Item 5.7

Report

The EIJB Annual Performance Report 2016-17
Edinburgh Integration Joint Board

14 July 2017

Executive Summary

1 The Edinburgh Integration Joint Board is required by the Public Bodies (Joint Working) (Scotland) Act 2014to produce an annual performance report. The initial report on performance covering 2016 to 2107 is noted as an appendix to this report.

Recommendations

2 The Integration Joint Board is asked to approve the attached Annual Performance Report for publication.

Main report

3 All Integration Joint Boards are required by the Public Bodies (Joint Working) (Scotland) Act 2014 to publish an annual performance report for the period April to March by 31 July. The report as detailed in Appendix 1 is the first Annual Performance Report that will be published by the Edinburgh Integration Joint Board. An earlier version of the attached report has been considered by the IJB Performance and Quality Sub-group and feedback received has been taken into account in producing the current version.

4 As required by the legislation and related guidance the report considers and 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
- reviewof the EIJB strategic commissioning plan

5 The performance report will be used to inform the programme of work for 2017/18 that will be undertaken to implement the EIJB Strategic Plan. Progress in relation to

performance will be monitored throughout the year and future reports will now be produced on an annual basis.

Key risks

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

Financial implications

7 Financial details in relation to performance are included within the report.

Involving people

8 The Annual Performance report has been produced with the involvement of key stakeholders represented on the IJB Performance and Quality Group.

Impact on plans of other parties

9 None

Report author

Rob McCulloch-Graham

Chief Officer, Edinburgh Health and Social Care Partnership

Contact: Wendy Dale, Strategic Planning, Service Re-Design and Innovation Manager

E-mail: wendy.dale@edinburgh.gov.uk | Tel: 0131 553 8322

Appendices

Appendix A	Annual Performance Report of the EIJB
Appendix B	Appendices to the Annual Performance Report

Appendix A

Delivering Health and Social Care in Edinburgh

Edinburgh IJB Annual Performance Report 2016/17

Contents

Foreword

I am delighted to welcome you to 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. As anticipated we have faced a number of significant challenges and experienced some success.

There are too many people in Edinburgh waiting too long to receive the support they need to help them remain at home or to return home from hospital. 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. Although we delivered a balanced budget in 2016/17 our financial position continues to be a challenge.

On a more positive note: there has been significant progress in moving towards the implementation of a new structure that will support the delivery of services on a locality basis and we have started to see the number of people whose discharge from hospital is delayed begin to reduce.

In line with the expectations set by the Scottish Government the report considers our performance from a number of 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
- 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

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. We will continue to monitor progress during the year and in future we will produce and publish a performance report every year.

Rob McCulloch-Graham

Chief Officer Edinburgh Integration Joint Board

Introduction and overview

The Edinburgh Integration Joint Board (IJB) was legally established in July 2015. The Board is 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 from the third, independent and housing sectors.

Whilst the provision of housing is not delegated to the Integration Joint Board, the Board recognises the impact of having somewhere warm, dry and safe to live on 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

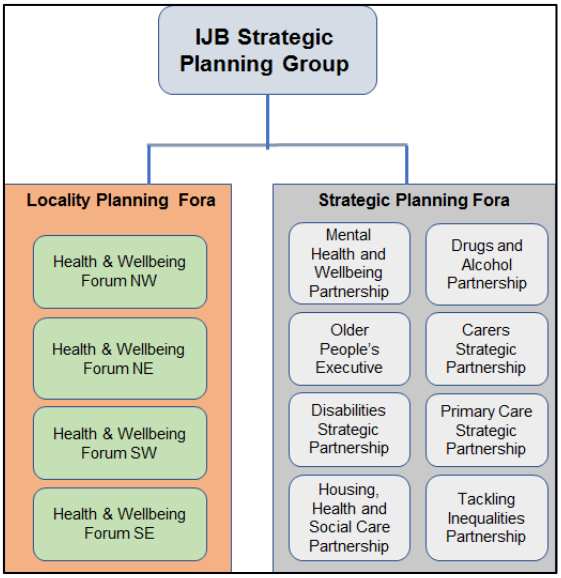
In March 2016, the IJB published its strategic plan setting out the strategic direction for health and social care services in Edinburgh from 2016 to 2019. The plan included our vision of 'People and organisations working together for a caring, healthier, safer Edinburgh'. To help us deliver this vision the plan identified the six linked key priorities in the diagram below. 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 required 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 interface organisations and providers of health and social care services; providers of social housing and the IJB 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 fora include representatives of key stakeholder groups and act as a wider constituency for members of the Strategic Planning Group enabling them to represent a wide range of opinion.



Our strategic plan identified the following 12 areas of focus which we believe will allow us to deliver our six key priorities:

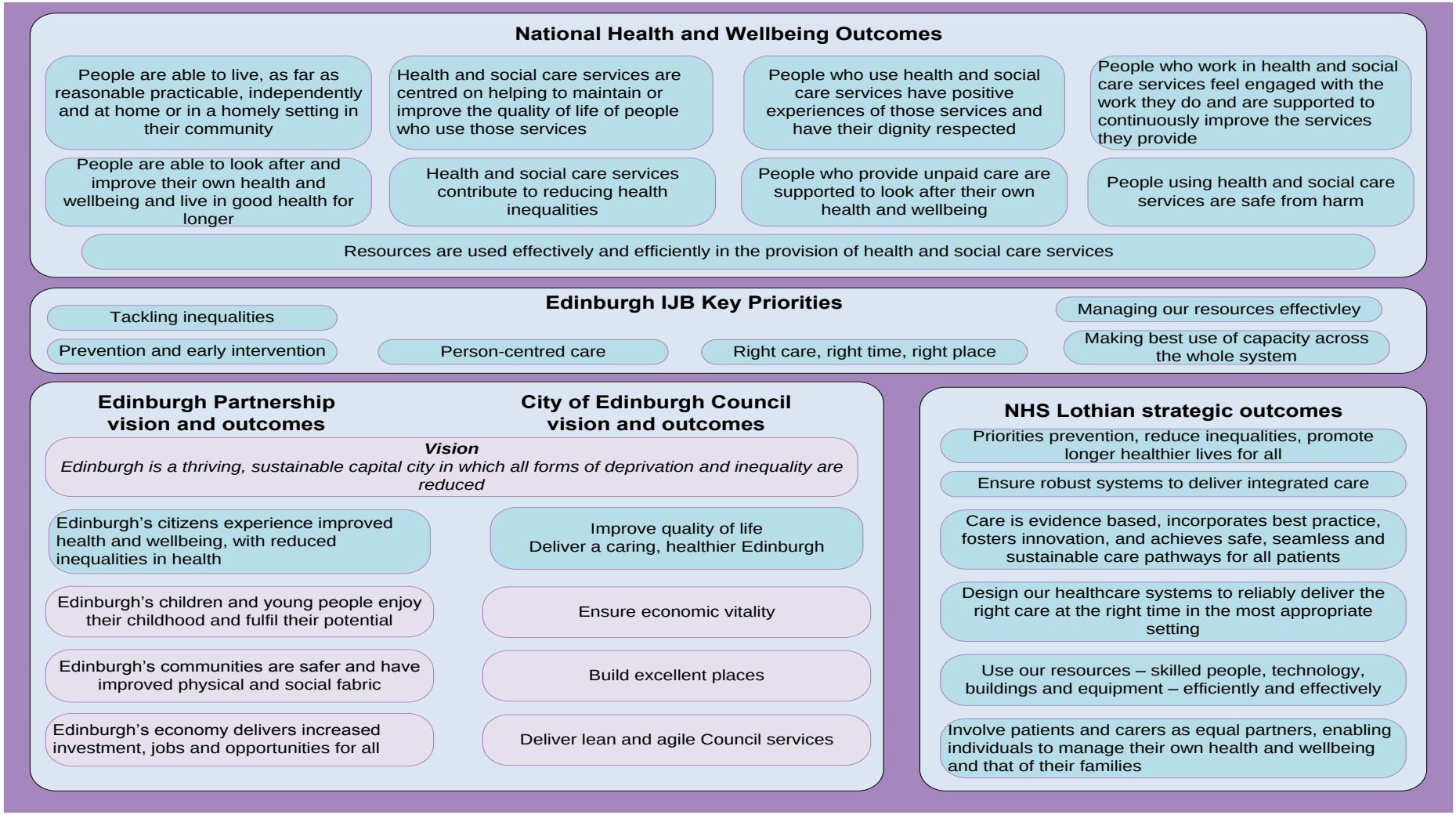
- achieving integration at a locality level
- tackling inequalities
- consolidating our approach to prevention an early intervention
- ensuring a sustainable model of primary care
- improving care and support for frail older people and those with dementia
- redesigning Mental Health and Substance Misuse 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

