Edinburgh Integration Joint Board

Annual performance report 2024/25

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Foreword

As the recently appointed Chair of the Edinburgh Integration Joint Board (EIJB) and new EIJB Chief Officer, we have the pleasure of introducing you to Edinburgh's Annual Performance Report for 2024 – 2025.

It has been another busy year for the EIJB. Our focus over the last year has been to protect and improve services that the most vulnerable people in Edinburgh rely on every day.

In November, we received a review of progress made against the inspection of adult support and protection in Edinburgh, undertaken in 2023. This review commended the improvements we have made, with progress made in all but one area. This is an example of the commitment we have had, in collaboration with our partners, to service improvement over the past year.

This has also been seen through our efforts to restructure the Edinburgh Health and Social Care Partnership (EHSCP). This aims to ensure that our management structure is fit for purpose to deliver high quality services across the city. While we continue to focus on responding to the needs of local areas, we have moved to city-wide management arrangements. This has enabled a greater focus on consistency and quality of services across the city. A second phase of this work, including within the strategic planning directorate, continues into 2025/26. This includes strengthening the Partnership's expertise and resource in planning and quality improvement, among other areas to better deliver the priorities of the EIJB.

We have also continued this year to promote the financial sustainability of the EIJB. Like most of the health and social care sector, we are facing increased demand for services beyond what we have financial resources to manage. This has meant we have had to make difficult decisions to consolidate services to ensure we can continue to meet our statutory requirements and deliver care to our most vulnerable.

In 2024/25 we delivered £43m of savings across 25 savings projects. This significant programme of savings spans the range of services in the organisation. However, given continuing rising demand and costs, we need to go further to ensure that the EIJB can move to a more stable financial footing. This has included a further programme of savings totalling £29m set out for 2025/26.

Over 2024/25, we also undertook public consultations on our new EIJB Strategic Plan 2025-28, approved in June 2025. This plan will run for the next three years and provides a clear and realistic indication of what we believe that we can achieve in each area of the IJB's responsibility over the next three years and how we intend to do it. Our purpose as an IJB remains to provide the best health and social care services that we can with the resources we have available.

In this 2024/25 annual performance report, we outline the progress we have made in continuing to develop and improve our services and our performance against the national health and wellbeing indicators set out by the Scottish Government. Overall,

our performance in 2024/25 is positive, with 9 out of 13 of the measures with an update this year performing in the top half of partnerships. 85% performed better or similar to the Scottish average and 8 out of 13 indicators have seen an improved or steady ranking on benchmarked performance compared to last year, with improvements also seen in other areas.

We would like to thank Pat Togher, who left the role of Chief Officer in December 2024 and Katharina Kasper, who has recently stepped down as Chairperson for the EIJB. Both Pat and Katharina led the EIJB through a financially challenging year while ensuring our performance remained as positive as it is. We are pleased to have Katharina remain on the Board and wish Pat every success in his current role.

Finally, we thank our staff and partners for their continued dedication, commitment and passion in delivering these high-quality services throughout the year.

Councillor Tim Pogson	Christine Laverty
Chair	Chief Officer

Overview

Introduction

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

In June 2025, the EIJB approved a new Strategic Plan following consultation over 2024/25. The plan sets the direction of travel for the EIJB and the work of the Edinburgh Health and Social Care Partnership (EHSCP) for the three financial years running from 1 April 2025 to 31 March 2028

The content in this report covers the financial year April 2024 to March 2025 unless otherwise stated. Therefore the structure continues to relate to the priorities outlined in the previous EIJB Strategic Plan.

Delivery arrangements

The EIJB's role is a strategic planning body which does not directly deliver services, employ staff or hold cash. However, the board retains oversight of service delivery and the in-year budget position as this highlights any issues that need to be accounted for when planning the future delivery of health and social care services.

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

The health and social care services we deliver and commission include:

- carers support services to a subset of the 45,000 and 70,000 adult carers estimated in Edinburgh
- social care assessment and other social work services provided to around 10-12,000 people a year
- care at home services provided to around 8,000 adults and older people over the course of the year
- technology enabled care, such as community alarms, provided to around 9-10,000 people a year
- around 2,000 people supported through learning disability services
- dementia services to support the estimated 8-9,000 people in Edinburgh with dementia
- primary care services including pharmaceutical services, district nursing and General Practice (GP) services and enhanced primary care services across around 70 GP practices

- mental health and wellbeing services and services that support people with substance use problems
- services to prevent admission to and support discharge from hospital, such as hospital at home services, with about 5,000 discharges supported each year
- around 3,500 people supported in care homes and nursing homes across each year
- adult support and protection services, with around 3,000 assessments completed each year.

Core services are those operated by EHSCP. To ensure close links to local communities, our community health and social care services are delivered by locality teams organised around four localities: South East, South West, North East and North West. We continue to have a focus on shaping services that are responsive to the different characteristics and needs of our distinct Edinburgh communities. To ensure that people living in different parts of the city can access the same standard of service, services across all four localities now report into the same Head of Service. There are five Heads of Service covering:

- Assessment and Care Management
- Community Hospitals, Care Homes and Technology
- Home First, Community Rehabilitation and Reablement
- Mental Health, Substance Use and Learning Disabilities
- Primary Care.

Hospital 'set aside' services are acute hospital services which although delegated to the EIJB, are operationally managed by NHS Lothian. Similarly, hosted services are those which are delegated to the EIJB and managed on a pan-Lothian basis. The majority of these are operationally managed outwith EHSCP.

Our major strategic change projects include key pieces of work that were previously part of the transformation programme, including some of those outlined in this report. However, it also focuses on ensuring that services are sustainable in the longer term. To be sustainable, we need to deliver services within our budget, but we also need to address the challenge of increasing demand for health and social care services and ensure that we can continue to attract and retain a skilled and capable workforce.

About Edinburgh and our localities

- Edinburgh is one of the largest health and social care partnerships in Scotland, with an estimated population of 523,250 at mid-2023 (30 June 2023)
- 82,811 residents were aged 65 or over, with this age group projected to increase the most over the coming years[1].
- Edinburgh is also the wealthiest city in Scotland, with 81.8% of the working age population in employment.[2]
- 38.2% of the economically inactive population within the city are students, and 13.6% look after others.[2]
- However, 15% of the population, and as many as 20% of children, live in relative poverty[3].

- This poverty is spread throughout the city, with two thirds of those living in poverty not living in areas described as deprived. The majority of those in poverty are in employment.

An overview of our localities is provided here and our joint strategic needs assessment (JSNA) provides more detail on the population and demographics of Edinburgh.

North East

- 120,844 people live in the North East locality[1]
- 51.2% are female and 48.8% are male[1]
- 14.5% are aged under 18, 72% are 18-64 and 13.4% are over 65[1]
- 20.6% of people lived in the least deprived SIMD quintile, and 18.8% lived in the most deprived quintile[1]
- Life expectancy at birth is 80.3 years for women and 75.8 for men[1]
- 18 GP practices[4]

North West

- 144,233 people live in the North West locality[1]
- 51.9% are female and 48.1% are male[1]
- 19.9% are aged under 18, 61.3% are 18-64 and 18.8% are over 65[1]
- 49.8% of people lived in the least deprived SIMD quintile, and 9.3% lived in the most deprived quintile[1]
- Life expectancy at birth is 83.1 years for women and 79.4 for men[1]
- 18 GP practices[4]

South East

- 138,112 people live in the South East locality[1]
- 53% are female and 47% are male[1]
- 14.8% are aged under 18, 71.8% are 18-64 and 14.8 are over 65[1]
- 49.8% of people lived in the least deprived SIMD quintile, and 8.3% lived in the most deprived quintile[1]
- Life expectancy at birth is 82.4 years for women and 78.3 for men[1]
- 18 GP practices[4]

South West

- 111,381 people live in the South West locality[1]
- 50.1% are female and 49.9% are male[1]
- 17.3% are aged under 18, 65.9% are 18-64 and 16.8% are over 65[1]
- 40.5% of people lived in the least deprived SIMD quintile, and 12.7% lived in the most deprived quintile[1]
- Life expectancy at birth is 82.9 years for women and 78.4 for men[1]
- 16 GP practices[4]

[1] PHS LIST Locality Profiles (February 2025)

[2] NOMIS Official Census and Labour Market Statistics
[3] https://www.edinburghhsc.scot/the-ijb/jsna/poverty/
[4] National Primary Care Clinicians Database (NPCCD), Public Health Scotland (Jan 2025)

Performance overview

In the performance section of this annual performance report, we report progress against the national indicators (NI) set by the Scottish Government and ministerial strategic group (MSG) for health and community care indicators. There are 23 national indicators but four of them (indicators 10, 21, 22 and 23) have not yet been finalised for reporting and one (indicator 20) has not been reported since the pandemic due to data issues. There are also six MSG indicators, but some of the indicators have multiple measures associated with them (identified using letters, eg, MSG 2a/b/c).

There is no update for NI-1 to NI-9 in 2024/2025 as these are results from the Scottish health and care experience survey (HACE survey) which is run every two years. Other indicators have also not had an update for 2024 or 2024/25 yet due to the timing of national data releases.

