenging financial situation, it is crucial that the EIJB and EHSCP continue to take every opportunity to deliver more effective ways of working to make best use of available resources.

Developing primary care capacity

Population increase and the availability of a suitably trained workforce remain the major concerns for Edinburgh in respect of primary care provision. In the 11 years since 2009, the practice-registered population of the city has grown by 67,000. This steady increase of approximately 6,000 new patients a year is predicted to continue for the next 20 years. Across the UK the shortage of GPs (in particular) has been highlighted as a key challenge to all health and social care systems.

There are 70 GP practices in Edinburgh networked into four localities, each of which has two GP quality clusters. Edinburgh also recognises five demand groupings which help to broadly describe the different populations served across the city. As of January 2020, around half of the practices were operating restricted lists, indicating they were unable to immediately register all patients who requested access to their lists, as would be the case in a stable population.

In order to increase the capacity of primary care, significant investment through the national new GP contract is being made to expand the primary care workforce across six clinical areas. The vehicle for this investment is the Primary Care Improvement Plan (PCIP) agreed by the EIJB and supported by NHS Lothian. By March 2020, a total of 116 WTE staff had been recruited city-wide, broken down by locality as follows: North East 29 WTE; North West 31 WTE; South East 24 WTE and South West 32 WTE. These staff are mainly a mixture of pharmacists, nurses, physiotherapists and community link workers, in accordance with what each practice considered would best contribute to their stability and the transformation of general practice.

Over the last two years, funding has also been made available to encourage the use of technology within Edinburgh's practices. While most of the investment has been on routine items such as automatic check-in facilities and laptops for use during home visits, the availability of these items has helped teams work more efficiently. Almost every city practice had benefitted from this technology fund by March 2020. We have also made investment in improved pathways and encouraged practices to develop their administrative staff to help with the clinical workload.

Edinburgh has a significant challenge in respect of GP premises with around 12 out of 60 current premises meriting immediate replacement because of the physical condition or capacity limitations. In addition, developments are needed to accommodate the new growing population and where existing practices cannot expand. NHS Lothian has limited capital to support new developments and there are limited opportunities to develop new premises owing to a competitive market for any site opportunities.

During 2019/20, we have made significant steps towards an improved balance between population and appropriate primary care premises, in particular:

- South East Edinburgh initial agreement, March 2020 - this sets out proposals to address GP capacity issues resulting from extensive housing developments under construction in the outer area of the South East locality together with proposed re-provision of two existing practice premises. The initial agreement was submitted to the NHS Lothian Capital Investment Group as part of the capital prioritisation process. You can find more information within the EIJB report from October 2019.
- Brunton Medical Practice re-provision - this practice is based in the North East locality and has been a long-standing priority for new premises because of the building's functional unsuitability for delivery of primary care services. Following the EIJB's and NHS Lothian's approval of the initial agreement, work has continued to develop the standard business case.
- The relocation of the Inclusive Edinburgh practice (part of the integrated homelessness service) as part of the wider joint work to integrate homeless services at Panmure St Anne's. Construction was due to commence in March 2020, but the site start was delayed because of COVID-19 restrictions.
- Consideration of an opportunity to relocate two city practices into an adapted commercial property was progressed with support from both NHS Lothian and EIJB.
- During 2019/20 almost half of city practices benefitted from a programme of small grants run by EHSCP with funding from a combination of NHS Lothian, Scottish Government and non-recurrent PCIP funds.
- The community link workers programme continues to go from strength-to-strength – see the tackling inequalities chapter for more detail.

Increasing capacity for psychological therapy services

The current standard for psychological therapies is for at least 90% of patients to start treatment within 18 weeks of referral. Edinburgh has been challenged in meeting this target for a prolonged period of time resulting in a significant number of people waiting for longer than 18 weeks. The EIJB therefore agreed in August 2019 (Psychological Therapies Additional Investment report) to allocate reserves to fund the appointment of 17 WTE temporary staff for a period of 18 months to deliver psychological therapies to the people who have been waiting for services for over 18 weeks.

Supporting carers

The EIJB recognises the crucial contribution young and adult carers make to their communities across Edinburgh and is committed to providing personalised services to support carers in their caring role and enable them to look after their own health and wellbeing.

In August 2019, the EIJB approved a new Edinburgh Joint Carers' Strategy and associated implementation plans aligned to the requirements set out in the Carers (Scotland) Act 2016. The strategy was developed through a comprehensive partnership approach involving the Edinburgh Carers Strategic Partnership Group, the EHSCP and the City of Edinburgh Council's Communities and Families service.

The strategy is focused on supporting carers, ensuring sustainability of caring, and valuing carers as equal partners in care. The strategy is focused around six priority areas:

- identifying carers
- information and advice
- carer health and wellbeing
- short breaks
- young carers
- personalising support for carers.

