Edinburgh Integration Joint Board

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Annual Performance Report 2025/26

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Foreword

It has been a year of significant change and progress for the Edinburgh Integration Joint Board and the Edinburgh Health and Social Care Partnership.

In June 2025, we approved our new strategic plan for 2025 to 2028. This sets out our shared ambitions for the next three years. Our purpose remains clear – to provide the best health and social care we can for the people of Edinburgh with the resources available to us. In the first year of our plan, we are making progress across our main aims, with 75% of our measures showing positive results.

Over the past year, we have also made good progress in supporting more people to live independently at home. Our reablement service increased from 1,715 people supported in 2024/25 to 3,678 last year. This has helped more people live independently without needing additional care, reducing the need for over 7,000 hours of support each week.

We have also strengthened support in the community by introducing a new enhanced rehabilitation team. This team provides more intensive support at home, helping people leave hospital sooner. The service is continuing to grow and helped 198 people return home earlier over 2025/26.

We are particularly proud that 19 people have moved on from long stays at the Royal Edinburgh Hospital into supported accommodation, living more independent and fulfilling lives in the community. This is part of a wider programme to improve mental health services, which will continue into next year.

We have continued to shift the balance of care towards community settings. This included opening more beds in our care homes and improving our end-of-life care pathway. As part of this work, Liberton Hospital closed in December 2025.

As a result of our work to improve how people move through hospital and leave when they are ready, the number of delayed discharge days reduced by 28%. The time people spend in hospital also reduced by 14%, showing the impact of our work to support more timely stays. We are also seeing improvements in our wider performance, with 77% (20 out of 26) of national indicators in the top half of health and social care partnerships across Scotland.

This significant progress would not have been possible without the dedication and hard work of our staff. We would like to thank everyone for their continued commitment to improving services and delivering the best possible outcomes for the people of Edinburgh.

Councillor Lezley Marion Cameron
Chair

Christine Laverty
Corporate Director Edinburgh Health & Social Care Partnership and Chief Officer IJB

Overview

The Edinburgh Integration Joint Board (EIJB) was set up in 2016 to bring together the planning and oversight of certain NHS Lothian and City of Edinburgh Council services. The aim was to improve people's health and wellbeing by making health and social care services work more efficiently and effectively.

In June 2025, the EIJB approved the strategic plan for 2025 to 2028. This plan sets out the main priorities and direction for the EIJB and for the Edinburgh Health and Social Care Partnership (the Partnership).

The strategic plan covers all areas for which the EIJB is responsible and focuses on the overall direction of travel and the key aims to be achieved over the next three years. The detailed actions needed to deliver these aims are being developed through implementation plans for each area.

During 2025/26 and into 2026/27, implementation plans are being developed and presented to the EIJB Strategic Planning Group. These plans will act as roadmaps for delivering the strategic plan, setting out what actions will be taken, when and where they will be delivered and, importantly, why they are needed.

This report provides an update on progress during the first year of the strategic plan against its key aims. As implementation planning continues, measures are still being developed for some areas. Unless otherwise stated, the report covers the period from April 2025 to March 2026.

About Edinburgh and our localities

- Edinburgh is one of the largest health and social care partnerships in Scotland, with an estimated population of 530,680 (in mid-2024).[1]
- About 85,182 people are aged 65 years old and over, and this group is expected to grow the most in the coming years.[1]
- Edinburgh is also the wealthiest city in Scotland, with 83.3% of the working age population in employment.[2]
- Of those not working, 25% are students and 15.4% care for others.[2]
- However, 15% of people and as many as 20% of children live in relative poverty.[3]
- Poverty is spread across the city. Around two thirds of people living in poverty do not live in the most deprived areas, and most are in work.

An overview of our localities is provided below and our Joint Strategic Needs Assessment provides more detail.

North East

- 126,101 people live in the North East locality[1]
- 14.7% are aged under 18, 71.8% are 18-64 and 13.5% 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]

North West

- 148,891 people live in the North West locality[1]
- 19.7% are aged under 18, 61.6% 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]

South East

- 138,714 people live in the South East locality[1]
- 13.7% are aged under 18, 71.0% are 18-64 and 15.2% 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]

South West

- 116,974 people live in the South West locality[1]
- 16.6% are aged under 18, 67.3% are 18-64 and 16.1% 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]

1 NRS Mid-2024 Small Area Population Estimates for 2011 Data Zones

2 NOMIS Official Census and Labour Market Statistics

3 https://www.edinburghhsc.scot/the-ijb/jsna/poverty/

Delivery arrangements

The EIJB is responsible for strategic planning and setting the budget for services. It does not directly deliver services or employ staff. Instead, it oversees how services are delivered and monitors how money is spent. This helps identify any issues and ensures these are considered when planning future services.

The Partnership delivers services in line with the EIJB's strategic plan. Our staff are employed by either the City of Edinburgh Council or NHS Lothian. The Chief Officer leads the Partnership and is accountable to the chief executives of both organisations. Most of the EIJB services are provided to those aged over 18. The health and social care services we provide in Edinburgh each year include:

- social care assessments and other social work services for around 13,000 people
- care at home services for about 8,500 adults and older people
- support for around 3,500 people in care homes and nursing homes
- technology-enabled care (such as community alarms) for around 10,500 people
- support for around 2,000 people through learning disability services
- services for the estimated 8,000–9,000 people living with dementia
- support services for some of the estimated 45,000–70,000 unpaid adult carers
- primary care services, including pharmacies, district nurses, GP practices and enhanced primary care across about 70 GP practices
- community mental health and substance use services
- services that help people stay at home or support them to leave hospital, with around 5,000 discharges supported
- adult support and protection services, with around 2,500 assessments
- supporting flow through around 700 unscheduled care beds in acute hospitals
- A&E services for around 108,000 attendances
- 124 beds across community hospitals for rehabilitation and complex care
- 200 beds within the Royal Edinburgh Hospital

To help services remain connected to the communities they serve, the Partnership is organised around four localities: South East, South West, North East and North West. To make sure people can access services of the same standard, services in the four local areas report to the same head of service, who cover:

- 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
- Strategic Change
- Contracts, Commissioning and Brokerage

'Set aside' hospital services are overseen by the EIJB and delivered by NHS Lothian. 'Hosted' services are delegated to the EIJB but planned and managed across Lothian, with most delivered outside the Partnership.

National health and wellbeing outcomes

The National Health and Wellbeing Outcomes set out what health and social care services aim to achieve.

Table 1: National health and wellbeing outcomes

National health and wellbeing outcomes
People are able to look after and improve their own health and wellbeing and live in good health for longer
People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
People who use health and social care services have positive experiences of those services, and have their dignity respected
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
Health and social care services contribute to reducing health inequalities
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
People using health and social care services are safe from harm
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
Resources are used effectively and efficiently in the provision of health and social care

Performance overview

In our strategic plan, we committed to 41 primary aims to improve the delivery of services for people in Edinburgh and ensure we could continue to deliver services sustainably within the budget available to us.

After the first year, we are making significant progress against these aims. For year one, we can report progress against 27 of our primary aims. We are seeing positive progress in the desired direction for 74% of these, with the remainder staying steady in year 1, as shown in the following table.

Table 2: Progress against strategic plan primary aims

Progress	Number of primary aims	% of measures in place
Progress in desired direction	20	74%
Progress has been steady	7	26%
Issues with progress	0	0%
Data not yet available	14	n/a

For some measures, performance is moving in the right direction but has not yet met the target set for this year. We assess progress against the overall direction set out in the Strategic Plan, while also showing performance against the 2025/26 targets, where available, to support comparison.

Work will continue in 2026/27 to put reporting mechanisms in place around additional measures.

Prevention and early intervention

Intervening to prevent health inequalities getting worse

Primary aim: To promote equity of access to our services and outcomes, measured by reducing the variation in waiting lists between different groups of the population

Table 3: Overall assessment of progress – Intervening to prevent health inequalities getting worse

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing but currently measured as milestone	On track

Our aim is to help reduce inequalities by improving access to, and the quality of, health and social care services. We cannot look at health inequalities on their own. We need to consider them in all our planning. Because of this, we are focusing on how to make sure inequalities are considered across all our plans.

We also need good, reliable data. This will help us understand how people with different backgrounds and needs use our services, or why they may not use them, and whether those services meet their needs. We are working to improve this data so we can better address health inequalities.

The first version of our health inequalities implementation plan will be ready by September 2026. It will set out in more detail how we will include health inequalities in our planning and how we will measure progress. In 2025/26 and 2026/27, we are tracking progress using a milestone measure, as shown in the following table.

Table 4: Progress against milestone measure – Intervening to prevent health inequalities getting worse

Action for completion	Target date for completion	Status
First version of health inequalities implementation plan detailing approach to this measure reviewed by the Strategic Planning Group	30 September 2026	On track

Improvement in vaccination attendance

Over the last 12 months the vaccination service has delivered over 260,000 vaccinations, with an over 60% uptake rate. For the first time since the COVID-19 pandemic, we have seen an upward trend in the flu uptake.

By offering appointments at people's local clinics, we increased attendance among people who had not received a vaccination for more than three years by 18%. We also improved access by delivering vaccinations through pop-up clinics in communities with higher levels of deprivation and lower vaccination uptake.

Intervening early to maximise independence following transition to adult services

Primary aim: To ensure care provision matches need while maximising independence when young people move to adult services, measured by a reduction in the average care hours required long-term

Table 5: Overall assessment of progress – Intervening early to maximise independence following transition to adult services

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Data not yet available

We are responsible for adult social care, and children's social care is managed by the City of Edinburgh Council. We usually take over support when young people leave school at 16, with some exceptions.

Most people have complex needs linked to a learning disability, physical disability, mental health condition or a combination of these. Moving into adult services often involves major changes, such as moving to new housing, adapting the family home or putting in place a new support package. We also support people to take on more adult roles, including making their own decisions, managing money, having more control over their care and possibly accessing employment.

Fifty young people will move into adult services in 2026, with around 30 needing formal paid support. Senior managers with expertise in learning disability support, social work, planning and commissioning have reviewed their assessments. They

focus on putting the right support in place to achieve positive outcomes for young people and their families. To ensure good social work practice, we ensure critical and substantial needs are met and take account of the needs of families and carers, including carer assessments.

Currently, we have not yet developed a measure for this aim, but it is likely to focus on the level of support provided to people leaving school. We will ensure support is appropriate and not over-provided, promoting greater independence in adulthood.

Preventing people from coming to harm due to unsafe use of drugs or alcohol

Primary aim 1: To reduce harm from substance use, measured by reducing the number of alcohol-specific deaths and drug-related deaths

Table 6: Overall assessment of progress – Preventing people from coming to harm due to unsafe use of drugs or alcohol

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Steady

The rate of alcohol-specific deaths in Edinburgh remains a significant concern, with little improvement seen over the past five years. It fell from a high of 29 per 100,000 people in 2001–2005 to a low of 18 in 2011–2015, following a similar pattern to the national trend. In the most recent figures (2020–2024), Edinburgh's rate is just below the national average of 22 per 100,000.

We focus on reducing harm linked to alcohol use and are reviewing our current pathway to improve access to treatment. This includes strengthening community detoxification services and improving referrals to inpatient care. We are also monitoring detox activity in primary care, with the aim of developing a full detoxification treatment pathway for general practices.