The table below shows our quartile performance and how our relative ranking has changed for those indicators with an update this year. We remain in the top half of Health and Social Care Partnerships across Scotland for 69% of the indicators (9 out of 13) with an update this year. 8 out of 13 indicators (62%) with trend data this year have seen an improved or steady ranking on benchmarked performance compared to last year, with improvements also seen in other areas. 85% (11 out of 14) of the updated indicators have performed better than, or the same as, the Scottish rate. Our benchmarked performance is shown in the table below, including our quartile position and the change in our ranking compared to last year.

While we have seen a decline in ranking in some indicators this year, there are also indications of positive directions of travel for many of these indicators that we will continue to build on:

- NI-14 and MSG1 Emergency admissions and MSG 2a Emergency bed days (acute) – We remain better than the Scottish average and lower than our rate in 2023/24. The drop in ranking is from the 1st to 2nd lowest for admissions and 4th to 5th for bed days.
- NI-15 End of life – The drop in ranking is by one place, 18th to 19th, and our figure has stayed steady at 89.7%.
- NI-18 Care received at home - The drop in ranking is by one place, 8th to 9th, and our figure has stayed steady around 68%.

	Core indicator	Time period	Quartile	Change in rank from previous year
NI - 12	Emergency admission rate (per 100,000 population)	2024	1	⬇
NI - 13	Emergency bed day rate (per 100,000 population)	2024	1	⬆

	Core indicator	Time period	Quartile	Change in rank from previous year
NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	2024	3	➡
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	2024	3	⬇
NI - 16	Falls rate per 1,000 population aged 65+	2024	2	⬆
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2024/25	2	➡
NI - 18	Percentage of adults with intensive care needs receiving care at home	2024	2	⬇
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	2024/25	3	➡
MSG1	Rate of Emergency Admissions (lowest rate = Quartile 1)	2024	1	⬇
MSG2 a.	Unscheduled Bed Days (Acute):	2024	1	⬇
MSG3 .a	Rate of A&E Attendances (lowest rate = Quartile 1)	2024/25	2	➡
MSG3 .b	4-hour Performance	2024/25	3	⬆
MSG4	Delayed Discharge Bed Days:	2024/25	2	⬆

Source: Public Health Scotland **Notes:** Quartile and trend: The quartile shown denotes which quartile the Edinburgh partnership was in during the time period noted, i.e. quartile 1 being within the best performing 8 HSCPs and quartile 4 being the eight worst performing HSCPs. The arrows indicate the change in Edinburgh's position relative to the other partnerships across Scotland, between the 12-month time period noted and the previous 12 months. Dashes indicate that we do not have previous comparative data for the indicator. Only indicators with an update for 2024 or 2024/25 are included. MSG2b is not included due to data completeness issues. The colours in the quartile column reflect the quartile each measure was in for the latest available time period. Dark green is in quartile 1 or the top 25% of partnerships, light green is in quartile 2, light red is in quartile 3 and dark red is in quartile 4, or the lowest 25% of partnerships.

Strategic priorities

Priority 1: Prevention and early intervention

Investing in effective, evidence-based prevention and early intervention services is the right thing to do for people as it is the best way to avoid harm from occurring and minimises the extent of any harm that does occur. By identifying those people most at risk of poor outcomes and providing effective early support we can prevent problems occurring or minimise the impact on the individual's health and wellbeing.

Long-term conditions

We have a range of initiatives underway across our health and social care teams to improve care for people living with long-term health conditions, and those who are at risk of falls. An improvement project is looking at improving delirium recovery, rehabilitation and frailty prevention and reduction. A multi-agency improvement team are leading this work to deliver the proposed eight quality domains for delirium care across the interface of hospital and community care.

We have also undertaken work across the health and social care system to improve the outcomes of people living in the community at risk of falls. This focuses on taking preventative action to reduce falls and the need for unscheduled care, such as hospital admissions. We have also been developing a new falls prevention and management pathway, including consistent care bundles that correspond directly to falls risk levels.

Prevention of harm

We have a responsibility for adult protection and our Chief Officer sits on the multi-agency Chief Officers Group for Public Protection responsible for all areas of public protection across Edinburgh. This group is supported by the Adult Protection Committee, which saw a new independent chair in post from summer 2024.

Following the inspection into adult support and protection services in Edinburgh published in February 2023, a review of progress was published in November 2024. This follow up concluded that steady and tangible progress was being made in line with the adult protection improvement plan including measures being taken to address gaps in practice and ongoing internal audit work. The report also noted a strengthened social work senior leadership and Adult Protection Committee. These changes quickly strengthened leadership and governance, ensuring significant progress towards consistent, competent, and effective adult support and protection practice in Edinburgh that have kept people safe from harm.

Assistive Technology Enabled Care 24 (ATEC 24)

Assistive Technology Enabled Care 24 (ATEC24) hosts a range of preventative and enabling supports to citizens of Edinburgh, which includes:

- Community alarms
- Telecare
- Sheltered housing
- Assistive living
- Community equipment loan service

These services support vulnerable people living across Edinburgh, East Lothian and Midlothian. The service promotes independent living, aiming to prevent unnecessary hospital admission, facilitate hospital discharge and reduce loneliness and isolation.

The community equipment loan service has supported 61,716 equipment orders and delivered a total of 88,612 items and collected a total of 52,292 items. Over the past year we have focused on improving the service. This has included ensuring the efficiency of routes for deliveries and collections, reviewing stock to maximise use of warehouse space, and targeting the return of high-cost items to reduce further unnecessary purchasing costs.

The assistive living team has visited in the region of 1,200 people, with an average of 93 new requests for assistance every month. The majority have received equipment, minor adaptation(s) and/or advice. Technology practitioners, introduced in 2024, provide specialist advice and training to promote the use of technology enabled care and lifestyle monitoring across the partnership.

We also implemented a new alarm receiving centre and responder app in May 2024. This has maximised the teams' capabilities to monitor alarm calls and respond to people's needs in their own home as efficiently as possible. The service supported a total of 8,500 customers with a service. This support included:

- 1,948 new installations of technology
- 166,528 alarm calls for assistance answered
- 12,149 in-home responses for emergency support.

In addition, the service has changed 1,500 analogue alarms to digital alternatives in people's homes. Nearly all customers are now in receipt of a digital alarm and are connected to our digitally enabled alarm receiving centre.

Over the last year, three interim step-down properties have been available to enable people to be discharged from hospital when they are medically fit to do so but unable to return home due to a housing need. Nine people have benefited from this temporary supported housing service.

We've listened to feedback about how our sheltered housing service is delivered and how we deploy our teams across the city has changed, to ensure people receive a greater level of consistency and support. The service has provided:

- 6,154 housing support visits
- 15,724 proactive wellbeing calls
- facilitated 2030 hours of activities to people living in sheltered housing, assisting them to live as independently and as safe as possible at home.

Priority 2: Tackling inequalities

Health inequalities are systematic, unjust and avoidable differences in the health of people occupying different positions in society. The fundamental causes of health inequalities are an unequal distribution of income, power and wealth which can lead to poverty and the marginalisation of individuals and groups. These fundamental causes also influence the distribution of wider social determinants of health, such as:

- the availability of good quality affordable housing
- green space
- work, education and learning opportunities
- access to services
- and social and cultural opportunities.

These also have strong links to mental and physical health.

EIJB grant programme

The EIJB grants programme was established in 2019 as a three-year programme where 64 third sector organisations were awarded a share of an annual £5 million fund to deliver projects linked to the EIJB's 2019-22 strategic plan, principally, the priorities of prevention and early intervention and tackling inequalities. The programme was due to end in March 2022 but was subsequently extended due to continued disruption resulting from the Covid pandemic. As part of the EIJB's 2024/25 savings plan, the programme's funding was reduced by 10% to £4.5 million.

Overall, the programme demonstrated high user satisfaction and reporting on positive impacts, with activities targeted at disadvantaged communities. The projects addressed factors such as community resilience and improved physical and mental health and wellbeing. All the services were able to demonstrate they were providing useful services to the community and bringing benefit to the city.

However, in light of the continued challenging financial situation of the EIJB, a review of the grants programme was undertaken in 2024/25. This evidenced that the money currently invested in the EIJB grants programme had to be spent on other priorities, with a more focused approach to prevention and a greater emphasis placed on realising a reduction in the need for other services provided by the EIJB

The evidence base illustrated that the types of intervention funded by the grants programme do have a positive preventative effect but that this effect is not large enough to offset the full cost of those preventative interventions. Robust evidence does exist for other types of preventative interventions where the EIJB would be likely to realise a positive return on investment, but these are not funded by the current grants programme.

As a result, the EIJB made the hard decision in December 2024 to conclude the grants programme during 2025/26. An extension of three months to the end of June 2025 was provided to assist recipients with accessing alternative funding or redesigning services.

Recognising the vital role of third sector organisations as part of a wider health and social care system delivering care and support for people in local communities, we are also committed to working with the third sector over the next three financial years to help deliver the priorities set out in the recently approved EIJB Strategic Plan. .

Edinburgh Alcohol and Drug Partnership (EADP)

In 2024-25, key performance indicators related to the EIJB's remit showed improvements, including:

- local services "fully achieved" 9 of the 10 Medication Assisted Treatment Standards including offering same day start of Opiate Replacement Treatment, reaching out to people at acute risk and offering evidence-based psychological interventions
- the number of people from Edinburgh admitted to residential rehabilitation continued to rise: 80 people were admitted in 2024-25, 69 of them at Lothian and Edinburgh Abstinence Project and 11 in other facilities

Progress in other areas of EADP activity which pertain to the EIJB's own area of responsibility include:

- the EADP developed and adopted a new strategy for 2025-28
- the programme of work for "putting the voice of lived and living experience at the heart of EADP decision-making" continued to be implemented
- exploratory and development work for an Edinburgh Drug Checking Service and an Edinburgh Safer Drug Consumption Facility progressed as planned.

