Edinburgh Integration Joint Board

REPORT

Annual Performance Report 2020-21

Edinburgh Integration Joint Board

26 October 2021

Executive Summary	1. The purpose of this report is to provide the Edinburgh Integration Joint Board (EIJB) with a copy of the draft EIJB Annual Performance Report 2020-21 (APR) for approval. 2. The APR has been reviewed by the Performance and Delivery Committee at their committee meeting on 27 July and by circulation of the final draft in September 2021. 3. We have streamlined the content for the APR this year to allow a greater focus on our performance in relation to the COVID-19 pandemic. While we continue to make good progress with our transformation programme, the pandemic has impacted many areas of our work, with most of the national performance indicators not comparable to previous years due to the scale of disruption caused by the pandemic. 4. Following approval by the EIJB, we will submit the APR to the Scottish Government and publish it on our website by 31 October 2021.

Recommendations	It is recommended that the EIJB approves the publication of the APR 2020-21

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations	No direction required	✓
	Issue a direction to City of Edinburgh Council	
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

Report Circulation

1. The APR 2020-21 was considered by the Performance and Delivery Committee as the lead Committee for performance issues at their committee meeting on 27 July 2021 and by circulation of the final draft in September 2021.

Main Report

2. Integration Joint Boards (IJBs) are required by legislation to produce an APR each year covering performance over the previous financial year.

3. The APR provides an opportunity for us to set out our story of overall performance over the last year and how we work to improve health and social care in Edinburgh. It covers significant pieces of work we have progressed over the last year as well as key performance indicators.

4. Given the disruption over the last year, the APR has a strong focus on COVID-19. This highlights the restrictions on our services, the exceptional work of our staff and the ways in which we worked with partners to adapt services and continue to provide support during the crisis.

5. The report then provides a summary of progress against key projects, including our transformation programme, under each of the EIJB's strategic priorities. There is also a dedicated section on our performance against the Core Indicators and Ministerial Strategic Group (MSG) indicators that the EIJB is required to report on.

6. We have ensured that the APR aligns with our communication and engagement principles, as set out in the Communications and Engagement Strategy presented to the EIJB on 22 June 2020, particularly that it is clear and accessible.

7. In line with accessibility guidance from the UK Government, we will be publishing the APR as a suite of webpages on our website, rather than as a single pdf. This will make sections of the report easier for people to access individually, as well as ensuring accessibility requirements are met. As a result, the pdf presented to the EIJB for approval does not contain any design elements.

Timeline for publication

8. IJBs are required by the Public Bodies (Joint Working) (Scotland) Act 2014 to publish an APR by 31 July each year for the previous financial year. This is problematic due to the timing of when performance data against the Core Indicators is available and this year due to continuing pressures related to the pandemic.

9. As agreed at the Performance and Delivery Committee on 14 April 2021, we are utilising a provision in the Coronavirus (Scotland) Act, allowing us to delay publication of the APR beyond the usual deadline of 31 July. Utilising this provision, we have delayed publication of the APR to end October, following approval by the EIJB on 26 October 2020.

10. Discussions are ongoing with Scottish Government about the requirement for IJB annual performance reports to be published by 31 July each year.

Implications for Edinburgh Integration Joint Board

Financial

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

Legal / risk implications

12. There are no direct legal or risk implication arising from this report.

Equality and integrated impact assessment

13. As detailed above, the APR has been created in line with accessibility requirements to meet the clear and accessible principle in our Communications and Engagement Strategy.

14. There are no direct equality implications arising from this report.

15. An integrated impact assessment is not required.

Environment and sustainability impacts

16. There are no direct environmental or sustainability impacts arising from this report.

Quality of care

17. The report seeks to demonstrate our continued effort to improve the quality of care and experience for the citizens of Edinburgh and where applicable across Lothian.

Consultation

18. The APR was developed in consultation with a working group containing performance leads and data analysts from The City of Edinburgh Council and Public Health Scotland as well as the Communications and Engagement Manager. Senior managers have reviewed the sections directly relevant to their areas of work.

19. We are grateful for the case studies received from partners, including grant recipients, of their work over the last year.

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Appendices

Appendix 1 EIJB Annual Performance Report 2020/21

Edinburgh Integration Joint Board

Annual Performance Report 2020/21

Note: This document is for drafting and approval purposes only, the final APR will be embedded on our website to ensure we meet accessibility requirements.

Foreword

Our work over 2020/21 has been shaped by the response to the new coronavirus (covid-19) and resulting global pandemic. The services we deliver were significantly impacted by the restrictions put in place to control the spread of the virus.

Our frontline staff continued to deliver exceptional services to our most vulnerable citizens, including adjusting to service changes required due to physical distancing and increased infection control. We also developed new and adapted ways of working to allow quality support to continue to be provided while restrictions were in place. We made more use of telephone and online methods of connecting with people in need of support, from outbound wellbeing calls to online exercise classes.

It has been a difficult and challenging time. We thank our dedicated staff for their professionalism and fortitude and the many unpaid carers that provide vital care and support to the most vulnerable in our society.

In this Annual Performance Report for 2020/21, we outline our progress over the last year against our Strategic Plan 2019-22 and the ways that we responded to the pandemic across our services. As in previous years, we detail our performance against the six strategic priorities in our strategic plan and against the national health and wellbeing outcomes and associated indicators.

Despite the disruption this year, we continue to deliver on our transformation programme. This included redefining the Edinburgh offer, embracing the three conversations approach, and adopting the principle of home first. These pieces of work have become more crucial considering the impact the pandemic had on our services and the lives of individuals across Edinburgh.

We compare favourably to the Scottish average in 11 out of 19 of the national indicators and are closing in the gap in others. We have positive trends in the majority of the indicators we can compare across the life of the partnership. However, our performance against almost all the national indicators in 2020/21 has been affected by the covid-19 pandemic. While this makes it difficult to directly compare our performance against previous years, the changes seen in Edinburgh figures this year broadly reflect national trends.

The rate of emergency admissions and bed days dropped in Edinburgh in 2020, in line with the national drop in people attending hospital. Readmissions continued at a higher rate than the Scottish average and we are continuing work to better understand our performance in this area. The downward trend in the rate of days people over 75 spend in hospital when they are ready to be discharged continued. Between 2019/20 and 2020/21, this figure decreased by 51% in Edinburgh compared to a 37% decrease in the figure for Scotland. This likely builds on the success of our Home First model, which was accelerated during the pandemic.

During 2020/21 the Chair of the Edinburgh Integration Joint Board was held by Angus McCann, as appointed by NHS Lothian. On 27 June 2021, Councillor Ricky Henderson was appointed by the City of Edinburgh Council as our Chair for the next two years. We thank Angus for his work as Chair and look forward to continuing to work with him as our new Vice-Chair.

Councillor Ricky Henderson, Chair
Edinburgh Integration Joint Board

Judith Proctor, Chief Officer
Edinburgh Integration Joint Board

Overview

Introduction

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

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

Our current Strategic Plan 2019-22 is available online. This performance report sets out our progress against the strategic priorities and transformation plans within the Strategic Plan. The content in this report covers the financial year April 2020 to March 2021 unless otherwise shown.

About Edinburgh

Edinburgh is one of the largest health and social care partnerships in Scotland, with a population of 527,620 as of June 2020. 79,979 residents were aged over 65, with this age group projected to increase the most over the coming years.

Edinburgh is also the wealthiest city in Scotland, with 74.6% of the working age population in employment. 38.1% of the economically inactive population within the city are students.

However, 15% of the population, and as many as a fifth of children, live in relative poverty. This poverty is spread throughout the city, with two thirds of those living in poverty not living in areas described as deprived. The majority of those in poverty are in employment.

Our recently updated joint strategic needs assessment (JSNA) provides more detail on the population and demographics of Edinburgh.

Our Localities

We organise our community health and social care services in Edinburgh around four localities: South East, South West, North East and North West. The management of most community health and social care services is carried out in these localities, including assessment and care management, home care, day centres for older people and care homes in Edinburgh.

This allows us to plan and tailor services to the communities we are supporting. Each locality has a hub team that responds to new and urgent work and two cluster care management teams that arrange and review ongoing support. There is also a mental health and substance misuse team in each locality. We are in the process of developing locality operational plans that will support and implement our Strategic Plan.

There is a lot of variation across, and within, the four localities with areas of high and low deprivation found in each.

North East

- 118,760 people live in the North East locality[1]
- 50.8% are female and 49.2% are male
- 15.2% are aged under 18, 71.4% are 18-64 and 13.5% are over 65
- 16.5% of the population reside within the 20% most deprived areas of Scotland[1]
- life expectancy at birth is 80.5 years for women and 76.1 for men[2]
- 31,900 average home care hours per week between January and March 2020
- 1,464 receive home care service
- 18 GP practices[3]

North West

- 149,417 people live in the North West locality[1]
- 51.8% are female and 48.2% are male
- 19.9% are aged under 18, 62.7% are 18-64 and 17.3% are over 65
- 9.0% of the population reside within the 20% most deprived areas of Scotland[1]
- life expectancy at birth is 83.6 years for women and 79.8 for men[2]
- 25,600 average home care hours per week between January and March 2020
- 1,378 receive home care service
- 18 GP practices[3]

South East

- 136,200 people live in the South East locality[1]
- 52.1% are female and 47.9% are male
- 13.8% are aged under 18, 72.3% are 18-64 and 13.9% are over 65
- 9.4% of the population reside within the 20% most deprived areas of Scotland[1]
- life expectancy at birth is 82.4 years for women and 78.3 for men[2]
- 25,100 average home care hours per week between January and March 2020
- 1,170 receive home care service
- 19 GP practices[3]

South West

- 120,553 people live in the South West locality[1]
- 49.8% are female and 50.2% are male
- 17.3% are aged under 18, 67.3% are 18-64 and 15.4% are over 65
- 12.6% of the population reside within the 20% most deprived areas of Scotland[1]
- life expectancy at birth is 83.3 years for women and 79.1 for men[2]
- 27,900 average home care hours per week between January and March 2020
- 1,251 receive home care service
- 16 GP practices[3]

[1] Edinburgh Joint Strategic Needs Assessment
[2] The Scottish Public Health Observatory (ScotPHO)
[3] National Primary Care Clinicians Database (NPCCD), Public Health Scotland

Key messages from the year

Covid response

As with all areas of society the coronavirus pandemic had a huge impact on our delivery of services. While we continued to deliver vital support to the most vulnerable, initial analysis highlights that the pandemic has exacerbated existing health and social inequalities[4].

Employment and social impacts from the pandemic adversely affected many of the people who use our services, including those with disabilities and their carers. Unpaid carers were particularly affected by the restrictions on the services that support their caring role, such as respite care. Early research also suggests that loneliness and anxiety may have risen during the pandemic but the impact on heath and wellbeing in Edinburgh is not yet clear[5].

The covid-19 pandemic is likely to continue to affect health and wellbeing and how we deliver our services for the immediate future. We continue to monitor and prepare for this longer-term impact by learning lessons from our experiences over 2020/21.