Figure 1: Rate of alcohol-specific deaths

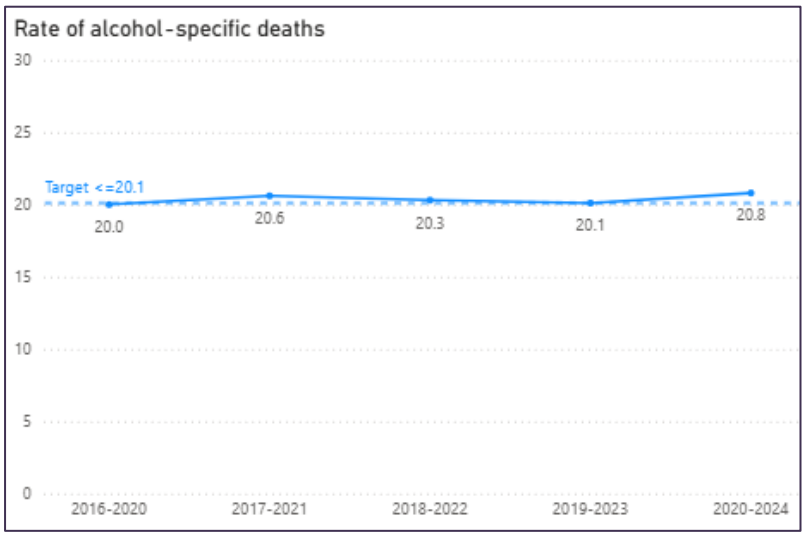


Table 7: Rate of alcohol-specific deaths

Year	2016-20	2017-21	2018-22	2019-23	2020-24	Target
Rate of alcohol-specific deaths	20.0	20.6	20.3	20.1	20.8	<=20.1

Source: Age-sex standardised rate per 100,000 population (all ages) of alcohol-specific deaths, shown as five-year averages, from National Records of Scotland (NRS) annual publication, released September each year

We have seen a fall in drug-related deaths recently. However, suspected drug-related deaths in Edinburgh remain high compared to past levels and international figures. Several factors drive this, including:

- a large, ageing, and increasingly vulnerable group of high-risk drug users
- changes in the drug supply and patterns of drug use
- poverty-related inequalities.

In April 2026, we launched a public consultation on the potential for a safer drug consumption facility in Edinburgh.

Edinburgh Medication Assisted Treatment Clinic

Edinburgh Medication Assisted Treatment Clinic (EdMAC) gives same day access to medications like methadone and buprenorphine. Once people engage with the service, they can also access help for issues like homelessness, mental health and medical needs.

Over 80 per cent of the service users that joined in 2024 were still in treatment six months later, an unusually high retention rate for this type of service. An independent evaluation also praised how quickly support was delivered and the quality of service provided. Link to independent evaluation

Figure 2: Suspected drug-related deaths

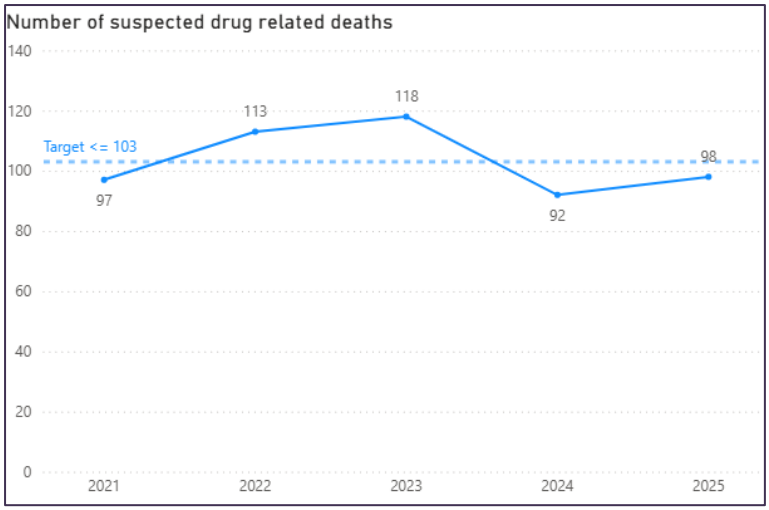


Table 8: Suspected drug-related deaths

Year	2021	2022	2023	2024	2025	Target
Number of suspected drug-related deaths	97	113	118	92	98	<=103
Official statistics	109	113	111	92	n/a	n/a

Source: Police Scotland operational data. This is management information and not subject to the same level of validation and quality assurance as official statistics. NRS publishes official statistics in September each year.

Preventing harms resulting from severe mental illness

Primary aim 1: To provide effective support to prevent people from attempting to take their own lives, measured by reducing the number of deaths recorded as probable suicide

Table 9: Overall assessment of progress – Preventing harms resulting from severe mental illness – reducing number of deaths recorded as probable suicide

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Reducing

Suicide rates in Edinburgh have fallen after four years of little change. Overall, the rate fell from 17.4 per 100,000 people in 2011–2015 to 11.1 in 2020–2024, now below the national rate of 14 per 100,000 people. While this represents progress, the number of people affected by suicide remains too high. We want to do more to prevent as many deaths as possible.

Over the past four years, we have focused on early mental health support, including open access services such as the Thrive Welcome Team and crisis services that assess risk and plan support to help prevent suicide. We have worked closely with partners to improve public spaces where there are concerns. We will continue to strengthen our approach with a dedicated suicide prevention lead and a local action plan.

Figure 3: Rate of deaths recorded as probable suicides

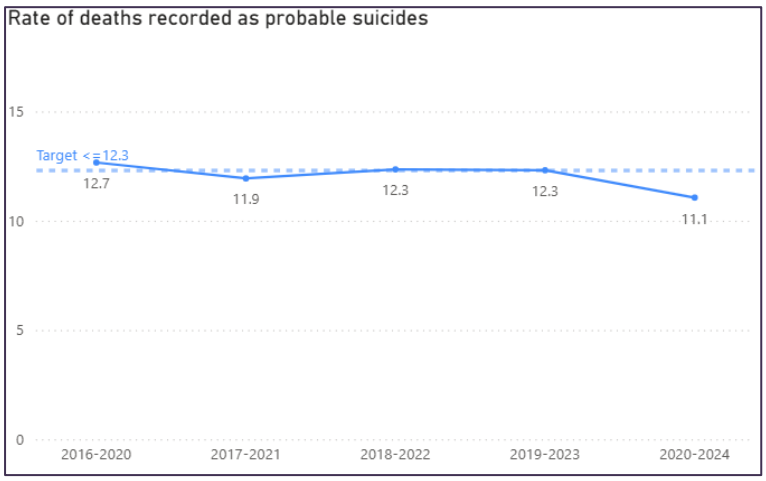


Table 10: Rate of deaths recorded as probable suicides

Five-year period	2016–20	2017–21	2018–22	2019–23	2020–24	Target
Rate of deaths recorded as probable suicide	12.7	11.9	12.3	12.3	11.1	<=12.3

Source: Age-sex standardised rate per 100,000 population (all ages) of deaths recorded as probable suicide, shown as five-year averages, from National Records of Scotland (NRS) annual publication in September each year.

Primary aim 2: To support people with mental illness to live well in the community, measured by a reduction in the number of people who have to stay in hospital unnecessarily

Table 11: Overall assessment of progress – Preventing harm resulting from severe mental illness – reducing unnecessary hospital stays for people with mental illness

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Reducing

The yearly average for 2025/26 hides the improvement made over the year. In the final quarter, the average fell to 26, which is 28% lower than the first quarter average of 36. This means we met our year 1 target of fewer than 31 delays by the end of the year. We have increased our capacity to support discharges from the Royal Edinburgh Hospital by setting up a dedicated hospital social work team. The team identifies alternatives to supported accommodation where possible and supports timely discharge.

Nineteen people moving successfully to supported accommodation

In May 2025, we commissioned a 19-bedroom supported living service for people with severe and long-term mental illness. Each person had been in hospital for at least a year, with many staying for several years.

This has been a life changing opportunity for the 19 people who've left hospital, helping them become more independent and live in a safe, homely environment, with an average of 25 hours of community support each week.

"Life is good and I can see a future" "This is my new beginning"

"I feel I have more confidence now" "So glad to be out of hospital!"

Figure 4: Average daily number of mental health delayed discharges

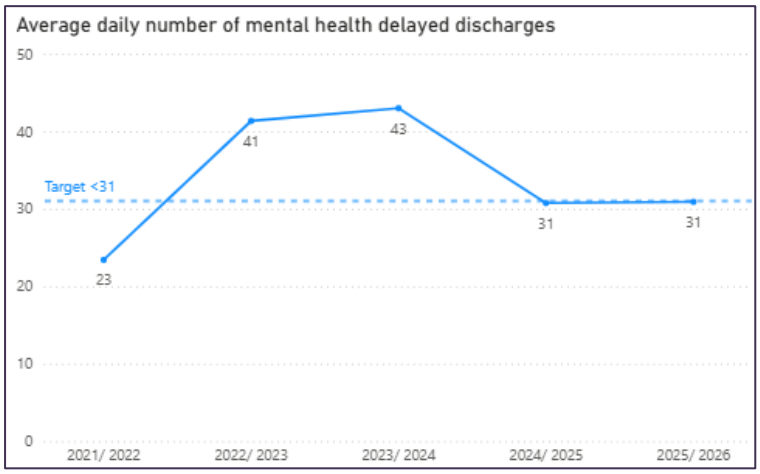


Table 12: Average daily number of mental health delayed discharges

Financial year	2021/22	2022/23	2023/24	2024/25	2025/26	Target
Average daily number of mental health delays	23	41	43	31	31	<31

Source: NHS Lothian internal data. All nationally reported delay codes including health and social care reasons, code 9 and code 100 delays.

Intervening early to support people with long-term conditions to live healthy lives in the community

Primary aim: To intervene early to prevent long-term conditions worsening, measured by reducing the number of hospital beds occupied by people with specific long-term health conditions

Table 13: Overall assessment of progress – Intervening early to support people with long-term conditions to live healthy lives in the community

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Reducing

Our strategic plan identifies dementia, respiratory conditions, heart failure, neurological conditions and diabetes as priority areas for action. Rates of these

conditions, particularly diabetes, are rising as the population ages. However, we have reduced the time people spend in hospital because of these conditions through prevention work and by supporting more timely discharge once medical treatment is no longer needed.

Patient story: Pulmonary rehab

Pulmonary rehabilitation is a six-week programme for people with long-term respiratory conditions, such as Chronic Obstructive Pulmonary Disease (COPD). It includes education and tailored group exercise sessions and helps people manage their condition more effectively.

"I'm 78 and I've got COPD. It makes you feel tired, in a way kind of useless because you're not able to do things that you used to do quite easily, any effort, and you were out of breath. Physiotherapy has made me realise the importance of exercise and the fact that I actually enjoy it. I feel more confident. I definitely have a lot more energy and I'm happier"

Read more about Dougie's story

Figure 5: Average daily beds occupied by long-term condition

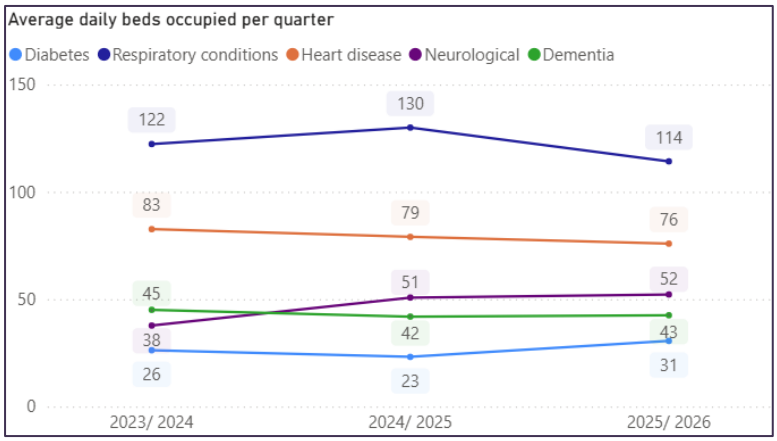


Table 14: Average daily beds occupied by long-term condition

Condition	2023/24	2024/25	2025/26	Target
Dementia	45	42	43	<43
Respiratory conditions	122	130	114	<130
Heart failure	83	79	76	<80
Neurological	38	51	52	<50
Diabetes	26	23	31	<23

Source: NHS Lothian local data.

Preventing falls and the harms that result from falls

Primary aim: To prevent people coming to harm from falls, measured by reducing the number of people admitted to hospital following a fall with a fractured neck of femur, lower leg or forearm

Table 15: Overall assessment of progress – Preventing falls and the harms that result from falls

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Reducing

We are reducing the number of people admitted to hospital with fractures after a fall. This is likely linked to a stronger focus on improving care pathways, including developing a new Falls Screening and Identification Tool for use by health and care staff. We have also introduced Edinburgh Leisure's Balanced Life physical activity programme, delivering over 59 classes a week to 636 people in 12-week blocks.

