Corporate Policy and Strategy Committee

10am, Tuesday, 3 October 2017

Edinburgh Integration Joint Board Annual Performance Report 2016/17

Item number	8.3
Report number	
Executive/routine	
Wards: All	
Council Commitments	

Executive Summary

1 All integration authorities are required by the Public Bodies (Joint Working) (Scotland) Act 2014 to produce an annual performance report no later than three months after the financial year to which the report relates. The first annual performance report of the Edinburgh Integration Joint Board covering 1 April 2016 to 31 March 2107, which was published on 1 August 2017, is attached as Appendix A.

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Report

Edinburgh Integration Joint Board Annual Performance Report 2016/17

1. Recommendations

1.1 Corporate Policy and Strategy Committee is asked to note the first Annual Performance Report of the Edinburgh Integration Joint Board, which is attached as Appendix A.

2. Background

2.1 All Integration Joint Boards are required by the Public Bodies (Joint Working) (Scotland) Act 2014 to publish an annual performance report for the period 1 April to 31 March no later than 3 months after the end of the period. The report attached as Appendix 1 is the first Annual Performance Report published by the Edinburgh Integration Joint Board.

3. Main report

3.1 As required by the legislation and related guidance the report details performance in the following areas:

- delivery of the nine National Health and Wellbeing Outcomes and related key priorities of the Integration Joint Board
- finance and best value
- moving to a locality based model of planning and delivering services
- inspection of services
- review of the Integration Joint Board strategic commissioning plan

3.2 In the longer term, the expectation is that the annual performance report will include data for the current year and four preceding years, to allow comparison and show trends. As integration authorities have only recently been established, the requirement is that the report covers only the period since services were delegated on 1 April 2016. This makes benchmarking difficult.

3.3 For 2016/17, all Integration Joint Boards have been required to report performance against 23 national indicators intended to measure progress in delivering the nine

national health and wellbeing outcomes. From 1 April 2017 onwards, a further six national indicators will be used to measure the progress of integration.

3.4 The approach taken in the Edinburgh Annual Performance Report has been to illustrate performance against the 23 national indicators compared to other Integration Joint Boards, where this information has been published. The other comparator used is performance in the previous year, whilst recognising that this predates the delegation of services to the Integration Joint Board. A set of local indicators has also been developed.

3.5 The main body of the Annual Performance Report provides a narrative around the areas outlined in paragraph 3.1 above and includes a number of case studies for illustrative purposes. Data detailing performance against specific indicators or in specific areas, is provided in the appendices to the main report, attached as Appendix B to this report.

4. Measures of success

4.1 The Annual Performance Report of the Edinburgh Integration Joint Board details performance in relation to services delegated to the Board. The report is being used to inform future strategic planning by the Board and services delivered through the Health and Social Care Partnership. The data contained in the appendices is being used to establish a baseline against which future performance can be measured.

5. Financial impact

5.1 Details of financial performance during 2016/17 are included within the Annual Performance Report.

6. Risk, policy, compliance and governance impact

6.1 In order for the performance report to be useful, it is necessary for performance to be recorded and monitored and used as a means to improve service delivery and quality.

7. Equalities impact

7.1 The Annual Performance Report details the performance of services that are used by all sections of the community both specialist services and universal services, such as primary care. In responding to Outcome 5 of the National Health and Wellbeing Outcomes, the Performance Report addresses performance in relation to reducing health inequalities.

8. Sustainability impact

8.1 There are no direct sustainability impacts arising from this report.

9. Consultation and engagement

9.1 The development of the Annual Performance Report was overseen by the Performance and Quality Sub-group of the Integration Joint Board, membership of which includes citizens with lived experience of using health and social care services and unpaid carers, along with representatives of the third and independent sectors.

10. Background reading/external references

10.1 Scottish Government Guidance on Integration Partnership Performance Reports

Michelle Miller

Interim Chief Officer Edinburgh Health and Social Care Partnership

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11. Appendices

Appendix A – Edinburgh Integration Joint Board Annual Performance Report

Appendix B – Appendices to Edinburgh Integration Joint Board Annual Performance Report

Delivering Health and Social Care in Edinburgh

Edinburgh Integration Joint Board Annual Performance Report 2016/17

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Foreword

This is the first Annual Performance Report of the Edinburgh Integration Joint Board (EIJB). The report provides a review of the progress made during 2016/17, the first year of operation of the Edinburgh Integration Joint Board and Health and Social Care Partnership.

In line with the expectations set by the Scottish Government the report considers our performance from several different perspectives:

- the progress we have made in:
    - achieving the nine national Health and Wellbeing Outcomes and the related key priorities of the Integration Joint Board;
    - moving to a locality based model of planning and delivering services;
    - making our strategic plan a reality;
- the way in which we have managed our finances and delivered best value; and
- how other people see us based on feedback from people who use our services, unpaid carers and staff and external organisations who inspect and regulate health and social care services

As anticipated we have faced many challenges during 2016/17 to improve the quality of services at a time of significant resource reduction, whilst moving to an integrated four locality model of operation.

The major challenges we faced included:

- too many people in Edinburgh waiting too long to receive the support they need to help them live independent and healthy lives at home; making a significant reduction in the number of people waiting for support and the length of time they are waiting will be an absolute priority during 2017/18;
- a significant proportion of the GP practices in Edinburgh are operating with restricted lists and there are significant difficulties recruiting and retaining care workers in a city with virtually full employment;
- the Joint Inspection of Services for Older People that took place in 2016/17, identified a number of weaknesses in service planning and delivery and found some of our key processes to be 'unsatisfactory'. We have developed a robust action plan in response to the recommendations from the Inspection the implementation of which is being proactively managed.
- although we delivered a balanced budget in 2016/17 our financial position continues to be a challenge.

Whilst we do not wish to gloss over the performance and quality challenges, we have some positives to report. There has been significant progress in implementing the new structure that will support the delivery of services on a locality basis, and will

introduce more preventative and proactive services for the citizens of Edinburgh. We believe that this will allow us to provide more responsive and person-centred services focused on assessing, treating and supporting people as close to home as possible so they can live their lives in ways that suit them.

One of our great strengths is the dedication of our workforce all of whom are committed to providing the best services possible to keep the citizens of Edinburgh safe and healthy. Whilst the Joint Inspection report on Services for Older People was critical in several areas it did identify that services where they were received were good.

> *"When people received services, they were generally of good quality and made a positive difference."* *Joint Inspection of Services for Older People May 2017*

Our performance in respect of unscheduled care is amongst the best in Scotland.

Our teams are fully aware of the challenges that remain to be met in providing "the right care in the right place at the right time". With our restructure virtually complete and our staff teams motivated and keen to meet these challenges, we are in a much-improved position at the end of this reporting period.

The information contained in this report has been used to inform the programme of work we are taking forward to implement our strategic plan during 2017/18. The challenges are still great but the goal is within sight and I look forward to presenting next year's report.

Rob McCulloch-Graham

Chief Officer Edinburgh Integration Joint Board

Introduction and overview

The Edinburgh Integration Joint Board (IJB) was legally established in July 2015. Since April 2016, the Board has been responsible for the strategic planning and operational oversight of most community health and social care services for adults and some hospital based services.

In the main, the services for which the Board is responsible are managed, delivered and commissioned through the Edinburgh Health and Social Care Partnership. The Partnership brings together staff employed by the City of Edinburgh Council and NHS Lothian to provide integrated services under the leadership of a single Chief Officer. The Partnership also commissions services on behalf of the Integration Joint Board from a range of providers in the third, independent and housing sectors.

Whilst the provision of housing is not delegated to the Integration Joint Board, the Board recognises the importance of having somewhere warm, dry and safe to live for the health and wellbeing of citizens. The links between housing, health and social care are set out in the Housing Contribution Statement which accompanies the Strategic Plan.

The Edinburgh IJB is also responsible for some services that are managed directly by NHS Lothian or one of the other Health and Social Care Partnerships in Lothian.

Services for which the Edinburgh IJB is responsible include:

- Adult social work services
- Community dentistry, pharmacy and ophthalmology
- Community nursing
- Health and social care services for older people, adults with disabilities, adults with mental health issues and unpaid carers
- Health promotion and improvement
- Palliative and end of life care
- Primary care (GP)
- Services provided by Allied Health Professionals (e.g. Therapists)
- Sexual health
- Substance misuse
- Support for adults with long term conditions
- Unscheduled admissions to hospital

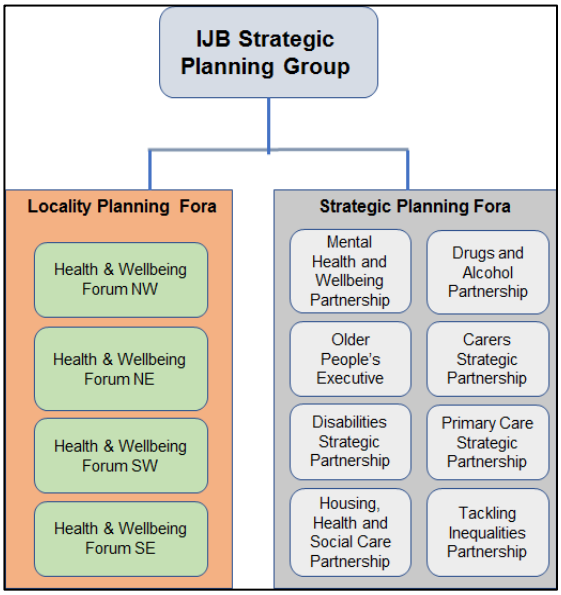
In March 2016, the IJB published its strategic plan setting out the strategic direction for health and social care services in Edinburgh from 2016 to 2019. The plan included our vision of 'People and organisations working together for a caring, healthier, safer Edinburgh'. To help us deliver this vision the plan identified the six linked key priorities in the diagram overleaf. The priorities reflect the dual role of the Integration Joint Board in planning services to meet current need and manage future demand.

Edinburgh Integration Joint Board Key Priorities

Strategic Planning

The Public Bodies (Joint Working) (Scotland) Act 2014 requires integration authorities to establish a strategic planning group for the purposes of consulting on their strategic plans. Our strategic plan published in March 2016 was produced in collaboration with our Strategic Planning Group, membership of which includes the Chair and Vice-chair of the Integration Joint Board; citizens with lived experience of using health and social care services or caring for someone who uses them; representatives of the City of Edinburgh Council and NHS Lothian; third and independent sector interface organisations and providers of health and social care services; providers of social housing and the Integration Joint Board's Professional Advisory Group that represents health and social care professionals.

We have established a strategic planning framework to support the Strategic Planning Group. This includes the locality health and wellbeing forums, strategic planning forums for mental health and wellbeing, older people, people with disabilities, and substance misuse. The framework also includes two cross-cutting forums focused on housing and tackling inequalities. Members of the locality and strategic planning forums include representatives of key stakeholder groups and act as a wider constituency for members of the Strategic Planning Group, providing them with access to a wide range of opinion.



Our strategic plan identifies the following twelve areas of focus which we believe will allow us to deliver our 6 key priorities:

- Achieving integration at a locality level
- Tackling inequalities
- Consolidating our approach to prevention and early intervention
- Ensuring a sustainable model of primary care
- Improving care and support for frail older people and those with dementia
- Transforming services for people with disabilities
- Supporting people living with long term conditions
- Redesigning Mental Health and Substance Misuse services
- Maximising the use of technology to support independent living and effective joint working
- Improving our understanding of the strengths and needs of the local population
- Integrated workforce planning and development
- Living within our means

We reviewed our strategic plan at the end of 2016/17 to identify the progress made in terms of what we set out to do and agree priorities for delivery in 2017/18. The outcome of this review has informed the content of our Annual Performance Report.

Our approach to reporting performance

In producing this annual report, we have used several sources of information:

i. National indicators
A core set of 23 national indicators has been developed to measure the performance of each health and social care partnership in achieving the Health and Wellbeing Outcomes. The indicators look at both the operational performance of partnerships and the experience of citizens who make use of health and social care services. Our performance against the 23 national indicators is detailed in Appendix 1. Comparative data for other areas across Scotland is not available for all indicators in respect of 2016/17, where this is the case and comparative data for 2015/16 is available, this has been used instead.

ii. The National Health and Care Experience Survey
A postal survey is undertaken every two years of a subset of people registered with a GP asking about their experience of accessing and using their GP practice, some social care services and support for unpaid carers. The survey is the source of nine of the core set of 23 national integration indicators. The survey was last carried out in 2015/16 which predates the establishment of the Integration Joint Board; however, the results of this survey identify issues that the Board needs to address and provide a baseline against which to measure future performance. The full results for Edinburgh can be accessed here.

iii. Local indicators
A set of indicators has been adopted locally to track progress against the strategic plan and towards the priority outcomes; some are used to measure performance within and between the four localities whilst others show performance at a citywide level. The local indicators can be found in Appendix 2.

iv. Feedback
We receive feedback from a number of sources including compliments and complaints and through formal inspections which may be themed or in respect of a specific service. We have also undertaken local satisfaction surveys.

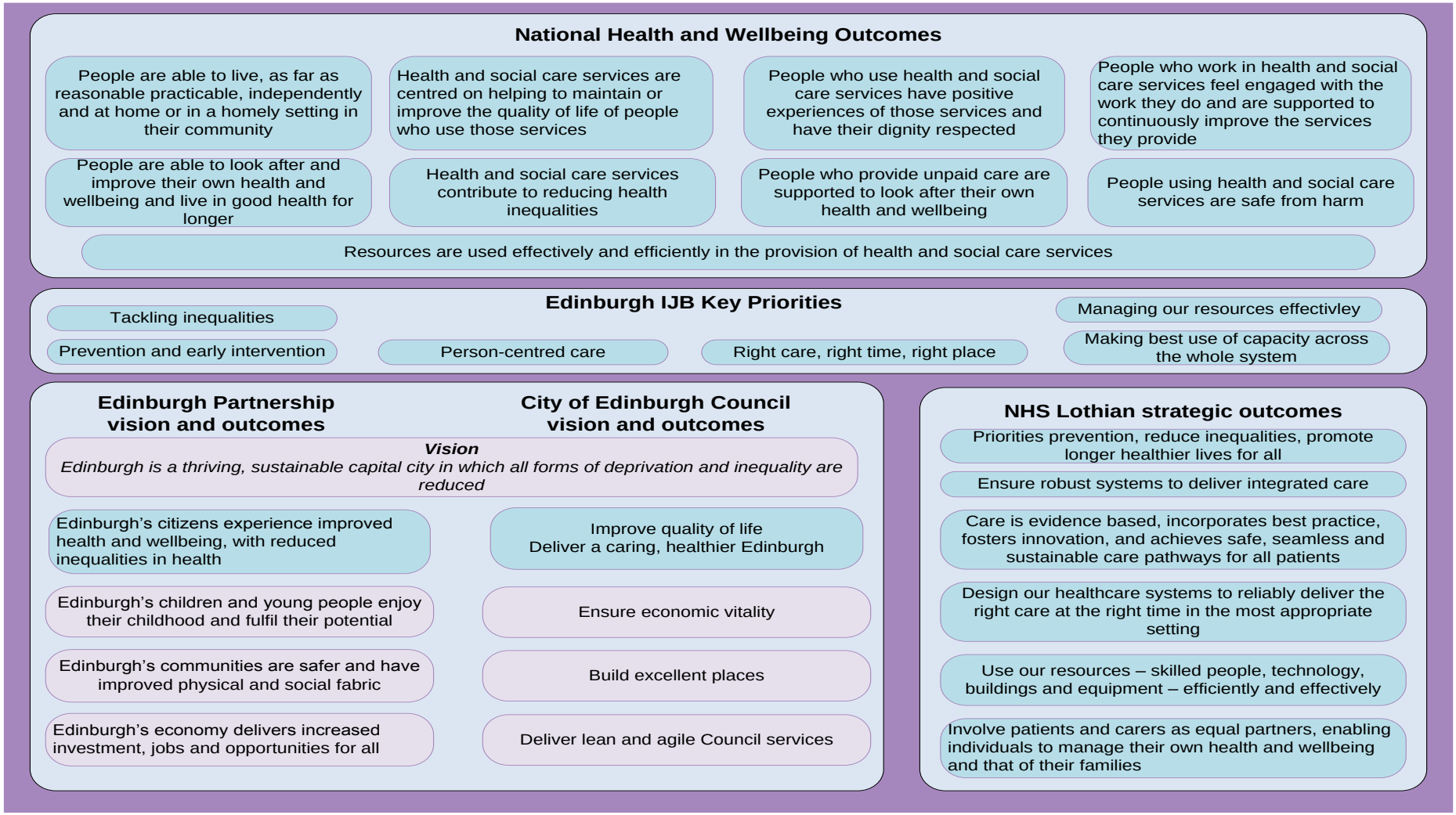
v. Case studies
We recognise the importance of stories in helping us to identify the impact of our strategic plan and the services provided and commissioned through the Health and Social Care Partnership. We have included some case studies in this report and will be developing ways of collecting these on a regular basis to help us improve future.