- transforming services for people with disabilities
- supporting people living with long term conditions

In describing our progress in delivering against the national health and wellbeing indicators we have detailed actions related to the 12 areas of focus.

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 priorities for delivery in 2017/18, many of which are also detailed in the section on the national health and wellbeing indicators below.

The six priorities 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.



Delivering against the National Health and Wellbeing Outcomes

The nine National Health and Wellbeing indicators shown at the top of the diagram on the previous 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.

A core set of 23 national indicators have 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.

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; an overall picture of performance against the indicators is also given in Appendix 2.

Outcome 1

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

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

What does the data tell us?

Core indicators

Of those responding to the national health and wellbeing survey in 2015/16 (the last year for which data is available):

- 96% reported they were able to look after their health very well or quite well. This is above the Scottish average.

City of Edinburgh	Peer Group Average	Scotland
96.0%	93.0%	94.0%

- 89% of people said they had positive experiences of care at their GP practice. This is above the Scottish average.

City of Edinburgh	Peer Group Average	Scotland
89.0%	88.0%	87.0%

Local indicators

During 2016/17

- The number of people registered with GP practices in Edinburgh has increased by 7,000.
- 82.4% of those referred for drug and alcohol services started to receive treatment within the 3-week target timescale.

- Just over half (50.4%) of people referred to psychological services were seen were within 18 weeks.

Progress we have made

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.

In 2016/17 we have:

- worked with 18 individual GP practices to ensure stability in the short to medium term including the replacement of medical sessions through the use of pharmacists, advanced nurse practitioners, community psychiatric nurses, link workers and physiotherapists
- worked with NHS Lothian to provide new or extended premises for 8 practices
- 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 report 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 the local medical centre taking referrals from people suffering ill health which is in part due to social issues such as debt or social isolation.

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.
- Improve compliance with waiting times for psychological therapies

Case Study – Carr Gomm Community Compass

Service

Carr Gomm, Community Compass project works in partnerships with the local medical centre, taking referrals from people suffering ill health due in part to social issues such as debt or social isolation. Community Compass link workers take a person-centred approach to identify the individual's issues and offer support to attend community groups

Person

Sarah, a 38-year-old mother of 3, had experienced homelessness and abuse in the past and her children had difficulties of their own and required support. Sarah was referred to Community Compass and met with a link worker once or twice, but did not want to be referred on anywhere else and did not attend the appointments arranged for her with other agencies.

Approach

The link worker persisted and began to build up a trusting relationship with Sarah who began to accept the suggestions of support her link worker made. She started to attend Carr Gomm's conversation café and meet other people and members of staff from other agencies. As she became less fearful of the idea of support, she began to accept it on a one to one basis from elsewhere. This meant that she could start to address the issues which had been holding her back for some time.

Impact

Sarah also made friends with one of the women in the group and has started going to the gym with her. This has helped improve both her physical health and mental health as she is now getting out and about, socialising and exercising.

As a result, Sarah is now in a much better place, feeling better about herself and feeling physically fitter. She is also more able to support her children, which makes her happier.

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

To do this, 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.

What does the data tell us?

Core indicators

- 82% of adults supported at home who responded to the national health and wellbeing survey in 2015/16 (the last year for which data is available) agree that they are supported to live as independently as possible.

City of Edinburgh	Peer Group Average	Scotland
82.0%	85.0%	84.0%

- In 2016/17 Edinburgh had a low emergency admission rate with 8,277 admissions per 100,000 population. The latest nationally available data are for 2015/16 where Edinburgh had the lowest level in Scotland with 8,393 admissions per 100,000 population compared with 12,138 nationally.

City of Edinburgh	Peer Group Average	Scotland
8,277	Not yet published	

- Edinburgh had a low emergency bed day rate with 108,605 emergency bed days per

100,000 population. The latest nationally available data are for 2015/16 where Edinburgh ranked 21st Scotland with 112,147 emergency bed days per 100,000 population. This was below the Scottish emergency bed day rate of 122,713 emergency bed days per 100,000 population.

City of Edinburgh	Peer Group Average	Scotland
108,605	Not yet published	

- Edinburgh has a relatively high rate readmissions within 28 days with 105 per 1,000 admissions. The latest nationally available data are for 2015/16 where Edinburgh had the sixth highest rate of readmissions to hospital within 28 days with 107 readmissions per 1,000 admissions. This is above the Scottish figure of 96 readmissions per 1,000 admissions.

City of Edinburgh	Peer Group Average	Scotland
104.6	Not yet published	

- Edinburgh has 62% of adults with intensive care needs receiving care at home. Edinburgh ranks 22nd.

City of Edinburgh	Peer Group Average	Scotland
62.3%	61.6%	61.6%

- Edinburgh has the third highest rate of bed days lost due to delayed discharge, losing 1,396 bed days per 1,000 population aged 75+ compared with the Scottish rate of 842 bed days lost per 1,000 population 75+.

City of Edinburgh	Peer Group Average	Scotland
1,396	600	842

The following two indicators are under development nationally so no comparable data is available:

- Percentage of people admitted to hospital from home during the year, who are discharged to a care home
- Percentage of people who are discharged from hospital within 72 hours of being ready

Local indicators

- The number of people waiting in hospital for discharge for social care reasons during 2016-17 at the monthly census point ranged from 67 in April 2016 to 216 in January 2017

- The number of people waiting for discharge from hospital while guardianship was considered halved from 30 in May 2016 to 14 in March 2017

Progress we have made

Providing the right care at the right time has been a significant challenge for the Health and Social Care Partnership with too many people waiting too long for the support they need either in hospital or the community. However, our performance in relation to emergency admissions compares well with the rest of Scotland.

