Edinburgh Integration Joint Board

REPORT

Annual Performance Report 2022/23

Edinburgh Integration Joint Board

8 August 2023

Executive Summary	1. The purpose of this report is to provide the **Edinburgh Integration Joint Board (EIJB)** with a copy of the final EIJB Annual Performance Report 2022/23 (APR) for approval. 2. The APR was presented to the Performance and Delivery Committee at their committee meeting on 2 August. As agreed at the Performance and Delivery Committee on 26 April 2023, the content for the APR for 2022/23 reflects the structure and - broadly speaking - the content of the APR for 2021/22, as this was previously well received by the EIJB and our partners. This structure allows for key messages on progress against the priorities in our strategic plan and performance against the national indicators. This year, however, there is no specific content about the impact of the pandemic. 3. The APR has been provided for review and approval as a pdf but will be published as a suite of webpages to ensure we comply with UK accessibility guidelines. Every effort has been made to ensure clear, concise and accessible language, in line with the direction set out in our Communication and Engagement Strategy presented to the IJB in June 2020. 4. As the terms of the Coronavirus (Scotland) Act no longer apply, the APR must now be published before the end of July. However, informal discussions with Scottish Government have confirmed we can delay publication for a month until after our approval process is complete. This meeting of the EIJB represents the final stage of the process, and once the report is approved, it will be published online before the end of August.

Recommendations	1. It is recommended that the EIJB approves the publication of the APR 2022/23.

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 2022/23 was presented to the Performance and Delivery Committee as the lead Committee for performance issues at their committee meeting on 2 August 2023. A version was also circulated to committee members prior to circulation to EIJB but no significant feedback was received. An update will be verbally provided to EIJB on any further changes from the committee meeting on 2 August at the EIJB meeting on 8 August 2023.

2. A version of this report was also considered by the Executive Management Team on 13 July 2023.

Main Report

3. Integrated Joint Boards are required by legislation to produce an Annual Performance Report (APR) each year covering performance over the previous financial year.

4. 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.

Content

5. The report provides a summary of progress against key projects undertaken over the last year under each of the IJB's strategic priorities. This includes

details of projects in our Innovation and Sustainability portfolio as well as any information we are required to include in the report, including financial information and inspections by the Care Inspectorate. The foreword has been reviewed by our Communications and Engagement Manager to ensure alignment with the key messages for the EIJB in our communications plan.

6. There is a dedicated section in the APR on our performance against the Core Indicators and Ministerial Strategic Group (MSG) indicators that the IJB is required to report on. In line with guidance from PHS Scotland, we report data for indicators 12, 13, 14, 15 and 16 for the calendar year 2022 as a proxy for 2022/3, as data for the full financial year is incomplete and, in some cases, misleading. However previous years use financial years as normal. Information for indicator 20 has not been published beyond 2019/20 as detailed cost information was not available during the COVID-19 pandemic.

7. Almost all these figures have been affected substantially by the pandemic and therefore we need to be cautious about comparing figures between years. The report notes where we have been able to identify factors that will have influenced the figures over 2022/23 as well as the key projects we have under way that will improve performance against each indicator.

Accessibility

8. In line with the Communications and Engagement Strategy presented to the IJB on 22 June 2020, we have ensured that the APR aligns with our communication and engagement principles, particularly that it is clear and accessible.

9. Where possible, we have kept language simple and concise to promote understanding and accessibility. While considering the need to present data appropriately, we have also kept tables and graphs to a minimum to support the use of screen readers.

10. In line with accessibility guidance from the UK Government, we will be publishing the APR as a suite of webpages on our website, not just 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.

Timeline for publication

11. The Scottish Government have advised that the Coronavirus Scotland Act (2020) no longer applies, and to retain the pandemic deadline of autumn for publication of the APR, legislative change would be required. Consequently, we have reverted to pre-pandemic arrangements and the Scottish Government announced that Integration Authorities should publish this year's APR by the end of July.

12. However, core indicator and MSG data is not published by Public Health Scotland until mid-July. Because of the difficulties in obtaining and collating all the data and narrative in time to meet this deadline, and because the Committee calendar is such that a July deadline would not permit the APR to go through our approval process, discussions with the Scottish Government have confirmed that we may delay publication until the end of August.

13. This meeting of the EIJB represents the final stage of the process, and once the report is approved, it will be published online before the end of August.

Implications for Edinburgh Integration Joint Board

Financial

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

Legal / risk implications

15. There are no direct legal or risk implications arising from this report.

Equality and integrated impact assessment

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

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

18. An integrated impact assessment is not required.

Environment and sustainability impacts

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

Quality of care

20. 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

21. Senior managers have reviewed the sections directly relevant to their areas of work. The final draft APR has been reviewed by the Partnership's Communications and Engagement Team.

Report Author

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Appendices

Appendix 1 EIJB Annual Performance Report 2022/23

Edinburgh Integration Joint Board

Annual Performance Report 2022/2023

Edinburgh Integration Joint Board

Annual Performance Report 2022/23

Foreword

2022/23 has been another challenging year for the health and social care sector throughout Scotland and this has been felt across our services in Edinburgh. Health, care and wellbeing continues to be affected by the aftermath of the pandemic, with an ongoing 'cost of living crisis' exacerbating existing inequalities.

The Edinburgh Integration Joint Board (EIJB), like others across Scotland, operates within a complex environment. Health and social care services are under pressure due to an ageing population, with increasing numbers of people living with long term conditions, whilst also facing a reducing working age population that is further impacted by challenges in workforce supply and pressure on budgets. This is ultimately leading to unparalleled challenges to the sustainability of our health and social care system. A refreshed EIJB Strategic Plan was put on hold until 2023/24 to allow us to target resources at the delivery of services and ensuring the smooth flow of patients through hospitals to free up beds to support our most vulnerable residents.

In this Annual Performance Report for 2022/23, we outline our challenges and achievements this year as well as our progress against the six Strategic Priorities in our Strategic Plan 2019-22, and against the Scottish Government's National Health and Wellbeing Outcomes and associated indicators.

After a difficult few years responding to the pandemic and ensuing pressures across the system, we have seen positive improvements across a wide range of indicators covered in this report. 13 out of 15 indicators have seen an improved or steady ranking on benchmarked performance compared to last year and we remain in the top half of partnerships for 9 of the indicators with an update in this report, with improvements also seen in other areas. In particular, we have seen positive movement in our levels of bed days spent in delay for over 75s this year. Edinburgh is one of only four partnerships that saw improved performance in delays in 2022/23, with a 6% reduction in Edinburgh compared to a 23% increase nationally, although challenges remain to reduce our level of delays to sustainable levels.

Despite these improvements and the positive stories of our service delivery and innovation shown throughout this report, there remains work to be done. The Care Inspectorate undertook two inspections of our services this year: Adult Support and Protection and Adult Social Care and Social Work. We welcome careful and ongoing scrutiny of our work and that of our partners to ensure that systems and practices are working effectively – and to make improvements when they are not. While these inspection reports highlight areas where we are getting it right, they also highlight key areas for improvement and reflect broader challenges that are common to health and social care partnerships across Scotland. In particular, the inspection reports highlighted concerns around the design, structure, implementation and oversight of key processes, social work workforce capacity, quality assurance and approaches to early intervention and prevention.

Despite the challenges we face, particularly in resourcing and recruitment, we need to build on our strengths – most obviously the commitment of our hard-working colleagues who give their all working in the Edinburgh Health and Social Care Partnership (EHSCP), supporting needs of those who have deeply complex and difficult lives. We have developed an improvement plan, approved by the EIJB in June 2023, to support frontline colleagues and respond to areas for improvement highlighted by the Care Inspectorate. Our priorities within this improvement plan are:

- A focus on early intervention, prevention and demand management
- Reducing waiting lists and improving access to services
- Best use of resources to meet demand and an improved structure
- Getting basic and key processes right
- Workforce – improving recruitment, retention and governance
- Better governance, including professional supervision, manager oversight and quality assurance.

Alongside this improvement plan, the EIJB approved a budget savings programme in June 2023 to enhance financial sustainability of our services within a difficult financial environment and demographic pressures. By using a person-centred approach, the EIJB can deliver better results for people more efficiently over the course of the strategy. In addition, through the use of stronger commissioning and an improved 'digital front door' for people looking to access services, the deficit reduction will be made through creating a modern service, fit for the future.

Our thanks go to all our staff, partners, unpaid carers and volunteers for their dedication and hard work through this difficult year and we look forward to continuing to support you to provide vital care and support to our most vulnerable citizens.

Images to be added

Katharina Kasper
Chair
EIJB

Mike Massaro-Mallinson
Interim Chief Officer
EHSCP

Overview

Introduction

The 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.

This performance report sets out our progress against the strategic priorities within the EIJB Strategic Plan 2019-22, which remains extant and is available online. The content in this report covers the financial year April 2022 to March 2023 unless otherwise stated. An update to the EIJB Strategic Plan was delayed as we responded to post-pandemic systems pressures and our response to recent inspections. The refreshed EIJB Strategic Plan is expected to be published in late 2023.

Delivery arrangements

The 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, and our Chief Officer is accountable to the Chief Executives of both the City of Edinburgh Council and NHS Lothian.

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.

Our major change projects are now collectively referred to as Innovation and Sustainability. The Innovation and Sustainability Portfolio includes some of the key pieces of work that were previously part of the transformation programme, including Home First, Three Conversations and the Edinburgh Wellbeing Pact, which are outlined in this report. However, it also focuses on ensuring that services are sustainable in the longer term. To be sustainable, we need to deliver services within our budget, but we also need to address the challenge of increasing demand for health and social care services and ensure that we can continue to attract and retain a skilled and capable workforce.

About Edinburgh and our localities

Edinburgh is one of the largest health and social care partnerships in Scotland, with a population of 526,470 as of July 2021. 81,277 residents were aged 65 or over, with this age group projected to increase the most over the coming years. Edinburgh is also the wealthiest city in Scotland, with 80.9% of the working age population in employment. 34.7% of the economically inactive population within the city are students, and 19% look after others.[1] However, 15% of the population, and as many as 20% 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. An overview of our localities is

provided here and our joint strategic needs assessment (JSNA) provides more detail on the population and demographics of Edinburgh.

North East

- 125,188 people live in the North East locality[1]
- 50.8% are female and 49.2% are male
- 15.1% are aged under 18, 71.6% are 18-64 and 13.3% are over 65
- 21.2% of people lived in the least deprived SIMD quintile, and 18.2% lived in the most deprived quintile[2]
- Life expectancy at birth is 80.6 years for women and 76 for men[1]
- 36,392 average home care hours per week between January and March 2023
- 1,564 were receiving home care at the end of March 2023
- 18 GP practices[3]

North West

- 148,992 people live in the North West locality[1]
- 51.6% are female and 48.4% are male
- 19.7% are aged under 18, 62.6% are 18-64 and 17.7% are over 65
- 50.3% of people lived in the least deprived SIMD quintile, and 9.1% lived in the most deprived quintile[2]
- Life expectancy at birth is 83.4 years for women and 79.6 for men[1]
- 30,886 average home care hours per week between January and March 2023
- 1,616 people receive were receiving home care at the end of March 2023
- 18 GP practices[3]

South East

- 138,730 people live in the South East locality[1]
- 52.4% are female and 47.6% are male
- 14% are aged under 18, 71.5% are 18-64 and 14.5% are over 65
- 49.5% of people lived in the least deprived SIMD quintile, and 8.8% lived in the most deprived quintile[2]
- Life expectancy at birth is 82.5 years for women and 78.1 for men[1]
- 26,935 average home care hours per week between January and March 2023
- 1,300 people were receiving home care at the end of March 2023
- 18 GP practices[3]

South West

- 113,560 people live in the South West locality[1]
- 49.7% are female and 50.3% are male
- 17.6% are aged under 18, 66.4% are 18-64 and 16% are over 65
- 40.8% of people lived in the least deprived SIMD quintile, and 12.9% lived in the most deprived quintile[2]
- Life expectancy at birth is 83.2 years for women and 78.8 for men[1]
- 31,757 average home care hours per week between January and March 2023
- 1,358 people were receiving home care at the end of March 2023
- 16 GP practices[3]

[1] The Scottish Public Health Observatory (ScotPHO)
[2] PHS LIST Locality Profiles
[3] National Primary Care Clinicians Database (NPCCD), Public Health Scotland

Performance overview

In the Performance section of this Annual Performance Report, we report progress against the National Indicators set by the Scottish Government and Ministerial Strategic Group for Health and Community Care (MSG) indicators.