Pausing and remobilising services

As part of our covid-19 response, we developed a mobilisation plan setting out the actions we were taking to ensure the health and care system was prepared for the impact of the virus. To protect our staff and service users, we had to make the very difficult decision to pause some of our services, including day centres and respite care. Many other services, including community resources, were disrupted, offering reduced delivery or changing the way they deliver support. Care provision was also reduced during this time, with supported people prioritised so that care continued to be provided to the most vulnerable in our society. Incoming demand dropped for much of the year.

Our hospital-based services were also impacted by the pandemic. Wards where covid-19 was present were closed to new admissions and social distancing measures were introduced across other wards. This meant some beds had to be closed to allow enough circulation space, reducing the capacity available. As a result, there was a nationwide focus at the start of the pandemic on creating capacity in hospitals by ensuring only those that needed to be in a hospital setting occupied beds. We utilised temporary ‘Safe Haven’ beds and assessment of long-term needs at home (Discharge to Assess) to ensure fewer people were delayed in hospital and were able to move home, or if their needs required it, move to a care home.

Demand for hospital services decreased during the pandemic as hospitals shifted focus and the public were asked to adjust their behaviour to protect the NHS. This saw a notable drop in elective procedures and a reduced number of people attending accident and emergency. As services begin to increase capacity and reintroduce regular procedures, and as people return to their usual activities, we expect to see a rise in hospital attendances and ongoing treatment.

[4] Edinburgh Joint Strategic Needs Assessment
[5] Personal well-being in the UK, quarterly - Office for National Statistics (ons.gov.uk)

In May 2020, we set up a Route Map Project Board to ensure we could implement the Scottish Government's Route Map through and out of the covid-19 Crisis across our services. This work was paused as restrictions returned later in 2020 but restarted in early 2021 to support the remobilisation of our services into 2021-22.

Supporting continuing services

Throughout the pandemic, our care homes, home care and reablement workforce and our external providers continued to deliver care and support to people across Edinburgh. These services faced significant challenges during the initial wave of covid-19, with high levels of staff absence due to covid-19 or self-isolation requirements, and periodic outbreaks of covid-19 within care homes.

Early in the pandemic we mobilised a Care Home Support team to provide ongoing support to the care homes for older adults in Edinburgh. The service was made up of staff from services which were temporarily halted due to the pandemic. In line with Scottish Government guidance, assurance visits took place in all care homes for older adults focusing on infection control measures, use of PPE, resident wellbeing and supporting staff with additional reporting and testing regimes. After the initial few months of forming this new service, staff were asked to return to their substantive posts as services opened back up. Recognising the value of this service as a consistent support to care homes, we recruited a team of 12 nurses at the end of 2020 to continue this valuable service.

In May 2020, the Scottish Government issued an update to the *National Clinical and Practice Guidance for Adult Care Homes in Scotland* in response to the Covid-19 pandemic. A multi-disciplinary team, including our Chief Nurse, key clinical leads and the Chief Social Work Officer was put in place. This team provided assurance to the health board and Scottish Government that the care homes within our remit had the support they needed to provide the highest standards of care to residents.

The treatment of covid-19 also presented challenges to our teams as they sought to continue care in the community in the face of a rapidly spreading new virus. To support our community nursing teams to reduce the suffering for those requiring palliative care due to covid-19, clear guidance and resources were developed, including 'grab bags' and exceptional use guidelines for the administration of covid-19 medicine.

Adapting our services – provision of PPE

We host the Southeast Mobility and Rehabilitation Technology (SMART) team, which provides a range of rehabilitation technology services. To meet the demands of the pandemic, the team adapted their services and redeployed staff. Routine services were paused, with only urgent and essential repairs and maintenance undertaken.

Instead, the service shifted their attention to the creation and distribution of Personal Protective Equipment (PPE) and other support to frontline services. The SMART team managed a PPE advice line and PPE distribution for all our services, with 8.4 million items issued across the southeast of Scotland. The team also utilised their resources to manufacture over 34,000 face shields (visors), with 1,875 made on biggest day.

This incredible flexibility was representative of many of our teams during the pandemic.

Supporting the most vulnerable through the pandemic

Throughout the pandemic front-line mental health and substance misuse services remained operational in the statutory and third sector. Face-to-face contact was kept at a minimum and PPE used as required. Special arrangements were made to drop off medicines, with telephone and digital contact used to assess and support people in recovery. A thriving Edinburgh recovery community put on a programme of digital events to support people and their families. As restrictions eased, walk and talk sessions were arranged and group work was resumed in line with the Scottish Government's Route Map.

Remarkable work was carried out with the homeless community during the early part of lockdown. People were accommodated in city centre hotels and this provided opportunities for better care, including access to health and psychosocial interventions. A significant number of people were started on substitute prescribing to reduce harmful drug use.

The work of the public protection committee continued, with adult protection case conferences being held through digital means.

Innovative responses to the pandemic

Throughout the year, we worked with partners to innovate and improve our collective services within the restrictions in place. Digital technology and the redeployment of staff allowed us all to work in new ways that provided greater flexibility to our service delivery.

As with many other organisations, we had to rapidly switch much of our work to digital channels last year. Where possible, our staff moved to working from home and many of our services moved to online delivery. This technology provided increased flexibility to both our service delivery and the people that use our services. We will work with our partners to consider where it is appropriate to continue these ways of working into the future.

Wellbeing calls

Over 46,000 outbound calls were made through the partnership's ATEC24 (Assistive Technology Enabled Care 24) service. These calls provided an opportunity to check on individuals' wellbeing, provide companionship and offer advice and support on coping with lockdown. Of those participating in a customer satisfaction survey, 96% felt the wellbeing phone calls during the pandemic had been helpful and enabled them to feel well-supported.

Wellbeing calls were also made to 457 people identified with dementia who were not receiving formal service involvement. These calls allowed a focus on wellbeing, including food/medication/shopping check, daily living activities, general wellbeing, and carer support, with advice and onward referrals provided as required.

Supporting people to stay active (long term conditions programme)

During the early stages of the Covid-19 pandemic, it was recognised that care home residents had reduced physical activity levels, leading to deconditioning and increased risk of falls. In response, a multi-disciplinary care home falls prevention support service was tested between May – October 2020 using the video-consulting platform 'Near Me'. The aim was to support care home staff to reduce the risk of falls and increase physical activity

during the pandemic. Nine care homes received support, resulting in a 61% reduction in reported falls.

We also continued to support people living with long term conditions, many of whom were shielding, through the *Fit for Health* physical activity programme, run in partnership with Edinburgh Leisure. While sports and leisure venues were closed, we used a pre-recorded *Fit for Health* class, coupled with motivational and wellbeing calls, to support people with long term conditions to stay active at home. The pre-recorded *Fit for Health* class was viewed over 4,000 times. A further two *Fit for Health* pre-recorded classes were made available to all participants in November 2020, with over 170 views in the first month. During December, we launched twice weekly live-streamed *Fit for Health* classes, which increased to three classes a week from January 2021. Live streaming allows for up to 24 people per week to access Fit for Health on a supported video platform where instructors provide live feedback to participants.

Case study – Steady Steps

Gwen and Arnold, both 91, were attending Steady Steps at the Craiglockhart Leisure Centre prior to lockdown in March 2020. Both were referred to Steady Steps by their physio after having serious falls around the home. During the pandemic, Gwen and Arnold continued their exercise through pre-recorded Steady Steps sessions initially, then live sessions over Zoom. They said:

"We believe the online videos have played an important role in maintaining our mobility, strength, and balance, it gave us structure to our week during the long months of isolation. The fact that we knew [the Steady Steps instructor] beforehand and having that continuity of seeing a familiar face made the online class so enjoyable. It was like having an old friend in the living room with us."

As a result of Steady Steps online support, Gwen and Arnold have continued to be active during lockdown. They are feeling physically and mentally stronger and the classes have provided an opportunity to socialise with others.

Digital connections

With many of our services, including older people's day services, having to pause in-person support during the pandemic, our providers have continued to support as many people as possible using digital means to connect with service users. This included the use of virtual groups, where individuals could continue to meet and enjoy activities together online, and online events like presentations on various subjects.

Case Study – Online support from day service providers

Prior to the pandemic, Michael[6] was retired and providing care for his wife who was living with dementia and attending a day service once per week. At the start of lockdown, the day service provider offered a wellbeing call once a week, which Michael took as his wife was unable too. When the provider began offering virtual support groups, Michael signed himself

[6] Name has been changed.

and his wife up to three different groups. They both looked forward to the interaction with staff and other participants.

Unfortunately, Michael's wife went into hospital and subsequently passed away. As the family were quite far away, the provider encouraged Michael to continue using the groups for socialisation and to help minimise his isolation and loneliness.

Michael has since been working with the provider to form a carers group, as he had enjoyed connecting with the other carers in the groups so much. This has kept him busy and provided a place where he can continue to talk about his wife.

For those without digital access, support was available from many of the organisations that we fund through our grants programme. These organisations were quick to assist those that needed help in making the transition to the use of digital technology.

Case Study - Golden Years digital inclusion service

Danny[7] is 66 years old. He recently moved into a new flat provided by City of Edinburgh Council. Before that, he lived in veterans housing but had lost contact with the residents of the veterans' home and was feeling increasingly isolated. Due to the restrictions caused by the covid-19 pandemic he was unable to meet his social worker and his only daughter lives abroad. Danny spends all his time alone at home, only occasionally going to the local shop, but is not confident doing this due to the covid-19 situation.

Danny was referred to Golden Years digital inclusion service by Family Housing Support. The service provided him with a Chromebook and training to support him to set up and use the device. Danny feels less isolated now, enjoying weekly meetings with both his daughter and social worker. He is also able to access online shopping, banking and healthcare services, connect with his friends online and further develop his hobbies despite the restrictions brought on by the pandemic.

ATEC24's Sheltered Housing Support Service have also recently purchased technological devices, tablets and keyboards for each of the Sheltered Housing schemes with community rooms, using community benefit funding from Utilita. These devices will enable citizens to interact with services online including ordering repeat prescriptions and attending medical appointments using the Near Me initiative. Building their confidence with these devices also allowed citizens to use social media, email or video calls as a means of maintaining connections with family or friends they are unable to see in person, reducing the negative impact of isolation from the pandemic restrictions.

Transformation progress

Our transformation programme continued into 2020-21. After redeployment of resources due to the pandemic, the EIJB approved a rescheduled transformation programme in July 2020.

Our transformation programme is a wide-ranging and ambitious programme of change and innovation, aiming to deliver high-quality and sustainable health and social care services for our citizens. The programme has been structured around the Three Conversations model, with three main programmes of work aligned to conversation stages and a further element

[7] Name has been changed.

delivering cross-cutting, enabling change. The programme is scheduled to run until March 2022.

The key projects within the transformation programme progressed in 2020-21 are discussed under the most relevant strategic priority:

- Edinburgh Pact and community mobilisation – Prevention and Early Intervention
- Three conversations – Person Centred Care
- Bed-Based review – Managing our resources effectively
- Home Based Care – Making the best use of the capacity across the system
- Workforce Strategy – Making the best use of the capacity across the system
- Home First – Right Care, Right Place, Right Time

Strategic priorities

Priority 1: Prevention and early intervention

Investing in prevention and early intervention services is a key part of our strategy. By identifying those people most at risk of poor outcomes and providing effective early support we can prevent problems occurring or minimise the impact on the individual's health and wellbeing.