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
- refocused our reablement service to target those most likely to benefit, this has led to an average reduction in ongoing needs increasing from 37% to 52%
- 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%.
- provided access to the 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
- 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

Priorities for 2017/18

- Develop and implement a prevention strategy covering the three levels of prevention detailed in the strategic plan.
- Reducing both the numbers of people waiting for support and the length of waiting times is a major priority for us in 2017/18.
- 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.
- Investigate reasons for hospital readmission rates and develop plans to address

Case Study – Impact of delays in assessment

Background

Following a chance remark from a friend Bill was referred to the specialist Parkinson's nurse 4 years after being diagnosed with the condition and 2 years after he had started to develop non-related dementia. Bill's mood swings were becoming increasingly aggressive and he frequently fell.
Bill was allocated some carer time which allowed his wife, Alice, some respite.

Person

On a number of occasions, Bill disappeared and Police assistance was necessary to retrieve him.
In January, Bill had a serious fall and was hospitalised. For 7 weeks he was cared for in a small isolation ward. He became increasingly distressed by his aloneness, constantly in tears, packing his clothes and wanting home. His distress obviously alarmed Alice.

Approach

After 7 weeks Bill was transferred to the Royal Edinburgh Hospital. It became clear that Bill needed 24-hour care and would not be able to return home.

Alice visited a number of homes and found one in their locality, which meant easy visiting for family. His place was in danger of being lost because of the delay in assessment in REH. However, this was eventually resolved with all parties cooperating.

Impact

Bill's stay was short lived as he constantly set off the alarms, broke a garden fence trying to get out and being extremely aggressive towards other residents.

He has now returned to REH and an order for guardianship is being prepared.

Alice says that all staff involved with caring for Bill have shown great tolerance and understanding. The delays involved have, however, contributed to her distress.

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

Practicing 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 prioritise 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.

Core indicators

Of those adults supported at home who responded to Scottish Health and Care Experience Survey in 2015/16 (the last year for which data is available):

- 76% agreed that they had a say in how their help, care or support was provided. This is a significant reduction from 83% in 2013-14

City of Edinburgh	Peer Group Average	Scotland
76.0%	81.0%	79.0%

- 71% agreed that their health and social care services seemed to be well co-ordinated

City of Edinburgh	Peer Group Average	Scotland
76.0%	81.0%	79.0%

- 77% of adults receiving any care or support rated it as excellent or good.

City of Edinburgh	Peer Group Average	Scotland
71.0%	75.0%	75.0%

Local indicators

- 91 % of people who responded to the Scottish Health and Care Experience Survey in 2016/16 said they had been treated with respect by their GP practices

- the proportion of people who chose to be supported through options 1 and 2 of self-directed support (i.e. direct payments and individual service funds) increased from 14% in 2016 to 16% in 2017

Evidence from the 2015/16 Health and Care Survey shows that whilst the percentage of people who agree that they are supported to live as independently as possible is around the Scottish average there has been a significant reduction in the number of people who agree that they have a say in how their health care and support is provided. We know from the findings of the joint inspection of services for older people that most people receiving support are happy with the quality of services. The significant reduction in levels of satisfaction is therefore likely to reflect the views of those who have experienced long waits to receive the support they need.

The number of people supported through direct payments has continued to increase, which indicates that more people are exercising their right to control their own support.

Progress we have made

During 2016/17, we have:

- increased the value of direct payments by £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 North East Edinburgh Locality. The next step is to implement this approach within the other localities in Edinburgh and six further care homes.
- established a network of autism champions and provided training to front line staff to improve understanding of autism and the local services available

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.
- 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

Service

The IMPACT (IMProved Anticipatory Care and Treatment) service is a nurse led service which was set up to improve the quality of life for people with long term conditions, offer support to their carers and reduce preventable hospital admissions.

Person

Joan, who is 83 years old, was referred to IMPACT for assessment and support with pulmonary fibrosis and oxygen therapy.

Joan was extremely fatigued and breathless, struggling with all personal care and domestic chores. Although, three weeks earlier, Joan had been a very active member of her community, her condition had changed rapidly requiring long term oxygen.

Joan's daughter was coming the following week to take her to a respiratory appointment and Joan was determined to stay at home until then.

Approach

The IMPACT Team discovered that Joan had a urinary tract infection and a chest infection and was on the cusp of hospital admission but she felt able to cope overnight.

IMPACT contacted the GP who prescribed antibiotics that were delivered the next morning.

Joan agreed to a referral to the Intermediate Care Team (ICT) and following a joint visit the ICT agreed to provide support with personal care, and meal preparation.

Impact

Joan was able to stay at home until daughter arrived and managed to attend her clinic appointment. Care continues and Joan feels well supported and stated: *"I can't believe I'm getting all this help so quickly. It's amazing and makes me feel very relieved. I thought I'd wait ages (for care)."*

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.

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.

What does the data tell us?

Core indicators

- 82% of adults supported at home who responded to Scottish Health and Care Experience Survey in 2015/16 (the last year for which data is available) agreed that their services and support had an impact in improving or maintaining their quality of life.

City of Edinburgh	Peer Group Average	Scotland
82.0%	84.0%	84.0%

- Edinburgh has the second lowest proportion of time spent at home or in a community setting during the last six months of life at 85.5%.

City of Edinburgh	Peer Group Average	Scotland
85.5	87.0	87.5

- 80% of care services inspected were graded 'good' (4) or better. This is the third highest proportion for a city authority.

City of Edinburgh	Peer Group Average	Scotland
80%	85%	83%

Local indicators

- Over 50% of people who received a reablement service did not require an ongoing support at the end. Those people who did need ongoing support required 52.5% fewer hours than they required at the start of the reablement service.

Progress we have made

During 2016/17 we have:

- 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.

- 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.
- Residents of one care home were supported by 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 Council-run care home for older people 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 evidence how effective we are in helping people to identify and achieve their personal outcomes and to manage their own conditions, and using this evidence to continue to learn and improve where we are achieving this and where we need to improve.
- 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.
- Implementing the locality Hub teams which will work to prevent people going into hospital where possible.
- Developing and implementing a palliative care and end of life strategy.

Case Study – Edinburgh Community Food

Service

Edinburgh Community Food (ECF) receives funding through the Health and Social Care Partnership to provide a range of services and activities promoting healthy eating and tackling health inequalities across the city; particularly with people on low incomes, in poor communities and with marginalised communities of interest.

Person

John attended Edinburgh Community Food's six month-long nutrition and cooking course for men in recovery. He had been referred onto the course by brain injury charity Headway. Staff at Headway felt that although John had improved significantly since his stroke he still adopted a poor diet and lifestyle which resulted in him being tired and stressed out.

Approach

John continued to engage with Headway whilst attending ECF's course and regularly enthused to staff about the course. He brought in the recipes and informed staff at Headway that he had been cooking at home and for friends and family. Staff at Headway noticed a significant difference in his mood and were pleased to see him looking so well. He appeared to be much more content and relaxed and reported that he was very happy with how things were going.

Impact

John now makes his own, healthy meals from scratch and has lost a significant amount of weight. He is more aware of the importance of eating healthily and finds that he has much more energy and is able to do a lot more during the day.

John has also reduced his weekly food spend by over 50% and has reduced food waste significantly.

John is now an ambassador for healthy eating and has encouraged friends and family to take up the healthy eating option.

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

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

What does the data tell us?