13 out of 15 indicators with an update this year have seen an improved or steady ranking on benchmarked performance compared to last year and we remain in the top half of partnerships for nine (60%) of the indicators, with improvements also seen in other areas. Our benchmarked performance is shown in the table below, including our quartile position and the change in our ranking compared to last year.

In particular, we have seen positive movement in our levels of bed days spent in delay for over 75s this year. Edinburgh is one of only four partnerships that saw improved performance in delays in 2022/23, with a 6% reduction in Edinburgh compared to a 23% increase nationally, although challenges remain to reduce our level of delays to sustainable levels.

For the areas that have not seen improvement this year, we remain above the national average in both indicators and the reduction in the actual rate is small.

Core Indicator		Time Period	Quartile	Change in rank from previous year
NI-11	Premature mortality rate	2022	2	↓
NI - 12	Emergency admission rate (per 100,000 population)	2022	1	↑
NI - 13	Emergency bed day rate (per 100,000 population)	2022	1	↑
NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	2022	2	↑
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	2022	3	↑
NI - 16	Falls rate per 1,000 population aged 65+	2022	3	↑
NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2022/23	2	↓
NI - 18	Percentage of adults with intensive care needs receiving care at home	2022	2	↑
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	2022/23	4	↑
MSG 1.a	Rate of A&E Attendances (lowest rate = Quartile 1)	2022	2	↑
MSG 1.b	4-hour Performance	2022	4	↑
MSG 2	Rate of Emergency Admissions (lowest rate = Quartile 1)	To Oct-22	1	↑
MSG 3a.	Unscheduled Bed Days (Acute):	To Oct-22	1	↑
MSG 3c.	Unscheduled Bed Days (MH):	To Sep-22	4	→
MSG 4	Delayed Discharge Bed Days:	To Mar-23	3	↑

Source: Public Health Scotland **Notes:** Quartile Trend: The Quartile shown denotes which quartile the City of Edinburgh partnership was in during the time period noted. The arrows indicate the change in the City of Edinburgh's position relative to the other partnerships, between the 12-month time period noted and the previous 12 months.

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.

The Edinburgh Wellbeing Pact and Community Mobilisation

The Edinburgh Wellbeing Pact is framed around the principles of mutuality and reciprocity, and these remain central to all the enactment activities which have been initiated to date. As part of our Community Mobilisation project, we are developing new ways to engage and fund the third sector, with emphasis on community collaboration and assets.

The Edinburgh Pact and community mobilisation work undertaken in the last year has demonstrated how complex the structures and processes are in our commissioning space. The creation of the *More Good Days* Strategic Public Social Partnership (PSP) will provide a better way of moving forwards with our shared narrative and allow incremental changes and developments to be made. Work with colleagues from procurement, commissioning and Health Improvement Scotland has helped to shape the proposal, and the PSP will enable us to be responsive and flexible to unallocated funding, as well as additional or new allocations received. Our ability to be agile in our responses to an ever-changing context is resulting in a more dynamic and fluid plan. This is helping to build an increasing, citywide social movement with a shared narrative of achieving *more good days* for everyone.

There are also a number of collaborations continuing to develop thanks to the extension of the current Health Inequalities Grant Programme to 31 March 2025 and the introduction of our innovative *Capacity to Collaborate* programme. Twenty-two awards ranging from £2,075 to £24,075 were supported during 2022/23 through the *Capacity to Collaborate* Awards.

We also worked with our City of Edinburgh colleagues on their *Warm and Welcoming Spaces* initiative, producing the 'The nights are fair drawin' in' booklet with helpful information and sources of help, which was distributed to libraries, community centres and arts venues across the city.

Initiatives supported by community mobilisation	Benefits
Edinburgh Community Resilience Programme with Cyrenians and Queen Margaret University	The programme helps increase community resilience to support the health and wellbeing of Edinburgh's older people. The programme builds on previous expertise and research which considers community navigation, social prescribing approaches and the *Making it Clear* resilience framework.
Op Ready with Edinburgh Leisure	The project focuses on those whose current health status is affecting their receiving knee or hip surgical procedures.
Community Taskforce Volunteer Programme	The programme received recurring funding to enable the trained task force of over 400 people to continue to help Edinburgh residents with practical tasks such as dog walking, shopping collection and support after a hospital discharge.
Fit and Active programme for People with Learning Disabilities with Edinburgh Leisure	The programme has created opportunities for people with learning disabilities to be physically active and socially connected.
Learning by Doing Community Commissioning process	This approach has been used for the second year of allocation of the Scottish Government's Mental Health and Wellbeing fund.

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. There is a Long-Term Conditions Section on our website with information for people living with long term conditions, their families and carers.

We continue to promote Anticipatory Care Planning (ACP), which helps people living with long term conditions make informed choices about how and where they want to be treated and supported in future. This year we launched ACP pages on the NHS Lothian website, providing guidance and resources for citizens and practitioners. In addition, the *7 steps to ACP for care homes* is now available on the national Homecare Decisions website and app, providing care home staff with guidance and best practice information. Training and improvement support for care home staff across Lothian will be provided through the Lothian Care Academy. The Edinburgh ACP Stakeholder Group continues to share best practice and support for health and social care teams and voluntary sector partners.

In response to identified need, the Edinburgh Self-Management Practitioner Network produced a Self-Management Practitioner Toolkit, providing guidance, tools, and practical tips to improve practice. Facilitated sessions are provided to teams, giving

an opportunity to come together to focus on enabling people to be better informed, prepared, and supported in ways that are right for them.

In December 2022 we were appointed as a GIRFE Pathfinder. GIRFE is a Scottish Government initiative that sets out to advance a multi-agency approach of support and services from young adulthood to end of life care. GIRFE will place the person at the centre of decisions that affect them to achieve the best outcomes. The initial focus will be to improve coordinated care and support for people living with frailty and people who frequently attend the Emergency Department (ED) who are also registered at a Deep End GP practice.

In terms of digital support, the LTC team is supporting the implementation of remote blood pressure monitoring for use in GP surgeries across Lothian. The National Blood Pressure Service is being rolled out under a national agreement endorsed by the Scottish Government, supported by National Services Scotland, Technology Enabled Care (NSS TEC).

The LTC Falls co-ordinators are actively engaging with the new Lothian-wide Prevention and Management of Falls Strategic Group, which has been set up to improve collaboration and consistency of falls prevention work through the availability of education and training, Lothian-wide data collection and development of a Lothian-wide Falls strategy for all health and social care staff. Care home falls prevention and management procedures and tools are being updated to facilitate improved practice, data gathering and training. Plans are being developed to meet falls related aspects of My Health, My Care, My Home.

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.

Between April 2022 and March 2023, there were 2,350 adult protection contacts across the city. This is a 24% increase from the 1,901 contacts in 2021/22, which has put considerable pressure on our social work resources and impacted on our ability to respond to assessments for social care, as adult support and protection cases are prioritised. Of the 2,350 referrals received during the year, further action was taken in almost all cases (97.4%). Roughly half of them required social work involvement other than Adult Protection.

Almost a third of referrals (29.9%, 702) progressed to investigation in the period. Infirmity due to old age was the most common client group for those whose case was being investigated (27.4%), followed by mental health (23.2%). The cases that resulted in an investigation were principally due to neglect (26.6%) and physical harm (25.2%). Of the 702 investigations, almost three quarters (72.9%) resulted in further action. There were also 1,111 adult protection case conferences in the year, of which a third (32.9%) were initial case conferences.

Case Study 1: Health All Round – Ecotherapy

Pete is a man in his late thirties who initially presented with suicidal thoughts and anxiety. Pete was very keen to explore a closer relationship with nature as well as opening up his social circle, and so he was offered a place on the ecotherapy programme. During the first four sessions, Pete was very quiet and seemed to be on the periphery of the group. Although the group made him feel welcome, he was visibly shy and clearly uncomfortable within a group atmosphere. He did, however, continue to come along to the weekly group which occurs in various outdoor locations.

After several months of attending the group, one day Pete was visibly excited and became very chatty during the group check-in. He said that the ecotherapy group had inspired him to drive to the Borders and climb a hill. Whilst he was up there, he had a moment 'where I felt just amazing…my anxiety didn't matter, my thoughts didn't matter. There were little birds and squirrels all around me and the views were amazing. I felt like I was a part of something big and beautiful.' Since then, there has been a clear change for the better with Pete.

Pete still comes to the weekly ecotherapy group and rarely misses a session. He is now one of the more active group members and he has become popular. He regularly updates us about a friendship that he has developed with a wild fox and he reports on how connecting with nature has been life-changing for him, reporting less anxiety and fewer suicidal thoughts. Pete has also started socialising with some group members outside of the ecotherapy group.

Personal Outcomes:

- Pete has spent more time in the natural world
- Pete has become part of a group
- Pete found that this strategy helped to alleviate his problems with low mood, anxiety and suicidal thoughts.

Wider Impacts:

Building stronger, more resilient communities - Pete's enthusiasm for nature now inspires new group members and he has helped one or two new people to feel welcome in the group. He has gone from being a quiet presence who didn't seem to be enjoying himself to someone who helps other group members to connect with nature and is an asset to the group.

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.

EIJB Grant Programme 2022/23

In April 2022, our grant programme was extended by a further three years to March 2025. This extension was provided to allow third sector organisations to consolidate and continue to develop and redesign their services following the pandemic. The programme aims to address two key priorities of our Strategic Plan - to tackle inequalities and promote prevention and early intervention.

In 2022/23, 71 projects, including two successful projects from our Innovation programme, received funding through the EIJB Grant Programme. In total, we provided £5,161,802 for the continued provision of preventative and early intervention services across the city. The grants awarded through the programme included grants ranging from £300k for citywide provision of specialist income maximisation services, to very small grants of £8k for small scale volunteer-led services.

In general, the return to normal service provision is progressing well, with many organisations continuing to redesign their services to incorporate lessons learnt from the pandemic and develop new ways to deliver services to a wider group of service users.

Throughout 2022/23, it is estimated that services funded through the grant programme will benefit approximately 44,000 people across the programme's priority outcomes for reducing health inequalities, with 80-85% of the targets set either met or exceeded. The user satisfaction of services provided through the grant programme remains high with an average satisfaction score of 93%. In addition to this, the effectiveness of the programme is further augmented through the additional benefit of funding leverage, which is estimated at around £13m across the programme; the inclusion of volunteer hours provides an additional financial value of £1.9m to this total.

Overall, the programme has helped progress against the National Health and Wellbeing Outcomes, with activities targeted at disadvantaged communities, and it has addressed factors such as community resilience and improved physical and mental health and wellbeing. As such it has contributed to the mitigation and resolving of the causes of health inequalities.

Mental Health and Wellbeing (Thrive Edinburgh)

Our third Thrive Edinburgh Conference took place on 25 November 2022, chaired by the Lord Provost and attended by over 140 people. It focused on how we continue to *change the conversation, change the culture* around our city's mental health and wellbeing.

Our Community Commissioning process aims to bring organisations together to explore local community needs, challenges and aspirations, and we allocated all our Communities Mental Health and Wellbeing funding, supporting over 120 organisations and partnerships in delivering a wide range of support across the city.

In terms of our Redesign Urgent Care Plan, we increased capacity in the Mental Health Assessment Services by three WTE Mental Health Nurses; introduced senior clinical makers; employed navigators for wider community support and community connection; and progressed work with the TRAK team to develop a more effective mental health triaging and referral system.

Four Thrive Welcome Teams are based in Edinburgh's localities. The multi- agency and multi-professional teams were prototyped from February 2020 through to August 2021, with teams augmented through formal organisational review transferring the Primary Care Liaison Team members into the Thrive Welcome Teams. As part of the Big Lottery-funded Living Well UK programme, an external independent evaluation was conducted and published in July 2022. The recommendations of the evaluation were considered by the Thrive Welcome Teams and wider Thrive Collective.

