Notice of Meeting and Agenda

Edinburgh Integration Joint Board
9.30 am Friday 14 July 2017

Main Council Chamber, City Chambers,
Edinburgh

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This is a public meeting and members of the public are welcome to attend.

1. Welcome and Apologies

1.1 Including the order of business and any additional items of business notified to the Chair in advance.

2. Declaration of Interests

2.1. Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

3. Deputations

3.1. None.

4. Minutes and Updates

4.1. Previous Minutes - 16 June 2017 (circulated) – submitted for approval as a correct record.

4.2. Sub-Group Updates

4.2.1 Audit and Risk Committee

(a) Note of Meeting of 2 June 2017 (circulated)

4.2.2 Professional Advisory Group

(a) Note of Meeting of 6 June 2017 (circulated)

4.2.3 Performance and Quality Sub Group

4.2.4 Strategic Planning Group

5. Reports

5.1. Rolling Actions Log – July (circulated)

5.2. Inspection of Older People's Services – Improvement Actions –IJB Chief Officer will report

5.3. Community Justice Outcomes Improvement Plan 2017/18 – report by the Head of Safer and Stronger Communities (circulated)

5.4. Whole System Delays – report by the IJB Chief Officer (circulated)

5.5. Update on the 2017/18 Financial Position - report by the IJB Chief Officer (circulated)

5.6. Edinburgh Wellbeing Public Social Partnership – report by the IJB Chief Officer (circulated)

5.7. The EIJB Annual Performance Report 2016-17 – report by the IJB Chief Officer (circulated)

5.8. Council 29 June 2017 – Health and Social Care Reports- report by the IJB Chief Officer (circulated)

5.9. Appointments to Committees and Sub-Groups – report by the IJB Chief Officer (circulated)

5.10. IJB Calendar of Meetings – report by the IJB Chief Officer (circulated)

Board Members

Voting
Councillor Ricky Henderson (Chair), Carolyn Hirst (Vice-Chair), Michael Ash, Shulah Allen, Councillor Derek Howie, Alex Joyce, Councillor Claire Miller, Councillor Alasdair Rankin, Councillor Susan Webber and Richard Williams.

Non-Voting
Carl Bickler, Colin Beck, Sandra Blake, Andrew Coull, Wanda Fairgrieve, Christine Farquhar, Kirsten Hey, Beverley Marshall, Angus McCann, Ian McKay, Ella Simpson, Rob McCulloch-Graham, Michelle Miller, Moira Pringle, George Walker and Pat Wynne.

Item 4.1 Minutes

Edinburgh Integration Joint Board

9.30 am, Friday 16 June 2017
Council Chambers, Edinburgh

Present:

Board Members: Carolyn Hirst (in the Chair), Shulah Allen, Mike Ash, Colin Beck, Carl Bickler, Andrew Coull, Wanda Fairgrieve, Christine Farquhar, Councillor Ricky Henderson, Kirsten Hey, Councillor Derek Howie, Alex Joyce, Rob McCulloch-Graham, Ian McKay, Councillor Claire Miller, Michelle Miller, Moira Pringle, Ella Simpson, Councillor Susan Webber, Richard Williams and Pat Wynne.

Officers: Colin Briggs, Eleanor Cunningham, Wendy Dale, Sarah Hughes-Jones, Allan McCartney, Ross Murray, Julie Tickle, David White, Kevin Wilbraham and Cathy Wilson.

Apologies: Angus McCann and George Walker.

1. Membership

The Chair expressed the Joint Board's thanks for the service of former board members who had not returned following the 2017 Local Government Election. She also welcomed the newly appointed Joint Board members.

2. Minutes

Decision

1) To approve the minute of the Joint Board of 24 March 2017 as a correct record.

2) To approve the minute of the Joint Board of 28 April 2017 as a correct record.

3. Sub-Group and Committee Minutes

Decision

To note the Sub-Group and Committee minutes.

4. Rolling Actions Log

The Rolling Actions Log for 16 June 2017 was presented.

Decision

1) To approve the closure of actions 4, 11 and 12.

2) To otherwise note the outstanding actions.

(Reference – Rolling Actions Log – 16 June 2017, submitted.)

5. Inspection of Older People's Services

An update was provided on the joint inspection of older people's services, which was carried out between October and December 2016 by the Care Inspectorate and Healthcare Improvement Scotland, and the improvement plan that had been developed to address the findings of the inspection. During discussion, the following points were raised:

- Options for the re-provision of Liberton Hospital and Gylemuir House Care Home would be considered at a future meeting of the Joint Board.
- A concern had been highlighted by the Professional Advisory Group that staff felt they had not had the opportunity to contribute to the improvement plan. The Chief Officer assured members that social work staff had been consulted at a recent workshop around the assessment process and that engagement with frontline staff would continue.
- The Chief Officer assured members that the third sector would be involved in implementing and monitoring the improvement plan going forward.
- It was anticipated that the improvement plan would evolve over time.

Decision

1) To note the findings of the inspection and resource implications required to take forward the improvements.

2) To note the progress made on the 17 recommendations made by the Care Inspectorate and in particular those that have been identified as a priority.

3) To agree that the IJB Performance and Quality Sub-Group would be the main governance group for monitoring progress relating to the action plan and that the Chief Officer submit recommendations to the Joint Board determining how actions would be attributed to each sub-group.

4) To agree that progress updates on improvement actions coming out of the Inspection of Older People's Services became a standing agenda item.

(References – minute of the Integration Joint Board 20 January 2017 (item 10); report by the IJB Chief Officer, submitted.)

6. Whole System Delays – Recent Trends

An overview was provided of performance in managing hospital discharge against Scottish Government targets. Key reasons for delay were explained, and a number of workstreams aimed at reducing delays were outlined.

It was advised that work was ongoing with contracted care at home providers to help improve performance.

Decision

1) To note the improvement in performance in respect of delayed discharge.

2) To note the actions being taken to maintain that improvement.

(References – minute of the Integration Joint Board 24 March 2017 (item 5); report by the IJB Chief Officer, submitted.)

7. Primary Care Funding and Investment

Proposals for funding and investment into Primary Care were outlined.

Decision

1) To agree a programme of 'Stability and Transformation' injections into individual GP Practices during 2017/2018.

2) To agree the establishment of an Edinburgh primary care Linkworker network. This would be a Partnership led project which aimed to support more social prescribing.

3) To agree investment in additional management capacity to ensure effective implementation and robust evaluation.

4) To agree that the management of these investments would be made through the Edinburgh Health and Social Care Partnership (EHSCP) Primary Care Support Programme.

5) To agree the use of any non-recurring flexibility into an agreed group of technological investments (50/50 funding with practices) and to support development work by cluster groups.

(Reference – report by the IJB Chief Officer, submitted.)

Declaration of interests

Carl Bickler declared a non-financial interest in the above item as a General Practitioner.

Ella Simpson declared a non-financial interest in the above item due to EVOC's involvement in the Link Worker project.

Richard Williams declared a non-financial interest in the above item as a General Practitioner.

8. Expansion of the Acute Medical Unit at the Royal Infirmary of Edinburgh

An update on work between the four Lothian Joint Boards and NHS Lothian's Acute Services on the future shape and function of the Acute Medical Unit at the Royal Infirmary of Edinburgh was provided.

Decision

1) To note that NHS Lothian had approved capital funding to support the expansion of the Acute Medical Unit (AMU) at the Royal Infirmary of Edinburgh.

2) To agree the directions detailed in section 23 of the Chief Officer's report to use additional capacity over winter 2017/18 and working with officers of NHS Lothian to develop a sustainable model of care beyond this.

3) That the Professional Advisory Group be consulted throughout the process and sighted on future reports.

(Reference – report by the IJB Chief Officer, submitted.)

Declaration of interests

Andrew Coull declared a non-financial interest in the above item as the Clinical Director for Acute and General Medicine.

9. Responsibilities for Data and Information

The responsibilities of the Joint Board in relation to information governance were outlined. Progress to date, future considerations and current actions to ensure compliance were advised. It was confirmed that the Joint Board would be responsible for any monetary penalties imposed because of failure to comply.

Decision

1) To note progress made to date in relation to ensuring compliance with information governance legislation.

2) To approve the proposal to register the Joint Board with the UK Information Commissioner.

3) To note the intention to report to a future Joint Board meeting on General Data Protection Regulations requirements and responsibilities.

(Reference – report by the IJB Chief Officer, submitted.)

10. Actions to Support the Opening of the new Royal Edinburgh Building

An update on the move from the Royal Edinburgh Hospital to the new Royal Edinburgh Building, including details of measures to prevent admissions, reduce length of stay and facilitate discharge, was provided.

Decision

1) To note the progress made to facilitate the move for adults over 65 to the new Royal Edinburgh Building (REB) which had been assessed as having a RAG status of "green" and that progress around the transfer of patients was being monitored through the weekly delayed discharge meeting.

2) To note the progress made to reduce the number of people delayed in acute adult services and the growing risk of over occupancy of adult acute due to a risk in acute admissions and a delay in commissioning community capacity. The status of this work had a RAG assessment of "red".

3) To note that additional community capacity of between 12 and 15 places was required at Grade 4 or 5 to enable the move to the new Royal Edinburgh Hospital (REH) which had seven less acute beds on 31 August 2017 and to

maintain a bed occupancy within the new bed compliment of 90%. Maintaining the 90% occupancy is dependent on assuring a zero delayed discharge rate which is a risk without sustained additional community capacity.

4) To note that work was in progress to secure additional community capacity at Crighton Place for four Grade 4 community beds as set out in a previous report to the Joint Board on 24 March 2017. The occupancy date for this accommodation was planned for 31 August 2017.

5) To delegate authority to the Strategic Planning Group to approve the business case for the proposed development at Niddrie Mains to enable the partnership commission an additional nine Grade 5 places.

6) To note that the commissioning of the Niddrie Mains accommodation was being progressed in parallel to the business case process. Funding had been identified in the Joint Board's financial plan, however there was a risk that the places would not be available for occupation in time for the move to REB. The accommodation was not likely to be ready until end of September 2017, which would require a contingency plan to maintain a ward at the REH to accommodate Edinburgh patients whilst the additional community was being procured.

7) To note that a Public Information Notice was issued on Wednesday 7 June 2017 to identify market interest and shape the market for a longer term plan to provide additional supported accommodation. This would be the subject of further business case(s) which would be presented to the Strategic Planning Group in the first instance.

(References – minute of the Integration Joint Board 24 March 2017 (item 10); report by the IJB Chief Officer, submitted.)

11. Financial Position 2016/17

An update on the Joint Board's financial position for 2016/17 was provided.

Decision

To note that, subject to external audit review, the Joint Board had achieved a breakeven position for 2016/17.

(References – minute of the Integration Joint Board 24 March 2017 (item 8); report by the IJB Chief Officer, submitted.)

12. Annual Accounts 2017/18

The unaudited 2016/17 annual accounts for the Joint Board were presented for consideration before submission to the external auditors.

Decision

1) To note the draft financial statements submitted.

2) To note the proposed timescale for completion of the financial statements.

3) To note that support services to a value of £750,000 had been provided (page 24 of the Chief Officer's report). The final version would be amended before submission to external auditors.

(References – minute of the Integration Joint Board 16 September 2016 (item 7); report by the IJB Chief Officer, submitted.)

13. Integration Indicators

Proposals for measuring progress under integration were presented to members for approval. It was highlighted that the "balance of care" indicator would need to include a figure for the proportion of people supported by unpaid carers.

Decision

To approve the adoption of indicators and targets as a means of measuring progress under integration, in response to the invitation from the Ministerial Strategic Group for Health and Community Care.

(Reference – report by the IJB Chief Officer, submitted.)

14. Community Justice Outcome Improvement Plan 2017/18 – referral from the City of Edinburgh Council Health, Social Care and Housing Committee

The Health, Social Care and Housing Committee on 18 April 2017 considered a report which detailed the Community Justice Outcomes Improvement Plan 2017/18. The report was referred to the Joint Board for information.

Decision

1) To note the report referred to the Joint Board by the Health, Social Care and Housing Committee on the Community Justice Outcome Improvement Plan 2017/18.

2) To note that a further report would be presented to the next meeting of the Joint Board on 14 July 2017.

(References – minute of the Health, Social Care and Housing Committee 18 April 2017 (item 7); report by the Head of Safer and Stronger Communities and Chief Social Work Officer, submitted.)

15. Urgent Business

15.1 Schedule of meetings

To note that the frequency of board meetings had been amended to reflect the decision of the Joint Board at its March 2017 meeting. The next formal meeting would be on 14 July 2017 in the Main Council Chamber, City Chambers.

15.2 Code of Conduct Training

To note that a second training session on the Code of Conduct would take place on Monday 19 June 2017 at 2pm in the Mandela Room, City Chambers. It was recommended that all board members attend.

Item 4.2.1 a - Minutes

Audit and Risk Committee

9.30 am, Friday 2 June 2017
City Chambers, Edinburgh

Present:

Angus McCann (Chair), Michael Ash, Councillor Ricky Henderson (Substitute), Robin Jones, Alex Joyce, Councillor Claire Miller (Substitute) and Ella Simpson.

Officers: Magnus Aitken (PwC), Sarah Bryson (Health and Social Care, CEC), Gavin King (Corporate Governance Manager, CEC), Michael Lavender (Audit Manager – Scott-Moncrieff), Ross Murray (Governance, CEC), Lesley Newdall (Chief Internal Auditor) and Moira Pringle (Interim Chief Finance Officer).

1. Welcome

Angus McCann welcomed Councillors Ricky Henderson and Councillor Claire Miller who had agreed to substitute as Council representatives in order to allow the Committee to meet its statutory requirements.

Magnus Aitken was also in attendance by invitation of the Chair to answer any questions on internal audit matters.

2. Minute

Decision

To approve the minute of 11 November 2016 as a correct record.

3. Outstanding Actions

Decision

1) To agree the closure of actions 1, 2 and 3.

2) Lesley Newdall to prepare a statement highlighting the impact of the lack of audit resource for submission to the Joint Board.

3) Moira Pringle to liaise with the Chief Officer and report back on his intention with regard to filling the role of Chief Risk Officer.

4) To otherwise note the outstanding actions.

(Reference – Outstanding Actions – June 2017, submitted.)

4. Work Programme

Decision

To note the Work Programme and upcoming reports.

(Reference – Audit and Risk Committee Work Programme – June 2017, submitted.)

5. Risk Register Update

An update on the refresh of the risk register, including defined ownerships for each risk, was submitted.

Decision

1) To note the refreshed risk register and the process for ensuring all risks were captured and remained relevant.

2) To agree to receive the refreshed register at the Committee meeting in September 2017.

3) To incorporate a process for tracking the development of risks in future update reports.

(References – minute of Audit and Risk Committee 6 March 2017 (item 5); report by the Interim Chief Finance Officer, submitted.)

6. Internal Audit Update – June 2017

The internal audit activity in the previous quarter on behalf of the Joint Board and relevant activity by the Internal Audit functions of the Joint Board's constituent organisations (City of Edinburgh Council and NHS Lothian) was detailed.

Decision

1) To note the Joint Board Internal Audit Activity identified within the Chief Internal Auditor's report and to note the areas of higher priority findings in the reviews highlighted.

2) To note the referrals of the Review of Data Integration & Sharing and Work Force Planning audits to the NHS Lothian Audit and Risk Committee and City of Edinburgh Council Governance, Risk and Best Value Committee for their consideration.

3) That overdue management actions continue to be included in future update reports.

(References – minute of the Audit and Risk Committee 6 March 2017 (item 6); report by the Chief Internal Auditor, submitted.)

7. Interim Internal Audit Annual Opinion – June 2017

An Interim Internal Audit Annual Report and Opinion for the Joint Board based on Internal Audit activity undertaken for the financial year ended 31 March 2017 was submitted.

An interim opinion was submitted as the 2016/17 Internal Audit Plan had not been fully completed and only limited assurance could be provided on the risks detailed within. A final opinion for the year would be prepared and presented once the plan was complete.

Decision

To note the interim internal audit opinion for the year ended 31 March 2017.

(Reference – report by Chief Internal Auditor, submitted.)

8. Edinburgh Integration Joint Board – Unaudited Annual Accounts 2016/17

The Unaudited Annual Accounts for the Joint Board for 2016/17 were submitted. It was advised that accounts would be submitted to the Joint Board on 16 June 2017 before submission to external auditors.

Decision

To note the draft financial statements and proposed timescale for completion.

(References – minute of the Audit and Risk Committee 1 July 2016 (item 4); report by Chief Internal Auditor, submitted.)

9. Internal Audit Plan 2017/18

The Internal Audit Plan for the period 1 April 2017 to 31 March 2018 was submitted. The Plan was risk based and derived from the Joint Board's Risk Register and Risk Map.

Decision

1) To note the limited assurance resource available to the Joint Board.

2) To approve the proposed plan as making the best use of the limited assurance resource available to the Joint Board.

(References – minute of the Audit and Risk Committee 1 July 2016 (item 6); report by Chief Internal Auditor, submitted.)

10. Principles to govern the relationships between the Committee and the NHS Lothian Audit and Risk Committee, and the Committee and the City of Edinburgh Council Governance Risk and Best Value Committee

Five key principles to govern the relations between the Audit and Risk Committee and both the NHS Lothian Audit and Risk Committee and the City of Edinburgh Council Governance, Risk and Best Value Committee were submitted for approval.

Decision

To approve the principles set out in the report by the Chief Internal Auditor to govern the relationship between the Committee, NHS Lothian Audit and Risk Committee and the City of Edinburgh Council Governance, Risk and Best Value Committee.

(Reference – report by the Chief Internal Auditor, submitted.)

11. Reflections on the Previous year – Discussion Item

Decision

1) To advise that the Joint Board schedule a Development Session exploring governance and links between Committees and Sub-Groups.

2) That Lesley Newdall circulate any required interim updates by way of email through the Chair.

(Reference – report by the Chief Internal Auditor, submitted.)

Minutes

Edinburgh Integration Joint Board
Professional Advisory Group

9.30am Tuesday 06 June 2017
Mandela Room, City Chambers, Edinburgh

Present:

Board Members
Carl Bickler (Co-Chair), Colin Beck (Co-Chair), Eddie Balfour, Kirsten Hey, Elaine Hamilton, Sheena Borthwick, Robin Balfour, Carol Chalmers, Sharon Cameron, Kirsten Hey, Belinda Hacking

Apologies
Alison Meiklejohn, Rob McCulloch-Graham, Julie Gallagher, Aileen Kenny, Caroline Lawrie, Andy Jeffries, Alasdair FitzGerald, Katie McWilliam, Michael Ryan, Kathryn Anderson, Patricia McIntosh, Stephen McBurney, Moyra Burns

1. Membership

Decision

To note that work concerning the membership of the Professional Advisory Group would be undertaken.

2. Note of the meeting of the Edinburgh Integration Joint Board Professional Advisory Group of 16 March 2017 and Matters Arising

Decision

To approve the minute of the meeting of the Edinburgh Integration Joint Board Professional Advisory Group of 16 March 2017 as a correct record.

3. Note of the meeting of the Edinburgh Integration Joint Board of 24 March 2017 and Matters Arising

Decision

To note the minute of the meeting of the Edinburgh Integration Joint Board of 24 March 2017.

4. Transport to the New Royal Edinburgh Buildings

Decision

To note that the Professional Advisory Group concerns regarding transport links to and from the New Royal Edinburgh Buildings had been highlighted to the Chief Officer Edinburgh Health & Social Care Partnership.

5. Lothian Hospital Plan

Decision

To note that the Professional Advisory Group's thoughts regarding the Lothian Hospital Plan had been highlighted to the Chief Officer Edinburgh Health & Social Care Partnership.

6. Post codes versus GP based locality services

Decision

1) To note that the Professional Advisory Group concerns regarding GP locality boundaries had been highlighted to the Chief Officer Edinburgh Health & Social Care Partnership.
2) To agree to circulate the response from the Chief Officer Edinburgh Health & Social Care Partnership to members of the Professional Advisory Group.
3) To agree that Colin Beck would chase up a former response from the Chief Officer Edinburgh Health & Social Care Partnership.

7. Note of the meeting of the Edinburgh Integration Joint Board of 28 April 2017 and Matters Arising

Decision

1) To note the minute of the meeting of the Edinburgh Integration Joint Board of 28 April 2017.
2) To welcome the savings identified to mitigate against the risks, highlighted by the Professional Advisory Group, associated with the Scottish Government's reduction in funding for Alcohol and Drug Partnerships in 2016/17.

8. IJB Quality and Performance Group – Update of recent activities

Carl Bickler presented an update of recent activities of the IJB Performance and Quality Sub-Group and key priorities for the next year, including:

- Performance against the core integration indicators.
- Alignment with other key groups and work streams.
- Exploring ways of getting and using feedback from customers.
- Overseeing the actions associated with the Care Inspectorate recommendations.
- Measuring Performance Under Integration.
- Bi-annual update on performance with the Strategic Plan.

Decision

1) To note the overview of activities and key priorities for the next 12 months.
2) To note details regarding Primary Care assessment and progress against the strategic plans actions (rubrics) would be circulated to members.
3) To agree that Sharon Cameron would attend the Performance and Quality Sub-Group.
4) To agree that future meetings of the Professional Advisory Group would include a standing item on feedback from the Performance and Quality Sub-Group.
5) To note the Colin Beck would approach the Convener of the IJB Audit and Risk Committee to discuss Professional Advisory Group representation on the Committee and that consideration would be given to how best to cooperate with other IJB sub groups.
6) To agree the Carl Bickler would approach the Strategy and Insight Team to request further details on the points raised within the presentation.

9. Liberton Hospital

The proposed plans for Liberton Hospital were discussed and the following points were raised.

- The proposed plan includes 60 Intermediate Care beds.
- Existing Orthopaedic wards had closed to new patients. Patients requiring Orthopaedic had been relocated to the Royal Infirmary.
- Midlothian and East Lothian beds had been repatriated.
- Data was being collected on the level of Intermediate Care service required citywide.
- Interim beds at Liberton are for people waiting for a package of care.
- A Standard Operating Procedure had been developed, and work is underway to develop a pathway for patients.
- The deadline to move services out of Liberton was July 2018.
- Work around the impact of the closure of Liberton Hospital was ongoing.
- Concerns were raised that a new facility would not be completed within the expected timeframe.

Decision

To note that an update on Liberton Hospital would be considered at the next meeting of the Professional Advisory Group.

10. Feedback from Inspection of Older People's Services and Inspection of Older Peoples Services – Improvement Plan

Colin Beck and Carl Bickler provided an update on the joint inspection of older people's services by the Care Inspectorate and Health Improvement Scotland had been undertaken during October to December 2016.

During discussions, the following points were raised:

- The evaluation was generally poor, and included an "unsatisfactory" rating for Quality Indicator 5 – delivery of key process.
- An Improvement Plan had been developed in response to the report.
- It was also noted that the inspection came at a difficult time for staff.

- Concerns had been raised by staff that they had not had the opportunity to be involved in the Improvement Plan prior to sign-off.

Decision

To note the update and the concerns concerning the lack of opportunity for frontline staff to have any input in the Improvement Plan.

11. Professional Advisory Group Review

The Care Inspectorates report entitled 'Services for older people in Edinburgh' made specific reference to the IJBs supporting subgroups. The action plan developed to address the concerns contained within the report made reference to the need to revise the role, remit, membership and governance processes around the Professional Advisory Group.

Decision

To note the review of the Professional Advisory Group would be concluded by July 2017.

12. Mental Health of Older People and Admission Prevention

There was discussion on the work of the Memory Clinic in North West Edinburgh.

Decision

To note that Mental Health of Older People and Admission Prevention would be considered at the next meeting of the Professional Advisory Group.

13. Needs of injecting drug users

A brief update was provided around the needs of injecting drug users and the provision of safe injecting facilities.

Decision

To note that a paper concerning the needs of injecting drug users would be considered at the next meeting of the Professional Advisory Group.

14. AOCB

Members were asked to consider patient stories that reflect Health and Wellbeing Outcomes.