Delivering against the National Health and Wellbeing Outcomes

The nine National Health and Wellbeing indicators shown at the top of the diagram on the following page, are a set of high level statements produced by the Scottish Government. The outcomes describe what Health and Social Care Partnerships are working to achieve through the integration of services and the pursuit of quality improvement.

This section of the Annual Report details our performance against the nine outcomes from 1 April 2016 to March 2017. Information about our performance against each of the 23 national indicators is given throughout this section and in Appendix 1.

The 6 priorities within our strategic plan have strong links to the National Health and Wellbeing Outcomes and the strategic priorities of NHS Lothian, the City of Edinburgh Council and the Edinburgh Community Planning Partnership. These linkages are illustrated in the diagram below.



Outcome 1

People are able to look after and improve their own health and wellbeing and live in good health for longer

What we say in our strategic plan

Our strategic plan sets out a clear intention to develop a new relationship with and between citizens and communities, our services and staff and the many organisations who contribute to encouraging, supporting and maintaining the health and wellbeing of the people of Edinburgh.

Preventing poor health and wellbeing outcomes is a key priority within our strategic plan, we aim to do this by working with our partners to support and encourage people to:

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

How are we performing?

Access to responsive primary care services is central to supporting people to look after their own health and wellbeing. GP practices in Edinburgh are under considerable pressure from increased demand due to the growing population in the city and the national shortage of people wanting to enter the profession. Actions to help alleviate this situation have included making better use of the wider primary care workforce, improving GP premises and working collaboratively with partners to improve health and wellbeing in local communities. We also work with individuals affected by long term conditions to support them to manage their condition(s) themselves as far as possible.

Overall 96% of Edinburgh citizens who responded to the 2015/16 Health and Care Experience Survey said that they were able to look after their health very well or quite well. This compares with an average of 94% across Scotland.

Approximately 38 of the 74 GP practices in the city (51%) are operating restricted lists which means that they have introduced criteria to limit the number of new registrations. The number of people registered with GPs increased by 7,000 during 2016/17 and approximately 3.25 million patient consultations were undertaken by GP practices during this period.

Despite these pressures, patients' satisfaction with the services they receive from their GP practice measured through responses to the 2015/16 Health and Care Experience Survey was above the Scottish average:

- 89% of respondents rated the overall care provided by their practice as 'good' compared to a satisfaction level of 87% in Scotland as a whole;
- 85% of respondents in Edinburgh said that they 'could get to see a doctor or nurse within 2 working days' and agreed that the 'arrangements for getting to see a nurse were excellent or good' (compared to a Scottish average of 84% and 82% respectively).

However, only 76% of respondents agreed that the arrangements for getting to see a doctor were excellent or good. Whist this result is disappointing it is better than the national picture where only 71% of respondents agreed with the statement. Given the considerable pressures that GP practices are working under, it is perhaps not surprising that people feel that their GP is not as accessible as they would like.

Progress we have made

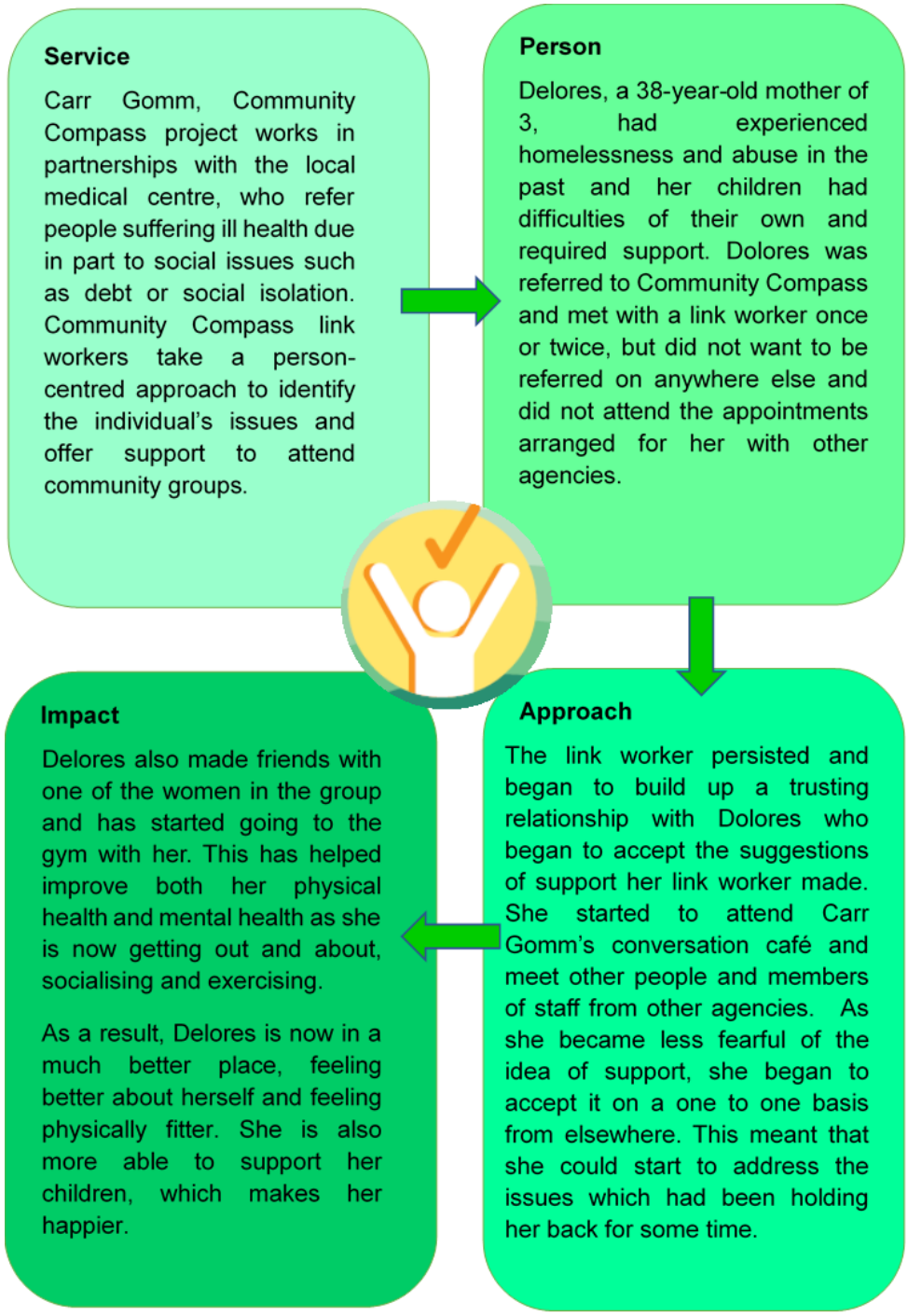
In 2016/17 we have:

- worked with 18 individual GP practices to ensure stability in the short to medium term including the use of pharmacists, advanced nurse practitioners, community psychiatric nurses, link workers and physiotherapists to supplement medical sessions;
- consulted with GPs across the city as to how funding should best be used to augment the workforce and stabilise Primary Care; this includes capacity to develop social prescribing and implement a network of link workers;
- worked with NHS Lothian to provide new or extended premises for eight practices and support population growth;
- developed plans that will see four new primary care premises open in 2017/18;
- consulted extensively with GPs to ensure that there is a premises plan that supports the City's Local Development Plan (2016–2026) which will see the population of Edinburgh increase by a further 50,000;
- developed the 'Fit for Health' physical activity programme in partnership with Edinburgh Leisure helping people with long term conditions to manage their own condition by improving their strength, mobility and cardiovascular function. 78% of participants reported greater wellbeing including weight loss and improved sleep – positively influencing both their physical and mental wellbeing;
- supported people whose health is affected by social issues such as debt or social isolation through Carr Gomm's Community Compass project, which works with local medical centres.

Priorities for 2017/18

- Continue the programme to enhance GP premises, including: relocation of Polworth practice; commissioning Ratho Medical Practice, North West Partnership Centre, Leith Walk Medical Practice and Allermuir Health Centre; co locate the Access Practice with a range of other services to support homeless people with complex needs.
- Implement the plan developed for the use of funding to augment the workforce and stabilise primary care.

Case Study – Carr Gomm Community Compass



Outcome 2:

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

What we say in our strategic plan

Delivering the right care in the right place at the right time for each person, is a key priority within our strategic plan. We aim to ensure that people:

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

How are we performing?

To provide the right care in the right place at the right time, we need to ensure that we have the right mix and capacity of services across all settings including preventative services in the community, proactive care and support at home, effective care at times of transition and intensive care and specialist support. Our performance in this regard has been mixed. Whilst we have been relatively successful at keeping people out of hospital and caring for them at home, too many people are waiting too long for the support they need either in hospital or in the community. This remains a significant challenge for the Edinburgh Health and Social Care Partnership.

Of those responding to the Health and Care Experience Survey in 2015/16, 82% agreed that they were supported to live as independently as possible.

Our performance in relation to emergency admissions to hospital in 2015/16, the last year for which comparative data is available, was the best in Scotland with 8,393 admissions per 100,000 of the population compared to the Scottish average of 12,138 admissions per 100,000 of the population. The rate of emergency bed days occupied, 112,147 per 100,000 of the population, also compared favourably to the national figure of 122,713. Whilst comparative data is not available for 2016/17 both the rate of emergency admissions and the rate of emergency bed days occupied have fallen in Edinburgh; admissions by 116 and bed days occupied by 3,542, which is positive. However, the

number of people who are readmitted to hospital within 28 days of being discharged is relatively high.

In 2015/16, 62.3% of adults with intensive care needs were supported to live at home which is better than the Scottish average of 61.6%. However, if we are to be successful in achieving our ambition of shifting the balance of care to the community, this is an area where performance needs to improve.

The Reablement Service provides intensive support for a short period to help people regain their confidence, skills and independence. The majority of people using this service have either needed no ongoing support or the level of support required has reduced.

Our biggest challenges in relation to providing people with the right care at the right time in the right place relate to providing a timely response to requests to assess people's needs and put packages of care in place within the community and supporting people to be discharged from hospital when they are fit to leave.

All urgent assessments are carried out within 24 hours; however, in March 2017, 1,428 people were waiting for social care assessments to take place in the community, the average waiting time was 101 days against a maximum target on 28 days. Although the number of people waiting was beginning to reduce by March 2017, the length of wait was growing. Our assessment processes have been reviewed and streamlined to address this significant challenge.

Our partner providers in the third and independent sectors continue to face difficulties in the recruitment and retention of staff. This impacts directly on our performance in respect of delayed discharges which is poor and has been for some time. There were 176 people whose discharge from hospital had been delayed in March 2017, although this is a reduction from 221 people in January 2017, the number remains unacceptably high. We have a target to reduce this number to 50 by the end of December 2017.

Progress we have made

During 2016/17, we have:

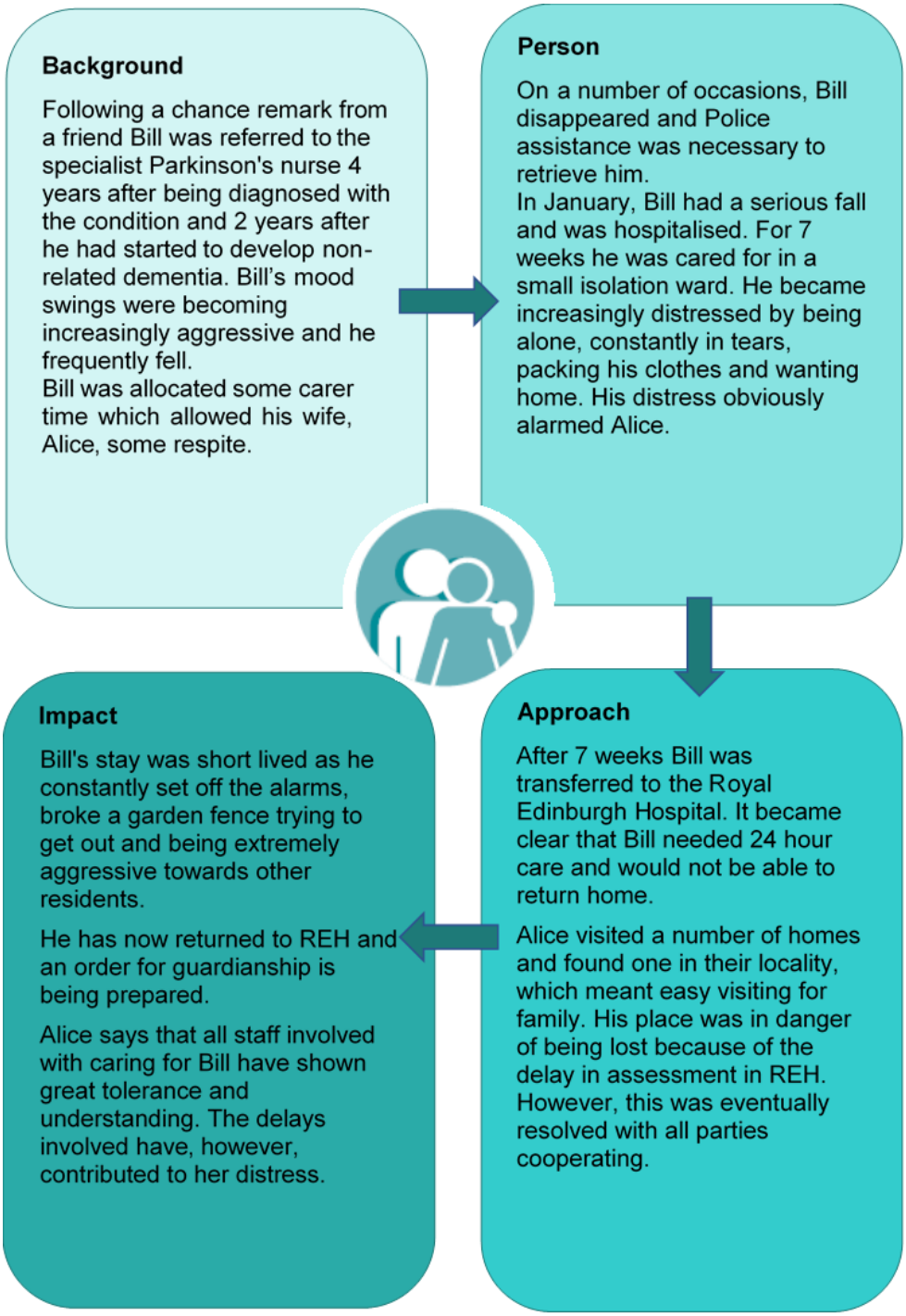
- established a locality based structure with integrated teams that will provide care and support closer to home to avoid hospital admission, facilitate timely discharge from hospital and help people maintain and regain their independence;
- established a new orthopaedic supported discharge team which facilitates safe, supported, early discharge by providing short term rehabilitation at home. 73% of the people supported did not need any further help;
- used dedicated Mental Health Officer time to speed up the granting of Guardianship Orders for people who lack capacity and are delayed in hospital. This resulted in the number of people waiting being reduced by almost 50%;

Priorities for 2017/18

- Reduce both the numbers of people waiting for support and the length of waiting times.

- Investigate reasons for hospital readmission rates and develop plans in response
- Work with the providers of care at home services to increase capacity.
- Simplify and streamline our assessment and review processes This will provide additional capacity to reduce the length of time people wait.
- Increase the provision within the community to allow people to move out of long stay hospitals, including Murray Park and the Royal Edinburgh Hospital.

Case Study – Impact of delays in assessment



Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected.

What we say in our strategic plan

Practising person centred care is a key priority in our strategic plan and is key to delivering our vision for where we want to be by 2020 when:

- *people and communities work with local organisations to determine priorities and plan, design, deliver and evaluate services; and*
- *people, their families and carers are supported to decide how their care and support needs should be met and take control over their own health and wellbeing.*

We aim to do this by placing good conversations at the centre of our engagement with citizens.

How are we performing?