In February 2022 the Scottish Government announced their intention to allocate £3.2 million over 3 years to support the development of the Primary Care Mental Health and Wellbeing Teams in Edinburgh. This allocation is being reviewed as part of the Scottish Government's budget deliberations following the UK budget settlement. Following the announcement of this new funding, it was agreed to combine all current and planned funding to form eight Thrive Welcome (PCMHWBTs) Teams across the city. These teams would be built up from the current Thrive Welcome Teams in line with the values and practice model, serve local communities (20-minute neighbourhoods) and the GP clusters across the city, and include a local GP mental health lead, working with the local team lead. These changes will embed a '*no wrong door*' and value-based approach, helping us to achieve the Thrive/PCMHWBT aspirations of open access and no upper age limit services. The Thrive Welcome Teams Locality co-design and co-production groups were established, and the co-design process commenced on 8 December 2022.

Some other key highlights of the year include:

- Phase two of the development of the iThrive website was completed, enabling real time referrals into the Thrive Collective services and support.
- *Out of Sight, Out of Mind* celebrated its tenth birthday with an inspiring exhibition presenting over 100 artworks made by people who have lived experience of mental health issues.
- We embarked on a new partnership with the Scottish Storytelling Centre in creating a space for people and families to come together on the third Sunday of every month for fun activities including storytelling, family ceilidhs and arts and craft activities.

- Our City (E)Scaping Community of Practice was established, with spaces transformed into green and public art sites to foster collaboration and boost mental health and wellbeing.
- The third edition of *Coorie In* was produced, which highlights useful tips and advice for supporting people's mental health and wellbeing over the winter months. Eight thousand booklets were distributed across the city. The related small grants scheme supported 115 programmes providing 39,000 opportunities for people to connect over the winter months.
- The Royal Edinburgh Hospital's Volunteer Hub supported 43 inpatients, generating 54 volunteer hours; and 68 members of the public volunteered 2,078 hours.
- The New Era Programme was established to accelerate community developments and housing with support to enable more people to be discharged from the Royal Edinburgh Hospital
- Further funding was secured from the Armed Forces Covenant Fund to develop the Scottish Veterans Wellbeing Alliance and to develop interventions for veterans at high risk of attempting suicide. This programme will be delivered in partnership with the Centre for Military Research, Education and Public Engagement, Edinburgh Napier University.

Edinburgh Alcohol and Drug Partnership (EADP)

Several national and local initiatives are focused on ensuring that the design and delivery of services are informed by the lived and living experience of those who rely on them, as this can have a significant impact on how people respond to support, and influences the culture and insight of the system.

In 2023, the ADP commissioned EVOC to support the Lived Experience panel reach its potential and ensure that the voice of lived experience is central to the planning, monitoring and evaluation of current and future service provision. Amongst other things, a Recovery Community Development specialist has been employed to recruit people to the panel, to engage the recovery communities in its work, and to work with Edinburgh Recovery Activities (ERA), EADP, Advo Card, Scottish Recovery Consortium (SRC), and other key stakeholders. A report with recommendations on the future shape of the panel and its work will be produced.

The use of experiential evidence in the development of plans and services is a requirement of the Medication Assisted Treatment (MAT) standards. In 2023 the EADP developed a network of peer researchers - people with lived experience of substance use and recovery who have been trained by SRC - to interview others with a focus on their experience of treatment and support. Over 50 interviews were completed and the results informed and continue to inform the MAT standards reporting and planning.

The Access Place

The newly designed Access Place experienced a successful first year of operation in its new premises. People experiencing homelessness face many health and social inequalities, and we created Edinburgh's Access Place with integration at its heart, offering a multi-agency, trauma-informed service under one roof. Everyone working

at the Access Place has been trained in trauma-informed practice, recognising the impact that trauma has had on many of those accessing the service. People experiencing homelessness who have multiple and complex needs receive high quality, co-ordinated care and support to access permanent accommodation and improve their mental and physical health.

The service offers access to primary care; vaccination programmes; women's only clinics; temporary and permanent accommodation; social work and social care support; welfare benefits advice; veterinary support; support with mental health and substance use; occupational therapy; peer support; community linking; outreach support; and employment support. Anyone using the service has choice and flexibility in how they do so, and for those supported the service is a single point of access; our teams work together across citywide partnerships and networks, learning together, co-ordinating and co-designing each person's pathway to better wellbeing and independence.

Case Study 2: Rowan Alba CARDS Befriending Service

Elisabeth is a 56-year-old female who had been made homeless during the Covid-19 pandemic due to her excessive drinking and had been placed in elderly sheltered accommodation. Initially contact was made by telephone; Elisabeth explained she was in a very bad way and was extremely reluctant to have a home visit as she was embarrassed about her living conditions. She was assured by the service provider that she would not be judged and that it was her wellbeing that was important. Elisabeth agreed to a visit, and indeed her living conditions were bad. Elisabeth was in poor physical condition, her house was messy and infested with cockroaches, she was lying on a mattress on the floor surrounded by discarded cigarette ends, food containers and empty vodka bottles, and she admitted she had given up.

A trusting relationship was built up over a number of visits and after several weeks Elisabeth agreed to accept help with her situation. She was helped to move into supported accommodation in the Grassmarket. Elisabeth has become very houseproud of her new accommodation. She has vastly reduced her alcohol intake and following a reassessment of her circumstances has been prioritised for Edinburgh's Detox Clinic services. Elisabeth has been attending alcohol recovery meetings and meeting new people. Initially, Elisabeth was adamant that she didn't want a volunteer assistance, however, she is now looking forward to meeting her new volunteer and attending outings or events run by CARDS.

Personal Outcomes:

- Improved mental and physical health
- Improved self-management of long-term alcohol condition including reduced addiction
- Reduced isolation and more opportunities to connect to the community
- Improved confidence and self-esteem
- Increased support to maintain a home

Wider Impacts:

Our support has reduced reliance on crisis services such as. A&E, emergency housing and social work. Long term, through being supported to volunteer, clients contribute to strong and inclusive communities.

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

The Three Conversations approach focuses on what matters to a person and on working collaboratively with them as experts in their own lives, with staff considering a person's strengths and community networks to achieve positive outcomes. Implementation began in 2019, with 23 innovation sites currently adopting this way of working to support people more quickly and promote early intervention and prevention. This year, Astley Ainslie, Longstone Digital Tech Team and SCD Response Team became live innovation sites and started using the Three Conversations approach.

The contract with Partners 4 Change ended July 2022, and the roll-out of the approach has been supported internally since then. However, the rollout programme has been affected by current system-wide pressures and capacity, including the temporary withdrawal of programme and project management support, so the rollout has been refocused on the continued implementation to the four Locality Teams.

During 2022/23, 53% of new people who contacted us benefitted from personalised short-term support, such as building community connections and providing equipment, advice or information, rather than formal long-term care services being required or increased. This figure was 35% last year. The number of people without formal long/term care services requiring repeat support remains low, and when required has been due to unforeseen changes to their circumstances.

Care Inspectorate Reviews

We deliver 34 registered adult care services that are subject to inspection by the Care Inspectorate. Following a reduction in inspection frequency due to the Covid-19 pandemic, 2022/23 saw the resumption of inspections across all sectors in the Partnership.

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, 4 and 5 being assessed as 'adequate', 'good' and 'very good' respectively.

During 2022/23, nine inspections took place. No requirements or areas for improvement were made and all services inspected in 2022/23 were rated 'good' or above. The grade evaluations can be summarised as follows:

Service Name	Date of inspection	How well do we support people's wellbeing?	How well are care and support planned?	How good is our staff team?	How good is our leadership?
Fords Road Home for Older People	09/06/2022	5	N/A	N/A	4
Clovenstone House	05/10/2022	4	5	N/A	5
Castle Crags - Care at Home / Housing Support	21/11/2022	5	N/A	N/A	5
Castle Crags - Care at Home / Housing Support Group 2	27/01/2023	5	5	5	4
Positive Steps	06/12/2022	6	5	5	5
SE Home Care Service Cluster 2	07/12/2022	5	N/A	N/A	5
South West Home Care Service Canal	20/12/2022	5	N/A	N/A	5
SW Hub – Re-ablement Service	30/01/2023	5	N/A	N/A	5
Support Works	09/02/2023	5	N/A	N/A	5
Be Able South	01/03/2023	5	N/A	N/A	4

Quality Improvement and Assurance in Care Homes

A particular focus over the past 12 months has been working with the team at Royston Court Care Home to maintain the standards achieved as a result of the improvement work in 2021/22. This includes quarterly checks to ensure that improvements made are embedded and sustained. The home continues to make good progress with their improvement work which will hopefully be recognised and validated in their annual inspection from the Care Inspectorate.

As a result of the Care Inspectorate identifying an area for improvement, we have been working on the standardisation of person-centred care plan documentation. This work has progressed well and the aim is to move all residents across to the new care plan documentation by the end of August 2023. This will improve outcomes for residents and allow staff to deliver and evaluate the best possible standards of care.

We also offered Scottish Improvement Foundation Skills training to staff across the Partnership as part of the plan to increase Quality Improvement Capacity and Capability. To support improvement in the care homes and increase staff

understanding of Quality Improvement methodology, two spaces were allocated to care home staff on each cohort. This will allow us to build a team of improvers within the care homes to identify and drive improvement.

Joint inspection of Adult Support and Protection

In late 2022, a Joint Inspection of Adult Support and Protection took place involving the Care Inspectorate, Healthcare Improvement Scotland, and His Majesty's Inspectorate of the Constabulary. Some of positives highlighted within this report included:

- Partnership working across health and Police Scotland is making an invaluable contribution to identifying adults at risk of harm and working well with partners to improve their safety and wellbeing
- The third and independent sectors in Edinburgh continue to be a real asset in the health and social care integration landscape, with providers being highlighted as giving 'vital support' to adults at risk of harm
- The way we are conducting large scale investigations has been positively recognised
- Our strategic leadership throughout COVID-19 has been recognised in ensuring business continuity during the pandemic

However, the report also raised some challenges and areas for us to continue to work on to improve the quality of our Adult Support and Protection activity:

- Like many other HSCPs who have already been inspected in this area, the quality of chronologies and risk assessments in Edinburgh have been highlighted as needing improvement
- The quality of adult protection case conferences has also been cited as an area requiring improvement
- Our wider vacancy challenges, particularly within our social work teams, have also been noted
- Quality assurance activity, capacity assessments and consistency of support and protection for all people when required were also highlighted as areas requiring improvement.

An improvement plan focusing on these areas for improvement has been created and will be overseen by the Edinburgh Adult Protection Committee, which includes senior staff from the Council, NHS Lothian, Police Scotland, the voluntary sector and partner agencies. Regular updates will be circulated on the plan and progress made.

Inspection of Adult Social Work and Social Care Services

A second Care Inspectorate report was published in March, following a request from the Minister for Mental Wellbeing and Social Care that they undertake an inspection of council services delegated to EHSCP. The report highlighted the indirect consequences of broader system pressures, with recruitment issues being a major factor. Alongside that, there remains a need to address our partnership structures

and governance, our pace of delivery and to invest in our shared systems and processes.

Key areas identified for improvement focused on:

- The design, structure, implementation and oversight of key processes, including the assessment of people's needs and their case management
- Approaches to early intervention and prevention, which were uncoordinated and inconsistent
- Self-directed support (SDS), which had not been implemented effectively
- Insufficient support for unpaid carers
- Staff being under considerable pressure and sometimes overwhelmed, though the report also noted most staff experienced and valued positive, responsive and person-centred support from their immediate line manager
- Strategic leadership and management oversight of key processes, meeting legislative requirements, policies, procedures and guidance and to ensure sufficient capacity and capability to deliver safe and effective services for vulnerable people
- Embedding approaches to self-evaluation for improvement and quality assurance were not well-embedded
- Social Work governance with strategic decisions being well informed by a social work perspective

A joint improvement plan with the Adult Support and Protection inspection has been developed in response to the report. This incorporated some of our current developments that align to needs identified in this report. This includes the recent appointment of a Principal Social Work Officer which will strengthen our leadership and support of social work. The plan also sets out our improvement activity under six priorities:

- A focus on early intervention, prevention and demand management
- Reducing waiting lists and improving access to services
- Best use of resources to meet demand and an improved structure
- Getting basic and key processes right
- Workforce – improving recruitment, retention and governance
- Better governance, including professional supervision, manager oversight and quality assurance.

A strategic Inspection Oversight Group has been established to support the improvement work. This group will oversee and approve inspection improvement plans, ensuring actions are focused on outcomes and are SMART. This group will also provide regular updates for staff and stakeholders as we progress, and report into our governance structures and committees.