Priority 3: Person-centred care

Being person-centred is about focusing care on the needs of the person rather than the needs of the service and working with people to develop appropriate solutions instead of making decisions for them. Person-centred care is a key part of delivering quality health and social care services, alongside ensuring that services are safe, effective and efficient.

Care Inspectorate reviews

We deliver 32 registered adult care services that are subject to inspection by the Care Inspectorate. During 2024/25, 12 inspections took place across nine care services. 88% of services received a grade of 'good' or above across all inspected key questions. 100% of services received at least one grade 4 or above for a key question.

One service, Edinburgh Community Rehabilitation and Support Service, received a grade 6 (excellent) for a key question and was considered sector-leading by the Care Inspectorate.

In care homes, the inspections found that people's health and wellbeing needs were being met, and staff were committed to helping people achieve their best possible outcomes. Improvements in care planning and quality assurance processes should continue to promote better care for people. Improvement plans are in place for those care homes where grades of 3 were awarded so that future grades are in line with high quality of care.

In homecare services, the inspection found that improvements in goal setting and technology were helping people be supported to get the most out of life. Staffing arrangements were found to be working well for people and helping ensure a consistently effective approach to delivering care and support.

In disability services, the inspections found that people's personal outcomes and wellbeing were being improved by the excellent care and support provided. Services continue to focus on quality assurance and quality improvement.

Service	Date of inspection	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 are care and support planned?
Edinburgh Community Rehabilitation and Support Service	04/04/2024	6 – excellent	5 – very good	5 – very good	5 – very good	5 – very good
Firrhill Housing Support and	21/05/2024	4 – good	4 - good	5 – very good	Not assessed	Not assessed

Service	Date of inspection	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 are care and support planned?
Care at Home Service						
Inch View	23/01/2025	3 - adequate	Not assessed	Not assessed	Not assessed	Not assessed
Inch View	23/10/2024	Not assessed	3 - adequate	3 - adequate	Not assessed	Not assessed
Inch View	10/06/2024	2 – weak	2 - weak	2 - weak	4 – good	3 - adequate
Marionville Court	30/07/2024	4 – good	Not assessed	4 - good	Not assessed	Not assessed
North Merchiston	17/10/2024	4 – good	Not assessed	5 – very good	Not assessed	Not assessed
Royston Court	17/01/2025	5 – very good	5 – very good	4 - good	4 - good	4 - good
Royston Court	12/06/2024	3 - adequate	3 - adequate	3 - adequate	Not assessed	Not assessed
South East Hub Services	21/11/2024	4 – good	5 – very good	5 – very good	Not assessed	Not assessed
Support Works: Group Three	14/02/2025	5 – very good	4 - good	5 – very good	Not assessed	5 – very good
Support Works: Group Two	03/02/2025	5 – very good	5 – very good	Not assessed	Not assessed	Not assessed

Joint inspection of adult upport and protection

Adult support and protection cuts across prevention, early intervention and person centred care. As stated above, in November 2024, a review of progress since the joint inspection of adult support and protection was published. The joint review concluded that ‘significant progress’ has been made in four out of the seven priority areas and, in particular, that significant progress has been made in ensuring that ‘there is consistent, competent, effective adult support and protection practice that keeps adults at risk of harm safe and delivers improvements to their health and wellbeing.’

The findings of the joint review of progress are an endorsement of the value and importance of additional professional governance, leadership and assurance within the EHSCP structure which has been enhanced through phase 1 of the management restructure. It is understood from the Care Inspectorate that there is no intention to follow up on the Inspection of Social Work and Social Care.

The weaknesses outlined in the 2023 inspections remain a focus of improvement for the Health and Social Care Partnership and have therefore been embedded in the EIJB Strategic Plan and Clinical and Care Governance Framework.

One Edinburgh: Home-based care

Approved by EIJB in September 2023, the One Edinburgh programme represents a strategic change in the delivery of home-based care for the people of Edinburgh. Our ambition is to enable people to remain independent at home for as long as possible and to use capacity within the health and social care system in the right place, at the right time.

In 2024/25, we delivered enhanced and therapy-led reablement training to our internal workforce. Our internal care at home teams will now provide high quality, short-term reablement interventions to people who have been identified as potentially requiring care at home support.

Reablement is a short-term service that helps people to do as much as possible for themselves at home. We work with people to identify the right level of support to allow them to keep living safely at home. People can receive reablement for a few days, or a few weeks and together we agree goals and outcomes that are important to the individual. At the end of reablement we should be confident about any ongoing or longer-term care needs. Ongoing care will be commissioned through our partner care providers.

We have worked closely with care at home providers across the city since EIJB approval to procure a new framework in October 2023. The One Edinburgh framework started on 1 June 2025. The framework will allow us to benefit from a stronger, more robust, stable and resilient cohort of partner providers, alongside a single sustainable rate for care at home services in the community.

Priority 4: Managing our resources effectively

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

Financial management and performance

Financial information is a key element of our governance framework. Each year we produce a financial plan which sets out how we ensure our limited resources are targeted to support delivery of our strategic plan. At its meeting in March 2024, the EIJB agreed the medium-term financial strategy.

Regular updates on financial performance against this plan and progress with the savings and recovery programme were provided to the Performance and Delivery Committee as well as to the EIJB itself.

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

	Budget £m	Actual £m	Variance £m
Assessment and care management	111	108	2
Directorate, strategic planning and PSWO	56	52	5
Home first, community rehabilitation and reablement	105	106	(0)
Hospitals, care homes and technology	55	54	1
Mental health, substance use and learning disabilities	162	163	(1)
Primary care	237	242	(6)
Sub total core services	**726**	**725**	**1**
Hospital 'set aside' services	104	107	(2)
Services hosted by other partnerships/NHS Lothian	118	116	2
Reimbursement of independent contractors	78	78	0
Total all delegated services	**1,026**	**1,026**	**(0)**

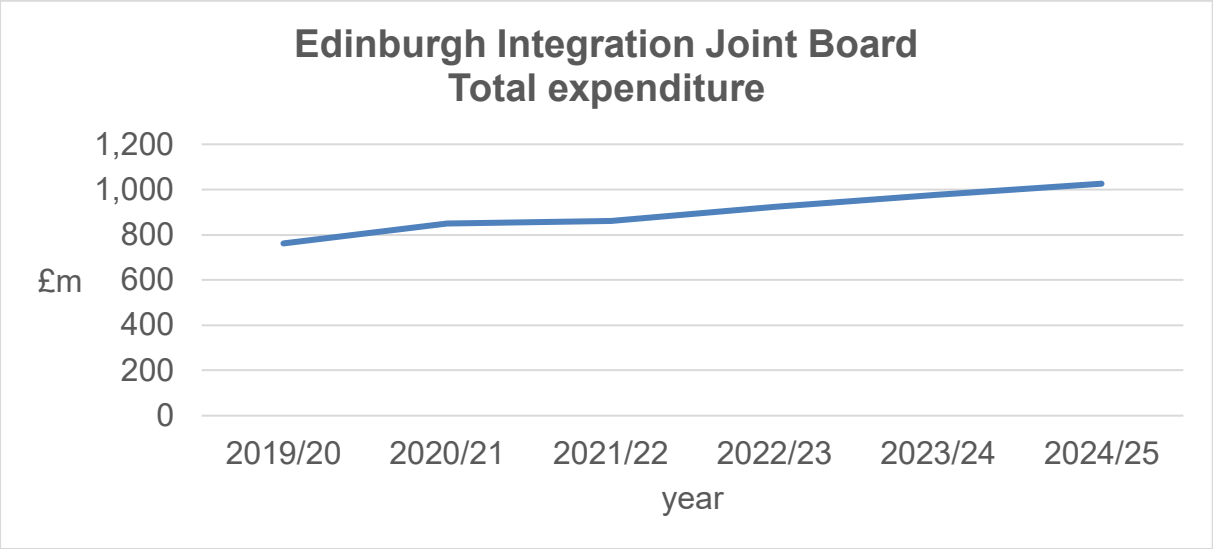
Variance within individual services was driven by slippage in savings delivery offset by underspends in employee costs as a result of vacancies. However, following additional one-off investment from partners, a break-even position was reported against the budget for the year. Additional funding received from partners (£14m from the Council and £2m from NHS Lothian) has been allocated against the key financial pressures in the table above.

Whilst this is clearly a positive outcome, as in previous years we relied on one-off measures to achieve balance. The underlying deficit remains and, indeed, increases when we moved into 2025/26. This is predominantly due to increasing growth in

costs linked to inflation and demographic growth, including increasing complexity of care needs as the population ages.