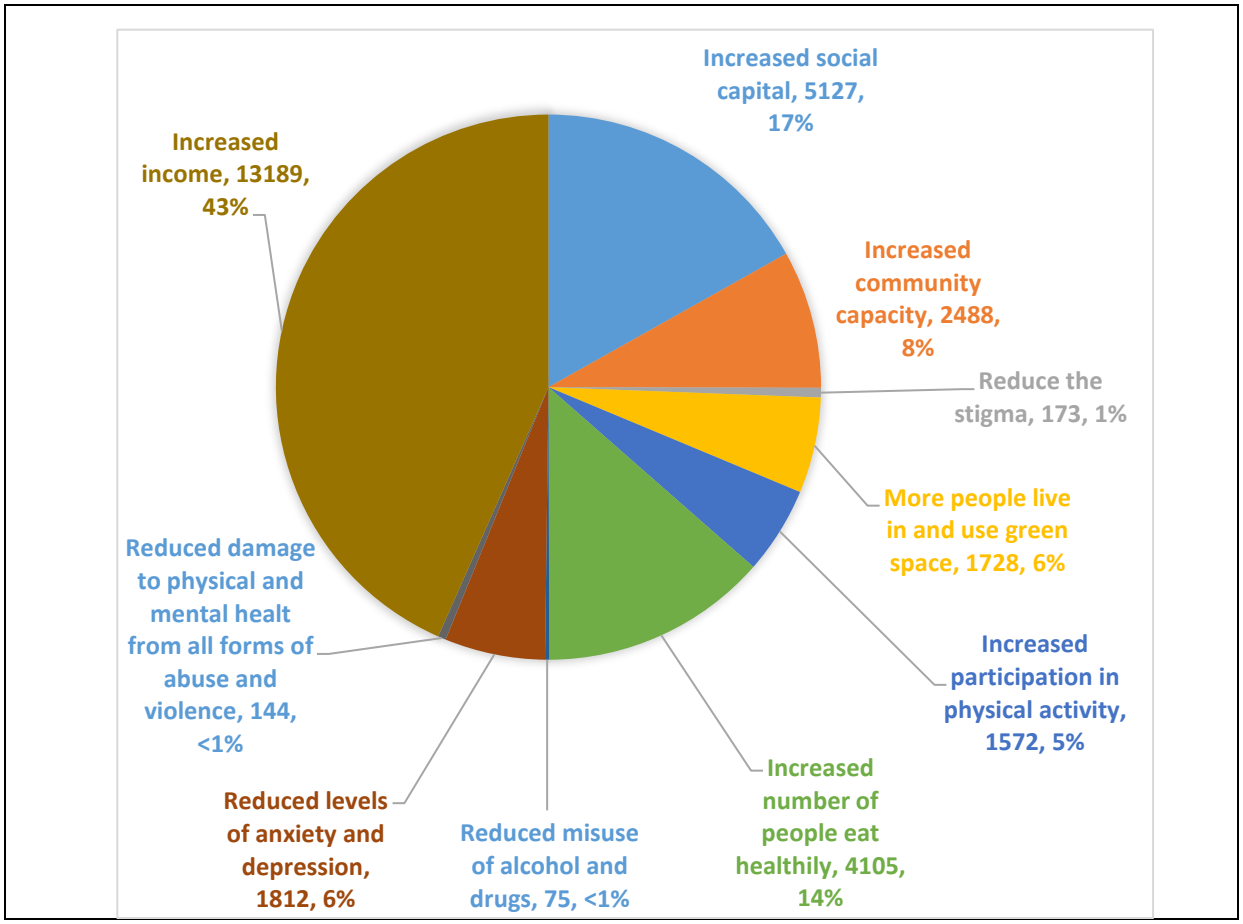
Core indicators

- Edinburgh's rate of 406 early deaths per 100,000 population is below the Scottish rate of 441 deaths per 100,000 and is the lowest of the four city authorities.

City of Edinburgh	Peer Group Average	Scotland
406.3	472.5	440.5

Local indicators

- Over 30,000 individuals used services provided through the Health Inequalities Grant Programme. Responses to a survey shows average customer satisfaction rate was 91% and on average 77% of participants surveyed, agreed or strongly agreed that the service had the intended positive impact on them. The diagram below shows the number of individuals being supported to achieve each priority outcome.



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.
    - *"Without you, I would not have made it – thank you. From my heart, thank you…" This person, whose lifestyle had been chaotic successfully moved from a B&B into supported accommodation.*
- awarded £1.8m to 36 organisations through the health inequalities grant programme.
- 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

- expanded the Headroom initiative, set up to improve outcomes for people in areas of the city with concentrated economic hardship, from 16 to 23 GP practices, covering around half of the city's areas of concentrated economic disadvantage.

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 in order 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

Service

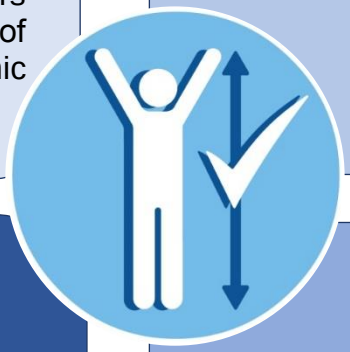
Headroom aims to improve outcomes for people in areas of the city with concentrated economic hardship. At the heart of Headroom is the relationship between the patient and the health professional and the opportunities this creates to deliver patient centred care.

The health professional signposts the patient to local activities provided by the Council, the third sector and other community organisations.

During the last 12 months, Headroom has from 16 to 23 GP practices working with a patient population that covers around50% of the city's areas of concentrated economic disadvantage.

Person

Craig, is a 53-year-old man who has recently moved to Edinburgh with his son fleeing domestic violence, suffered from high levels of anxiety and was referred to a Headroom Community Activity Mentor (CAM).



Approach

Through his referral to a CAM, Craig was successfully linked in with the following services:

- CHAI Advice Service
- Community One Stop Shop
- Dads Rock
- Gate 55 Employability Hub

Impact

Attending these groups and services helped to Craig's anxiety levels and helped to integrate him into his local community more. It also helped Craig to become more involved in his son's life. After initial assistance from his CAM, Craig started to feel more confident which led to him starting Gaelic lessons with his son, completing a sponsored half marathon and starting to look for work.

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.

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 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".*

What does the data tell us?

Core indicators

Of those unpaid carers who responded to Scottish Health and Care Experience Survey in 2015/16 (the last year for which data is available) 37% feel supported to continue in their caring role. This has reduced from 44% in 2013/14. The Scottish average has also reduced over this period (to 41%).

City of Edinburgh	Peer Group Average	Scotland
37.0%	42.0%	41.0%

Local indicators

- We carried out 700 carers assessments during 2016-17.

Progress we have made

A number of wider factors (for example changes in the welfare benefits system) will impact on unpaid carers and will influence the extent to which they feel supported. In Edinburgh, 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."*

During 2016/17 we have:

- funded a new carers support 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 WGH, to support people and their carers with pharmacy issues at the point of going home from hospital and continuing the support in the community is required
- established a multi-agency project team, including representation from unpaid carers, to implement the requirements of the Carers Act
- 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, 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 a capacity plan which takes account of the requirement for respite.
- Carers support workers will be trained to undertake unpaid carer assessments.

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

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 this by ensuring that people receive the right care in the right place at the right time.

What does the data tell us?

Core indicators

- Of those adults supported at home who responded to Scottish Health and Care Experience Survey in 2015/16, 82% agreed they felt safe compared to the Scottish average of 84%.