Evidence from the 2015/16 Health and Care Experience Survey shows that of those respondents who receive care and support with daily living activities, 89% felt that they were treated with respect and 86% agreed that they were treated with compassion and understanding, which is above the Scottish average of 85%. However, overall service user satisfaction levels are generally lower than we want them to be. The percentage of people who agreed that their health and social care services seem to be well co-ordinated fell from 75%, which is the Scottish average, to 71%. In the same survey, only 77% of people rated the care or support they received as good or excellent which is below the Scottish average of 81%. Whilst 80% of care services were graded as good or better in Care Inspectorate inspections in the same year.

Further work needs to be undertaken with our service users and other stakeholders to inform our improvement programme.

The percentage of people receiving care and support services in Edinburgh responding to the Health and Care Experience Survey in 2015/16 who agreed that they had a say in how their health care and support was provided reduced significantly from 83% in 2013/14 to 76% in 2015/16 which is below the Scottish average of 79%. The total number of people who made a choice as to how their care and support is arranged and managed through the four options of self-directed support increased from 3,989 in 2015/16 to 4,527 in 2016/17. However, the 2016/17 rate of 10 per 1,000 of the population aged 18+ is below the Scottish average of 11, which is the minimum we should aspire to achieve. Reinvigorating our approach to self-directed support to ensure that citizens in need of social care support can exercise greater choice over the way in which their care and support is provided will be a priority in 2017/18.

Progress we have made

During 2016/17, we have:

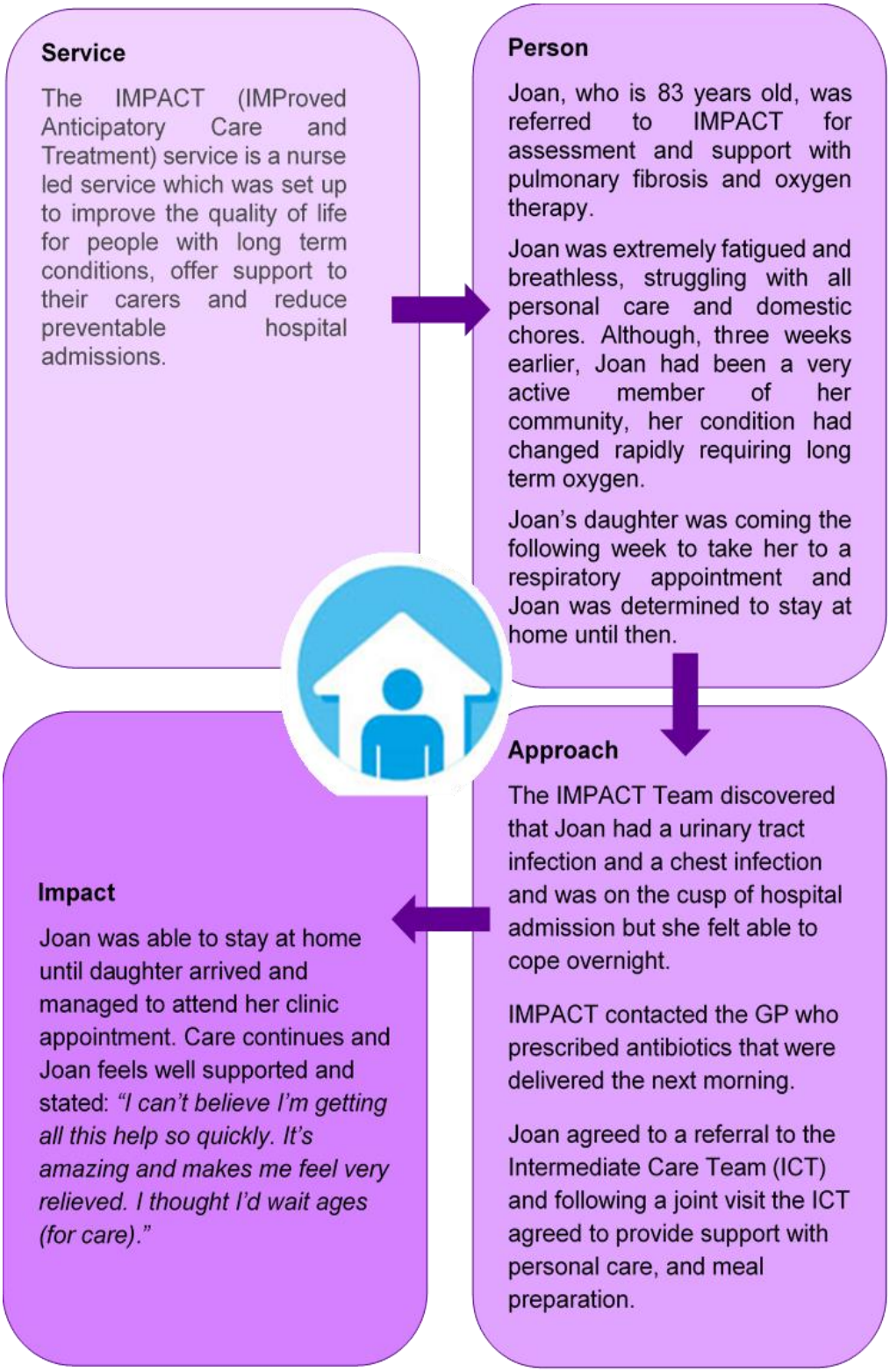
- increased the value of direct payments from £16.4m to £18.5m;
- rolled out a programme of training to GP practices on anticipatory care planning and the development of key information summaries, ensuring these contain information based on the person's wishes, including preferred place of care. To date training has been delivered in over 90% of practices in the city and four care homes in the North East Locality. 137,185 key information summaries were created in 2016/17. The next step is to implement this approach within the other localities and 6 further care homes;
- worked with people with learning disabilities moving from Murray Park and their families, to commission community based accommodation;
- established a network of autism champions and provided training to front line staff to improve understanding of autism and the local services available;
- funded a multi-agency approach to delivering Promoting Excellence in Dementia Care training across care homes, home care and supported housing services to improve awareness of the Promoting Excellence Programme and improve the quality of care for people living with dementia;
- tested the CleverCogs service through Blackwood Homes and Care, which provides night time support to people with disabilities and/or poor mental health using night time digital video calling service. Feedback from individuals was very positive, including increased feelings of control over how their support is provided and improved family and social relationships through the "Friends and Family" video link;
- engaged with citizens who use community mental health services and third sector and community organisations to take a Public Social Partnership approach to developing locality based preventative services that promote good health and wellbeing.

Priorities for 2017/18

- Reduce waiting times for assessment and review by streamlining existing processes whilst ensuring assessments and reviews are comprehensive and reflect the views of the person being assessed and the professionals involved.
- Co-design and deliver a person-centred support planning and brokerage service to provide better outcomes and deliver best value.
- Adopt the national anticipatory care plan, launched in July 2017; complete the anticipatory care planning training with GP practices and introduce this approach in all care homes across the city.
- Transfer 165 mental health patients from out-dated wards in the existing Royal Edinburgh Hospital to a new purpose built facility on the same campus.

- Reinvigorate our approach to the implementation of self-directed support for all citizens

Case Study – IMPACT (IMProved Anticipatory Care and Treatment) Team



Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

What we say in our strategic plan

Our linked priorities of tackling inequalities, investing in preventative approaches that help people retain their independence for as long as possible and involving people in decisions about how they can be best supported in the right place at the right time are key elements in improving the quality of life for citizens.

How are we performing?

82% of adults in Edinburgh who responded to the Health and Care Experience Survey in 2015/16 agreed that the services and support they received had an impact in improving or maintaining their quality of life. This is below the Scottish average of 84%.

Delays in accessing the care, support and treatment that people need is likely to have a negative impact on their quality of life. The challenges we face in putting non-urgent community based care in place and supporting people to be discharged from hospital has been detailed under Outcome 2 above. There are national targets for accessing some specific services. In March 2017, 89% of those referred for treatment related to drug and/or alcohol abuse started their treatment within three weeks compared to the national target of 90%. However, in the same month, only 54.5% of those referred for psychological therapies had their first appointment for treatment within 18 weeks compared to the national target of 90%. Average performance against this target in Scotland was 78%.

Most people want to live healthy and independent lives staying in their own home for as long as possible. In 2016/17, 53% of people who had been supported through the Reablement Service required no ongoing support and the overall reduction in the volume of support needed was 52.5%. During the same period, 220 people started to receive a Dementia Post Diagnostic Support Service, a rate of 6.3 per 1,000 of the population aged 75+. The service aims to equip people diagnosed with dementia and their families with the tools, connections and resources they need to live as well as possible with dementia.

Hospital is not a good place for people to be if they can be diagnosed, treated and supported in the community and most people would rather remain at home if at all possible. In 2016/17, 22% of people with acute chronic obstructive pulmonary disease (COPD) exacerbations which placed them at risk of being admitted to hospital, were referred to the Community Respiratory Team and treated at home or in the community rather than being admitted to hospital.

During 2016/17 the number of people waiting in hospital for Guardianship Orders to be issued was reduced by almost 42% from 24 to 14.

Most people also want to be able to die in the place of their choosing. In 2015/16, on average 13.3% of the last 6 months of life was spent in large hospital settings; the target for 2017/18 is to reduce this to 10% of the last 6 months of life.

Progress we have made

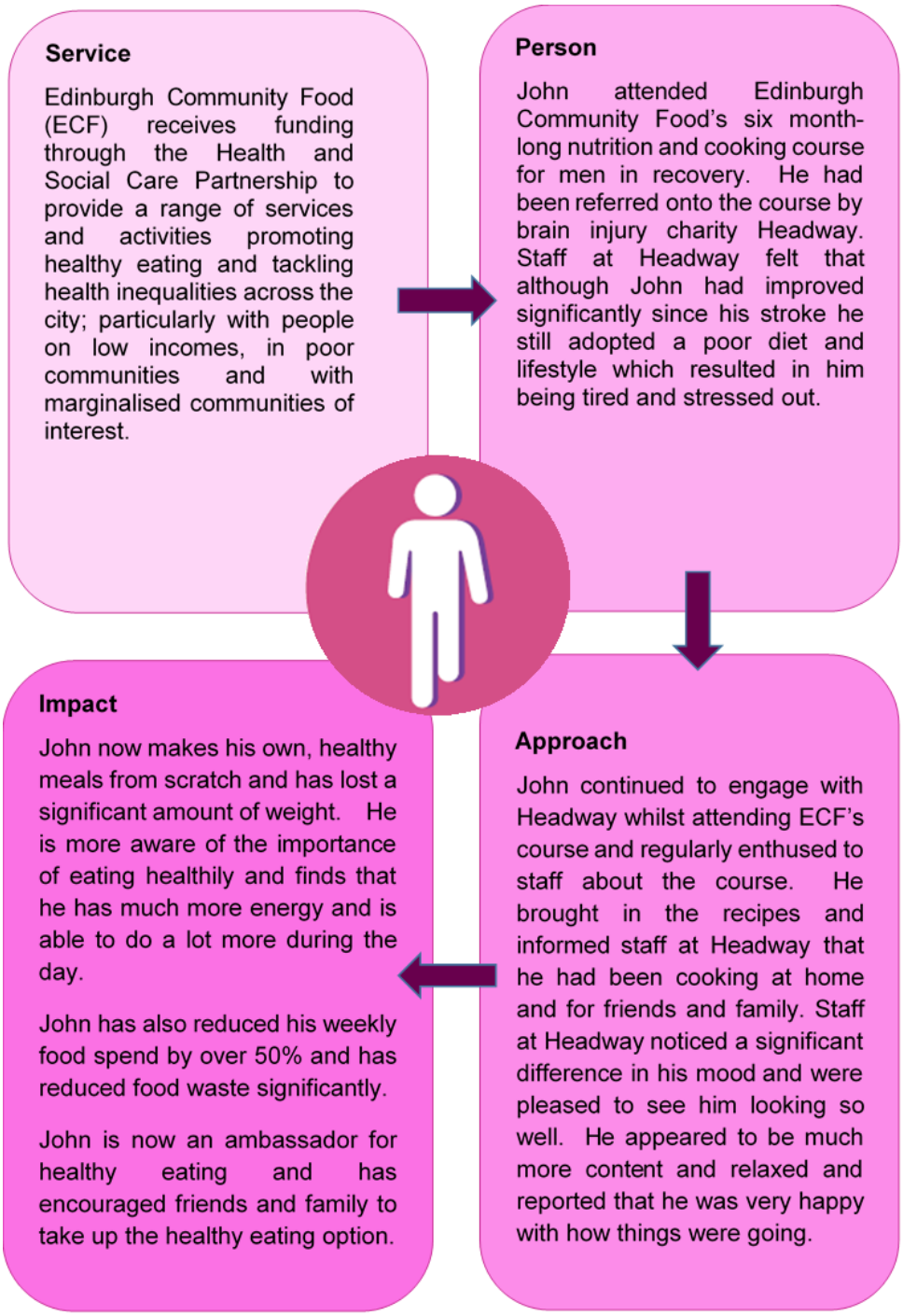
During 2016/17 we have:

- refocused our reablement service to target those most likely to benefit, this has led to an average reduction in the amount of ongoing care required of 52% as opposed to a reduction of 37% prior to the targeted approach being taken;
- developed a Public Social Partnership approach to expanding the capacity to provide community based mental health and wellbeing support at a locality level;
- established an integrated mental health and substance misuse team in each locality;
- commenced the process to retender the Dementia Post Diagnostic Support service with capacity to support more people;
- provided access to "dementia boxes" in local libraries as part of dementia awareness raising training so that people can learn more about how it feels to have dementia;
- set out "where we'd like to be" in supporting people with long term conditions through having good conversations with the person to find out what matters to them and work in partnership with them to manage their condition;
- supported residents of one care home to work with a filmmaker to create short films about their lives in a care homes under an initiative for the creative ageing festival, 'Luminate', providing new, creative experiences for those involved. This is available online;
- held a care home Olympics to tie in with the 2016 Olympics in Rio. Teams of residents from each of the care homes for older people operated by the Council competed in a number of events including indoor curling, javelin, 'funky moves' (memory game), 'Care Homes do Countdown' and a dancing competition.

Priorities for 2017/18

- Developing ways to demonstrate our effectiveness in helping people to identify and achieve their personal outcomes and manage their own conditions, in order to inform future improvement activity.
- Shifting the balance of care from hospital sites to communities for frail older people, people with disabilities and those with mental health problems so that people get the right care in the right place at the right time.
- Developing and implementing a palliative care and end of life strategy.

Case Study – Edinburgh Community Food



Outcome 5: Health and social care services contribute to reducing health inequalities.

What we say in our strategic plan

Tackling inequalities by working with our partners to address the root causes, as well as supporting those groups whose health is at greatest risk from current levels of inequality is a key priority within our strategic plan. We aim to do this by:

- *supporting individuals to maximise their capabilities and have control over their lives*
- *creating healthy and sustainable communities that can resist the effects of inequality on health and wellbeing*
- *ensuring that core health and social care services are delivered in such a way as to reduce and not exacerbate health inequality*
- *recognising that some sections of the population need targeted support to address the cause and effect of inequalities*

How are we performing?

Each of the four localities in Edinburgh has both areas of affluence and areas experiencing multiple deprivation as defined by the Scottish Index of Multiple Deprivation. Poorer health and earlier deaths affect those who face social and economic barriers such as poor housing, lack of employment, low pay or discrimination. People living in the least affluent areas are more likely to develop long term conditions and to develop them at least ten years earlier than their fellow citizens living in the most affluent parts of the city; they are also at greater risk of emergency admission to hospital.

The premature mortality rate for Edinburgh in 2015 was 406.3 per 100,000 of the population, this is below the Scottish average of 440.5 per thousand.

Whilst the delivery of health and social care services can have some impact on reducing health inequalities, many of the factors that can lead to health inequalities are outside the control of the Integration Joint Board. We are therefore, working with our partners in the Edinburgh Community Planning Partnership to develop and implement a coordinated approach to tackling inequalities across the city.

The Headroom Project was set up to improve outcomes for people in areas of the city with concentrated economic hardship building on the relationship between the patient and the health professional and the opportunities this creates to deliver patient centred care. The number of GP practices involved in the Project increased from 16 to 23 in 2016/17, covering around half of the city's areas of concentrated economic disadvantage. Different GP practices have taken different approaches whilst all involve some degree of social prescribing either through the use of Community Activity Mentors or by organising

activities themselves such as the respiratory choir, set up for people with breathing difficulties, through co-operation between Richmond Church and Niddrie Medical Practice. Although the choir was initially led by nurses from the Medical Practice the members now run it themselves.