Case Study 3: Minority Ethnic Health Inclusion service (MEHIS)

Zoda is a 48-year-old African single parent with three children under 12 years who moved to Edinburgh to escape domestic abuse. She speaks several African languages and Spanish but struggled to read her medical appointment letters in English. Zoda was referred to MEHIS by her GP as she had potentially serious medical conditions and was missing her medical appointments. The African Link worker visited Zoda at home.

The African Link worker supported Zoda to understand the health system in Scotland, understand her medical conditions, provided self-management advice and advocated for her at GP and hospital appointments.

Unfortunately, Zoda's health deteriorated and after an in-hospital stay she lost her only job on a zero-hour contract. The Link worker continued supporting Zoda with the professionals (physiotherapists, occupational therapists, pharmacists) involved in her care and she was linked to:

- English classes
- Food banks / Pantries
- Family, physical and other social activities
- Informal, trusted African support groups (who provided invaluable care / assistance to Zoda and children during her hospital stay)
- Housing and benefits advice

Personal Outcomes:

Zoda's mental health has improved and she commented,

"I am so glad the GP connected me to someone like me who can understand my situation."

"I was alone with my children, now we have an African family."

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 available resources.

Financial management and performance

Financial information is a key element of our governance framework. Each year we produce a financial plan which sets out how we ensure our limited resources are targeted to support delivery of our strategic plan. Our financial plan for 2022/23 was agreed by the board in March 2022. An update was presented in August 2022.

Regular updates on financial performance against this plan 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.

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 board needs 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.

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

Service	Budget £m	Actual £m	Variance £m
NHS DELIVERED SERVICES			
Community services	66	65	1
General medical services	97	99	(1)
Prescribing	81	84	(4)
Reimbursement of independent contractors	68	68	0
Services hosted by other partnerships/NHS Lothian	115	114	1
Hospital 'set aside' services	114	120	(6)
Other	72	63	9
Sub total NHS	**612**	**612**	**(0)**
CITY OF EDINBURGH DELIVERED SERVICES			
External purchasing	207	215	(8)
Care at home	34	30	4
Day services	17	17	1
Residential care	22	21	1
Social work assessment and care management	19	15	3
Other	11	12	(1)
Sub total Council	**310**	**310**	**0**
Net position	**923**	**923**	**0**

A break-even position was reported against the budget for the year. This was predicated on the value of vacancies across Council and NHS services, slippage on investment funding and the use of reserves. Whilst this is clearly a positive outcome for 2022/23, it should be noted that we relied on one-off measures to achieve balance. Despite this, the underlying deficit remains and, indeed, increases when we move into 2023/24.

The underlying financial pressures facing us have not materially changed; these include:

- Externally purchased services where demographic factors continue to drive demand for these services; this is also evidenced in the continuing growth in direct payments and individual service funds. As in previous years we saw significant growth during 2022/23
- Medicines prescribed by General Practitioners cost £81m in 2022/23. This is an area where, although Edinburgh has one of the lowest costs per head of population, we see costs rising year on year as volumes increase and costs fluctuate; and
- Expenditure in set aside which continues to be one of the main financial issues facing NHS delegated services. NHS Lothian agreed a one-off additional allocation to reflect this.

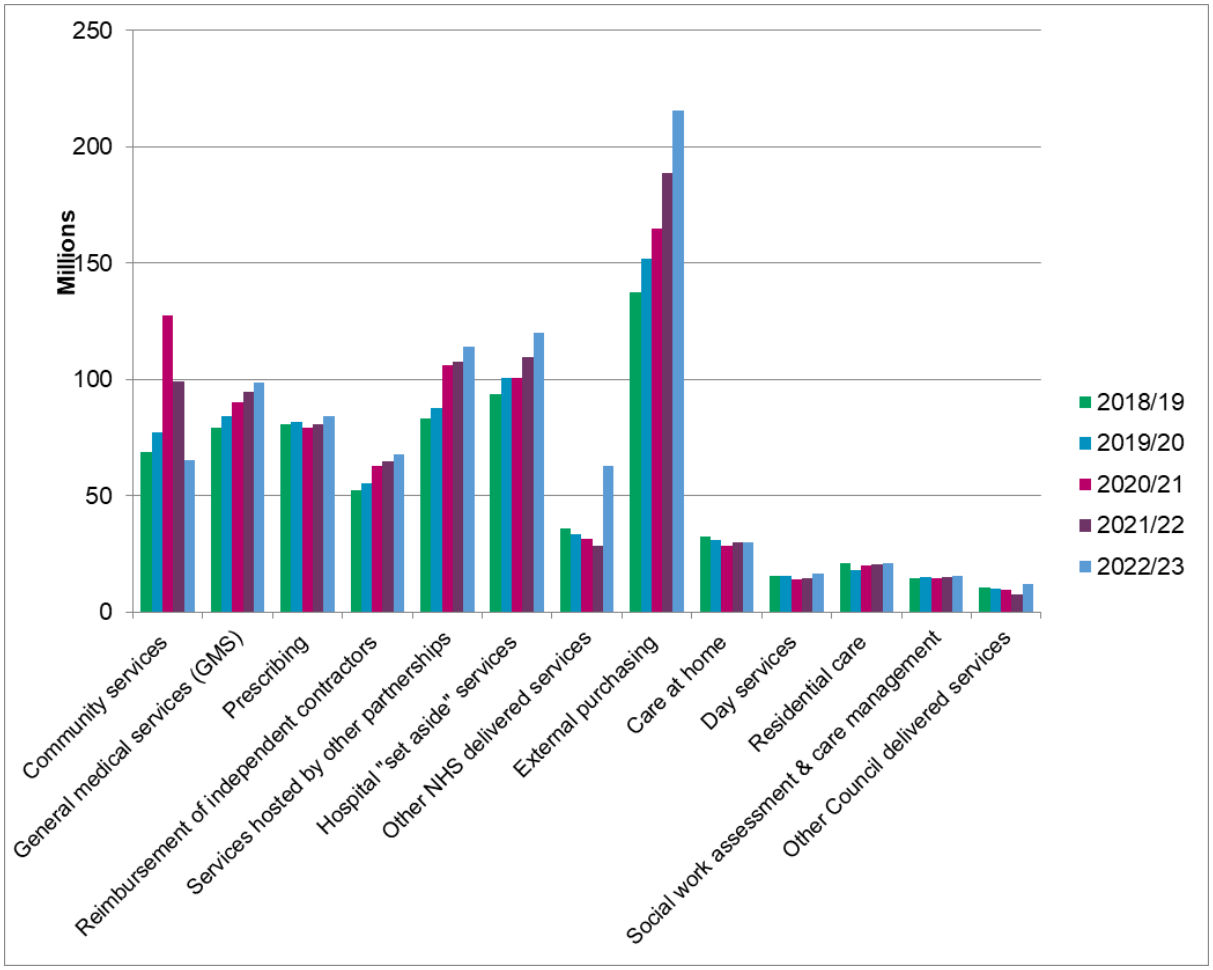
These pressures have been offset in year by high levels of vacancies across a number of services in both the City of Edinburgh Council and NHS Lothian. We continue to face significant challenges in recruiting and retaining staff, and given the impact on service delivery, operational staff continue to prioritise recruitment.

It is clearly extremely positive that we are able to report a break-even position against our in-year budget. However, the continued reliance on one-off measures to achieve financial balance remains a concern. As a board we face a number of material and long-standing financial pressures and a baseline gap in our financial plan which we struggle to address on a recurring basis. Our medium term financial strategy (MTFS) begins to set out what a path to financial sustainability could look like and this will continue to be developed in the coming financial year.

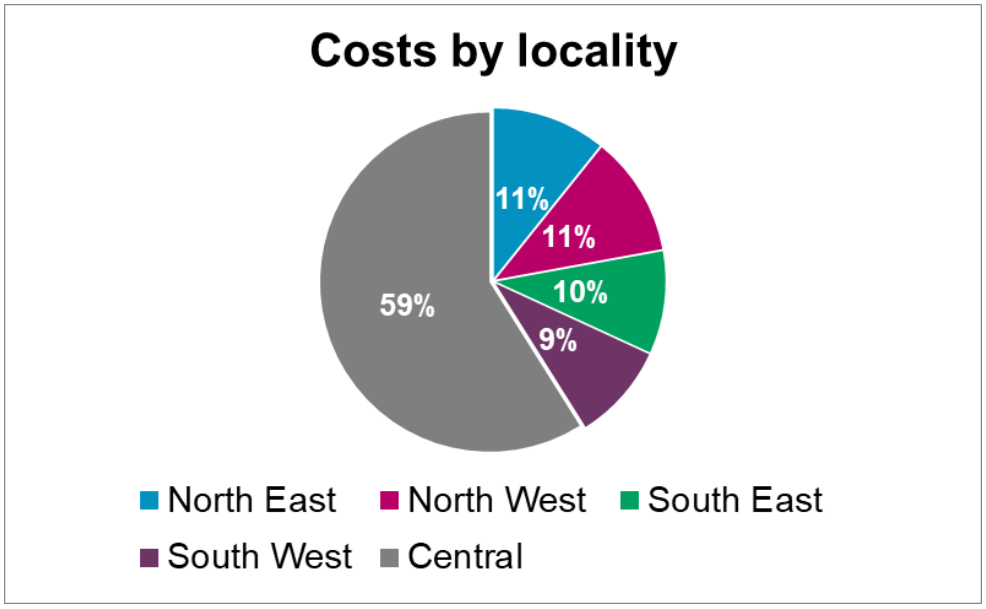
The pandemic clearly had an impact on our finances, and this was closely monitored during the year. We incurred net additional costs of £19m as a direct result of COVID-19. The main categories of associated expenditure being: sustainability payments made to support providers during the pandemic; purchase of additional capacity; additional staffing; and increased prescribing costs. In line with their commitment, these costs were met in full by the Scottish Government and are summarised below:

	£m
Costs incurred by City of Edinburgh Council	
Staff costs	1.1
PPE	0.4
Provider sustainability payments	5.8
Loss of income	1.0
Shortfall on funding for interim care beds	2.9
Total earmarked reserves	**11.2**
Costs incurred by NHS Lothian	
GP prescribing	1.9
Additional FHS contractor costs	0.1
Total general reserve	**1.9**
Total	**13.1**

The chart below shows costs in key areas for the last five financial years:



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



Bed-Based Review

The bed-based review is ongoing and seeks to redesign bed-based services across the city, taking into consideration demand and capacity to ensure provision of sustainable services. The project covers bed-based services in hospital settings, and beds located in the community.

An enhanced model of care is being introduced into our larger 60-bedded care homes to include registered nurses to provide nursing cover seven days per week. Recruitment to this model is well under way and one care home is nearly at full establishment, while the other two larger care homes in the estate are actively recruiting. The new model of care will allow the Partnership to provide much needed nursing and dementia care at local authority funded rates to meet existing and future demand and support flow from hospital into the community. This has also removed the requirement for District Nurses to attend these care homes during the day so their residents have all been removed from District Nursing caseloads increasing capacity in the community for the service.

Edinburgh continues to have an imbalanced bed base and doesn't have the right type of beds in the right place to meet existing and projected demand. Phase 1 of the Bed Based Care Strategy was approved by the IJB in September 2021, but due to a number of issues this has not been implemented as planned. Significant adaptations are required to the former Drumbrae Care Home in order for the facility to be compliant with recently updated healthcare standards. This has meant that progress has yet to be made with the building-based redesign of bed-based services outlined in phase 1 of the bed-based care strategy. This has affected the Partnership's ability to relocate bed-based services from the Liberton Hospital site and has meant that hospital-based complex clinical care (HBCCC) needs to continue to be provided from the existing facilities until a resolution can be found. Work planned in 2023/24 to revise the bed-based modelling will support us to move this work forward to ensure we have the right bed base to meet the needs of Edinburgh's population.

Priority 5: Making best use of 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.

Recruitment and Retention

During 2022/23, a Recruitment and Retention Oversight Group was set up to support initiatives to address health and social care recruitment challenges. This is supported by regular performance monitoring around recruitment and retention. We also increased our resources to support hiring managers with recruitment processes in the social work area to ensure onboarding could take place efficiently and effectively.

We engaged with Capital City Partnership (CCP) to support our recruitment activity across the city, with outreach activity and community-focused engagement being undertaken to identify and generate interest in joining the partnership. The main drive is at entry level for social care services and since November 2022 local and targeted recruitment fairs have taken place monthly. Referrals (registered to the programme) now total 437. A total of 56 interviews have taken place with more in the pipeline and 32 job offers have been made. CCP also secured support of Community Renewal for additional staff support, established a short Health and Social Care training course programme using CCP Vocational Training Framework (VTF) funding and have established strong links to Department of Work and Pensions (DWP) and MyJobScotland.