In 2026/27, we will expand this programme to provide more strength and balance support for people at risk of falls. We will also continue testing new approaches, including work in care homes, and roll out the falls screening tool alongside a new self-management tool.

Figure 6: Number of admissions with falls and fracture diagnostic codes

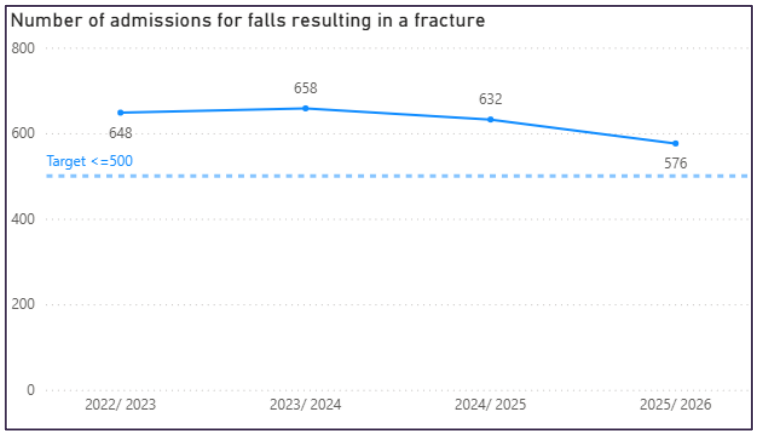


Table 16: Number of admissions with falls and fracture diagnostic codes

Year	2022/23	2023/24	2024/25	2025/26	Target
Admissions for falls resulting in fractures	648	658	632	576	500

Source: NHS Lothian internal data.

Intervening early to help people with frailty live well in the community and avoid crisis

Primary aim 1: To support people to receive the care and support they need, measured by increasing the number of people over the age of 65 with a clinical frailty score recorded

Primary aim 2: To enable people to spend more time at home, measured by reducing the number of people with frailty in hospital

Table 17: Overall assessment of progress – Intervening early to help people with frailty live well in the community and avoid crisis

Aim	Strategic plan desired direction of travel	Direction of travel in year 1
Primary aim 1	Increasing	Increasing
Primary aim 2	Reducing	Data not yet available

People who are frail are more likely to become ill or injured and take longer to recover. It often means they need more support, such as care at home, care homes, hospital treatment, medication or primary care. We want to prevent or reduce the impact of frailty where possible, but we first need to identify people at risk.

Over the past year, we have seen a sharp increase in the number of people aged over 65 with a frailty assessment recorded by GPs. This is likely due to new funding to support GP practices to identify and assess frailty.

We want to build on this so we can better target support for vulnerable people. We are also working to include frailty assessments in other community teams and to record frailty scores in our systems. This is helping us understand how people with frailty move through services, including hospital care.

Figure 7: % of people aged over 65 with a frailty assessment recorded

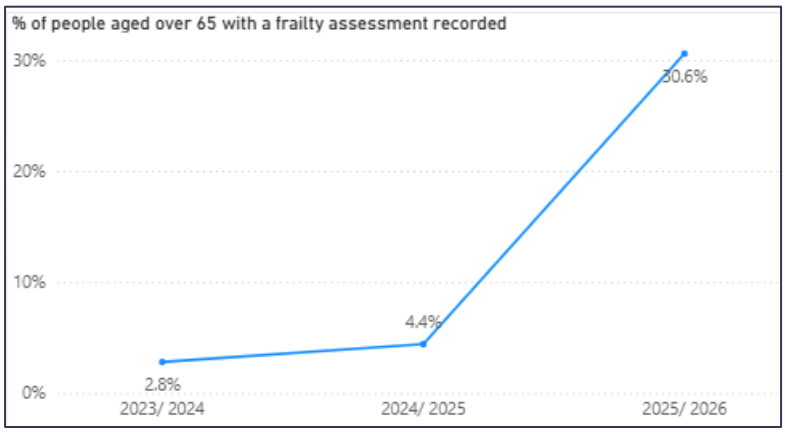


Table 18: % of people aged over 65 with a frailty assessment recorded

Year	2023/24	2024/25	2025/26	Target
% with a frailty assessment	2.8%	4.4%	30.6%	Not yet set

Source: General Practices internal data.

Preventing unnecessary hospital admissions for care home residents

Primary aim: To ensure people's health needs are met within care homes, measured by reducing the number of hospital beds occupied by people living in care homes

Table 19: Overall assessment of progress – Preventing unnecessary hospital admissions for care home residents

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Reducing

The number of care home residents attending A&E, and the number subsequently admitted to hospital, has continued to fall over the past year. Due to the way information is currently recorded, we are not yet able to measure the number of hospital beds occupied by care home residents. Improving this data remains a priority for 2026/27. The information available suggests that our work is helping to reduce avoidable hospital stays among care home residents.

Figure 8: A&E attendances and admissions for care home residents

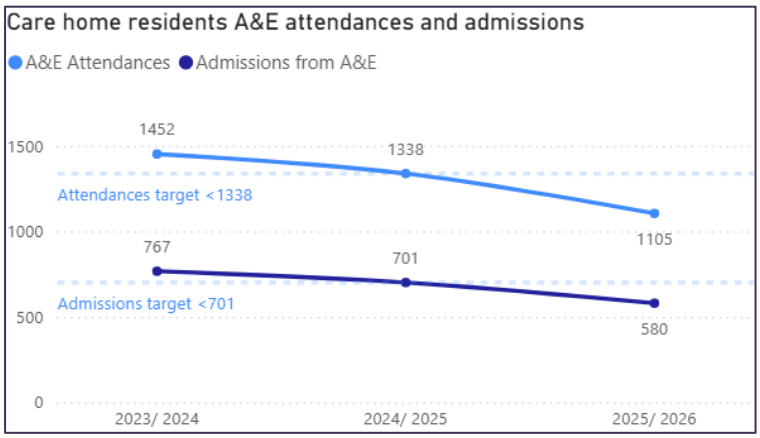


Table 20: A&E attendances and admissions for care home residents

Year	2023/24	2024/25	2025/26	Target
A&E attendances for care home residents	1,452	1,338	1,105	<1,338
Admissions from A&E for care home residents	767	701	580	<701

Source: NHS Lothian internal data. Based on weeks starting within calendar year.

Intervening earlier to better support people in their last year of life

Primary aim: To support people to spend more time with the people they love and where they feel most comfortable, measured by increasing the proportion of the last six months of life people spend at home or in a community setting

Table 21: Overall assessment of progress – Intervening earlier to better support people in their last year of life

Strategic plan desired direction of travel	Direction of travel in year 1
Increasing	Steady

During 2025/26, we invested in community services to support people in their last year of life who would previously have received care in hospital. This reduced the need for complex care beds, and we closed Liberton Hospital in December 2025.

From March 2025, we refocused our Hospital to Home and in-reach nursing teams on end-of-life care. This prevented emergency admissions, saved an estimated 10 beds each day and helped people stay at home for a more comfortable and compassionate death.

In July 2025, we introduced a fast-track care home admission pathway for people expected to die within six weeks. Since then, six people have used the pathway and moved from hospital to a care home for end-of-life care.

We also commissioned seven intermediate palliative care beds at the Marie Curie Hospice for people whose needs could not be met at home or in a care home. We are still evaluating the service, but the beds are being well used and most people access them within a few days.

Liberton Hospital

As part of our commitment to modernise care and improve experiences, we have now closed Liberton Hospital. We safely delivered the closure by redesigning and relocating Intermediate Care, Hospital Based Complex Care, Hospital at Home services and the Day Hospital. This affected more than 300 staff as well as many patients and families.

Over the past two years, the team managed significant and complex change, including bed reductions, service redesign, major workforce transitions and the relocation of clinical and support services. Throughout, they maintained high standards of care and kept patients and staff safe.

Figure 9: Proportion of the last six months of life people spend at home or in a community setting

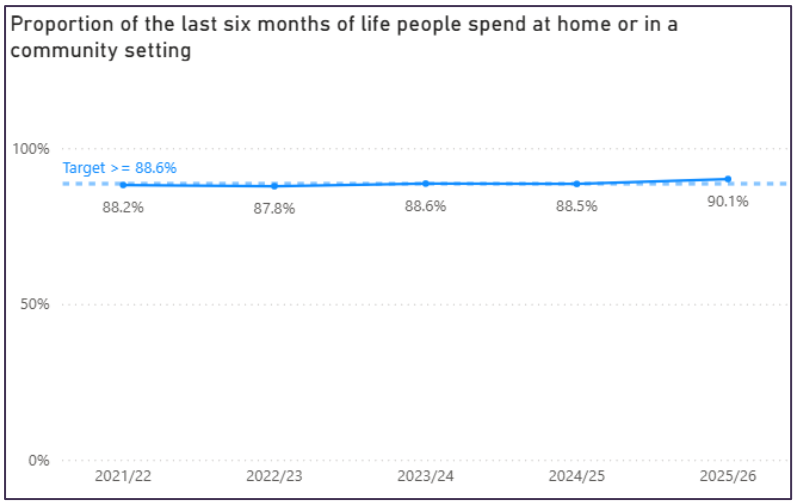


Table 22: Proportion of the last six months of life people spend at home or in a community setting

Financial year	2021/22	2022/23	2023/24	2024/25	2025/26	Target
Proportion of time	88.2%	87.8%	88.6%	88.5%	90.1%	>=88.6 %

Source: Public Health Scotland data. Same as national indicator 15. 2025/26 is 2025 calendar year data.

Maximising independence

Reablement

Primary aim: To embed a reablement approach to enable people to be as independent as they can, measured by reducing the packages of care required following reablement

Table 23: Overall assessment of progress – Reablement

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Reducing

Reablement is a short-term support service, usually lasting up to six weeks, delivered in people's homes. It helps people set goals and supports them to achieve them.

In 2025/26, we expanded the service by moving all in-house home care to a reablement model. This more than doubled the number of people benefiting from this approach from 1,715 to 3,678. On average, people needed 48% fewer care hours long term as they became more independent.

The service took time to embed, so it did not meet the monthly target early in the year but exceeded it in the final months.

Figure 10: Weekly hours reduced from start to end of reablement per month

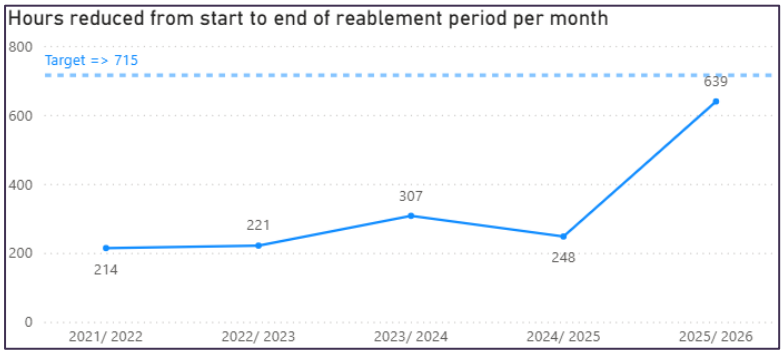


Table 24: Weekly hours reduced from start to end of reablement per month

Year	2021/22	2022/23	2023/24	2024/25	2025/26	Target
Reduction in hours per month	214	221	307	248	639	715

Source: City of Edinburgh Council internal data

Reablement in the community

Local district nurses referred a community member who was becoming less physically able and had recently been diagnosed with dementia and incontinence. As well as meeting their reablement goals, they gave the following feedback:

"Although nervous of carers coming in morning and evening, we were both put at ease by the friendly competent workers. I was very impressed by the dignity they afforded, and the friendly manner that they had, without any condescension. They included my husband in all aspects of his care."