Decision

To note Carl Bickler would contact members to request patient stories that reflect Health and Wellbeing Outcomes.

15. Date of Next Meeting

Decision

To note the next meeting of the Professional Advisory Group would be held on 1 August 2017.

Item 5.1 – Rolling Actions Log – July 2017

July 2017

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
1	**Communications and Engagement Strategy 2016 to 2019**	13-05-16	To present an implementation plan to the Joint Board once resources had been identified.	Chief Officer	Not specified	A communications update will be submitted to the September Joint Board meeting An engagement update will be submitted to the October Joint Board meeting
2	**Rolling Actions Log (ICT Steering Group)**	15-07-16 And 16-09-16	To invite the ICT Steering Group to consider and recommend business-critical ICT issues where the Joint Board might require to issue directions. To ask the ICT Steering Group to report back to the Joint Board on a recommended way forward.	ICT Steering Group	Not specified	**Recommended for closure** – directions not required at this point in time.

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
3	**Delivery of the EH&SC Strategic Plan – action plan**	16-09-16	To receive twice yearly reports from the SPG on the delivery of the strategic plan. This would include: • Tracking of ongoing and proposed major programmes/business cases.	Chief Officer		**Recommended for closure** – See item 5.7
4	**Performance and Quality Sub-Group**	18-11-16	To consider the final draft of the annual performance report at an IJB Development Session prior to being presented for approval at a formal meeting.	Chief Officer	Not specified	**Recommended for closure** – See item 5.7
5	**Joint Inspection of Older People**	20-01-17	That the assurance statement be discussed at a future development session	Chief officer	Not specified	**Recommended for closure –** will be considered through the Performance and Quality Sub-Group
6	**Annual Review of the Strategic Plan**	24-03-17	To agree to consider the updated plan at the Joint Board Development Session in April 2017 before formal approval at the Joint Board in June 2017.	Chief Officer.	April/June 2017	**Recommended for closure** – See item 5.7
7	**Annual Review of the Strategic Plan**	24-03-17	That actions to improve undelivered elements be included in the Annual Performance report.	Chief Officer	Not specified	**Recommended for closure** – See item 5.7
8	**Programme of Development Sessions and Visits**	24-03-17	To agree to receive a programme of development sessions and visits for 2017/18 at the June 2017 meeting of the Joint Board.	Chief Officer	June 2017	The August 2017 Development Session will take the form of an induction/refresher for board members. The full programme will be agreed following this.

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
9	**Inspection of Older People's Services**	16-06-17	To agree that progress updates on improvement actions coming out of the Inspection of Older People's Services become a standing item.	Chief Officer	July 2017	**Recommended for closure –** see item 5.2
10	**Responsibilities for Data and Information**	16-06-17	To note the intention to report to a future Joint Board meeting on General Data Protection Regulations requirements and responsibilities.	Chief Officer	Not specified	
11	**Community Justice Outcome Improvement Plan 2017/18**	16-06-17	To note that a further report would be presented to the next meeting of the Joint Board on 14 July 2017.	Head of Safer and Stronger Communities	July 2017	**Recommended for closure** – see item 5.3

ITEM 5.3

Community Justice Outcomes Improvement Plan 2017/18

Integration Joint Board

14 July 2017

1. Executive Summary

1.1 On 16 June 2017, the Edinburgh Integration Joint Board considered a report by the Head of Safer and Stronger Communities and Chief Social Work Officer on the Edinburgh Community Justice Outcomes Improvement Plan 2017/18 (the Plan). A further report was requested for 14 July 2017.

2. Recommendations

2.1 The Edinburgh Integration Joint Board is asked to note this up-date on the Plan.

3. Background

3.1 The Community Justice (Scotland) Act 2016 introduced a local model for the planning and delivery of community justice services, effective from 1 April 2017. Service planning responsibilities have been transferred from the now abolished Community Justice Authorities to community planning partnerships, and a new national body, Community Justice Scotland has been created to provide leadership for the sector and assurance to Scottish Ministers on the delivery of improved outcomes.

3.2 The Edinburgh Community Safety Partnership developed the Plan on behalf of the Edinburgh Partnership and is responsible for its implementation. The Plan sets out ongoing work by partners to prevent and reduce offending by addressing the underlying causes. It highlights initiatives to reduce inequalities, improve individuals' resilience and build strong, safe and inclusive communities.

3.3 The Plan identifies priority areas for improvement to achieve the aspirations for community justice, where people have better access to the services they require, such as health and wellbeing, welfare, housing and employability, all of which help prevent and reduce offending.

3.4 The Edinburgh Partnership approved the Plan on 30 March 2017, and it was submitted to Community Justice Scotland on 31 March 2017.

4. Main report

4.1 The Plan is ambitious in that there are 36 actions across seven outcome improvement areas. These actions all have owners, and progress is monitored through the Edinburgh Community Safety Partnership and its sub-groups. There have been several significant developments in the first quarter of 2017/18.

4.2 The City of Edinburgh Council has seconded a manager to the Scottish Government to lead on the re-accreditation of the Caledonian men's programme, supported by the criminal justice sector manager for groupwork services. The Caledonian system is a court-mandated programme for perpetrators of domestic abuse, and in addition to the men's programme, there are programmes for women victims and for children. For the first time, the women's and children's programmes are to be accredited as part of the same process that will re-accredit the men's programme.

4.3 The Caledonian Women and Children's Service is separately funded through the Equally Safe (Violence Against Women and Girls) Fund, and in June 2017, funding was confirmed for the period 1 July 2017 to 30 June 2018. Funding was also confirmed from the same fund for the Respekt programme, which is a non-court mandated programme to address domestic abuse in the Polish speaking community.

4.4 The Alcohol Problem Solving Court commenced in February 2016, initially as a one year pilot and now extended for a second year. The principles of the court are: judicial oversight, rapid assessment, early access to treatment, and close partnership working, all delivered within current resources, utilising community payback legislation. The lead Sheriff has provided the most recent up-date, and of the 32 orders made to date, 8 have been completed successfully and 17 continue with evidence of positive progress. The men subject to the orders have had more entrenched alcohol problems and more chaotic lifestyles than envisaged at the start of the pilot, but there has been notable success in maintaining engagement with them. An evaluation is underway and will report later in the year.

4.5 A partner in the delivery of substance misuse services for the Alcohol Problem Solving Court was Lifeline, which delivered the Edinburgh and Midlothian Offender Recovery Service, as well as three of Edinburgh's recovery hubs. Lifeline has recently gone into administration, for reasons unconnected to its Edinburgh contracts, and the service has been taken

over by an organisation called: Change, Grow, Live (CGL). There has been no impact on local delivery and the Offender Recovery Service continues to be delivered to contract. All contracts are subject to quarterly reviews.

4.6 The importance of involving people with lived experience in the delivery of services was stressed in the Plan, with examples such as Community in Motion, the Aid and Abet peer support service, and the Just Us service-user led group of women in the criminal justice system. A peer support and mentoring service has now been commissioned, with outcomes related to physical and mental health, substance misuse, accommodation, finance, and relationships. The service will commence in September 2017.

4.7 The Plan highlights the benefits of unpaid work projects and seeks to raise the profile of those undertaking it. The “Brake the Cycle” project involves people subject to community payback who repair and service lost and abandoned bicycles, and distribute them to schools and community projects. A benefit of this project is to encourage cycling and healthy lifestyles for young people. In June 2017, the project was extended following a request from the Dame Marie School in Haiti, after a devastating hurricane destroyed most of the children’s and teachers’ homes and their school. The newly delivered bicycles will mean that children will not have to walk long distances to go to school and will arrive at school fresh and ready to learn. The bicycles will enable some people to start a delivery business, which will provide an income for their family. Others will allow children to spend less hours walking to collect drinking water for their family.

5. Financial implications

5.1 For the past three years, the Scottish Government has provided £50,000 per annum to each local authority to support the development of their Community Justice Outcomes Improvement Plan. This funding is due to be reviewed at the end of the current financial year. All the services delivered by community justice are funded by ring-fenced Scottish Government grant.

6. Involving people

6.1 People involved in the criminal justice system have influenced the Plan in several ways. Consultation events were held for victims and witnesses, and for offenders. Feedback from people subject to court orders and post-sentence licences, gathered through supervision reviews and end of licence questionnaires, has helped shape services. A public consultation process informs the Community Payback Order annual report, gathering the views of people involved in the criminal justice system and the public. This consultation has also influenced the Plan.

6.2 Consultation events are planned throughout 2017/18, with the first three scheduled for the week beginning 10 July. These events will take place in localities across the city.

7. Impact on plans of other parties

7.1 The Community Empowerment (Scotland) Act 2015 requires the City of Edinburgh Council to produce a Locality Improvement Plan for each of the four localities in October 2017. These plans will have similar and cross-cutting priorities in common with the Edinburgh Community Justice Outcomes Improvement Plan 2017/18, and some of the outcomes will be delivered through partnership arrangements across Council and health services and other planning partners.

7.2 The Council's transformation programme introduced the Family and Household Support Service, part of Safer and Stronger Communities, based in each of the localities, bringing together staff from community safety, household support and family support services. The outcomes for this service are aligned with the community justice outcomes, especially those related to early intervention and restorative practice.

Background reading/references

Edinburgh Community Justice Outcomes Improvement Plan 2017/18 (attached).

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Edinburgh Community Justice Outcomes Improvement Plan

2017 - 2018

Skills Development Scotland

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Working together for a safer Scotland

POLICE SCOTLAND
Keeping people safe

SCOTTISH PRISON SERVICE

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Community Justice Outcomes Improvement Plan 2017-18

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Introduction

The Community Justice (Scotland) Act 2016 transferred community justice planning responsibilities from Community Justice Authorities to community planning partnerships with effect from 1 April 2017. Edinburgh's Community Safety Partnership, on behalf of the Edinburgh Partnership (community planning) is responsible for the development and implementation of the Edinburgh Community Justice Outcomes Improvement Plan.

The Scottish Government's vision for community justice is that Scotland is a safer, fairer and more inclusive nation where we:

- prevent and reduce offending by addressing its underlying causes
- safely and effectively manage and support those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all citizens

The Edinburgh Partnership has four strategic priorities:

- Edinburgh's communities are safer and have improved physical and social fabric
- Edinburgh's citizens experience improved health and wellbeing with reduced inequalities in health
- Edinburgh's children and young people enjoy their childhood and fulfil their potential
- Edinburgh's economy delivers increased investment, jobs, and opportunities for all

Edinburgh's Community Justice Outcomes Improvement Plan is based on contextual information, the seven national outcomes and associated indicators, the National Strategy for Community Justice and Edinburgh's Community Plan.

Contextual information

Listed below are the characteristics of the city that provide the local context for planning community justice services are.[1]

- Edinburgh is a city of contrasts, with high levels of both prosperity and poverty.
- Partners seek to deliver universal services proportionate to need.
- Vulnerable people and those living in Scotland's 15% most deprived communities are at greatest risk of crime.
- Although unemployment has been falling across the city, people with offending backgrounds face significant barriers to accessing employment despite the fact that employment contributes to a reduction in reoffending.
- For households on low to moderate incomes, demand for housing continues to outstrip supply.
- Drug and alcohol problems affect the city severely, with an estimated 22,400 adults dependent on alcohol and 6,600 people dependent on heroin and/or benzodiazepines.
- Economic and social costs of crime to communities are significant.
- Supporting a person in prison deepens the social marginality already experienced by many families; support is often provided by women, which may reinforce traditional gender roles and leaves women in custody with few supports.
- Around 300 people in the city are estimated to have complex needs associated with homelessness, addiction, mental health and offending, placing significant demands on services, and for whom, despite significant resource allocation, outcomes are mostly poor.

[1] 'CJOIP contextual information' and 'Feedback from general consultation and engagement activity' available on request. Detailed data is available in Edinburgh's locality profiles.

- Children affected by parental imprisonment are at much greater risk of developing behavioural problems, low attainment levels, school attendance problems, and school expulsion; two thirds of boys with a parent in prison are likely to offend themselves.
- Violent crime levels continue to drop; this is reflected in perception of crime levels; reconviction rates remain constant at just under 30%.

A wide range of engagement and consultation activity is carried out in Edinburgh, by a range of partnerships and organisations, with communities, groups and the general public, on different issues affecting people living and working in the city. Feedback highlights that people strongly support prevention, as a shared responsibility of all services, and tackling inequalities as priorities. Building trust with professionals and longevity of relationships are highlighted as very important by service users. Services need to be able to see the whole picture, not just someone's offending history.

Current service provision has been mapped and is outlined in the transitional plan for the delivery of community justice 2016-17.

Achievements towards the national outcomes and indicators and priority areas for improvement actions

This section provides a high level overview of achievements of community justice partners in Edinburgh in relation to the national outcomes and indicators[2]. This has helped partners identify priorities for improvement action.

STRUCTURAL OUTCOMES

Outcome 1: Communities improve their understanding and participation in community justice

National indicator 1: Activities carried out to engage with communities as well as other relevant constituencies

Community justice partners in Edinburgh carry out a wide range of activities to engage with communities. Feedback informs service development and strategic planning. Engagement with service users is based on the National Standards for Community Engagement and informs service redesign and improvement action. Examples include the residential accommodation service for men who pose a risk of serious harm; the Alcohol Problem Solving Court pilot; the redesign of domestic abuse services; the antisocial behaviour strategy; the Edinburgh Local Policing Plan 2014 -17; and an ongoing awareness raising programme in relation to hate crime.

Direct engagement with people who use services takes place routinely. People who are subject to statutory supervision are encouraged to participate actively in the development of their plans and to reviews of these plans. They complete exit questionnaires and participate in exit interviews at the end of community payback orders, and they provide feedback at the end of programme work. This informs future interventions. Case file audits, Multi-agency Public Protection Arrangements (MAPPA) audits, and practice evaluations have consistently demonstrated that service users' views are taken into account. Service users' views and the response from local communities to assistance given by those undertaking unpaid work are reported each year in the Community Payback Order Annual Report. Family involvement in integrated case management for serving prisoners is a priority, in recognition of the impact of imprisonment on families and the key role that family members can play in the reintegration of people who are released from custodial sentences.

[2] Most of the evidence/examples listed below fit with more than one outcome and indicator. Information has been placed in line with the descriptors included in the Outcomes, Performance and Improvement Framework.

National indicator 2: Consultation with communities as part of community justice planning and service provision

An online consultation has gathered views on how offending could be further reduced and community facing events have been held, involving people with lived experience.

Public events were held for victims and witnesses and for people involved in the criminal justice system and their families. The victims and witnesses' event resulted in Victim Support (Scotland) becoming a full partner in the Edinburgh Community Safety Partnership and related actions being included in this Plan. The event for people involved in the criminal justice system highlighted that relationships as much as services are valued most, that people are less concerned about which *agency* provides support than the *person* who delivers it, that they value persistence and others not giving up on them, and that, for some, if they had received the right support earlier, they might not have been drawn into the criminal justice system.

Throughout 2017-18, there will be a series of engagement events for people involved in the criminal justice system, linked to their local area. This will inform service delivery, as well as providing a service user perspective for the Community Payback Order Annual Report.

The City of Edinburgh Council's move to a more locality-focused model in 2016 is reflected in community justice and related services' strong locality focus. Each locality will be producing its Locality Improvement Plan by October 2017 and the outcomes will be aligned with those in this Plan. The localities each have a multi-agency community improvement partnership, responding to local expressed need, where priorities are set and aligned to this Plan. City-wide issues, such as motor cycle crime, begging, or hate crime have bespoke community improvement partnerships.

A communications framework has been developed build relationships with key audiences regarding the positive contribution of the Multi-agency Public Protection Arrangements (MAPPA). This framework is reflected in the Scottish Government's draft public consultation strategy on offender management. The framework has been translated into an action plan for Edinburgh, which focuses on raising awareness among the inter-agency workforce.

National indicator 3: Participation in community justice, such as co-production and joint delivery

Partners are committed to using people's lived experience to improve and develop interventions. There are already a number of initiatives that reflect our aspiration to secure the participation of communities.

Community in Motion is a partnership initiative to develop a community-based problem-solving, restorative justice approach in North East Edinburgh. Motivated by the opportunities created by community empowerment and community justice legislation, and the move to locality working, Community in Motion has developed a framework for joint working, increasingly preventative in focus, with more community involvement and an emphasis on restorative and problem solving practices. It is anticipated that the range of initiatives developed in the North East locality will provide a practical model, which can be scaled up across other localities or city-wide.

Violent Offender Watch (VOW) has taken learning from our Total Place experience in engaging local communities to respond to crime in their area. VOW is led by Police Scotland and aims to reduce reoffending by tackling issues of drug/alcohol misuse, accommodation, finance, personal relationships, health, attitudes/behaviour and employment/training. The outcomes are to:

- reduce violent and acquisitive crime
- reduce drug and alcohol-linked offending
- reduce antisocial behaviour
- promote community safety and well-being

- reduce the fear of crime
- encourage offenders to become involved in training and work initiatives

VOW commenced in 2013. In early 2016, the decision was taken to focus on the North East locality working within the Community in Motion framework. Intrinsic to its operation is **Aid and Abet,** a peer-led organisation providing mentoring and support to people leaving prison. Volunteer mentors are all people with lived experience of the criminal justice system, and are in recovery from alcohol or drug addiction. The project has developed with support from Scottish Churches Housing Action since June 2014 and has been providing mentoring services since March 2015.

A **peer mentoring service** in partnership with **Aid and Abet** has been developed as a result of resource transfer funding received from the Scottish Government in September 2016 to support community-based sentences. The service is for people who are subject to Community Payback Orders and aims to improve health/wellbeing and relationship outcomes. All volunteer mentors have lived experience of the criminal justice system. The outcomes for service users are that they will:

- be registered with a GP
- access appropriate health services/treatment to improve physical and mental well-being
- be registered with substance misuse services and in receipt of appropriate treatment/interventions to support recovery
- attend, where appropriate, an organisation designed to address other addiction issues, for example gambling
- be in stable accommodation
- be in receipt of the correct benefits or in employment
- have improved relationships with their families and communities

Just Us is a service user-led group of women with experience of trauma, mental health issues and criminal justice involvement. Statistics indicate that in excess of 80% of women in criminal justice have at least one mental health diagnosis. The aim of the group is to work with professionals to raise awareness and reduce stigma around women involved in the criminal justice system with mental health issues. Just Us has been developed by women who have been involved in the Willow Service (see below).

Alcohol Problem Solving Court

Alcohol sales in Scotland are 20% higher per capita than England and Wales. A disproportionate number of people in the criminal justice system have mental health problems and problems with drug and alcohol misuse. 50% of Scottish prisoners were drunk at the time of their offence. Short-term prison sentences are ineffective, with a 66% reoffending rate. These statistics are the backcloth to the development of an alcohol problem solving court pilot in Edinburgh, which commenced in February 2016. The pilot was developed in response to a request from a Sheriff, and discussions with partners, including the City of Edinburgh Council, NHS Lothian, Police Scotland and Lifeline. The target group is males over 18 years of age, with a pattern of alcohol related offending resulting in frequent appearances in Court, who are appearing on summary procedure and assessed as suitable for a Community Payback Order,

The key elements of the court are: quicker assessment, faster access to treatment, court review, and peer support for those on orders. The outcomes sought are to reduce the use of imprisonment, and to reduce reoffending by impacting positively on the person's health and well-being by:

- reducing alcohol dependency
- reducing harmful consumption of alcohol
- improving mental health
- improving physical health
- reducing accident and emergency attendances

- increasing uptake of education, volunteering and employment

The pilot is being evaluated and the model will be continued throughout 2017-18. Consideration will be given to the appropriateness of this model to other problems.

The Edinburgh and Midlothian Offender Recovery Service (EMORS) is commissioned jointly by the City of Edinburgh Council, Midlothian Council and NHS Lothian. It brings together three services – arrest referral, prison treatment and support, and voluntary throughcare – and takes a recovery-centred approach, working with individuals to build and encourage the creation of recovery capital, helping more people move away from problematic alcohol and drug use and other issues that increase the likelihood of reoffending. By adopting a holistic approach, the service provides robust routes into a range of support services and networks, helping people access support that is right for them. This includes support from people with lived experience of alcohol and drug use.

EMORS has an extensive service user participation strategy and works with people to achieve the following outcomes:

- address substance misuse
- reduce offending behaviour
- improve health, skills and personal resources
- improve social relationships and social support
- improve practical skills

EMORS has recruited peer volunteers in response to service users' feedback that they would like to see more visible recovery within the service.

Community improvement partnerships exist in each locality to respond to local issues, including antisocial behaviour and low level offending, along with city-wide community improvement partnerships, which address wider issues such as motorcycle crime or new psychoactive substances. As the Locality Improvement Plans are developed in 2017-18, the community improvement partnerships will be a vehicle for addressing the priorities for local areas.

Project Halt is police led and has recently been introduced as a response to widespread concern about the level of housebreaking, and associated vehicle theft, in Edinburgh. The project provides a mechanism to divert people from reoffending, based on research about the recurring socio economic factors, which underpin motivation. The key areas addressed, using a partnership approach, are drug abuse, housing, benefits, employment and education.

National indicator 4: Level of community awareness of/satisfaction with work undertaken as part of a CPO

Unpaid work directly and indirectly benefits communities. Beneficiaries regularly provide evidence of their satisfaction with the service, especially the physical differences made to gardens or buildings. They also frequently comment on the team work of the groups, their positive attitude, and their hard work. There has been increased interest in, and referrals for, unpaid work. Public consultation for the Community Payback Order Annual Report 2015-16 highlighted that over 80% of respondents thought that community payback provided people with an opportunity to repay the community for the crimes they had committed and that it helped reduce reoffending.

Partnerships for the other activity element of unpaid work have been developed with a variety of organisations, and there are options to suit all abilities and needs, being as inclusive as possible. Other activity allows people to take the skills, learning and experience gained in unpaid work into activities that

help them to sustain progress beyond the period that they have been subject to statutory supervision. Further information is available at national indicator 18 below.

National indicator 5: Evidence from questions to be used in local surveys/citizens panels, etc.

The Edinburgh People Survey (2015) highlights that 63% of respondents agree that the City of Edinburgh Council provides protection and support for vulnerable people (compared to 52% in 2014) and that 83% agree that their neighbourhood is a place where people of different backgrounds get along, broadly consistent with previous years.

An engagement and consultation programme is being carried out across the city in relation to the **Edinburgh Vision 2050** and the **Locality Improvement Plans**. Community safety is one of the key themes. **Family and Household Support Teams** have been established in Edinburgh to provide integrated community safety, housing support and family support services (see below).

National indicator 6: Perceptions of the local crime rate (quantitative)

New questions were introduced to the Edinburgh People Survey in 2015, exploring perceptions of how commonplace various types of crime and antisocial behaviour are perceived to be in neighbourhoods:

- 85% state that violent crime is not common in their neighbourhood.
- 78% state that vandalism and graffiti are not common in their neighbourhood.
- 75% state that antisocial behaviour is not common in their neighbourhood.
- 75% do not consider street drinking and alcohol-related disorder to be a problem in their neighbourhood.
- 84% feel safe in their neighbourhood after dark.

The 2016 Survey results will be used to compare results from previous years and identify areas for improvement. The Survey for 2017 will be carried out in the latter half of the year.

Police Scotland's most recent national survey, 'Your View Counts' conducted in 2016, included 1413 Edinburgh responses. Local priorities were identified as housebreaking, antisocial behaviour, car theft, violent crime, drug dealing and drugs misuse. The survey results will be used to inform the future Edinburgh Local Policing Plan and the delivery of community justice services, including the development of the current services that seek to address these issues.