Further work around recruitment, workforce planning and training and development, including for leadership, is planned as part of our response to the recent inspections of Adult Support and Protection and Adult Social Care and Social Work.

Workforce Strategy

Working Together is Edinburgh Partnership's workforce strategy for a caring, healthier and safer Edinburgh. This ambitious strategy has been developed to ensure we have a skilled and capable workforce for today and tomorrow that can deliver on our strategic priorities and meet the health and social care needs of the citizens of Edinburgh.

The strategy highlights 4 key broad priority areas of focus, these being: Health and Wellbeing; Culture & Identity; Capacity and Transformation; and Leadership & Development. A Workforce Steering Group comprising senior executives and lead Trade Union and Partnership representatives was formed to begin leading on the implementation of our strategy. Key areas identified so far include: Supervision & Support; Workforce Plan; and Visible Leadership.

Progress has been challenging due to a number of factors including winter and system pressures, and ongoing resource and capacity issues. As a result, we are reviewing our structural and governance arrangements as part of a reset for this important and necessary work. We are also working on an update to our workforce plan which is due for submission to the Scottish Government in October 2023.

One Edinburgh: Home-Based Care

'One Edinburgh' is part of our Home-Based Care and Support project within the Innovation and Sustainability Portfolio and is our collaborative approach to the delivery of internal and external home-based support. It aims to deliver a vision of preventative approaches and support solutions that enable more people to remain independent at home, or in a homely setting, for as long as possible.

There are three pillars to the One Edinburgh care at home programme.

Total Mobile – We began to implement our new mobile workforce scheduling solution for our internal Home Care and Reablement provision. An enabler for our internal redesign, we anticipate completion by the end of 2023. Almost 600 devices are now deployed to the Homecare and Reablement team who are also benefiting from access to email, Microsoft Teams, public transport apps for route planning, and the Thrive app for vital access to learning and development training.

Internal Re-Design – We have progressed with the redesign, planning and modelling of our internal homecare services to shift from long term care support services to a focus on prevention and reablement, though some long-term care at home will still be delivered internally. This will support our approaches to prevention and early intervention, supporting individuals to live independently for longer.

We established a citywide care at home operational leadership group at the start of 2022 which has oversight, monitors activity and capacity levels, ensures maximised use of capacity, and drives forward performance improvements in relation to this. The team meets daily, making quick evidence-led decisions and taking actions around the internal and external care at home capacity across Edinburgh. The aim was to centralise discussions and planning approaches about care at home support across the city, with specific focus on reducing hospital delays and community unmet need; reducing the time that individuals wait for support to be arranged; and maximising the commissioning of capacity available through the external market.

Significant improvements have been delivered through this group with a reduction from January 2022 to March 2023 of 83% in the number of people delayed in hospital waiting for a package of care and an average reduction of 84% in the number of days people wait for care at home support arrangements to be put in place. For the same period in the community, there has been a reduction of 72% in people waiting for care at home support arrangements, and an average reduction of 36% in the number of days waiting for these arrangements to be put in place.

One Edinburgh Care at Home Commissioning – While the internal re-design analysis and modelling was undertaken, framework commissioning was largely on hold during 2022/23. However, the ongoing activity with care at home providers to continue the shift towards new collaborative working continued. With clarity about what our proposed internal care at home provision will be, there was further analysis and modelling undertaken late in 2022/23 to define what will need to be commissioned from the external care at home market.

Primary Care (General Medical Services)

The application of the Primary Care Improvement Plan (PCIP) and Transformation and Stability (T&S) funds in Edinburgh enjoyed another constructive year in 2022/23. These funds are now almost all recurringly committed to supporting the equivalent of

approximately 300 additional full time primary care staff across the city. Our latest evaluation indicates that these staff make a workload contribution equivalent to almost 600 additional medical sessions each week, helping offset the continuing impact of Covid-related pressure and the ongoing population increase. The feedback from patients treated by these new professionals is overwhelmingly positive, as the experience of these staff working in Primary Care.

Pharmacotherapy accounts for 38% of the PCIP funding. The workforce combines primary care workload augmentation with cost and quality-related activity. As a result of the ongoing attention of GPs to high quality and cost-effective prescribing, now facilitated at practice level by the pharmacotherapy team, Edinburgh has lower expenditure per head of population than any other area of Scotland. The number of pharmacy technician staff has grown and these staff are increasingly able to provide multi-practice support for relatively routine processing of medicine-related activity. All pharmacotherapy activity is carefully monitored to ensure that quality and safety are enhanced as part of this work.

Fifty-five of our 70 medical practices are currently accessing the Community Treatment and Care Centres (CTAC) services, and there are plans for further expansion in 2023. CTACs take a proportion of several time-consuming procedures, such as complex wound dressings and ear irrigation, away from medical practices, thus allowing Practice Nurses to provide more ‘long-term condition’ management and care. Our vaccination team has removed almost all routine vaccination from medical practices, with approximately 300,000 vaccinations delivered during 2022. While some patients will now need to travel further than their local surgery to receive some elements of primary care treatment, this will allow medical practices to concentrate on the services they are best placed to provide.

We have invested in both Primary Care Mental Health Nurses and physiotherapists embedded in practice teams. This allows many more patients to be treated locally and quickly rather than referred to another specialised service team. In addition, our Community Link Worker service now covers approximately half of City practices, offering both direct support and advice to patients about relevant community resources available both locally and across Edinburgh.

An important part of the primary care transformation process is the ongoing development of the primary care premises required to support our growing population. In 2023, we were able to offer new accommodation for two of our medical practice teams and helped almost 20 others with improvements to their premises which enabled more patients to be absorbed. We also renewed the ‘Edinburgh Primary Care Population and Premises Report’ to ensure we adjusted our plans to the additional requirements of the City of Edinburgh Council’s ‘City Plan 2030’. This year, we had a large number of people from the Ukraine who followed on from new citizens coming to Scotland from Afghanistan the previous year. One of our medical practices took the lead in ensuring people living on the ship in Leith and in two city hotels had the support they needed, whilst others were welcomed into local practices when they were able to secure local accommodation.

Whilst much progress was made in 2022, the pressure of population increase, the aftershocks of Covid and the ‘cost of living crisis’ has meant that Primary Care remains under considerable pressure.

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.

Supporting Carers

Amid ongoing recovery from the pandemic and a cost of living crisis, our focus was on the continuation and embedding of the contracted provision of support to carers provided mainly through our voluntary sector partners. Work was also progressed on the Edinburgh Joint Carers Strategy 2023 -2026 refresh, taking account of the national carer strategy developments, and feedback on the agreed local six priorities which remain our key focus. The refreshed strategy was developed by a short life working group which reported to the Edinburgh Carer Strategic Partnership Group, (CSPG), whose membership includes carer organisations, EHSCP and CEC managers, and the EIJB Carer representative. The refreshed strategy is the result of collaboration and wide engagement with carers, supported people and other key stakeholders. It is based on a set of Key Principles:

- Maintain the six key priority areas and associated local outcomes
- Align Edinburgh's priorities with the five national themes, outcomes and proposed actions
- Maintain the Equal Partners in Care (EPiC) approach
- Develop a carer outcomes measuring framework
- Indicate achievable actions/commitments to continue to enhance carers' supports and national commitments
- Maintain the Human Rights-based approach to commissioning

Of the 137 Key Performance Indicators associated with the contracted provision, from January 2022- March 2023: 13 exceeded the target; 102 were fully met; 7 were partially met; 14 were not met; and 1 remains under development. The contract reporting now aligns with the financial year. Of the 14 KPIs not met, 11 were related to the newly developed KPIs associated with the wider roll out of the Adult Carer Support Plans (ACSP) and associated emergency plans.

Other key achievements have seen the VOCAL carer map going live, helping carers to find information, advice and support across the city. Throughout this period, and of particular help owing to the cost of living crisis, welfare benefits and financial advice support provided has enabled carers to maximise their benefit entitlement: the Performance and Evaluation report 2022-23 indicates just over £1.6m of benefits being accessed for carer households. Across Edinburgh carers have been supported by our valued voluntary sector on a one-to-one basis; have accessed peer support and short breaks from caring (including leisure centre membership); and have been helped to access funding. Carers have also been supported through day, evening and residential short breaks. Young Carer Statements continue to be offered, to optimise support for young carers, and their transition to young adult carers.

We have been recognised by Shared Care Scotland for innovation through market facilitation to generate a variety of person-centred short break options for people with Learning Disabilities within the Short Break Hub (The Hub). The Hub supports people with planning and brokering short breaks, exploring support options which meet people's personal outcomes, and matching people who have a short break budget to social care organisations who can provide replacement care. It also co-ordinates ongoing relationships between families and providers. Between April 2022 and March 2023, The Hub has supported 283 people to access a variety of short breaks, including daytime, evening or overnight support; social events; breaks away together for the person being cared for and the carer or other family members; and breaks with friends. 80% of respondents to a recent survey rated their experience of The Hub positively, and 85% of respondents rated the experience of the person they care for as positive.

The Hub's relationship-based approach to brokering short breaks has led to improved support options and outcomes and has created the opportunity to consider all aspects of people's support flexibly across a range of service models. This approach offers more consistency for users and greater sustainability for providers. The local market has grown, with 14 providers offering or engaged in conversations to not only provide short breaks but to consider all supports people need to live a good life.

Work on Adult Carer Support Plans (ACSPs), supporting an outcome-focused approach, has developed over 2022, with the template, supporting leaflets, practitioner guides and internal processes reaching completion. Delivery of training with our partners began in March 2023 and full implementation is July 2023. This will see a rise from approximately 500 ACSPs completed each year since 2019, further optimising support for carers.

Other key developments up to March 2023 include:

- Statement around recovery from Covid-19
- Response to cost-of-living crisis and reinvestment of funds for replacement care
- Carer Landscape: Edinburgh Action Research (CLEAR) getting under way to capture wider carer supports and contribution to the Carer Strategy, beyond the commissioned services
- Developments around reporting on carer outcomes, with the co-production of the development of an outcomes framework well under way, encouraging a reflective approach in year 2 by way of preparation for year 3 reporting.

Key focus areas for development for the forthcoming year are indicated in the refreshed strategy, will form the focus for the Carer Strategic Partnership work plan going forward and are aligned with the key implementation plan of the refreshed Strategy 2023-26. This includes developments around SDS, female carers, young adult carer action plan, place based short breaks, Adult Carer Support Plan roll out, and change to reporting timeline and review of KPIs.

Home First

As part of the redesign of unscheduled care, Home First is supporting the delivery of the Lothian Strategic Development Framework with three priority areas of focus: reducing ED attendances, reducing length of stay and reducing admissions.

We have continued to work with NHS Lothian on the implementation of Discharge without Delay (DwD). Phase one of the programme identified six acute site medicine of the elderly wards at the Western General Hospital and Royal Infirmary of Edinburgh for a quality improvement approach. This introduced planned date of discharge (PDD) and embedded Home First social care staff (social workers and Home First coordinators) within the ward multi-disciplinary teams at their daily meetings. This collaboration was particularly successful on the WGH wards, with data showing a 50% reduction in bed occupancy by patients in delay over a 12-month period and when directly comparing winter periods. They also reported a 9-day reduction in median length of stay and a 35% increase in discharge rate when comparing quarter one of 2023 with the same period in 2022. The data is less indicative of improvement at the RIE and this likely reflects site progress against the agreed phase one actions. Due to the learning from pilot work at Fillieside and the success of the DwD programme, PDD has also been introduced across our other bedded units.

Over winter, we trialled a new on-site social work model in the Royal Edinburgh Hospital which provided timely and proportionate interventions to reduce social work assessment waiting times and promote a Home First approach. There has been an overall reduction in length of stay, occupied bed days, number of patients in delay and community demand for assessments. The team have improved performance, enhanced multidisciplinary team relationships and improved the patient experience.