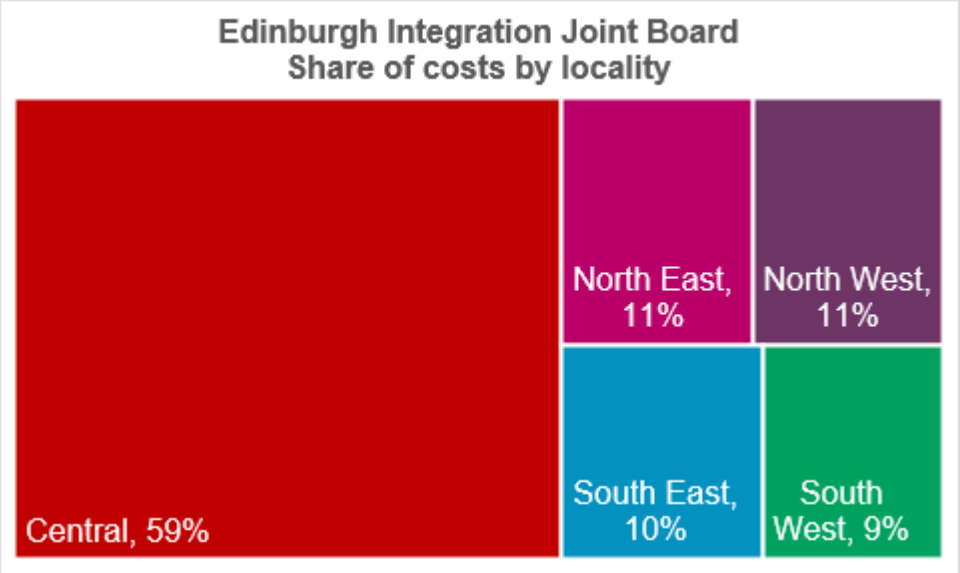
Our medium-term financial strategy begins to set out what a path to financial sustainability could look like and this will continue to be developed in parallel with the new Strategic Plan 2025-28.

The chart below shows how our costs have changed over the last five financial years.



	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m	2023/24 £m	2024/25 £m
Total expenditure	762	849	862	923	978	1,026

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



Savings and recovery programme

The savings and recovery programme was developed as part of the medium-term financial strategy for the EIJB. This aims to provide a structured approach to reaching financial balance and sustainability through delivery of a multi-year programme of change and efficiency.

The 2024/25 programme had an ambitious in-year target of £47.85 million to be delivered via 25 projects. The programme was managed via the Savings Governance Board, which meets monthly chaired by the Chief Officer. In total, the programme achieved a total in-year saving of £42.65 million, or 89% of the target.

Fifteen of the 25 projects delivered in full. Of these, five projects realised significant additional savings in excess of their original targets (hosted and set aside, spot purchasing, gross funding, supplementary staffing and budget control). A further three projects delivered over 50% of their savings targets (interface with hospital, maximising income and community equipment). In each of these projects, in-year scoping showed that the original target could not be achieved and measures were sought to address the imbalance, delivering additional savings where possible, with partial success.

Priority 5: Making best use of capacity across the system

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

Workforce strategy

'Working Together', published in July 2022, is the EIJB's workforce strategy (2022-25). It was developed to support the delivery of a skilled and capable workforce that can deliver on our strategic priorities and meet the health and social care needs of the citizens of Edinburgh. Delivery of the workforce strategy is overseen by the EHSCP Workforce Board.

Over the last year, the Workforce Board has overseen crucial initiatives linked to the key strategic priorities of the workforce strategy. As part of the 2023-24 pay agreement for Agenda for Change staff in NHS Scotland, a review of the system led to a reduction in the standard working week from 37.5 to 37 hours (pro rata for part-time staff) in 2024/25. This change applied only to those on NHS terms and conditions. A second phase will further reduce the working week to 36 hours from 1 April 2026.

The Health and Care (Staffing) (Scotland) Act 2019 provides a legal framework to ensure appropriate staffing levels in health and care services, aiming to support safe, high-quality care and improved outcomes. It came in to force on 1 April 2024 and in response, professional and service leads have established governance and reporting systems. This has included detailed position statements that track progress, highlight risks, and outline escalation procedures.

Our workforce strategy is now due for renewal. This is important as we need to acknowledge the ever-changing context at national, regional and local levels and the impact this has on our strategic planning and priorities. To support the delivery of our strategic plan, it is essential that the development of our updated workforce strategy is closely aligned with both service and financial planning, ensuring a fully integrated approach.

Restructure

To successfully deliver the ambitions outlined in the strategic plan, it is essential that we build firm foundations and infrastructure for the partnership. This includes ensuring the optimum organisational staffing structure for our teams and services.

During 2024/25, a new organisational management structure was agreed and implemented for operational services within the partnership. This saw a move away from the previous focus on a locality management model, with the introduction of

new Head of Service roles with city-wide responsibility for specific aspects of service delivery.

The new model has enabled greater consistency across our services, with single lines of accountability ensuring absolute clarity of decision-making and providing the best possible foundation for the delivery of the ambitions set out in the new strategic plan. While services are managed across the city, there remains a focus on services being focused on the communities they serve. Budgets have been realigned to the new Head of Service areas, meaning that financial accountability has also been strengthened.

In 2025/26, the second phase of this work will continue with the restructure of the strategy division and the next level of operations.

Supporting carers

Progress for unpaid carers over 2024/25 included the extended roll out of adult carer support plans with wider provider partners since July 2023, further enhancing performance. We also improved our performance reporting against carer outcomes, with the co-production, development, testing and full utilisation of an outcome framework, and considerations about how the new City of Edinburgh Council case management system will further enhance carer information.

A review of the role of the Carer Strategic Partnership Group has taken place, to now provide a specific strategic focus. Operational implementation and quality assurance oversight, alongside contract monitoring and reporting is being taken forward separately to allow specific focus on these areas. We commenced a comprehensive review of unpaid carer commissions to inform priorities for commission from April 2027 onwards.

We have also continued to enhance our internal carers support team. This team focuses on supporting unpaid carers in Edinburgh with hospital discharge, adult carer support plans and information and advice. Referrals for hospital discharge carer support have increased by 58% in the past year as this team has grown capacity and continued to embed and promote the support available within hospitals.

Primary care (general medical services)

Primary care in Edinburgh is as busy as ever, with GPs and practice nurses delivering around 3 million patient appointments last year. An additional 12,000 patients have been registered with medical practices, highlighting the ever-growing Edinburgh population.

With the increasing Edinburgh population, pressure remains on medical practices already working at capacity. Continued access to appropriate care for the people of Edinburgh is our priority and all practices are working exceptionally hard to maintain this despite the pressure on resources. Practices are supported by our multi-disciplinary workforce which delivered over 400,000 appointments last year. Our

vaccination teams continue to support the health of people in Edinburgh and delivered approximately 338,000 vaccinations across the year.

A new purpose-built medical surgery opened at Maybury in January 2025 to serve the ever-growing population in the North-West of the city and a South East practice was successfully moved to a new site from outdated premises. Work continues on the development of practice premises as part of the new Liberton High School, and we continue to explore other solutions to help maintain access to primary care services across the city.

The government funded Primary Care Phased Investment Programme (PCIP) which Edinburgh successfully bid for has been underway since April 2024. Funding focussed on the South-East of the city is providing the opportunity to test how an increase in multi-disciplinary teams and service delivery impacts on medical practice workload and capacity, with the overarching aim of evaluating what fuller PCIP implementation could look like.

Digital and data strategy

In February 2025, our new EIJB digital and data strategy was approved. This is a 3-year strategy, covering the period from 2025 – 2028. The strategy has been developed in direct alignment with the development of the EIJB Strategic Plan, including the phased timescales which reflect the wider strategic digital and data transformation requirements.

We live in a digital world, and it is changing the way we work and provide services. We must change the way we think about, plan, and deliver services. Good health and social care relies on strong human relationships. Digital technology cannot replace those but can enhance them by transforming how we enable people to monitor and manage their own health, and how we connect and support people to access information and services. It can also help us capture and bring together information about people who use our services in a way that can help us plan and deliver them more effectively.

The digital and data strategy aims to articulate the ambitions and priorities of the EIJB in relation to digital and data. We are reliant upon the support of our partners to deliver on this and need to operate within the strategies and plans set out by our partners for related services such as IT, business intelligence, and information governance. We are therefore taking a partnership approach to delivery of this strategy to meet the needs of people accessing health and social care in Edinburgh and the workforce providing it.

It is critical that while we build on services offered digitally, we consider those who are digitally excluded due to a lack of access, skills, and capabilities. The digital and data strategy aims to promote digital inclusion by addressing the barriers to opportunity, access, knowledge, and skills in using technology.

The new EHSCP Digital and Data Board and developing governance structure will work with partners to promote best use of digital technology and data available across the system and monitor our delivery against the strategy.

Priority 6: Right care, right place, right time

We want to ensure people are supported to live as independently as possible. We are committed to ensuring people are supported at home and within their communities whenever possible and are admitted to and stay in hospital only when clinically necessary.

Mental health and wellbeing

The organisational review of our operational teams has provided new leadership to, and a renewed focus on, our mental health services. We are continuing to restructure the service to ensure that we have the management capacity needed to drive change and improvement across these services, while maintaining the valuable services currently delivered by our teams.

There continues to be issues with capacity at the Royal Edinburgh Hospital, with too many people with mental illness staying in hospital longer than they need to. We have been working with colleagues across NHS Lothian to identify areas for improvement to support appropriate use of capacity across hospital and community services. Over the past year we have seen some progress in reducing the amount of delayed discharges in the Royal Edinburgh Hospital, with occupied bed days due to health and social care delays for Edinburgh residents reducing by 7% this financial year compared to 2023/24.