Outcome 1 priority areas for improvement actions

Priority area (indicator)	Improvement action	Lead	Completion
1	Explore more effective ways of engaging hard to reach groups	Prolific Offenders Sub Group	31 March 2018
2	Develop and implement a communications plan for community and service user engagement to include wider reporting of success stories in community justice	Prolific Offenders Sub Group	31 March 2018
3	Evaluate the initiatives/pilots and use these evaluations to inform the strategy for community justice services	Prolific Offenders Sub Group	31 March 2018
3	All partners will as far as possible ensure that victims of crime receive the support they need, by referring to Victim Support Scotland and/or other partners as appropriate	All sub groups/Victim	31 March 2018

		Support	
4	Highlight benefits to communities of unpaid work projects and raise the profile of those undertaking it	Senior Manager, Community Justice	31 October 2017 (CPO Annual Report)

Outcome 2: Partners plan and deliver services in a more strategic and collaborative way

National indicator 7: Services are planned for and delivered in a strategic and collaborative way

Edinburgh's Reducing Reoffending Partnership was established in 2013 as a strategic group responsible for coordinating a multi-agency response to reoffending, acknowledging that effective reduction in reoffending depends on a complex, multi-agency and multi-sector approach to the delivery of a wide range of both universal and specialist services. The partnership included representation from the City of Edinburgh Council (criminal justice, community safety, housing, and employability services), Police Scotland, NHS Lothian, the Edinburgh Drug and Alcohol Partnership, the Scottish Prison Service and the Edinburgh Voluntary Organisations Council. In 2016, in preparation for the changes introduced by the Community Justice (Scotland) Act 2016, including widening the membership to include all statutory community justice partners, the Reducing Reoffending Partnership was amalgamated with the Edinburgh Community Safety Partnership. The Edinburgh Community Safety Partnership reports to the Edinburgh Partnership (community planning).

Examples of services that are planned and delivered in a strategic and collaborative way include:

Family and Household Support teams were established in 2016 as part of the City of Edinburgh Council's Transformation Programme. The teams deliver effective, joint and collaborative working of community safety, housing support and family support services in each of the four localities. Community police officers are partners in this service. The outcomes for the new service are that:

- communities participate in the creation of a healthy, safe and just city
- people's life chances are improved by addressing their need for education, health, social and financial inclusion, housing and safety
- individuals are resilient and have capacity for change and self management

The outcomes have been developed to align closely with community justice priorities and focus on effective intervention, prevention, and reducing reoffending and antisocial behaviour, with a strong emphasis on restorative practice. To complement and cement the shared vision, both services are managed within the Council's Safer and Stronger Communities under the leadership of the Chief Social Work Officer.

The criminal justice social work **accommodation service** provides an important link between prison and the community for men subject to statutory supervision released from long-term prison sentences. The service addresses both risk and need, on a multi-agency basis. Release planning starts well in advance of liberation, working with the Scottish Prison Service through the integrated case management process. The aim is reintegration, helping residents to move on to their own accommodation and live safely in their community, using as far as possible universal services that are available to all citizens. The July 2016 Care Inspectorate report assessed the service as very good and commented on the positive links with other agencies to help achieve positive outcomes.

Willow is a partnership between the City of Edinburgh Council, NHS Lothian and the third sector, working with women in the criminal justice system. It aims to reduce offending behaviour and health inequalities; to improve the health, wellbeing and safety of women in the criminal justice system; and to increase their

access to services and involvement in their local community. Service users are involved in the design and continuous improvement of the service. Willow facilitates effective, comprehensive and better coordinated responses from public services to address the inequalities faced by women in the criminal justice system. Performance information from Willow demonstrates improvements in women's lives across a range of indicators, including engagement with services, improved problem solving skills, reduction in alcohol and drug use, and a better understanding of how current difficulties relate to previous experiences of trauma. Many women who attend Willow have managed to resume care of their children, which they had previously lost, after making positive changes to their lives.

Willow is featured as an example of good practice in the Angiolini Report and has continued to build on its strengths in intervening years. The service has benefitted from Scottish Government support and resources transferred from the Scottish Prison Service. The success of the project has resulted in the service being oversubscribed and a plan is in place to ensure the capacity issues are addressed.

The **Scottish Prison Service (SPS)** has a Service Level Agreement (SLA) with the City of Edinburgh Council to deliver the prison-based social work service at HMP Edinburgh. While the SLA primarily relates to statutory responsibilities, there has been a long history of close working between the SPS and the City of Edinburgh Council. The social work team provided support around the introduction of women to HMP Edinburgh, most of whom are not statutory prisoners. Social workers work closely with other disciplines in HMP Edinburgh on risk assessment, sentence planning, education, health, and the delivery of programmes.

The Positive Lifestyles Project is a collaboration between Police Scotland and the Scottish Prison Service in HMYOI Polmont, working with through care officers and the third sector to divert young men on the cusp of, or involved in, Serious Organised Crime towards positive lifestyles and to prevent violence within the prison establishment. Prisoners vulnerable to the influences of Serious Organised Crime are identified and supported to achieve their aspirations and reduce the severity and frequency of their offending.

Inclusive Edinburgh was established to address problems faced by people with complex needs who may struggle with homelessness, unemployment, drug and alcohol problems, or mental or physical ill-health, who sometimes become involved in crime, and who are often the victims of violence. The Inclusive Edinburgh review examined the combined services delivered by statutory and voluntary sector partners to this group of vulnerable people, with a view to redesigning services so that partners can respond in a coordinated and psychologically-informed way. The majority of Inclusive Edinburgh cases have exhausted operational service options and require the concentrated effort of senior managers across partner agencies to achieve a breakthrough. The project aims to improve the life chances, health and well being of the most vulnerable, disenfranchised and disengaged citizens whose needs place significant demands on services, but for whom outcomes are mostly poor.

NHS Lothian's Health Promotion Service works with partners and organisations on health initiatives to reduce health inequalities in Edinburgh using a systems approach, which recognises the interaction and interdependence of external and personal factors that influence health. The service employs a range of methods to carry out health promotion work in neighbourhoods and localities.

A multi-agency partnership approach was adopted in the commissioning of the **Edinburgh and Midlothian Offender Recovery Service** for short-term prisoners from the two local authority areas, delivered by Lifeline. The service is funded jointly by the City of Edinburgh Council, Midlothian Council and NHS Lothian, and provides continuity of care, from the point of arrest, throughout an individual's stay in prison, and during the transition period from prison to community. The voluntary throughcare element recognises that

transition from prison to community is a critical time, and the service includes prison gate pick up and support out of hours to help individuals manage the challenges they face when returning to their communities on release.

Effective transition planning for children and young people takes place through close working relationships between the City of Edinburgh Council's **Young People's Service** and adult criminal justice services, Police Scotland and the Scottish Children's Reporter Administration. Strategic direction is provided by the multi-agency young people's sub group of the Community Safety Partnership. The service is multi-disciplinary, working with young people up to the age of 18, including those subject to community payback or through care. Working within the Whole Systems Approach, the Young People's Service can demonstrate an increase in referrals for early and effective interventions, as well as in the number of 16/17 year olds diverted from prosecution in the adult court.

National indicator 8: Partners have leveraged resource for community justice

Community justice partners in Edinburgh recognise the potential that exists within individuals, groups and organisations, and the contribution they can all make to improved community justice outcomes. Some examples of how partners have leveraged this potential are set out below.

- Developing information sharing protocols within the City of Edinburgh Council and between the Council and Police Scotland. Criminal justice social work crime categorisation has been linked with that of Police Scotland to achieve meaningful analysis of prolific offender demographics and crime categorisation. This has informed the development of the services described above, frequently delivered on a multi-agency basis.
- Co-location of services (e.g. Willow, Community in Motion, recovery hubs, Family and Household Support Teams). This has delivered financial and operation efficiencies, but more importantly, has provided more coherent services to communities, often avoiding service users having to repeat their stories or having to visit a number of sites to achieve a resolution to a problem.
- Edinburgh's Child and Adult Protection and Offender Management Committees have multi-agency quality assurance sub groups, where learning from case file audits, practice evaluations, initial case reviews and significant case reviews is shared across agencies. Action plans inform service improvements.

National indicator 9: Development of community justice workforce to work effectively across organisations/professional/geographical boundaries

Community justice partners in Edinburgh understand the development of the workforce as a joint responsibility.

- Learning and development opportunities on child and adult protection, sexual exploitation, human trafficking and MAPPA are jointly delivered by partners to the inter-agency workforce.
- The training plan for criminal justice social work staff in Edinburgh is developed and delivered across local authority boundaries, frequently on a multi-agency basis.
- Capacity and training has been built in to the Caledonian System men's programme to respond to the level of domestic abuse.
- The Willow service for women and the Drug Treatment and Testing Order service are both multi-disciplinary teams, with staff from the City of Edinburgh Council and NHS Lothian. Staff are co-located, locally managed and undertake joint training and development.
- The Alcohol Problem Solving Court pilot has included joint training of criminal justice social workers, NHS staff and third sector partners.

- A range of supports is in place to address the potential impact of work on criminal justice social work staff, particularly with regard to vicarious trauma. Staff have access to practice development sessions on self care, reflective group consultations, external support and consultancy from clinical psychology.

National indicator 10: Partners illustrate effective engagement and collaborative partnership working with the authorities responsible for the delivery of MAPPA

The City of Edinburgh Council is a key partner in the Edinburgh Lothians and Scottish Borders Strategic Oversight Group, which is chaired by Edinburgh's Chief Social Work Officer. A MAPPA Operational Group reports to the Strategic Oversight Group, and brings together the Responsible Authorities to take forward priorities identified by the Strategic Oversight Group.

The Edinburgh Offender Management Committee (OMC) ensures that the statutory responsibilities placed on local partner agencies for the assessment and management of sexual offenders and those who pose a risk of serious harm are discharged effectively. Feedback for Edinburgh from the thematic review of MAPPA was very positive, and no issues were identified for Edinburgh specifically. The OMC reports to the Edinburgh Chief Officers' Group – Public Protection, and each year provides an annual report and a business plan.

The OMC ensures that there are comprehensive policies and procedures for the management of high risk offenders, which take account of key transition points between services and ensure effective partnership working. All policies and procedures are reviewed and updated on an annual basis. All key staff across agencies have been briefed on the new MAPPA Guidance published in March 2016. Arrangements for Category 3 cases have been introduced successfully.

Outcome 2 priority areas for improvement actions

Priority area (indicator)	Improvement action	Lead	Completion
7	Family and Household Support teams and frontline staff to develop a wider understanding the criminal justice sector, links to the wider community justice agenda and the support services available in localities.	Senior Management Team, Safer and Stronger Communities	30 Sept. 2017
7	Criminal justice staff to increase awareness of remit of Family and Household Support teams and interventions available, including the identification of opportunities for more effective support for individuals and families.	Sector Manager, Community Intervention	30 Sept. 2017
7	Develop closer links with Education to prioritise the prevention agenda (link between school exclusions and later offending in young people).	Youth Justice Sub Group	30 Sept. 2017
7	Further consolidate the Willow service model and build capacity across community justice to ensure that matters relating to women in the criminal justice system are appropriately addressed.	Women's Sub Group	31 March 2018
7	Evaluate the impact of the Inclusive Edinburgh initiative.	Senior Management Group, SSC	31 Dec. 2017

8	Maximise the best use of resources for community justice from all partners in a financially challenging climate.	ECSP through quarterly reporting	31 March 2018
9	Identify opportunities to widen staff participation from all sectors in training and development initiatives.	All partners	31 March 2018
9	Work towards a 'one person one plan' (one key contact) model to simplify a service user's journey through multiple interventions.	All Partners	31 March 2018
9	Map all mentoring and community navigating work to facilitate sharing evidence based best practice, and develop opportunities for shared learning.	Prolific Offenders Sub Group	30 September 2017
9	Develop a shared understanding across internal and external partners of the expectations for community justice, including a better understanding of each contributor's strategic role.	Prolific Offenders Sub Group	31 March 2018

Outcome 3: People have better access to the services they require, including welfare, health and wellbeing, housing and employability

National indicator 11: Partners have identified and are overcoming structural barriers for people accessing services

The Willow Service (see above) was highlighted as an example of good practice by the Commission on Women Offenders and is being developed further to improve outcomes for women in the criminal justice system. Willow provides holistic support and facilitates access to services, including parenting support, employability, and health and wellbeing, based on risk and need in a psychologically informed environment.

A number of the services outlined under indicator 3 above, such as the Aid and Abet peer mentoring project, Violent Offenders Watch, the Edinburgh and Midlothian Offender Recovery Service, and the Alcohol Problem Solving Court, support people to access mainstream services such as GPs, health services and treatment to improve physical and mental wellbeing, substance misuse services and interventions to support recovery, and services to address other addiction issues, such as gambling.

Resource workers are integrated into the **Drug Treatment and Testing Order Teams**, focusing on supporting people subject to an order to access services in the community, as well as supports that will help them maintain a stable and offence free lifestyle after the end of statutory supervision. The Drug Treatment and Testing Order II pilot, which manages a lower level of substance misuse offending, which had been running in Edinburgh, has now been rolled out nationally. The pilot saw a higher proportion of women and young people being assisted to address drug misuse at an early stage.

Skills Development Scotland (SDS) works with young people aged 16 to 19 years to help them reach positive destinations. Those who are furthest from the employment market, including those with a history of offending behaviour, receive intensive support from an SDS work coach. An SDS adviser works within HMYOI Polmont and HMYOI Cornton Vale to support young people aged 16 and 17 who are within two months of their release to ensure a plan is in place to support their journey into work. SDS also runs a job

club at the Council's Through Care and After Care (TCAC) team premises and the SDS work coach attends the TCAC drop in sessions.

The **Scottish Prison Service** facilitates a work placement programme for prisoners, and placements have been undertaken at Sue Ryder's in Seafield, NHS Western General Hospital and the Salvation Army.

The **visitor's centre at HMP Edinburgh** is run by Barnardo's Scotland on behalf of the Onward Trust. The centre recognises the importance of family contact for prisoners and the impact on families of the imprisonment of a family member, and has for several years provided valuable support to prisoners' families and visitors. It has been the model for similar facilities at other prisons. Prison staff, working in partnership with Barnardo's, now deliver parenting programmes to prisoners. The service is about to commence further work in the community, as well as exploring the possibility of prisoner work placements in the visitor centre.

A **complex needs employability** service, part of the Inclusive Edinburgh initiative, has been co-produced with service users, and the preferred bidder will be announced soon. The service will be up and running during 2017-18. The service will assist people to become employment-ready, as well as helping into employment those who are able to sustain work. Additional initiatives to bring down barriers to employment are referenced under national indicator 18.

Multi-agency work is underway to develop a **preventative approach to online offending** in response to the rising number of convictions for internet-based offending. A communications plan is being developed to support a pilot campaign, which will seek to divert and deter those who may be about commit an offence by downloading or viewing indecent images of children. The deterrence messages will direct potential offenders to a self help resource as well as highlighting the consequences of offending. The campaign will also target those who may be concerned about a family member's behaviour and provide information on where to obtain help and advice.

Work is ongoing in schools to prevent children offending online as well as becoming victims of online offending behaviour, and clear messages are being developed to inform communities on how partners are addressing this issue.

Initiatives to address **access to housing** for prisoners recognise the crucial role of settled accommodation in assisting people to reintegrate into communities on release from custody.

- Sustainable Housing on Release for Everyone (SHORE) is an early intervention approach being developed for prisoners on remand or those serving short-term sentences to provide support with sustaining their tenancy/accommodation until release.
- Project Halt is a multi-agency group co-ordinated by Police Scotland looking to engage with prisoners with a history of housebreaking and support them to reduce their risk of reoffending. Sustainable accommodation is core to these plans.
- Multi-Agency Through-Care Service (MATS) is a multi-agency approach to pre-liberation plans for prisoners, which is being piloted in HMP Edinburgh. It brings together 11 agencies, including Scottish Prison Service Throughcare Support Officers, the voluntary sector (Four Square for housing advice, and Lifeline), Department for Work and Pensions, the Job Centre, Open Secret (a service for prisoners who have suffered abuse), Advocard, Cruise, Shine Women's Mentoring Service, and employability and addiction support. The initiative will develop a pathway on release for short-term prisoners to support them to access the services they need, including housing.
- Develop Yourself Now and Move on (DYNAMO) arranges planned moves for young prisoners, who stay at Stopover upon release, transition to a Four Square supported training flat, and then move to a secure tenancy. During this time, the person is supported to engage with all relevant agencies.

National indicator 12: Existence of joint-working arrangements such as processes/protocols to ensure access to services to address underlying needs

Identifying key transition points between services and ensuring effective partnership working are key objectives of the Offender Management Committee. This has resulted, for example, in the identification of **Community Justice Adult Support and Protection Leads**, who are first points of contact for any supervising officer who has concerns or is given information about an adult at risk who is subject to statutory supervision.

The escalating concerns procedure has been developed as part of Inclusive Edinburgh and is a multi-agency approach to collaborative, problem-solving interventions to manage individuals or groups presenting particular challenges in local communities who are not adults at risk as defined by the Adult Support and Protection (Scotland) 2007 Act, but who are at risk of harm. This includes those who have dangerous behaviours, which fall outwith the remit of MAPPA, and which make them hard to support or leave them unsupported in the community.

The **Edinburgh and Midlothian Offender Recovery Service** (see above), is delivered by Lifeline. In addition to providing support from point of arrest, through prison and beyond release, Lifeline also manages three addiction recovery hubs, which assist people to address their substance misuse. This approach is based on coordinated working between health services, local authorities, the Scottish Prison Service and other support services to ensure that people can benefit from appropriate pathways from custody to reintegration into communities.

The **Alcohol Problem Solving Court** (see above) uses community payback legislation to provide fast track alcohol assessments where a person's frequent offending behaviour is accompanied by alcohol misuse and, in appropriate cases, community payback supervision supports access to alcohol misuse services. Court reviews ensure judicial oversight of an individual's progress, in line with the drug treatment and testing order model.

The **Drug Treatment and Testing Order (DTTO)** delivers a service to Edinburgh, Midlothian and East Lothian. In common with the Alcohol Problem Solving Court, it is recognised that people with substance misuse problems have an immediate need for support and access to services, and should not have to wait a long time for assessment. The DTTO team has agreed a process with the court for the provision of rapid assessment reports so that the court can make as early a disposal as possible and the person can access services.

The DTTO team and the Willow Service each bring together on a single site staff from the City of Edinburgh Council and NHS Lothian, and have explicit pathways to a range of support services.

In November 2016, the Scottish Violence Reduction Unit introduced the **Navigator** system into the accident and emergency department of the Edinburgh Royal Infirmary. Supported by one year Scottish Government funding, Navigator staff work with health professionals on overnight and weekend shifts at the busiest times, recognising that to be with someone when they are injured, scared or angry and to be able to reach out a helping hand, makes a lasting difference. Interventions are tailored to the needs of the individual and engagement within the hospital is followed up after discharge, with links to local services where required.

There is a strong tradition of criminal justice working across local authority boundaries in Lothian and Borders. **Shared services** include court social work (Edinburgh, Midlothian, East Lothian), DTTO (Edinburgh, Midlothian and East Lothian), Caledonian (Edinburgh, Midlothian, East Lothian, and Scottish Borders), and the Community Intervention Service for Sex Offenders (all five local authorities). This allows for specialist interventions when required, effective sharing of skills and resources, and economies of scale,

e.g. where there might not be sufficient volume of demand in one area to allow delivery of a service (e.g. groupwork).

National indicator 13: Initiatives to facilitate access to services

Initiatives to ensure that people who have offended get the support they need, when they need it, in order to encourage desistance include, as highlighted throughout this plan, Willow, the Aid and Abet peer mentoring service, the Alcohol Problem Solving Court pilot, and the outreach service of the residential unit for high risk offenders.

Partnerships for the 'other activities requirement' under community payback orders have been developed with a variety of organisations, twelve of which provide other activity at this time to help facilitate **access to employment** (see national indicator 18 for more information).

Willow staff have played a critical role in shaping national developments regarding the future of the custodial estate for women. As part of the re-provisioning of the estate, five **community custody units are** to be established across the country, and there have been initial discussions between the Scottish Government, the Scottish Prison Service, and the City of Edinburgh Council regarding potential sites in Edinburgh. Based on research and the Willow experience, these units will have as much of an independent feel to them as possible, where women will carry out usual day to day activity and will have staged access to the local community for health services and employability in order to minimise the impact of imprisonment on the lives of the women and their families, including children.

The Scottish Prison Service has created the **Throughcare Support Officer role** to help individuals on their journey to desistance by working with them to prepare for the transition from custody to the community. Partners are working together to improve transitions and outcomes for at least the first twelve weeks following release, as this period is known to be critical and highest risk. In HMP Edinburgh, the co-commissioned Edinburgh and Midlothian Offender Recovery Service (see above) works with Throughcare Support Officers and other partners in this developing area.

National indicator 14: Speed of access to mental health services

The NHS Local Delivery Plan 2016-17 includes a target for 90% of patients to commence psychological therapy-based treatment within 18 weeks of referral. Available data includes the whole community and is available for the NHS Lothian geographical area. Figures published by the Scottish Government (June 2016) show that in the NHS Lothian area, 69.5% of patients commence psychological therapy-based treatment within 18 weeks of referral.

There is a link between mental health and reoffending. This is recognised by the Willow Service, which operates to a trauma-informed model and has psychological services on site. Accessing mental health services is also challenging for men with offending backgrounds and work underway to identify the level of need for mental health services among this client group, with a view to designing a pathway into mental health services. Already, the Edinburgh Payback Programme, a groupwork intervention for men subject to community payback orders, has been re-designed as a Men's Programme, and has drawn on lessons from the Willow service that can be applied to men.

The Health and Social Care Integration Joint Board's Strategic Plan 2016-19 commits to redesigning mental health and substance misuse services to improve access. The Board's strategic approach recognises the importance of prevention and the advantages of timely access to personalised mental health services to aid recovery and sustain wellbeing. A mental health locality partnership model will be implemented, focusing initially on the population in the North East of Edinburgh as this area has the highest percentage of people with longer term health issues. The model will maximise the opportunities of the 'Gamechanger' Public Social Partnership to improve people's health and life chances.

The Edinburgh Partnership's Community Plan 2015-18 identifies improving Edinburgh's citizens' experiences of health and wellbeing and reducing inequalities in health as a priority. The preventative actions being taken to deliver on this priority are detailed in the Edinburgh Partnership's Prevention Strategic Plan 2015-18.

National indicator 15: Speed of access to drug and alcohol services

The NHS Local Delivery Plan 2016-17 includes a target for 90% of patients to access drug/alcohol treatment within three weeks of referral. Overall, in 2015-16 in Edinburgh, 86% of people waited less than three weeks to start drug/alcohol treatment. 5% waited longer than six weeks. The data includes the whole community.

The Health and Social Care Integration Joint Board's Strategic Plan 2016-19 details actions to deliver on reviewing treatments and recovery pathways for substance misuse services in collaboration with the Edinburgh Alcohol and Drug Partnership. Further actions are set out below.

- Implement inpatient and community programmes (Lothian and Edinburgh Abstinence Project (LEAP)).
- Establish a model of care within Recovery Hubs using lived experience peer supporters.
- Explore new harm reduction and recovery approaches to engage more effectively with people receiving treatment for drug misuse through their GP.
- Develop and implement a stepped care approach to psychosocial and therapeutic interventions across recovery services.

National indicator 16: **% of people released from a custodial sentence (quantitative) who are:**

- **Registered with a GP**
- **Have suitable accommodation**
- **Have had a benefits eligibility check**

There is no systematic process to collect this information consistently. Input is required from a range of partners to identify need and facilitate access to accommodation as required. The main data source is likely to be the Scottish Prison Service, and will include throughcare, housing, health boards and Scottish Prison Service exit surveys.

Data on the percentage of households presenting as homeless due to 'discharged from prison' is being used as a proxy indicator and shows that this has remained fairly constant over the last four years:

2012-13			**2013-14**			**2014-15**			**2015-16**		
Prison	All	% from prison	Prison	All	% from prison	Prison	All	% from prison	Prison	All	% from prison
152	4315	3,5%	127	4102	3,1%	118	4017	2,9%	122	3638	3,4%

The data does not necessarily include all people who presented as homeless who had been in prison. If people stay with family/others for the first few weeks after release, housing officers may record their cause of homelessness as 'domestic ejection'.

