REPORT

EIJB Annual Performance Report 2023/24

Edinburgh Integration Joint Board

20 August 2024

Executive Summary	1. The purpose of this report is to provide the **Edinburgh Integration Joint Board (EIJB)** with a copy of the draft EIJB Annual Performance Report 2023/24 (APR) for approval. 2. The APR was reviewed by the Performance and Delivery Committee at their committee meeting on 7 August. As agreed at the Performance and Delivery Committee on 10 April 2024, the content for the APR for 2023/24 reflects the structure and - broadly speaking - the content of the APR for 2022/23, 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. 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 until after our approval process is complete in August. This meeting of the EIJB represents the final stage of the process, and once the report is approved, it will be published online as soon as practicable.

Recommendations	It is recommended that the **EIJB:** 1. Approves the publication of the APR 2023/24.

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	

Main Report

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

2. 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

3. 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.

4. 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 2023 as a proxy for 2023/24, 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.

5. 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 2023/24 as well as the key projects we have under way that will improve performance against each indicator.

Accessibility

6. 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.

7. 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.

8. 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

9. 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. However, core indicator and MSG data is not published by Public Health Scotland until 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, informal discussions with Scottish Government have confirmed we can delay publication until after our approval process is complete in August.

10. This meeting of the EIJB represents the final stage of the process, and once the report is approved, it will be published online as soon as practicable.

Strategic Priorities

Strategic Priorities	✓	Key points within report that address strategic priorities
Prevention and Early Intervention	✓	The performance report provides an overview of performance and progress against all strategic objectives.
Tackling Inequalities	✓	
Person Centred Care	✓	

Managing our resources effectively	✓	
Making best use of capacity across the system	✓	
Right care, right place, right time	✓	

National Health and Wellbeing Outcomes

Please note which national Health and Wellbeing Outcomes your report aligns to			✓
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	✓	6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	✓
2. People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	✓	7. People who use health and social care services are safe from harm.	✓
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	✓	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.	✓
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	✓	9. Resources are used effectively and efficiently in the provision of health and social care services.	✓
5. Health and social care services contribute to reducing health inequalities.	✓	Not applicable	

Implications for Edinburgh Integration Joint Board

Financial

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

Risk, legal, policy, compliance, governance, and community impact

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

Equality and Poverty Impact

13. 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.

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

15. An integrated impact assessment is not required.

Environment, climate, and sustainability impacts

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

Quality of care

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

Consultation

18. The APR 2023/24 was presented to the Performance and Delivery Committee as the lead Committee for performance issues at their committee meeting on 7 August 2024.

19. The Executive Management Team reviewed the report on 4 July 2024 and 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 to ensure it aligns with our communication key messages.

Report Author

Andrew Hall

Service Director Strategic Planning

Contact for further information:

Name: Susan McMillan, Performance and Evaluation Manager, EHSCP
Email: susan.mcmillan5@nhslothian.scot.nhs.uk Telephone: 07890 023 566

Appendices

Appendix 1 EIJB Annual Performance Report 2023/24

Edinburgh Integration Joint Board

Annual Performance Report 2023/24

Edinburgh Integration Joint Board

Annual Performance Report 2023/24

Foreword **2**

Overview **4**

Introduction *4*

Delivery arrangements *4*

About Edinburgh and our localities *5*

Performance overview *7*

Strategic Priorities **9**

Priority 1: Prevention and early intervention *9*

Priority 2: Tackling inequalities *12*

Priority 3: Person-centred care *16*

Priority 4: Managing our resources effectively *21*

Priority 5: Making best use of capacity across the system *26*

Priority 6: Right care, right place, right time *30*

Performance **33**

National Indicators *33*

Ministerial Strategic Group Indicators *43*

Looking ahead **44**

Foreword

Like other Integration Joint Boards (IJB's) across Scotland, Edinburgh is facing a challenging financial environment. Factors such as an ageing population, an increase in the number of people living with long term conditions and resource availability mean we are not able to continue to match the current level of demand.

We recognise the need to redesign services and reshape the services we commission. Our main focus is to protect our core services that the people of Edinburgh rely upon, and concentrate on statutory services and the people that need our help the most.