Edinburgh Wellbeing Pact and Community Mobilisation

The commitment to create an Edinburgh offer was one of the key elements of our Strategic Plan for 2019-2022. To achieve this, we have been developing the Edinburgh Wellbeing Pact - a reciprocal agreement between the Partnership and everyone who lives and works in Edinburgh, inviting citizens, staff and partners to contribute to realising a shared vision. We are working towards an ambition to create healthy communities, empowered by local services and organisations that support people to prevent crisis and manage their health and personal independence at home.

In 2020-21, we began a dialogue with citizens, staff from EHSCP and partner agencies, communities of interest, community planning partners, and interested stakeholders. Due to restrictions, all engagement activities took place online, including:

- 12 focus groups with 84 frontline staff and practitioners
- Public survey through our website with 356 responses
- 11 Community of Interest groups with 91 participants including black and minority ethnic communities, faith groups, and people with specific health conditions
- 8 voluntary sector forum meetings with 191 participants
- 23 in-depth interviews with city leaders from the third sector, public sector, elected members, Board members, academia and private sector
- 115 images submitted through "Picturing Health", a project inviting people to take photographs of what health and care meant to them

From all the conversations to date we identified 6 emerging themes: Shared Purpose; Relationships; Community Mobilisation; Agility; Radical Transformation; and Measuring and Evidencing Change. We want to build thriving communities in Edinburgh and embrace the opportunity to create a different type of relationship with residents, communities and organisations across the city.

We are now moving to enactment of the Wellbeing Pact through a 3-year community mobilisation and commissioning plan. The plan, which was approved by the EIJB in April 2021, will see the development of more collaborative, partnership approaches to supporting community sector organisations, including the roll-out of community-based approaches to commissioning to replace traditional grants programmes. To shape what community mobilisation can look like for Edinburgh, we held two collaboration events with a wide range of key stakeholders in January and March 2021, with further events planned in 2021-22.

Long-term conditions programme

Our long-term conditions programme provides support to health and social care teams to improve care for people living with long-term health conditions and those who are at risk of

falls. This year we created a new Long Term Conditions Section on our website. As well as information for people living with long term conditions, it includes information for families and carers.

Supporting people living with Chronic Obstructive Pulmonary Disease (COPD)

Edinburgh's Community Respiratory Hub provides support to people living with Chronic Obstructive Pulmonary Disease (COPD) who are at high risk of hospital admission. During 2020, the Community Respiratory Team assessed 414 people, who were at immediate high risk of hospital admission because of an acute exacerbation of their COPD. Following assessment, the Community Respiratory Team supported 84% of these people to be safely cared for at home, avoiding hospital admission.

In place of our Pulmonary Rehabilitation classes we offered support for those already engaged, or with completed assessments, to use the myCOPD app. The myCOPD app supports people living with COPD to better manage their condition and improve their outcomes. Telephone coaching and group virtual classes were also offered.

Supporting people at risk of falls

By proactively providing support on how people can stay active and steady on their feet, we can either prevent falls happening or improve the way a fall is managed. Working in partnership with the British Red Cross, 250 'Staying Active' packs were distributed via community nurses and physiotherapists to people who were shielding and at risk of falls during Covid-19 pandemic and 600 Staying Active leaflets were distributed via the City of Edinburgh Council's shielding phone line.

Anticipatory care planning

Anticipatory care planning (ACP) is a person-centred, proactive, 'thinking ahead' approach, with health and care professionals working with individuals, carers and their families to make informed choices about their care and support. Key Information Summaries, which contain anticipatory care planning information such as care preferences taken securely from the GP electronic record, are shared with health professionals if people need urgent care.

During the pandemic, we focussed on supporting practitioners to have care planning conversations and create plans for people living with long term conditions who were most at risk of Covid-19. The number of Key Information Summaries for people living in Edinburgh has increased from 66,966 in March 2020 to 237,372 in March 2021 (254% increase).

To support the creation of Covid-19 relevant ACPs, all care homes for older people and GP practices in Edinburgh were provided with a Covid-19 revised edition of the *7 steps to ACP for care homes*. We also continue to work with VOCAL and the Edinburgh Carer Support Team to support carers through care planning conversations.

Self Management

Self management supports people living with long term conditions to be actively involved in their own health and wellbeing as the leading partner in their care. In partnership with Lothian Centre for Inclusive Living, we successfully tested and adopted a new Self Management Support Worker post during the pandemic. This role will help people with long term conditions develop self-management skills and connections with community support.

We also launched the Edinburgh Self Management Network during Self Management week (28th September-2nd October 2020). This online network supports practitioners to share good practice, find out about services, activities and events, and innovate self-management approaches. This network has created a self-management toolkit, including the Edinburgh Connect Here Directory of City Wide Community Resources, which contains over 2,000 community resources to help people live with their long term condition.

Digital support

We also accelerated the rollout of the telemonitoring programme to support diagnosis and self-care of hypertension and reduce the requirement for patients to attend health centres to have their blood pressure checked. People using this approach require one less consultation per annum on average, a 25% reduction in face to face contacts with a clinician. This was particularly important for patients who were shielding over the last year, many of whom have cardiovascular disease.

Between April 2020 and March 2021, 1,561 new patients have used the Florence Scale Up Blood Pressure programme in Edinburgh to remotely monitor their blood pressure and adhere to their shared management plan. In total, 4,014 patients in Edinburgh from across 60 GP practices use this programme.

Prevention of harm

We have a responsibility for adult protection and our Chief Officer sits on the multi-agency Chief Officers Group for Public Protection that is responsible for all areas of public protection across Edinburgh. This group is supported by the Adult Protection Committee.

The Adult Protection Committee meets bi-monthly to provide assurance and governance of the quality of Adult Support and Protection in Edinburgh. Its membership is drawn from agencies across the public and voluntary sector involved in Adult Protection. The committee considers routine reports to ensure the policies and processes in place keep adults in Edinburgh safe. It also considers what can be learnt and applied from case reviews.

Between April 2020 and March 2021, there were 1,868 adult protection contacts across the city. 43.5% of these referrals were made by Police Scotland, followed by City of Edinburgh Council (22.5%) and NHS Lothian (7.5%). Of the 1,868 referrals received during the year further action was taken in nine out of ten cases.

Just over a quarter of referrals (505) progressed to investigation in the period. Mental health was the most common client group for those whose case was being investigated, followed by infirmity due to old age. The cases that resulted in an investigation were principally due to physical harm (24.4%) and financial harm (20.2%). Of the 505 investigations, seven out of ten resulted in further action.

There were also 641 adult protection case conferences in the year, of which just under a third were initial case conferences.

Priority 2: Tackling inequalities

We have a key role to play in addressing inequality, in particular the health inequalities that represent thousands of unnecessary premature deaths every year in Scotland. The fundamental causes of health inequalities are an unequal distribution of income, power and wealth which can lead to poverty and the marginalisation of individuals and groups. These fundamental causes also influence the distribution of wider social determinants of health, such as the availability of good-quality affordable housing, green space, work, education and learning opportunities, access to services and social and cultural opportunities. These also have strong links to mental and physical health.

Edinburgh Poverty Commission

We are a member of the Edinburgh Partnership, the body responsible for community planning in the city. In 2019 the Edinburgh Partnership and City of Edinburgh Council set up the Edinburgh Poverty Commission to explore the extent and nature of poverty in Edinburgh.

In May 2020 the Edinburgh Poverty Commission published an interim report on Poverty and Coronavirus in Edinburgh. This was followed by a full report, A Just Capital: Actions to End Poverty in Edinburgh, on 30 September 2020. A supplementary data and evidence paper was also published.

These reports highlighted the extent of poverty across Edinburgh, with an estimated 77,600 people in poverty in Edinburgh in the year prior to the covid-19 outbreak (15% of the population compared with 19% for Scotland). Almost two thirds of people (65%) who are living in poverty do not live in the 20% most deprived datazones in Scotland, meaning poverty exists across Edinburgh.

Grants programme

Our grants programme aims to prevent poor health and wellbeing and reduce health inequalities by investing in projects that tackle the root causes of health inequalities and support those whose health is at greatest risk from inequality.

2020/21 was a difficult year for everyone, however the impact of covid-19 and the restrictions imposed have not been felt equally, with the most disadvantaged hit the hardest. The year saw a heightened reliance on digital technologies and the negative consequences of being digitally excluded were greater than ever. Funded organisations were quick to assist those that needed help in making the transition to the use of digital technology.

An annual Grant Monitoring and Evaluation Report is completed each year using monitoring returns from funded organisations. We have not yet finalised the comprehensive report for 2020/21, however returns demonstrate how grant funded organisations quickly adapted to the lockdown restrictions. Most recipients continued to provide their services, albeit in a different way, and some organisations quickly re-organised to provide emergency support. This included the delivery of food packages and assistance with shopping and prescriptions.

Many of the case studies contained in this report are from projects funded through our grant programme. These demonstrate how recipients have not only continued to improve the

health and well-being of individuals in-line with the seven priorities of the programme but have, in some cases, been lifelines for many vulnerable individuals during this difficult time.

Case study – Cook Club

Katrina[8] is a mother of 5 children and has literacy issues, meaning she finds it hard to follow recipes or look for healthier options in the supermarket. She had very little experience of cooking from scratch. To help with weight management, her social worker referred her to the Cook Club, a project to support people to learn to cook homemade meals run by Edinburgh Community Food through the Edinburgh & Lothians Greenspace Trust Out & About healthy lifestyle programme. These sessions were run on Zoom throughout lockdown.

To enable her to participate fully in the sessions, Katrina was sent a pictorial, Easy Read version of the recipe. This resource shows step-by-step how to prepare the food with simple written instructions to familiarise the participant with key words. The online session was also run in such a way as to allow Katrina to cook the steps in a friendly and non-pressured environment.

In later weeks Katrina also encouraged two of her children to participate, demonstrating the positivity that Katrina was showing around her newfound abilities in the kitchen. At the evaluation at the end of the sessions Katrina said: *"Making food from scratch is easier that I though. It's good to learn new things and meet new people."*

Mental health services

Our mental health and wellbeing strategy, Thrive Edinburgh, sets out the links between underlying societal inequalities and mental health as well as our roadmap for improving the support on offer in Edinburgh to promote good mental health and wellbeing for all. Our strategy is built on four pillars: Change the Conversation, Change the Culture; Partner with Communities; Act Early; and Use data and evidence to drive change.

In October 2020, we launched the i-Thrive website to support a change in the conversation and culture and provide advice to those in need. This was supplemented by the Thrive News Bulletin and "Thrive on Thursday Dialogue" sessions to share information and explore emerging issues and opportunities. We also launched the Thrive Exchange Community of Practice in June 2020, consisting of 55 people with an active interest in research.