Over 30,000 citizens have made use of third sector services funded through the Health Inequalities Grant Programme, total value £1.8 million. An evaluation based on self-reporting by grant recipients, shows the average customer satisfaction rate amongst those using the services was 91% and on average 77% of participants surveyed, agreed or strongly agreed that the service had the intended positive impact on them. The table below shows the number of individuals supported to achieve each priority outcome for the Programme.

Health Inequalities Grant Programme Priority Outcomes	People supported to achieve outcome
Increased income	13,189 people
Increased social capital	5,127 people
Increased number of people eating healthily	4,105 people
Increased community capacity	2,488 people
Reduced levels of anxiety and depression	1,812 people
More people live in and use green spaces	1,728 people
Increased participation in physical activity	1,572 people
Reduced stigma	173 people
Reduced damage to physical and mental health from all forms of abuse and violence	144 people
Reduced misuse of alcohol and drugs	75 people

Progress we have made

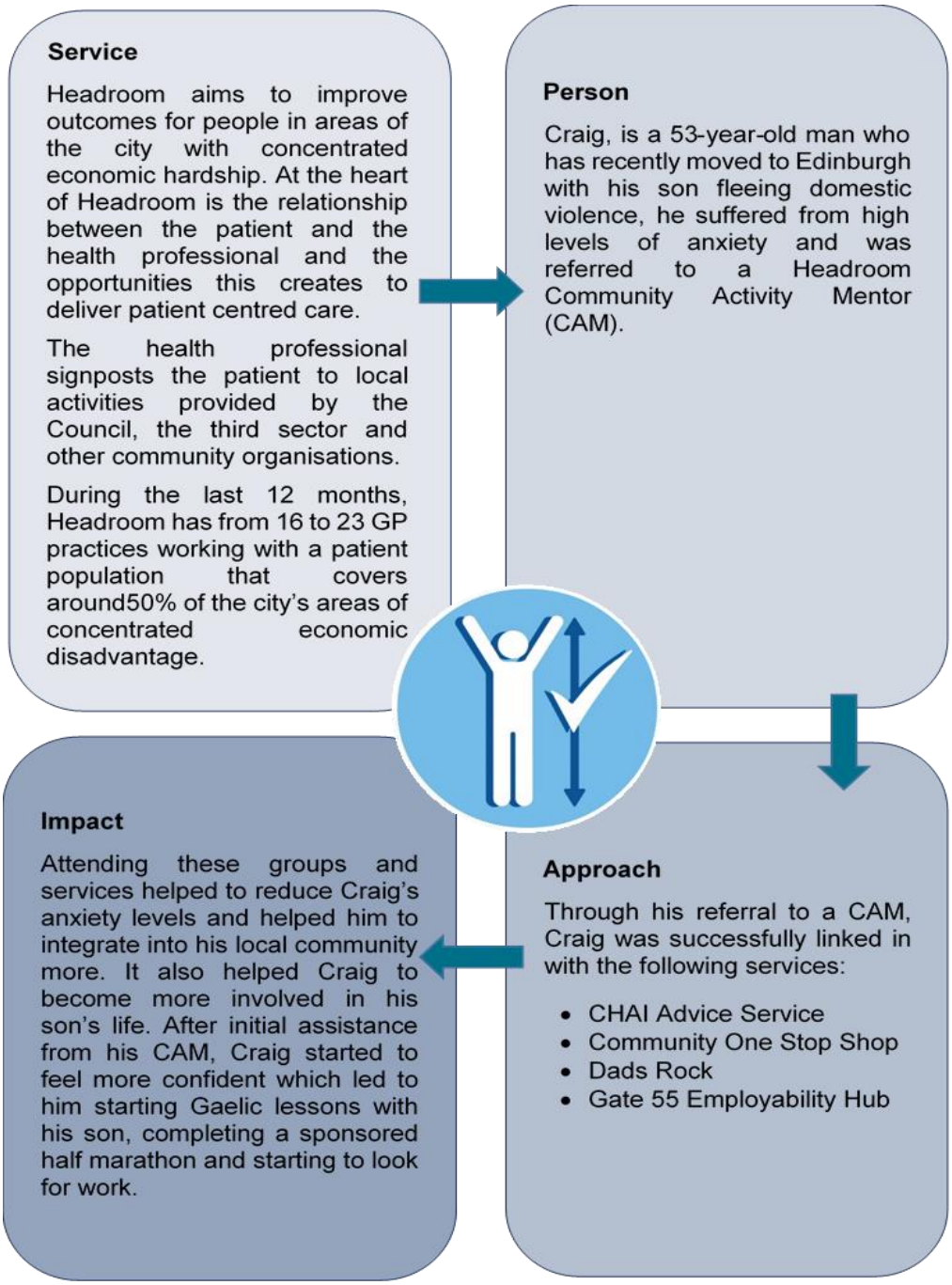
During 2016/17 we have:

- worked with fellow members of the Edinburgh Community Planning Partnership to consult with local communities to inform the evolving Locality Improvement Plans which will have a focus on tackling inequalities;
- provided a 'bridge' into more effective engagement with services for people who struggle to access service provision in traditional ways through the Inclusive Edinburgh project. We have introduced a "case coordinator" role with a focus on building effective relationships, leading to a higher quality of engagement with people with psycho-social issues;
- brought together people with lived experience, carers, and staff from a wide range of third sector agencies and statutory services to collaborate on the establishment of public social partnerships (PSPs) to improve outcomes for people's mental health and wellbeing.

Priorities for 2017/18

- Review the current grants programme to reflect the varying nature of the four localities in which we work and Locality Improvement Plans which will be published in October 2017.
- Introduce a network of link workers embedded in GP practices to help people access non-medical services to improve their overall wellbeing.
- Operationalise four locality wellbeing public social partnerships that will provide a range of social prescribing, meaningful activities and psychosocial and psychological support for people experiencing mental health problems.

Case Study – Headroom



Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

What we say in our strategic plan

Our strategic plan recognises the vital role that unpaid carers in Edinburgh play in supporting friends and family members with health and social care needs to live as independently as possible. Estimates for the number of unpaid carers range from 37,589 (2011 census) to 54,175 (Scottish Health Survey). We are also committed to delivering the vision set out in the Edinburgh Carers Strategy that "adult carers are able to live healthy, fulfilling lives and that they will be valued as equal partners in the provision of care and inform decisions about carer support. Carers will be able to sustain their caring role, if appropriate and if they choose it".

How are we performing?

We know from the Health and Care Experience Survey carried out in 2015/16 that the level of satisfaction amongst carers about the support available to them and the people they care for is low both in Edinburgh and across Scotland. 69% of unpaid carers from Edinburgh who responded to the survey said that they had a good balance between caring and other things in their life. This is slightly higher than the Scottish average of 68%; however, only 37% of those Edinburgh carers who responded said that they felt supported to continue caring, which is below the Scottish average of 41%.

A number of wider societal factors such as changes in the welfare benefits system will impact on unpaid carers and will influence the extent to which they feel supported, which makes it difficult to establish an absolute link to the performance of the Health and Care Partnership. However, in Edinburgh, we also know that the number of carers assessments undertaken in 2016/17 is very low; 5,079 people assessed for social care support indicated that they had an unpaid carer, but only 700 carers assessments were completed. Also, the length of time that people are waiting to receive support will inevitably have a detrimental impact on family and friends who are caring for them. The joint inspection of services for older people found that: "*there was insufficient recognition of the need to assess the needs of carers and provide timely support to them to help them maintain their caring role; and that carers often found it difficult to access support such as respite."*

The Edinburgh Strategic Carers Partnership has now been established as the joint planning forum for carers services linked to the Strategic Planning Group of the Integration Joint Board. The membership of this group includes carers and organisations that support both adult and young carers and will oversee the coproduction of the revised Carers Strategy and the work taking place in preparation for the implementation of the Carers Act (Scotland) 2016. We will also work with this group to establish local

performance indicators in respect of support for carers to drive forward improvement in this vital area.

Progress we have made

During 2016/17 we have:

- funded a new hospital discharge service which works alongside unpaid carers for adults, providing them with emotional support, information and advice; if required a carer support worker will also support carers in the vital first days at home;
- funded a carer support pharmacy technician, based in the Western General Hospital, to support people and their carers with pharmacy issues at the point of leaving hospital and provide ongoing support in the community if required;
- established a multi-agency project team, including representation from unpaid carers and Children's Services to implement the requirements of the Carers Act (Scotland) 2016;
- included content on carer support as part of the induction programme for new staff in Health and Social Care;
- provided dedicated one to one support, social opportunities, short breaks and residential breaks to people who have a caring responsibility, through 'Still caring', a collaboration between two third sector organisations, with reported benefits including improved resilience and being reconnected with their local communities.

Priorities for 2017/18

- To implement the requirements of the Carers Act (Scotland) 2016, including eligibility criteria, assessment and support planning.
- Work collaboratively with carers and carers organisations to review and update the joint carers strategy, taking account of current performance issues, feedback from carers and the legislation.
- Develop capacity plans that takes account of the requirement for respite.
- Train Carers Support Workers to undertake unpaid carer assessments.

Outcome 7: People who use health and social care services are safe from harm.

What we say in our strategic plan

The strategic plan sets out our twin objectives of ensuring that people are protected from abuse, neglect or harm at home, at work or in their community and protected from causing harm to others or themselves. We aim to achieve these by ensuring that people receive the right care in the right place at the right time. We also have a duty to ensure that the services we provide are high quality and safe.

How are we performing?

In 2015/16, 82% of people supported to live at home in Edinburgh who responded to the Health and Care Experience Survey said that they felt safe. This is below the Scottish average of 84%.

In 2016/17, we received 1,198 referrals where adult protection concerns were raised. 21% (425) of these referrals led to further work being undertaken under adult support and protection legislation, and 65% (1,292) led to further action being undertaken by social work teams. Longer term 'adult protection and support' plans were put in place in respect of 128 of the 425 (30%) referrals.

The report on the Joint Inspection of Services for Older People in Edinburgh highlighted that whilst systems and procedures were in place to ensure that adults are protected these were not adhered to consistently across the Partnership. Urgent action has taken place to address these deficiencies including the creation of two dedicated posts to provide additional training, development and support in respect of adult protection for the health and social care workforce.

The falls rate for people aged 65+ in Edinburgh is 21.5 per 100,000 of the population which is just above the Scottish average of 20.9 per 100,000 of the population. We are working to reduce this by investing in preventative approaches such as Steady Steps and supporting people at home rather than taking them to hospital when this is not necessary. 94% of the 5,200 calls to the Telecare Service in 2016/17 resulted in the person who had fallen being supported without the need for hospital admission.

We are integrating quality frameworks from health and social care so that they are overseen through a single Quality Assurance and Improvement Group that has oversight of:

- clinical standards and professional governance;
- health care acquired infection;
- inter-agency referral discussion (IRD) review system in relation to adult protection concerns;

- outcomes from multi-agency quality assurance meetings;
- significant adverse events;
- significant occurrence notifications.

Progress we have made

During 2016/17 we have:

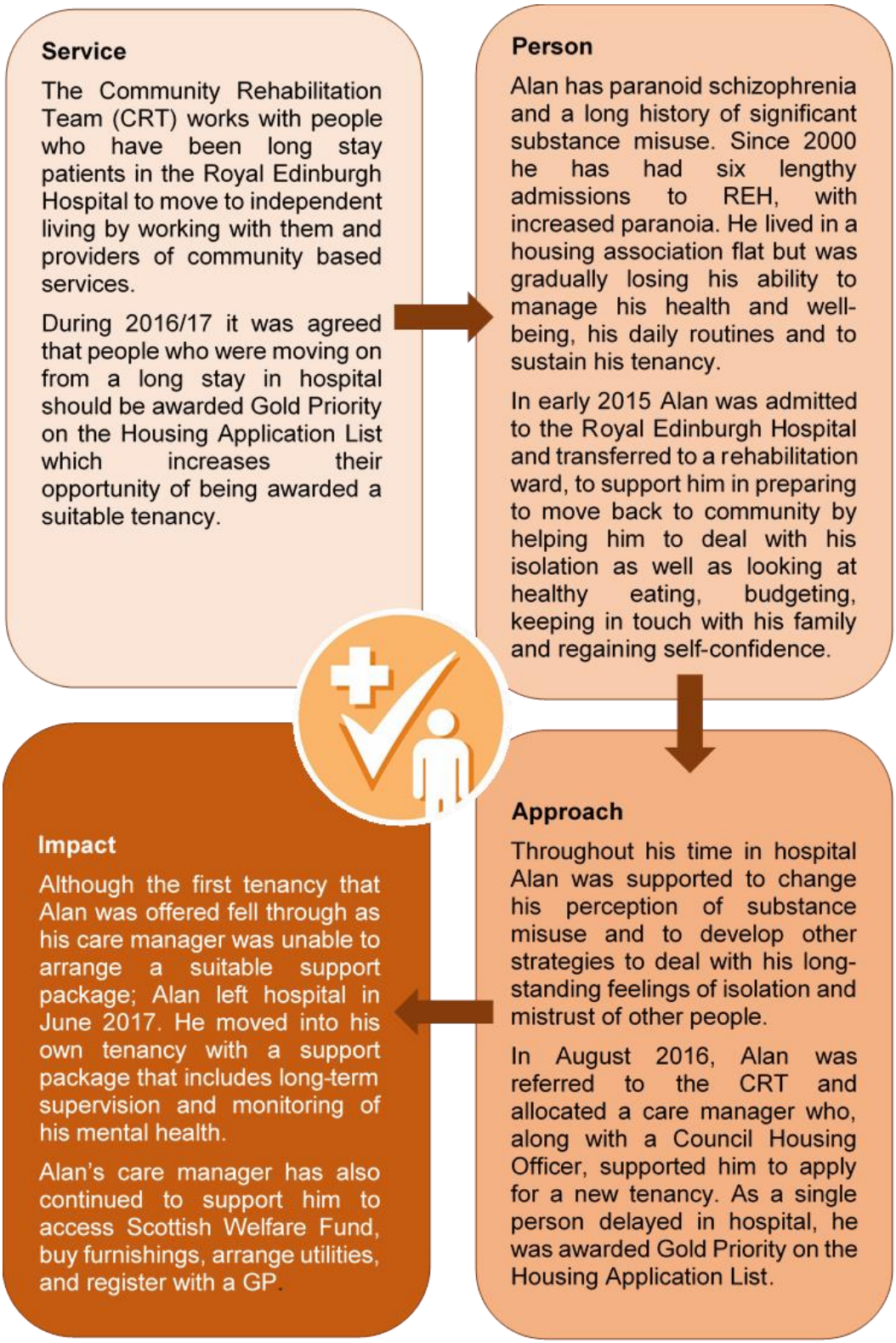
- undertaken a range of self-evaluation and quality assurance activities centred on Adult Protection, including;
    - practice evaluation and multi-agency case file audit found evidence that practitioners are skilled at engaging with service users often in very challenging circumstances
    - independent advocacy agencies have contributed to the adult support and protection training, which raises the awareness of the duty to consider independent advocacy for adults at harm
    - Easy read versions of adult protection leaflet have been produced
- implemented an Escalating Concerns Procedure that provides a framework enabling public partners to convene local multi-agency risk management case discussions (Getting It Right for Everyone) where the individual is not subject to adult protection, offender management or any other public protection process;
- responded to 5,200 calls from fallers to the Telecare service, 94% of whom were assisted by the support teams with no need for further assistance or admission to hospital;
- Edinburgh Leisure's 'Steady Steps' programme supported 302 older people in 2016/17 who have already had a fall, as part of the Falls and Fracture Prevention Pathway;
- provided approximately 700 places on a variety of evidenced-based suicide prevention courses (safeTALK; ASIST; STORM), these are delivered free of charge to professionals working with those at most risk;
- developed a crisis response service to prevent people with autism and learning disabilities being admitted to hospital from their family home or supported accommodation when there is a risk of the caring arrangement breaking down.

Priorities for 2017/18

- Strengthen adult protection processes and ensure staff compliance by increasing access to training and expert adult protection support for practitioners.
- Improve the falls pathway.
- Increase the use of technology enabled care and health by increasing the coverage of existing systems and exploring opportunities for innovation.

- Continue to collaborate with partners to co-produce a responsive, preventative service that will increase the resilience and independence for people with learning disabilities and their families and/or carers.

Case Study – Supporting people to move from hospital to independent living



Outcome 8: 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.

What we say in our strategic plan

Our strategic plan recognises the significant cultural change required to deliver efficient and effective integrated health and social care services. The skills, knowledge, experience and ideas of our workforce together with those of our partner agencies and unpaid carers are central to the delivery of that change. Taking a joined-up approach to developing this workforce will allow us to deliver on our priority of maximising capacity across the whole system.