(Response edited for length)

Rehabilitation

Primary aim: To support people to recover at home, measured by reducing the number of people receiving rehabilitation in hospital when they no longer require medical care

Table 25: Overall assessment of progress – Rehabilitation

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Data not yet available

In 2025/26, we embedded our new enhanced rehabilitation service. This builds on existing community rehabilitation by providing more intensive support at home, as an alternative to bed-based care. The service supports a tiered approach based on the level of physiotherapy and occupational therapy needed. Existing services continue to deliver lower-level support (tiers 1 and 2), while the enhanced service provides more intensive support (tiers 3 to 5).

Table 26: EHSCP tiered community rehabilitation model

Rehab	Therapy Dosage
Tier 5	2 x 1-hour sessions per day (Seven days per week)
Tier 4	1 x 1-hour sessions per day (Mon-Fri only)
Tier 3	3 x 1-hour sessions per week (Mon-Fri only)
Tier 2	Up to 2 x 1-hour sessions per week (Mon-Fri only)
Tier 1	Less than 1 x 1-hour session per week (Mon-Fri only)

The enhanced rehabilitation service began in August 2025 and expanded over the year. By the end of March, we had supported 198 people to leave hospital earlier, averaging six additional discharges each week. A January 2026 evaluation estimated that this service had reduced demand on hospital beds by 46 each day.

Enhanced rehabilitation

After leaving hospital following a fall that resulted in a broken hip, a person supported by the enhanced rehabilitation team said: *"I was very pleased with the follow up. After being in hospital for so long, I wasn't sure what to expect, but the team explained everything clearly and were very encouraging. I achieved all my goals. My main aim was to improve my mobility, and it did improve. It felt great to walk outside for the first time since my fall. My care visits reduced from four to two a day, and from two carers to one each time. I felt proud of what I achieved."*

Response edited for length

People with health or social care needs that are impacting on their ability to work

Primary aim: To enable people to access help to overcome barriers to work more easily, measured by increasing the number of people accessing relevant services by self-referral

Table 27: Overall assessment of progress – People with health or social care needs that are impacting on their ability to work

Strategic plan desired direction of travel	Direction of travel in year 1
Increasing	Data not yet available

During the year we developed a Joint Strategic Needs Assessment focused on how health affects employability, which will be available on the Edinburgh Partnership Data and Intelligence website.

Many of the services that support people with health and social care needs that impact on their ability to work are facing increased demand alongside capacity challenges. These pressures can mean that more people have to wait longer to access care.

Over 2026/27, we will be developing an implementation plan to improve access to key services that help people facing health-related barriers to work, including mental health, physiotherapy, podiatry and musculoskeletal (MSK) services.

Award for person-centred care

The Edinburgh Musculoskeletal (MSK) Advanced Physiotherapy Practitioner (APP) service is the first clinical team in NHS Lothian and the Partnership to achieve Gold in the Realistic Medicine and Value Based Health & Care Accreditation Framework.

Realistic Medicine and Value Based Health and Care focus on working with patients to understand what matters to them, making shared decisions based on evidence, and reducing harm and waste while using resources well. The framework, developed by NHS Lothian in 2025, helps teams reflect on how these principles are used in daily practice, recognise what works well, and improve.

This award recognises the APP service for consistently putting people at the centre of care. Achieving Gold shows these principles are part of everyday practice, from meaningful conversations to shared decisions, with care shaped around individual needs and priorities.

Protecting our most vulnerable

People supported under Adult Support and Protection legislation

Primary aim: To continue improving our ASP service to ensure we respond to concerns in line with our legal requirements, measured by an increase in the proportion of duty to inquire (DTI) assessments completed within target timescales

Table 28: Overall assessment of progress – People supported under Adult Support and Protection (ASP) legislation

Strategic plan desired direction of travel	Direction of travel in year 1
Increasing	Steady

We were close to meeting our 2025/26 target for completing duty to inquire assessments within agreed timescales but need to improve further. Referrals are increasing in both number and complexity. We still face challenges in having enough suitably qualified staff to progress inquiries alongside other assessment and case work. We have taken steps to increase staffing, improve training and change how this work is allocated.

Figure 11: Percentage of duty to inquire (DTI) assessments completed within timescale

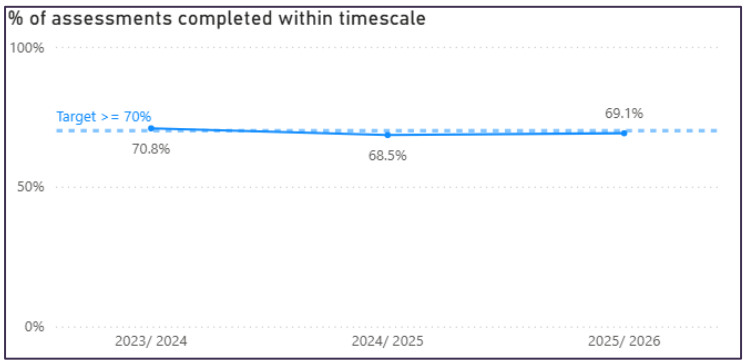


Table 29: Percentage of duty to inquire (DTI) assessments completed within timescale

Year	2023/24	2024/25	2025/26	Target
% of assessments completed within timescale	70.8%	69.7%	69.1%	>=70%

Source: City of Edinburgh Council internal data. Comparable data is not available prior to 2023/24.

People supported under Mental Health Act

Primary aim 1: To ensure people can be treated in the community where appropriate, measured by a reduction in the rate of Short-term detention certificates (STDCs) and Compulsory treatment orders (CTOs)

Primary aim 2: To ensure we comply with legal requirements, measured by increasing the number of social circumstance reports completed within agreed timescales

Table 30: Overall assessment of progress – People supported under Mental Health Act (MHA)

Aim	Strategic plan desired direction of travel	Direction of travel in year 1
Primary aim 1	Reducing	Mixed
Primary aim 2	Increasing	Data not yet available

We want to make sure people's rights are protected and that any use of compulsory powers is lawful, necessary, proportionate, beneficial and used for the shortest possible time.

Data for 2025/26 is not yet available for this measure. However, in 2024/25, the number of Short-Term Detention Certificates (STDCs) fell, while the number of Community Treatment Orders (CTOs) continued to rise. Edinburgh also continues to have higher rates of both STDCs and CTOs than the Scottish average.

To address this, we are reviewing and updating guidance on the use of STDCs and CTOs, with a focus on ensuring they are only used when necessary and that less restrictive alternatives are considered wherever possible. We will also continue working with clinical and community partners to strengthen alternatives to detention, including intensive community support and crisis response services.

Figure 12: Rate of Short-term detention certificates (STDC) and Community treatment orders (CTO)

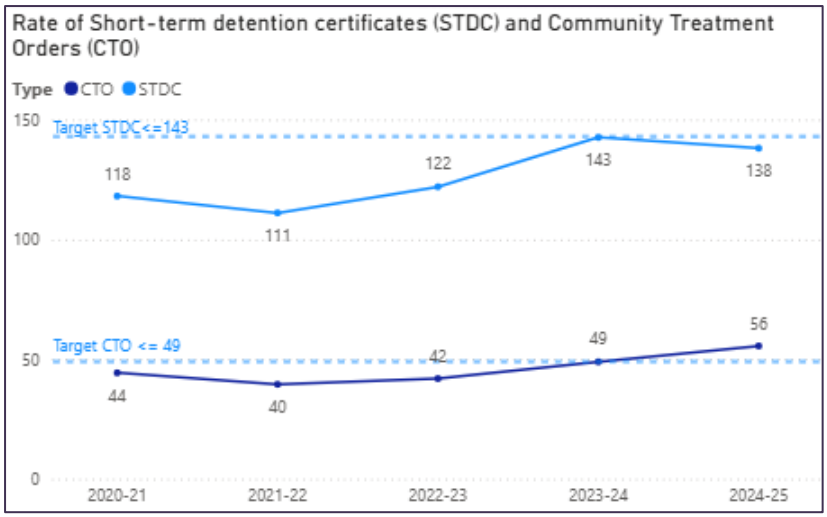


Table 31: Rate of Short-term detention certificates (STDC) and Community treatment orders (CTO)

Year	2020/21	2021/22	2022/23	2023/24	2024/25	Target
STDC	118	111	122	143	138	<=143
CTO	44	40	42	49	56	<=49

Source: Mental Welfare Commission for Scotland Mental Health Act Monitoring Report. Age-sex standardised rates per 100,000 population (all ages)

People supported under the Adults with Incapacity Act

Primary aim 1: To eliminate the backlog of AWI activity, measured by reducing the number of outstanding guardianship reports

Primary aim 2: To ensure we comply with our legal responsibilities, measured by increasing the number of guardianship reports completed within the statutory 21-day timescale

Table 32: Overall assessment of progress – People supported under the Adults with Incapacity (AWI) Act

Aim	Strategic plan desired direction of travel	Direction of travel in year 1
Primary aim 1	Reducing	Steady
Primary aim 2	Increasing	Data not yet available

We are committed to maintaining enough mental health officers and have recently recruited four additional posts. Eight social workers also completed the Mental Health Award. We will continue to support staff to access high quality training and we are reviewing capacity and demand to understand pressures and future need. This will help us maintain a sustainable skilled workforce and meet our statutory duties.

Figure 13: Average number of open AWI roles on the assessment waitlist

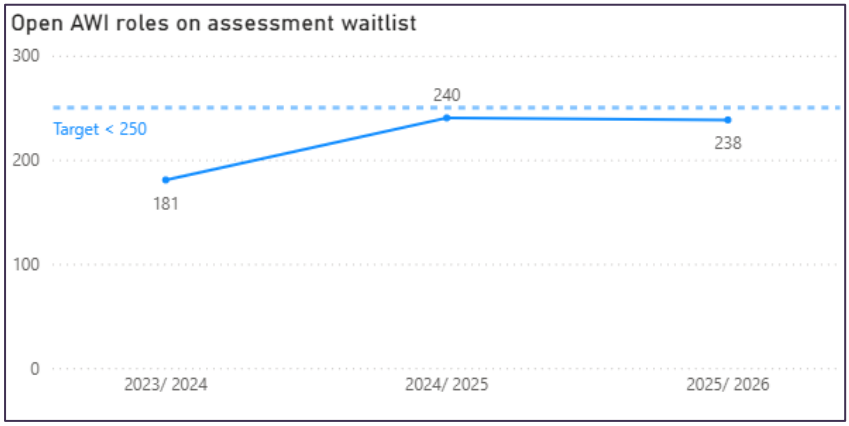


Table 33: Average number of open AWI roles on the assessment waitlist

Year	2023/24	2024/25	2025/26	Target
Average number on waitlist	181	240	238	<=250

Source: City of Edinburgh Council internal data. Comparable data is not available prior to 2023/24.

Using our resources effectively

Right care, right place, right time

Primary aim 1: To agree and implement 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

Primary aim 2: To implement a consistent method of counting capacity and demand data for all services

Table 34: Overall assessment of progress – Right care, right place, right time

Aim	Strategic plan desired direction of travel	Direction of travel in year 1
Primary aim 1	Milestone measure	On track
Primary aim 2	Milestone measure	On track

Edinburgh's health and social care system can be hard to navigate and is often fragmented. This can lead to inefficiency and inconsistent support, with help depending on where people ask rather than what they need. A single point of access will address this by offering a one-stop service for decisions and access to support, reducing variation and improving consistency.

Funding for a team of 96 full-time staff was approved by the EIJB in February 2026. The team includes social workers, nurses and allied health professionals. A programme is in place to deliver this new service, now called Connect Edinburgh. It will also improve processes, systems and practice to ensure referrals flow smoothly through the team.

Table 35: Progress against milestone measure – Right care, right place, right time

Action for completion	Target date for completion	Status
All referrals into Connect Edinburgh are consistently counted and a process for determining RAG status for available capacity in each of the services being referred to has been agreed and is in use.	31 March 2027	On track
Standard set of questions agreed and in use across all referrals to Connect Edinburgh.	31 December 2026	On track

Primary care

Primary aim 1: To enable people to receive the most appropriate care in their communities, measured by improving continuity of care

Primary aim 2: To enable people to receive the most appropriate care in their communities, measured by improving the number of practices able to accept new patients

Table 36: Overall assessment of progress – Primary care

Aim	Strategic plan desired direction of travel	Direction of travel in year 1
Primary aim 1	Increasing	Data not yet available
Primary aim 2	Increasing	Increasing

We aim to have no more than two GP practices in each locality unable to accept new patients (with closed lists) at any one time. During 2025/26, the number of practices with closed lists decreased overall. However, in the South East locality, we exceeded this target in two months when several practices temporarily closed their lists due to resource pressures. We continue to work closely with GP practices to help them manage demand and capacity, and to ensure people across the city can access GP services when they need them.