City of Edinburgh	Peer Group Average	Scotland
82.0%	85.0%	84.0%

- The falls rate for those aged 65+ in Edinburgh (21.5 per 1,000 population) was slightly above the national rate (20.9 per 1,000 population). Edinburgh's rank was 12th.

City of Edinburgh	Peer Group Average	Scotland
21.5	22.5	20.9

Local indicator

- The average length of wait for a social care assessment in 2016/17 was 83 days. It should be noted that this does not include cases screened as urgent, which were all assessed within 24 hours.
- At the end of March 2017, 385 people were waiting in the community for a total 2,720 hours of care per week. This excludes people waiting for an increase to their existing package of care. A further 77 people were waiting to move on from the reablement service requiring a total of 793 hours of care.
- The table below shows activity during 2016/17 regarding the identification of adult protection concerns

Adult protection referrals	**1134**
Large scale adult protection contacts	**158**
Inter-agency Referral Discussions (IRD)	**329**
IRD as a % of referrals	**29%**
Adult protection initial case conference	**79**
Initial case conference as a % of IRD	**24%**

	Adult protection case conference reviews	**110**	

Progress we have made

During 2016/17 we have:

- undertaken a range of self-evaluation and quality assurance activities centred around 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 a solution-focussed risk management procedure for cases that do not meet Adult Protection (or other) risk management frameworks, but where people are still considered to be at risk
- responded to 5,200 calls from fallers to the Telecare service, 95% of whom were assisted by the support teams with no need for further assistance or admission to hospital
- 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.
    - *"It was a magical moment feeling equipped and confident rather than helpless and overwhelmed" safeTALK trainee*
- developing 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
- quality frameworks from health and social care have been integrated and are overseen through a single Quality Assurance and Improvement Group that has oversight of Health Care Acquired Infection, Significant Adverse Events, clinical standards and professional governance. Quality assurance groups established to ensure that specific services are providing safe person-centred care.

Priorities for 2017/18

- Strengthen adult protection processes and ensure staff compliance by increasing access to training and expert adult protection support for practitioners.
- Increasing 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

Service

The Community Rehabilitation Team (CRT) works with people who have been long stay patients in the Royal Edinburgh Hospital to move to independent living by working with them and providers of community based services.

During 2016/17 it was agreed that people who were moving on from a long stay in hospital should be awarded Gold Priority on the Housing Application List which increases their opportunity of being awarded a suitable tenancy.

Person

Alan has paranoid schizophrenia and a long history of significant substance misuse. Since 2000 he has had six lengthy admissions to REH, with increased paranoia. He lived in a housing association flat but was gradually losing control of his ability to manage his health and well-being, his daily routines and to sustain his tenancy.

In early 2015 Alan was admitted to the Royal Edinburgh Hospital and transferred to a rehabilitation ward, to support him in preparing to move back to community by helping him to deal with his isolation as well as looking at healthy eating, budgeting, keeping in touch with his family and regaining self-confidence.

Approach

Throughout his time in hospital Alan was supported to change his perception of substance misuse and to develop other strategies to deal with his long-standing feelings of isolation and mistrust of other people.

In August 2016, Alan was referred to the CRT and allocated a care manager who, along with a Council Housing Officer, supported him to apply for a new tenancy. As a single person delayed in hospital, he was awarded Gold Priority on the Housing Application List.

Impact

Although the first tenancy that Alan was offered fell through as his care manager was unable to arrange a suitable support package; Alan left hospital in June 2017. He moved into his own tenancy with a support package that includes long-term supervision and monitoring of his mental health.

Alan's care manager has also continued to support him to access Scottish Welfare Fund, buy furnishings, arrange utilities, and register with a GP.

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.

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.

What does the data tell us?

Core indicators

The indicator on percentage of staff who say they would recommend their workplace as a good place to work is under development nationally.

Local indicators

- Mandatory training is in place for staff across both parts of the Partnership including health and safety, information governance and equality and rights
    - The compliance rate across all topics for Council staff was 51% (known to be under-recorded)
    - For NHS staff, compliance ranged from 55% for the Knowledge and Skills Framework (KSF) Review to 90% for Health and Safety
- Completion of the staff annual performance review for the Council's staff of the Partnership was 95%
- The staff survey 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 (regular profession specific clinical supervision within the partnership).
    - 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.
- started to develop 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 living wage.
- Having identified gaps in knowledge and skills in some care homes, an initial training proposal was developed focusing on three distinct training opportunities two of which clearly relate to Promoting Excellence informed and skilled practice levels of the framework and in addition a facilitators programme for Cognitive Stimulation Therapy. The Dementia Training Partnership was formed with representatives from Scottish Care, CEC, NHS Lothian to deliver that training. The programme was designed to be a sustainable and affordable model delivering:
  - 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.

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.

What does the data tell us?

Core indicators

- Nationally data are not yet available for 2016/17, however, Edinburgh spent 23.5% of the health and social resource on emergency admissions. In 2015/16 Edinburgh has the 13th highest percentage of the health and care resource spent on emergency admissions with 23.4% of the resource spent this way. This compares with the national percentage of 23.5%.

City of Edinburgh	Peer Group Average	Scotland
23.5%	Not yet published	

The indicator on expenditure on end of life care is under development nationally.

Progress we have made

As can be seen from our performance against some key indicators, 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 that arising from the strategic plan. These will set out our intentions for investment and disinvestment.

Case study – CleverCogs

Service

Blackwood Homes and Care have been funded through the Integrated Care Fund to pilot CleverCogs a night time digital video calling solution that provides support to people with disabilities or mental health problems in their home at night linked to support advisors who:

- Provide reassurance
- Alleviate loneliness
- Undertake tasks remotely such as closing curtains
- Remind people to take their medicine, giving advice if needed
- Get healthcare advice if needed and get help in an emergency

People

Jim had several short stays in hospital in the year before he became part of the CleverCogs pilot. Since then, he has only been admitted once. The night support staff use the video link to support Jim to manage his anxieties, allowing him to talk through the options and allow him to understand that calling NHS24 is not always necessary during the night. Usually later that night, he will call to say he is going to sleep and does not mention calling NHS24. In December and January alone, support staff have talked him out of calling NHS24, or for an ambulance on 25 occasions.

Approach

Ann was unable to leave hospital because a care package that included overnight support could not be arranged in her one bedroom flat and so a sleepover from a care worker would not have been possible. She would have needed temporary alternative accommodation which could have taken several months to arrange. CleverCogs enabled Ann to return to her own home.

Impact

Many customers do not want staff sleeping in their house but still need and want access to support during the night. They can now still have a service but it is under their control.

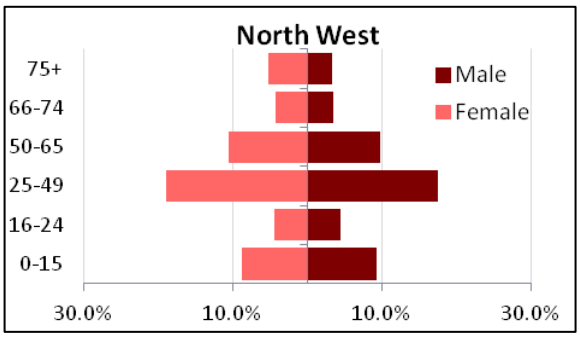
The overnight sleepover cost per customer has been estimated at £78. For ten customers at end of March 2017, the projected savings from May 2016 to March 2017 from using CleverCogs rather than having a sleepover in place was £87,048. There has also been a saving in avoiding hospital admissions.