The Scottish Government's Code of Guidance on Homelessness includes recommendations for partners in dealing with prison leavers (2,32) and sets out the local authority's accommodation duties towards applicants who are homeless or threatened with homelessness (chapter 9).

Outcome 3 priority areas for improvement actions

Priority area (indicator)	Improvement action	Lead	Completion
11	Raise awareness of psychologically and trauma informed approaches to service delivery.	Women's Sub Group	31 March 2018
11	Map existing employability services assisting people to become employment ready and identify gaps in provision.	Sector Manager, Community Intervention	30 Sept. 2017
11	Develop the complex needs employability service.	Sector Manager, Community Intervention	30 Sept. 2017
12	Deliver year two of the Alcohol Problem Solving Court and identify other areas where the model might be applied.	Senior Manager, Community Justice/NHS Rep.	31 March 2018
12	Explore options for sustainability of the Navigator Programme.	Senior Manager, Community Justice//NHS Rep.	31 October 2017
12	Improve continuity in health intervention from DTTO to community management on expiry of DTTO.	Sector Manager, City-wide Services	31 March 2018
12	Work with other local authorities to maintain and enhance services across local authority boundaries.	Senior Manager, Community Justice/	31 March 2018
13	Develop a clearer understanding of third sector services, build closer links, and improve collaborative working to remove gaps in service provision.	EVOC/ECSP	31 March 2018
14	Improve speed of access to mental health services in Edinburgh.	NHS Lothian Rep.	31 March 2018
14	Design a pathway to make it easier for men with offending backgrounds to access mental health services.	Prolific Offenders Sub Group	30 Sept. 2017
15	Improve the speed of access to drug and alcohol misuse services.	NHS Lothian Rep.	31 March 2018
15	Establish baseline information for those within the community justice system accessing drug and alcohol services.	Prolific Offenders Sub Group	30 Sept. 2017

16	Liaise with NHS Lothian/Scottish Prison Service to establish baseline figures in relation to GP registration.	Prolific Offenders Sub Group	30 Sept. 2017
16	Liaise with Scottish Prison Service and community justice partners to establish accurate baseline information on prisoners having suitable accommodation and benefits check on release.	Prolific Offenders Sub Group	30 Sept. 2017

Outcome 4: Effective interventions are delivered to prevent and reduce the risk of further offending

National indicator 17: Targeted interventions have been tailored for and with an individual and had a successful impact on their risk of further offending

Interventions tailored with individuals to reduce their risk of further offending are outlined in Edinburgh's transitional plan for the delivery of community justice 2016-17, some of which have been highlighted above. These include the Violent Offender Watch, supervised bail, diversion from prosecution, Drug Treatment and Testing Orders, the Community Intervention Service for Sex Offenders, Willow, the prison based social work team, the Positive Lifestyles Project, community payback orders, the Caledonian system, the residential unit for high risk offenders, the Offender Recovery Service, employability initiatives, the escalating concerns group, Community in Motion, the Young People's Service, Community Improvement Partnerships and the newly established integrated Family and Household Support teams.

The Community Payback Order Annual Report 2015-16 in particular highlights how a range of partners work with criminal justice social work staff to assist offenders subject to community payback to make positive changes in their life. A range of interventions available to case managers supports behavioural and lifestyle change for offenders. Some examples are set out below.

The **Edinburgh Payback Programme** is for men to address general offending, including attitude and lifestyle issues, and reintegration work, which links people to services to support desistance after completion of the order. The programme also provides a module for road traffic offending. Drawing upon the successes of the Willow service, the programme has developed into a service for men where workers from criminal justice, health and other partners help men to address a broad range of needs, such as physical, mental and sexual health, abuse and trauma as well as confidence, self esteem and life skills.

The **Serious Offender Liaison Service (SOLS)** is based at the Orchard Clinic of the Royal Edinburgh Hospital and provides an assessment and consultancy service to criminal justice social work and partner agencies in relation to sexual offending.

The **Learning Disability Service** based at the Royal Edinburgh Hospital supports those with a learning disability who are subject to community payback. The service provides a wide range of support from art therapy to speech and language therapies. It also contributes to the intervention work with sex offenders with a learning disability to change their behaviour. Guidance on relationships and sexual health exists for those caring for people with leaning disabilities, entitled Making Choices Keeping Safe.

The **Scottish Prison Service** delivers activities and interventions that either address offending behaviour or support the needs of people in the care of the Scottish Prison Service. Examples include Alcohol Awareness, Drugs Action for Change, SMART Recovery, Constructs, Moving Forward Making Changes and the Youth Justice Programme targeting general offending behaviour in medium-high risk 16-17 year olds.

National indicator 18: Use of 'other activities requirement' in Community Payback Orders (CPOs)

Partnerships for the 'other activities requirement' have been developed with a variety of organisations. There are options to suit all abilities and needs, being as inclusive as possible. Twelve organisations provide other activity at this time. Examples of the new additions in the past year are set out below.

- Skills Path works with people who have a recognised disability, developing skills and experience, and provides the opportunity for people to move on to paid employment in various sectors.
- Street Soccer Scotland is a non-profit social enterprise, which delivers a range of football related services to socially disadvantaged adults and young people. Through sport, people develop new skills and increase confidence, self-esteem and better self-efficacy. People are shown how to build a portfolio, gain SQAs in communication, and develop first aid skills.
- Veterans First Point has been developed by veterans for veterans. Funded by the Scottish Government and NHS Lothian, it provides a one-stop shop for veterans and their families, helping ex-service personnel to reintegrate to civilian life.
- Youth Build Edinburgh assists young people who experience considerable disadvantage to access sustainable employment and comprehensive training in construction.

Improvement actions for 2017-18 will be to develop other activity work further, not only providing additional opportunities for people, but raising the awareness of the benefits of unpaid work/other activity in local communities and amongst partners. Improved publicity for completed unpaid work projects, through on-site information or local networks will also raise the profile of the benefits to communities and to people undertaking the work.

National indicator 19: Effective risk management for public protection

Partners in Edinburgh have established strong, multi-agency governance arrangements for public protection. Edinburgh's Chief Officers' Group – Public Protection is responsible for the leadership and performance management of the multi-agency aspects of public protection in the city. The Local Police Commander and the Chief Executives of the Council and NHS Lothian are members of the group.
Five committees/partnerships (child protection, adult support and protection, offender management, alcohol and drugs, violence against women, multi-agency serious organised crime) manage performance and oversee the quality of services. The Edinburgh, Lothian and Scottish Borders Strategic Oversight Group monitors the operation of MAPPA and makes changes to improve effectiveness where required.

As part of the City of Edinburgh Council's Transformation Programme, Housing and Regulatory Services are introducing a generic housing officer, responsible for a geographical patch of Council tenancies. This will enable housing officers to have oversight of changing household composition in the area and to ensure that the Responsible Authorities under MAPPA routinely receive relevant information. This improves risk management with regard to allocating homes near known sex offenders and other offenders subject to MAPPA.

The young people risk management case conference process, an arrangement similar to MAPPA, is being used to work with young people who pose a significant risk of harm.

Addressing human trafficking and counter terrorism (Prevent and CONTEST) have been added to the public protection remit. Inter-agency guidance has been developed for staff and training takes places on a continuous basis to raise awareness about these issues and enable staff to respond appropriately. Serious and organised crime in the city is addressed on a multi-agency basis.

National indicator 20: Quality of CPOs and DTTOs

As highlighted in the Community Payback Order Annual Report 2015-16, most people who carry out unpaid work recognise that this can be an opportunity to learn a new skill, often as part of a team, as well as giving something back to the community. Some people who have completed their unpaid work hours are now volunteers within the same project. Exit surveys carried out with people who have completed an order highlight positive outcomes in areas including reduction in drug and alcohol use, uptake of employment and training, improved relationships and stable accommodation. As in previous years, many people cite the importance of the relationship with their social worker in helping them to improve their life and stop offending.

Teams delivering community payback and DTTO are subject to the City of Edinburgh Council quality assurance processes, which include case file audits, practice evaluations and focused themed audits, such as violent offenders or MAPPA. All of these processes result in improvement action plans, which are subject to ongoing monitoring. Lessons from Serious Incident Reports, Initial and Significant Case Reviews and actions from audits and practice evaluations are overseen by the Protection Committees' multi agency quality assurance sub groups.

National indicator 21: Reduced use of custodial sentences and remand (quantitative)

- **Balance between community sentences relative to short custodial sentences under 1 year**
- **Proportion of people appearing from custody who are remanded**

The Scottish Courts and Tribunal Service is now represented on the Edinburgh Community Safety Partnership. A system will be established for the relevant data to be provided. The Scottish Prison Service provides figures on prison populations by local authority as a snapshot, which is used for planning purposes.

The Crown Office and Procurator Fiscal Service will link into local authorities' community planning processes on a sheriffdom basis. This will also include work to extend awareness and knowledge of prosecution diversions amongst procurator fiscals to maximise the best use of appropriate community justice interventions.

The Edinburgh Community Safety Partnership is committed to reducing the use of short-term custodial sentences by developing the services outlined in this plan, which enable early intervention when difficulties are identified, have a focus on prevention, and, when people are convicted, have a clear focus on the prevention of re-offending. An important part of this strategy has been to develop credible community-based alternatives to custody that have the support of the courts and local communities.

National indicator 22: The delivery of interventions targeted at problem drug and alcohol use (quantitative)

In 2015-16, across Lothian, 28,972 Alcohol Brief Interventions were delivered against a target of 9,738. 12,179 of these were delivered in priority settings (primary care, maternity services, accident and emergency). A further 16,793 were delivered in wider settings, including higher education, dentistry, criminal justice, sexual health services, young people's services, and occupational health. Edinburgh continues to deliver on this pan Lothian target and no improvement goals have been set for the Edinburgh Alcohol and Drug Partnership.

National indicator 23: Numbers of police recorded warnings, police diversion, fiscal measures, fiscal diversion, supervised bail, and community sentences (including CPOs, DTTOs and RLOs)

1025 Community Payback Orders were imposed in 2015-16, compared to 1114 in the previous year, consistent with fewer criminal justice social work reports being requested by courts. The Community Payback Order Annual Report provides information on all aspects of community payback, including the nine possible requirements.

The annual aggregate return to the Scottish Government provides detailed information on criminal justice social work reports, bail, diversion, voluntary assistance and statutory throughcare.

All statistical information provided from these and other sources (such as the Level of Service, Case Management Inventory (LS/CMI)) is used to plan and develop services.

Improvement action for 2017-18 is to work with Police Scotland and the Crown Office and Procurator Fiscal Service to establish baseline figures.

National indicator 24: Number of short-term sentences under 1 year

Snapshot data is available regarding males and females in prison by local authority and sentence (undetermined sentence, remand, fine defaulters, less than 3 months, 3 months to less than 6 months, 6 months to less than 2 years, 2 years to less than 4 years, 4 years or over, including life). This information is being used to inform planning.

Outcome 4 priority areas for improvement actions

Priority area (indicator)	Improvement action	Lead	Completion
18	Further develop 'other activity' work to increase opportunities for those subject to Community Payback Orders.	Manager, CPO Unpaid Work Team	31 October 2017 (CPO Annual Report)
21	Establish baseline information and work with the Scottish Courts and Tribunal Service to obtain relevant data for comparison.	Sector Manager, City-wide Services	30 Sept. 2017
21	Work with the Crown Office and Procurator Fiscal Service to extend Procurator Fiscals' knowledge of suitable prosecution diversions opportunities in criminal justice and the third sector.	Sector Manager, City-wide Services	30 Sept. 2017
23	Work with Police Scotland to establish baseline figures for police warnings and diversions.	Sector Manager, City-wide Services	30 Sept. 2017
23	Work with the Crown Office and Procurator Fiscal Service to establish baseline figures for fiscal diversions, supervised bail, and community sentences.	Sector Manager, City-wide Services	30 Sept. 2017

PERSON-CENTRIC OUTCOMES

Outcome 5: Life chances are improved through needs, including health, financial inclusion, housing and safety being addressed.

Outcome 6: People develop positive relationships and more opportunities to participate and contribute through education, employment and leisure activities.

Outcome 7: Individuals' resilience and capacity for change and self-management are enhanced.

National indicators 25, 26 and 27: Individuals have made progress against the outcome.

Local interventions designed to improve person-centric outcomes all follow a holistic approach addressing improved life chances, developing positive relationships and resilience at the same time. Consequently, the person-centric outcomes and related indicators are addressed jointly in this plan, as evidenced above. Outcomes are measured for individuals accessing community justice services. Examples are set out below.

The Caledonian System is the integrated approach to addressing domestic abuse. It combines a programme for male offenders with support services for women and children affected by domestic abuse, as both victims and witnesses. In the **evaluation of the Caledonian System** women reported that they felt safer and men who completed the programme were judged by case workers as posing a lower risk to partners, children and others by the end of the programme.

An evaluation of the **Edinburgh domestic abuse court** roll-out sought feedback from victims. It demonstrates the many successes of the domestic abuse court roll-out and the positive impact that can be achieved through effective support and intervention from all agencies and at every stage of the process.

The **Edinburgh Domestic Abuse Court Advocacy Service** (EDDACS) assists victims of domestic abuse to make informed choices relating to their circumstances, including person-centred work to improve confidence where victims are required to attend court at witnesses.

Performance information from **Willow** has demonstrated improvements in women's lives across a range of indicators, including improved mental health and engagement with services, improved problem solving skills, reduction in harmful behaviours to self and in alcohol and drug use, and a better understanding of the link between current difficulties and previous experiences of trauma. Many have been helped to resume care of their children.

The Care Inspectorate report on the residential unit for those who pose a risk of serious harm (July 2016) highlights that 'service users were supported to access housing, employment/training, health and finance and that outcomes for service users were positive.'

The positive outcomes for people subject to **community payback** are summarised in the exit questionnaires completed at the end of each order. Positive outcomes are cited in many areas, including employment and training, relationships and accommodation, and a reduction in drug and alcohol use.

The **Community Interventions Service for Sex Offenders** (**CISSO**) delivers the accredited programme for convicted sexual offenders: Moving Forward Making Changes. A national outcome evaluation is being planned for 2017. No control group is available therefore the evaluation will assess progress made towards short- and medium-term outcomes, which are expected to contribute towards the long-term outcome of decreasing offending behaviour.

Scottish Government reporting: Performance information for the Caledonian system is reported to the Scottish Government. An evaluation of the programme was conducted in 2016, which accompanies a summary of the key findings.

An annual report on the delivery of social work services in Edinburgh is also submitted. This is a requirement of each local authority to enable monitoring of the national social work landscape.

Edinburgh's Community Payback Order Annual Report 2015-16 is published online; along with other local authorities' annual reports it informs the Scottish Government Summary of Community Payback Order Local Authority Annual Reports 2015-16.

Outcomes 5, 6 and 7 priority areas for improvement actions

Priority area (indicator)	Improvement action	Lead	Completion
25	Indentify opportunities within existing pathways for vulnerable people to have access to health, wellbeing or other relevant interventions.	All	31 March 2018
27	Examine services proven to improve outcomes for individuals and consider whether the successful models can be replicated elsewhere.	Prolific Offenders Sub Group	31 March 2018

Alignment to National Outcomes and Community Planning

The Edinburgh Community Justice Outcomes Improvement Plan supports the Scottish Government's National Outcomes to: tackle the significant inequalities in Scottish society; live our lives safe from crime, disorder and danger; and build strong, resilient and supportive communities. It is being developed in line with the Edinburgh Community Planning Partnership's vision: Edinburgh is a thriving, successful and sustainable capital city in which all forms of deprivation and inequality are reduced.

The Edinburgh Partnership works towards four strategic outcomes:

- Edinburgh's economy delivers increased investment, jobs, and opportunities for all (strategic priority: reducing unemployment and tackling low pay)
- Edinburgh's citizens experience improved health and wellbeing with reduced inequalities in health (strategic priorities: shifting the balance of care; reducing alcohol and drug misuse; reducing health inequalities)
- Edinburgh's children and young people enjoy their childhood and fulfil their potential (strategic priorities: improving early support; improving outcomes for children in need; improving positive destinations)
- Edinburgh's communities are safer and have improved physical and social fabric (strategic priorities: reducing antisocial behaviour, violence, harm; reducing reoffending; improving community cohesion, participation and infrastructure; increasing availability of affordable housing; reducing greenhouse gas emissions)

Development of the Community Justice Outcomes Improvement Plan has identified four key themes, which align with the vision for community justice in the National Strategy, and cut across a number of Edinburgh's strategies and improvement plans listed at Appendix1.

- Making communities safer through reducing crime and antisocial behaviour
- Reducing inequalities by improving access to services (health, housing, welfare)
- Building strong and inclusive communities
- Improving individuals' resilience and life chances by creating more opportunities for participation in society (access to employment, education)

Public consultation events have highlighted those themes important to local communities and the Community Justice Outcomes Improvement Plan will feed into the development of the four Locality Improvement Plans, which will be in place by October 2017, and into the Edinburgh City Vision 2050.

Governance Arrangements

Edinburgh's Community Safety Partnership (CSP) has developed the Community Justice Outcomes Improvement Plan on behalf of Edinburgh's Community Planning Partnership. Statutory partners approved the Plan on 1 March 2017. The CSP has responsibility for implementing and monitoring the Plan, including delivering the improvement actions for the structural and person-centred outcomes. The CSP will report progress under the national indicators to the Edinburgh Partnership annually, in addition to carrying out an annual review of the Plan. Edinburgh's reporting structure for community justice is set out below.

Participation statement

The Community Justice Outcomes Improvement Plan has been developed with the full participation of community justice partners and the third sector. Partners who contributed to the Plan's development are listed at Appendix 2.

Feedback from the following activities was used to inform the Plan:

- online public consultation using survey questions and inviting comments
- Community Safety Partnership workshops to explore priority areas
- a short life community justice working group to gather input from partners
- consultation with people with offending backgrounds and their families
- consultation with victims and witnesses of crime and their families

The third sector is represented on the Community Safety Partnership and was included in the short life working group. Additional consultation events are planned with service users and the third sector in 2017/18 to support the Plan's review and further development.

Appendix 1: Sources

Scottish Government National Performance Framework

Edinburgh Partnership Community Plan 2015-18

Edinburgh Partnership Prevention Strategic Plan 2015-18

Integration Joint Board Strategic Plan 2016-19

The City of Edinburgh Council Business Plan 2016-20

Edinburgh Local Policing Plan 2014-2017

Antisocial Behaviour Strategy 2016-19

Local Fire and Rescue Plan for the City of Edinburgh 2017-20

Edinburgh Alcohol and Drug Partnership Strategy and Delivery Plan 2015-18

Integrated Plan for Children and Young People 2015-18

Appendix 2: Partners

The partners are members of Edinburgh's Community Safety Partnership (CSP):

Elected member and chair of the CSP

Chief Social Work Officer, the City of Edinburgh Council

Senior Manager, Community Justice, City of Edinburgh Council

Senior Manager, Integration Joint Board for Health and Social Care

Programme Manager, Edinburgh Alcohol and Drug Partnership

Chief Superintendent, Police Scotland

Area Manager, Scottish Fire and Rescue Service

Governor, HMP Edinburgh, Scottish Prison Service

Strategic Programme Manager, NHS Lothian

Chief Executive, Edinburgh Voluntary Organisations Council

Area Manager, Skills Development Scotland

Procurator Fiscal, Crown Office and Procurator Fiscal Service

Scottish Courts and Tribunals Service

Report

Whole System Delays – Recent Trends

Edinburgh Integration Joint Board

14 July 2017

Executive Summary

1. The purpose of this report is to update the Integration Joint Board on:

   - the current performance in respect of delayed discharge;
   - actions being taken to reduce the number and length of delays; and
   - actions being taken to improve the monitoring and management of performance

Recommendations

2. The Integration Joint Board is asked to note:

   - the performance in respect of delayed discharge; and
   - the actions being taken to maintain that improvement

Background

3. Performance in respect of the number of people whose discharge from hospital is delayed and the length of those delays has been an ongoing challenge. Edinburgh has regularly had the highest number of delayed discharges of any Integration Authority in Scotland.

4. A programme of work has been put in place overseen by the Flow Programme Board. The board has agreed three new workstreams to focus on both delays from hospital and those within the community. Those are:

   - to review and operations through the Care at Home contract;
   - to optimise the flow of patients; and
   - to better utilise technology enabled care

5. Recognising the importance and urgency of the need to reduce the number and length of delayed discharges the Integration Joint Board has asked to receive regular updates on performance.

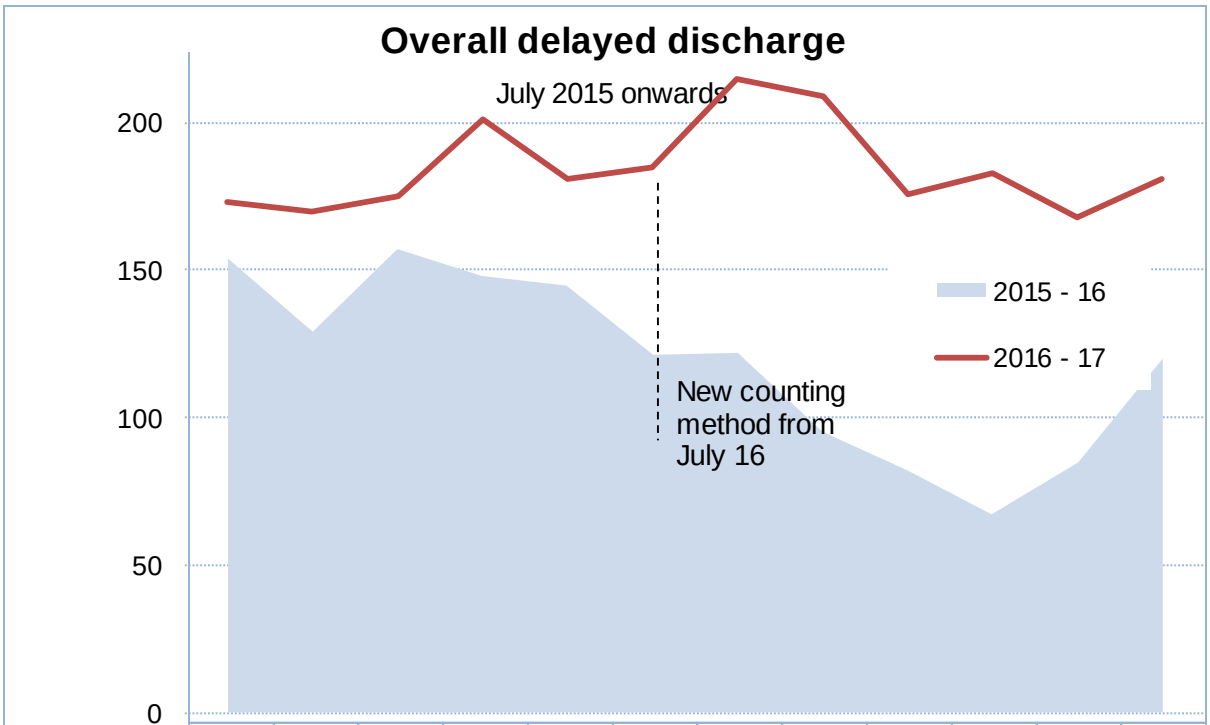
Main report

6. The current target in respect of the number of people whose discharge from hospital is delayed is that this should be no more than 50 for non-complex cases by December 2017. Table 1 below shows the trajectory that has been agreed to reach this target.

2017	May	June	July	Aug	Sep	Oct	Nov	Dec
Non-complex	163	147	131	115	98	82	66	50
Complex	27	24	22	20	17	15	12	10

Table 1 Phased targets for the number of people whose discharge from hospital is delayed

7. Chart 1 below shows the number of people whose discharge from hospital was delayed over the last two years using the monthly census data. Note that the figures for June 2017 are provisional at this stage pending verification of the census data. The shaded area shows performance for July 2015 to June 2016 and the red line shows levels for the current year. The target trajectory is shown by the green line.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2015 - 16	154	129	157	148	145	121	122	95	82	67	85	120
2016 - 17	173	170	175	201	181	185	215	209	176	183	168	181
Target 16-17										179	162	147

Chart 1: Number of people delayed in hospital July 2016 to June 2017 excluding complex cases (June 2017 figures are provisional).