During 2019/20 we have seen progress in delivering the implementation plans, namely:

- provision of a dedicated carer support worker within the Edinburgh Community Stroke Service to identify carers earlier in their caring journey
- published the 'short breaks service statement' which outlines how carers can access short breaks from caring and the types of support available in Edinburgh
- the Hospital Discharge Carers Support Service has continued to complete adult carer support plans with carers across the city, completing 445 plans over 2019/2020
- we have made approximately £34,000 of carer payments to meet the needs 80 carers, identified through adult carer support plans
- worked with third sector partners to test young carer statements across Edinburgh which inform the roll-out of statements in 2020/2021
- worked with carer support organisations across the city to develop specifications to meet future demand for carer support.

Case study – carer support

Amanda has been looking after her husband for over ten years since he suffered strokes which resulted in long-term physical and cognitive impairments. Amanda was not connected to any sources of support until staff from her husband's day care service linked her to a dedicated carer support worker (CSW) in 2019.

Amanda and the CSW completed an adult carer support plan (ACSP) together. This conversation highlighted the need for Amanda to focus on her own health and wellbeing and to take some time out, which she found difficult to do due to her caring role. Accessing complementary therapies was seen as a way Amanda could support her physical and mental health.

Amanda accessed subsidised treatments through a carers' organisation and funding was utilised via the ACSP and a carers payment. When reviewing her ACSP eight months later, Amanda reported significant improvements to her overall health from both the complementary therapies and linking with the carer organisation and their other short break options. A further carer payment has been provided to enable Amanda to continue receiving support for the next year until her plan is reviewed again.

Telecare and technology-enabled care

In 2018, EHSCP teamed up with Blackwood Homes and care group to create an innovative SMART home for Edinburgh's citizens, their carers, health and social carer staff and third sector agencies within Edinburgh.

The SMART home and technology service is a small team of occupational therapy staff, technology development workers and a team lead from our Assistive Technology Enabled Care (ATEC24) service. The team provide a variety of services, including:

- assistive technology occupational therapy assessment and intervention
- training, smart home tours
- information and advice
- complex telecare assessment.

By adopting a mixed economy approach to delivering technology solutions, the team ensures people have the technology systems and solutions that best meet their desired outcomes, needs, abilities and environment. The smart home resource is an interactive space for Edinburgh citizens and EHSCP staff to explore, test and engage with the latest technology-enabled care options, and discover how they have the potential to transform the day-to-day lives of people living with disabilities and those who have a caring role.

Between April and December 2019, the team delivered:

- telecare training for 32 partnership staff
- developed a digital champion model and delivered associated training for 20 partnership staff
- twelve digital technology drop-in sessions for digital champions plus ongoing training and development including three continuous professional development sessions
- responded to over 100 information and advice enquiries
- over 500 smart home tours involving Edinburgh citizens, EHSCP staff and third sector organisations
- over 20 complex technology assessments for telecare
- over 60 referrals for assistive technology occupational therapy assessment, support and guidance.

As with every other service across the EHSCP, the service has had to adapt to a new way of working since the emergence of COVID-19 with clients supported through video-conferencing and a training plan to support practitioners working in localities.

Our performance

The national health and wellbeing performance outcome linked to this priority is:

- 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. (HWB-6).

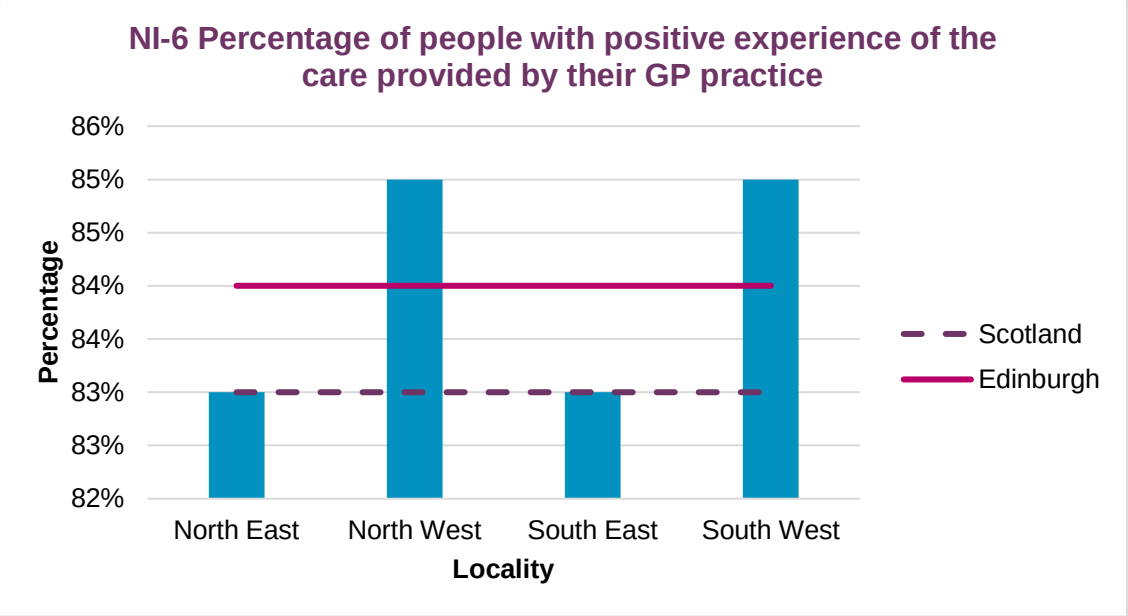
National Indicator (NI)		Edinburgh 2018/19	Edinburgh 2019	Difference	Performance
NI-6	Percentage of people with a positive experience of the care provided by their GP practice	No Health and Care Experience survey data is available for 2018/19, as the survey is conducted on a bi-annual basis. The publication of the 2019/20 survey was delayed by the Scottish Government due to the COVID-19 pandemic.			
NI-8	Total combined % carers who feel supported to continue in their caring role				

RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

NI-6 Percentage of people with positive experience of the care provided by their GP practice

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-6	2017/18
Scotland	83%
Edinburgh	84%
North East	83%
North West	85%
South East	83%
South West	85%



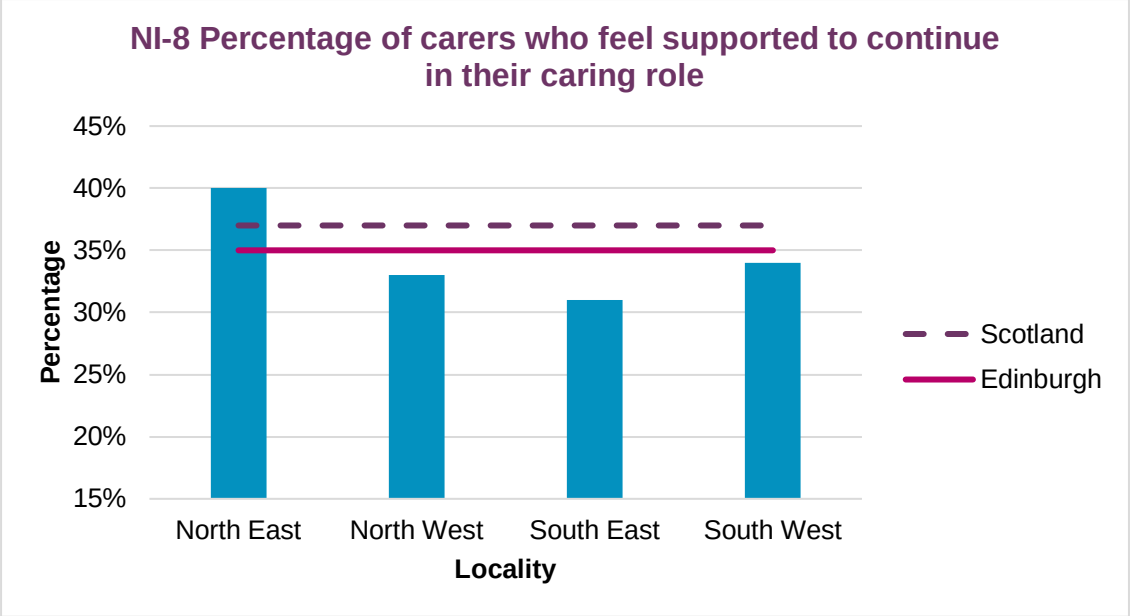
Source: Scottish Government HACE survey 2017/18

In the Heath and Care Experience survey, 84% of respondents stated that they had a positive experience of the care provided by their GP practice, which is higher than the Scottish average of 83%. There is a slight variation once broken down into the four localities with North East and South East reporting slightly lower rates compared to North West and South West.

NI-8 Percentage of carers who feel supported to continue in their caring role

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-8	2017/18
Scotland	37%
Edinburgh	35%
North East	40%
North West	33%
South East	31%
South West	34%



Source: Scottish Government HACE survey 2017/18

Only 35% of carers feel supported to continue in their carer role. This is slightly below the Scottish average of 37%. There is variation when examining the results by locality. The South East locality has the lowest percentage of 31%, whilst the North East has the highest rate of 40%, which is higher than the Scottish average.

Priority 6
Right care, right place, right time

Context

As part of making sure people receive the right care in the right place at the right time, the EIJB is committed to ensuring:

- people are safe and protected
- people are supported at home and within their communities whenever possible and are admitted to hospital only when clinically necessary
- people are discharged from hospital as soon as clinically fit to do so and receive the necessary support at home to recover and regain their independence
- there are smooth transitions between services and care is reviewed regularly to ensure it remains appropriate.

Throughout 2019/20 we have focused on redesigning services to ensure timely discharge from hospital, prevent avoidable hospital admissions, and to shift the balance of care to ensure that more community provision is available.