Home First supports discharge through a range of services/teams:

- Our Discharge To Assess service continues to be well utilised across the city with over 2500 referrals received in the last financial year. Discharge to Assess supports people in their transition home by offering assessments and rehabilitation in their familiar environment, not the hospital setting.
- The introduction of the RESET team (third sector resilience workers) has supported people home from hospital with non-statutory services such as befriending, assistance with grocery shopping and support with welfare applications.
- Our Hospital to Home service also provides short term support to people who are medically well to go home but who may have a gap between discharge and their care package beginning, enabling more people to be discharged without delay.
- District nursing has introduced a home IV pathway; working with OPAT at the Western General Hospital to support patients to receive IV antibiotic therapy at home. The service is available to patients who are unable to attend OPAT on a daily basis due to their being housebound; this is supporting early discharge from hospital as well as prevention of admission.

Home First is continuing to provide and develop services to support people to remain at home or in a homely setting, preventing hospital admission and providing alternatives to hospital where it is safe to do so. The Home First coordinator located at the front door of acute sites continues to provide a dedicated focus to prevent unnecessary admission where possible by facilitating community alternatives. A single point of access was introduced via the Flow Centre to provide a professional response to requests from healthcare professionals for people who require urgent therapy and/or urgent social care interventions. This pathway has successfully prevented 80% of admissions from 456 referrals. Through the Home First navigators, the Flow Centre has developed a greater understanding of alternative urgent therapy

and care pathways and is better equipped to recommend alternative options with the ability to highlight potential social admission requests.

Hospital at Home has increased its service capacity in the last year, which has enabled the service to support an additional 52 patients per month; this equates to an increase in capacity of 58%. Patients managed by the Hospital at Home team have on average a reduced length of stay of 18 days when compared with patients admitted to an acute site. The Hospital at Home service has also introduced enhanced referral pathways to include the Scottish Ambulance Service, Emergency Departments, Acute Medicine Units and other hospital wards in addition to new pathways for community teams such as the heart failure, community respiratory and IMPACT teams. A bespoke capacity planning tool has been developed by the service.

Work has been ongoing with the care home support team to undertake a test of change to prevent admission from care home settings and to identify frequent attenders from care home settings. This is progressing well and has adopted a collaborative approach across all key stakeholder groups.

ATEC 24

Assistive Technology Enabled Care 24 (ATEC 24) offers a range of preventative and enabling supports to citizens of Edinburgh, which includes community alarms; telecare; sheltered housing support; the bathroom equipment assessment team (BEAT); children's occupational therapy; and a Community Equipment Loan Service to Edinburgh, East and Midlothian communities.

The Community Equipment Loan Service (CELS) provides specialist daily living equipment on loan to those with an assessed need, determined by a health or social care professional. On 31 January 2023, we were awarded accreditation with CECOPS, a national quality assurance organisation. CELS is the first and only equipment service in Scotland to be accredited.

Since 2018, we have increased the number of satellite stores we support with small aids and equipment from 17 to 43, enabling equipment to be accessed locally and quickly and reducing environmental impacts, with 17,304 items delivered to satellite stores in the past year. We also supplied almost 39,000 items through our Click and Collect Service, introduced in 2020 in response to Covid-19 restrictions and now maintained as a core function. In 2022, we delivered approximately 91,000 items to people living in their own homes as part of our standard delivery schedule, with an additional 17,638 items delivered as a crisis response within a 24-hour timescale, usually supporting people coming out of hospital. This represents a 44% increase in standard deliveries over the past five years, with an almost 400% increase in crisis deliveries.

The Assistive Living Team (ALT) was formed to support early intervention with citizens who present with less complex needs through the provision of equipment, telecare and community-based support. During the last year, ALT took part in a second phase of a Scottish Government pro-active telecare / outbound calling test of change, with the external evaluation by University of West of Scotland identifying significant cost avoidance to the telecare, Scottish Ambulance Service and hospitals from this work.

The telecare service continues to develop and implement plans around the analogue to digital transition, ensuring the telecare technologies in people's homes and the platform we are using to answer customers' calls is compatible with the updated digital telephony network by 2025. In March 2023, 35% of our Telecare customers were in receipt of compatible technologies. Continuing to grow our telecare service is a key aspect of our Inspection Improvement Plan.

Learning disabilities

In 2022 the Innovation and Sustainability Portfolio selected Learning Disabilities Services as its primary pipeline project area to develop and improve outcomes for service users with Learning Disabilities. This has seen the collaboration of multi-agency and multi-disciplinary professionals from both the public and voluntary sectors. People with lived experience have engaged in reviewing progress and provided feedback on identified change areas. This iterative process has identified 13 key areas requiring some change and improvement work, refined from the nine outlined in the report to EIJB in September 2022. The Edinburgh Learning Disability Advisory Group, a participatory group involving individuals who have a learning disability; their support staff; learning disability third sector organisations and our staff, is engaged in ensuring that the proposals being developed are scrutinised by people with lived experience. The project is currently developing action plans to address the change proposals and still has some significant milestones ahead.

Health Improvement Scotland launched a programme in 2020 called New Models of Day Support – this programme was designed to support Partnerships to define and further develop approaches to day support that best meets the needs of individuals who have a learning disability. To take this forward the EHSCP developed a local project team with representation from third sector providers and partnership staff. There has been engagement with individuals who have learning disabilities and their carers during this project to ensure that their views are taken into consideration when developing person-centred change proposals. This project is in the final stage and the intention is to produce a menu of opportunities that reflects the aspirations of people with learning disabilities to be included in a wide range of activities including volunteering, employment, further education, and social activities.

On 29 March 2023 we held a Capacity to Collaborate event at the Edinburgh Community Rehabilitation and Support Service. This event brought together EHSCP colleagues, third sector and private organisations and people from the world of physical disability, hidden disabilities, neurological conditions and long-term conditions to promote our rehabilitation and self-management services and resources. The event highlighted the multiple avenues of support available to help people on their journey and emphasised the power of collaboration, offering marketplace stalls, a main discussion on reflective practice and collaboration, and a demo of the Smart House Tech Hub.

Case Study 4: FAIR Ltd – Welfare Rights and Financial Capability Advice Service

Colin lives with his wife Jeanette. Jeanette gets Personal Independence Payment (PIP) Enhanced Daily Living and Enhanced Mobility. They get full Housing Benefit and claim as a couple for Employment and Support Allowance, and Jeanette gets the Support group component. After Jeanette phoned FAIR to ask for help with a PIP review form, they were allocated an Advice Worker.

A home visit brought into focus the complexity of their case - Jeanette is house bound, she has diabetes and is very obese. She has not left the house in two years and has carers that come to the house to dress and wash her. The PIP review was completed with both Colin and Jeanette. However, from further discussion and engagement with Colin's doctor, it emerged that Colin had a learning difficulty and receives medication for migraines but he was not in receipt of PIP and had lost his Disability Living Allowance years ago when he began to care for Jeanette despite his own limited abilities.

The couple were also needing to move house as it was not a suitable property for promoting Jeanette's mobility or her personal care needs. FAIR ensured the appropriate housing association was contacted to address these concerns. FAIR continued to pursue Colin's situation and referred him to the NHS Community Learning Disability Team for a learning disability assessment. They also supported him through a PIP claim, which was successful with both Colin and Jeanette being awarded PIP Enhanced Care and Enhanced Mobility claims.

Personal Outcomes:

- Personalised Support and access to a named skilled Advice Worker
- Working towards better health outcomes, including reduced isolation
- Better financial situation - Colin was able to buy a new washing machine with his PIP backdated money

Wider Impacts:

Good partnership work between agencies to get best outcome for clients. They are both less isolated and there are plans for services to help them to work towards moving to a more suitable property and to be more organised in their home.

Performance

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.

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. The table below shows how the strategic priorities from our Strategic Plan contribute to these national outcomes and the national indicators associated with each priority.

Strategic priority	**National outcomes this priority contributes to**	**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 and 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 and social care services contribute to reducing health inequalities	Indicator 11
Person-centred care	*Outcome 3:* People who use health and 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 capacity across the system	*Outcome 8:* People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	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

Performance against National Indicators

There are 23 indicators but four of them (indicators 10, 21, 22 and 23) have not yet been finalised for reporting and one (indicator 20) has not been reported since the pandemic due to data issues. 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 indicators 12 through 16 are Scottish Morbidity Records (SMRs), which are nationally collected discharge-based hospital records. For these indicators, calendar year 2022 is used as a proxy for 2022/23 due to the national data for 2022/23 being incomplete. We have done this following guidance issued by Public Health Scotland which was communicated to all Health and Social Care Partnerships. Using more complete calendar year data for 2022 should improve the consistency of reporting between Health and Social Care Partnerships.

Health and Care Experience Survey Indicators

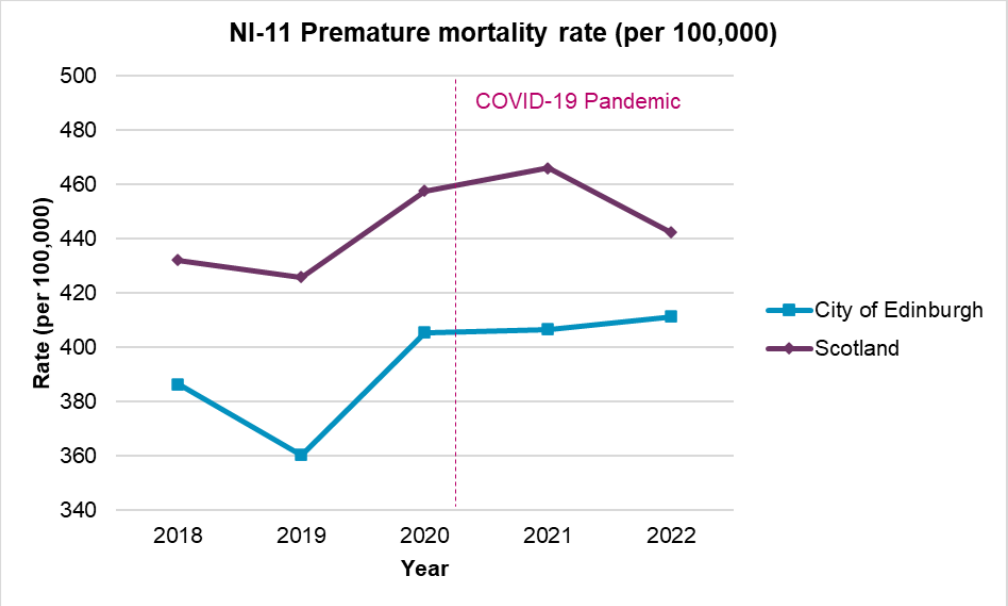
National indicators (NI) 1 to 9 are based on the Scottish Health and Care Experience Survey (HACE) commissioned by the Scottish Government and sent randomly to around 5% of the Scottish population every two years. The next update is due in May 2024. The results of the most recent 2021/22 survey were reported in last year's Annual Performance Report, reproduced for reference below. Reductions in almost all indicators since 2019/20 suggested the pandemic had affected both local and national responses.

National Indicator (NI)	2021/22 Edinburgh	2021/22 Scotland	2019/20 Edinburgh	2019/20 Scotland	2017/18* Edinburgh	2017/18* Scotland	2015/16* Edinburgh	2015/16* Scotland
NI-1: Percentage of adults able to look after their health very well or quite well	91.6%	90.9%	93.8%	92.9%	93.6%	92.9%	96.1%	94.5%
NI-2: Percentage of adults supported at home who agree that they are supported to live as independently as possible	78.9%	78.8%	77.6%	80.8%				
NI-3: Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	68.9%	70.6%	76.7%	75.4%				
NI-4: Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated	64.8%	66.4%	72.6%	73.5%				
NI-5: Percentage of adults receiving any care or support who rated it as excellent or good	77.4%	75.3%	82.2%	80.2%				
NI-6: Percentage of people with a positive experience of the care provided by their GP practice	73.8%	66.5%	82.5%	78.7%	84.2%	82.6%	86.9%	85.3%
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	79.2%	78.1%	83.2%	80.0%				
NI-8: Percentage of carers who feel supported to continue in their caring role	30.4%	29.7%	33.0%	34.3%	34.8%	36.5%	36.6%	40.0%
NI-9: Percentage of adults supported at home who agreed they felt safe	79.4%	79.7%	86.5%	82.8%				

Source: Scottish Government HACE surveys *Please note that 2019/20 and 2021/22 results for indicators 1, 2, 3, 4, 5, 7 and 9 in the Core Suite Integration Indicator update may differ from those recently released in the HACE publication. In addition, results for some indicators are only comparable to 2019/20 and not to results in earlier years.