Following additional one-off investment from partners (totalling £21 million), a break-even position was reported against the budget for the year. We also delivered a complex £21 million savings programme, comprising 22 projects. As we moved into 2024/25 and face further demand led pressures, our budget deficit increased to £60 million and a package of reform has been agreed to address this in a manageable way.

We have also worked closely with community organisations to be innovative in how we invest remaining funding. Early intervention and prevention approaches are at the heart of the services we deliver, and our strong partnership working is crucial to this.

After joint inspections of both our adult support and protection work and adult social work and social care by the Care Inspectorate in early 2023, a major focus for 2023/24 has been implementing actions from the first year of our improvement plan. Our priorities in year one have included early intervention and prevention, improved access to services, and staff recruitment and retention.

In this 2023/24 annual performance report, we outline the progress we have made in continuing to develop and improve our services and our performance against the national health and wellbeing indicators set out by the Scottish Government. Overall, our performance in 2023/24 is positive, with 18 out of 24 of the measures performing better or similar to the Scottish average. 11 out of 18 indicators with trend data have seen an improved or steady ranking on benchmarked performance compared to last year and we remain in the top half of partnerships for 14 of the 24 indicators with an update in this report, with improvements also seen in other areas. While we have been on a trajectory of improvement over this last year, we recognise that this may be difficult to maintain given the financial challenges we face.

Despite challenges in recruitment across Edinburgh Health and Social Care Partnership, our strength is our hard working and passionate colleagues who care deeply for the people we support throughout Edinburgh. Their dedication to the community, and in providing the best care possible, allows us to continue supporting the Edinburgh community in the best way we can. In June 2023 Katharina Kasper took over as Chair of the Edinburgh Integration Joint Board (EIJB) and towards the end of 2023 Pat Togher joined as our new Chief Officer of the EIJB to lead the Edinburgh Health and Social Care Partnership (EHSCP).

Katharina Kasper
Chair
EIJB

Pat Togher
Chief Officer
EHSCP

Overview

Introduction

The Edinburgh Integration Joint Board (EIJB) was established in 2016 to bring together 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 2023 to March 2024 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 2024.

Delivery arrangements

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

The health and social care services we deliver and commission include:

- carers support services to a subset of the 45,000 and 70,000 adult carers estimated in Edinburgh
- social care assessment and other social work services provided to around 10-12,000 people a year
- care at home services provided to around 8,000 adults and older people over the course of the year
- technology enabled care provided to around 9-10,000 people a year
- around 2,000 people supported through learning disability services
- dementia services to support the estimated 8-9,000 people in Edinburgh with dementia
- primary care services including pharmaceutical services, district nursing and GP services and enhanced primary care services across around 70 GP practices
- mental health and wellbeing services and services that support people with substance misuse
- services to prevent admission to and support discharge from hospital, such as hospital at home services, with about 5,000 discharges supported each year
- around 3,500 people supported in care homes and nursing homes across each year

- adult support and protection services, with around 3,000 duty to inquire assessments completed each year.

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. Throughout 2023/24 we undertook a review of these delivery arrangements, with structural changes to move to the delivery of citywide services to be implemented throughout 2024/25. These changes will allow us to streamline delivery of services across the city, while continuing to have a focus on shaping services that are responsive to the different characteristics and needs of our distinct Edinburgh communities.

Our major strategic change projects include some of the key pieces of work that were previously part of the transformation programme, including some of those 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 512,700 as of March 2022.
- 82,100 residents were aged 65 or over, with this age group projected to increase the most over the coming years[1].
- Edinburgh is also the wealthiest city in Scotland, with 82.8% of the working age population in employment.
- 49.6% of the economically inactive population within the city are students, and 14.5% look after others.[4]
- However, 15% of the population, and as many as 20% of children, live in relative poverty[5].
- 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[2]
- 50.8% are female and 49.2% are male[2]
- 15.1% are aged under 18, 71.6% are 18-64 and 13.2% are over 65[2]
- 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[2]

- 35,573 average home care hours per week between January and March 2024
- 1,566 were receiving home care at the end of March 2024
- 18 GP practices[3]