8. Table 2 below shows the number of complex delays (Code 9) that are excluded from the census reporting.

	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17
Total	173	170	175	201	181	185	215	209	176	183	168	181
Excluded cases	25	23	24	27	23	18	12	13	16	32	34	24
Of which, Guardianship	23	20	20	22	16	17	11	12	14	18	19	12
Grand Total	198	193	199	228	204	203	227	222	192	215	202	205

Table 2: Excluded cases (Code 9) (June 2017 figures are provisional)

9. As illustrated in Chart 1 there has been a reduction in the number of people whose discharge has been delayed over the last four months from the high figure of 215 in January. The recent activity although an improvement, is now above the trajectory to meet the target of 50 for December.

10. Detailed performance reports are now available on a locality basis which has allowed performance targets to be set for each locality in respect of delayed discharges. A 'star chamber' meets weekly where Locality and Hub Managers are held to account for performance and any issues having a negative impact on timely discharge can be escalated immediately.

11. The Flow Programme Board has recently reviewed the content of the programme and identified three specific areas for attention:

- Maximising capacity through the care at home contract. The Board wish to review this area due to the care at home contracts being new and were given a "bedding in" period, but to date have not delivered the capacity required or expected.
- Optimising flow through the hospital system and discharge from hospital
- Technology enabled care as a means of increasing capacity to support people to live independently in the community, avoiding the need for admission to hospital and facilitating timely discharge

12. Lack of capacity in care at home to support discharge from hospital continues to be a significant problem which is why the Flow Board has decided to take an interest in this area. A meeting with all providers was held to ascertain how the Partnership can support retention and recruitment of care staff. From that meeting the Council HR department has agreed to advertise in MyJobScotland on behalf of all contractors. Training for contracted staff will be offered to SVQ level and further local advertising will be supported through all Partnership outlets such as GP Surgeries and Pharmacies.

Further work will be undertaken to examine whether there is availability of housing within each locality for care workers.

Technology enabled care has the potential to provide innovative ways of supporting people to remain at home which may reduce some of the pressure on the care at home service. The focus on the work to optimise flow will build on the improvements seen through the operationalisation of the MATTs and the introduction of the 'star chamber' approach to managing performance.

Key risks

13. Whist the recent reduction in the number of people whose discharge is delayed from hospital is very welcome. The current trajectory is off target and there is a risk that the December target will not be met. Close scrutiny through the weekly Delayed Discharge Star Chamber will seek to rectify the slippage against the planned trajectory through increased management support through the daily Multi Agency Triage Team meetings and the weekly Star Chambers.

Financial implications

14. There are no financial implications arising directly from this report.

Involving people

15. As the locality Hubs and Clusters become operational there will be further engagement with local communities to further develop the model.

Impact on plans of other parties

16. The ability of the Edinburgh Health and Social Care Partnership to significantly reduce the number of people currently delayed in hospital and the length of those delays impacts on NHS Lothian and the other three Integration Boards within Lothian. These partners are kept informed of progress by the Chief Officer of the Edinburgh Integration Joint Board through the IJB Chief Officers Acute Interface Group.

Background reading/references

None

Rob McCulloch-Graham

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Item 5.5

Report

Update on 2017/18 Financial Position Edinburgh Integration Joint Board

14 July 2017

Executive Summary

1. The purpose of this report is to provide the Integration Joint Board (IJB) with a high level overview of the financial position for the first two months of 2017/18.

Recommendations

2. The EIJB is asked to note that:

   a) delegated services provided by NHS Lothian are reporting an overspend of £2.1m for the first 2 months of 2017/18, a variation of £1.0m from the financial plan trajectory;

   b) detailed financial information in respect of delegated services operated by the City of Edinburgh Council is not yet available; and

   c) the emerging financial position for both NHS and council services is of concern.

Background

3. When resources have been delegated via directions by the IJB, the City of Edinburgh Council (CEC) and NHS Lothian (NHSL) apply their established systems of financial governance to the delegated functions and resources. Accordingly, budget monitoring of IJB delegated functions is undertaken by finance teams within CEC and NHSL. This arrangement reflects the IJB's role as a strategic planning body which does not directly deliver services, employ staff or hold cash resources. However, it is important that the IJB has oversight of the in year budget position as this highlights any issues that need to be accounted for when planning the future delivery of health and social care services.

Main report

Overview

4. As has been previously reported, CEC and NHSL have different arrangements for financial performance management. Specifically, in the early months of the financial year CEC undertake high level monitoring of areas of high financial risk but do not produce detailed reporting information. As such it is therefore not possible to produce a consolidated IJB financial postion at this point. This paper therefore outlines the key issues impacting on partnership services ran by CEC and reports on the financial position of NHS services only.

NHS services

5. The financial plan to the NHSL board in April showed an outstanding £22.4m gap to be closed in order to achieve breakeven by the end of the year. Edinburgh IJB's share of this was £6.5m.

6. Partnership services delivered by the NHS are showing an overspend of £2.1m for the first two months of the year. Comparing this to the expected outturn per the financial plan, this is £1m in excess of anticipated (based on a pro rata share of the financial plan overspend). Both the overspend and the variance from trajectory give cause for concern. Table 1 gives a summary of the position at month 2, with more detail provided in the appendix.

7. Work is ongoing to understand the variation from trajectory and the quarter 1 review will present the first key opportunity to review the detail of the financial position across NHS Lothian and what options might be available to meet the statutory target of breakeven. Meetings are now scheduled and a formal update on the revised forecast and any other supporting actions for cost reduction will be presented to the NHSL Finance and Resources Committee at its meeting of 20 September.

	Budget £k	Actual £k	Variance £k	FP trajectory £k	Variance from trajectory £k
NHS services					
Core services	36,861	38,194	(1,333)	(686)	(647)
Hosted services	13,686	13,643	43	27	16
Set aside services	15,946	16,747	(801)	(346)	(455)
Total NHS services	**66,493**	**68,584**	**(2,091)**	**(1,006)**	**(1,085)**

Table 1: summary financial position for NHS services to May 2017

8. As in 2016/17, the key drivers continue to be pressure on prescribing; nursing budgets in community hospitals; and junior medical staffing in acute (set aside) services. It is recognised that this position is a cause for concern and the partnership management team is working with colleagues in NHSL to develop and implement a recovery plan.

9. The overall position for NHSL includes a release of reserves of £1.7m, none of which is reflected in the reported results for the IJB.

Council services

10. As discussed above, CEC do not produce detailed financial performance information until after the first quarter. However high level monitoring has been ongoing which has identifed 2 key areas where further scrutiny is required.

    a) The purchasing budget continues to be under pressure in a number of areas, including: an ongoing increase in **direct payments** which impacts on the funding available for CEC arranged services; the increase in care at home capacity required as delays are addressed; and the requirement to deliver efficiencies. Whilst the IJB made provision in the financial plan, it is unlikely to be sufficient to deal with the combined impact of these factors. The partnership management team is working with Locality Managers to develop detailed implementation plans for delivery of approved purchasing efficiencies. Discussions with senior CEC management are also taking place to identify potential options; and

    b) Agency costs remain high, particularly within care homes and learning disability services. The Interim Chief Nurse is leading an exercise to review establishments and rostering arrangements in care homes. It is anticipated that this will lead to a reduction in the use of agency staff and this will be monitored closely as the project rolls out. It is anticipated that agency expenditure in the learning disability services will reduce as the structure is fully implemented.

Key risks

11. Non delivery of recovery actions to the value required identified in the financial plan is one of the main risks continuing to face the IJB.

Financial implications

12. Outlined elsewhere in this report.

Involving people

13. The successful implementation of these recommendations will require the support and co-operation of both CEC and NHSL personnel.

Impact on plans of other parties

14. As above.

Background reading/references

15. None.

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Links to priorities in strategic plan

Managing our resources effectively

NHS LOTHIAN ELEMENT OF IJB FINANCIAL POSITION 2017/18

	Position to end May 2017		
	Budget £k	Actual £k	Variance £k
Core services			
Community AHPs	855	1,046	(191)
Community Hospitals	1,626	1,813	(186)
District Nursing	1,749	1,790	(41)
GMS	10,594	10,645	(51)
Mental Health	1,501	1,496	5
Other	1,806	2,235	(429)
Prescribing	13,345	13,784	(438)
Resource Transfer	5,385	5,385	0
Sub total core	**36,861**	**38,194**	**(1,333)**
Hosted services			
AHPs	1,090	1,075	15
Complex Care	102	188	(86)
GMS	775	731	45
Learning Disabilities	1,471	1,503	(32)
Lothian Unsched. Care Serv.	989	1,030	(40)
Mental Health	4,126	4,003	123
Oral Health Services	1,537	1,452	86
Other	(42)	(108)	66
Palliative Care	389	388	0
Psychology Service	724	716	8
Rehabilitation Medicine	659	631	28
Sexual Health	519	515	4
Substance Misuse	737	943	(206)
UNPAC	608	575	33
Sub total hosted	**13,686**	**13,643**	**43**
Set aside services			
A & E (outpatients)	1,035	1,041	(6)
Cardiology	2,652	2,614	38
Diabetes	198	216	(18)
Gastroenterology	840	962	(122)
General Medicine	5,068	5,682	(614)
Geriatric Medicine	2,946	2,966	(20)
Infectious Disease	1,137	1,181	(44)
Management	246	274	(28)
Other	459	405	54
Rehabilitation Medicine	342	362	(20)
Therapies	1,023	1,043	(20)
Sub total set aside	**15,946**	**16,747**	**(801)**
Grand total	**66,493**	**68,584**	**(2,091)**

Item 5.6

Report

Edinburgh Wellbeing Public Social Partnership
Edinburgh Integration Joint Board

14 July 2017

Executive Summary

1. The purpose of this report is to update the Edinburgh Integrated Joint Board (EIJB) on the progress of the Edinburgh Mental Health and Wellbeing Public Social Partnership (PSP). The PSP was supported by the EIJB with a report being submitted to the Board on 19 August 2016, and it brings together third sector provision previously commissioned by City of Edinburgh Council and NHS Lothian at a cost of c £2.1m over two years. The extended contracts for these services will expire on 31 October 2017 and it is envisaged that locality tests of change developed through the PSP will commence on 1 November 2017 and run for a period of 24 months.

Recommendations

2. To agree the continuation of four locality wellbeing PSPs which will provide a range of social prescribing, meaningful activities and psychosocial and psychological support to people experiencing mental health problems.

3. To agree the continuation of four pivot partnerships for the provision of:

- Crisis partnership to support for People in Crisis 24/7/365;
- Peer Collaborative to build capacity for peer working across the city;
- Active and Green Partnership which will promote physical activity, physical health and the use of green spaces; and
- Mind Space Partnership which will provide a range of evidence based psychosocial, accredited counselling and psychological interventions.

4. To agree in principle the resource allocation set out in section 25 and governance arrangements set out in section 16, subject to approval by the City of Edinburgh Council Finance and Resources Committee to enter into agreements with providers as set out in section 15.

Background

5. In August 2016 the EIJB agreed to implement a Public Social Partnership for Mental Health and Wellbeing Services. The PSP would build on good practice and established relationships to co-produce, test and develop innovative approaches for service delivery to improve collaboration and maximise locality resources.

.

6. There are an estimated 120,000 people in Edinburgh who experience either common or complex mental health issues, which equates to over 25% of the population. Mental Health and Wellbeing services (MHWs) enable people to feel safe, well and included in their chosen community through meaningful activity, and help people recover and live as well as they can.

Social Prescribing Improving access and supporting people to get help and support as early as possible Information and Advice Peer workers Link workers Community facilitators	**Meaningful activities** Supporting people to access activities, interests, education, which are meaningful to them Volunteering Employment Arts Ecotherapy	**Support** Specific supports and treatment for people experiencing mental ill health Psychological support including counselling Support in Crisis Supporting early discharge and providing an alternative to admission
Delivered in places where people feel safe and secure		

7. The PSP process has required a significant time commitment from all stakeholders. It may be that lessons learned will result in a future streamlined approach. Nevertheless it should be noted that the PSP has brought together people with lived experience; carers; and staff from a wide range of third sector agencies and statutory services to promote a spirit of collaboration and cooperation to focus on how best to use our resources to improve outcomes for people's mental health and wellbeing.

8. The PSP has been built on a set of core values which are:

- equality of partners;
- mutual respect and trust;
- open and transparent communications;
- co-operation and Consultation;
- a commitment to being positive and constructive;
- a willingness to work with and learn from others; and
- a shared commitment to providing excellent services to the community.

Main report

9. In August 2016 the EIJB recognised significant opportunities to adopt a different approach to planning and commissioning services in line with the principles of the Christie Commission. The Scottish Government support the Public Social Partnership (PSP) approach.

10. Supported by the City of Edinburgh Council Procurement team the formal PSP process began in December 2016. Potential partners were asked to submit applications to become PSP "interested partners". Forty-three organisations submitted interested partner forms.

11. An Implementation Monitoring and Evaluation Group (IMEG) comprising representation from carers, service users, EVOC, Health and Social Care Strategic Planning and NHS Lothian Strategic Planning was set up to oversee the development of the PSP. The group has met regularly to oversee the process since October 2016.

12. Between January and March 2017 a series of ten co-production events - *Talk, Share, Plan, Repeat'* - took place. The aim of the dialogue events was to enable interested partners to explore, discover, and design what services and supports were required to meet the mental health and wellbeing needs and aspirations of people living in Edinburgh.

13. The events were facilitated by Animate Consultancy and reports were circulated following each event.

14. The Edinburgh Strategic Joint Needs Assessment was used to establish some baselines of need in each locality. Added to this were the stakeholder reports from the dialogue events. Although Edinburgh services have not been planned on a locality basis, some potential to

identify key local delivery partners was evolving as part of the PSP process. These factors resulted in a proposed financial allocation. Initial draft Memoranda of Understanding (MoUs) were drawn up detailing proposed delivery partners, key deliverables and financial allocations.

15. The draft MoUs have been further refined in response to consultation. On 28 June 2017, all delivery partners and stakeholders were invited to attend a further dialogue session to enable additional inputs to the draft version 3 of the MoUs. Additional funding has been secured from Scottish Government to support the PSP as we move into the pre-implementation stage from August to October 2017.

16. The aim of the four **Locality Mental Health and Wellbeing Partnerships** is to use the assets of the locality to provide a range of meaningful activities and psychosocial and psychological support for people who are experiencing or have experienced mental health problems. This will be facilitated through creating safe, secure and psychologically informed environments with open access contact points for people seeking help, support, advice and signposting. The Partnerships will comprise of third sector key delivery partners, statutory services, and service users to build on current good practice, develop new relationships, and further innovate within their communities to deliver integrated services and support based on the needs and aspiration of localities. The Tests of Concepts will formally commence on 1 November 2017 for a period of two years. Each of the locality partnerships and the pivot partnerships will be overseen by a Monitoring and Evaluation Group. These Monitoring and Evaluation Groups will report to the Edinburgh Mental Health and Wellbeing Partnership.

17. The aim of the **Edinburgh Networked Crisis Support Partnership** is to provide round the clock support for people in crisis including residential provision. There will be opportunities for partners to be trained in evidence based brief interventions for people experiencing distress.

18. The aim of the **Peer Collaborative Partnership** is to deliver peer support by paid peer workers and volunteer across the four localities and to create a “peer collaborative” which provides opportunities for reflective practice, peer supervision, training, and supporting peer volunteering, peer learning development, good practice standards and career progression.

19. The aim of the **Active and Green Spaces Wellbeing Partnership** is to use the physical assets of each locality (including leisure centres, schools, colleges, universities, public sector buildings, gardens, wooded areas, parks and back greens) to provide a range of meaningful activities to promote improved physical and mental health. This will include activities around exercise, gardening and food.

20. The aim of the **Mind Spaces Partnership** is to provide psychological and psychosocial support for people experiencing distress. This will include low intensity psychological therapies – for example Cognitive Behavioural Therapy, Interpersonal Therapy delivered in different formats including online, individual and group.

21. People in Edinburgh requiring support and care may prefer to access support out with the locality in which they reside. This important issue of citizen choice has been factored into the Partnerships. This was highlighted as a key point within the Integrated Impact Assessment.

Key risks

22. Contracts and service level agreements for current service providers are in place until 31 October 2017. If the PSP recommendations are not supported, then there is a risk that services will cease without there being service in place from 1 November 2017.

23. To ensure the Edinburgh Wellbeing PSP meets its legal duties in considering equality, human rights, sustainability and the environment in planning decisions and to create an opportunity to identify and tackle unanticipated impacts on wider causes of poor outcomes in our communities, an Inequality Impact Assessment was considered in April 2017. This identified a number of key issues for consideration by the Partnerships. Follow-up sessions to ensure that the issues are addressed by the Partnerships will commence in August 2017.

Financial implications

24. Required efficiency savings were achieved in 2016-17 and the total agreed resource for the PSP was set at £2,117,506 .

25. The proposed financial allocations for the two-year test of period are set out below:

North East	
Support in Mind	164,000
NEECS	81,000
Link Up	60,000
Seasons	36,000
	341,000
North West	
Living Well	121,000
Pilton Community Health	53,000
Health in Mind	145,000
	319,000

South East	
Contact Point	151,000
Health in Mind	145,000
Alma	5,000
	301,000
South West	
SAMH	174,000
Health in Mind	105,000
The Cryenians	25,000
Broomhouse	5,000
	309,000
Crisis Support Partnership	
Penumbra	**400,000**
Active and Green Spaces	
Cyrenians	10,000
ELGS	10,000
Edinburgh Leisure	80,000
	100,000
Mind Spaces Partnership	
Penumbra - Self Harm	90,000
Health in Mind	60,000
	150,000
Peer Support Collaborative	
Penumbra - Plan 2 Change	145,000
Health in Mind	25,000
The Cyrenians	5,000
Carr Gomm	5,000
SAMH	5,000
Thistle Foundation	5,000
Places for People	5,000
	195,000

26. It is important to highlight that a significant number of the proposed service providers either own or lease assets to deliver services from, and there is clear added value using this approach. Most of the providers currently receive additional income streams from a wider range of funding sources to enhance the quality, choice and delivery of services.

27. In summary, 18 third sector providers are recommended to receive funding for a 24 month period as part of the Edinburgh Wellbeing PSP.

28. Eighteen months (March 2019) into the Test of Concepts delivery period, a recommendation regarding procurement process will be made by the governing group: the Edinburgh Mental Health and Wellbeing Partnership, to the EIJB Strategic Planning Group.

Involving people

29. The PSP has an ongoing commitment to ensuring that people with lived experience have a voice and are involved in coproduction and the decision making process. This is further supported and strengthened by the volunteer representative supported by Advocard and Edinburgh Carers Council representatives on the Implementation, Monitoring, and Evaluation Group.

Impact on plans of other parties

30. The PSP has links to the following other workstreams:

- Edinburgh Strategic Plan
- Lothian Joint Mental Health and Wellbeing Programme
- Royal Edinburgh Hospital Campus Development
- Edinburgh Community Planning Partnership Groups
- Community Link Workers
- Rivers PSP
- Gamechanger PSP

Background reading/references

The Christie Commission Report (2011) Commission on the Future Delivery of Public Services

Animate Edinburgh Wellbeing PSSP Dialogue reports (January to March 2017)

Edinburgh Wellbeing Services Report to EIJB 19 August 2017

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Links to priorities in strategic plan

Tackling inequalities by working with our partners to address the root causes, as well as supporting those groups whose health is at greatest risk from, current levels of inequality: reduce, and not exacerbate, health inequality

Preventing poor health and wellbeing outcomes by supporting and encouraging people to achieve their full potential, stay resilient and take more responsibility for their own health and wellbeing; making choices that increase their chances of staying healthy for as long as possible and where they do experience ill health, promoting recovery and self-management approaches.

Practicing person centred care by placing 'good conversations' at the centre of our engagement with citizens so that they are actively involved in decisions about how their health and social care needs should be addressed.

Developing and making best use of the capacity available within the city by working collaboratively with individual citizens, including unpaid carers, communities, the statutory sector, third and independent sectors and housing organisations

Making the best use of our shared resources (e.g. people, buildings, technology, information and procurement approaches) to deliver high quality services.