Addressing delayed discharge

Being delayed in discharge from hospital is bad for patients, bad for staff, and bad for the financial health of the health and social care system. Home First is a key plank of our approach to ensure timely discharge from hospital. You can find out more about this innovative transformation project within the 'overview' section of this report and a report to the EIJB in October 2019.

Ensuring that people receive the care they need to enable them to continue to live at home or to return home after a hospital stay is also important. Edinburgh has faced challenges in providing a care at home service for those who need it because of a lack of capacity within the care sector. However, we have seen progress during 2019/20 with the continuation of the Sustainable Community Support Programme (SCSP) which has resulted in improved recruitment and retention of staff in independent sector providers, allowing an expansion of capacity. As part of the SCSP, the current care at home contact was extended in October 2019 for a further 22 months.

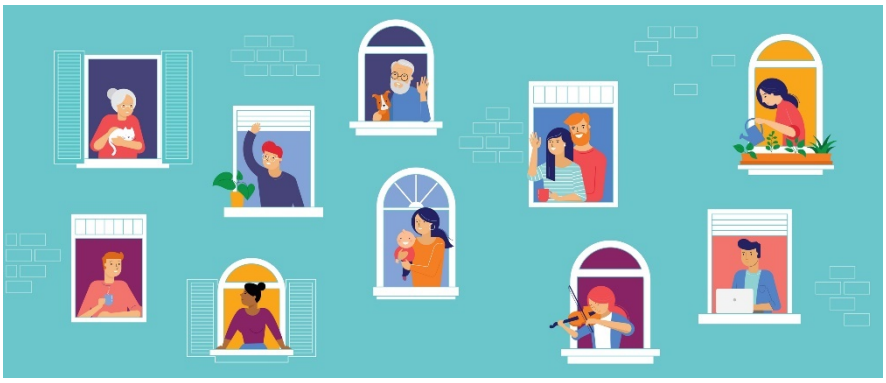
For some people care homes will be the most appropriate setting for their care and support needs. The EHSCP has nine care homes for older people which can support a maximum of 404 residents. This includes 15 beds set aside for respite at one of our care homes. We care for people with complex care and medical needs, those who have dementia or other cognitive impairment and those with palliative or end of life care needs. People can be admitted from

hospital but also from the community. The EHSCP also holds contracts with other care home providers and we have increased this capacity in response to the COVID-19 pandemic.

The EHSCP continued to support and promote a national Power of Attorney campaign during 2019. There has been a 15.76% increase in Power of Attorney registrations during 2019.

Shifting the balance of care

We know that long and protracted stays in hospital are not good for people or in keeping with rights-based care. Moving people from long-stay institutional or hospital care to greater independence in the community shows success in shifting the balance of care in Edinburgh.



As of February 2020, 29 people from Edinburgh with a learning disability were living in hospital, mainly in the Royal Edinburgh Hospital (REH). Many have been hospitalised for a long period of time and have no medical reason to be there. The EIJB has already made a commitment to developing 22 community placements over the next two years, so that people with a learning disability can leave hospital. The EIJB has also agreed to create a small 'step-down' community resource to support a transition for people who have become stuck in hospital because of a breakdown of care, for example the loss of a tenancy or families no longer able to provide care. The likely step-down period would be around six months, however, this would vary with individual needs and a clearly defined entry and exit strategy.

You can find more information about these plans within the Learning Disability – Step Down report.

The Thrive workstream 'A Place to Live' is focused on ensuring that people with mental health issues have a place to call home where they feel safe, receive the support they need and are able to connect with and be part of their local community. There are currently 272 supported accommodation places across the city with additional support for people across the five Wayfinder grades of support. Through Edinburgh's affordable housing allocations policy, people ready to leave hospital and grade 5 supported are prioritised through the application of the gold status award. Recent developments include commissioned Grade 5 and Grade 4 units in the south east, south west and north east of the city.

We spot-purchase visiting support services for people with complex mental health needs living in their own tenancies. Currently over 760 people are receiving a care and support spot-purchased service which includes visiting support and supported accommodation.

Future plans include creating a new framework agreement for commissioning all the current supported accommodation services and visiting support services for people with mental health issues. This will give a better fit with the Three Conversations approach and more flexibility between multiple providers and Partnership staff in clusters and localities.

Palliative and end-of-life care

The EIJB hosts palliative and end-of-life care on behalf of the four Lothian IJBs and is committed to ensuring that high quality and person-centred care is available for all who need it, when they need it.

There are two hospices within the city of Edinburgh, both providing a range of specialist inpatient and community-led palliative and end-of life care services to those residing across the whole of Lothian. The IJB approved a new Memorandum of Understanding with the hospices was approved in principle in February 2020. This sets out a new approach to commissioning based on transparency and openness, as well as a focus on outcomes and effectiveness.

Our performance

The national health and wellbeing performance outcome linked to this priority is:

- people can live, as far as reasonably practicable, independently and at home or in a homely setting in their community (HWB-2).