North West

- 148,992 people live in the North West locality[2]
- 51.6% are female and 48.4% are male[2]
- 19.7% are aged under 18, 62.6% are 18-64 and 17.7% are over 65[2]
- 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[2]
- 29,083 average home care hours per week between January and March 2024
- 1,524 people receive were receiving home care at the end of March 2024
- 18 GP practices[3]

South East

- 138,730 people live in the South East locality[2]
- 52.4% are female and 47.6% are male[2]
- 14% are aged under 18, 71.5% are 18-64 and 14.5% are over 65[2]
- 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[2]
- 27,122 average home care hours per week between January and March 2024
- 1,345 people were receiving home care at the end of March 2024
- 18 GP practices[3]

South West

- 113,560 people live in the South West locality[2]
- 49.7% are female and 50.3% are male[2]
- 17.6% are aged under 18, 66.4% are 18-64 and 16% are over 65[2]
- 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[2]
- 31,664 average home care hours per week between January and March 2024
- 1,320 people were receiving home care at the end of March 2024
- 16 GP practices[3]

[1] Scotland's Census (2022)
[2] PHS LIST Locality Profiles
[3] National Primary Care Clinicians Database (NPCCD), Public Health Scotland (Jan 2024)
[4] NOMIS Official Census and Labour Market Statistics (Oct 2022 – Sept 2023 release)
[5] https://www.edinburghhsc.scot/the-ijb/jsna/poverty/

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 (MSG) for Health and Community Care indicators.

We remain in the top half of partnerships for 58% of the indicators (14 out of 24) with an update this year. 11 out of 18 indicators (61%) with trend data this year have seen an improved or steady ranking on benchmarked performance compared to last year, 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 continued to see positive movement in our levels of bed days spent in delay for over 75s this year. Edinburgh has moved out of the bottom quartile, with a 17% reduction over 2023/24 compared to a 2% decrease nationally, although challenges remain to reduce our level of delays to sustainable levels. We also have the lowest rate in the country for emergency admissions and fifth lowest on emergency bed days.

While we have seen a decline in ranking in some indicators this year, there are also indications of positive directions of travel for many of these indicators that we will continue to build on:

- NI-8 Carers who feel supported to continue – We increased our positive response slightly from 30.4% to 31.3%, though recognise we have a long way to go to improve this measure.
- NI-11 Premature mortality - We remained below than the Scottish rate and our per population rate was within 1% of the previous year.
- NI-14 Emergency readmissions – We remain below the Scottish average and lower than our rate between 2019 and 2022.
- NI-16 Falls rate – We remain lower than our rate between 2019 and 2022.
- MSG1.a A&E Attendances – We remained better than the Scottish rate and our per population rate was within 7% of the previous year.
- MSG3.a Acute emergency bed days – We remained within the top 5 best performing partnerships and our per population rate was within 3% of the previous year.
- MSG3.c Mental health emergency bed days – While we remained in the bottom quartile, our per population rate improved by 4% on the previous year.

Core Indicator		Time Period	Quartile	Change in rank from previous year
NI - 1	Percentage of adults able to look after their health very well or quite well	2023/24	2	↑
NI - 2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	2023/24	2	-
NI - 3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	2023/24	3	-

Core Indicator		Time Period	Quartile	Change in rank from previous year
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	2023/24	3	-
NI - 5	Total percentage of adults receiving any care or support who rated it as excellent or good	2023/24	2	-
NI - 6	Percentage of people with a positive experience of the care provided by their GP practice	2023/24	2	→
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	2023/24	2	-
NI - 8	Total combined % carers who feel supported to continue in their caring role	2023/24	3	↓
NI - 9	Percentage of adults supported at home who agreed they felt safe	2023/24	1	-
NI-11	Premature mortality rate (per 100,000 population)	2023	2	↓
NI - 12	Emergency admission rate (per 100,000 population)	2023	1	→
NI - 13	Emergency bed day rate (per 100,000 population)	2023	1	↑
NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	2023	3	↓
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	2023	3	↑
NI - 16	Falls rate per 1,000 population aged 65+	2023	4	↓
NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2023/24	2	↑
NI - 18	Percentage of adults with intensive care needs receiving care at home	2023	2	↑
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	2023/24	3	↑
MSG1. a	Rate of A&E Attendances (lowest rate = Quartile 1)	2023/24	2	↓
MSG1. b	4-hour Performance	2023/24	4	↑
MSG2	Rate of Emergency Admissions (lowest rate = Quartile 1)	2023	1	→
MSG3 a.	Unscheduled Bed Days (Acute):	2023	1	↓
MSG3 c.	Unscheduled Bed Days (MH):	2023	4	↓
MSG4	Delayed Discharge Bed Days:	2023/24	3	↑