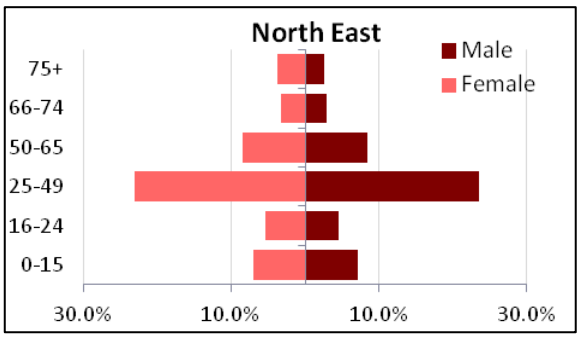
Locality working

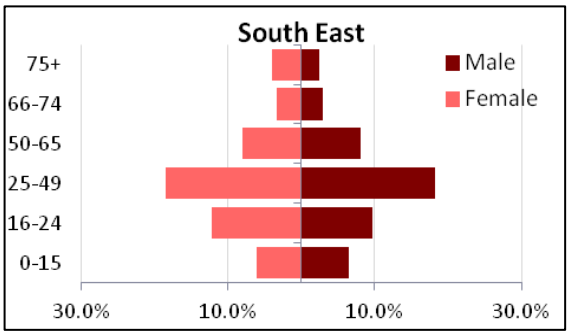
The population of Edinburgh is almost half a million people, accounting for 9% of the total population of Scotland and is predicted to grow faster than any other area of Scotland.

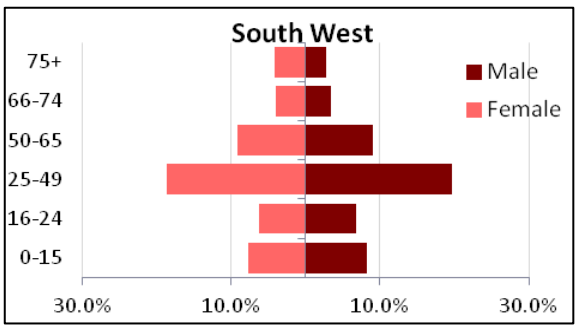
We have worked with the other members of the Edinburgh Community Planning Partnership to establish four geographic localities using neighbourhood partnership boundaries as the basis for service planning and delivery in the city. Whilst the city is often perceived as affluent each locality contains both 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[1]	114,061	141,718	133,041	109,990	498,810	867,800	5,373,000
All Males[1]	55,999	68,144	63,568	54,942	242,653	421,564	2,610,469
All Females[1]	58,062	73,574	69,473	55,048	256,157	446,236	2,762,531







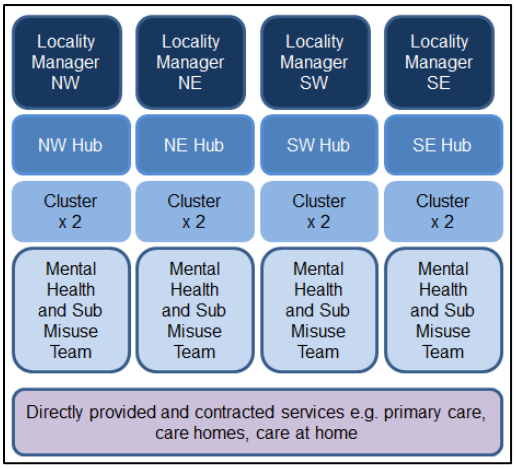


Our main priority in 2016/17 has been to implement our new locality structure to support the planning and delivery of services within the four localities. Each of the four Locality Managers oversees four integrated teams made up of nurses, social workers and allied health professionals (therapists):

- the Locality Hub provides short-term support at a time of crisis to avoid people being 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) that comes together daily 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 medical and social care services.

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)

Finalisation of the realignment of budgets to the new locality structure is a priority for 2017/18.

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. Fora 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 and Best Value – Including Governance

Financial information is a key element of our performance management framework with our financial performance reported at each meeting of the IJB.

Financial Plan 2016/17

Strong financial planning and management needs to underpin everything that we do to ensure that our limited resources are targeted to maximise the contribution to our objectives. A financial assurance process was undertaken on the 2016/17 funding contributions made available by NHS Lothian and the City of Edinburgh Council. Through this, baseline pressures of £5.8 million were 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, 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

During the year, we worked closely with NHS Lothian to identify measures to mitigate the funding shortfall described above and, at the year end, the full value of the pressure had reduced to £2.5 million. This 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 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. 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 table 1 below:

Table 1: 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)**

How others see us

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

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 complaints systems, by carrying out satisfaction surveys and by involving service users and carers in planning forums and reference groups.

In terms of formal complaints 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 complaints are 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 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 the following 17 recommendations:

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 • 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.

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. A detailed improvement plan is in place to respond to these recommendations and an Improvement Board meets regularly to oversee delivery of actions within the plan. 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.

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:

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.

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

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.

Our Performance

This chapter gives a brief overview of:

- Our approach to managing and improving performance
- Our performance on the national sets of indicators for integration, how we compare with other partnerships in Scotland including our targets, and what we are doing to achieve these
- What our local indicators tell us about our performance

Details of performance and activity across the range of measures is shown in Appendix 1.

Our integrated performance framework

The purpose of our performance framework is to:

- Fuel dialogue with all stakeholders, enabling better understanding of our performance, leading in turn to better decision making
- Use data more effectively to inform solutions
- Allow us to track progress with the strategic plan effectively and know when remedial actions are needed
- Show how we impact on all parts of the health and social care system.

To achieve this, the following need to be in place:

i. **The performance framework is embedded** in the "analyse, plan, do and review" cycle of needs assessment and strategic planning – aligning performance monitoring with strategic priorities will ensure that what is measured matters.

ii. **Performance management arrangements**, which:

- ensure that the right performance information is considered by the right people at the right time to guide action and learning leading to service improvement
- support understanding of the whole system of care, including service quality, effectiveness, and efficiency
- are supported by sound, reliable and holistic data
- engage stakeholders

iii. **Clear roles, responsibilities and accountability**

- Key indicators are owned by a named manager, who is responsible for the underlying performance.
- Staff at all levels need to be clear about their role in owning and using performance information to improve services.
- Data is seen as an asset, and data quality is part of everyone's job

National indicators

A core set of 23 national indicators have been developed as a means of comparing performance in the implementation of integration. These will be supplemented from April 2017 onwards with a set of six integration indicators.

Outcome Measures

The Health and Care Experience Survey is carried out every two years[1] and is the source of nine of the national set of core integration indicators. Two sets of results are available so far: 2013-14 and 2015-16. The questions relate to:

- people being able to look after their health
- the effectiveness and co-ordination of support people receive at home and whether they feel safe
- experience of their GP practice
- whether unpaid carers feel supported

Key points for Edinburgh

Where available, data for 2016-17 is used for Edinburgh, but data for other Partnerships is not available for all of these measures, and so 2015-16 data has been used instead.