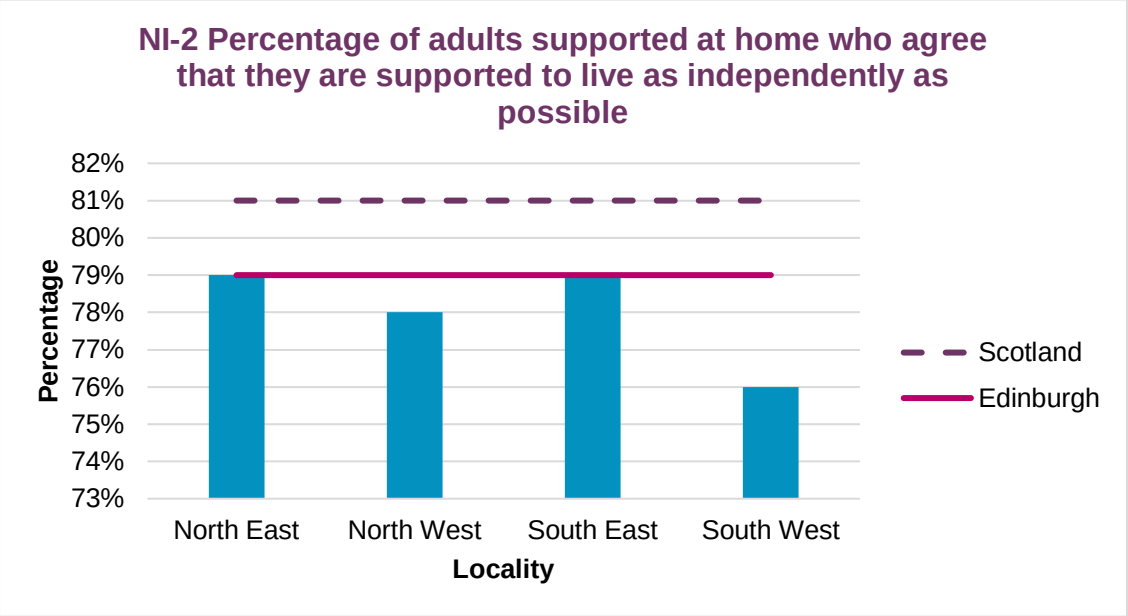
National Indicator (NI)		Edinburgh 2018/19	Edinburgh 2019	Difference	Performance
NI-2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	No Health and Care Experience survey data is available for 2018/19, as the survey is conducted on a bi-annual basis. The publication of the 2019/20 survey was delayed by the Scottish Government due to the COVID-19 pandemic.			
NI-13	Rate of emergency bed days for adults (per 100,000)	112,108	104,707	-7,401	●
NI-15	Proportion of last 6 months of life spent at home or in community setting	85%	87%	+2%	●
NI-18	Percentage of adults with intensive care needs receiving care at home	62% *(2018)*	N/A	N/A	N/A
NI-19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	1,621	1191 *(2019/20)*	-430	●

RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

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

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-2	2017/18
Scotland	81%
Edinburgh	79%
North East	79%
North West	78%
South East	79%
South West	76%