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

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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

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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

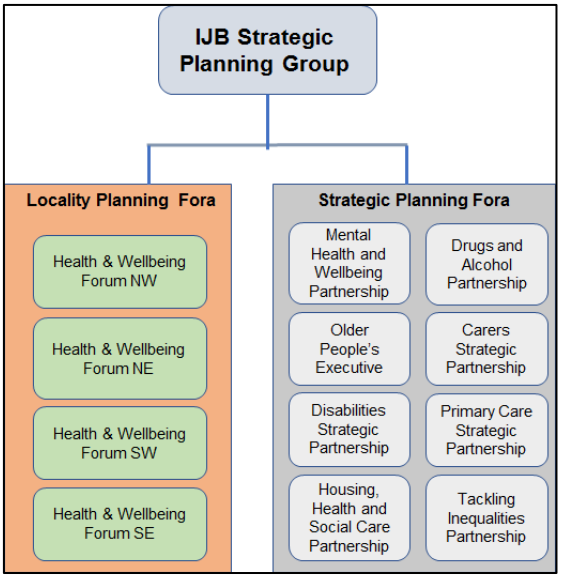
In March 2016, the IJB published its strategic plan setting out the strategic direction for health and social care services in Edinburgh from 2016 to 2019. The plan included our vision of 'People and organisations working together for a caring, healthier, safer Edinburgh'. To help us deliver this vision 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:

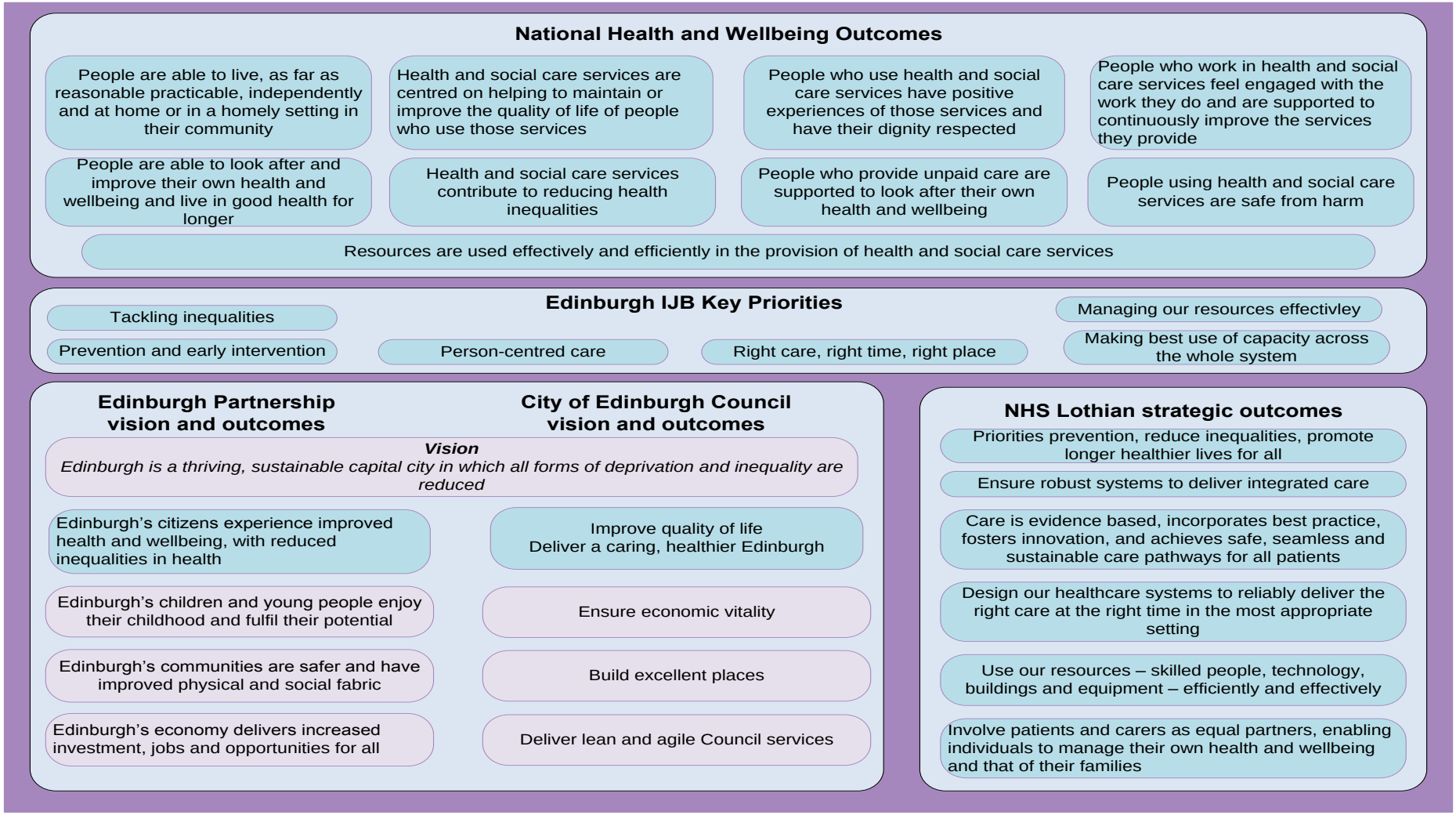
- achieving integration at a locality level
- tackling inequalities
- consolidating our approach to prevention an early intervention
- ensuring a sustainable model of primary care
- improving care and support for frail older people and those with dementia
- redesigning Mental Health and Substance Misuse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

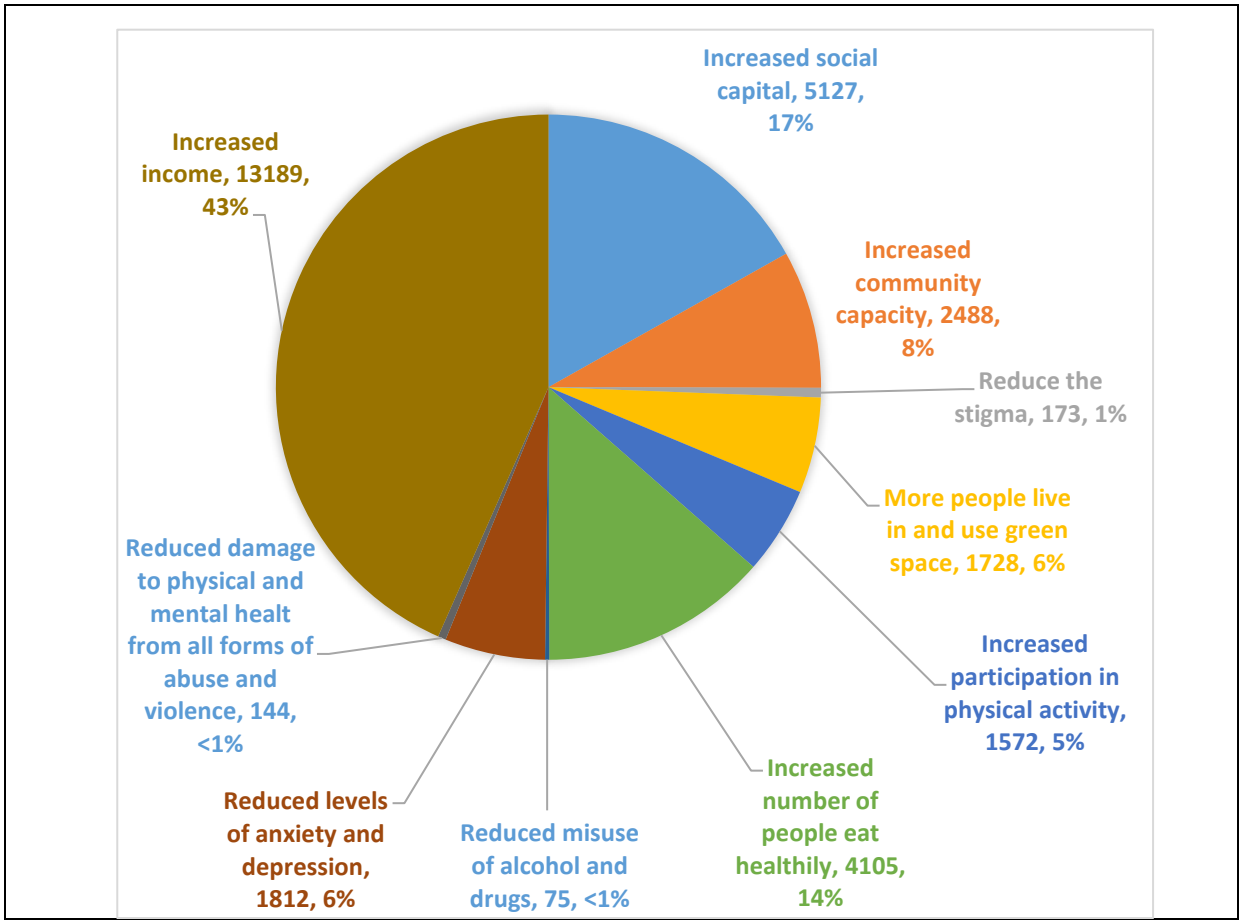
Core indicators

- 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

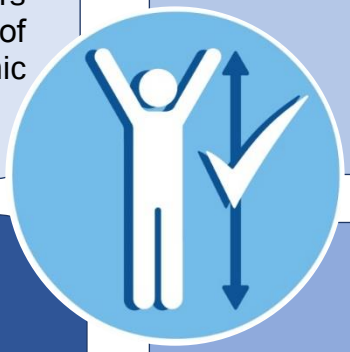
Headroom aims to improve outcomes for people in areas of the city with concentrated economic hardship. At the heart of Headroom is the relationship between the patient and the health professional and the opportunities this creates to deliver patient centred care.

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.

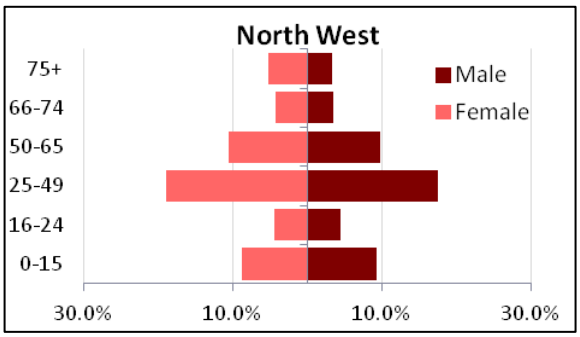
The overnight sleepover cost per customer has been estimated at £78. For ten customers at end of March 2017, the projected savings from May 2016 to March 2017 from using CleverCogs rather than having a sleepover in place was £87,048. There has also been a saving in avoiding hospital admissions.

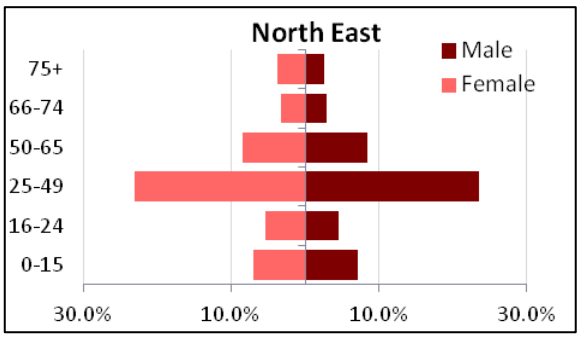
Locality working

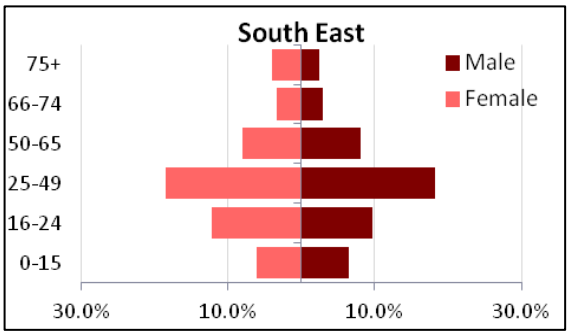
The population of Edinburgh is almost half a million people, accounting for 9% of the total population of Scotland and is predicted to grow faster than any other area of Scotland.

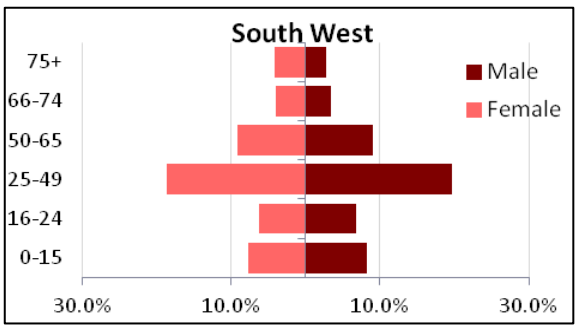
We have worked with the other members of the Edinburgh Community Planning Partnership to establish four geographic localities using neighbourhood partnership boundaries as the basis for service planning and delivery in the city. Whilst the city is often perceived as affluent each locality contains both 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







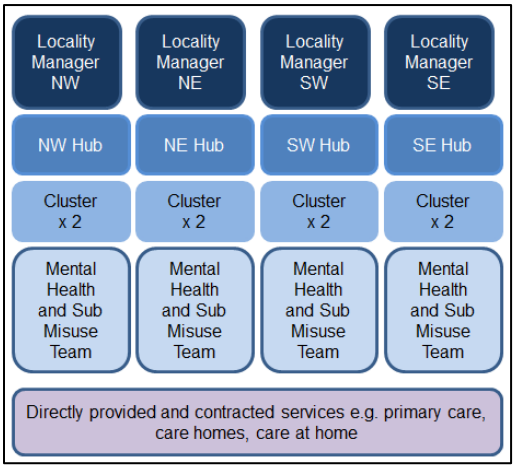


Our main priority in 2016/17 has been to implement our new locality structure to support the planning and delivery of services within the four localities. Each of the four Locality Managers oversees four integrated teams made up of nurses, social workers and allied health professionals (therapists):

- 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

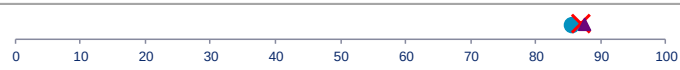
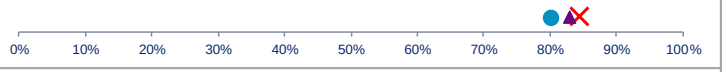
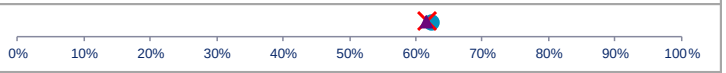
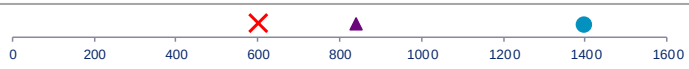
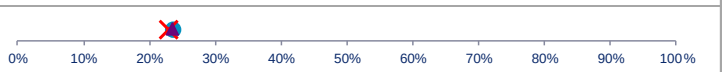
- Low levels of adults who feel supported to live as independently as possible (82% - ranking 25th), who agree they have a say in how their services are arranged (76% - ranking 28th) and agreeing that their health and social care service seems well coordinated (77% ranking 29th)
- Quality of care: 19th 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

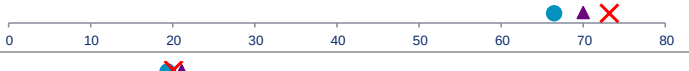
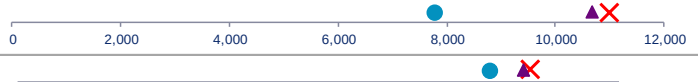
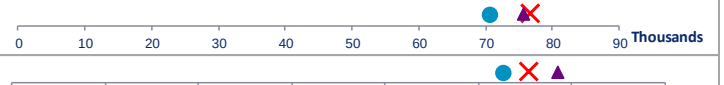
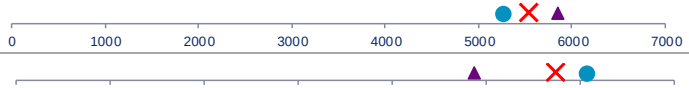
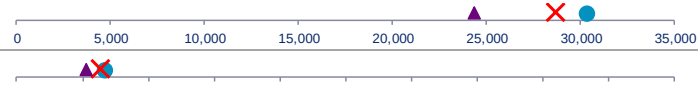
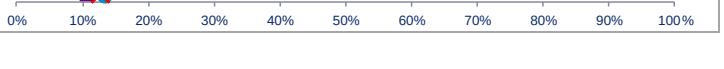
Annual Perfomance Report Appendix 1

National Indicators

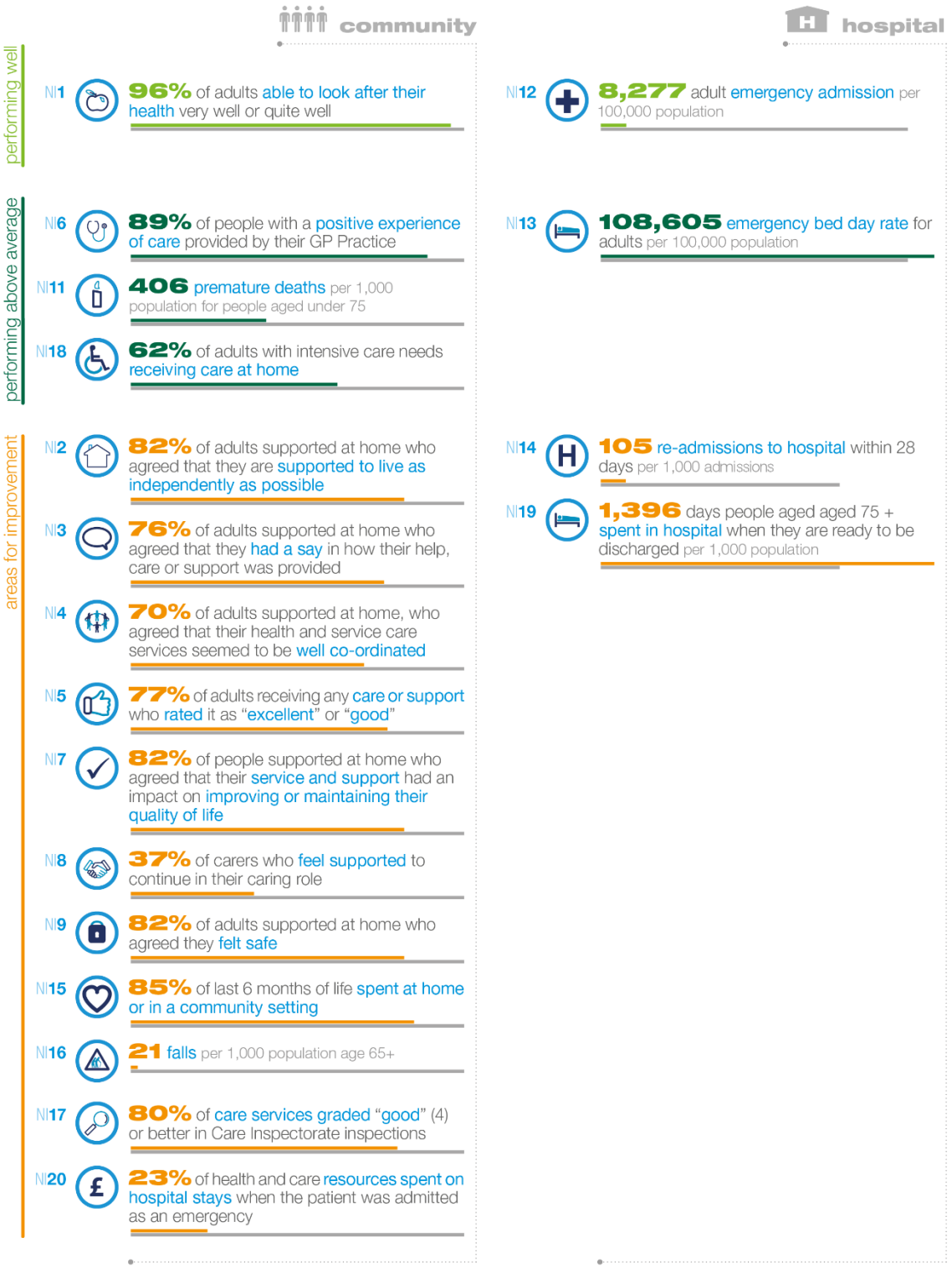
The scatter plots to the right of the table illustrate where Edinburgh City (the blue dot) lies in relation to both the Peer Group (red cross) average and the Scotland (purple triangle) values.

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

Appendix A

Delivering Health and Social Care in Edinburgh

Edinburgh IJB Annual Performance Report 2016/17

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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

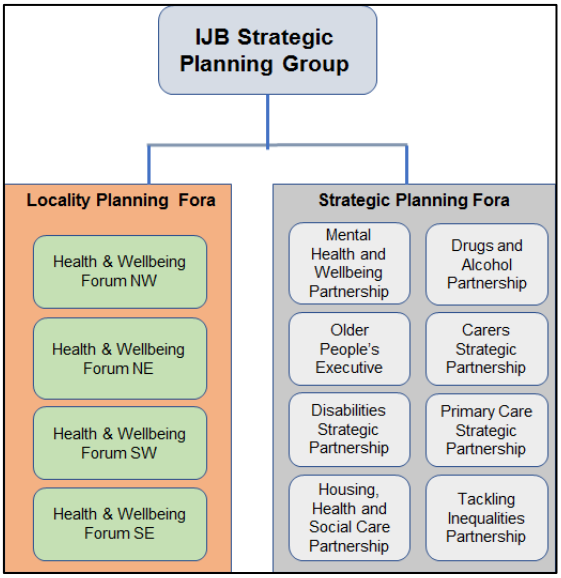
In March 2016, the IJB published its strategic plan setting out the strategic direction for health and social care services in Edinburgh from 2016 to 2019. The plan included our vision of 'People and organisations working together for a caring, healthier, safer Edinburgh'. To help us deliver this vision 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:

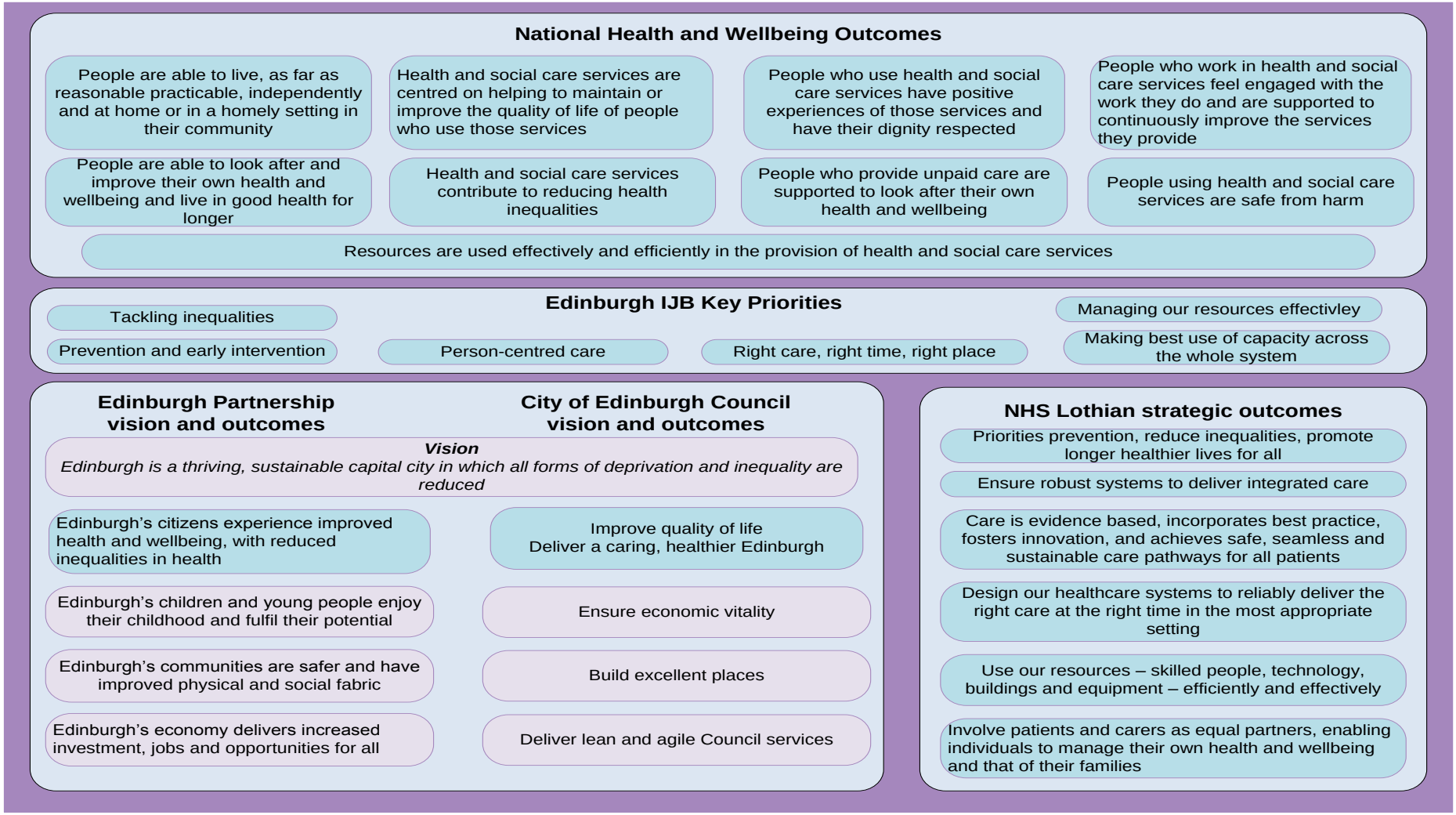
- achieving integration at a locality level
- tackling inequalities
- consolidating our approach to prevention an early intervention
- ensuring a sustainable model of primary care
- improving care and support for frail older people and those with dementia
- redesigning Mental Health and Substance Misuse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

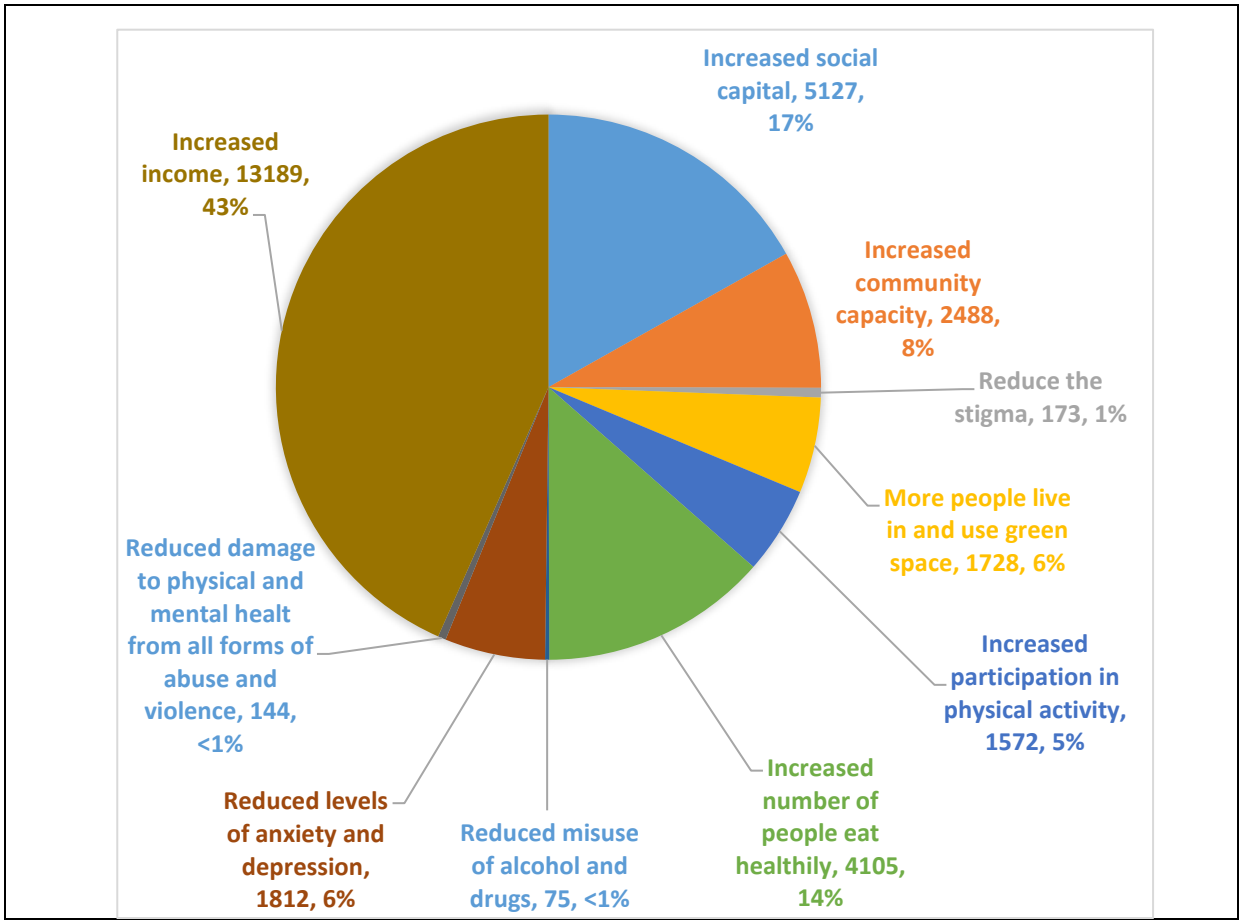
Core indicators

- 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

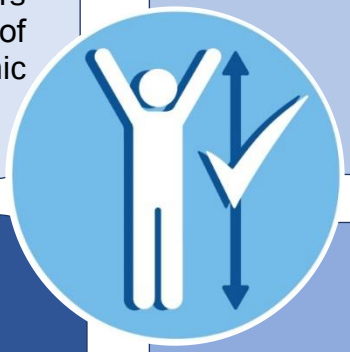
Headroom aims to improve outcomes for people in areas of the city with concentrated economic hardship. At the heart of Headroom is the relationship between the patient and the health professional and the opportunities this creates to deliver patient centred care.