Compared with the whole of Scotland, Edinburgh has:

- Relatively low levels of premature mortality (death under the age of 75), ranking 17th highest out of the 32 partnerships
- High levels of adults able to look after themselves very well or quite well (96% - ranking 4th)
- The lowest rate of emergency hospital admissions (all ages) in 2015/16 and relatively low rate of emergency bed days ranking 21st in 2015/16. There was a relatively high readmission rate however, ranking 6th in 2015/16
- An above average experience of care from their GP ranking 15th at 89%
- An above average percentage of people with intensive care needs supported at home (62%) ranking 22nd
- In 2015-16, Edinburgh spent the same proportion as the Scottish average (23%), and ranked 13th highest, for the proportion of health and care resource spent on hospital stays when the person was admitted as an emergency
- 12th highest rate of falls
- Low levels of people supported at home feeling safe (82% - ranked 24th) and carers feeling supported (37% - ranked 29th)

[1] The Scottish Health and Care Experience Survey is a postal survey which is sent to a random sample of patients who were registered with a GP in Scotland

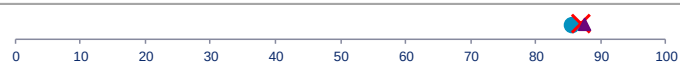
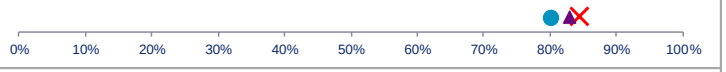
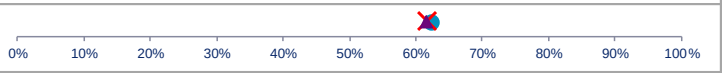
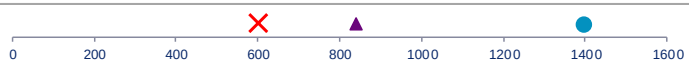
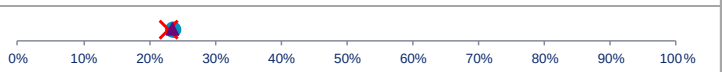
- Low levels of adults who feel supported to live as independently as possible (82% - ranking 25th), who agree they have a say in how their services are arranged (76% - ranking 28th) and agreeing that their health and social care service seems well coordinated (77% ranking 29th)
- Quality of care: 19th highest for the proportion of services graded by the Care Inspectorate 4 (good) or above – services included are: care homes for adults and older people; housing support services; support services including care at home and adult day care; adult placements and nurse agency

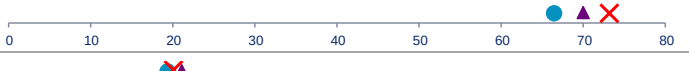
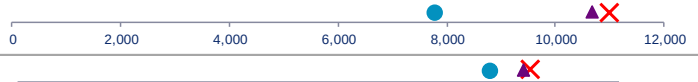
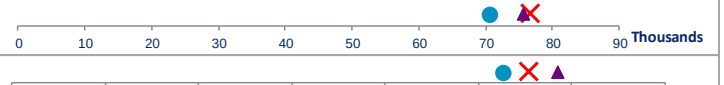
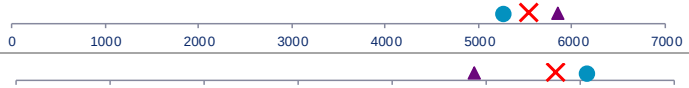
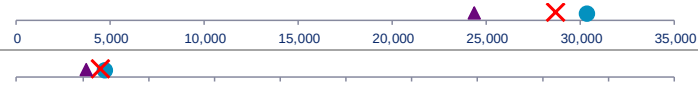
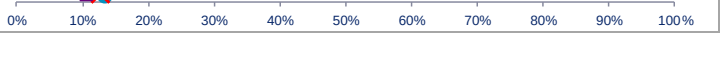
Annual Perfomance Report Appendix 1

National Indicators

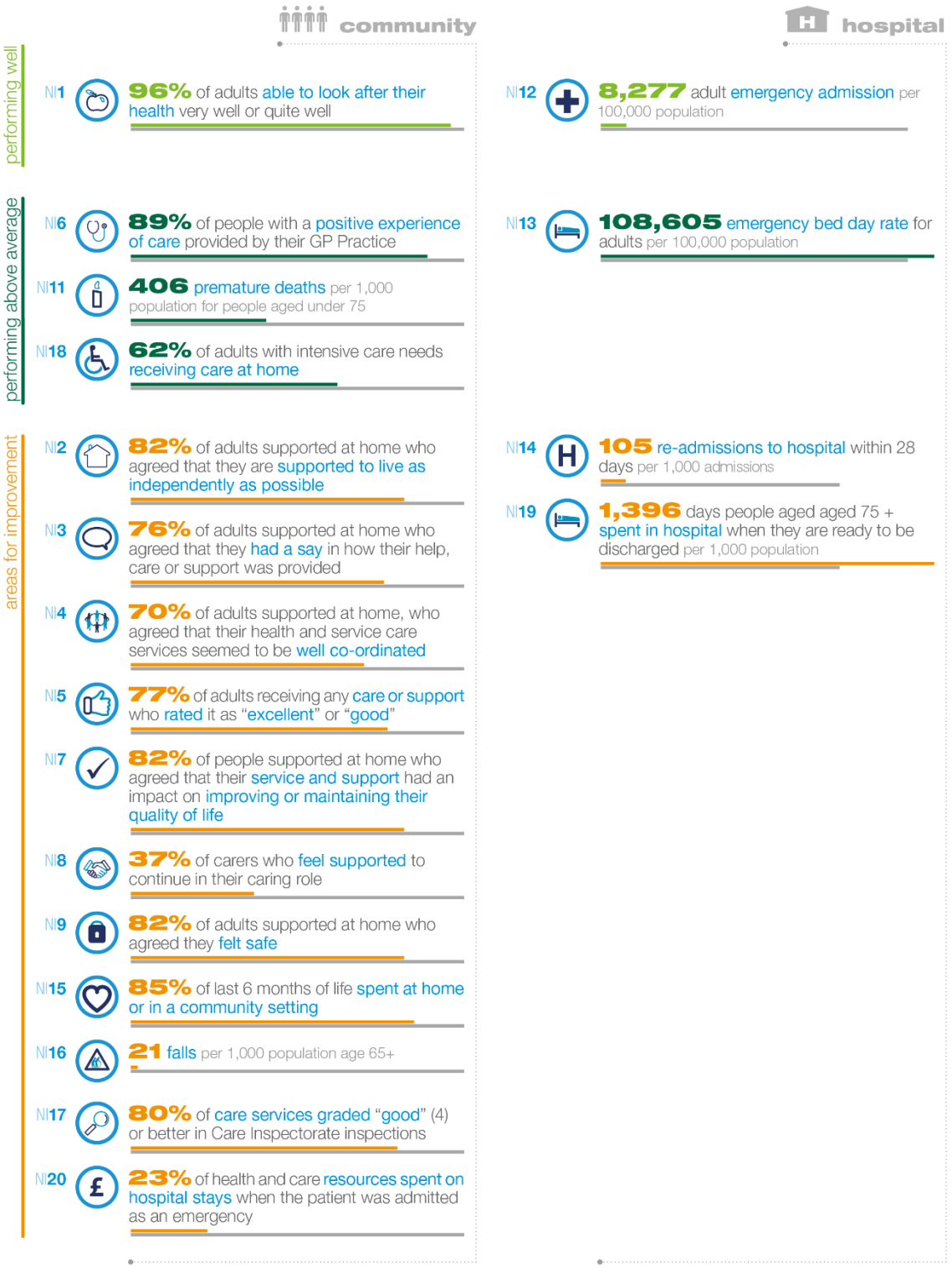
The scatter plots to the right of the table illustrate where Edinburgh City (the blue dot) lies in relation to both the Peer Group (red cross) average and the Scotland (purple triangle) values.