Figure 14: Number of GP practices with closed lists

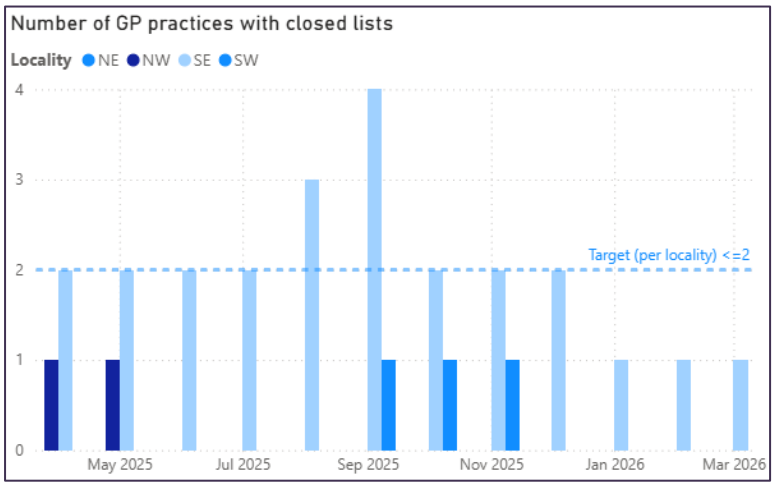


Table 37: Number of GP practices with closed lists

Month	North East	North West	South East	South West	Target (per locality)
Apr-25	0	1	2	0	2
May-25	0	1	2	0	2
Jun-25	0	0	2	0	2
Jul-25	0	0	2	0	2
Aug-25	0	0	3	0	2
Sep-25	0	0	4	1	2
Oct-25	0	0	2	1	2
Nov-25	0	0	2	1	2
Dec-25	0	0	2	0	2
Jan-26	0	0	1	0	2
Feb-26	0	0	1	0	2
Mar-26	0	0	1	0	2

Source: General Practices internal data.

New pharmacotherapy initiatives

We continue to introduce new pharmacotherapy services to improve access, continuity of care and holistic support for patients. One initiative in the South West transformed a substance dependency clinic based within a GP practice, doubling patient capacity and improving engagement.

Led by an Advanced Clinical Pharmacist, the clinic provides holistic, trauma-informed care and brings together support from health visitors, link workers and the local substance use service. Patients receive personalised recovery plans, while preventive care is built into the service through routine blood-borne virus testing, sexual health screening and the provision of naloxone.

As well as improving outcomes for people, the clinic has become a training hub for pharmacists looking to develop similar services across Lothian.

Unscheduled care

Primary aim: To ensure flow through our hospitals to enable people to access hospital care when they need it most, measured by reducing the number of people staying in hospital for more than 7 days

Table 38: Overall assessment of progress – Unscheduled care

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Reducing

In December 2024, the Scottish Government gave us recurring funding to increase community care capacity. This aimed to reduce hospital bed use, shorten stays and cut delays in discharge. The funding supported new services that helped people return home sooner with extra care and rehabilitation. Three changes moved care from hospital to the community:

- Enhanced care provided more support at home so people could return safely and be assessed for long-term needs.
- Enhanced rehabilitation increased the level and intensity of rehab at home.
- End-of-life care increased beds to give people more choice.

All three reduced longer hospital stays, especially those over seven days. During the rest of the strategic plan period, we will focus on reducing the number of people in hospital who no longer need medical care. We will do this by investing in high-demand community services and improving access to care, helping to create space for people who need admission.

Figure 15: Number of discharges where the length of stay was longer than 7 days

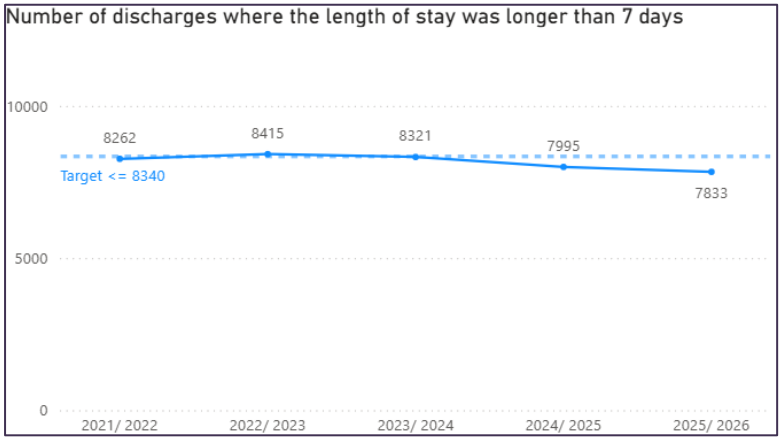


Table 39: Number of discharges where the length of stay was longer than 7 days

Year	2021/22	2022/23	2023/24	2024/25	2025/26	Target
Number of discharges with a length of stay over 7 days	8,262	8,415	8,321	7,995	7,833	<=8,340

Source: NHS Lothian local data.

Home First

Primary aim: To enable people to live well in their own homes, measured by reducing the number of people in hospital that do not need to be there

Table 40: Overall assessment of progress – Home First

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Reducing

We have seen a steady fall in delayed discharges over the past five years. While we did not meet our 2025/26 target, the average daily delays are 25% lower than in 2024/25, and now well below the national rate. In March 2026, we had 26.5 people per 100,000 delayed, compared to 41.3 nationally. This improvement reflects stronger discharge planning and better joint working across health and social care. We have also improved flow from hospital into community services, supported by a more stable reablement model and enhanced rehabilitation in the community.

Figure 16: Average daily number of delayed discharges

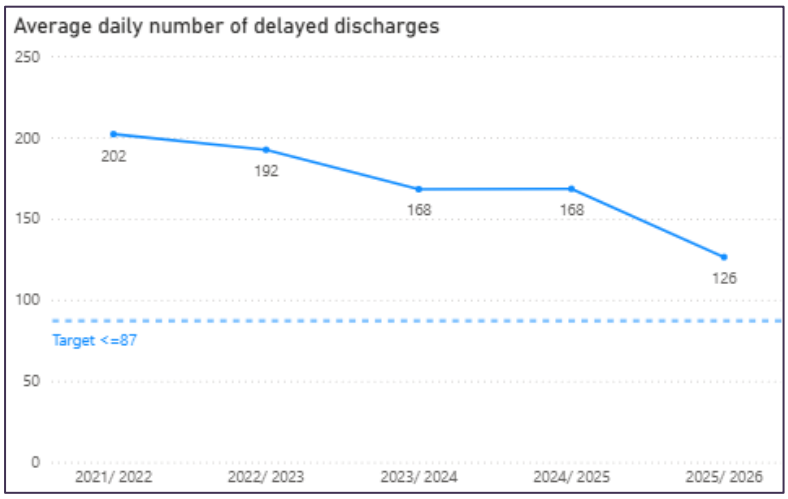


Table 41: Average daily number of delayed discharges

Year	2021/22	2022/23	2023/24	2024/25	2025/26	Target
Average daily number of delayed discharges	202	192	168	168	126	<=87

Source: Public Health Scotland monthly delayed discharges.

Mental health

Primary aim 1: To improve experiences of our mental health services, measured by increasing the proportion of people reporting a positive experience of accessing mental health services

Primary aim 2: To ensure access to services when needed, measured by reducing waiting times for mental health services

Table 42: Overall assessment of progress – Mental health

Aim	Strategic plan desired direction of travel	Direction of travel in year 1
Primary aim 1	Increasing	Data not yet available
Primary aim 2	Reducing	Data not yet available

Hospital care for people with serious mental illness is provided at the Royal Edinburgh Hospital, managed by NHS Lothian on our behalf. The hospital has operated above safe occupancy for several years, and community teams also face capacity pressures. In response, we are reforming the serious mental illness pathway. This requires whole-system improvement across health and social care in Lothian.

We are developing a transformation plan that will take several years. To ease short-term pressure, the EIJB agreed in February 2026 to invest £6.7 million over two years to stabilise hospital capacity.

Our wider programme includes reviewing Community Mental Health teams, redesigning rehabilitation, expanding supported accommodation and redeveloping the Mental Health Assessment Service. We will present our plans to the EIJB in 2026/27.

Learning disabilities

Table 43: Overall assessment of progress – Learning disabilities

Aim	Strategic plan desired direction of travel	Direction of travel in year 1
Primary aim 1	Reducing	Reducing
Primary aim 2	Reducing	Reducing

Primary aim 1: To enable people with learning disabilities to live well in the community, measured by reducing the number of people with learning disabilities in hospital for more than 12 months

We have reduced the number of people with a learning disability staying in hospital for more than 12 months. This reflects our work to reduce inpatient beds and improve how people leave hospital, in line with the Dynamic Support Register and the Coming Home report.

We expect several people to leave hospital over the next year, but this can be complex and take time. Challenges include limited housing, the need for home adaptations, staffing pressures and legal processes, such as Guardianship.

We are also developing a Dynamic Support Co-ordination Team to strengthen prevention and community support, helping reduce the need for hospital admission.

Figure 17: People with learning disabilities in hospital for more than 12 months

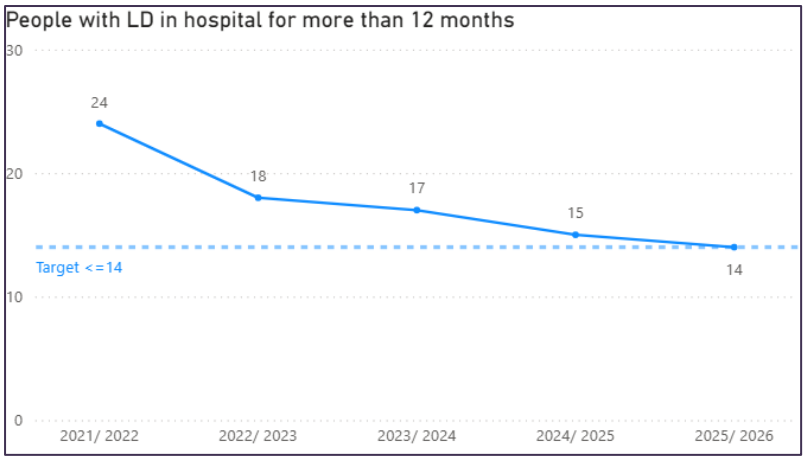


Table 44: People with learning disabilities in hospital for more than 12 months

Year	2021/22	2022/23	2023/24	2024/25	2025/26	Target
People in hospital for more than 12 months in a learning disabilities specialty	24	18	17	15	14	<=14

Source: NHS Lothian local data.

Primary aim 2: To commission more effective care provision that meets needs while maximising independence, measured by reducing the average costs associated with care at home for people with learning difficulties

Spot purchasing is still the main way we buy social care services for people with learning disabilities, while we develop a wider framework to create a more stable supply.

Many providers are under financial pressure due to rising costs, including higher energy prices and increased employer National Insurance contributions. This is pushing up costs per service. We are working with providers to develop a framework that brings more consistency to costs and contracts.

Progress has been slower than planned, with delivery now expected in quarter 1 of 2027/28. Despite rising unit costs, the average weekly cost per care package has fallen below target.