Indicator 11: Premature mortality rate

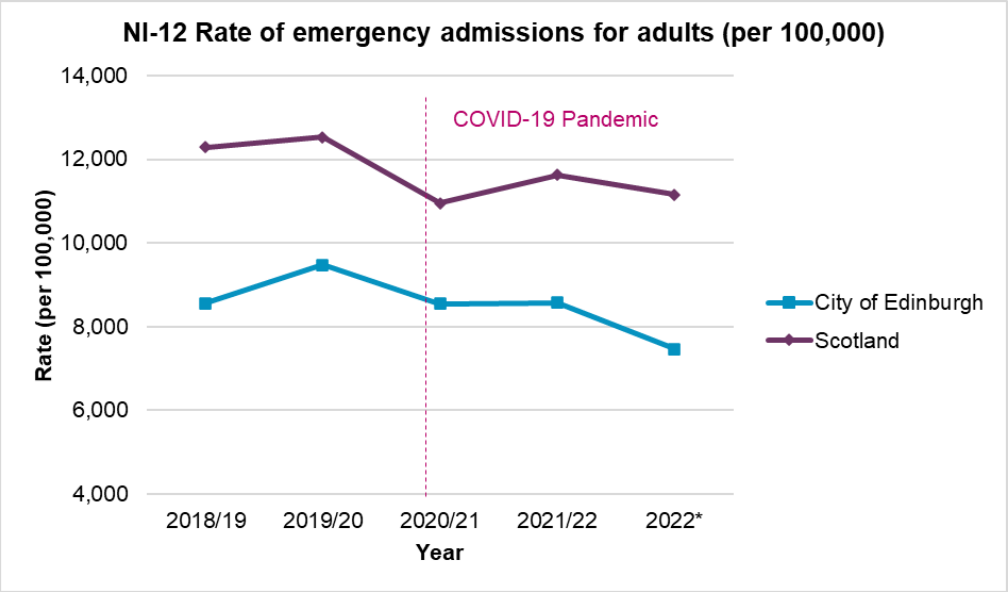
While we remain below the Scottish rate, the rate of premature mortality in Edinburgh has increased slightly over the past year, against a backdrop of improving performance across Scotland. Edinburgh remains in the top 50% of partnerships but moved from being ranked 11th to 14th out of the 32 areas. This represents a small number of additional deaths, but more work will be undertaken to understand why the trend in Edinburgh is not consistent with the wider country.



	2018	2019	2020	2021	2022
City of Edinburgh	386	360	405	407	411
Scotland	432	426	457	466	442

Indicator 12: Rate of emergency admissions for adults

Edinburgh has the lowest rate of emergency admissions in Scotland, and it is now the lowest it has been in at least six years, including during the pandemic. While admissions are affected by flow through the hospital system, 2022/23 also saw the lowest rate of A&E attendances by Edinburgh residents for many years.

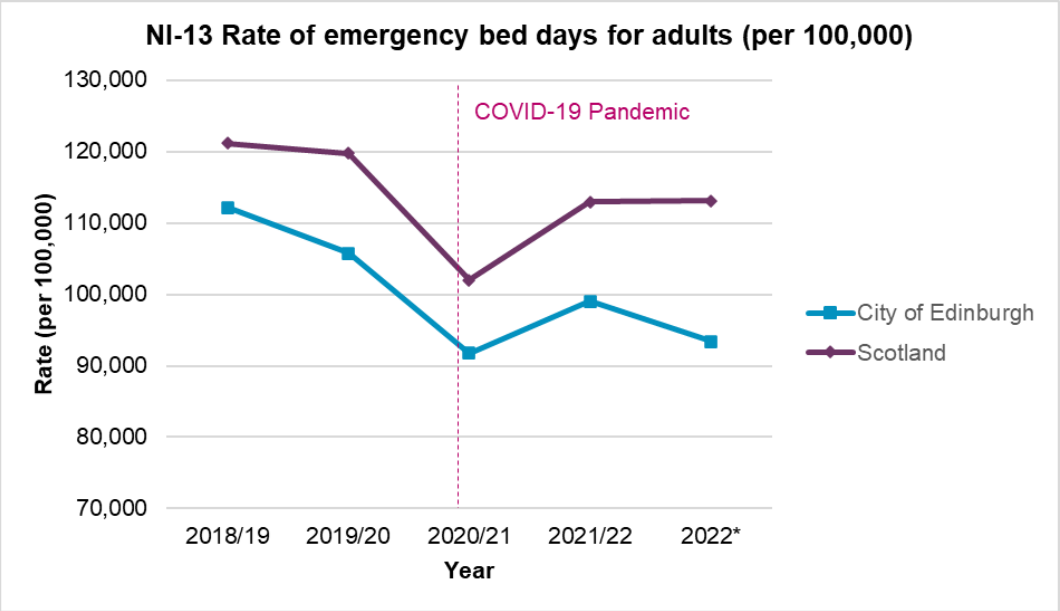


The rate of emergency admissions varies across our localities, as per the table below:

	2018/19	2019/20	2020/21	2021/22	2022*
City of Edinburgh	8,566	9,482	8,554	8,571	7,472
Scotland	12,284	12,529	10,957	11,632	11,155
North East	9,134	10,235	9,128	8,887	7,596
North West	8,962	9,963	9,272	9,230	8,369
South East	7,303	8,001	7,058	7,374	6,244
South West	9,065	9,946	8,940	8,897	7,751

Indicator 13: Rate of emergency bed days for adults

Edinburgh has the seventh lowest rate in Scotland and the rate is the lowest it has ever been, other than during the pandemic. The decrease in emergency bed days in the last year has been sharper for Edinburgh than Lothian or Scotland as a whole.

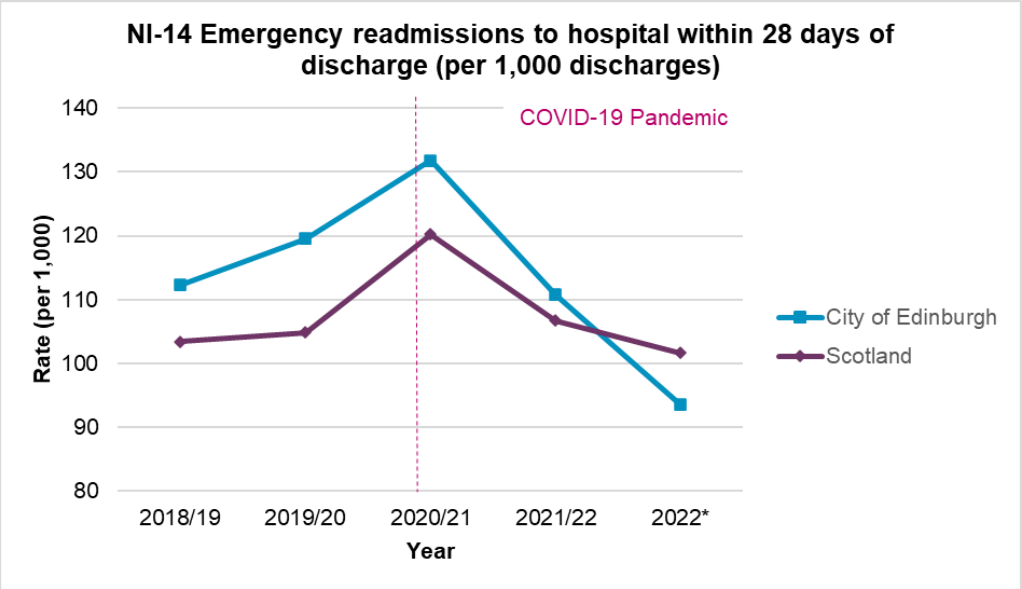


As with emergency hospital admissions, performance varies across our localities depending on demographics:

	2018/19	2019/20	2020/21	2021/22	2022*
City of Edinburgh	112,193	105,746	91,722	99,005	93,387
Scotland	121,174	119,753	101,967	112,939	113,134
North East	108,143	101,361	88,545	96,170	92,825
North West	115,417	108,557	95,104	104,369	96,759
South East	114,311	105,906	94,207	94,641	88,599
South West	109,839	106,807	87,777	100,933	95,818

Indicator 14: Readmissions to hospital within 28 days of discharge

Edinburgh has seen a sharp drop in the rate of emergency re-admissions to hospital within 28 days of discharge and is now below the Scottish rate. The re-admissions rate improved across the whole of Lothian so further analysis will be undertaken alongside other Lothian HSCPs to understand the factors supporting this improvement and how it can be maintained.

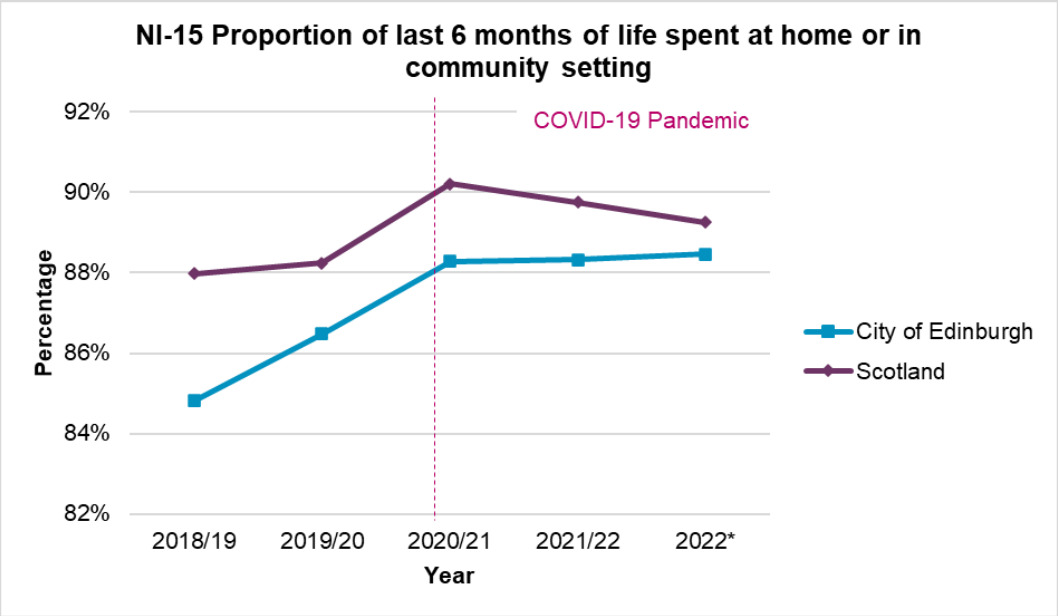


Performance of this indicator varies by locality:

	2018/19	2019/20	2020/21	2021/22	2022*
City of Edinburgh	112	120	132	111	94
Scotland	103	105	120	107	102
North East	119	124	134	113	96
North West	104	112	137	110	94
South East	110	119	119	104	86
South West	119	124	135	118	98

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

The Edinburgh rate is now the highest it has ever been and is almost in line with the Scottish rate. Edinburgh is ranked 23rd but there are minimal differences between rates in different partnerships on this measure.

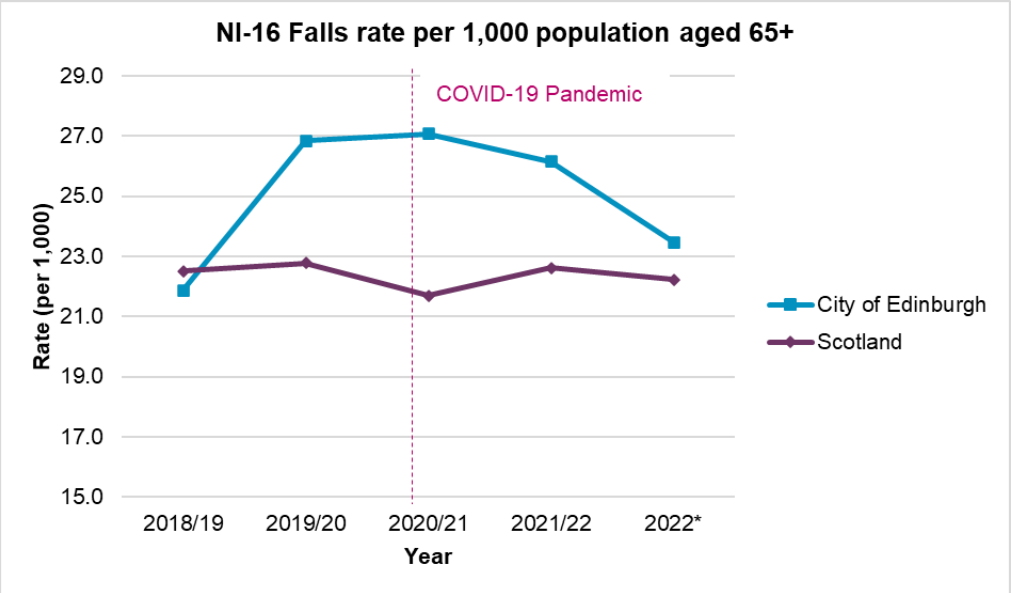


The breakdown by locality is as follows:

	2018/19	2019/20	2020/21	2021/22	2022*
City of Edinburgh	85%	86%	88%	88%	88%
Scotland	88%	88%	90%	90%	89%
North East	85%	87%	88%	88%	88%
North West	83%	85%	87%	88%	88%
South East	87%	88%	89%	89%	89%
South West	86%	87%	89%	89%	89%

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

Edinburgh has seen a drop in the rate of emergency admissions for falls in 2022 and the rate is the lowest it has been since changes were made to admission practices in Lothian (at the Edinburgh Royal Infirmary) in 2019. However, with a rate of 23.4, we are slightly above the Scottish figure of 22.1 and rank 21st out of all of the partnerships. The falls rate also improved across the whole of Lothian so further analysis will be undertaken alongside other Lothian partnerships to understand the factors supporting this improvement and how it can be maintained.