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.

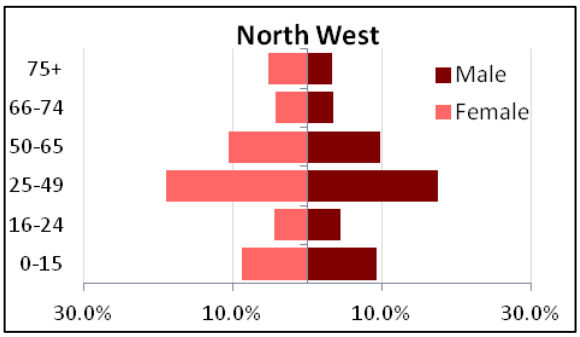
The overnight sleepover cost per customer has been estimated at £78. For ten customers at end of March 2017, the projected savings from May 2016 to March 2017 from using CleverCogs rather than having a sleepover in place was £87,048. There has also been a saving in avoiding hospital admissions.

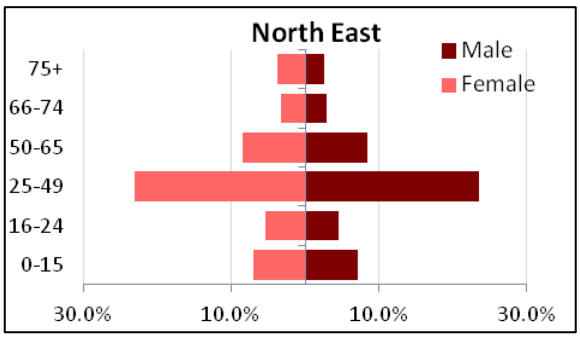
Locality working

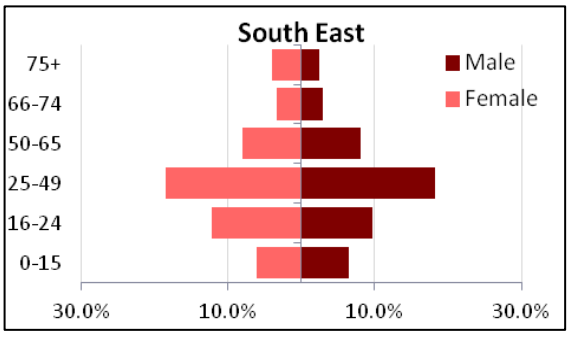
The population of Edinburgh is almost half a million people, accounting for 9% of the total population of Scotland and is predicted to grow faster than any other area of Scotland.

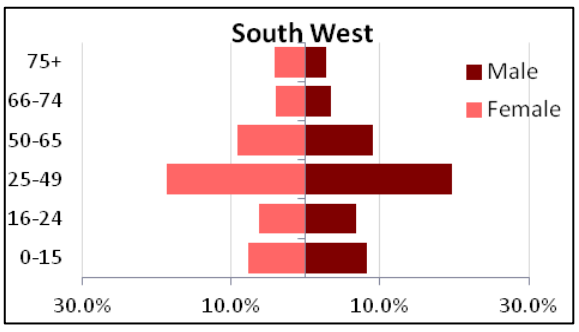
We have worked with the other members of the Edinburgh Community Planning Partnership to establish four geographic localities using neighbourhood partnership boundaries as the basis for service planning and delivery in the city. Whilst the city is often perceived as affluent each locality contains both 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







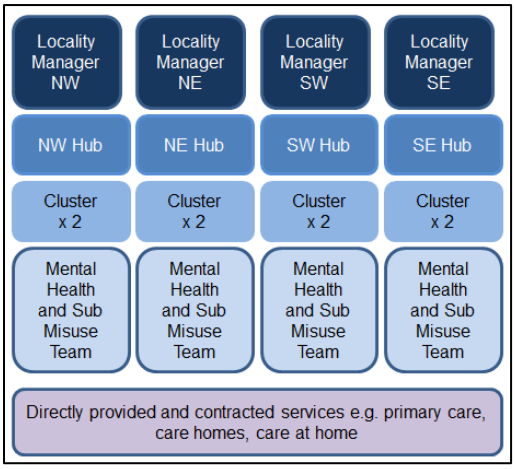


Our main priority in 2016/17 has been to implement our new locality structure to support the planning and delivery of services within the four localities. Each of the four Locality Managers oversees four integrated teams made up of nurses, social workers and allied health professionals (therapists):

- 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)

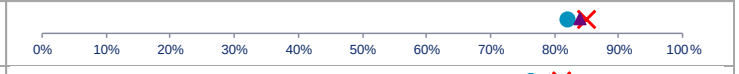
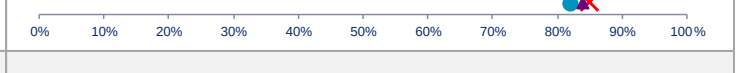
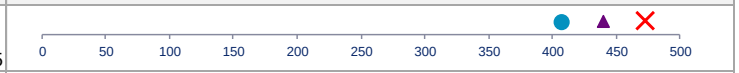
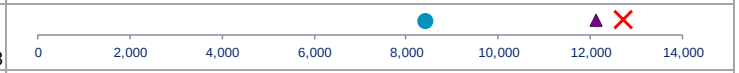
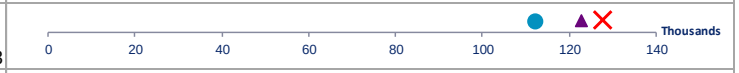
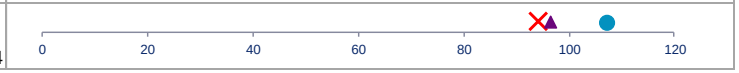
[1] The Scottish Health and Care Experience Survey is a postal survey which is sent to a random sample of patients who were registered with a GP in Scotland

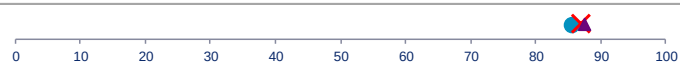
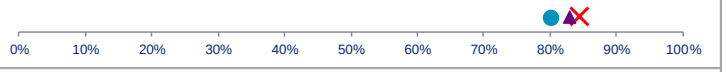
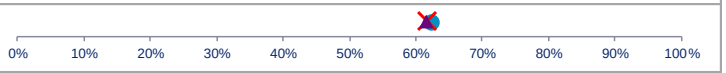
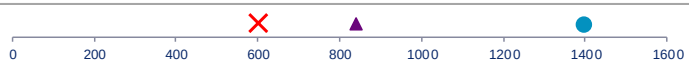
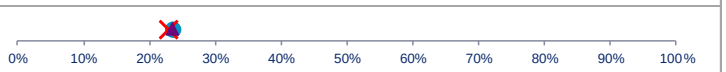
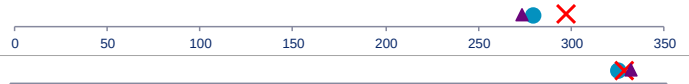
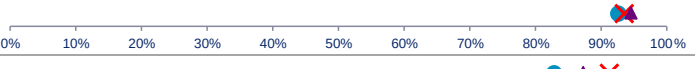
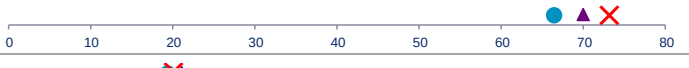
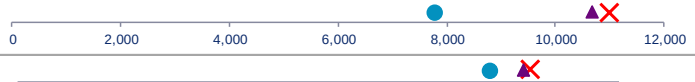
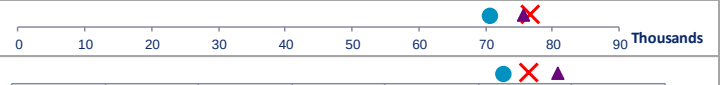
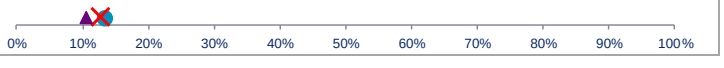
- Low levels of adults who feel supported to live as independently as possible (82% - ranking 25th), who agree they have a say in how their services are arranged (76% - ranking 28th) and agreeing that their health and social care service seems well coordinated (77% ranking 29th)
- Quality of care: 19th 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

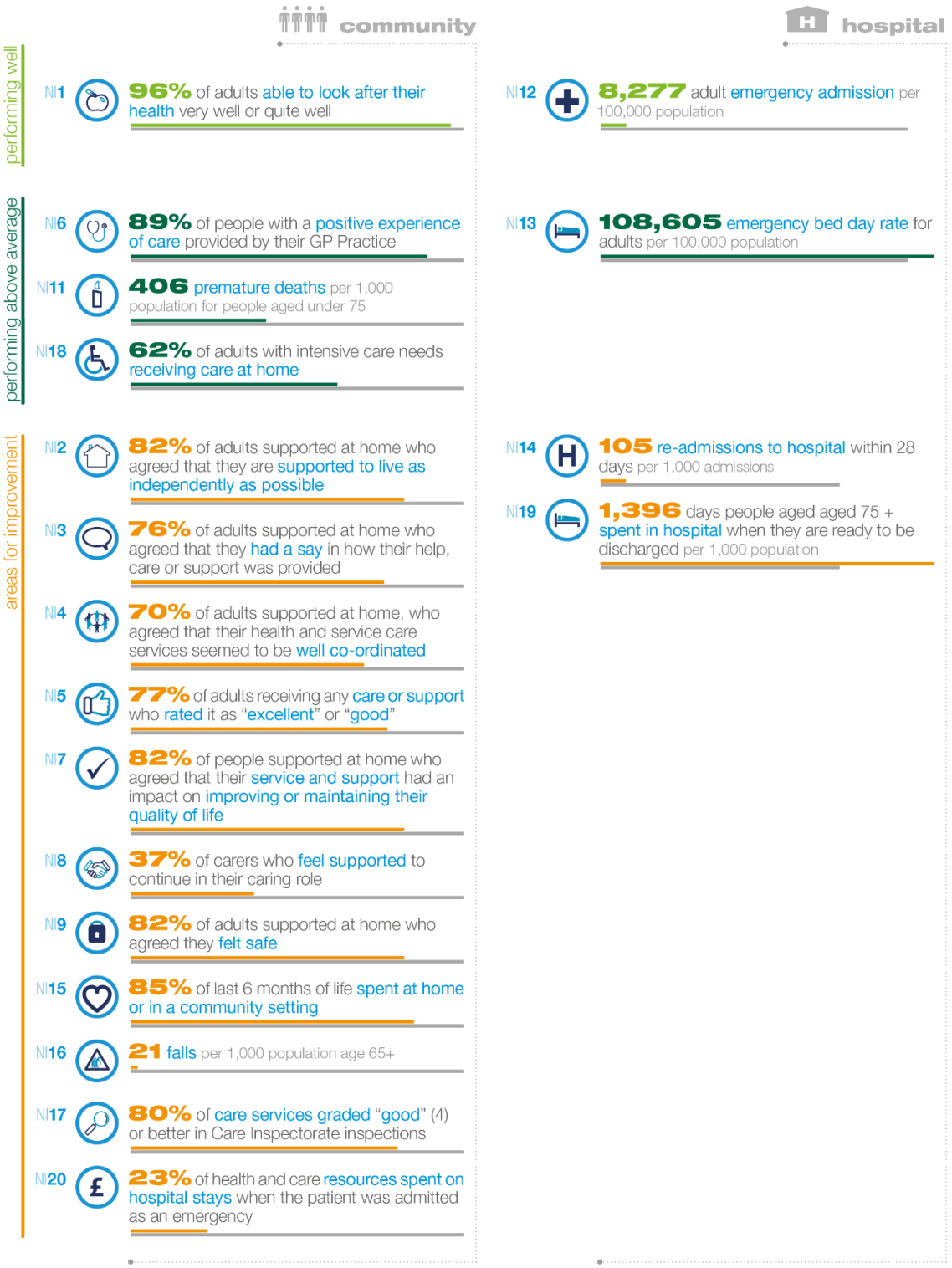
National Indicators

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

Item 5.8

Report

Council 29 June 2017 – Health and Social Care Reports Edinburgh Integration Joint Board

Executive Summary

1. The City of Edinburgh Council on 29 June 2017 considered the following reports by the Chief Officer of the IJB:

   1.1. Independent Advocacy Services

   1.2. Framework Agreement for Day Support Services for Adults with Learning Disabilities.

2. These reports are submitted to the Joint Board for information.

Recommendations

3. The Joint Board is asked to note the reports and the decision by the City of Edinburgh Council to approve the recommendations as submitted.

Main report

4. The City of Edinburgh Council considered the report Independent Advocacy Services on 29 July 2017. It was agreed:

   4.1. To approve the award of contacts to AdvoCard and to Partners in Advocacy for the provision of Independent Advocacy services from 1 July 2017 for three years, with annual options to extend for a maximum of two further years. Total estimated contact value, including possible extensions, was £3,900,000.

5. The City of Edinburgh Council also considered the report Framework Agreement for Day Support Services for Adults with Learning Disabilities. It was agreed:

   5.1. To approve the establishment of a Framework Agreement for Day Support Services for Adults with Learning Disabilities for three years, commencing 2 October 2017 to 1 October 2020, with an option to extend for up to a further 12 months.

   5.2. To approve the award of the following twenty providers onto that Framework Agreement:

Active Healthcare Services
Autism Initiatives
Capability Scotland
Carr Gomm
Clayton Care Limited
Columcille Ltd
Community Integrated Care
CrossReach
ENABLE Scotland
Garvald Edinburgh
Inclusion Alliance
Leonard Cheshire Disability
Places for People Scotland Care & Support
Scottish Autism
The Action Group
The Redwoods Caring Foundation
The Richmond Fellowship Scotland Limited
Tiphereth Ltd
Upward Mobility Ltd
Visualise Scotland

Key risks

6. See attached reports.

Financial implications

7. See attached reports.

Involving people

8. See attached reports.

Impact on plans of other parties

9. See attached reports.

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Appendices

Appendix A	Independent Advocacy Services – report by the Chief Officer of the IJB
Appendix B	Framework Agreement for Day Support Services for Adults with Learning Disabilities - report by the Chief Officer of the IJB

Appendix A

The City of Edinburgh Council

10.00am, Thursday, 29 June 2017

Independent Advocacy Services

Contract Ref: CT 0173

Item number
Report number
Executive/routine
Wards

Executive Summary

This report seeks Council's approval to award contracts for the provision of Independent Advocacy Services to AdvoCard and to Partners in Advocacy from 1 July 2017 for a period of three years, with annual options to extend for a maximum of two further years.

These two contracts will replace similar contracts which end on 30 June 2017.

The total estimated value of the contracts, including extensions, is £3,900,000.

Links

Coalition Pledges
Council Priorities
Single Outcome Agreement

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Report

Independent Advocacy Services

1. Recommendations

1.1 It is recommended Council approves the award of contracts to AdvoCard and to Partners in Advocacy for the provision of Independent Advocacy Services from 1 July 2017 for three years, with annual options to extend for a maximum of two further years. Total estimated contract value, including possible extensions, is £3,900,000.

2. Background

2.1 There is a statutory requirement for the Edinburgh Health and Social Care Partnership (EHSCP) to make provision for independent advocacy services for people in receipt of health or social care services. The Scottish Independent Advocacy Alliance (SIAA) principles and standards define an independent advocacy organisation as "an advocacy organisation that is structurally, financially and psychologically separate from service providers and other services".

2.2 The Scottish Government has issued guidance to ensure that advocacy is sufficiently independent to avoid compromise.

2.3 The Council currently has contracts in place with Partners in Advocacy (two contracts) and AdvoCard (one contract) for provision of independent advocacy in respect of:

2.3.1 Older people and people with physical disabilities (Partners in Advocacy)

2.3.2 People with learning disabilities (Partners in Advocacy)

2.3.3 People with mental health support needs and carers of people with mental health support needs and / or learning disabilities (AdvoCard)

3. Main report

3.1 A Future Contract Opportunity (FCO) notice was published on the Public Contracts Scotland website on 7 March 2016 and 17 organisations registered interest.

3.2 The initial procurement plan was to undertake co-production followed by an appropriate procurement process with award of contracts in September 2016 and a contract start date of 1 December 2016.

3.3 On 8 September 2016 the Finance and Resources Committee approved the extension of current contracts to 30 June 2017 to allow additional time for consultation and co-production with service users as detailed in section 9 of this report.

3.4 Based on feedback from current and potential service providers, the Advocacy Project Board agreed that the procurement should be a 'Competitive Procedure with Negotiation', which satisfied the provider preference for an opportunity to make presentations to the evaluation panel and allow for face-to-face negotiation as necessary.

3.5 The requirement was split into two "lots", namely Independent Advocacy for People with Mental Health Support Needs and Unpaid Carers (Lot 1) and Independent Advocacy for People with Learning Disabilities, Adults with Autistic Spectrum Condition, Older People and Adults with Physical Disabilities (Lot 2).

3.6 On 5 November 2016, a Contract Notice was published on the Public Contracts Scotland (PCS) website, together with related documents, including a final draft service specification. Three formal Requests to Participate (RTPs) were received by the deadline of 5 December 2016.

3.7 On 8 December 2016, an Invitation to Tender (ITT) was published, together with related documents, including the service specification. Two tenders were received by the deadline of 20 January 2017; one for each of the two Lots.

3.8 Following evaluation, the tender submitted by AdvoCard for Lot 1 scored 86.88% and the tender submitted by Partners in Advocacy for Lot 2 scored 70.69%.

4. Measures of success

4.1 A new service specification was developed through the procurement process, which meets the needs of people who use independent advocacy services in Edinburgh.

5. Financial impact

5.1 The total cost of Independent Advocacy Services in 2016/17 was jointly funded by City of Edinburgh Council and NHS Lothian (NHSL) and was £836,000. Following agreement with NHSL to reserve part of its contribution for specialist advocacy provision at the Royal Edinburgh Hospital for people from East, Mid and West Lothian, the jointly funded 2017/18 budget for Edinburgh based service users is £783,446.

5.2 The estimated contract value for Lot 1 is £530,000 per annum, which provides 20,010 hours of service per annum.

5.3 The estimated contract value for Lot 2 is £250,000 per annum, which provides 10,000 hours of service per annum.

5.4 The overall estimated value of both contracts is £780,000 per annum, which is within the allocated budget of £783,446.

5.5 The costs associated with procuring these contracts are estimated at between £10,001 and £20,000.

6. Risk, policy, compliance and governance impact

6.1 There are no risk, policy, compliance or governance impacts arising from this report.

7. Equalities impact

7.1 There are positive equality impacts arising from this report as it facilitates access by vulnerable people to independent advocacy services. An Integrated Impact Assessment (IIA) has been undertaken.

8. Sustainability impact

8.1 The sustainability risk has been assessed as low and no mitigating actions are required. There are no impacts on carbon, adaptation to climate change and sustainable development arising directly from this report.

8.2 The successful tenderers have offered community benefits in support of volunteers and service users, including free training and representation in governance and management arrangements, as well as placement opportunities for social workers

9. Consultation and engagement

9.1 A Future Contract Opportunity (FCO) notice was published on the Public Contracts Scotland website on 7 March 2016 and seventeen organisations registered interest.

9.2 Consultation was conducted from 15 August to 22 September 2016 and involved using a targeted approach to seek the views of current service users and unpaid carers. Current providers were also consulted to discuss their perspectives. In addition, a brief questionnaire was issued to mental health officers, NHS community mental health teams and social work practice teams to seek their feedback.

9.3 The total number of service users and carers who responded to the consultation was 133. The total number of staff involved in the consultation was 69.

9.4 In total there were 13 consultation events held during the period of the consultation. Out of the total, nine were facilitated by Council and NHS officers and four were facilitated by staff of the current providers of independent advocacy.

9.5 There were also 63 individual responses to the consultation questions from service users and carers.

9.6 The draft service specification was continuously developed throughout the period of consultation and coproduction to take account of input from the wide range of stakeholders.

10. Background reading/external references

10.1 Scottish Independent Advocacy Alliance website http://www.siaa.org.uk

Rob McCulloch-Graham

Chief Officer, Edinburgh Health and Social Care Partnership

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11. Links

Coalition Pledges	P30 – Continue to maintain a sound financial position including long-term financial planning
Council Priorities	CP2 – improved health and wellbeing: reduced inequalities
	CP3 – Right care, right place, right time
	CP4 – Safe and empowered communities
Single Outcome Agreement	SO2 – Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health
Appendices	Appendix 1 – Summary of Tendering and Tender Evaluation Processes

Appendix 1

Summary of Tendering and Tender Evaluation Processes

Contract	Independent Advocacy Services Contract Ref: CT 0173
Contract period (including any extensions)	1 July 2017 to 30 June 2022
Estimated contract value	Lot 1 £2,650,000 (including extensions) Lot 2 £1,250,000 (including extensions)
Standing Orders observed	2.5 EU Principles have been applied 2.13 Commercial and Procurement Services provided resource to undertake tendering 3.2 Director has responsibility for all contracts tendered and led by their Directorate 5.1 Tenders evaluated on basis of most economically advantageous tender
Portal used to advertise	Public Contracts Scotland
EU Procedure chosen	Competitive Procedure with Negotiation
Tenders returned	2
Tenders fully compliant	2
Recommended suppliers	Lot 1 Advocard Lot 2 Partners in Advocacy
Primary criterion	Most economically advantageous tender to have met the qualitative and technical specification of the client department
Evaluation criteria and weightings and reasons for this approach	Quality 70% Price 30% Quality was considered more important than price in the context of the service.
Evaluation Team	Council officers from Health & Social Care and a representative of NHS Lothian with relevant experience
Consideration of procurement methodology and processes to ensure SME friendly	Future Contract Opportunity (FCO) notice was published on the Public Contracts Scotland website on 7 March 2016. Extended consultation with all key stakeholders. Logging of requirements.