Figure 18: Average weekly cost per package for people with learning disabilities

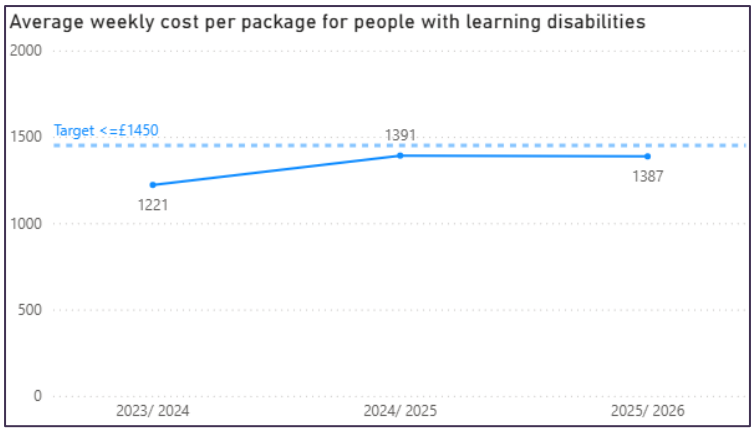


Table 45: Average weekly cost per package for people with learning disabilities

Year	2023/24	2024/25	2025/26	Target
Average weekly cost per package for people with learning disabilities	£1,221	£1,391	£1,387	<=£1,450

Source: City of Edinburgh Council local data. Comparable data is not available prior to 2023/24.

Care Homes

Primary aim 1: To promote the availability of sufficient care home beds at the NCHC rate, measured by a reduction in the number of people waiting for a care home

Table 46: Overall assessment of progress – Care Homes

Strategic plan desired direction of travel	Direction of travel in year 1
Reducing	Reducing

Around 2,400 people receive care across Edinburgh and most (87%) are in private facilities. Around 15% of these placements receive funding above the National Care Home Contract (NCHC) rate. We have worked with providers to increase placements at the NCHC rate in Edinburgh.

After an 85-bed care home closed in 2024/25, three more private homes closed in 2025/26, removing a further 88 beds. We increased internal capacity by opening 30 beds at North Merchiston and Castlegreen. A new private care home also opened in March 2026, adding further capacity.

The average number of delayed discharges for people waiting for a care home fell from a peak of 72 in 2024/25 to a five-year low of 46. We achieved this through improved hospital social work assessment and discharge processes. Our enhanced care at home pathway also helped more people return home with support instead of moving to a care home or while deciding on long-term care.

Figure 19: Average daily hospital beds occupied by people waiting for a care home

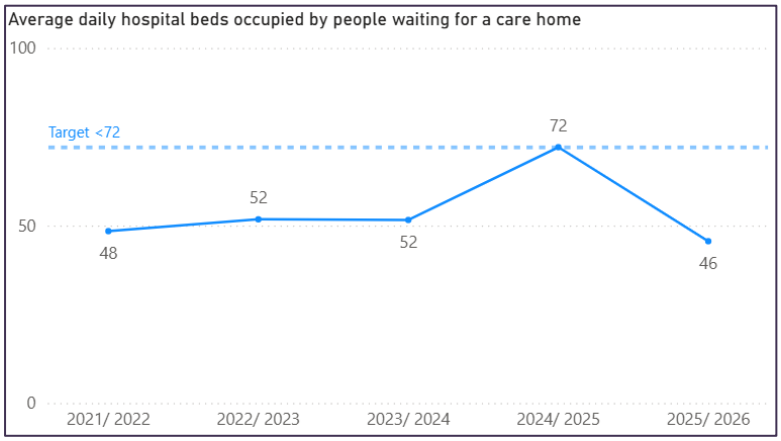


Table 47: Average daily hospital beds occupied by people waiting for a care home

Year	2021/22	2022/23	2023/24	2024/25	2025/26	Target
Average daily hospital beds occupied by people waiting for a care home	48	52	52	72	46	<72

Source: NHS Lothian internal data. All nationally reported delays using the six code 24 delays codes.

Care at home and day services

Primary aim 1: To ensure the IJB recovers all the money it is entitled to for providing social care, measured by increasing the money recovered in line with the council's charging policy

Primary aim 2: To support people to be as independent as possible, measured by reductions in the average hours of care required per person

Table 48: Overall assessment of progress – Care at home and day services

Aim	Strategic plan desired direction of travel	Direction of travel in year 1
Primary aim 1	Increasing	Data not yet available
Primary aim 2	Reducing	Steady

We purchase around 137,500 hours of care at home each week for 5,600 people from independent and third sector providers. External providers also deliver most day services, providing nearly 90% of placements.

Given this reliance, we must connect people to the right care. We set up a central brokerage team to improve consistency, control and efficiency. We will review its pathways, systems and processes in 2026/27.

Councils can charge for some services, such as housework and day services, where people can afford to pay. In 2025/26, we carried out a public consultation on changes to our charging policy. After more than 650 responses, we decided to keep the current policy and will instead review how we recover costs.

Over the past two years, a dedicated team reviewed care to ensure people receive the right support and can stay independent. We will make this a permanent function.

Average care hours have stayed stable. This likely reflects earlier hospital discharge with larger care packages and reduced demand for care home places due to more care at home. We are also using more alternatives to formal support for people with lower needs, which may affect average hours.

Figure 20: Average weekly care at home hours per person

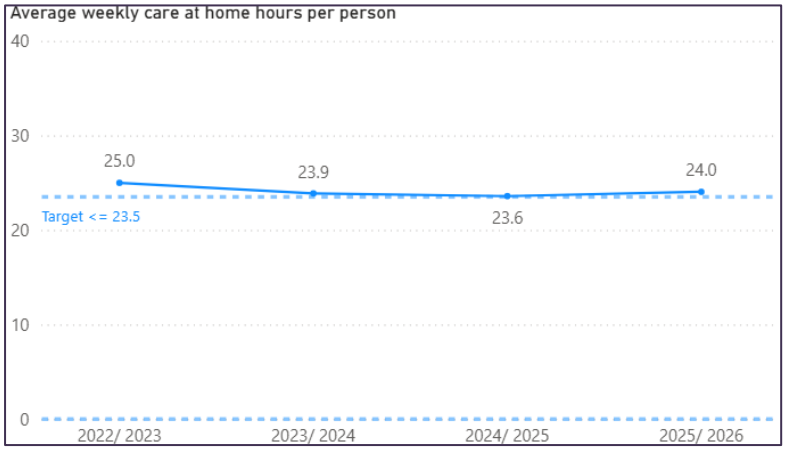


Table 49: Average weekly care at home hours per person

Year	2022/23	2023/24	2024/25	2025/26	Target
Average weekly care at home hours	25.0	23.9	23.6	24.0	<=23.5

Source: City of Edinburgh Council internal data.

Sexual health

Primary aim: To work with all Lothian IJBs to implement a plan that makes sexual health services good quality and financially sustainable without increasing Edinburgh IJB's overall expenditure across all our services

Table 50: Overall assessment of progress – Sexual health

Strategic plan desired direction of travel	Direction of travel in year 1
Milestone measure	Measure not yet available

Sexual health services are hosted by East Lothian Health and Social Care Partnership on our behalf. The service provides comprehensive and inclusive sexual and reproductive healthcare from the Chalmers Centre and 10 local clinics across the Lothians.

The range of services provided, and the number of people using them, has grown over time. During 2025/26, the service recorded around 90,000 attendances from across Lothian. Services now include abortion care, condom provision, contraception, gender services, gynaecology, genitourinary medicine, genital skin services, outpatient HIV care, menopause support, PrEP, psychology services, psychosexual clinics, sexually transmitted infection management and vasectomy services. The service also provides a range of specialist clinics, outreach services, prevention work and health improvement activities for specific groups and communities.

The service continues to face significant pressures. During 2025/26, both the number of people waiting for an initial assessment and waiting times increased. We are working with East Lothian to better understand these pressures and review how services are delivered. It is also clear that the cost of providing some sexual health services is higher than the funding currently available.

We remain committed to working with each of the Lothian health and social care partnerships to develop and implement a plan that delivers high-quality, financially sustainable sexual health services. We will continue to work on this over the remainder of the strategic plan period, with the aim of improving services while living within the resources available across the health and social care system.

Workforce

Primary aim: To ensure that our workforce plan aligns to our strategic objectives, local service plans and is affordable

Table 51: Overall assessment of progress – Workforce

Strategic plan desired direction of travel	Direction of travel in year 1
Milestone measure	On track

We do not employ staff, and we commission services from NHS Lothian, the City of Edinburgh Council, third sector organisations and independent providers. Staff managed by the Partnership deliver most services commissioned from NHS Lothian and the City of Edinburgh Council.

To deliver our strategic plan, we must build strong foundations and infrastructure. In 2025/26, we continued phase two of our management restructure to ensure a structure that supports high quality services. We moved to city-wide management while maintaining a focus on local need. This has improved consistency and quality across the city. We also strengthened capacity in planning and quality improvement.

In 2025/26, we prepared for the reduced working week for Agenda for Change staff in NHS Scotland. From 1 April 2026, the standard week reduced to 36 hours with no loss of pay. We worked with teams to implement this while maintaining staff wellbeing and patient safety.

We are now working on a new workforce strategy for 2026. After a restructure, we are now focused on making sure we have the right skilled people in place to deliver our services and meet people's needs.

Table 52: Progress against milestone measure – Workforce

Action for completion	Target date for completion	Status
New EIJB Workforce Strategy approved by EIJB	31 December 2026	On track

Unpaid carers

Primary aim 1: To support adult carers within their caring role, measured by increasing self-reported wellbeing of carers and improved experience

Primary aim 2: To support adult carers to maintain their caring relationship as long as they wish to do so and move on from caring when appropriate, measured by reducing the number of relationships breaking down in crisis

Table 53: Overall assessment of progress – Unpaid carers

Aim	Strategic plan desired direction of travel	Direction of travel in year 1
Primary aim 1	Increasing	Steady
Primary aim 2	Reducing	Data not yet available

There are between 45,000 and 70,000 adult carers in Edinburgh, with an estimated 40% of these providing 20 hours or more of care each week. We aim to improve carers' experience and wellbeing. The latest Health and Care Experience (HACE) survey shows wellbeing has stayed steady, so more improvement is needed.

Our local carers strategy aims to strengthen carers' rights and support them to maintain their health, wellbeing and a life alongside caring. Our current strategy was published in 2023 and is due for review by March 2027. The updated strategy will align with our strategic plan and will meet the requirements of the Carers (Scotland) Act 2016. We have carried out extensive evidence gathering to inform the new Joint Carers Strategy, including updating our Joint Strategic Needs Assessment.

Figure 21: HACE survey carers questions

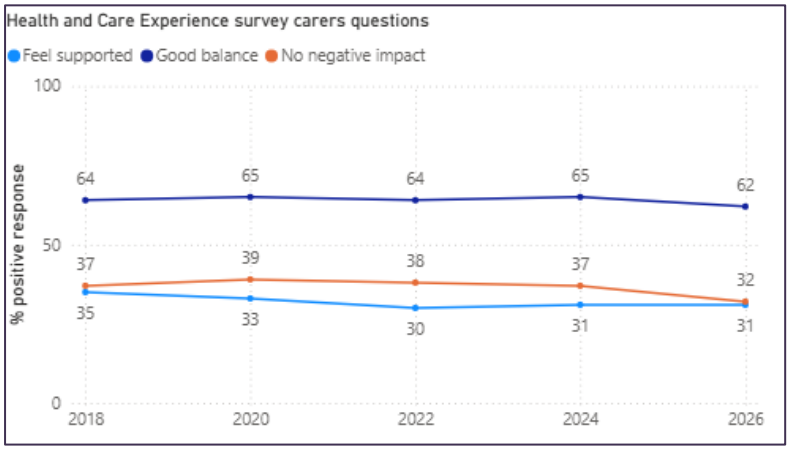


Table 54: HACE survey carers questions

Year	2018	2020	2022	2024	2026
% positive response to 'Caring has not had a negative impact on my health and wellbeing'	37	39	38	37	32
% positive response to 'I have a good balance between caring and other things in my life'	64	65	64	65	62
% positive response to 'I feel supported to continue caring'	35	33	30	31	31

Source: Scottish Government Health and Care Experience Survey. No target has been set for these measures as they may later be supplemented with local data.