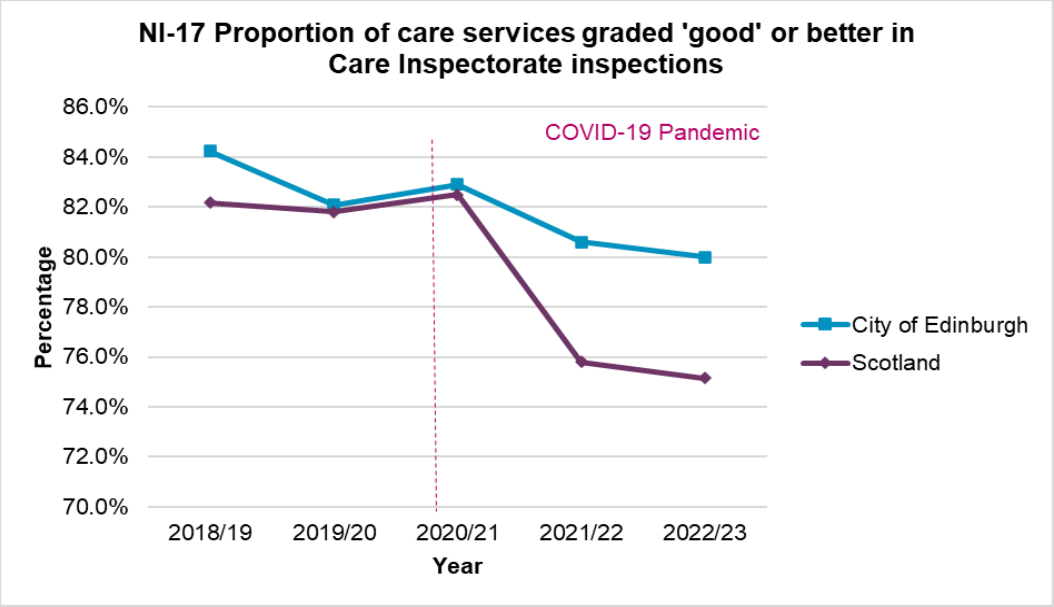


The breakdown by locality is as follows:

	2018/19	2019/20	2020/21	2021/22	2022*
City of Edinburgh	22	27	27	26	23
Scotland	23	23	22	23	22
North East	23	30	28	28	22
North West	22	27	29	27	26
South East	22	28	26	25	24
South West	21	23	24	24	21

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

Following a reduction in inspection frequency due to the Covid-19 pandemic, 2022/23 saw the resumption of inspections across all sectors in the Partnership. 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. While the figure of 80% for 2022/23 represents the lowest figure for the partnership in five years, it is 5% above the figure for Scotland as a whole.

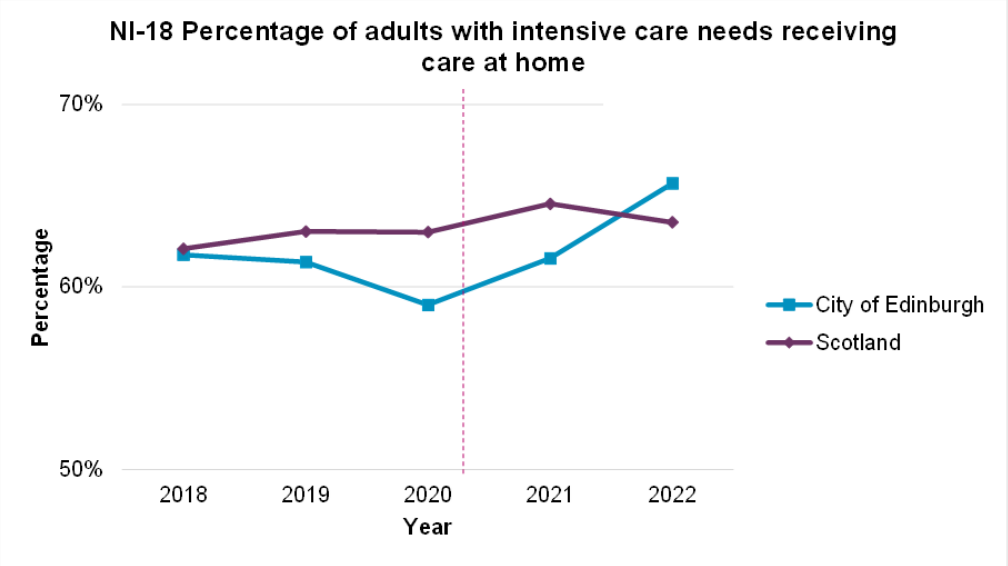


	2018/19	2019/20	2020/21	2021/22	2022/23
City of Edinburgh	84.2%	82.1%	82.9%	80.6%	80.0%
Scotland	82.2%	81.8%	82.5%	75.8%	75.2%

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

The percentage of adults receiving personal care at home (rather than in residential care or HBCCC) has increased slightly in 2022, taking us above the Scottish average. This is likely linked to our progress in reducing our unmet need list for care at home.

Our performance in this indicator has improved compared to the previous year and is now at the highest level in the last six years. Our ranking compared to other partnerships improved from 20th to 12th out of 32 partnerships, moving us into the second quartile. We continue to work to shift the balance of care from hospital settings to the community, through our bed-based review and Home First approach.

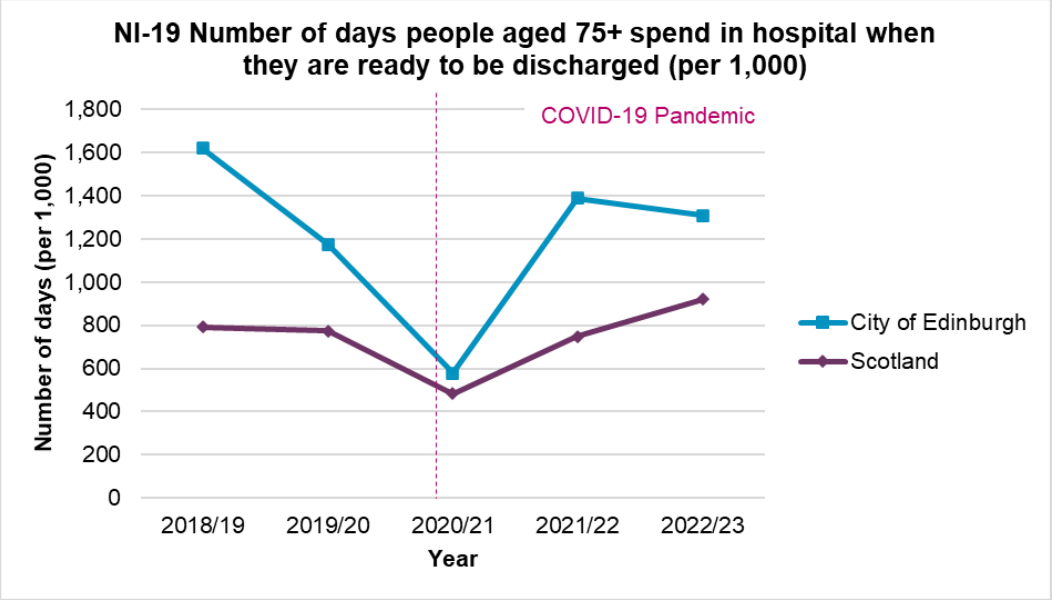


	2018	2019	2020	2021	2022
City of Edinburgh	61.8%	61.4%	59.0%	61.6%	65.7%
Scotland	62.1%	63.0%	63.0%	64.6%	63.5%

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

Edinburgh is one of only four partnerships that saw improved performance in delays in 2022/23. Our performance improved in each quarter so the results do not reflect the progress made throughout the year. In March 2022 we ranked 2nd for this indicator; in March 2023 we ranked 8th, with 1st being the worst performing.

The improvement in delay levels has been supported by our interim placement programme, which supported 174 people out of hospital saving 12,988 bed days in 2022/23, and work under way through our 'One Edinburgh' approach to home-based care is supporting increased efficiency and capacity gains in this sector. Our bed-based strategy will implement changes that support increased capacity in intermediate care and a move to a nursing model within our internal care homes. Ongoing work through the Home First project on implementing a Planned Date of Discharge will also support more proactive discharge planning.



	2018/19	2019/20	2020/21	2021/22	2022/23
City of Edinburgh	1,621	1,175	579	1,388	1,310
Scotland	793	774	484	748	919

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

NHS Boards have not been able to provide detailed cost information since 2019/20 due to changes in service delivery during the COVID-19 pandemic. As a result, PHS have not provided information for indicator 20 beyond 2019/20. PHS previously published information to calendar year 2020 using costs from 2019/20 as a proxy, but given the impact of the COVID-19 pandemic on activity and expenditure, PHS no longer consider this appropriate.

Ministerial Strategic Group Indicators

We also report on the performance indicators set by 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.

Since the 2017/18 baseline was set, we are moving in the desired direction for all but one of these indicators: Mental Health Bed Days.

Indicator	2017/18 Baseline total	Desired direction of travel	Latest available figures	Achieved Direction of travel	Latest Period
A&E Attendances	103,986	↓	99,264	↓	2022/23
Unplanned Admissions	35,597	↓	30,741	↓	2022/23
Emergency Occupied Bed Days:					
Acute	330,759	↓	282,529	↓	2022/23
Geriatric Long Stay^	22,324	↓	18,063^	↓	2022/23
Mental Health	122,841	↓	126,649p	↑	2022/23
Delayed Discharges	76,933	↓	70,208	↓	2022/23
Last 6 months of life spent in a community setting	85.7%	↑	88.4%	↑	2021/22
Balance of Care: at home#	95.6%#	↑	96.0%	↑	2021/22

^ 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 is now 95.5%

Looking ahead

Our focus over 2023/24 will be on the delivery of the budget savings programme and Inspection Improvement Plan agreed by the EIJB in June 2023, and the refreshed EIJB Strategic Plan. By evolving our Innovation and Sustainability Programme to incorporate these plans, we will work to balance the need for service improvements and financial sustainability alongside continuously promoting positive outcomes for service users.

We will consult on the refreshed Strategic Plan, with revised strategic objectives which have evolved in light of the impact of COVID-19, the economic situation, and lessons learned from recent inspections and engagement with partners. We will continue to engage with, and respond to, work undertaken by our partners in the wider health and social care landscape, including developments in the data and digital space and in preparation for a National Care Service (NCS). We will carefully consider how we can use these developments to enhance person-centred care and support to our staff and service users. Innovation and sustainability will remain central to our thinking and underpin our desire to foster a culture of continuous improvement.

We are also moving forward with new leadership. In June 2023, NHS Lothian appointed Katharina Kasper to take over as Chair of the EIJB from Councillor Tim Pogson, who will remain as Vice-Chair, as appointed by the City of Edinburgh Council. Following the recent departure of our EIJB Chief Officer, Judith Proctor, Mike Massaro-Mallinson was appointed as Interim Chief Officer from June 2023. We thank Tim and Judith for their work in supporting the EIJB through the challenging times we have faced in recent years. With a fresh leadership team, we look forward to meeting the challenges ahead.