With our community partners, we held the first Thrive Fest online arts festival for Mental Health Awareness Day on 10 October 2020 and took the 8th annual Out of Sight, Out of Mind artwork exhibition live and online. We have also developed an action plan to progress the Rights in Mind workstream and worked with Universities and Colleges to strengthen care pathways.

To support early intervention, we prototyped Thrive Welcome Teams, which integrate public and third sector teams in each of our localities. These received positive feedback from both staff and people using the teams and are now being rolled out more widely. The contracts for our newly commissioned Thrive Collective Services also commenced on 1 December 2020, with an annual value of £2.6m.

[8] Name has been changed.

LGBT and dementia

People from the LGBT community often face barriers to accessing good health and social care support and, even when they can access care, it sometimes fails to meet their specific needs. With our support, Scottish Care created Proud to Care: LGBT and Dementia, a good practice guide for health and social care workers and accompanying self-audit tool. This resource aims to support health and social care workers to better work with people with dementia receiving support, who also identify as being part of the LGBT community.

While the planned launch of this tool was cancelled due to covid-19, the Edinburgh Dementia Training Partnership sent out electronic copies to all care homes and care at home services and funded hard copies for all these services.

Priority 3: Person-centred care

Being person-centred is about focusing care on the needs of the person rather than the needs of the service and working with people to develop appropriate solutions, instead of making decisions for them. Key to this is working with people using health and social care services as equal partners in planning, developing and monitoring care to make sure it meets their needs and achieves positive outcomes.

Three Conversations

We continue to roll out the Three Conversations model as a strategic and cultural framework to working with the people who approach us for support. This approach aims to achieve improved outcomes for people and families, working in a more preventative and personal way. Three Conversations is based on the principle that we should focus on what matters to people, working collaboratively with them as the experts in their own lives. It recognises the power of connecting people to the strengths and assets of community networks, and the necessity to work dynamically with people in crisis. Staff are encouraged to think creatively about how to support people to deliver improved outcomes.

This approach is allowing us to respond to new requests for support very quickly, with the average time to speak to a worker reduced to 2.5 days between December 2020 and February 2021 compared with an average of 37.3 days for those working in the traditional assessment model. As we no longer start with a presumption that paid for support is the only or best response, we are better able to connect people to wider support meaning fewer people require paid for or formal long-term services.

The impact of covid-19 in early 2020 caused a period of uncertainty and slowed progress as we adjusted to pandemic restrictions and staff were redeployed to care homes or other teams to help with the crisis situation. However, the innovation sites rose to the challenge of providing services within the lockdown situation and in 2020-21 we successfully set up a further five new innovation sites and expanded one existing site. Innovation sites have reported that the Three Conversations approach provided an excellent foundation for how they are supporting people through the crisis, and many have utilised digital innovations to remain connected.

Care Inspectorate Reviews

We deliver 34 registered adult care services that are subject to inspection by the Care Inspectorate. Due to the impact of the covid-19 pandemic, the Care Inspectorate suspended inspections of all adult care services other than care homes for older adults. The Care Inspectorate developed a new assessment question to meet the duties placed on the Care Inspectorate by the Coronavirus (Scotland) (No. 2) Act and subsequent guidance that they must evaluate infection prevention and control and staffing.

Inspection results are graded on a scale from 1 ‘unsatisfactory’ (urgent remedial action required) to 6 ‘excellent’ (outstanding or sector leading), with the grades 3 and 4 being assessed as ‘adequate’ and ‘good’ respectively.

During 2020/21, 7 covid-focused inspections of our care homes for older adults took place, with grade evaluations summarised below. Our other adult care services were not inspected in 2020/21.

Service Name	Date of Inspection	How good is our care and support during the covid-19 pandemic?	Requirements (covid)	Areas for improvement (covid)
Cherry Oak Care Home	06-Oct-20	3	0	3
Ferrylee	17-Feb-21	4	0	0
Inch View	11-May-21	4	0	0
Jewel House	28-Sep-20	4	0	4
Marionville Court	13-Jan-21	3	0	2
Royston Court	28-Jul-20	2	3	5
Royston Court	16-Dec-20	3	2	0

During 2020/21, one non-covid inspection took place in Royston Court. As described in the section below, this care home was the focus of improvement work this year.

Service Name	Date of Inspection	How well do we support peoples' wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting?	How well is care and support planned?
Royston Court	09-Mar-21	3	3	Not assessed	Not assessed	3

Quality Improvement and Assurance in Care Homes

A Care Home Transformation Group, chaired by our Chief Nurse, was established in June 2020 to oversee a programme of transformation and improvement across care homes.

In 2020/21 improvement work focused on Royston Court Care Home, a 60 bedded purpose-built Local Authority Care Home in North West Edinburgh providing care for frail elderly and people with a dementia. This care home had several outstanding requirements and areas of improvement from previous inspections, which the Care Inspectorate condensed into 7 requirements and 7 areas for improvement in September 2020.

Our quality team worked with the care home to implement the Quality Management System approach to improvements. This included understanding the challenges and issues, getting to know the residents and their needs, and reviewing current processes, systems, documentation and reporting. The team also measured quality of care against the health and social care standards to identify areas for improvement. All staff groups were engaged in the plans for improvement and encouraged to develop and act upon change ideas.

An unannounced inspection in December 2020 showed an overall marked improvement across all areas with an indication that improvement is moving in the right direction, with grades expected to be higher at future inspections and if there is evidence of sustained improvement. Since the inspection in December there was another unannounced inspection

in March 2021. Across these inspections all seven requirements and 5 of the areas for improvement were met. Further progress has been made around the requirements and areas for improvement and a sustainability plan has been developed to ensure the progress made will be maintained and built on.

Older People's Services Joint Inspection

During 2020/21, we continued to engage with the Care Inspectorate and Healthcare Improvement Scotland (HIS) (known as the Joint Inspectors) on how we are improving our Older People's Service following the Older People's Services Joint Inspection (May 2017) and Progress review (June 2018). The remaining actions on our revised improvement plan, agreed in May 2019, are largely being delivered through our transformation programme. In particular, the Three Conversations, Bed Based Review, Home Based Care, Home First and Workforce Strategy projects outlined in this report will allow us to robustly respond to the recommendations of the Joint Inspection and ensure we continue to provide quality services for older people. A formal response from the Joint Inspectors on our improvement activity is expected in August 2021.

Priority 4: Managing our resources effectively

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

Financial management and performance

Financial information is a key element of our governance framework with financial performance for all delegated services reported at each of our IJB meetings. Budget monitoring of delegated functions is carried out by the finance teams in the City of Edinburgh Council and NHS Lothian, reflecting the EIJB's role as a strategic planning body which does not directly deliver services, employ staff or hold cash. However, the IJB maintains 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.

Each year we produce a financial plan which sets out how we ensure our limited resources are targeted to support delivery of our strategic plan. For 2020/21 our financial plan (which can be found here) was agreed by the IJB in July 2020. Regular updates on financial performance were provided to the Performance and Delivery Committee as well as to the EIJB itself. Included in these reports were details of the financial impact of the pandemic and progress with the savings and recovery programme.

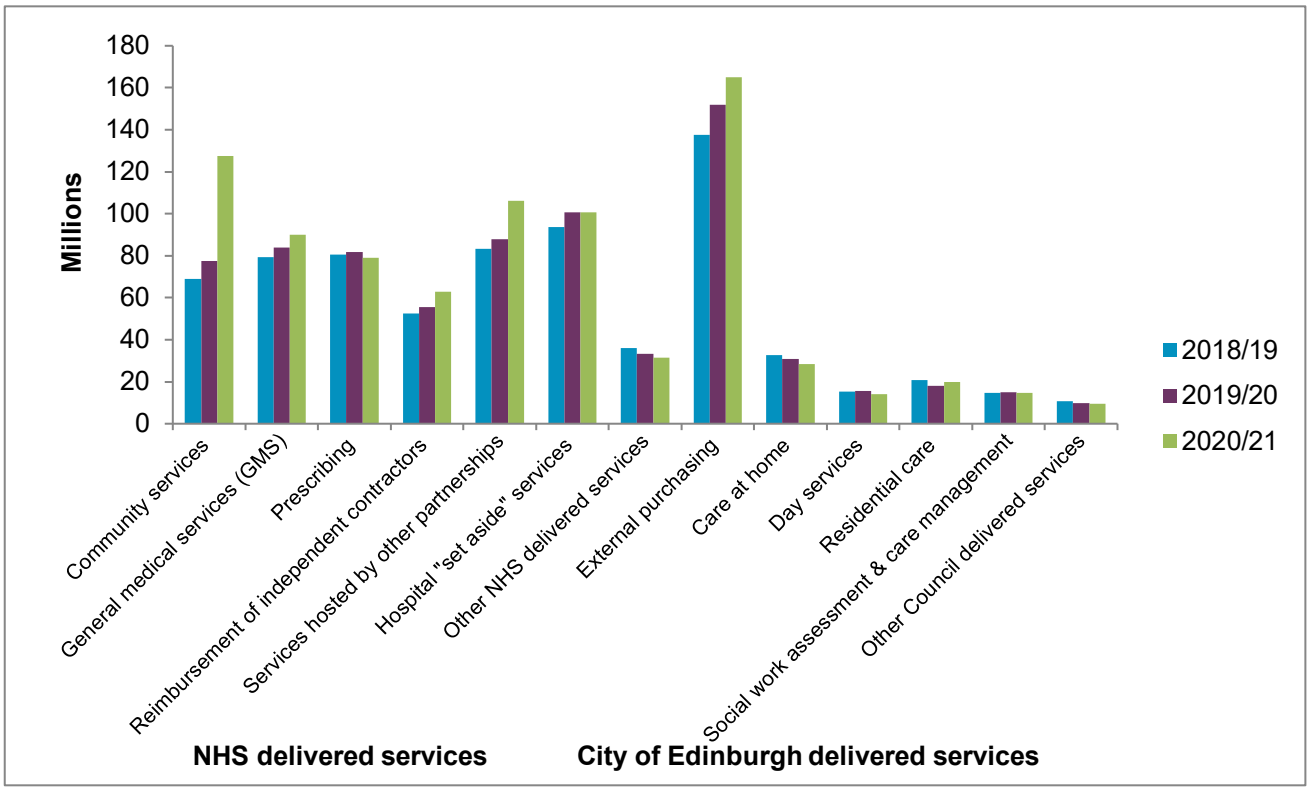
You will find a comparison of costs against the budget for the year summarised in the table below:

Service	20/21 budget £m	20/21 actual £m	Variance £m
NHS DELIVERED SERVICES			
Community services	126	127	(1)
General medical services (GMS)	90	90	(0)
Prescribing	79	79	(0)
Reimbursement of independent contractors	63	63	0
Services hosted by other partnerships/NHS Lothian	107	106	1
Hospital 'set aside' services	101	101	(0)
Other	33	31	2
Subtotal NHS	**599**	**598**	**1**
CITY OF EDINBURGH DELIVERED SERVICES			
External purchasing	157	165	(8)
Care at home	30	28	1
Day services	16	14	2
Residential care	22	20	2
Social work assessment and care management	15	15	1
Other	11	10	2
Subtotal Council	**252**	**252**	**0**
Net position	**850**	**849**	**1**

Whilst there is no doubt that we will continue to face significant financial pressures, we saw our previous improvements in financial planning and performance sustained during 2020/21 as we delivered a surplus of £1m against the budget for the year. These funds have been transferred to our reserves and will be carried forward to 2021/22 for prioritisation by the IJB.