Quality

Primary aim 1: To develop quality management systems for all service areas

Primary aim 2: To increase the capacity and capability of teams to undertake total quality management

Table 55: Overall assessment of progress – Quality

Aim	Strategic plan desired direction of travel	Direction of travel in year 1
Primary aim 1	Milestone measure	On track
Primary aim 2	Milestone measure	On track

Over the past year, we have made progress in developing quality management systems across our services. Each service now has a framework in place, though at different stages. We will continue to strengthen these systems and develop an overall approach to planning and managing services. Staff say this is already helping them better understand how their services are planned, monitored and improved. We will next assess how well these systems track performance and show impact, as part of our wider review of clinical and care governance.

Quarterly performance and quality meetings with heads of service help us review key indicators. Services report each quarter, and this informs assurance to the EIJB Clinical and Care Governance Committee. These meetings run alongside finance meetings to maintain a balanced focus on performance, quality and cost.

A new quality and safety team has been set up to support this work. The team will help services identify improvements and take a whole-system approach to learning from safety and feedback data.

Table 56: Progress against milestone measure – Quality

Action for completion	Target date for completion	Status
A quality assurance framework is in place to allow the review and assessment of the quality management systems (target operating models) put in place by each Head of Service	31 March 2027	On track
Quality skills framework and baseline measurement of skills in place	31 March 2027	On track

Coproduction

Primary aim: To develop a competency framework and associated training plan for leading and learning through co-production

Table 57: Overall assessment of progress – Co-production

Strategic plan desired direction of travel	Direction of travel in year 1
Milestone measure	On track

We are committed to improving how we use co-production in planning and delivering services. During 2026/27, our new team will develop and implement a co-production

framework, setting out how we will work with people and communities to design, improve and deliver services.

Table 58: Progress against milestone measure – co-production

Action for completion	Target date for completion	Status
Co-production competency framework and associated training plan in place	31 March 2028	On track

Collaborative commissioning

'Collaborative commissioning' is our new approach developed with our Third Sector Reference Group. It aims to deliver savings while improving collaboration and encouraging new ways of working.

The approach focuses on testing new ideas that could be scaled up to achieve better outcomes for people in Edinburgh. It recognises the need to work differently, especially with third sector partners, to continue meeting people's needs and delivering good quality care.

A change management group has led this work, using the Scottish Government's service design approach to make sure services are shaped around people. Partners from across the third sector have been involved through workshops and information sessions.

A two-stage funding process has been introduced. Stage 1 ran from February to May, with Stage 2 planned to begin later in 2026. We are currently developing a new community engagement and participation strategy, which will help strengthen our co-production work.

Building resilient communities/ethical commissioning and climate change

Primary aim 1: To improve community resilience, measured by increasing the proportion of commissioned services which can evidence effective corporate governance (e.g. regularly reviewed and tested risk registers, business continuity plans, financial health checks) in place

Primary aim 2: To ensure ethical commissioning principles are applied across our services, including around climate change

Table 59: Overall assessment of progress: Building resilient communities/Ethical commissioning and climate change

Aim	Strategic plan desired direction of travel	Direction of travel in year 1
Primary aim 1	Increase	Measure not yet available
Primary aim 2	Increase	Measure not yet available

We apply ethical commissioning principles to all newly commissioned services. This includes ensuring providers can demonstrate that they:

- Deliver high-quality services
- Treat all service users fairly and equally
- Provide benefits to local communities
- Operate sustainably and minimise environmental impact
- Have effective risk management and business continuity arrangements in place
- Follow fair work practices

These areas are monitored through our contract management arrangements, with further measures being developed to assess overall impact.

One Edinburgh framework

Our new contractual framework for One Edinburgh care at home services was introduced in June 2025. It provides access to a stronger, more sustainable group of provider partners through a single rate for community-based care at home services. Developed in partnership with providers through a co-production approach, the framework included engagement sessions on ethical commissioning principles. As part of the procurement process, providers were required to demonstrate how they apply these principles and maintain service continuity.

Finance

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 2025, 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.

Table 60: Comparison of costs against budget for 2025/26

Costs	Budget £m	Actual £m	Variance £m
Assessment and care management	112	111	1
Central	37	22	15
Home first, community rehabilitation and reablement	115	118	(3)
Hospitals, care homes and technology	61	57	4
Mental health, substance use and learning disabilities	190	200	(10)
Primary care	248	253	(5)
Subtotal core services	**771**	**761**	**2**
Hospital 'set aside' services	116	116	(0)
Services hosted by other partnerships/NHS Lothian	128	128	(0)
Reimbursement of independent contractors	84	84	0
Total all delegated services	**1,091**	**1,089**	**2**

Variance within individual services was driven by slippage in savings delivery offset by underspends in employee costs as a result of vacancies. Following additional one-off investment from the NHS, allocated against the non-core key financial pressures, a surplus position was reported against the budget for the year.

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 2026/27. 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 implementation of the Strategic Plan. The chart below shows how our costs have changed over the last five financial years.

Figure 22: EIJB total expenditure

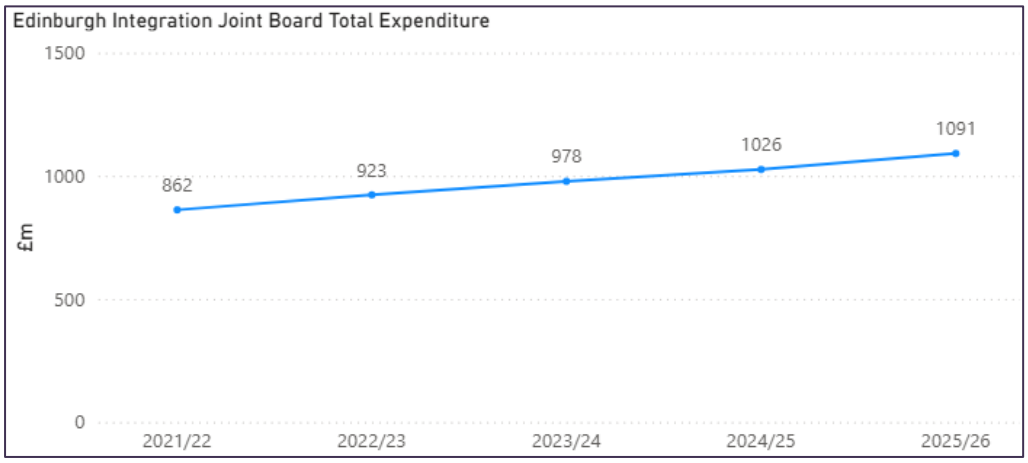
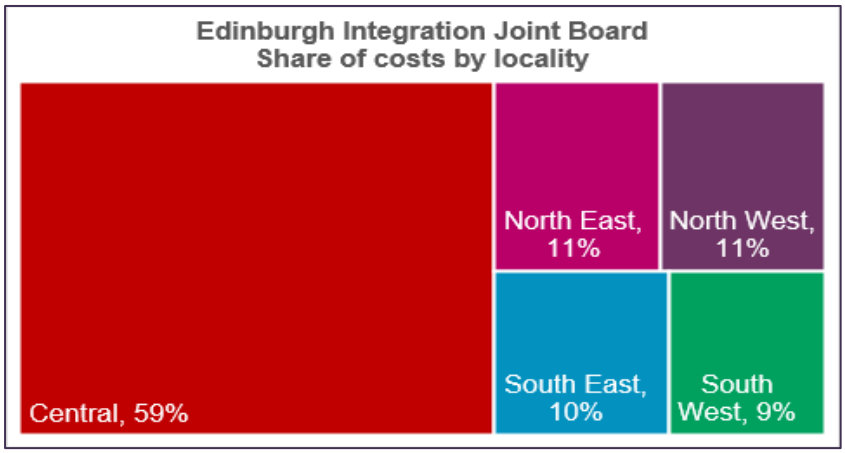


Table 61: EIJB total expenditure

Years	2020/21 £m	2021/22 £m	2022/23 £m	2023/24 £m	2024/25 £m	2025/26 £m
Total expenditure	849	862	923	978	1,026	1,091

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.

Figure 23: EIJB share of costs by locality



Savings and recovery programme

Our savings and recovery programme sets out a clear approach to achieving financial balance through a multi-year programme of change and efficiency. In 2025/26, we set ourselves a challenging target of £29 million across 19 projects. In total, £26.6 million was delivered, which is 92% of the target.

Six projects met their targets in full, five delivered savings well above target and three delivered over 95% of their target. Five projects were unable to deliver the full saving and, despite all efforts, mitigations or alternative savings were not achieved within the year.

Significant decisions

During the year, the EIJB agreed a number of instructions, called 'directions'. These are reviewed every year by the Performance and Delivery Committee, who then advise the EIJB on decisions around changes to each direction.

More details on each direction can be found by browsing the Edinburgh Integration Joint Board meetings.

Table 62: Directions agreed by EIJB

Title	Summary of direction
EIJB (1) - 01/05/25	Commission a new 19-bedded supported living complex for people with an assessed need
EIJB (2) - 01/05/25	Close a 15-bedded rehabilitation ward in the Royal Edinburgh Hospital and transfer the recurring budget to fund the commissioning of a new supported living accommodation for people with mental health needs
EIJB (1) - 13/05/25	Spot purchase four additional nursing care home beds for people with an assessed need
EIJB (2) - 13/05/25	Changes to Hospital Based Complex Clinical Care, hospice provision and palliative/ complex care transition planning
EIJB (1) - 17/06/25	Implement the Edinburgh Alcohol and Drug Partnership strategy 2025-2028
EIJB (1) - 26/08/25	Changes to services funded through block contracts and service level agreements
EIJB (1) - 10/02/26	Develop and pilot a walk-in practice at Wester Hailes Healthy Living Centre
EIJB (2) -10/02/26	Changes to mental health wards and staffing
EIJB (1) - 24/03/26	Recruit additional nursing, physiotherapy, occupational therapy staffing for establishment of a single point of access

Title	Summary of direction
EIJB (2) - 24/03/26	Recruit additional social care and support staff and procure community link worker capacity for establishment of a single point of access
EIJB (3) - 24/03/26	Expand the Hospital at Home service
EIJB (4) - 24/03/26	Establish a community neurological rehabilitation service
EIJB (5) - 24/03/26	Expand community rehabilitation capacity
EIJB (6) - 24/03/26	Recruit additional physiotherapists and support staff for incorporation into reablement service
EIJB (7) - 24/03/26	Recruit additional occupational therapists for incorporation into reablement service
EIJB (8) - 24/03/26	Set up a system where specialist teams go into the Western General Hospital and Royal Infirmary of Edinburgh emergency and admissions areas (front door areas) to support patients early on. Also, build specialist palliative care into Hospital at Home.
EIJB (9) - 24/03/26	Procure community-based falls prevention classes
EIJB (10) - 24/03/26	Implement contractual uplifts

Equality outcomes

Our Equality Outcomes 2024-28 explain how we will build equality into everyday working, as required by the Equality Act 2010. This section gives an update on our progress halfway through that plan.

Our strategic plan includes actions to help make sure our services are open and accessible to everyone. We will review the equality outcomes during 2026/27, alongside our planning for how to put the strategic plan into practice.

Table 63: Equality outcomes and progress

Equality outcome	Progress 2024-26
Early intervention and prevention – people are able to access information and support earlier to allow them to have more good days, maintain health and wellbeing and prevent crisis.	Our strategic plan sets out specific areas where we will focus on prevention and early intervention. Each individual implementation plan includes a section explaining how health inequalities and equality characteristics will be considered.
Improving access to services – people at risk of harm are identified, the right action is taken quickly and waiting times for those who need support is reduced.	A programme has started to design a single point of access for services, so that people find it easier to access and navigate our services and get the right help more quickly and easily. Our health inequalities implementation plan will focus on making sure people do not experience different levels of access to services because of protected characteristics.
Learning Disability Transformation – people with a learning disability are able to lead independent lives and be valued members of their community.	We have focused on supporting discharges from hospital and out of area placements for people with learning disabilities over the last year.
Reduce Inequalities – the health inequality gap is reduced through work with all our partners across statutory, voluntary and independent sectors.	We continue to take part in the work of the Edinburgh Partnership and the Local Outcomes Improvement Plans. This includes helping to develop Neighbourhood Prevention Partnerships, which will work together with local communities to design and deliver local services.
Communications – availability of information and accessibility is improved, and bureaucracy is reduced.	We audited our website to make sure all its content meets accessibility requirements. We also committed to building a co-production approach into our service planning.
Digital technology – will be an enabler for choice, flexibility and improved outcomes for people, and improve the experience of staff	The EIJB approved our Digital and Data Strategy, which included a commitment to digital inclusivity.