INDICATOR	Edinburgh City	*Peer Group Average*	*Scotland*
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

INDICATOR	Edinburgh City	Peer Group Average	Scotland	
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 - 2016	70,618.1	76,668.2	75,653.8	
Unscheduled bed days per 100,000 - geriatric long stay - 2015 (based on Apr-Dec)	5,250.6	5,531.6	5,851.6	
Unscheduled bed days per 100,000 - mental health specialties	30,298.8	28,696.1	24,346.9	
% 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

This tables below give an overview of the current key activity and performance indicators which are being used in Edinburgh to track progress against the strategic plan and towards priority outcomes. The indicator set 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, showing activity showing data for 2016/17.

Important note
A person's locality can by defined in two main ways: a) where they live (this is the most common) 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 - Outcomes

About this data
A core suite of integration indicators was 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 recorded as part of normal practice.

The source for the 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.

	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%	97%	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 and included delays in people being discharged from hospital and people with learning disabilities who need alternative accommodation.

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
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
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

3. Primary care

This section includes measures on primary care both in terms of the experience people have and details on the number of practices in each locality.

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	101.4
Number of GP practices	No.	18	19	20	17	74	18
Number of GP practices with restricted lists	No.	10	11	13	6	40	10

4. Support in the community

This section includes information on services that are available in the community to support people with identified needs both in the short term and on an ongoing basis.

Topics
Reablement is a short term domiciliary care service that aims to support people to regain the skills needed to live as independently as possible. Following the service people often require fewer hours of care, or no care at all. In June 2016 the criteria for accessing the service were revised to ensure that those who were most likely to benefit from the service were able to access it.

Carers assessments and multidisciplinary falls assessments are ways of identifying need and appropriate supports which will enable people to remain living in the community.

As part of the Self-directed Support Act, people who are eligible for social care must be offered a range of choices over how they receive their 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).

The post diagnostic support for older people, and their families, for those who have been diagnosed with dementia was an improvement area identified in Scotland's National Dementia. Information relating to the number of people starting a post diagnostic support service relates only to the service commissioned by the Partnership as opposed to any internal service providing similar support.

	Data Type	North East	North West	South East	South West	Edinburgh
Reablement - impact (reduction)	%	46.2%	52.3%	49.0%	64.3%	52.5%
Reablement - impact (no further package required)	%	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	11.09	9.51	11.48	12.61	10.92
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 diagnoses	No.	35	56	44	20	157
Dementia diagnoses as a rate per 1,000 population 75+	Rate	5.0	4.6	5.3	2.6	4.5

	Data Type	North East	North West	South East	South West	Edinburgh
Post diagnostic support service starts	No.	38	84	55	39	220
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 implantation of the new 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.

Developments of this data set are planned.

Proportion of 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
KSF review	%	54.7

Section 2. Time Series

1. Pressure, unmet need, waiting lists

This section includes indicators on people waiting in hospital for discharge, assessments and 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	28
Delayed Discharges: number NW	No.						52	58	57	57	61	64	39
Delayed Discharges: number SE	No.						39	48	40	42	69	51	57
Delayed Discharges: number SW	No.						48	48	37	41	50	51	50
Delayed Discharges: Total	No.	67	85	120	173	170	171	196	180	185	221	206	174

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
	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 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 includes data around those who have been referred for psychological treatment.

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 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 includes data on carers assessments, multidisciplinary falls assessments, the response and effect of the Community Alarm and Telecare Service, the balance of care and GP list size.

About this data
Carers assessments and multidisciplinary falls assessments indicate one way of identifying need and appropriate supports in the community to enable people to remain living in the community.

The Community Alarm and Telecare Service (CATS) provides a service to people, who following activation of their alarm or monitoring system require assistance. The indicators below show how the service maintains people at home following a fall and how they provide support without input from other bodies, such as the Scottish Ambulance Service, unless required.

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

	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 SW	No.	12	10	16	16	9	12	9	18	6	7	9	9
Carer Assessments Total	No.	69	50	60	57	53	60	61	65	47	42	61	69
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 those who are subject to a mental health legal order or guardianship process. Details on the percentage of cases meeting the three week referral to treatment start for drug and alcohol services are also given.

About this data

The final figure in this section is monitoring the number of people delayed for in hospital where the delay reason is due to delays in the guardianship process where they have been assessed as not having capacity and require legal process under the Adults with Incapacity (Scotland) Act 2000. Additional staff have been brought into post to assist with targeting these delays and the impact of their work is shown in the reduction in the number of delays.

	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
Data relating to actions contained in the Strategic Plan which relate to Long Term Conditions is shown below in particular around three actions over each quarter of 2016/17:

- Action 13: Prevention and Early Intervention: Priority focus on physical activity, supported self management of long term conditions and falls prevention
- Action 30: COPD integrated care model to target people most at risk of hospital admission
- Action 32: Increase quality and quantity of Anticipatory Care Plans created via Key Information

	Data Type	Apr – Jun 2016	Jul – Sep 2016	Oct-Dec 2016	Jan-Mar 2017
Number of A&E attendances due to falls for people aged 65+	No.	981	985	1013	930
Referrals to fallen uninjured person pathway	No.	35	43	56	81
Bed days for people with a primary diagnosis of COPD	No.	1,860	1,757	1,774	1,899

	Data Type	Apr – Jun 2016	Jul – Sep 2016	Oct-Dec 2016	Jan-Mar 2017
Acute COPD exacerbations at risk of admission referred to Community Rehabilitation Tean (CRT)	No.	263	237	286	267
Acute COPD exacerbations assessed by CRT where admission avoided	No.	83	44	58	49
Number of Key Information summaries	No.	29,892	33,835	35,587	37,871

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 Perfomance 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			

Care homes commissioned by EHSCP	Date of Inspection	Care & Support	Staffing	Management & Leadership
Sir James McKay Housing - Scottish Masonic Homes Limited	31/02/2017	4	5	5
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

Care homes commissioned by EHSCP	Date of Inspection	Care & Support	Staffing	Management & Leadership
Four Seasons Health Care - North Merchiston	12/11/2015	5	5	5
Lorimer House Nursing Home	25/01/2016	5	5	5
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

Home care services provided by EHSCP	Type	Date of Inspection	Care & Support	Staffing	Management & Leadership
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

Care at home services commissioned by EHSCP	Type of service	Date of Inspection	Care & Support	Staffing	Management & Leadership
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
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 servcies	Care at Home	02-Jun-16	4	4	4
Everycare (Edinburgh)	Care at Home	02-Nov-16	5	4	NA
Family Cirlce 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
MargarotForrest 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 Gorm Morningside	Care at Home	02-Feb-17	5	4	NA

Care at home services commissioned by EHSCP	Type of service	Date of Inspection	Care & Support	Staffing	Management & Leadership
Carr Gorm 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
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
Autsim Initiatives Bingham	Care at Home	04-May-16	5	4	4
Autsim 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