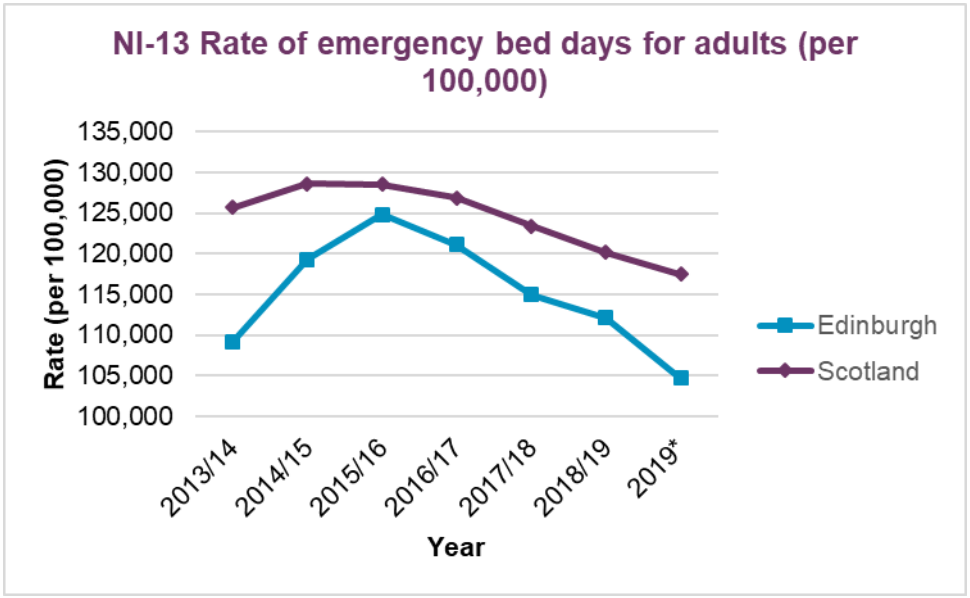
Scottish Government HACE survey 2017/18

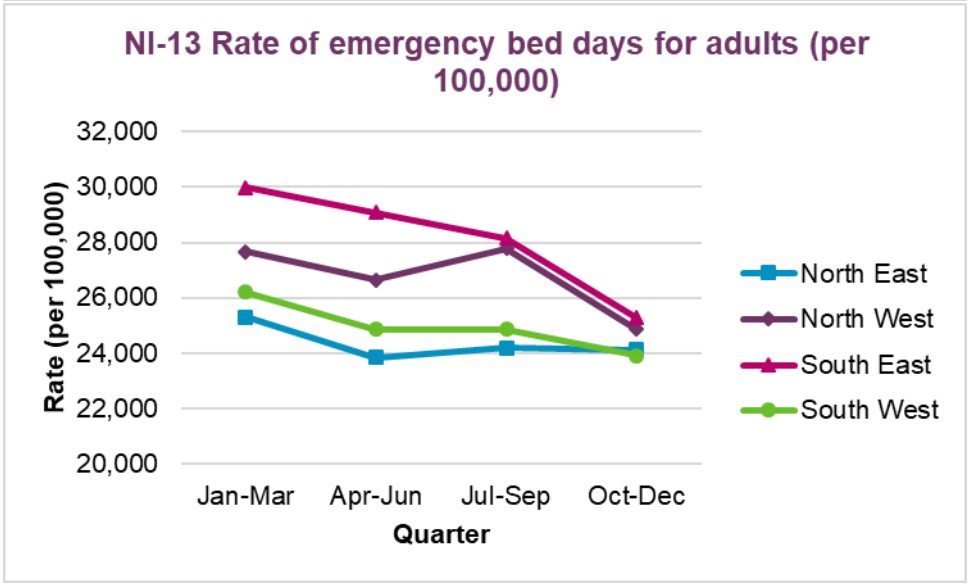
Edinburgh's performance decreased by 2% from 81% in 2015/16 to 79% in 2017/18. The Scottish average is 81%. There is a slight variation between the four Edinburgh localities with South West achieving 76%, and both North East and South East scoring 79%.

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

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019*
Edinburgh	109,231	119,311	124,858	121,090	114,972	112,108	104,707
Scotland	125,730	128,596	128,541	126,891	123,383	120,177	117,478

	2019			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
North East	25,292	23,845	24,194	24,107
North West	27,664	26,645	27,776	24,869
South East	29,992	29,086	28,148	25,269
South West	26,201	24,869	24,853	23,916