To support this, we are reviewing capacity and delivery arrangements within our internally delivered services, including our community mental health teams (CMHT) and thrive welcome teams. We are also contributing to pan-Lothian work on mental health including benchmarking of CMHT capacity and work on neurodiversity assessment times. This aims to promote the strengths of these teams while ensuring they continue to have sufficient capacity to meet demand.

Alongside a wider review of our contracted services, we are also reviewing the services we commission to support people with their mental health. Given the financial challenges the EIJB is facing, we need to ensure that we are targeting our early intervention and prevention resources on the areas that have the most evidence of reducing further care needs in the system. This may mean tough decisions to disinvest in some services to allow us to target our limited resources to support our most vulnerable residents.

Unscheduled care

In December 2024, the EIJB agreed to accept additional funding from Scottish Government to reduce the number of people in hospital (and particularly people delayed in their discharge from hospital) and to improve unscheduled care performance. This funded three new improvement initiatives:

1. enhanced care at home
2. enhanced community rehabilitation

3. end of life care beds.

Good progress has been made with the implementation of enhanced care at home. All day-time hours from appropriate internally provided care packages have now transferred from EHSCP to external providers. This has enabled us to accelerate the expansion of the city-wide reablement service. The transition of internally provided overnight care hours to external providers continued into 2025/26. Once complete, our teams will be able to provide a responsive and reablement-orientated care service to support people at times of crisis and throughout their recovery across the 24 hour period. This will help to avoid unnecessary admissions to hospital and support people to return home from hospital more quickly.

Recruitment to the new enhanced rehabilitation service is progressing well, with appointments to the service manager and clinical lead roles. This service is on track to launch in summer 2025, following further recruitment to the team. The original plan to commission end of life care beds in external care homes has been amended due to increased costs of the original proposal. This funding will now contribute towards a larger reform of palliative and end of life provision across the city to support more people to die comfortably at home or in a homely setting.

These initiatives have already resulted in an improvement in unscheduled care performance although there is still work to do. The number of Edinburgh residents delayed in their discharge from hospital has reduced by 17% in the Royal Infirmary of Edinburgh (RIE) and 32% in the Western General Hospital (WGH). Bed occupancy across both acute sites has also reduced by 4% and the number of people experiencing a long wait of over 12 hours in the emergency department has reduced by 94%. Performance against the 4-hour access standard at the RIE has improved from the baseline of around 44% but is highly variable ranging from 55% to 84% between days. Performance is expected to continue to improve as additional initiatives become operational.

Home first

As part of our focus on home first, we support people to be discharged home from hospital as early as possible. Our discharge without delay (DwD) programme focused on the development and testing of a Lothian DwD framework. Collaborative working achieved a 50% improvement in occupied bed days for delayed discharge patients across two medicine of the elderly wards at the WGH. The median length of stay was approximately nine days shorter compared to the same period the previous year.

We have also supported the wider implementation of planned date of discharge (PDD), an approach to discharge planning which starts at admission and works towards a specific date when the patient is expected to leave hospital. We contributed to the development of a new PDD functionality within the patient management system, which launched in March 2025.

The partnership between WGH and Edinburgh received recognition at the NHS Scotland national event in June 2024, illustrating the tangible benefits of effective collaborative working. Early supportive discharge (ESD), which includes support for complex discharge planning, has remained a priority for the home first in-reach team over the past year. At the RIE, the introduction of therapists to support people into and out of hospital has strengthened existing discharge pathways, contributing to hospital flow and reducing length of stay.

We also continued to embed our existing home first services. The discharge to assess (D2A) service remains a well-utilised pathway, with 3,052 referrals received between March 2024 and March 2025. The hospital to home (H2H) team plays a critical role in both the prevention of hospital admissions for patients in crisis or at the end of life, and in supporting timely discharge. Between 1 April 2024 and 31 March 2025, the team supported 372 people with their discharge and prevented 120 admissions, benefiting a total of 492 people. This represents an increase of 189 patients from the previous year, equating to approximately 2,289 bed days saved, which is 258 more than the prior year.

A single point of access via the flow navigation centre continues to provide a professional, coordinated response to urgent therapy and urgent care referrals. This pathway supported 302 referrals during 2024/25, avoiding attendance at hospital for 84% of people. 16% required medical treatment only available within a hospital setting.

The establishment of a frailty team in the emergency department has contributed to increased referrals to hospital at home (H@H) services. Additional investment in 2024/25 enabled expansion of nursing capacity, resulting in a 15% increase in patients supported—from 170 in March 2024 to 202 in March 2025. The team maintains close collaboration with front-door frailty teams at RIE and WGH, as well as with the Scottish Ambulance Service, palliative care, and community services to support alternatives to admission where appropriate.

The Edinburgh community respiratory team provided 12,670 clinical contacts in 2024/25, with a primary focus on preventing hospital admissions for individuals living with chronic obstructive pulmonary disease. An additional £60,000 in funding was secured to enhance staffing capacity during winter, including increased weekday and weekend coverage. This contributed to a 6% increase in clinical contacts during the year.

Older people’s pathway

The older people’s pathway (OPP) is reviewing community hospital and care home services in Edinburgh. To support the closure of Liberton Hospital at the end of 2025, the programme is leading work to ensure the care currently provided at this site is reprovisioned across other sites and services. As part of the mitigations for hospital bed closures, additional capacity in our internal care homes has been secured and a phased admission plan is underway.

Alongside the ward reconfiguration projects, the programme is now focusing on developing and improving pathways for people with complex, frail, end of life and palliative care needs across the city. This large programme of work seeks to enhance the availability of care in the community or community settings for these cohorts of patients with a view to preventing hospital admissions and supporting people to be cared for at home or in a homely setting.

Performance

National indicators

There are 23 indicators but four of them (indicators 10, 21, 22 and 23) have not yet been finalised for reporting and one (indicator 20) has not been reported since the pandemic due to data issues. National indicators (NI) 1 to 9 are based on the Scottish health and care experience survey (HACE) commissioned by the Scottish Government. The primary source of data for indicators 12 through 16 are Scottish morbidity records (SMRs), which are nationally collected discharge-based hospital records. For these indicators, calendar year 2024 is used as a proxy for 2024/25 due to the national data for 2024/25 being incomplete. We have done this following guidance issued by Public Health Scotland which was communicated to all health and social care partnerships. Using more complete calendar year data for 2024 should improve the consistency of reporting between health and social care partnerships.

Health and care experience survey indicators

National indicators (NI) 1 to 9 are based on the Scottish health and care experience survey (HACE) commissioned by the Scottish Government and sent randomly to around 5% of the Scottish population every two years. The latest update was received in July 2024 for the results of the 2023/24 survey. Results for indicators 2, 3, 4, 5, 7 and 9 for 2023/24 are not comparable to previous years due to changes in survey wording so previous years have not been reported here.

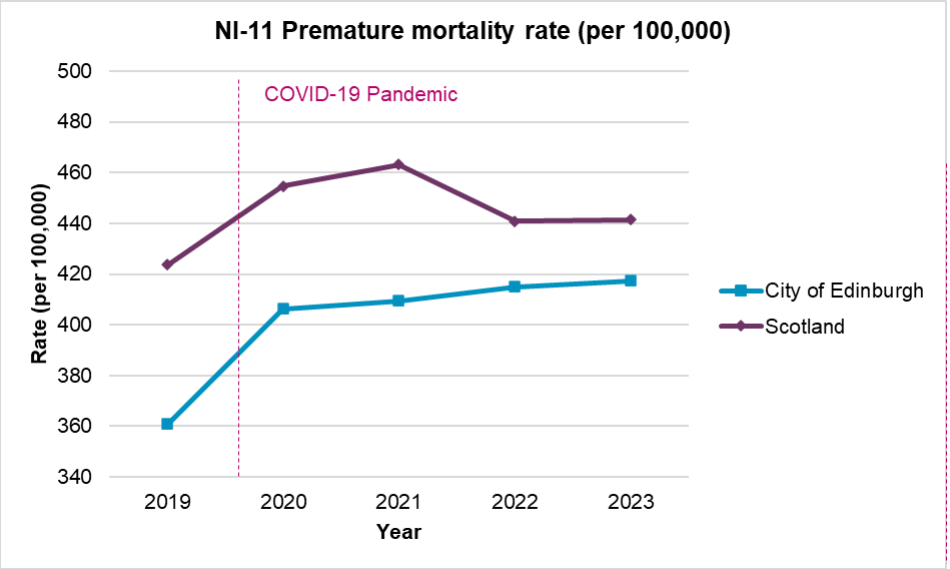
For those that are comparable, we have improved slightly on our 2021/22 results, though performance continues to be lower than the last pre-pandemic survey in 2019/20. The Edinburgh result was higher than the Scotland result in all but one of the indicators. Edinburgh performed slightly worse than the national figure on NI3: Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided, at 57.2% compared to 59.6% for Scotland.