Interpreting the financial results during a pandemic is not straightforward but it is evident from the table above that we continue to experience pressure in our purchasing budget. In the main this can be attributed to spot purchasing, predominantly care at home/care and support, residential services and direct payments. We saw growth in the purchasing budget during 2020/21 but this was largely in line with assumptions. The variance therefore relates to slippage in delivery of savings as the workforce was focused on continuity of service during the pandemic. Accordingly, the in-year savings target attributed to purchasing has been recognised in the 2021/22 financial plan and the savings target rolled over to 2021/22.

The chart below shows a comparison of costs in key areas for the last 3 financial years. The increases in certain categories from last year reflect the areas of additional spend to support the response to the pandemic.



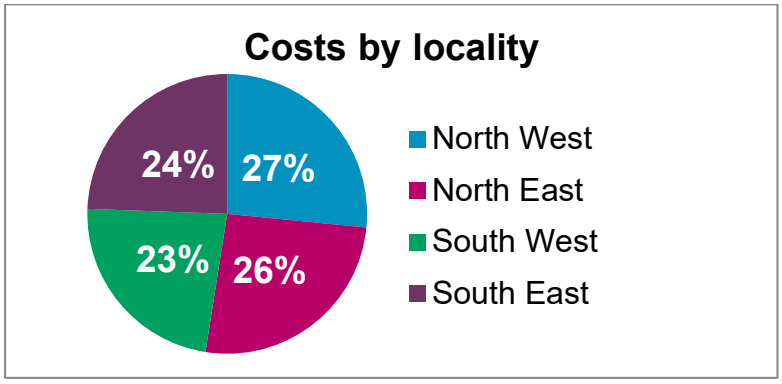
The pandemic clearly had an impact on our finances, and this was closely monitored during the year. We incurred net additional costs of £40m as a direct result of the pandemic. The main categories of associated expenditure being:

- sustainability payments made to support providers during the pandemic;
- purchase of additional capacity;
- additional staffing and reimbursement of independent contractors;
- increased prescribing costs, and;
- slippage in the delivery of the savings and recovery programme.

In line with their commitment, these costs were met in full by the Scottish Government and are summarised below:

	£m
Additional costs - Council services	
Additional staffing	2.0
Additional capacity	3.3
Equipment & sundries	1.5
Loss of income	2.2
Personal protective equipment	1.0
Social care provider sustainability payments	16.0
Underachievement of savings (net of offsets)	2.9
Subtotal Council costs	**29.0**
Additional costs - NHS services	
Additional Family Health Services (FHS) prescribing	2.5
Additional payments to FHS contractors	1.9
Additional set aside costs	4.0
Hospices - loss of income	0.8
Staff bonus payment	2.3
Subtotal NHS costs	**11.5**
Grand total additional costs	**40.4**

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



Bed-based review

The bed-based care project within our Transformation Programme is continuing the redesign of our bed base across the city, taking into consideration demand and capacity to ensure provision of sustainable bed-based services. The project has 8 workstreams relating to bed types, covering both medically led beds in hospital settings and beds located in the community led by social care staff.

Due to the size, scale and complexity of the project, a phased approach to project activities has been agreed. Phase one contains four workstreams (Intermediate care; Hospital Based Complex Clinical Care; Care Homes and Specialist Inpatient Rehabilitation), with a further four workstreams forming phase two (Respite; Palliative and end of life care; Mental Health and Supported Accommodation). No changes within our bed base can be made in isolation as they will affect different bed types across our estate and will have wider system implications, such as increased demand for Home Care and Reablement. The phasing took into consideration the impact changes would have on other service areas, the buildings and estate the services were located in, and the people cared for in the bed types.

As with much of our other work, the project was paused for a time during 2020 due to resource redeployment to support the pandemic response but was reinstated in June 2020. Further work was undertaken to gather data and evidence and a research phase was completed to understand other bed base models, demographics and population projections, and areas of good practice. Visioning workshops based on bed type were held with key stakeholders and service leads from each of the work streams. The outputs from the workshops were collated and key learning extracted to inform the bed-based strategy.

Phase one of the bed-based strategy will go to the EIJB for approval in 2021/22. Work will also commence on redesign options for phase two workstreams.

Priority 5: Making best use of the capacity across the system

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

Our people

Our people are our most valuable partners and the past year has proven this more than ever. The pandemic has been tough on everyone, and our people were incredibly committed to supporting the people of Edinburgh through this crisis. Many staff were temporarily redeployed to support our response to covid-19, with our 2020 iMatter pulse survey showing that 78% of respondents had experienced a change either in their job role or the environment they work in during the pandemic. This included staff who were redeployed to support continuing services, for example, staff from day care centres that had to close due to the restrictions worked alongside existing teams to enhance support in our residential units and home care service.

Through our transformation programme, we have been developing our inaugural workforce strategy, to help us ensure that we have a skilled and capable workforce that can deliver our vision of 'a caring, healthier and safer Edinburgh'. It will set out our vision and priorities for the workforce and a pathway for where we need to be. The strategy focuses on both our own workforce across the City of Edinburgh Council and NHS Lothian as well as the implications for those we work with such as the third and independent sectors, volunteers and the role of carers. At the end of 2020-21 we began engagement with staff on the proposed strategy.

While the pandemic caused some delay in this project, it has also been a catalyst for positive change, expediting changes to how and where we work as well as how we engage, network and communicate.

Once a nurse, always a nurse - A journey back to District Nursing

Sue works within our organisational development team but was asked to return to clinical practice for two months during the pandemic to support our district nursing team. It had been 18 years since Sue worked fully in district nursing, though she had picked up the odd shift to support the team over that time. Sue recently wrote about the experience of returning to the frontline:

"I have to say it was the most valuable and grounding experience, and I feel privileged to have had the opportunity. The extraordinary care, which is provided by community teams 24 hours a day, seven days a week, is truly inspiring. Being alongside caring and compassionate staff at all levels, feeling welcomed, safe and supported, enabled me to transition quickly back into a role I had loved, albeit such a long time since I had held a caseload in the community.

I knew my capabilities and limitations, so with the support of the DN Team Lead and the community nursing team, we agreed what was realistic and achievable in terms of competencies and clinical skills in a two-month period, ensuring patient safety at all times."

One Edinburgh approach to home-based care

The Market Shaping project within our Transformation Programme will look to transform Edinburgh's approach to supporting people in their own homes, recognising that choice and control for supported people cannot happen unless there is a sustainable market of providers and services to choose from. It will support the development of a market facilitation strategy and plan taking into consideration our approach to commissioning care at home services, our internal Home Care and Reablement provision, and further development of the One Edinburgh concept. A One Edinburgh Charter will set our expectations and values and ensure that all providers we work with are committed to offering equitable care and support, fair working practices and have common values in line with our own.

In line with the recommendations within the Independent Review of Adult Social Care, we are moving away from the traditional commissioning approach. Alongside work on the One Edinburgh Charter, the project team have been collaborating with providers to co-produce the new over 65s care at home contract. While the covid-19 pandemic meant that collaboration with providers had to pause to allow them to focus on delivering care to existing service users, this work has accelerated from August 2020 onwards. The new contract is expected to be in place by October 2022, with an emphasis on moving away from time and task models of care provision to focus on better outcomes for the people we support.

This project is also supporting the development of a market facilitation strategy and plan to ensure there is a sustainable market of providers and services for supported people to choose from.

Pharmacotherapy evolution

Pharmacotherapy is one of the main constituents of the Primary Care Improvement Plan and is expected to invest around £3.5 million each year over the 4-year implementation period (April 2018 – April 2022).

As with many other services, at the beginning of the 2020/21 financial year there was huge disruption to the established pattern of prescribing demand. This was likely linked to changing patterns of patient interaction and demand due to behaviour changes at the start of the pandemic. It is too early at this stage to say whether these changes in behaviour will be sustained. We also saw a strengthening of the role of the community pharmacy during the pandemic, as people stayed local and avoided hospital visits alongside the extension of the Pharmacy First service to allow all patients in Scotland access to treatment for minor ailments at a community pharmacy.

Despite this disruption, we continued to successfully implement many aspects of the Primary Care Improvement Plan linked to pharmacotherapy. New staff continued to be successfully inducted with around 20 new pharmacists and pharmacy technicians deployed and supported. Several new ways of working were explored such as providing pharmacotherapy

services remotely and a move towards utilising serial prescribing. This created additional capacity within the system and will be further explored, along with other innovations.

We also met our financial targets with around £2.1 million delivered against an adjusted target of £1.9 million.

Priority 6: Right care, right place, right time

As part of making sure people receive the right care in the right place at the right time, we want to ensure people are supported to live as independently as possible. We are committed to ensuring people are supported at home and within their communities whenever possible and are admitted to and stay in hospital only when clinically necessary. Central to our thinking is working towards the provision of care tailored to the individual, in a place which best provides this care and as close as possible to when it is required.

Home First

The Home First project is helping to avoid the need for hospital admissions and supporting people to get home as quickly as possible once it is safe for them to do so. We aim to embed the Home First ethos, with a dedicated staff team, into business as usual by March 2022.

Between April and August 2020, the Home First teams were dedicated to supporting the covid-19 response by helping people out of hospital and back home when it was safe to do so. This resulted in historically low delayed discharges. Since then we have supported the introduction of Home First navigators in both the Royal Infirmary of Edinburgh and the Western General Hospital to support earlier discharge planning and work with Home First teams in the community. From April 2020 the Home First team has been screening all referrals to intermediate care to ensure the patient is on the right pathway to have their care needs met, with a Home First co-ordinator successfully piloted within these intermediate care facilities to support this work.

The Home First team also supported the national drive to redesign urgent care initiated by the Scottish Government, with new pathways implemented in January 2021. Approximately 20% of all people who present to the front door of acute services could have their assessment, care and treatment elsewhere. The redesign of urgent care has implemented a single point of contact via NHS24 to triage patients and redirect them to the most appropriate service to meet their care needs. We have implemented an urgent therapy and social care pathway to support urgent referrals relating to social care. This pathway has been live from January 2021 and will be evaluated iteratively to ensure its success.

Supporting carers

Carers are a vital partner in supporting the most vulnerable people in society and were significantly affected by the restrictions put in place during the pandemic, with limited access to many of the services they rely upon, including respite care. Carer Centres continued to offer emotional support, information and practical advice to carers, including connecting carers with a service that's right for them. The Edinburgh Carers Strategic Partnership Group continues to work together to implement the Edinburgh Joint Carers' Strategy 2019-22 and ensure support is in place to mitigate the impact of the pandemic on carers.