Appendix B

The City of Edinburgh Council

10am, Thursday, 29 June 2017

Framework Agreement for Day Support Services for Adults with Learning Disabilities

Contract Ref: CT 0171

Item number	
Report number	
Executive/routine	
Wards	

Executive Summary

This report seeks the approval of Council to establish a Framework Agreement for Day Support Services for adults with learning disabilities, and to award twenty providers onto the Framework Agreement.

The term of the Framework Agreement will be three years, commencing 2 October 2017 to 1 October 2020, with an option to extend for up to a further 12 months. The total estimated value of contracts that may be awarded under the Framework Agreement, including extensions, is £28,000,000.

Links

Coalition Pledges	P43
Council Priorities	CP2, CP3
Single Outcome Agreement	SO2

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Report

Framework Agreement for Day Support Services for Adults with Learning Disabilities

Contract Ref: CT 0171

1. Recommendations

1.1 It is recommended Council approves the establishment of a Framework Agreement for Day Support services for Adults with Learning Disabilities for three years, commencing 2 October 2017 to 1 October 2020, with an option to extend for up to a further 12 months; and

1.2 approves award of the following twenty providers onto that Framework Agreement:

Active Healthcare Services
Autism Initiatives
Capability Scotland
Carr Gomm
Clayton Care Limited
Columcille Ltd
Community Integrated Care
CrossReach
ENABLE Scotland
Garvald Edinburgh
Inclusion Alliance
Leonard Cheshire Disability
Places for People Scotland Care & Support
Scottish Autism
The Action Group
The Redwoods Caring Foundation
The Richmond Fellowship Scotland Limited
Tiphereth Ltd
Upward Mobility Ltd
Visualise Scotland

2. Background

2.1 The Edinburgh Health and Social Care Partnership spends approximately £6,800,000 per annum on externally provided day support services for adults with learning disabilities.

2.2 Half of this amount is spent on services that support people from a day centre, and half is spent on community based support. Some support is on a shared basis, i.e.

provided to a group of service users and some is provided on a one to one basis. A total of 500 service users receive these externally provided services at an average cost of £13,600 per service user, per annum.

2.3 Establishing a Framework Agreement for procurement of these services will reduce the administrative burden on both the Council and providers. This will be done by:

(a) simplifying the procurement procedure by reducing or avoiding multiple, repetitive submission of tender documents

(b) introducing a single service specification for all day service models which reflects current national 'best practice' guidance and the outcome of local co-production activity;

(c) using standard Framework Agreement Terms and Conditions.

3. Main report

3.1 The aim of the service is to provide high quality care and support for adults with learning disabilities under Self Directed Support Option 3, where the Council arranges a service on behalf of an individual. The Council intends that an additional outcome of the procurement project will be to establish guide prices that can be used for budgeting for Direct Payments and Individual Service Funds under Options 1 and 2 of Self Directed Support.

3.2 Published in 2013, '*Keys to Life'* sets out the Scottish Government's ten year strategy for improving the quality of life for people with learning disabilities, who form the majority of day service users in Edinburgh. Many aspects of the strategy are also relevant to the lives of people with physical and other disabilities, a number of whom also use day services. '*Keys to Life'* identifies four overarching outcomes for day support services which they should strive to help people achieve:

(a) A Healthy Life: people with disabilities enjoy the highest attainable standard of living, health and family life;

(b) Choice and Control: people with disabilities are treated with dignity and respect and protected from neglect, exploitation and abuse;

(c) Independence: people with disabilities are able to live independently in the community with equal access to all aspects of society; and

(d) Active Citizenship: people with disabilities are able to participate in all aspects of community and society.

3.3 In terms of EU procurement regulations, these services fall under the 'light touch' regime. Although the 'light touch' regime is not subject to the full rigours of EU procurement regulations, there is a requirement for openness, transparency and fair and equal treatment, as well as a requirement to comply with the Public Contracts (Scotland) Regulations 2015, the 2016 Regulations, the Procurement of Care and Support Services 2016 (Best Practice), and the Council's Contract Standing Orders.

3.4 In support of the strategic aims of *'Keys to Life'* and acting on behalf of the Edinburgh Health and Social Care Partnership Integration Joint Board (IJB), the Council published a Prior Information Notice (PIN) on the Public Contracts Scotland (PCS) website on 7 December 2015 and 32 organisations expressed interest.

3.5 An extensive co-production exercise followed, which included consultation with service users and their carers and engagement with third sector day support providers in order to inform the development of a new single Service Specification. Further detail can be found under Section 9 of this report.

3.6 The Council published a Contract Notice on the Public Contracts Scotland (PCS) website on 12 January 2017 and an Invitation to Tender (ITT) was published on the Public Contracts Scotland-Tender (PCS-T) website the same day. A total of 33 organisations registered interest.

3.7 Twenty organisations submitted tenders by the deadline of 14 February 2017.

3.8 Tenders were evaluated on the basis of the most economically advantageous tender (MEAT), with a weighting of 70% for quality and 30% for price. This weighting was agreed by a project team of representatives from Health and Social Care, based on a shared understanding that quality is of greater importance than price for this type of service. A summary of the tender process is provided at Appendix 1 of this report.

3.9 Evaluation of the commercial (price) content of the bids was undertaken by the Council's Commercial and Procurement Services (CPS), based on the offer price per service user per hour for Building Based Services (Lot 1) and Community Based Services (Lot 2). Detail about combined Technical (Quality) and Commercial (Price) scores for each Lot is provided at Appendix 2 of this report.

3.10 Taking account of service user needs and wishes, accessibility and availability of services, the Council will award contracts to the highest ranked provider (as established at the point of the framework agreement award). If the provider declines the business, the next highest scoring provider will be awarded the business and so on.

4. Measures of success

4.1 There is an established single Service Specification for all day support services for adults with learning disabilities, which reflects current national 'best practice' guidance and the outcome of local co-production activity, together with standard Terms and Conditions.

4.2 There is an established list of prices for these services and future payments will only be made for periods of actual service delivery.

5. Financial impact

5.1 The maximum value of contracts placed during the lifetime of the framework agreement, including possible extension, is estimated to be £28,000,000.

5.2 There are no direct savings anticipated via this contract agreement. The 2016/17 budget for disability day care services was £6.8m. This will increase in 2017/18 by £197,200 as a result of implementation of the Living Wage uplift rather than because of the new contract. The new contract is for new business only and given there is a relatively low rate of turnover among the client group no further increase in overall spend is anticipated in 2017/18. However, the framework agreement will introduce greater transparency to service and price offers and will therefore enable service users, carers and assessors to make better informed decisions about the allocation of resources or personal budgets.

5.3 The costs associated with procuring this framework agreement are estimated to be from £10,001 to £20,000.

6. Risk, policy, compliance and governance impact

6.1 The Health and Social Care Contracts Team will be responsible for the management of the Framework Agreement and related contracts and for monitoring key performance indicators. This will mitigate any risk that contracts might fail to meet requirements.

7. Equalities impact

7.1 There are positive equality impacts arising from this report as the Framework Agreement will provide people with disabilities and their carers with the tools needed to make informed and affordable choices in respect of day services. An Equalities and Rights Impact Assessment (ERIA) has been undertaken.

8. Sustainability impact

8.1 The sustainability risk has been assessed as low and no mitigating actions are necessary. There are no impacts on carbon, adaptation to climate change and sustainable development arising directly from this report.

8.2 A range of community benefits were offered by bidders including:

(a) targeted recruitment and training within Edinburgh;

(b) supported employment for people with learning disabilities;

(c) supporting local businesses;

(d) volunteering placements for school pupils;

(e) workforce training;

9. Consultation and engagement

9.1 Co-production with service users and carers took place from 29 February to 13 June 2016.

9.2 Four easy read consultation questions were sent to all service users and carers and were developed to seek views on how people with learning disabilities would like to spend their day and what support should be like.

9.3 A variety of communication methods were used in the consultation. This took the form of questionnaires, online responses and four facilitated local meetings.

9.4 The outcome of the consultation and engagement process was used to develop the Service Specification in conjunction with third sector day support providers.

10. Background reading/external references

10.1 *'Keys to Life, Improving Quality of Life for People with Learning Disabilities'*, Scottish Government, 2013

http://www.gov.scot/Resource/0042/00424389.pdf

Rob McCulloch-Graham

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11. Links

Coalition Pledges	P43 - Invest in healthy living and fitness advice for those most in need
Council Priorities	CP2 - Improved health and wellbeing: reduced inequalities
	CP3 - Right care, right place, right time
Single Outcome Agreement	SO2 - Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health
Appendices	Appendix 1 - Summary of the Tender Process
	Appendix 2 - Combined Technical (Quality) and Commercial (Price) Scores for each Lot

Appendix 1 - Summary of the Tender Process

Day Support Services for Adults with Learning Disabilities Framework Agreement - Contract Ref: CT 0171

Contract	Framework Agreement for Day Support Services for Adults with Learning Disabilities - Contract Ref: CT 0171
Contract Period (including any extensions)	1 September 2017 to 31 August 2021
Estimated value of contract	£28,000,000 (total including extension)
Standing Orders observed	2.3 EU Principles have been applied 2.5 Health, social care and community services shall be procured in accordance with the Act 3.2 Director has responsibility for all contracts tendered and let by their Directorate 5.1 Tenders evaluated on basis of most economically advantageous tender
Portal used to advertise	Public Contracts Scotland
EU Procedure chosen	Open
Tenders Returned	20
Tenders fully compliant	20
Recommended Providers	Active Healthcare Services Autism Initiatives Capability Scotland Carr Gomm Clayton Care Limited Columcille Ltd Community Integrated Care CrossReach ENABLE Scotland Garvald Edinburgh Inclusion Alliance

	Leonard Cheshire Disability Places for People Scotland Care & Support Scottish Autism The Action Group The Redwoods Caring Foundation The Richmond Fellowship Scotland Limited Tiphereth Ltd Upward Mobility Ltd Visualise Scotland
Primary Criterion	Most economically advantageous tender to have met the qualitative and technical specification
Evaluation criteria and weightings and reasons for this approach	Quality (70%) Price (30%) This weighting was agreed by a project team of representatives from Health and Social Care, based on a shared understanding that quality is of greater importance than price for this type of service.
Evaluation Team	Council officers in Health and Social Care

Appendix 2 – Combined Technical (Quality) and Commercial (Price) Scores for Lot 1

Provider	Technical (Quality) Score	Commercial (Price) Score	Total Score
Active Healthcare Services	28.00	18.86	46.86
Autism Initiatives	35.00	19.37	54.37
Capability Scotland	55.13	16.71	71.83
Columcille Ltd	40.25	18.46	58.71
CrossReach	49.00	20.63	69.63
Garvald Edinburgh	35.88	16.96	52.83
The Redwoods Caring Foundation	38.50	28.70	67.20
Tiphereth Ltd	37.63	17.17	54.79
Upward Mobility Ltd	31.50	30.00	61.50
Visualise Scotland	43.75	15.35	59.10

Combined Technical (Quality) and Commercial (Price) Scores for Lot 2

Provider	Technical (Quality) Score	Commercial (Price) Score	Total Score
Active Healthcare Services	28.00	29.09	57.09
Autism Initiatives	35.00	28.17	63.17
Capability Scotland	55.13	27.04	82.17
Carr Gomm	53.38	26.68	80.06
Clayton Care Limited	34.13	27.43	61.55
Community Integrated Care	40.25	29.06	69.31
CrossReach	49.00	30.00	79.00

ENABLE Scotland	39.38	27.41	66.79
Inclusion Alliance	56.88	27.71	84.59
Leonard Cheshire Disability	46.38	29.23	75.61
Places for People Scotland Care & Support	53.38	29.18	82.55
Scottish Autism	37.63	25.44	63.06
The Action Group	35.00	27.99	62.99
The Richmond Fellowship Scotland Limited	48.13	28.95	77.08
Upward Mobility Ltd	31.50	24.62	56.12
Visualise Scotland	43.75	23.41	67.16

Item 5.9

Report

Appointments to Committees and Sub-Groups
Edinburgh Integration Joint Board

14 July 2017

Executive Summary

1. This report notifies the Joint Board that the City of Edinburgh Council has identified replacement voting members and a Chairperson to fill vacancies created by the end of the 2012-2017 Local Government term. It further seeks approval for the re-appointment of the membership for the Joint Board's Committee and Sub-Groups.

Recommendations

2. To note that the City of Edinburgh Council on 25 May 2017 agreed to appoint Councillors Ricky Henderson, Derek Howie, Claire Miller, Alasdair Rankin and Susan Webber to the Edinburgh Integration Joint Board as voting members.

3. To note that the Council agreed to nominate Councillor Ricky Henderson as Chair of the Joint Board at its 22 June 2017 meeting.

4. To agree the membership of the Committee and sub-groups as listed at appendix 1.

5. To approve two elected members to the Audit and Risk Committee, and one elected member as a member and Vice-Chair of the Performance and Quality Sub-Group.

6. To approve the revised terms of reference for the Performance and Quality Sub-Group as listed at paragraph 20.

Background

7. Due to the automatic resignation of Councillors at the end of the 2012-2017 local government term, the Council reappointed its voting membership to the Edinburgh Integration Joint Board (EIJB) on 25 May 2017. Vacancies still exist on the Joint Board's Performance and Quality Sub-Group and Audit and Risk Committee.

8. The Integration Scheme for the Edinburgh Integration Joint Board requires that appointment of the Chair alternates between the constituent bodies of the Joint Board after a period of two years, on the basis that during any period when the power to appoint the chairperson is vested in one Party, the other Party shall have power to appoint the vice-chairperson. The Council agreed to appoint Councillor Ricky Henderson as the Chair of the Joint Board at its meeting on 22 June 2017. This appointment will run until June 2019 when the right to appoint the Chair will revert to NHS Lothian.

9. The Joint Board's Standing Orders provide that it can appoint such committees, and sub-groups, including terms of reference and membership, as it thinks fit. Their membership and terms of reference are to be reviewed as and when required.

Main report

Joint Board Voting Member Vacancies

10. Five vacancies for voting members were created by the automatic resignation of councillors at the end of the 2012-2017 local government term. the following appointments were made by the City of Edinburgh Council on 25 May 2017:

    Councillor Ricky Henderson
    Councillor Derek Howie
    Councillor Claire Miller
    Councillor Alasdair Rankin
    Councillor Susan Webber

11. These appointments ensure the required balance of voting members between NHS Lothian and the City of Edinburgh Council.

12. The existing NHS voting members are as follows:

    Michael Ash
    Shulah Allan
    Alex Joyce
    Carolyn Hirst
    Dr Richard Williams

Chair and Vice-Chair of the Joint Board

13. The Chair and Vice-Chair of the Joint Board were previously appointed by NHS Lothian and the Council respectively in May 2015. This appointment period ran for a term of two years and expired in May 2017. It is now the duty of the Council to appoint to the position of Chair and NHS Lothian to appoint to the position of Vice-Chair for the term running until May 2019.

14. The City of Edinburgh Council agreed to appoint Councillor Ricky Henderson as Chair on 22 June 2017. NHS Lothian have agreed to appoint Carolyn Hirst as Vice-Chair.

Audit and Risk Committee

15. The end of the 2012-2017 local government term led to two vacancies on the Audit and Risk Committee. Responsibility falls to the Joint Board to appoint to this position under Standing Order 15.3.

16. Under the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 and Standing Order 15.2 the Committee must include an equal number of

voting members appointed by NHS Lothian and the Council. The Joint Board is therefore required to appoint two individuals from its Council voting membership.

17. A revised membership is included at appendix 1.

Performance and Quality Sub-Group

18. The end of the 2012-2017 local government term also led to the vacancy of the position of Vice-Chair on the Performance and Quality Sub-Group.

19. Membership and remit of the Performance and Quality Sub-Group has not previously been approved by the Joint Board. In light of this a review of the effectiveness of current arrangements was undertaken by group members. This was considered by the Sub-Group on 26 April 2017.

20. The remit of the group was developed by a series of stakeholder workshops and is submitted for approval as follows:

- Provide assurance to the Integration Joint Board that the whole system is operating effectively to deliver the strategic plan.
- Assess the impact and effectiveness of the strategic plan.
- Assess performance and quality from a strategic perspective
- Seek assurance that directions are being delivered.
- Support innovation and improvement by using evidence of performance and quality to learn and embed what works
- Ensure that the perspectives of all stakeholders are considered (including citizens, third and independent sector providers, people who use services and their carers).
- Provide a forum for discussion and debate in relation to emerging themes and national or local initiatives.
- Receive updates on the ongoing development of the Joint Strategic Needs Assessment and use these to influence further analysis.
- Oversee the annual performance report.

The current membership of the Performance and Quality Group has concluded that the group required streamlining and revised membership is recommended at appendix 1.

Professional Advisory Group

21. The remit and membership of the Professional Advisory Group (PAG) was approved by the EIJB on 15 January 2016. Membership is listed at appendix 1, no amendments are required.

Strategic Planning Group

22. The Public Bodies (Joint Working) Scotland Act 2014 places a requirement on Integration Authorities to establish a Strategic Planning Group as a means of engaging stakeholders in the production of the strategic plan and any decisions about significant changes to services to be made without revising the strategic plan.

23. The Strategic Planning Group was formally established by the EIJB on 13 May 2016 including remit and membership. This is listed at appendix 1, no amendments are required.

Key risks

24. Failure to appoint replacement voting members to the Joint Board within the period of six months would come under scrutiny by Scottish Ministers who would require to be notified in writing as to reasons why this had not occurred.

25. Failure to appoint individuals to the Audit and Risk Committee would result in the Joint Board falling to meet the requirements of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 and therefore decisions being liable to challenge.

Financial implications

26. There are no financial implications connected with this report.

Involving people

27. The proposed adjusted remit for the Performance and Quality Sub-Group followed a series of stakeholder workshops.

Impact on plans of other parties

28. There is no known impact on the plans of other parties.

Background reading/references

Minute of the City of Edinburgh Council 25 May 2017
Minute of the City of Edinburgh Council 22 June 2017
The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014
Final Integration Scheme – Edinburgh Integration Joint Board
Integration Joint Board – Standing Orders

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Appendix 1

Appointments to Committees and Sub-Groups

Audit and Risk Committee- 6 Members – 2 CEC, 2 NHS, 2 Other	
Angus McCann (Chair) Alex Joyce Mike Ash Councillor Alasdair Rankin	Ella Simpson Robin Jones (Co-opted onto Committee for 12 months from 6 March 2017). Councillor Susan Webber

Performance and Quality Sub-Group	
NHS Lothian and IJB Board Member	Shulah Allan, Vacancy
CEC elected member and IJB Board member	Councillor Derek Howie, Councillor Claire Miller
One representative from each of the following: - Professional Advisory Group - Third Sector - Independent Sector Representative - Citizen Representative	To be nominated by the Professional Advisory Group Third Sector representative from IJB Scottish Care TBC

Professional Advisory Group – 5 Standing Members	
5 standing members: Chief Social Work Officer Clinical Director Edinburgh Community Health Partnership (CHP) Chief Nurse (CHP) Allied Health Professional Manager (CHP) Staff Partnership Representative Each of the following should be represented: Nursing Staff Clinical Nurse Managers Allied Health Professional Members One each of the following from the NHS: Physiotherapist Occupational Therapist Speech and Language Therapist Podiatrist Art Therapist Medical Staff Clinical Leads from all GP and 'hosted service' areas. GP Sub Committee Member Consultant in Public health Medicine (or deputy) Optometrist Community Pharmacist Dentist Primary Care Pharmacist Co-ordinator Clinical Psychologist	Social Work manager for each social work care group: Older people Disabilities Mental Health Substance Misuse Assessment and Care Management A senior manager for each of the locally based services: Local Authority Occupational Therapist Local Authority Dietician A representative from housing support and homeless service Children's social work/care representative.

Strategic Planning Group	
Chair	Vice chair of the Integration Joint Board will be appointed
Vice Chair	Chair of the Integration Joint Board will be appointed
NHS Lothian	NHS Lothian to be asked to nominate an appropriate officer
City of Edinburgh Council	City of Edinburgh Council to be asked nominate an appropriate officer
Users of health services	The two service users who are non-voting members of the Edinburgh Integration Joint Board will be appointed
Users of social care services	
Carers of users of health services	The two unpaid carers who are non-voting members of the Edinburgh Integration Joint Board will be appointed
Carers of users of social care services	
Social care professionals	The Professional Advisory Group (PAG) to be asked to nominate a health and a social care professional. Ideally the representatives will be the co-chairs of the PAG.
Health professionals	
Commercial providers of health care	TBC
Commercial providers of social care	Scottish Care which is an interface organisation for the independent sector to be asked for a nomination
Non-commercial providers of social care	EVOC (Edinburgh Voluntary Organisations Council) and CCPS (Coalition of Care and Support Providers) which are interface organisations for the third sector to be asked for nominations
Non-commercial providers of health care	
Non-commercial providers of social housing	Edinburgh Affordable Housing Partnership which is a an interface group for providers of social housing to be asked for nominations
Third sector organisations carrying out activities related to health or social care	The third sector representative who is a non-voting member of the IJB will be appointed.
Localities	Pending the full establishment of the four localities it is proposed that the Community Engagement Manager from the City of Edinburgh Council undertakes this role.
Chief Officer of the EIJB	
Chief Finance Officer of the EIJB	
Strategic Planning Leads for the EIJB	
Performance Lead IJB	
Public Health Consultant working with IJB	

Item 5.10

Report

Calendar of Meetings

Edinburgh Integration Joint Board

14 July 2017

Executive Summary

1. Standing Orders require the Joint Board and its Committees to agree its calendar of meetings. The current schedule runs until August 2017. Dates for meetings until August 2018 have been calculated as part of the Council diary process and are proposed for approval.

Recommendations

2. To agree the proposed schedule of meetings until August 2018.

3. To note that a report will be submitted in March 2018 with dates for the 2018/19 period.

Background

4. On 29 June 2017 the City of Edinburgh Council agreed its Council Diary until August 2018, this included provisional dates for the Integration Joint Board.

5. A draft list of Joint Board meetings and development sessions was developed in consultation with the Chair and the Chief Officer. Proposals reflect the decision of the Joint Board to change the frequency of Development Sessions from bi-monthly to quarterly. No adverse comments have been received on the proposals.

6. A draft list of Audit and Risk Committee meetings was developed in consultation with the Chair of the Committee, the Interim Chief Finance Officer and the Chief Internal Auditor.

7. These now require to be approved by the Joint Board.

Main report

Integration Joint Board

8. The recommended schedule (all starting at 9.30am) is as follows:-

- 11 August 2017 – Business Meeting followed by a Development Session
- 22 September 2017
- 13 October 2017
- 17 November 2017 – Development Session
- 15 December 2017
- 26 January 2018
- 2 March 2018
- 27 April 2018 – Development Session
- 18 May 2018
- 15 June 2018
- 10 August 2018 – Development Session

9. An additional meeting had been added on 2 March 2018 to account for City of Edinburgh Council's Easter recess period.

10. There is scope to call Special Meetings where business requires.

Audit and Risk Committee

11. The recommended schedule (all starting at 9.30am) is as follows:-

- 11 September 2017
- 1 December 2017
- 16 March 2018
- 1 June 2018

12. Dates from August 2018 will be integrated with the Council diary planning process. Consultation will take place on the draft schedule, and formal approval sought from the Joint Board in early 2018.

Key risks

13. Forward planning of Joint Board business is undermined because of the absence of a forward calendar.

Financial implications

14. There are no financial implications as a result of this report.

Involving people

15. All members of the Joint Board, and key officers, were consulted on the draft schedule of meetings.

Background reading/references

Integration Joint Board Standing Orders

Meeting of City of Edinburgh Council 29 June 2017

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