How are we performing?

The national indicator on the percentage of staff who say that they would recommend their work place as a good place to work is under development so figures are not currently available. We are also working to develop a single system of obtaining feedback from our staff across both the City of Edinburgh Council and NHS Lothian using the iMatter system.

A survey of staff across the two employing agencies was undertaken by the Care Inspectorate and Health Improvement Scotland as part of the joint inspection of services for older people found that:

- 85% of respondents agreed that they enjoy their work;
- 79% of respondents agreed that they are well supported in situations where they may face personal risk;
- 78% of respondents agreed that they have access to effective line management;
- 76% of respondents agreed that they feel the service has excellent working relationships with other professionals;
- 76% of respondents agreed that they have good opportunities for training and professional development;
- 76% of respondents agreed that they feel valued by other practitioners and partners when working as part of a multi-disciplinary or joint team;
- 70% of respondents agreed that they feel valued by their managers;
- 64% of respondents agreed that their workload is managed to enable them to deliver effective outcomes to meet individual's needs;
- 47% of respondents agreed that their views are fully taken into account when services are being planned and provided;
- 36% of respondents agreed that there is sufficient capacity in the service to undertake preventative work.

Progress we have made

During 2016/17 we have:

- undertaken a major restructuring of services to support integration at a locality level. We have created teams of nurses, therapists and social care staff within a single management structure;
- introduced a blended approach to training, drawing from best practice in both NHS Lothian and the City of Edinburgh Council;
- ensured that all our contractual arrangements allow for payment of the Scottish Living Wage;
- continued to work with the Dementia Training Partnership to provide a sustainable and affordable model of training to deliver:
    - a confident and competent social care workforce, upskilled to meet current and future demands
    - consistency in service provision - raising standards across public and independent sector providers and
    - a forum for sharing good practice across traditional boundaries. Training was extended to care at home, supported housing and day care services;
- been successful in our application for Prospect Bank in Findlay House to become part of the Learning and Improvement Network for Specialist Dementia Units whose purpose is to bring together specialist dementia unit stakeholders to design a shared learning and improvement network.

Priorities for 2017/18

- Develop a workforce plan for the Health and Social Care Partnership which takes cognisance of the workforce strategy linked to the national Health and Social Care Delivery Plan.

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

What we say in our strategic plan

Making the best use of our shared resources to deliver high quality, integrated and personalised services, that improve the health and wellbeing of citizens whilst managing the financial challenge, is a key priority within our strategic plan. We use the term resources to include people, buildings, technology and information.

How are we performing?

In 2015/16, 23.4% of the total health and care budget was spent on hospital stays where the patient was admitted in an emergency, this is in line with the average figure for Scotland of 23.5%.

The indicator on expenditure on end of life care is being developed nationally and not yet available.

Progress we have made

As can be seen from our performance against some key indicators including delayed discharge and customer experience, we are not consistently using our limited resources to best effect. Improving flow through all stages of the pathway is an absolute priority.

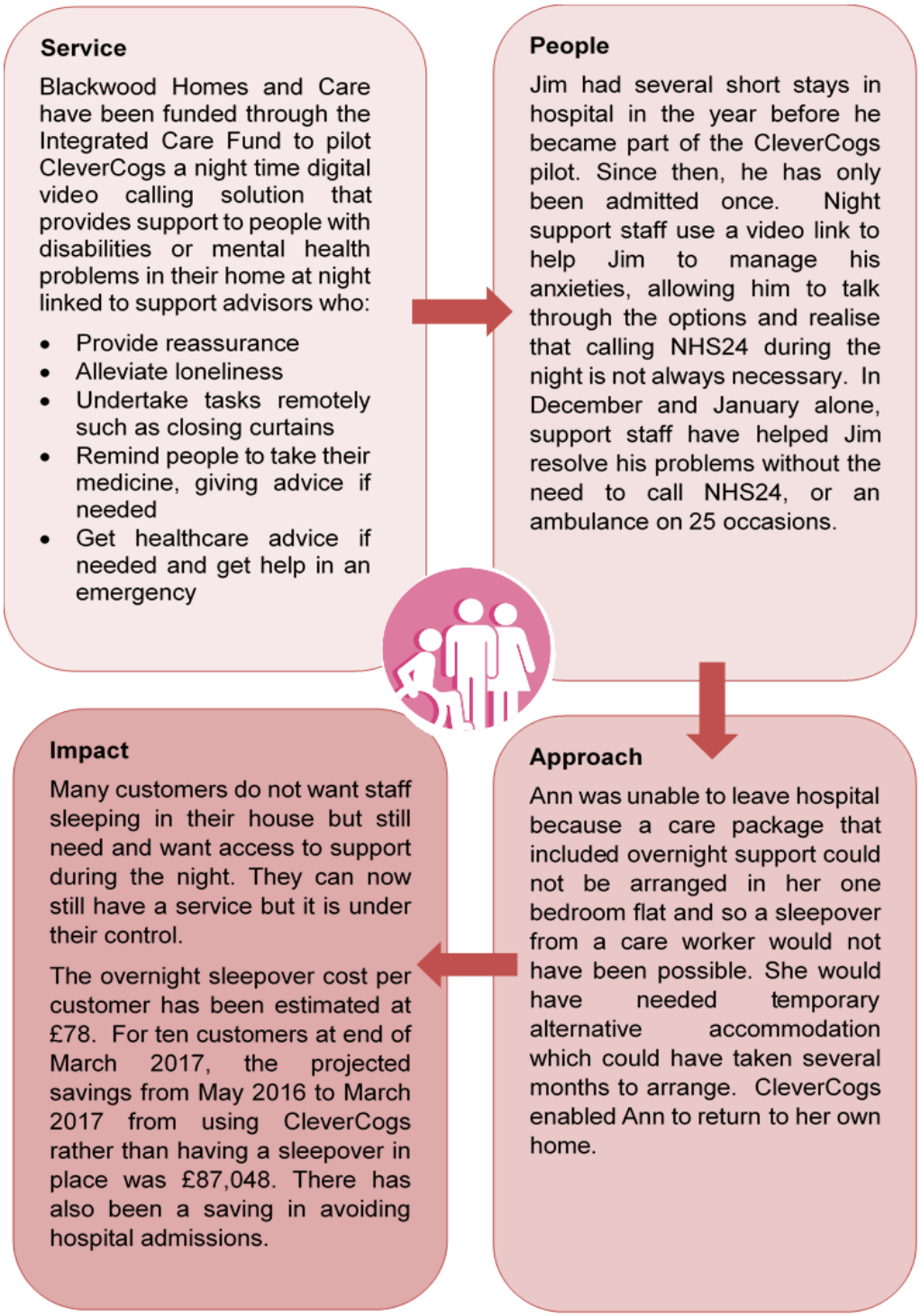
During 2016/17 we have:

- reconfigured hospital based complex continuing care beds and redirected staff to reduce the dependence on supplementary staffing
- brought together the Edinburgh Community Rehabilitation and Support Service as a single hub to provide support to people with physical disabilities across a range of activities from rehabilitation to lifestyle management.
- introduced a whole system approach to allow us to develop a shared understanding of flow across community and acute services to identify and implement targeted actions to address specific blockages
- developed MyConnect–a day support model for people with learning disabilities based on the principle of pooled personal budgets.
- The LOOPs Hospital Discharge Support Project is a partnership of three third sector organisations (Eric Liddell Centre, Health in Mind and Libertus), led by EVOC. The team is part of the new Locality Hub structure and participates in the daily Multi-Agency-Triage-Team (MATT) meetings in each locality to facilitate access to third sector and community based services. The Project aims to ensure that older people receive the support they need upon their return to the community.

Priorities for 2017/18

- Finalise our capacity plan for older people which will identify our future requirements and how these will be delivered.
- Collaborate with partners to produce a cross sector market facilitation strategy.
- Develop the financial frameworks that underpin the detailed delivery plans arising from the strategic plan. These will set out our intentions for investment and disinvestment.

Case study – CleverCogs

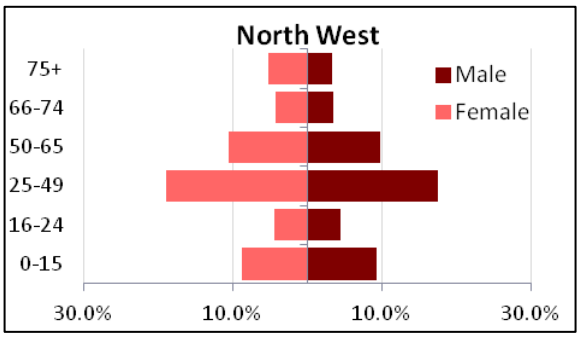


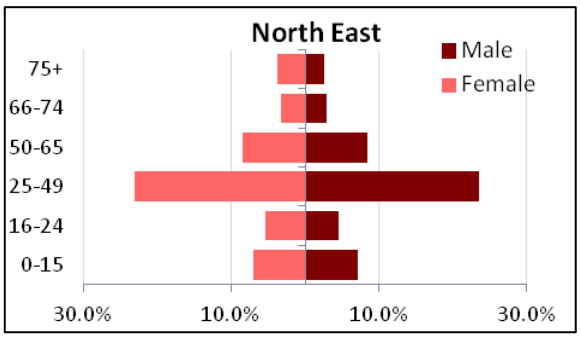
Locality working

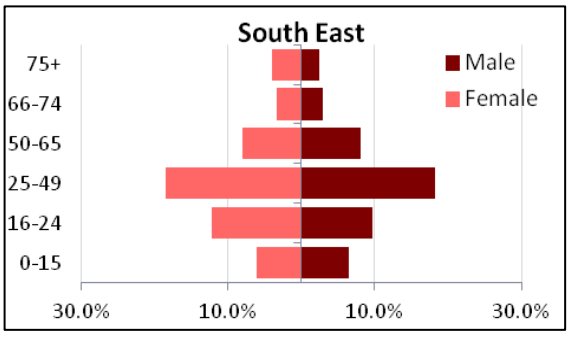
The population of Edinburgh is almost half a million people, accounting for 9% of the total population of Scotland and is predicted to grow faster than any other area of Scotland.

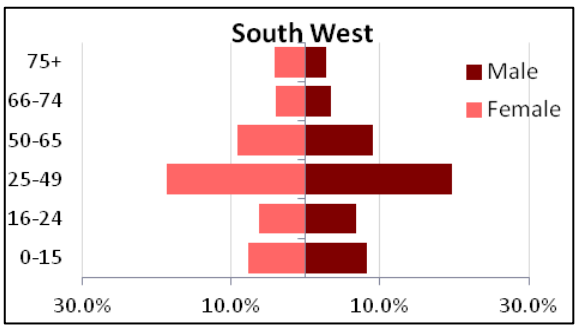
We have worked with the other members of the Edinburgh Community Planning Partnership to establish four geographic localities using neighbourhood partnership boundaries as the basis for service planning and delivery in the city. Whilst the city is often perceived as affluent each locality contains both areas of affluence and significant 'deprivation'. Profiles of the four localities can be found in our Joint Strategic Needs Assessment.

	North East	North West	South East	South West	Edinburgh	Lothian	Scotland
Total population	114,061	141,718	133,041	109,990	498,810	867,800	5,373,000
All Males	55,999	68,144	63,568	54,942	242,653	421,564	2,610,469
All Females	58,062	73,574	69,473	55,048	256,157	446,236	2,762,531







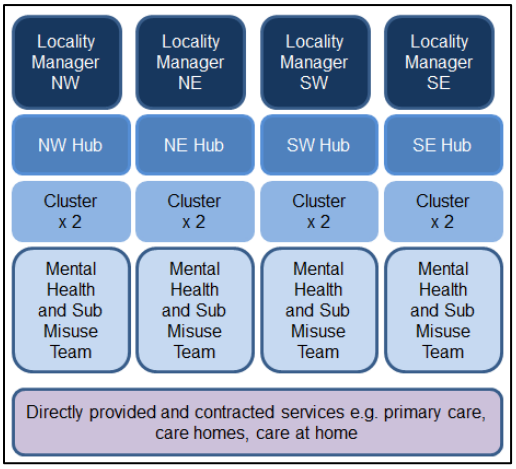


Our main priority in 2016/17 has been to implement a new locality structure to support the planning and delivery of services within the four localities. Each of the four Locality Managers oversees four integrated teams made up of nurses, social workers and allied health professionals (therapists):

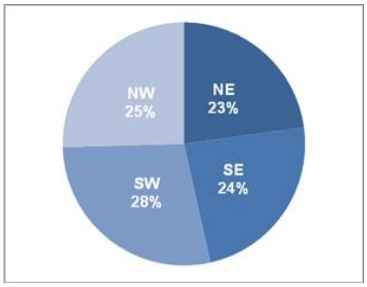
- the Locality Hub provides short-term support at a time of crisis to avoid the need for people to be admitted to hospital wherever possible, facilitate timely discharge from hospital and support people to maintain or regain their independence. A key function of the Hub is the Multi Agency Triage Team (MATT). The MATTs operate on a daily basis to work proactively with individuals in crisis and those ready for discharge from hospital to identify and put in place the most appropriate support to meet their needs. Third sector colleagues take part in the MATT function;
- the two Cluster Teams in each locality are linked to clusters of GP practices. The focus of these teams is to support those citizens who have longer term needs, again with a focus on supporting them to remain living as independently as possible within the community for as long as possible;
- each locality has a Mental Health and Substance Misuse Team that provides specialist support to citizens who have mental health issues and/or issues related to drugs and/or alcohol.

In addition to these teams each Locality Manager is responsible for a number of directly provided and contracted services, including:

- care homes;
- day centres and day services;
- home care and care at home;
- intermediate care and reablement;
- primary care services such as GPs, community nursing and community pharmacy.



A small number of specialist services will continue to be managed centrally and provide services on a citywide basis, examples of these are community equipment, telecare and emergency out of hours clinical and social care services.



The process to align resources to localities began in 2016/17, completing this is a priority for 2017/18. Each Locality Manager will have a clear budgetary framework to support them in developing and delivering services which best meet the needs of their individual populations. An estimate of the overall resource consumed within each locality in 2016/7 is shown in diagram opposite.

It is too early to establish the impact of the locality model, however, the following data from 2016/17 will be used as a baseline to allow us to assess impact in future years:

- Number of GP referrals to hospital
- Hospital admissions per 1,000 (by GP group)
- Sustainability of facilitated discharge (7-day readmission)

Our Locality Managers are members of the Locality Leadership Teams working with other community planning partners to co-ordinate the efforts of statutory, public, independent and third sector services within each locality to address common goals and concerns. During 2016/17 we have engaged with community planning partners at a locality level to engage the local community, including those in areas experiencing high levels of deprivation, in the development of Locality Improvement Plans. Forums have been established within each locality focused on health and wellbeing, bringing together representatives of public and third sector organisations and the local community to discuss and respond to local issues around health and social care.

Finance, Governance and Best Value

Finance and Governance

We have established a governance framework which covers the Integration Joint Board, its subgroups and sub committees as well as the Health and Social Care Partnership. The framework ensures that our structures and processes are transparent and responsive; provide appropriate accountability and scrutiny and encourage broad-based participation. Within these arrangements financial information is a key element of governance framework with financial performance for all delegated services reported at each meeting of the IJB.

Financial Plan 2016/17

Strong financial planning is required to ensure that our limited resources are targeted to maximise the contribution to our objectives. Like many other public sector bodies, we face significant financial challenges and will be required to operate within extremely tight financial constraints for the foreseeable future due to the difficult national economic outlook and increasing demand for services.

It was in this context that we undertook the financial assurance process on the 2016/17 funding contributions made available by NHS Lothian and the City of Edinburgh Council. Through this exercise a shortfall of £5.8 million was identified in the delegated NHS budget; with the council contribution assessed as representing a balanced plan, albeit incorporating a requirement to deliver savings of £15 million.

Based on this assessment, the IJB budgeted to deliver partnership services at a cost of £596 million. Funding adjustments during the year increased this budget to £676 million.

Financial performance 2016/17

Budget monitoring of IJB delegated functions is undertaken by finance teams within the City of Edinburgh Council and NHS Lothian, reflecting the IJB's role as a strategic planning body which does not directly deliver services, employ staff or hold cash resources. However, it is important that the IJB has oversight of the in-year budget position as this highlights any issues that need to be accounted for when planning the future delivery of health and social care services.

In 2016/17 we achieved a balanced budget position despite there being many pressures on the system.