National Indicator (NI)		2023/24*		2021/22*		2019/20*	
		City of Edinburgh	Scotland	City of Edinburgh	Scotland	City of Edinburgh	Scotland
NI-1	Percentage of adults able to look after their health very well or quite well	91.9%	90.7%	91.6%	90.9%	93.8%	92.9%
NI-2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	75.2%	72.4%				
NI-3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	57.2%	59.6%				
NI-4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	63.1%	61.4%				
NI-5	Total percentage of adults receiving any care or support who rated it as excellent or good	74.1%	70.0%				
NI-6	Percentage of people with a positive experience of the care provided by their GP practice	75.1%	68.5%	73.8%	66.5%	82.5%	78.7%
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	72.0%	69.8%				
NI-8	Total combined % carers who feel supported to continue in their caring role	31.3%	31.2%	30.4%	29.7%	33.0%	34.3%
NI-9	Percentage of adults supported at home who agreed they felt safe	78.6%	72.7%				

Source: Scottish Government HACE surveys *Please note results for indicators 2, 3, 4, 5, 7 and 9 for 2023/24 are not comparable to previous years due to changes in survey wording.

Indicator 11: Premature mortality rate

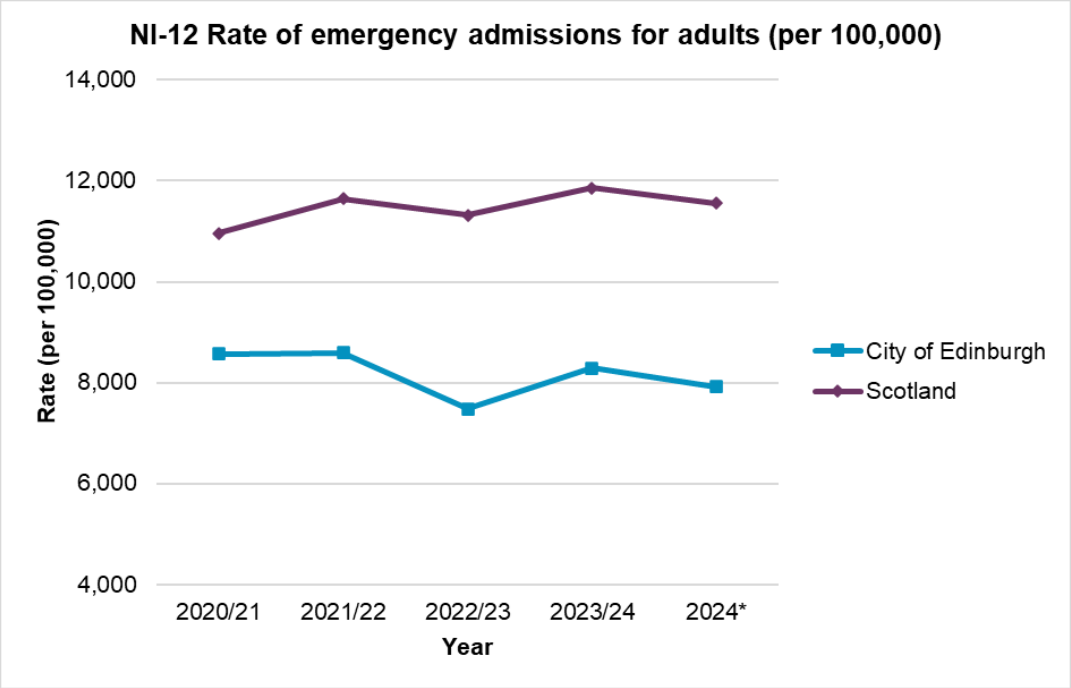
Premature mortality refers to deaths under the age of 75. At the time of approval, 2024 data for national indicator 11 has not yet been published by the National Records of Scotland (NRS) therefore we are unable to report the updated data here. Based on the 2023 data, while we remain below the Scottish rate, the rate of premature mortality in Edinburgh continues to remain higher than the levels seen before the pandemic. Edinburgh remains in the top 50% of partnerships but moved from being ranked 14th to 16th out of the 32 areas. The increase in the premature mortality rate has slowed though, with only a 0.6% increase between 2022 and 2023, representing a small number of additional deaths.



	2019	2020	2021	2022	2023
City of Edinburgh	361	406	410	415	417
Scotland	424	455	463	441	442

Indicator 12: Rate of emergency admissions for adults

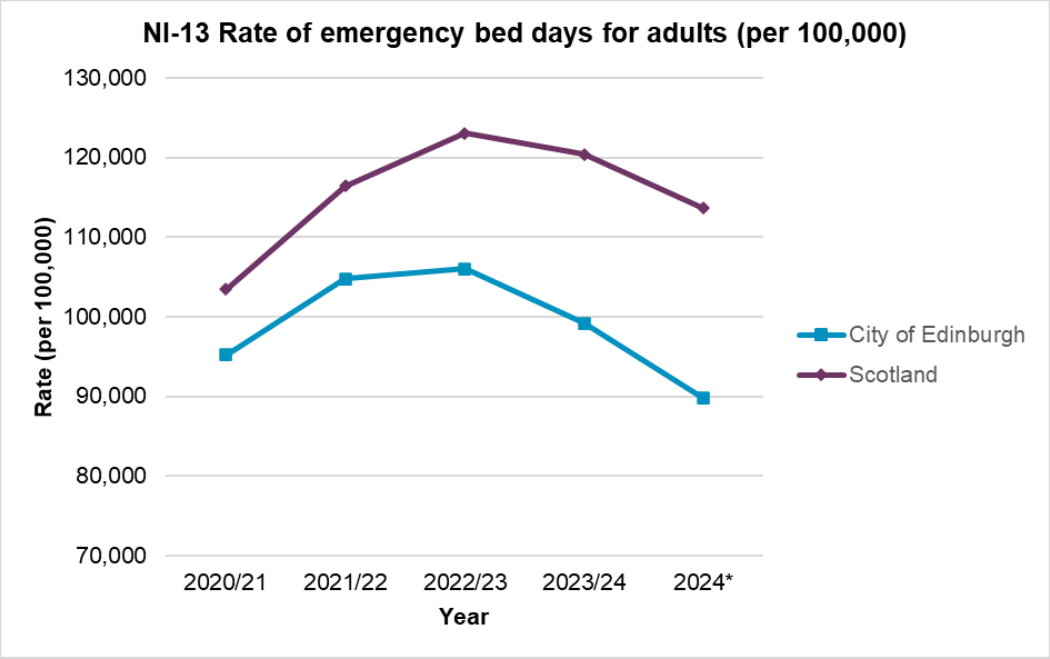
Edinburgh has the second lowest rate of emergency admissions in Scotland. The rate has decreased slightly from 2023/24 into 2024. Admissions can be linked to increased flow through the hospital system, including improvements in A&E 4-hour performance. In Edinburgh this has improved since January 2025 due to our unscheduled care programme outlined earlier, therefore the 2024 data presented here may not be reflective of activity across the whole financial year. The rate of emergency admissions varies across our localities, but all are below the national rate, as shown in the table below the chart.



	2020/21	2021/22	2022/23	2023/24	2024*
City of Edinburgh	8,567	8,593	7,483	8,291	7,916
Scotland	10,965	11,645	11,318	11,857	11,559
North East	9,138	8,905	7,620	8,775	8,416
North West	9,288	9,279	8,526	8,914	8,769
South East	7,066	7,369	6,175	6,972	6,483
South West	8,957	8,917	7,717	8,676	8,136

Indicator 13: Rate of emergency bed days for adults

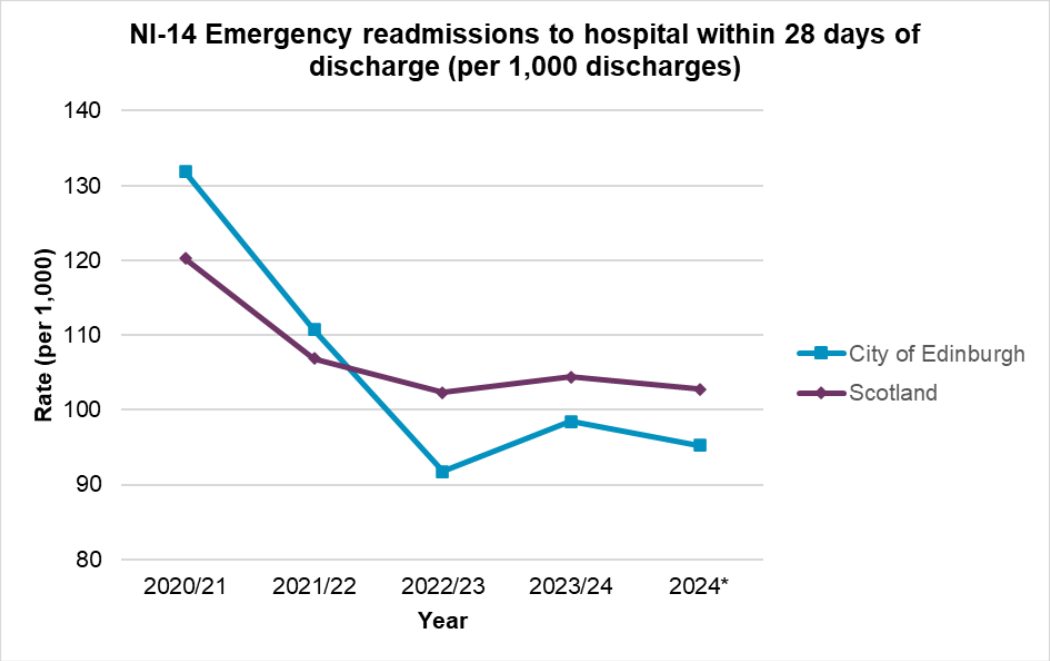
Edinburgh has the sixth lowest rate in Scotland and the rate is the lowest it has ever been. Bed days have dropped more sharply than emergency admissions shown in indicator 12, suggesting we continue to improve on length of stay in hospital. This is supported by initiatives such as early supported discharges and planned date of discharge, described in the home first section above. As with emergency hospital admissions, performance varies across our localities depending on demographics, but remains below the national rate in all areas, as shown in the table below the chart.