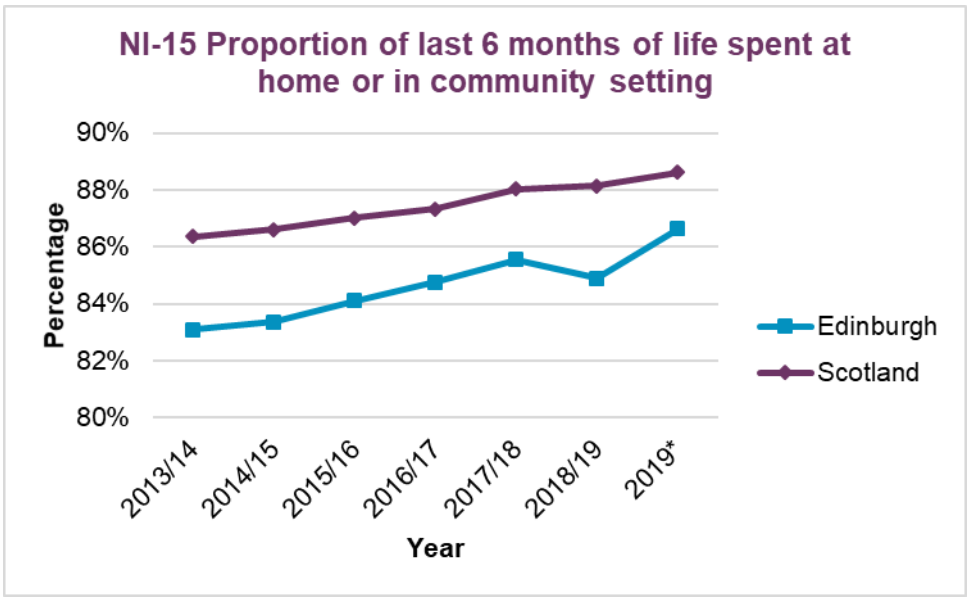
Source: Public Health Scotland

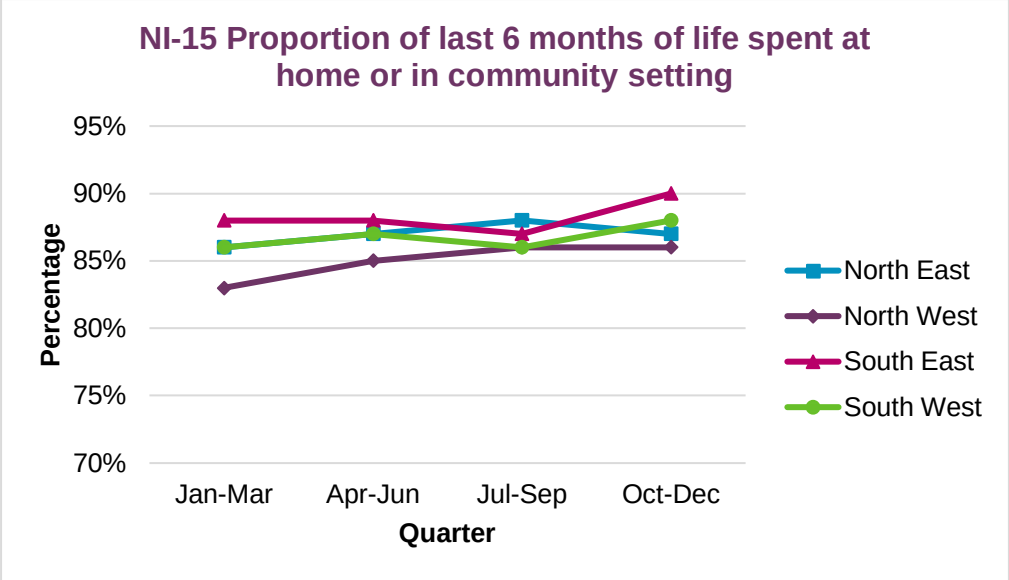
Edinburgh's long-term trend for emergency bed day rate per 100,000 population of adults age 18 and older has been steadily decreasing since 2013/14 to 2019. Performance between 2018/19 and 2019 improved by 7% from 112,108 bed days in 2018/19, to 104,707 in 2019. Edinburgh has been consistently outperforming the Scottish average since 2013/14. The Scottish average in 2019 was 117,478 emergency bed days per 100,000 adult population. All four localities have seen a decrease in emergency bed days, with the South East locality seeing the biggest decrease.

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

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019*
Edinburgh	83%	83%	84%	85%	86%	85%	87%
Scotland	86%	87%	87%	87%	88%	88%	89%

	2019			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
North East	86%	87%	88%	87%
North West	83%	85%	86%	86%
South East	88%	88%	87%	90%
South West	86%	87%	86%	88%



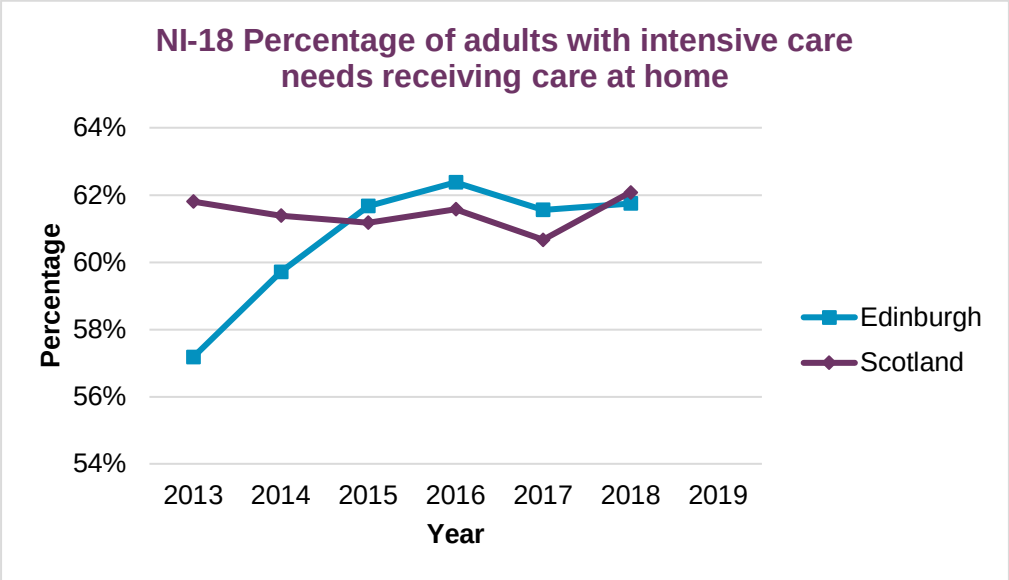


Source: Public Health Scotland

The percentage of the last six months of life is spent at home or in a community setting has been improving in Edinburgh with an increase of 2% from 85% in 2018/19, to 87% in 2019. This is slightly lower than the Scottish average in 2019 was 89%. All four localities have reported an increase, although the South East locality has a higher proportion with 88%.