During the year, we worked closely with NHS Lothian to identify measures to mitigate the funding shortfall described above which had reduced to £2.5 million by the end of the year. This which was funded by NHS Lothian through their achievement of an overall breakeven position. The cost of NHS delivered services therefore matched the income available. Similarly, following an additional contribution of £1.1 million from the City of Edinburgh Council, the health and social care services they provided also achieved a

break-even position. The combination of these one-off contributions allowed the IJB to achieve a balanced position for 2016/17.

In addition to this we carried forward £3.9 million of our £20.2 million allocation from the social care fund, established by the Scottish Government to support integration authorities. This money will be used in 2017/18 to support investments aligned to our strategic plan priorities.

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

Summary of financial performance 2016/17

	Budget £k	Actual £k	Variance £k
NHS delivered community services	26,636	27,300	(664)
General medical services	72,916	72,699	217
NHS delivered mental health services	35,098	34,148	950
Prescribing	77,974	80,167	(2,193)
Resource transfer	29,788	29,641	147
Other NHS partnership services	12,279	12,170	109
Reimbursement of independent contractors (dental, ophthalmology and pharmacy)	49,460	49,460	0
Learning disabilities	8,875	8,878	(3)
Other NHS hosted services	48,683	49,222	(539)
Set aside services	100,834	101,177	(343)
External purchasing	127,855	126,604	1,251
Care at home	14,336	14,422	(86)
Community equipment	1,518	1,542	(24)
Day services	14,748	14,829	(81)
Health improvement/health promotion	1,631	1,598	33
Information and advice	3,623	3,782	(159)
Intermediate care	1,611	1,619	(8)
Local area co-ordination	1,480	1,329	151
Reablement	7,810	8,669	(859)
Residential care	22,104	22,594	(490)
Social work assessment and care management	11,509	11,994	(485)
Telecare	700	717	(17)
Other	821	1,328	(507)
Net expenditure	**672,288**	**675,889**	**(3,601)**
Additional contributions			**3,601**
Net position			**(0)**

The current challenging financial climate reinforces the importance of managing expenditure within the financial resources available and this will require close partnership working between the IJB as service commissioner and NHS Lothian and the City of Edinburgh Council as providers of services.

Best Value

We have a duty to achieve best value, as do our partners, City of Edinburgh Council and NHS Lothian. As such we expect our partners to adhere to the principles of best value i.e. to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost in carrying out the directions of the board.

How others see us

This section of the report contains details of the feedback we have received from external sources either from individual citizens or through inspection by regulatory bodies.

Feedback from people who use our services

We recognise the importance of feedback from our service users as a way of checking that people are getting the support they need in ways that suit them and where we are not getting things right, feedback provides us with the opportunity to improve. Service user feedback is captured in three main ways: through compliments and complaints received through our formal feedback systems, by carrying out satisfaction surveys and by involving service users and carers in planning forums and reference groups.

In terms of formal feedback processes:

- NHS Lothian Patient Experience Team collect feedback in the form of concerns, complaints and compliments about health services. Outcomes and learning from patient feedback is shared with services and reported to the Health and Social Care Partnership Quality Assurance and Improvement Team. In 2015-16, 265 instances of service user feedback were recorded:
    - 91 formal complaints
    - 21 concerns
    - 6 enquiries / feedback
    - 147 compliments
- Social work related feedback is managed through a central team who support managers and staff to resolve and respond to complaints quickly and effectively. The table below summarises the complaints and compliments received in 2016/17.

Complaints	2015-16	2016/17	Commentary
Stage 1	173	67	• The figures show a reduction of 24% in stage 2 complaints • 71% of formal complaints were responded to within 20 working days or an agreed extension. • 18% of complaints were not completed within the targeted timescale. • 9% of complaints were withdrawn by the complainant.
Stage 2	114	87	
Complaints Review Committee (Stage 3)	5	14	
Cases escalated to SPSO	1	2	
Enquiries	219	155	
Care Service Feedback	37	36	
Positive Comments	21	8	

In the autumn of 2016 we carried out a user satisfaction survey in respect of our home care service. Of the 266 people who responded to this survey 94.7% said that they were very satisfied or quite satisfied with the service that they received.

Inspection by regulatory bodies

Our services are regulated through the Care Inspectorate, Health Improvement Scotland and the Healthcare Environment Inspectorate who carry out inspections of specific themes or services. The partnership responds to any areas of concern highlighted in inspection reports by developing and implementing improvement plans to address any areas of concern and respond to recommendations.

Themed inspections:

Between August and December 2016, the Care Inspectorate and Health Improvement Scotland undertook a joint inspection of services for older people in Edinburgh. The Partnership views the inspection as a helpful process and its findings confirm the need to continue to drive forward the improvements identified by the Integration Joint Board and the Health and Social Care Partnership following its inception in 2016.

The report from this inspection was published in May 2017. Services were evaluated against nine criteria as detailed in the table below:

Quality indicator	Evaluation	Evaluation criteria
Key Performance Outcomes	Weak	**Excellent** – outstanding, sector leading **Very good** – major strengths **Good** – important strengths with some areas for improvement **Adequate** – strengths just outweigh weaknesses **Weak** – important weaknesses **Unsatisfactory** – major weaknesses
Getting Help at the Right Time	Weak	
Impact on Staff	Adequate	
Impact on the community	Adequate	
Delivery of key processes	Unsatisfactory	
Strategic planning and plans to improve services	Weak	
Management and support of staff	Adequate	
Partnership working	Adequate	
Leadership and direction	Weak	

The inspection report also contained 17 recommendations detailed in the table below. A detailed improvement plan is in place to respond to these recommendations with a lead officer accountable for each of the actions. An Improvement Board meets regularly to oversee delivery of actions within the plan and the Performance and Quality Sub-group of the Integration Joint Board has a role in overseeing delivery of the Improvement plan on behalf of the Board.

Recommendations from the Joint Inspection of Services for Older People	
1	The partnership should improve its approach to engagement and consultation with stakeholders in relation to: • its vision • service redesign • key stages of its transformational programme • its objectives in respect of market facilitation.
2	The partnership should further develop and implement approaches to early intervention and prevention services to support older people to remain in their own homes and help avoid hospital admissions.
3	The partnership should develop exit strategies and plans from existing interim care arrangements to help support the delivery of community based services that help older people and their carers to receive quality support within their own homes or a setting of their choice.
4	The partnership should engage with stakeholders to further develop intermediate care services, including bed-based provision, to help prevent hospital admission and to support timely discharge.
5	The partnership should work in collaboration with carers and carers' organisations to improve how carers' needs are identified, assessed and met. This should be done as part of updating its carers' strategy.
6	The partnership should ensure that people with dementia receive a timely diagnosis and that diagnostic support for them and their carers is available.
7	The partnership should streamline and improve the falls pathway to ensure that older people's needs are better met.
8	The partnership should develop joint approaches to ensure robust quality assurance systems are embedded in practice.
9	The partnership should work with the local community and other stakeholders to develop and implement a cross-sector market facilitation strategy. This should include a risk assessment and set out contingency plans. (A market facilitation strategy sets out in detail the partnership's priorities for the commissioning of services)
10	The partnership should produce a revised and updated joint strategic commissioning plan with detail on: • how priorities are to be resourced • how joint organisational development planning to support this is to be taken forward • how consultation, engagement and involvement are to be maintained • fully costed action plans including plans for investment and disinvestment

Recommendations from the Joint Inspection of Services for Older People	
	• based on identified future needs • expected measurable outcomes.
11	The partnership should develop and implement detailed financial recovery plans to ensure that a sustainable financial position is achieved by the Integration Joint Board.
12	The partnership should ensure that: • there are clear pathways to accessing services • eligibility criteria are developed and applied consistently • pathways and criteria are clearly communicated to all stakeholders • waiting lists are managed effectively to enable the timely allocation of services.
13	The partnership should ensure that: • people who use services have a comprehensive, up-to-date assessment and review of their needs which reflects their views and the views of the professionals involved • people who use services have a comprehensive care plan, which includes anticipatory planning where relevant • relevant records should contain a chronology • allocation of work following referral, assessment, care planning and review are all completed within agreed timescales.
14	The partnership should ensure that risk assessments and management plans are recorded appropriately and are informed by relevant agencies. This will help ensure that older people are protected from harm and their health and wellbeing is maintained.
15	The partnership should ensure that self-directed support is used to promote greater choice and control for older people. Staff and multi-agency training should be undertaken to support increased confidence in staff in all settings so that they can discuss the options of self-directed support with people using care services.
16	The partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This will help to support sustainable recruitment and retention of staff, build sufficient capacity and ensure a suitable skill mix that delivers high-quality services for older people and their carers.
17	The partnership should work with community groups to support a sustainable volunteer recruitment, retention and training model.

Service inspections:

The Care Inspectorate is the statutory regulator of care services and awards grades to services in respect of the following separate areas: quality of care and support, quality of environment, quality of staffing and quality of management and leadership. The gradings used are set out in the table below:

Grade	Description
6	Excellent
5	Very Good
4	Good
3	Adequate
2	Weak
1	Unsatisfactory

The Edinburgh Integration Joint Board (EIJB) and City of Edinburgh Council (the contracting authority) has indicated its minimum expectation of all service providers is the achievement of a Care Inspectorate Grade 4 (Good) in all relevant inspection areas. As at May 2017, 82% of providers were meeting or exceeding the EIJB's minimum service quality requirements.

Those who fail to meet the minimum quality requirements are referred to the relevant Multi Agency Quality Assurance Group whose remit is to ensure the immediate wellbeing of service users and co-ordinate the delivery of support and challenge to providers who need to improve service standards. In the event a provider proves unwilling or unable to achieve improvement the Quality Assurance Group will progress the application of sanctions and/or termination of contractual relations with them.

Details of individual service inspections undertaken by the Care Inspectorate and the related gradings are given in Appendix 3. Copies of the inspection reports are held on the Care Inspectorate website. The report on the joint inspection of services for older people concluded that:

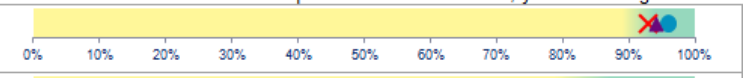
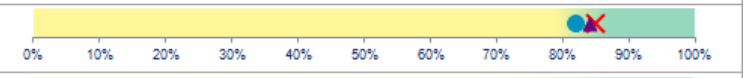
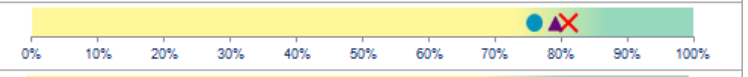
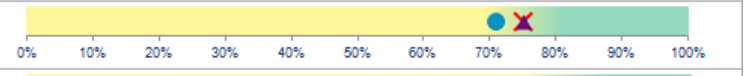
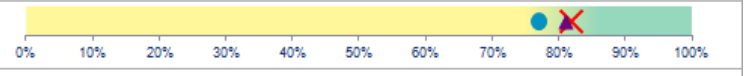
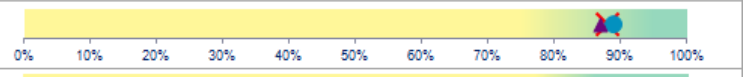
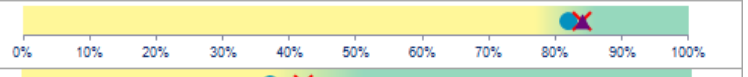
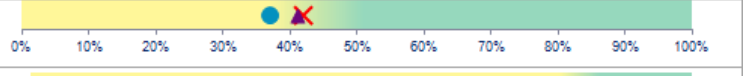
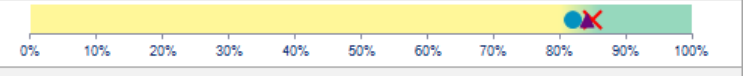
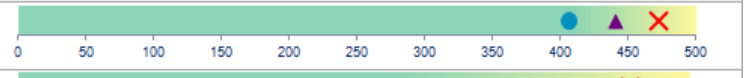
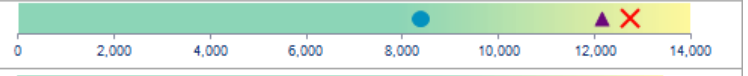
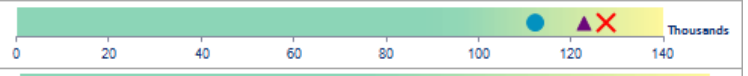
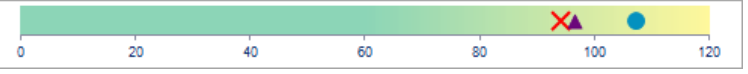
> "*In the main, at the time of inspection, regulated services were performing reasonably well across sectors and provision types and achieving positive grades.*"
>
> "*When people received services, they were generally of good quality and made a positive difference."*

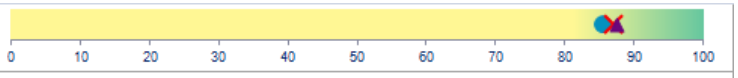
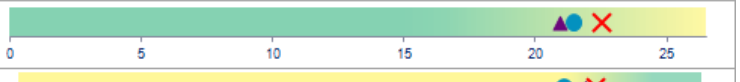
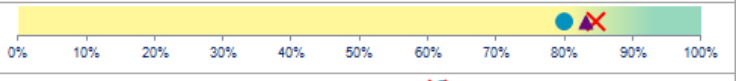
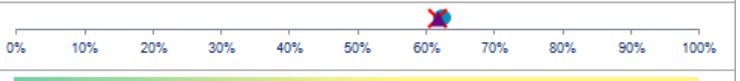
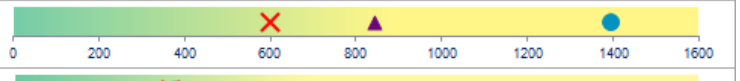
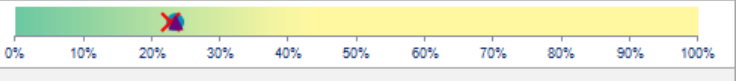
Health Improvement Scotland published a report on their inspection of Hospital Based Clinical Complex care in May 2016. The report includes six recommendations which are being addressed through an improvement action plan.

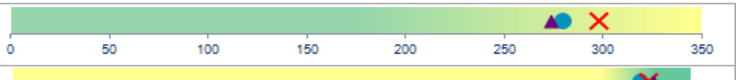
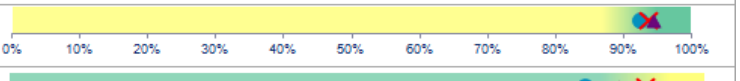
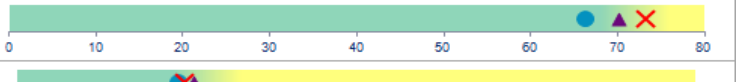
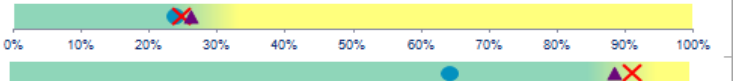
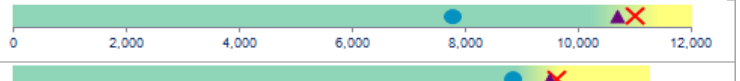
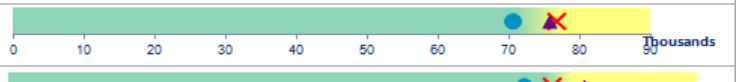
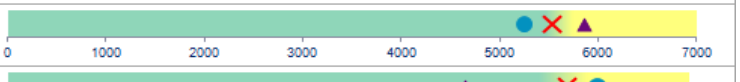
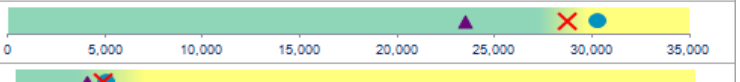
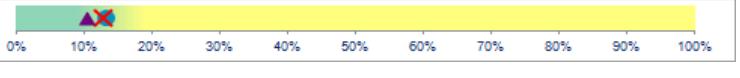
Appendix 1