	2020/21	2021/22	2022/23	2023/24	2024*
City of Edinburgh	95,184	104,797	106,041	99,148	89,765
Scotland	103,433	116,389	123,061	120,407	113,627
North East	91,415	101,273	103,680	102,453	93,232
North West	97,025	108,236	108,537	99,671	92,304
South East	101,089	105,491	108,699	97,554	84,716
South West	89,427	103,517	102,105	96,857	89,251

Indicator 14: Readmissions to hospital within 28 days of discharge

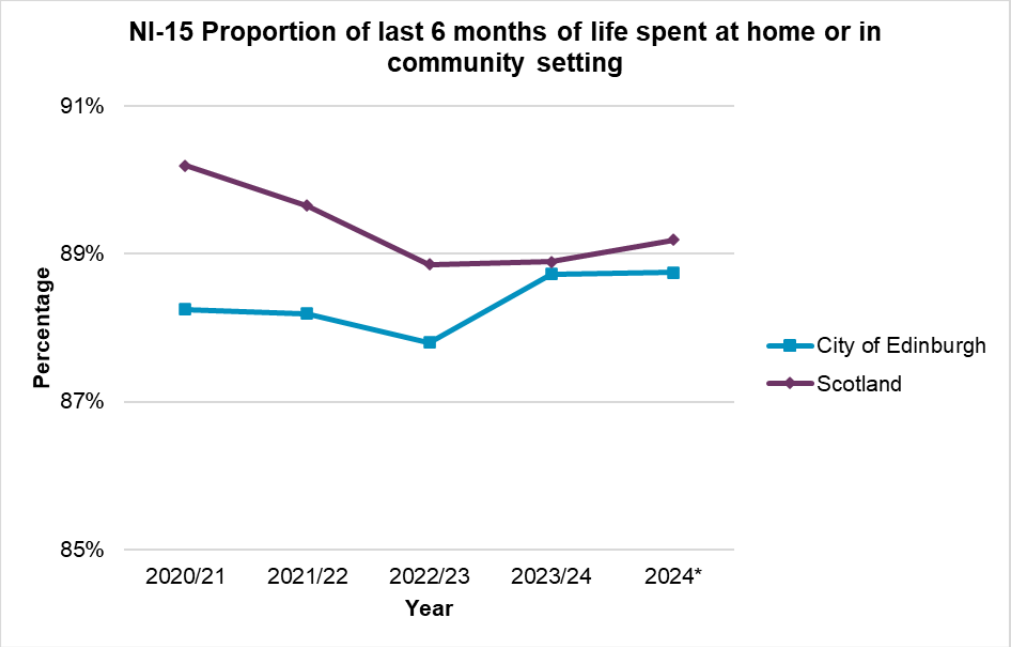
Edinburgh has decreased slightly in the rate of emergency re-admissions to hospital within 28 days of discharge in 2024. We also remain below the Scottish rate and are ranked 17th overall. While there has been a large drop in readmissions since 2020/21, further analysis undertaken by the local intelligence support team (LIST) at Public Health Scotland suggested this was due to a change in admissions practice for those requiring admission for less than a day. When the admissions through this route are removed, the readmissions rate in Edinburgh is steady over the past five years, suggesting that there has not been a wider trend in readmissions or a change in the needs of the population. The breakdown of this measure by locality is also shown in the table below the chart.



	2020/21	2021/22	2022/23	2023/24	2024*
City of Edinburgh	132	111	92	98	95
Scotland	120	107	102	104	103
North East	134	113	94	104	100
North West	137	110	93	94	93
South East	119	104	86	100	93
South West	135	117	95	97	95

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

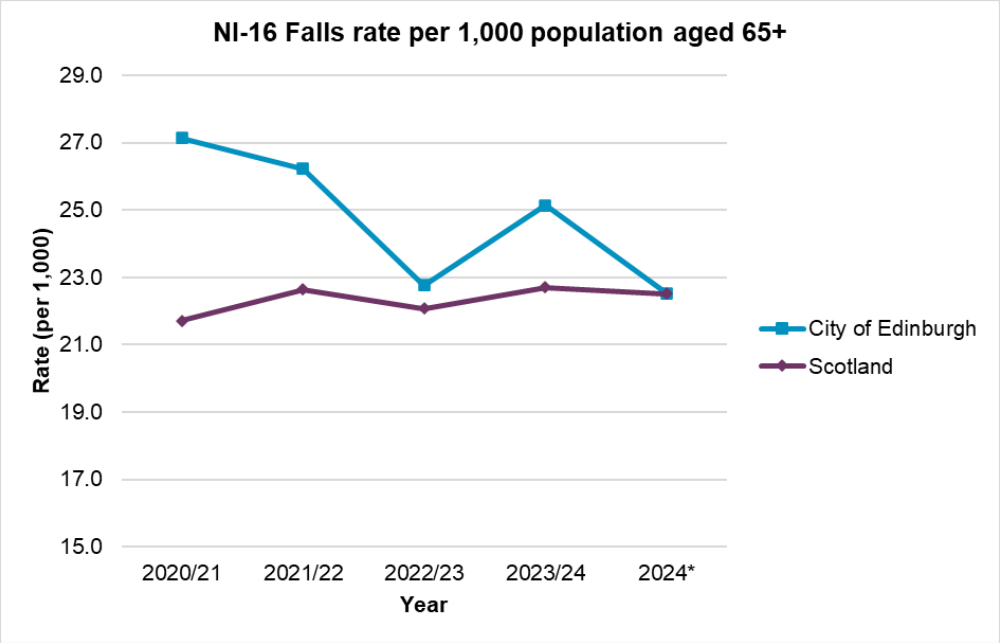
The Edinburgh rate has stayed steady over the last year and remains below the Scottish rate. Edinburgh is ranked 19th in Scotland on this measure. As outlined in the section on our older people's pathway programme, our work to reprovision care from the Liberton Hospital site is also reviewing our community hospital and care home services in Edinburgh. This large programme of work seeks to enhance the availability of care in the community for people with complex, frail, end of life and palliative care needs. This aims to prevent hospital admissions and support people to be cared for at home or in a homely setting, including at the end of life. The breakdown of this measure by locality is also shown in the table below the chart.



	2020/21	2021/22	2022/23	2023/24	2024*
City of Edinburgh	88%	88%	88%	89%	89%
Scotland	90%	90%	89%	89%	89%
North East	88%	88%	88%	89%	89%
North West	87%	88%	87%	89%	88%
South East	89%	89%	88%	89%	89%
South West	89%	89%	88%	88%	89%

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

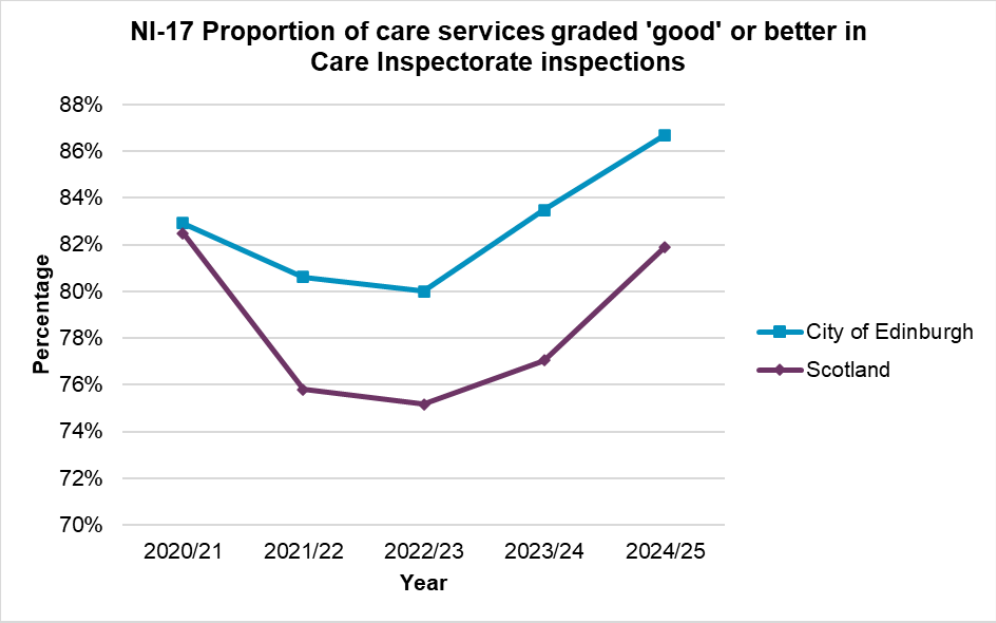
Edinburgh saw a drop in the rate of emergency admissions for falls in 2024 and it is now in line with the Scottish rate. With a rate of 22.5 per 1,000 over 65's in 2024, Edinburgh ranks 16th out of all the partnerships, an improvement from 26th in 2023/24. The breakdown of this measure by locality is also shown in the table below the chart.