During 2020/21 we also undertook a comprehensive commissioning exercise to establish new carer support contracts, which commenced on January 2021. These have been designed to expand supports that were already valued and deliver against the six key priority areas in the Edinburgh Joint Carer's Strategy 2019-22: Identifying Carers; Information and

Advice; Carer Health and Wellbeing; Short Breaks; Young Carers; and Personalising Support for Carers. They include additional supports for carers to have a break from caring.

Contracts were awarded to four lead providers, with a value of £17,373,169 over 8 years. Through encouraging providers to consider a collegiate approach, the contract award has supported the development of a Carewell Partnership, with a lead provider and four other providers, to deliver carer health and wellbeing support.

Assistive Technology Enabled Care

Our Assistive Technology Enabled Care (ATEC 24) service uses technology to help people live safely in their homes for as long as possible. This is a hosted service which operates on a Lothian-wide basis. The importance of this service has been highlighted during the pandemic when it has been more difficult to physically visit those in need of support.

In 2020/21, 1,200 new telecare installations were completed. Our telecare service responded to 550,000 alarm calls, with 11,500 emergency intervention visits.

We also established a 'click and collect' service for equipment to supplement our existing delivery service, with over 116,000 essential items provided across Edinburgh, Midlothian and East Lothian in 2020. An estimated 66,000 of these were provided to Edinburgh residents.

Sensory impairment community-based services

In 2020-21 we commissioned a new suite of sensory impairment community-based services. This included commissioning of specialist deaf social work services, deaf equipment service, eye clinic support service, rehabilitation and mobility service for people with sight loss, and administration and management of the Certificate of Vision Impairment register. Delivery of social work for people with vision impairment was brought inhouse to our locality teams, supported by interactive visual impairment awareness training delivered to 150 locality staff.

Contracts for deaf services were awarded to local provider Deaf Action commencing October 2020 to run for 3-5 years. The existing sight loss services were extended by 6 months to take account of covid-19, with new sight loss services commencing in April 2021 with our new community partners, also for 3-5 years. Sight Scotland (formerly Royal Blind) won the contract to deliver both rehabilitation and mobility training for people with a vision impairment, and the management of the Certificate of Vision Impairment database on behalf of the City of Edinburgh Council, while Visibility Scotland will deliver the Patient Support Service at the Princess Alexandra Eye Pavilion. Both organisations have great commitment to working in partnership with us and each other to deliver high-quality and seamless services to the person with sight loss.

Health and wellbeing outcomes

There are nine national health and wellbeing outcomes which have been set by the Scottish Government. Each Integration Joint Board (IJB) uses these outcomes to set their local priorities.

The table below shows how the strategic priorities form our Strategic Plan contribute to these national outcomes.

Strategic priority	National outcomes this priority contributes to	Associated national indicators
Prevention and early intervention	Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer Outcome 4: Health & social care services are centred on helping to maintain or improve the quality of life of people who use those services	Indicator 1 Indicator 7 Indicator 12 Indicator 16
Tackling inequalities	Outcome 5: Health & social care services contribute to reducing health inequalities	Indicator 11
Person-centred care	Outcome 3: People who use health & social care services have positive experiences of those services, and have their dignity respected Outcome 7: People who use health and social care services are safe from harm	Indicator 3 Indicator 4 Indicator 5 Indicator 9 Indicator 17
Managing our resources effectively	Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services	Indicator 14 Indicator 20
Making best use of the capacity across the system	Outcome 8: People who work in health & social care services feel engaged with the work they do and are supported to continuously improve information, support, care and treatment they provide	Indicator 6
Right care, right place, right time	Outcome 2: People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community 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 wellbeing	Indicator 2 Indicator 8 Indicator 13 Indicator 15 Indicator 18 Indicator 19

Underpinning the nine wellbeing outcomes sits a core suite of integration indicators, which all HSCPs report their performance against. These national indicators have been developed from national data sources to ensure consistency in measurement. There are 23 indicators but four of them (indicators 10, 21, 22 and 23) have not yet been finalised for reporting.

National indicators (NI) 1 to 9 are based on the Scottish Health and Care Experience Survey (HACE) commissioned by the Scottish Government. The primary source of data for national indicators 11 to 20 are Scottish Morbidity Records (SMRs) which are nationally collected discharge-based hospital records.

Calendar year 2020 is used for some of the indicators as a proxy for 2020/21 due to the national data for 2020/21 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships. Please note that figures presented will not take into account the full impact of covid-19 during 2020/21.

Performance against national indicators

Health and Care Experience Survey indicators

National indicators (NI) 1 to 9 are based on the Scottish Health and Care Experience Survey (HACE) commissioned by the Scottish Government. This survey is sent randomly to around 5% of the Scottish population every two years.

The most recent survey results for inclusion in this report are from the 2019/20 survey. In 2019/20 the survey was sent to 46,099 people in Edinburgh with 11,415 responses which shows a response rate of 25%. The response rate across Scotland was also 26%. The methodology was changed in 2019/20 therefore, following advice from PHS, we have provided the results from previous surveys but have not made direct comparisons.

Edinburgh is above the Scottish average for 2019/20 in six of the nine HACE survey indicators, as shown in the table below.

National Indicator (NI)	2019/20* Edinburgh	2019/20* Scotland	2015/16* Edinburgh	2015/16* Scotland	2017/18* Edinburgh	2017/18* Scotland
NI-1: Percentage of adults able to look after their health very well or quite well	93.8%	92.9%	96.1%	95.0%	93.6%	93.0%
NI-2: Percentage of adults supported at home who agree that they are supported to live as independently as possible	77.6%	80.8%	80.8%	83.0%	78.6%	81.0%
NI-3: Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	76.7%	75.4%	77.4%	79.0%	73.8%	76.0%
NI-4: Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	72.6%	73.5%	71.4%	75.0%	66.7%	74.0%
NI-5: Total percentage of adults receiving any care or support who rated it as excellent or good	82.2%	80.2%	78.1%	81.0%	80.4%	80.0%
NI-6: Percentage of people with a positive experience of the care provided by their GP practice	82.5%	78.7%	86.9%	85.0%	84.2%	83.0%

NI-7: Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	83.2%	80.0%	82.6%	83.0%	78.9%	80.0%
NI-8: Total combined % carers who feel supported to continue in their caring role	33.0%	34.3%	36.6%	40.0%	34.8%	37.0%
NI-9: Percentage of adults supported at home who agreed they felt safe	86.5%	82.8%	81.8%	83.0%	77.5%	83.0%

*Figures for 2019/20 are not directly comparable due to changes in methodology
Source: Scottish Government HACE surveys

The areas where we are just below the Scottish average are:

- Adults supported at home agree that they are supported to live as independently as possible
- Adults supported at home agreed that their health and social care services seemed to be well co-ordinated
- Carers feel supported to continue in their caring role

We continue to focus on improvement in each of these areas. Our Home First project, described here, seeks to increase the provision of care and support in the community so people can continue to live as independently as possible. The project is also looking at pathways through the health and social care services to ensure that these are provided in way that is well coordinated between services and makes sense for the individuals experiencing those services.

The Three Conversations approach, currently being rolled out as shown here, focuses on working differently to achieve improved outcomes for people and families. This includes collaborating with the people who are referred to our services to focus on what matters to them and help them make connections or build relationships in order to go on with their life independently. Our Three Conversations approach also seeks to improve coordination between services by ensuring a holistic approach is taken to the needs of individual to connect them with the different services, both internally and in the community, that will best support their needs.

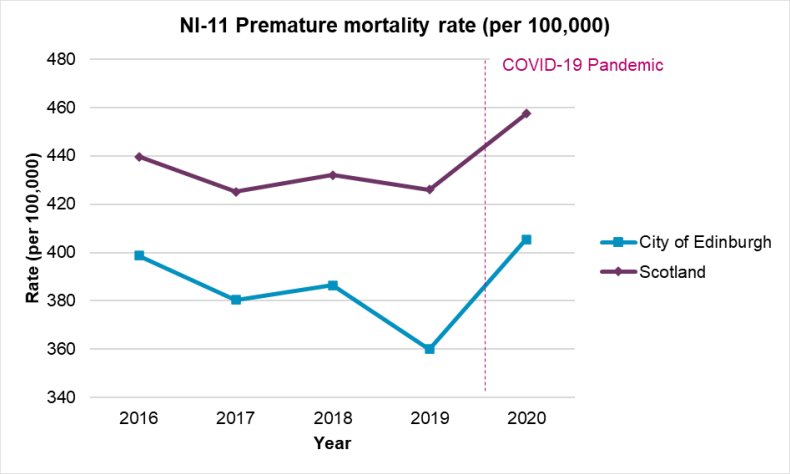
We have also put in place new contracts to support the implementation of our Joint Carers' Strategy, as described here. These will focus on increasing support for the health and wellbeing of carers as well as the provision of robust advice and information. As with many areas across Scotland, we still have work to do to identify all those in caring roles in Edinburgh and ensure they receive the support they need.

Indicator 11: Premature mortality rate

The impact of the pandemic can sadly be seen in this indicator. After declining for years, the premature mortality rate rose sharply in Edinburgh in 2020. This increase was also seen across Scotland. Edinburgh continues to have a lower premature mortality rate than the

Scottish average, and in 2020 Edinburgh is ranked 15 out of the 31 health and social care partnerships in Scotland.

Our Edinburgh Wellbeing Pact and community mobilisation approach will support continued improvement in this indicator, as described earlier. The Pact is underpinned by a shared common purpose: to achieve and maximise the wellbeing of all our citizens. It sets out a reciprocal agreement with the people of Edinburgh to create healthy communities, empowered by local services and organisations that support people to prevent crisis and manage their health and personal independence at home, working together to put wellbeing first.



	2015	2016	2017	2018	2019	2020
Edinburgh	406	399	380	386	360	405
Scotland	441	440	425	432	426	457

Source: Public Health Scotland

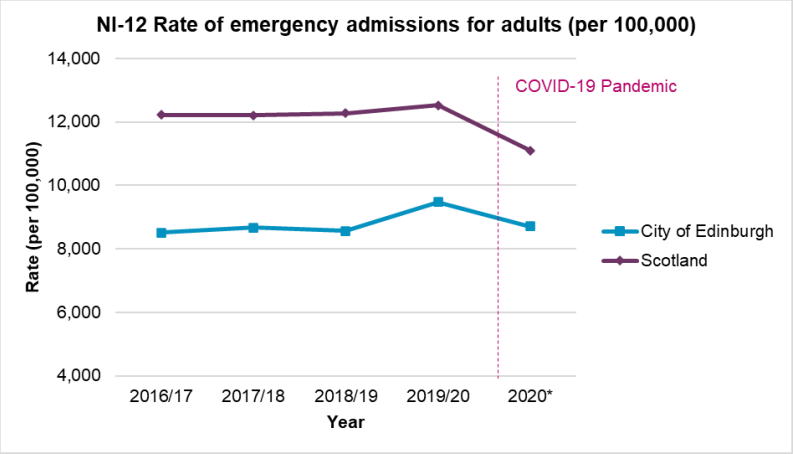
Indicator 12: Rate of emergency admissions for adults

We continue to have a much lower rate for emergency admissions than the Scottish average. The Edinburgh rate is the second lowest in Scotland, following Aberdeenshire.