Inspections

Care Inspectorate reviews

We deliver thirty-two regulated adult care services that are subject to inspection by the Care Inspectorate.

During 2025/26, seventeen inspections took place across seventeen care services (detailed below). These services were based in Care Homes for Older People, Disability Services, Reablement Services and Sheltered Housing.

All services received a grade 4 (good) or above across all inspected key questions. Twelve services received at least one grade 5 (very good) for key questions. Eight services received grade 5 (very good) for all key questions inspected.

One area for improvement was made for one support service: to support people's health and wellbeing, the provider should formalise the observation of staff practice and keep a reflective record which informs supervision, staff development and appraisal.

Five previous areas for improvement were met.

Care Homes for Older People Key Themes

The two main themes that came out from inspections were around people's care and wellbeing and the care home environment.

People experiencing care and their relatives reported having a very positive care experience, with care from staff who knew them well.

The care home environments were well maintained, clean and homely.

Disability Services Key Themes

Disability Services themed highly in care and wellbeing. People were able to engage in activities they really enjoyed at home and in the community and there was a strong focus on a holistic approach to enhancing people's wellbeing

Reablement Services Key Themes

Reablement Services themed highly in care and wellbeing. People were positive and motivated by the support they received. Support was responsive to people's changing needs. People experiencing care, their family members and other professionals the Inspectorate spoke with commented favourably about the high standard of service people received. Good quality assurance processes ensured high quality care and support.

Table 64: Services inspected by the Care Inspectorate

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?
Castlegreen Care Home	10/07/2025	5 – very good	Not assessed	Not assessed	5 – very good	Not assessed
Ferrylee Care Home	28/10/2025	5 – very good	Not assessed	5 – very good	5 – very good	5 – very good
Inch View Care Home	26/08/2025	4 – good	4 – good	4 – good	4 – good	4 – good
Jewel House Care Home	27/05/2025	4 – good	4 – good	4 – good	4 – good	4 – good
Marionville Court Care Home	30/07/2025	5 – very good	Not assessed	Not assessed	4 – good	Not assessed
North Merchiston Care Home	23/09/2025	4 – good	Not assessed	Not assessed	4 – good	Not assessed
Royston Court Care Home	16/01/2026	5 – very good	Not assessed	Not assessed	5 – very good	Not assessed
Edinburgh Support Services – Community Support	10/12/2025	4 – good	Not assessed	4 – good	Not relevant	Not assessed
Firrhill Housing Support and Care at Home Service	23/02/2026	5 – very good	Not assessed	5 – very good	Not relevant	Not assessed
Support Works: Group 1 Housing Support and Care at Home Service	17/04/2025	5 – very good	Not assessed	5 – very good	Not relevant	Not assessed
Positive Steps Housing Support and Care at Home Service	19/06/2025	5 – very good	Not assessed	4 – good	Not relevant	Not assessed
North East Home Care Service Leith	28/08/2025	5 – very good	Not assessed	5 – very good	Not relevant	4 – good
North East Home Care Service East	28/08/2025	5 – very good	Not assessed	5 – very good	Not relevant	4 – good

North East Reablement Service	01/09/2025	5 – very good	Not assessed	5 – very good	Not relevant	5 – very good
Overnight Home Care Service	31/03/2026	5 – very good	Not assessed	5 – very good	Not relevant	5 – very good
South West Reablement Service	22/07/2025	5 – very good	Not assessed	5 – very good	Not relevant	Not assessed
Sheltered Housing Support Service	07/05/2025	4 – good	4 – good	4 – good	Not relevant	4 – good

Performance against national indicators

There are 23 national health and social care indicators. Four (10, 21, 22 and 23) are not yet finalised for reporting, and one (20) has not been reported since the pandemic due to data issues.

National indicators 1 to 9 come from the Scottish Health and Care Experience Survey, sent to around 5% of the population every two years. The latest results, for 2025/26, were received in July 2026. Results for indicators 2, 3, 4, 5, 7 and 9 cannot be compared with data before 2023/24 due to changes in wording, so earlier figures are not shown.

Indicators 12 to 16 use Scottish hospital discharge records. As 2025/26 data is incomplete, we have used calendar year 2025 instead, following Public Health Scotland guidance. This should improve consistency across partnerships.

Indicator 20 has not been updated since 2019/20, as detailed cost data has not been available since the COVID-19 pandemic.

There are also six performance indicators set by the ministerial strategic group for health and community care (MSG). Some of the indicators have multiple measures associated with them (identified using letters, eg, MSG 2a/b/c). While similar to some of the core indicators, these figures are calculated in slightly different ways so are not comparable.

The table below shows our quartile and five year performance for each of these indicators. Quartile 1 or dark green represents Edinburgh being within the best performing eight HSCPs and quartile 4 or dark red represents Edinburgh being in the eight worst performing HSCPs. The trend column represents the five year overall direction of travel for the indicator. Dashes indicate that we do not have data available for that period. An * indicates the data is for calendar year rather than financial year. A p indicates the data is still provisional.

We remain in the top half of health and social care partnerships across Scotland for 77% of the indicators (20 out of 26). 18 out of 27 indicators (67%) have seen an improvement in performance over the five-year trend data. Also, 94% (17 out of 18) of the national core suite indicators have performed better than, or the same as, Scotland this year.

Table 65: National health & social care indicators

Indicator ref	Core indicator	Area	2021-22	2022-23	2023-24	2024-25	2025-26	Quartile	Five year trend
NI – 1	Percentage of adults able to look after their health very well or quite well	Edinburgh	91.6%	-	91.9%	-	91.0%	3	Steady
NI – 1	Percentage of adults able to look after their health very well or quite well	Scotland	90.9%	-	90.7%	-	90.6%	-	Steady
NI – 2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	Edinburgh	-	-	75.2%	-	79.5%	2	Improving
NI – 2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	Scotland	-	-	72.4%	-	73.6%	-	Improving
NI – 3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	Edinburgh	-	-	57.2%	-	72.8%	1	Improving
NI – 3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	Scotland	-	-	59.6%	-	63.9%	-	Improving
NI – 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	Edinburgh	-	-	63.1%	-	76.7%	1	Improving

Indicator ref	Core indicator	Area	2021-22	2022-23	2023-24	2024-25	2025-26	Quartile	Five year trend
NI – 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	Scotland	-	-	61.4%	-	65.0%	-	Improving
NI – 5	Total percentage of adults receiving any care or support who rated it as excellent or good	Edinburgh	-	-	74.1%	-	78.2%	1	Improving
NI – 5	Total percentage of adults receiving any care or support who rated it as excellent or good	Scotland	-	-	70.0%	-	72.1%	-	Improving
NI – 6	Percentage of people with a positive experience of the care provided by their GP practice	Edinburgh	73.8%	-	75.1%	-	77.0%	2	Improving
NI – 6	Percentage of people with a positive experience of the care provided by their GP practice	Scotland	66.5%	-	68.5%	-	70.7%	-	Improving
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	Edinburgh	-	-	72.0%	-	81.8%	1	Improving
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	Scotland	-	-	69.8%	-	71.7%	-	Improving
NI – 8	Total combined % carers who feel supported to continue in their caring role	Edinburgh	30.4%	-	31.3%	-	31.1%	3	Steady

Indicator ref	Core indicator	Area	2021-22	2022-23	2023-24	2024-25	2025-26	Quartile	Five year trend
NI – 8	Total combined % carers who feel supported to continue in their caring role	Scotland	29.7%	-	31.2%	-	31.9%	-	Improving
NI – 9	Percentage of adults supported at home who agreed they felt safe	Edinburgh	-	-	78.6%	-	78.5%	2	Steady
NI – 9	Percentage of adults supported at home who agreed they felt safe	Scotland	-	-	72.7%	-	74.7%	-	Improving
NI – 11	Premature mortality rate (per 100,000)	Edinburgh	409.5*	415.0*	415.6*	356.0*	-	2	Improving
NI – 11	Premature mortality rate (per 100,000)	Scotland	463.2*	440.9*	440.1*	426.1*	-	-	Improving
NI – 12	Emergency admission rate (per 100,000 population)	Edinburgh	8,955	7,483	8,143	7,629	8,068*	1	Steady
NI – 12	Emergency admission rate (per 100,000 population)	Scotland	11,777	11,327	11,764	11,333	11,470*	-	Steady
NI – 13	Emergency bed day rate (per 100,000 population)	Edinburgh	111,059	108,627	101,661	92,933	82,102*	1	Improving
NI – 13	Emergency bed day rate (per 100,000 population)	Scotland	118,395	124,329	121,590	116,715	108,988*	-	Improving
NI – 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	Edinburgh	111	92	98	98	102*	3	Steady
NI – 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	Scotland	107	102	105	103	104*	-	Steady

Indicator ref	Core indicator	Area	2021-22	2022-23	2023-24	2024-25	2025-26	Quartile	Five year trend
NI – 15	Proportion of last 6 months of life spent at home or in a community setting	Edinburgh	88.2%	87.8%	88.6%	88.4%	90.1%*	2	Improving
NI – 15	Proportion of last 6 months of life spent at home or in a community setting	Scotland	89.6%	88.8%	88.8%	89.0%	89.3%*	-	Steady
NI – 16	Falls rate per 1,000 population aged 65+	Edinburgh	26.2	22.8	24.8	22.3	24.4*	4	Steady
NI – 16	Falls rate per 1,000 population aged 65+	Scotland	22.5	22.1	22.5	21.9	22.2*	-	Steady
NI – 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	Edinburgh	80.6%	80.0%	83.5%	86.7%	84.6%	2	Improving
NI – 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	Scotland	75.8%	75.2%	77.0%	81.9%	83.1%	-	Improving
NI – 18	Percentage of adults with intensive care needs receiving care at home	Edinburgh	61.3% 2021)	66.9% (2022)	68.7% (2023)	68.2% (2024)	-	2	Improving
NI – 18	Percentage of adults with intensive care needs receiving care at home	Scotland	64.5% (2021)	64.7% (2022)	64.5% (2023)	64.7% (2024)	-	-	Steady
NI – 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	Edinburgh	1,388.6	1,256.8	1,020.0	1,065.1	771.2	2	Improving
NI – 19	Number of days people spend in hospital when they are ready to	Scotland	749.7	883.1	841.5	898.9	873.0	-	Declining

Indicator ref	Core indicator	Area	2021-22	2022-23	2023-24	2024-25	2025-26	Quartile	Five year trend
	be discharged (per 1,000 population)								
MSG1	Rate of Emergency Admissions	Edinburgh	94.4	81.5	90.5	84.1	88.3*	1	Steady
MSG2a	Unscheduled Bed Days (Acute):	Edinburgh	737.1	733.8	704.7	659.3	598.3*	1	Improving
MSG2b	Unscheduled Bed Days (Geriatric Long Stay):	Edinburgh	66.2	61.4	62.8	44.4	29.8*	Not available	Improving
MSG2c	Unscheduled Bed Days (Mental Health):	Edinburgh	308.1	304.9	288.9	281.5	281.7*	4	Improving
MSG3a	Rate of A&E Attendances	Edinburgh	240.8	230.6	236.6	232.5	238.5	2	Steady
MSG3b	4-hour Performance	Edinburgh	64.2%	49.2%	53.0%	54.3%	59.2%	3	Improving
MSG4	Delayed Discharge Bed Days:	Edinburgh	175.0	163.1	140.3	138.2	103.7	2	Improving
MSG5	Last 6 months of life spent in a community setting	Edinburgh	88.2%	87.8%	88.8%	88.4%	90.1% P*	2	Improving
MSG6	Balance of Care: at home	Edinburgh	99.2%	99.2%	99.7%	-	-	1	Steady

Source: Public Health Scotland