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

	2013	2014	2015	2016	2017	2018	2019
Edinburgh	57.2%	59.7%	61.7%	62.4%	61.6%	61.8%	N/A
Scotland	61.8%	61.4%	61.2%	61.6%	60.7%	62.1%	N/A



Source: Public Health Scotland

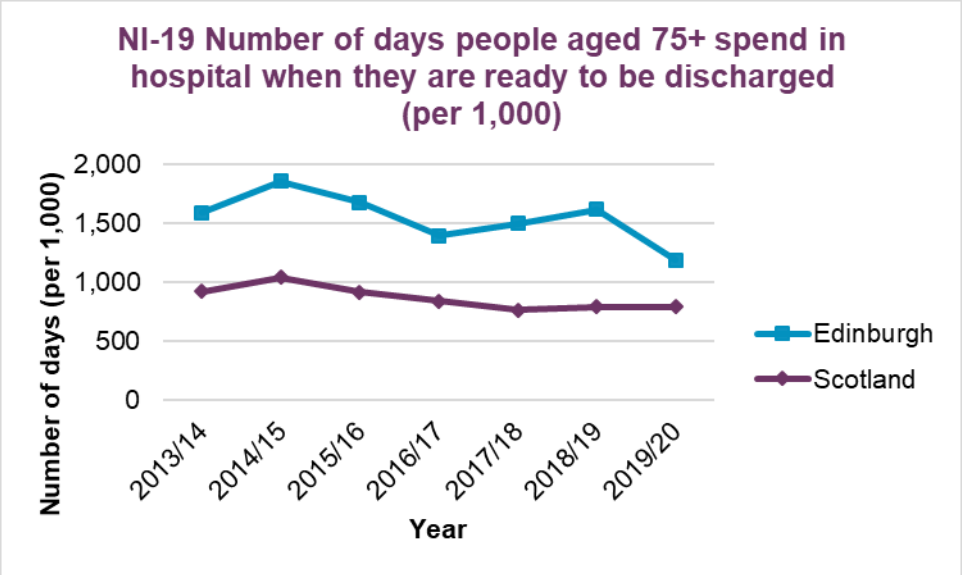
Edinburgh's long-term trend for adults with intensive care needs are receiving care at home has been increasing from 57% in 2013, to 62% in 2018.

The information for this indicator (NI-18), is published by the Insights in Social Care release produced by Public Health Scotland. The data relating to 2019/20 is not due to be published until later in the autumn and is not available for inclusion in this report.

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	2019/20
Edinburgh	1,592	1,861	1,679	1,395	1,502	1,621	1,191
Scotland	922	1,044	915	841	762	793	793

Edinburgh's performance improved by 27% from 1,621 days in 2018/19 to 1,191 in 2019/20. The Scottish average in 2019/20 was 793 days per 1,000 population.



Source: Public Health Scotland

We have made positive progress in reducing the number of days which people aged 75+ spend in hospital, per 1,000 population. The number of delayed discharges has reduced from a high of 1,861 in 2014/15, to 1,191 in 2019/20 and reducing. The Scottish average was 793 in 2019/20.

Looking ahead to 2020/21

In April 2020 we entered phase two of the current strategic planning cycle; a continuation and implementation of the transformation programme. Our transformation framework gives a strong foundation for the level of strategic change we want to deliver for the city. The framework applies a programme management approach to major service redesign and innovation and includes widespread collaboration and stakeholder engagement. The programme will respond to a significant number of challenges and work towards creating modern and sustainable services that optimise resource and meet the needs of our citizens in the years ahead. To deliver the transformation at pace, the programme provides a wide-ranging and ambitious programme of change supported by a dedicated transformation team.

Despite inevitable disruption to the transformation programme caused by the COVID-19 pandemic, work has continued where possible. We have seen some clear examples during the pandemic where response to the crisis has been a catalyst for the acceleration of transformational change. The Home First Edinburgh model has expanded, and we have seen considerable success in reducing delayed discharge and improved flow across the system. A wide variety of teams have embraced digital opportunities, with the use of ‘Near Me’ systems in primary care being particularly successful. Staff have also reported that the Three Conversations approach has given an excellent foundation for supporting people through the crisis.

We carried out a comprehensive lesson capture exercise in early April. Informed by these lessons, we have adapted the transformation programme to target priorities and optimise available capacity and exploit opportunities identified during COVID-19. We will now focus staff effort on an agreed set of immediate strategic priorities and work will begin in August 2020. The remaining project workstreams will be placed into a planned, follow on phase, due to start from January 2021. We will continue to focus on planned ‘quick wins’ to build momentum and confidence, whilst at the same time developing overarching plans and business cases for longer-term change, recognising that transformation gives us the best opportunity to deliver both financial sustainability and high quality and modern services.

We will review our current strategic plan in the second half of 2020. Until then we will continue with our existing strategic framework:

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 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*

For more information

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