The rate increased in 2019/20 due to a service change at A&E at the Royal Infirmary Edinburgh that artificially increased the number of emergency admissions. This change will continue to affect the emergency admission rate in 2020, however this has also been influenced by changes in behaviour due to the pandemic, with fewer people attending hospital A&E departments. The drop in emergency admissions in 2020 was much lower in Edinburgh than in Scotland, likely reflecting the lower number of emergency admissions to begin with. Due to the disruption over the last year, we can't accurately assess the ongoing trend in this indicator.

While we cannot yet know whether this behaviour change will be sustained, our Home First project, described here, continues to look for ways to treat patients at home or in the community where appropriate, including through a redesign of unscheduled care pathways.

The differences in the rate between our localities reflects the different demographics of these localities, shown here.



	2016/17	2017/18	2018/19	2019/20	2020*
Edinburgh	8,512	8,670	8,564	9,481	8,711
Scotland	12,229	12,210	12,279	12,522	11,100
Our localities					
North East	8,852	9,042	9,128	10,210	9,391
North West	9,360	9,471	8,961	9,974	9,267
South East	7,480	7,502	7,306	7,998	7,303
South West	8,402	8,750	9,059	9,959	9,071

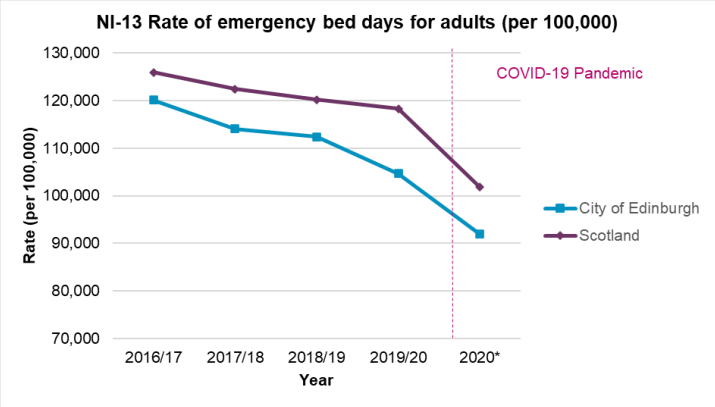
* 2020 calendar year data has been used instead of 2020/21 financial year data due to data availability.
Source: Public Health Scotland

Indicator 13: Rate of emergency bed days for adults

Like the rate of emergency admissions, the rate of emergency bed days has been consistently below the Scottish average over the last five years. We are the eighth best performing partnership on this indicator.

This indicator has also been affected by the impact of the pandemic and fewer people attending our hospital for emergency treatment. We are therefore unable to accurately compare to previous years, as we are unable to identify how much of the continuing drop in emergency bed days is due to the pandemic.

As with the rate of emergency admissions, the rate of emergency bed days varies across our localities depending on demographics outlined here.



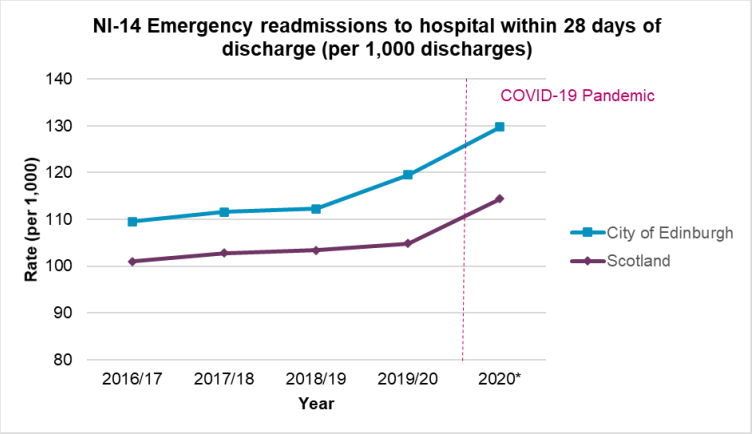
	2016/17	2017/18	2018/19	2019/20	2020*
Edinburgh	120,090	114,035	112,425	104,646	91,920
Scotland	125,948	122,388	120,155	118,288	101,852
Our localities					
North East	113,830	103,505	106,451	98,567	87,934
North West	129,659	120,854	114,742	105,552	90,960
South East	133,043	127,709	120,753	110,399	101,998
South West	98,478	99,542	105,390	102,810	84,613

* 2020 calendar year data has been used instead of 2020/21 financial year data due to data availability.
Source: Public Health Scotland

Indicator 14: Readmissions to hospital within 28 days of discharge

Edinburgh has been consistently above the Scottish average on this indicator and ranks in the lowest 20% of partnerships. Work is ongoing to better understand the reasons behind this high rate of readmissions and look at how we can target improvements in this area.

This indicator was also affected by the pandemic, with a sharp increase in both Edinburgh and Scotland between 2019/20 and 2020. The increase in rate in Edinburgh is roughly the same as the increase in Scotland. This is likely partially due to the lower number of people in hospital over 2020, meaning that those in hospital have more complex issues and are therefore more likely to have recurring issues that result in the need to be readmitted. Again, we can't accurately compare this indicator to previous years due to the impact of the pandemic on these figures.



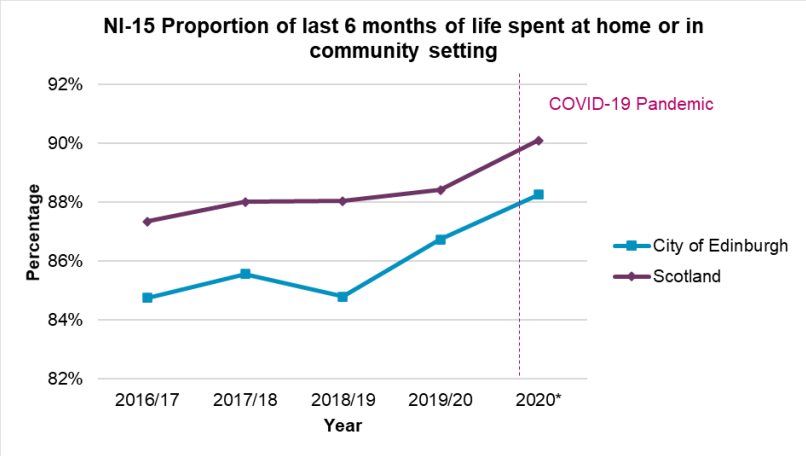
	2016/17	2017/18	2018/19	2019/20	2020*
Edinburgh	110	112	112	119	130
Scotland	101	103	103	105	114
Our localities					
North East	113	110	119	124	131
North West	104	106	104	112	130
South East	116	116	109	119	122
South West	107	117	119	124	135

* 2020 calendar year data has been used instead of 2020/21 financial year data due to data availability.
Source: Public Health Scotland

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

Edinburgh has a lower rate than the Scottish average on this indicator but while we have one of the lowest rates in Scotland, the difference with the national average is small. Over the last five years, we have made progress to close this gap and improve our performance in this space. As this measure is based on how much time people spent in hospital during the last six months of their life, the lower numbers in hospital in 2020 will have affected the trend.

Our Home First project is continuing to focus on supporting people at home or in a community setting where appropriate, including through our Hospital at Home service. Our bed based strategy is also looking to ensure we have the right mix of beds across hospital and community setting to support a shift in the balance of care to the community.



	2016/17	2017/18	2018/19	2019/20	2020*
Edinburgh	85%	86%	85%	87%	88%
Scotland	87%	88%	88%	88%	90%
Our localities					
North East	85%	85%	85%	87%	88%
North West	82%	84%	83%	85%	86%
South East	86%	87%	87%	88%	90%
South West	87%	86%	86%	87%	89%

* 2020 calendar year data has been used instead of 2020/21 financial year data due to data availability.
Source: Public Health Scotland

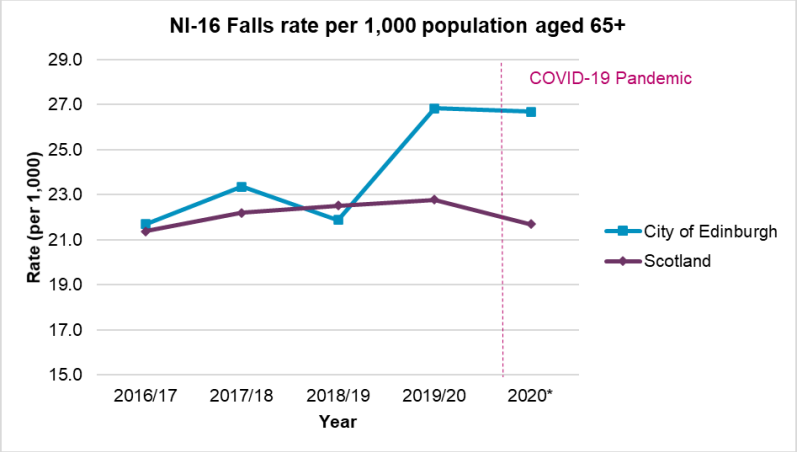
Indicator 16: Falls rate per 1,000 population in over 65s

The falls rate in Edinburgh is higher than the national average and in 2020 we have the third highest rate out of all the health and social care partnerships. However, in 2018/19 we had the 12th lowest rate out of the 31 partnerships. This rate is based on the number admitted to hospital following a fall, rather than all falls in the community.

The rate increased sharply from 2019/20 and was accompanied by a drop in the average length of stay following admission. It is likely this is linked to the service change at A&E at the Royal Infirmary Edinburgh that artificially inflated emergency admission numbers.

The restriction in activities associated with the pandemic may also have influenced this figure in 2020. Many people could have lost fitness or muscle tone following the inability for them to continue their normal activities, particularly those who were shielding. This increases the risk of falls and may have offset the reducing numbers attending hospital last year.

The staying active activities described here, run through our long term conditions programme and funded through our grants programme, continue to support our vulnerable population and those with long term conditions to stay active and reduce the likelihood of falls.



	2016/17	2017/18	2018/19	2019/20	2020*
Edinburgh	21.7	23.4	21.9	26.8	26.7
Scotland	21.4	22.2	22.5	22.8	21.7
Our localities					
North East	22.0	25.0	23.0	30.0	29.2
North West	22.0	24.0	22.0	27.0	27.8
South East	24.0	23.0	22.0	28.0	26.4
South West	19.0	21.0	21.0	23.0	23.1

* 2020 calendar year data has been used instead of 2020/21 financial year data due to data availability.
Source: Public Health Scotland

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

Indicator 17 has also been affected by the pandemic, as the Care Inspectorate altered the way they ran inspections and their areas of focus during the inspections.