National Indicators

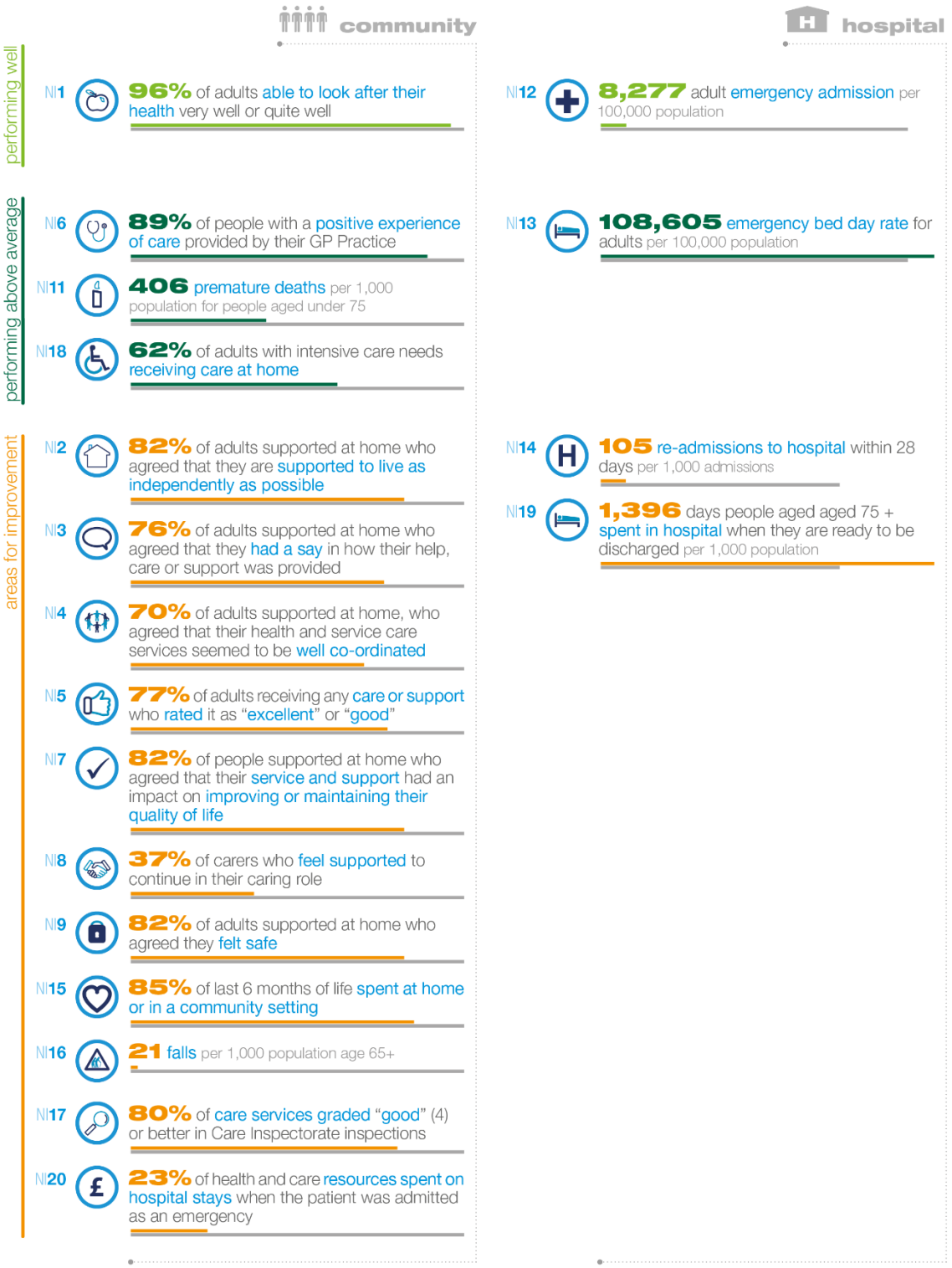
The scatter plots to the right of the table illustrate where Edinburgh City (the blue dot) lies in relation to both the Peer Group (red cross) average and the Scotland (purple triangle) values.

INDICATOR	Edinburgh City	Peer Group Average	Scotland	Green indicates the 'positive' side of the chart, yellow the 'negative'
1. Percentage of adults able to look after their health very well or quite well - 2015/16	96.0%	93.0%	94.0%	
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible. - 2015/16	82.0%	85.0%	84.0%	
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. - 2015/16	76.0%	81.0%	79.0%	
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.- 2015/16	71.0%	75.0%	75.0%	
5. Percentage of adults receiving any care or support who rate it as excellent or good - 2015/16	77.0%	82.0%	81.0%	
6. Percentage of people with positive experience of care at their GP practice. - 2015/16	89.0%	88.0%	87.0%	
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. - 2015/16	82.0%	84.0%	84.0%	
8. Percentage of carers who feel supported to continue in their caring role.- 2015/16	37.0%	42.0%	41.0%	
9. Percentage of adults supported at home who agree they felt safe.- 2015/16	82.0%	85.0%	84.0%	
*10. Percentage of staff who say they would recommend their workplace as a good place to work.**	*Not yet available.*			
11. Premature mortality rate (per 100,000 population) - 2015	406.3	472.5	440.5	
12. Rate of emergency admissions for adults (per 100,000) - 2015/16	8,393	12,728	12,138	
13. Rate of emergency bed days for adults (per 100,000) - 2015/16	112,147	127,683	122,713	
14. Readmissions to hospital within 28 days of discharge (per 1,000) - 2015/16	107.2	94.2	96.4	

15. Proportion of last 6 months of life spent at home or in community setting. -2016/17	85.5	87.0	87.5	
16. Falls rate per 1,000 population in over 65s. - 2016/17	21.5	22.5	20.9	
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections. - 2015/16	80%	85%	83%	
18. Percentage of adults with intensive needs receiving care at home. - 2015/16	62.3%	61.6%	61.6%	
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged. (per 1,000) - 2016/17	1,396	600	842	
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency. - 2015/16	23.4%	22.9%	23.5%	
*21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.**	*Not yet available.*			
*22. Percentage of people who are discharged from hospital within 72 hours of being ready.**	*Not yet available.*			
*23. Expenditure on end of life care.**	*Not yet available.*			

Ministerial Strategic Group Indicators	**Edinburgh City**	***Peer Group Average***	***Scotland***	
Rate of A&E Attendances per 1,000 population - 2016	279.4	297.5	273.3	
A&E performance against standard (seen within 4 hours) - 2016	92.5%	93.6%	94.4%	
Rate of emergency admissions from A&E per 1,000 - 2016	66.3	73.2	70.0	
Conversion rate from A&E to inpatient - 2016	23.8%	24.6%	26.0%	
Rate of emergency admissions per 100,000 - all ages - 2015	7,774.9	10,986.3	10,671.8	
Unscheduled bed days per 100,000 - acute specialties - 2015	70,618.1	76,668.2	75,653.8	
Unscheduled bed days per 100,000 - geriatric long stay - 2015	5,250.6	5,531.6	5,851.6	
Unscheduled bed days per 100,000 - mental health specialties - 2015	30,298.8	28,696.1	23,502.2	
% Last six months of life spent in a large hospital - 2015/16	13.3%	12.8%	10.6%	

Summary of the 23 National Indicators
for Edinburgh Health and Social Care Partnership



Appendix 2

Local Indicators

The tables below give an overview of the current key activity and performance indicators which are being used to track progress against the Edinburgh Integration Board's strategic plan and towards priority outcomes. The set of indicators is under development.

There are two sections:

1. Indicators which are available for Edinburgh's four localities, providing a snapshot, which, over time, will allow variation within and between areas to be identified and investigated.

2. Time series at city-wide level.

Important note
A person's locality can by defined in two main ways: a) where they live (this is the most commonly used) or b) where their GP practice is based.

A third way relates to the former boundaries, referred to as "sectors". These are being phased out, but still apply to some records.

In the tables below, the address of the person is used as the basis of the locality, unless stated.

SECTION 1 – Locality Measures

1. Core Integration Indicators by locality - Outcomes

About this data
A core suite of integration indicators has been developed by the Scottish Government in partnership with NHS Scotland, COSLA and the third and independent sectors. The indicators are in two categories, outcomes indicators, sourced from national survey data and other indicators derived from datasets and systems that are primarily used to support operational practice.

The table below shows the results from the Health and Care Experience Survey detailed in Appendix 1 broken down by locality. The survey was last carried out in 2015/16.

	Data Type	North East	North West	South East	South West	Edinburgh	Scotland
Percentage of adults able to look after their health very well or quite well	%	95%	96%	96%	95%	96%	94%
Percentage of adults supported at home who agree that they are supported to live as independently as possible	%	83%	80%	83%	82%	82%	84%
Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	%	78%	73%	77%	78%	76%	79%
Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	%	73%	66%	70%	73%	70%	75%
Percentage of adults receiving any care or support who rate it as excellent or good	%	76%	78%	77%	78%	77%	81%
Percentage of people with positive experience of care at their GP practice	%	86%	89%	91%	87%	89%	87%
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	%	85%	78%	84%	80%	82%	84%

	Data Type	North East	North West	South East	South West	Edinburgh	Scotland
Percentage of carers who feel supported to continue in their caring role	%	41%	42%	27%	40%	37%	41%
Percentage of adults supported at home who agree they felt safe	%	78%	83%	81%	87%	82%	84%

2. Pressures, unmet need, waiting lists

The indicators in this section relate to pressures on the health and social care system that present themselves both in the hospital and community. The indicators below focus on people waiting in hospital for discharge and people with learning disabilities who have an identified need for alternative accommodation. Additional information on people waiting for assessments is shown in section 2.

About this data
Delayed discharge data are collected monthly in line with national recording data definitions and guidance. The four indicators relating to delayed discharge are from the dataset that formed part of the census submission to ISD Scotland for patients delayed at 30 March 2017, the national census date, and for bed days lost to patients who were delayed throughout the whole month. Although data are not published at locality level, the locality of the patients delayed has been derived from their home address.

The number of people on the learning disability accommodation waiting list relates to those who are either in family home or hospital and require suitable long term accommodation. Of the 82 on the list, 60 require a place in 2017 and all but six are in the family home.

	Data Type	North East	North West	South East	South West	Edinburgh
Delayed Discharges: patients delayed March 2017	No.	29	39	47	59	176[1]
Delayed Discharges: patients delayed per 1,000 population aged 75+ March 2017	Rate	4.1	3.2	5.6	7.8	5.0
Delayed Discharges: bed days lost March 2017	No.	4,188	5,524	4,991	4,180	20,477[1]
Delayed Discharges: bed days lost rate per 1,000 population 75+ March 2017	Rate	595.6	457.0	596.8	548.9	583.5
Learning disability accommodation waiting list	No.	9	31	19	23	82

[1] Includes people who do not have a locality address e.g. of no fixed abode

3. Primary care

This section gives an overview of people's experience of primary care, GP practice capacity and pressures, and a high level indicator of hospital activity.

About this data
The source for the first group of indicators in this section is the Health and Care Experience Survey, a national, biennial survey which has sampling appropriate for the collation of data at locality level. The survey was last carried out in 2015/16.

Information relating to hospital admissions has been taken from TRAK (the NHS patient recording system). For this table, the localities are defined by where the person's GP practice is based.

	Data Type	North East	North West	South East	South West	Edinburgh	Scotland
Rate overall care provided by the GP Practice as excellent or good.	%	86%	89%	91%	87%	89%	87%
Can see or speak to a doctor or nurse within 2 working days	%	84%	84%	88%	85%	85%	84%
Can book a doctor's appointment 3 or more working days in advance	%	76%	82%	84%	80%	81%	76%
Overall arrangements for getting to see a doctor are excellent or good	%	70%	73%	81%	75%	76%	71%
Overall arrangements for getting to see a nurse are excellent or good	%	82%	85%	87%	84%	85%	82%
Strongly agree or agree patients are treated with respect	%	91%	92%	94%	92%	92%	92%
Strongly agree or agree patients are treated with compassion and understanding	%	84%	84%	88%	86%	86%	85%
Rate overall care provided by the GP Practice as excellent or good.	%	86%	89%	91%	87%	89%	87%
Hospital admissions per 1,000 (by GP group)	Rate	101.4	101.5	84.1	99.1	96.4	
Number of GP practices	No.	18	19	20	17	74	
Number of GP practices with restricted lists (31 March 2017)	No.	9	11	12	6	38	

4. Support in the community

Activity and performance on key supports for people with identified needs are summarised below.

Context
Reablement is a short term domiciliary care service that aims to support people to regain the skills needed to live as independently as possible.

The Social Care (Self-directed Support) (Scotland) Act 2013 places a duty on local authority social work departments to offer people who are eligible for social care a range of choices over how they receive their social care and support. The options are: a direct payment (option 1), an individual service fund (option 2) or for the council to arrange the support (option 3). Option 4 is a combination of two or more of the other options.

Post diagnostic support for people diagnosed with dementia forms part of the Scottish Government's dementia strategy. The indicator below relates to the service commissioned by the Partnership. Community mental health teams provide additional support.

About the data
Source: SWIFT (Health and Social Care's Client Information System).

	Data Type	North East	North West	South East	South West	Edinburgh
Reablement - impact (% reduction in hours of support needed)	%	46.2%	52.3%	49.0%	64.3%	52.5%
Reablement - impact (% of people who did not need a package of care)	%	42.9%	53.7%	53.5%	62.3%	52.6%
Carer assessments rate (per 1,000 population 16+)	Rate	1.25	2.21	1.37	1.41	1.68
Multidisciplinary falls assessments by Intermediate Care Teams as a rate per 1,000 pop 75+	Rate	11.1	9.5	11.5	12.6	10.9
Proportion of all services that are DP (Option 1) or ISF (Option 2) as at March 2016	%	13.7%	15.9%	14.9%	12.0%	14.0%
Proportion of all services that are DP (Option 1) or ISF (Option 2) as at March 2017	%	14.9%	19.2%	17.5%	14.4%	16.3%
Dementia post diagnostic support service starts	No.	38	84	55	39	220
Dementia post diagnostic support service starts as a rate per 1,000 population 75+	Rate	5.4	6.9	6.6	5.1	6.3

5. Staff

This section includes data on staffing in the new locality teams in the Edinburgh Health and Social Care Partnership

About this data
To allow the implementation of the integrated locality structure the staffing resource for each staff type in each locality was calculated. A comparison of those in post at the end of April 2017, compared with the allocation is given in this section.

This section is under development.

Proportion of locality social care staffing establishment which is in post	Data Type	North East	North West	South East	South West	Edinburgh
Senior OT	%	76%	106%	100%	111%	98%
Mental Health Officer	%	95%	93%	91%	93%	93%
Senior Social Worker	%	133%	93%	60%	83%	86%
OT	%	81%	91%	88%	93%	89%
Social Worker	%	90%	88%	89%	83%	90%
Community Care Assistant	%	110%	101%	100%	109%	101%

Mandatory training for NHS staff	Data Type	Compliance
Equality and diversity	%	89.3
Information governance	%	69.0
Health and safety	%	88.9
Health associated infections	%	70.7
Fire training	%	79.5
Manual handling	%	84.6
Public protection	%	81.8
Violence and aggression	%	88.5
Resuscitation	%	88.3

Section 2. Time Series

1. Pressure, unmet need, waiting lists

This section includes indicators on people waiting in hospital for discharge, for assessments and for support at home.

About this data
Delayed discharge data are collected monthly in line with national recording data definitions and guidance. Data are published at locality level to support operational and performance management.

The number of people waiting for a package of care includes people who are either waiting in hospital for a package of care or in the community where they have no package of care. The number of hours required includes those who require an increase to their existing package of care.

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
Delayed Discharges: number NE	No.						32	42	46	45	41	40	29
Delayed Discharges: number NW	No.						52	58	57	57	61	64	39
Delayed Discharges: number SE	No.						39	48	40	42	69	51	47
Delayed Discharges: number SW	No.						48	48	37	41	50	51	59
Delayed Discharges: Total	No.	67	85	120	173	170	171	196	180	185	221	206	176[2]

[2] Includes people who do not have a locality address e.g. of no fixed abode

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
Waiting list - social care assessments at month end	No.	1,348	1,409	1,635	1,421	1,629	1,606	1,547	1,444	1,522	1,430	1,495	1,428
Waiting list - social care assessment (average wait in days)	No.	69	70	69	78	97	76	80	84	92	89	92	101

2. Psychological treatment – 18 week target

This section focuses on response times for people who have been referred for psychological treatment. The national standard is for at least 90% of people referred for psychological therapies to start treatment within 18 weeks of referral.

About this data
The services included in this section relate to the former HEAT target 'Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological therapies from December 2014' as listed below:

- Primary care mental health teams
- Lothian Group service
- Community mental health teams
- Adult Psychology Teams
- Older adult behavioural support service
- Learning disabilities teams
- Substance misuse psychology teams
- Children & adolescent MH Services

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
People seen for 1st treatment appointment	No.	89	119	108	161	163	115	149	169	104	168	152	143
No. of people seen within 18 weeks	No.	50	58	61	84	82	57	60	80	57	70	80	78
No. of people seen over 18 weeks	No.	39	61	47	77	81	58	89	89	47	98	72	65
% seen within 18 weeks for 1st treatment appointment	%	56.2%	48.7%	56.5%	52.2%	50.3%	49.6%	40.3%	47.3%	54.8%	41.7%	52.6%	54.5%

3. Support in the community

This section focuses on activity in a range of supports intended to help people to remain living in the community, including: assessments of unpaid carers, fall assessments and telecare. It also shows GP list sizes in recent years and the balance of care – a key measure of the overall pattern of support.