	2020/21	2021/22	2022/23	2023/24	2024*
City of Edinburgh	27	26	23	25	23
Scotland	22	23	22	23	23
North East	28	28	23	29	24
North West	29	27	23	22	23
South East	27	26	24	25	21
South West	24	24	21	25	21

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

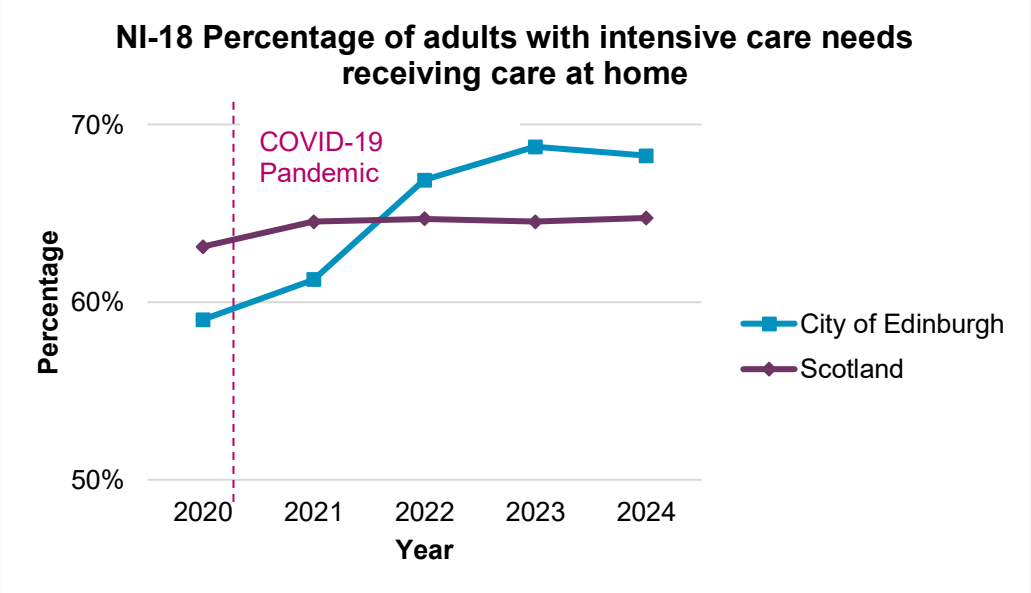
The data for NI-17 comes from the Care Inspectorate and covers all registered services in Edinburgh, not just those run directly by EHSCP. The figure covers the latest inspection result for each registered service, even if the inspection took place before the referenced financial year. 2024/25 is the highest rate in the last five years at 86.7%, 5 percentage points above the figure for Scotland as a whole.



	2020/21	2021/22	2022/23	2023/24	2024/25
City of Edinburgh	83%	81%	80%	83%	87%
Scotland	82%	76%	75%	77%	82%

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

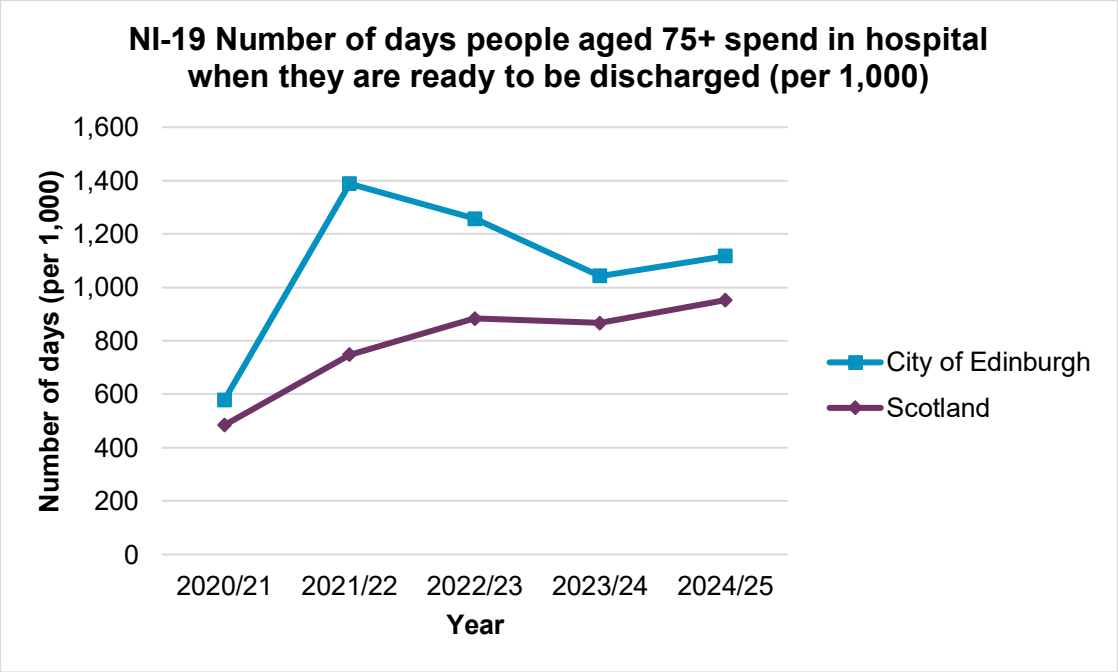
The percentage of adults receiving personal care at home, rather than in residential care or hospital based complex clinical care (HBCCC), has stayed steady from 2023, though we remain higher than the Scottish average. Our ranking compared to other partnerships is 9th out of 32 partnerships, maintaining the second quartile position.



	2020	2021	2022	2023	2024
City of Edinburgh	59.0%	61.3%	66.9%	68.7%	68.2%
Scotland	63.1%	64.5%	64.7%	64.5%	64.7%

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

In 2024/25, the delay rate in Edinburgh had a slight increase on 2023/24, though we remained ranked at 23rd nationally, as Scotland as a whole also saw an increase. We continue to see substantial improvement in delay levels and our full year rate hides significant progress made over the last quarter of 2024/25. For example, the number of bed days occupied by people in delay for a health and social care reason in March 2025 was 19% lower than in March 2024. Through our unscheduled care programme outlined earlier, we are continuing to have a focus on reducing bed days associated with delayed discharges.



	2020/21	2021/22	2022/23	2023/24	2024/25
City of Edinburgh	579	1,388	1,257	1,043	1,117
Scotland	484	748	883	867	952

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

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

Ministerial strategic group indicators

We also report on the performance indicators set by the ministerial strategic group for health and community care (MSG). These performance indicators give a view of how HSCPs are progressing against a range of whole system level measures. The performance indicators are largely based on hospital sector data due to routine availability of national data. While similar to some of the core indicators, these figures are calculated in slightly different ways so are not comparable.

Since the 2017/18 baseline was set, all our indicators have moved in the desired direction, though not all of these have moved to the extent that we would like to ensure we maintain flow through the hospital system. This remains a focus of our ongoing improvement initiatives.

Indicator	2017/18 Baseline total	Desired direction of travel	Latest available figures	Achieved Direction of travel	Latest Period
1. Unplanned admissions	35,597	↓	33,465	↓	2024
2a. Emergency occupied bed days: Acute	330,759	↓	282,723	↓	2024
2b. Emergency occupied bed days: Geriatric Long Stay^	22,324	↓	22,082^	↓	2024
2c. Emergency occupied bed days: Mental Health	122,841	↓	112,117p	↓	2023/24
3a. A&E attendances	103,986	↓	103,332	↓	2024/25
4. Delayed Discharges	76,933	↓	61,441	↓	2024/25
5. Last 6 months of life spent in a community setting	85.7%	↑	88.7%p	↑	2024
6. Balance of Care: at home#	95.6%*	↑	99.7%	↑	2023/24

^ Geriatric long stay unscheduled occupied bed days data is affected by SMR completeness issue.
p This data is provisional.
This indicator is still under development and may change in future releases.
* The Balance of Care 2017/18 baseline figure has been updated since it was last published.

Looking ahead

Our focus over 2025/26 will be on developing and delivering upon implementation plans against the EIJB Strategic Plan 2025-28, approved in June 2025. These implementation plans will be organised around our seven service portfolios, with a Portfolio Board set up for each area. Progress and performance of these portfolios will be monitored through the Strategic Plan Delivery Oversight Board and reported to the EIJB and committees.

We will also deliver on our budget savings programme agreed by the EIJB in March 2025. These initiatives will support us to work towards financial sustainability by cutting the structural deficit in a manageable way. While many of these initiatives are also focused around performance and service improvements, our tight financial situation may mean that we maintain rather than continue to improve upon our performance against the core indicators, as we balance the financial challenges we face with our performance ambitions.

Some of the key strategic change projects we will be progressing in 2025/26 are a redesign of our mental health pathways, working closely with our colleagues across NHS Lothian, and the development of a standard assessment tool which can be used at any entry point to the system which consistently determines the most appropriate service for an individual's needs. We will also be implementing the EIJB digital and data strategy, approved in February 2025 and implementing a new case management system that will cover our adult social care work.

We will continue to engage with, and respond to, work undertaken by our partners in the wider health and social care landscape. We will carefully consider how we can use these developments to enhance person-centred care and support to our staff and service users. Innovation and sustainability will remain central to our thinking and underpin our desire to foster a culture of continuous improvement.