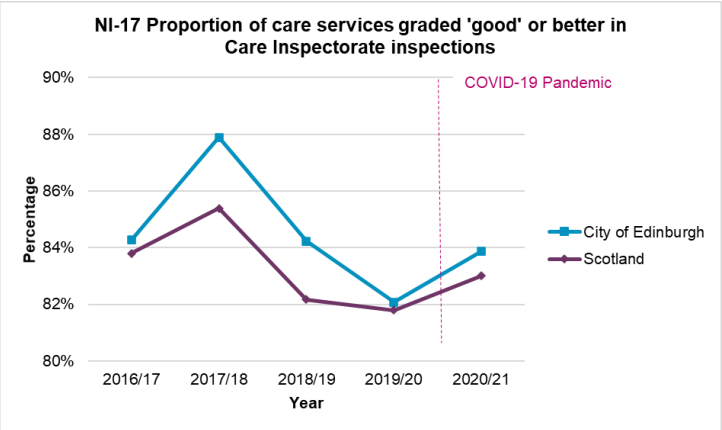
Advice from directors of Public Health in Scotland was that inspection visits would present a real risk of introducing and spreading covid-19 in Scotland's care homes. With agreement from Scottish Government, the Care Inspectorate therefore restricted their presence in services unless necessary. This approach resulted in most services not being graded as normal and instead retaining the grades they had last received.

Instead the Care Inspectorate intensified oversight using a range of remote and virtual approaches to ensure services were supported and operating well throughout the pandemic. The Care Inspectorate also developed a new question to allow them to focus inspections on how services were responding to pandemic, particularly in relation to increased infection prevention and control requirements.

The data for NI-17 comes from the Care Inspectorate and covers all registered services in Edinburgh, not just those that we run. The figure covers the latest inspection result for each registered service, even if the inspection took place before the referenced financial year.

In 2020/21, 84% of care services in Edinburgh had a grade of 'good' (4) or better, compared to 83% in Scotland, meaning we are above the Scottish average. We rank 20th out of 31

partnerships on this indicator. A summary of the Care Inspectorate reviews of our services during financial year 2020/21 and the work we have done to improve services in our care homes is shown here.



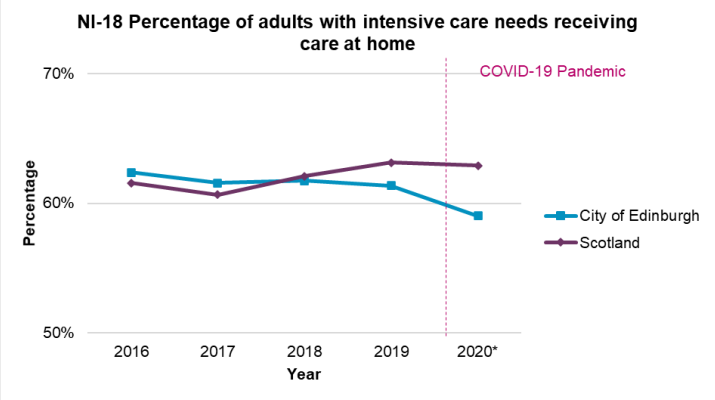
	2016/17	2017/18	2018/19	2019/20	2020/21
Edinburgh	84%	88%	84%	82%	84%
Scotland	84%	85%	82%	82%	83%

Source: Care Inspectorate

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

There has been a slight drop in the percentage of adults with intensive needs receiving care at home (those receiving personal care or direct payments for personal care) in 2020 from 61.4% to 59%. We remain below the national average and are ranked 24th out of 31 partnerships. In 2020 this indicator has likely been affected by the need to prioritise our support to the most vulnerable during the pandemic.

We continue to work to shift the balance of care from hospital settings to the community, including through our bed-based review and Home First approach.



	2016	2017	2018	2019	2020
Edinburgh	62.4%	61.6%	61.8%	61.4%	59.0%
Scotland	61.6%	60.7%	62.1%	63.1%	62.9%

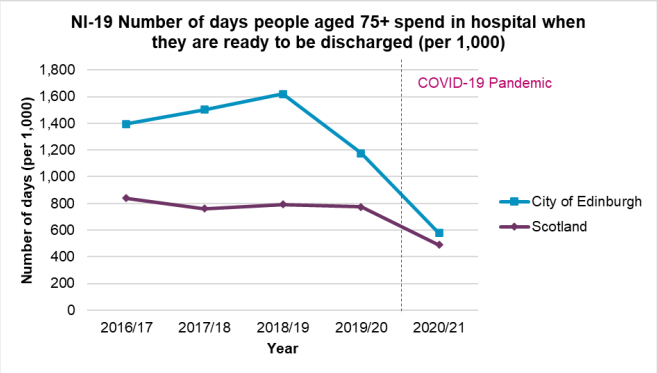
Source: Public Health Scotland

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

The rate of bed days lost due to delayed discharged for those over 75 has decreased sharply in 2020/21 for both Edinburgh and Scotland. The figure for Edinburgh was 579 compared to 488 in Scotland. This is a decrease in Edinburgh from 1,175 days in 2019/20.

The 2020/21 figures will be affected by the pandemic both due to the lower number of people being admitted to hospital and the focus on this area to free up beds to increase hospital capacity. However, between 2019/20 and 2020/21, this figure decreased by 51% in Edinburgh compared to a 37% decrease in the figure for Scotland. We remain higher than the national level, but the gap has closed over the last few years. In 2020/21 we were ranked 22nd out of 31 partnerships, an improvement from our ranking of 27th in 2019/20.

We continue to work to reduce the levels of delayed discharges in Edinburgh, however these are likely to increase again as our services remobilise and pressures on capacity increases following the removal of restrictions. Our bed-based strategy will implement changes that support increased capacity in intermediate care and nursing homes and a smoother pathway for referrals to additional bed-based care. Ongoing work through the Home First project on implementing a Planned Date of Discharge will also support more proactive discharge planning.



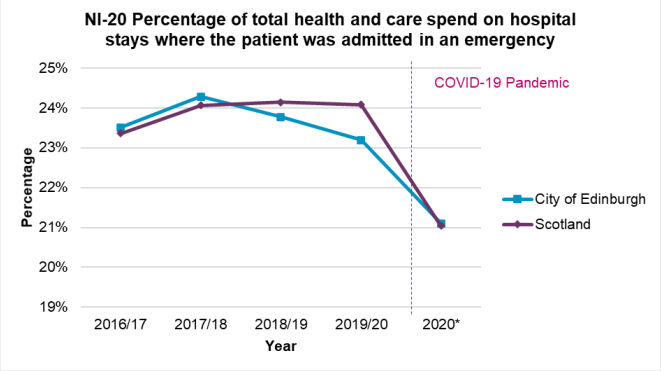
	2016/17	2017/18	2018/19	2019/20	2020/21
Edinburgh	1,395	1,502	1,621	1,175	579
Scotland	841	762	793	774	488

Source: Public Health Scotland

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

The percentage of total health and care spend on hospital stays resulting from emergency admissions has decreased in 2020. This figure includes spend that is not part of our budget so does not match our financial information. The figure in 2020 likely decreased due to the combination of increased spending, primarily community based, due to the pandemic, and the lower numbers of emergency admissions. As with other indicators, this means that we are unable to accurately compare trends across years.

This indicator is linked to our desire to shift the balance of care from hospital settings to the community where appropriate. This is supported by our Home First, bed-based strategy and community mobilisation projects within our Transformation programme. We have described our own financial situation in more detail here.



	2016/17	2017/18	2018/19	2019/20	2020*
Edinburgh	23.5%	24.3%	23.8%	23.2%	21.1%
Scotland	23.4%	24.1%	24.1%	24.1%	21.0%

* 2020 calendar year data has been used instead of 2020/21 financial year data due to data availability.
Source: Public Health Scotland

Ministerial Strategic Group indicators

We also report performance indicators to the Scottish Government through the Ministerial Strategic Group for Health and Community Care (MSG). These performance indicators give a view of how HSCPs are progressing against a range of whole system level measures. The performance indicators are largely based on hospital sector data due to routine availability of national data. While similar to some of the core indicators, these figures are calculated in slightly different ways so are not comparable.

As with the core indicators, these figures have been impacted by the pandemic. The restrictions on both people's movement and hospital activity resulted in lower numbers of A&E attendances, unplanned admissions, emergency bed days and delayed discharges. The percentage of the last 6 months spent in community setting and the population over 65 living at home (balance of care) were also likely affected by the reduction in hospital activity.

A summary of the MSG measures and performance for Edinburgh in 2020/21 is shown in the table below. No targets were set for 2020/21 due to the pandemic.

Indicator	2017/18 Baseline total	Desired direction of travel	Latest available figures	Latest period available
A&E Attendances	103,986	↓	83,458	2020/21
Unplanned Admissions	35,597	↓	36,642+	2020
Emergency Occupied Bed Days:				
• Acute	330,759	↓	268,972	2020
• Geriatric Long Stay^	22,324	↓	19,472^	2020/21
• Mental Health	122,841	↓	131,002p	2019/20
Delayed Discharges	76,933	↓	32,798	2020/21
Last 6 months of life spent in a community setting	85.7%	↑	86.7%p	2019/20
Balance of Care#	95.5%*	↑	95.7%p	2019/20

+ More detail on the change in emergency admissions since 2017/18 is provided here.

^ Geriatric long stay unscheduled occupied bed days data is affected by SMR completeness issue.

p This data is provisional.

This indicator is still under development and may change in future releases.

* The Balance of Care 2017/18 baseline figure has been updated since it was last published, it was previously 95.6%.

Looking ahead

The impact of covid-19 and related restrictions will likely have a continuing impact directly on health and wellbeing as well as indirectly through the economic situation that may exacerbate existing inequalities. We continue to monitor and prepare for this longer-term impact.

Over 2021/22 we will be refreshing and consulting on our Strategic Plan for 2022 to 2025. This will consider our evolving strategic priorities in light of the impact of covid-19 as well as wider trends our services need to respond to.

We will also draw on the findings of the Independent Review of Adult Social Care, released in February 2021, to ensure our strategic plan responds to the opportunities presented by this report. The full extent of changes to adult social care resulting from this report may not be realised for some time but we need to ensure our plans align to the direction endorsed by the Scottish Government.

Our focus on our transformation programme will continue over 2021/22. We will reach significant milestones in a few of our major projects, including:

- Finalise and embed the 'Edinburgh Pact' through community mobilisation and other transformation projects.
- Continue our bed-based care project by seeking approval of phase one of the bed-based strategy and commencing work on redesign options for phase 2 work streams.
- Embed the Home First ethos, with a dedicated staff team, into business as usual by March 2022.
- Roll out the Three Conversations approach to all services completing assessments, allowing a reduction in waiting times for assessment, better and more person-centred outcomes for individuals and reduced referrals to paid-for services.
- Develop a market facilitation strategy and plan to ensure there is a sustainable market of providers and services for supported people to choose from.
- Implement new Care at Home contracts by October 2022 following a co-production process focused on moving away from time and task models of care provision to focus on better outcomes for the people we support.

Our transformation programme was funded and resourced on a two-year basis, which is due to end in March 2022. Some projects will be transitioned into our business as usual structures by this time, with the ethos of Home First and Three Conversations embedded into our everyday work. Other projects will require ongoing support for implementation over a longer period – for example, the Bed Base Strategy and Market Shaping – and consideration will be given on how best to resource this within a core strategic programme of work.