About this data
Sources: SWIFT, ECO Stats.

The national balance of care figure reports the number of people receiving personal care at home via a direct payment or council-arranged service as a percentage of the total number of people requiring care. This local measure also includes those receiving personal care funded through an individual service fund.

The numbers included in the table around GP list size are recognised as being inflated by around 6% (this effect has been found in other areas of Scotland and investigated by NRS).

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
Carer Assessments NE	No.	14	5	7	7	7	11	10	12	9	12	8	16
Carer Assessments NW	No.	22	23	23	14	18	28	23	20	17	15	23	26
Carer Assessments SE	No.	20	9	13	19	14	8	13	12	10	6	15	12
Carer Assessments SW	No.	12	10	16	16	9	12	9	18	6	7	9	9
Carer Assessments Total[3]	No.	69	50	60	57	53	60	61	65	47	42	61	69

[3] Note that the total includes people whose locality is not recorded or is outside of Edinburgh.

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
Multidisciplinary falls assessments by Intermediate Care Teams	No.	29	49	39	36	40	15	27	30	39	27	24	30
Telecare: % of Hospital Admissions on response (65+)	%	1.7	2.5	1.1	0.5	0.4	0.6	0.5	0.8	1.6	1.2	0.6	1.2
Telecare: Response to Fallers (65+) – percent telecare staff response only (out of cases where action taken)	%	93.2	91.1	93.9	94.8	94.7	93.9	96.6	95.5	92.2	95	91	93.7
Balance of care	%	57.2	57.4	57.4	57.8	57.6	57.7	57	57.2	57.4	56.9	56.5	56.6

	Data Type	April 2013	April 2014	April 2015	April 2016	April 2017
GP list size	Number	519,434	525,755	530,699	536,016	543,249

4. Mental health and substance misuse

The indicators in this section relate to people who are subject to a mental health legal order or guardianship process, and to performance against the national standard for drug and alcohol treatment i.e. that 90 per cent of people will wait no longer than 3 weeks from referral received to appropriate treatment that supports their recovery. The guardianship process where they have been assessed as not having capacity and require legal process under the Adults with Incapacity (Scotland) Act 2000.

About this data
Sources: SWIFT, Trak, Drug and Alcohol Treatment Waiting Times Database, Edinburgh Leisure.

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
People on open MH legal orders (excluding guardianship)	No.	509	528	552	571	606	617	640	672	678	760	715	760
Percentage meeting 3-week target from referral to start of treatment for drugs and alcohol services	No.	85	71	79	83	86	79	80	81	85	83	89	
Delayed discharge guardianship delays	No.			24	23	20	20	22	16	17	11	12	14

5. Long Term Conditions

Data surrounding activity resulting from the Long Term Conditions Programme is shown below.

About this data
Sources: Trak, CATS service database, CRT database, Edinburgh Leisure

	Data Type	Apr – Jun 2016	Jul – Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Total
Number of A&E attendances due to falls for people aged 65+	No.	981	985	1013	930	3909
Referrals to fallen uninjured person pathway	No.	35	43	56	81	215
Bed days for people with a primary diagnosis of COPD	No.	1,860	1,757	1,774	1,899	7,290
Acute COPD exacerbations at risk of admission referred to Community Respiratory Team (CRT)	No.	263	237	286	267	1053
Acute COPD exacerbations assessed by CRT where admission avoided	No.	83	44	58	49	234
Number of Key Information summaries	No.	29,892	33,835	35,587	37,871	137,185

Fit for Health Programme	Data Type	2014-15	2015-16	2016-17
Fit for Health: no. referrals	No.	216	427	655
Fit for Health: no. engaged	No. (%)	185 (86%)	308 (72%)	523 (78%)
Fit for Health: Completion rate	No. (%)	22 (12%*)	100 (29%)	131 (33%)
Fit for Health: those completing who reported improved wellbeing	No. (%)	17 (77%)	80 (80%)	102 (77%)

*participants engaged through the referrals had not yet completed their 12 weeks at year end (first year)

Annual Performance Report Appendix 3

Inspection Gradings

Copies of the inspection reports are held on the Care Inspectorate website.

Care Home Services

Care homes provided by EHSCP	Type	Date of Inspection	Care & Support	Staffing	Management & Leadership
Firrhill	Learning Disabilities	29-Nov-16	5	NA	NA
Castle Crags	Learning Disabilities	03-Nov-16	5	4	NA
Clovenstone House	Older People	02-Aug-16	5	5	NA
Drumbrae	Older People	08-Sep-16	3	4	4
Ferrylee	Older People	30-Mar-17	4	4	4
Ferrylee	Older People	11-Apr-16	3	NA	NA
Fords Road	Older People	31-Oct-16	5	4	NA
Gylemuir	Older People	03-Apr-17	NA	NA	3
Gylemuir	Older People	22-Sep-16	3	3	2
Inch View	Older People	08-Nov-16	4	NA	NA
Jewel House	Older People	09-Jun-16	5	5	5
Marionville Court	Older People	13-Jan-17	4	4	4
Oaklands	Older People	26-Sep-16	4	4	4

Care homes commissioned by EHSCP	Date of Inspection	Care & Support	Staffing	Management & Leadership
Four Seasons Health Care - Castlegreen	Not inspected in time period			
Abercorn Care Limited - Abercorn Care Home	08/02/2107	5	5	5
Abercorn Care Limited - Spring Gardens	01/02/2017	5	5	5
Abercorn Care Limited - Viewpark	15/02/2017	5	5	5
Antonine Care Limited - Forthland Lodge	24/06/2016	4	5	4
BUPA - Victoria Manor Nursing Home	15/07/2016	3	3	3
Claremont Park Nursing Home	31/10/2016	3	3	3
Crossreach - Queens Bay Lodge	25/10/2016	5	5	5
Renaissance Care (Scotland) Ltd - Letham Park Care Home	01/06/2016	3	3	3
Renaissance Care (Scotland) Ltd - Milford House	01/02/2017	5	4	4
South Park Retirement Home	21/04/2016	5	4	5
Barchester Healthcare Ltd - Strachan House	28/03/2017	6	NA	NA
Belgrave Lodge - Dixon Sangster Partnership	06/12/2016	4	4	4
Bield HA - Craighall Care Home	07/08/2016	4	4	3
Bield HA - Stockbridge Care Home	31/01/2017	4	4	5
Braeburn Home	14/12/2016	5	5	5
Eildon House	Not inspected in time period			
HC-One Limited - Murrayfield House Nursing Home	08/09/2016	5	5	5
Laverock House	23/02/2017	4	4	4
Manor Grange Care Home LLP	New service			
Salvation Army - Eagle Lodge	Not inspected in time period			
Sir James McKay Housing - Scottish Masonic Homes Limited	31/02/2017	4	5	5

Care homes commissioned by EHSCP	Date of Inspection	Care & Support	Staffing	Management & Leadership
Struan Lodge Care Home	24/02/2016	5	5	5
BUPA - Braid Hills Nursing Home	26/11/2015	3	4	4
Cameron Park	25/08/2016	5	4	5
Cherryholme House	15/11/2016	4	4	4
Crossreach - Morlich Care Home	27/10/2016	6	NA	NA
Crossreach - The Elms	01/12/2016	2	2	2
Embrace (Kler) Ltd - Camilla House Nursing Home	13/09/2016	4	4	4
Erskine Hospital Ltd - Erskine Nursing Home	05/12/2016	5	5	5
Four Seasons Health Care - Colinton	09/06/2016	4	3	4
Four Seasons Health Care - Gilmerton Care Home	22/06/2016	4	4	4
Four Seasons Health Care - Guthrie House Nursing Home	23/06/2016	4	3	3
Four Seasons Health Care Group - St Margaret's Care home	29/09/2016	4	4	4
Jubilee House	07/07/2016	4	4	4
Little Sister of The Poor - St Joseph's Home for the Elderly	22/03/2017	5	2	NA
Mansfield Care Ltd - Belleville Lodge Nursing Home	14/12/2016	5	NA	NA
Randolph Hill Care Homes Ltd - Ashley Court Nursing Home	30/09/2016	4	4	4
Royal Blind - Braeside House	25/11/2016	5	4	4
Viewpoint HA - Lennox House Care Home	26/07/2016	5	5	5
Viewpoint HA - Marian House Care Home	13/10/2016	5	5	5
Viewpoint HA - St Raphael's Care Home	18/10/2016	5	5	5
Four Seasons Health Care - North Merchiston	12/11/2015	5	5	5
Lorimer House Nursing Home	25/01/2016	5	5	5

Care homes commissioned by EHSCP	Date of Inspection	Care & Support	Staffing	Management & Leadership
Randolph Hill Care Homes Ltd - Blenham House Nursing Home	09/03/2016	5	5	5
Salvation Army - Davidson House	12/09/2016	4	4	5
Thorburn Manor Nursing Home	21/03/2017	6	5	5

Home care and care at home services

Home care services provided by EHSCP	Type	Date of Inspection	Care & Support	Staffing	Management & Leadership
City of Edinburgh - Resource and Development Team	Support Service	20/02/2017	4	4	2
Intermediate Care - North	Home care	24/10/2016	4	NA	NA
Intermediate Care - South	Home care	24/10/2014	4	NA	NA
North East Edinburgh Home Care and Support Service	Home care	17/06/2016	5	4	NA
North West 1 Edinburgh Homecare and Support Service	Home care	18/01/2017	5	NA	4
North West 2 Edinburgh Home Care and Support Service	Home care	03/11/2016	4	4	NA
Overnight Home Care Service	Home care	27/05/2016	5	4	4
Positive Steps	Home care	20/02/2017	5	5	NA
South Central Edinburgh Home Care and Support Service	Home care	06/02/2017	5	NA	5
South East Edinburgh Home Care and Support Service	Home care	28/03/2017	4	4	4
South West Edinburgh Home Care and Support Service	Home care	22/08/2016	5	NA	4
SupportWorks	Home care	01/02/2017	5	4	NA

Care at home services commissioned by EHSCP	Type of service	Date of Inspection	Care & Support	Staffing	Management & Leadership
Hoseasons & Broomhouse (C&S) Quartermile (C&S)	Care at Home	12/12/2016	2	2	2
COMMUNITY INTEG CR SUPP LIV (CIC)	Care at Home	12/01/2017	3	4	4
DEAF ACTION	Care at Home	30/11/2016	5	NA	NA
LYNEDOCH CARE LTD	Care at Home	15/09/2016	5	NA	NA
MOCHRIDHE SUPPORT SERVICE	Care at Home	02/12/2016	5	NA	NA
PENUMBRA (VISITING SUPPORT)	Care at Home	30/11/2016	5	NA	5
Places for People St Leonards (Base C&S)	Care at Home	06/02/2017	5	5	NA
Places for People St Leonards (Base C@H)	Care at Home	06/02/2017	5	5	NA
Barony Housing Association Ardmillan Terrace, Mardale Crescent, Mayfield Rd, Upper Gray St (C&S) (C@H)	Care at Home	09/03/2017	5	NA	5
COMMUNITY HELP & ADV (CHAI)	Care at Home	Not inspected in time period			
CROSSREACH THRESHOLD EDINBURGH	Care at Home	07/03/2017	6	NA	5
ENABLE	Care at Home	26/08/2015	6	6	6
FREESPACE HOUSING	Care at Home	30/03/2017	2	2	2
FREESPACE HOUSING	Care at Home	08/09/2016	3	3	3
GARVALD EDINBURGH	Care at Home	26/10/2016	5	5	4
Leonard Cheshire Disability Stenhouse (Base C&S)	Care at Home	08/12/2016	6	5	NA
Link Living Edinburgh Mental Health Service	Care at Home	Not inspected in time period			
Places for People Edinburgh Mental Health Service	Care at Home	08/09/2016	4	4	4
REAL LIFE OPTIONS	Care at Home	24/11/2016	5	4	4

Care at home services commissioned by EHSCP	Type of service	Date of Inspection	Care & Support	Staffing	Management & Leadership
SUPPORT AND SOC CR NETWRK SSCN	Care at Home	04/01/2017	4	4	4
SUPPORT AND SOC CR NETWRK SSCN	Care at Home	03/05/2016	4	2	3
Bluebird Care	Care at Home	13-Oct-16	5	NA	NA
Care UK Homecare (Mears)	Care at Home	24-Aug-16	3	4	4
Carrick Home services	Care at Home	02-Jun-16	4	4	4
Everycare (Edinburgh)	Care at Home	02-Nov-16	5	4	NA
Family Circle Care	Care at Home	11-May-16	4	4	4
Home Instead Senior Care	Care at Home	16-Feb-17	6	NA	5
Independent Living Services	Care at Home	06-Feb-17	3	3	3
Highland Care Agency	Care at Home	25-Jan-17	2	1	2
Margaret Forrest Care Management	Care at Home	03-Oct-16	4	NA	NA
Prime Health Care	Care at Home	19-Sep-16	4	4	5
Professional Carers' Scotland	Care at Home	20-Jul-16	5	NA	4
Quality Care Resources	Care at Home	13-Feb-17	3	3	3
Bright care	Care at Home	10-Feb-17	5	NA	5
JB Nursing Employment Agency	Care at Home	07-Jul-16	4	3	4
Prestige Nursing PC Property	Care at Home	03-Mar-17	6	6	6
Blackwood Care	Care at Home	15-Mar-17	5	NA	5
Carewatch	Care at Home	17-May-16	4	5	4
Sutton Care Solutions	Care at Home	14-Jul-16	5	5	NA
Carr Gomm Morningside	Care at Home	02-Feb-17	5	4	NA
Carr Gomm Merchiston	Care at Home	28-Jun-16	4	3	3
Crossreach Eskmills	Care at Home	08-Nov-16	5	NA	NA
Harmony	Care at Home	17-Aug-16	5	NA	NA
L'Arche	Care at Home	29-Aug-16	5	5	4
Leonard Cheshire Bingham	Care at Home	15-Dec-16	5	5	NA
Leonard Cheshire Trafalgar Lane	Care at Home	29-Jul-16	5	5	5
Mears Care	Care at Home	15-Nov-16	5	NA	NA

Care at home services commissioned by EHSCP	Type of service	Date of Inspection	Care & Support	Staffing	Management & Leadership
Places for People Caltongate	Care at Home	20-Sep-16	5	5	NA
Richmond Fellowship	Care at Home	28-Mar-17	3	3	3
The Action Group A	Care at Home	08-Feb-17	5	NA	5
Thistle Foundation	Care at Home	07-Jun-16	5	NA	5
Autism Initiatives Bingham	Care at Home	04-May-16	5	4	4
Autism Initiatives Blackfriars	Care at Home	23-Nov-16	3	4	4
Places for People East Craigs	Care at Home	26-Jan-17	6	6	NA
Ark Housing	Care at Home	12-Aug-16	3	3	2
Avenue Care Services	Care at Home	10-Oct-16	4	NA	NA
Call In Homecare	Care at Home	29-Aug-16	4	NA	NA
Social Care Alba	Care at Home	24-Feb-17	4	4	NA
SCRT Careline	Care at Home	30-Jun-16	4	5	NA
Shaw Healthcare	Care at Home	02-Sep-16	4	5	NA
Aquaflo	Care at Home	24-Mar-17	2	2	2
MECOPP	Care at Home	Not inspected in time period			
Richmond Fellowship	Care at Home	Not inspected in time period			

Day services

Day Services commissioned by EHSCP	Date of Inspection	Care & Support	Staffing	Management & Leadership
Caring in Craigmillar	23/03/2017	5	4	NA
Lochend Neighbour Centre	New service			
North Edinburgh Dementia Care	16/03/2017	5	5	NA
Upward Mobility	01/12/2016	5	5	NA
Alzheimer Scotland	22/04/2016	5	NA	5
Corstorphine Dementia Project	Not inspected in time period			
Drylaw Rainbow Club	Not inspected in time period			
Lifecare	Not inspected in time period			
Queensferry Churches' Care in the Community	Not inspected in time period			
Eric Liddell Centre	15/06/2016	6	5	NA
Libertus	Not inspected in time period			
The Open Door	Not inspected in time period			
Places for People Pleasance Day Centre	Not inspected in time period			
Prestonfield and District NWP - Clearburn Club	Not inspected in time period			
Cornerstone Community Care Canalside	27/03/2017	5	4	4