Source: Public Health Scotland **Notes:** Quartile and 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. Dashes indicator that we do not have previous comparative data for the indicator. Only indicators with an update for 2023 or 2023/24 are included. MSG3b not included due to SMR completeness issue.

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 have developed new ways to engage and fund the third sector, with an 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 forward 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 any additional or new allocations received. In June 2023 we held a session for partners to reflect on work to date and to think about how the PSP should be taken forward and what should be prioritised. The reflections suggested people want to work collaboratively drawing on the strengths of one another and be responsive to the needs of the community, and most of all, to listen to and be aware of the needs of our communities.

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. Our support through Capacity to Collaborate for the innovative work of NeSSIE in the North West continues and the initial successes and learning has attached further funding from City of Edinburgh Council and Scottish Government. We continued to share 'The nights are fair drawin' in' booklet we produced with our City of Edinburgh Council colleagues as part of their *Warm and Welcoming Spaces* initiative. The booklet contains helpful information and sources of help, which was distributed to libraries, community centres and arts venues across the city.

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 are currently reviewing and updating our Future Care Planning resources (previously Anticipatory Care Planning or ACP) in readiness for the forthcoming programme of work being led by Scottish Government, working with a range of delivery partners, to develop a national programme on future care planning. We have launched a Future Care Planning care homes online training and improvement package, and updated the Future Care Planning social care implementation guidance and resources.

We are also undertaking scoping work with the national Right Decision Service team on the potential to co-design and deliver a self-management and shared decision-making tool to provide a platform for digitising existing practitioner resources, Self-Management Practitioner Toolkit and Connect Here Directories, which offer easy access to practitioner tools to help with:

- gaining a shared understanding of what matters to people about improving their health and wellbeing
- working alongside people so that they are at the centre of decision-making which facilitates care and support that is right for them
- taking a values & strengths-based approach to enable connection with the right support to prevent crisis and have more good days.

In terms of digital support, we have successfully supported the implementation of remote blood pressure monitoring for use in 68 GP surgeries which is used by around 10,500 patients across Lothian. The National Blood Pressure Service was rolled out under a national agreement endorsed by the Scottish Government, supported by National Services Scotland, Technology Enabled Care (NSS TEC).

In collaboration with NHS Lothian colleagues, we developed a new Care Homes Falls and Frailty Education package which has been made available to all Care Homes as part of a quality improvement project. The aim of the ongoing project is to increase the confidence of care home staff in managing a person who has had a fall as well as knowledge of falls prevention and risk factors and improving reporting and recording of falls.

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.

Following the publication of inspection into adult support and protection services in Edinburgh, we have been working to improve how we provide adult protection services. Between April 2023 and March 2024, there were 2,870 adult protection contacts across the city, compared with 2,851 last year (this is a restated figure following changes to how data are reported). This sustained level of adult protection referrals 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. One of the changes that has been implemented is being able to distinguish between investigations that have been performed with and without investigatory powers. Since June 2023 when this change was made, a quarter of referrals (24.6%, 641) progressed to inquiry using investigatory powers.

At 26%, physical harm was the most common type of harm for those referrals which resulted in an investigation with investigatory powers, closely followed by financial harm (24%). Infirmity due to old age was the most common client group for those whose case was being investigated (32.9%) There were also 1,329 adult protection case conferences in the year, of which a third (29.9%) were initial case conferences.

Case study: Edinburgh & Lothian Greenspace Trust (ELGT)

Services supported through our EIJB Grants programme help to support early intervention and prevention through reducing social isolation, improving mental wellbeing, promoting healthy lifestyles including physical activity and healthy eating and building strong, inclusive and resilient communities. For example, through participation in community groups funded through the grants programme, B was supported to form friendships, increase his independence and create positive change in habits and lifestyle to became fitter and healthier.

B has a mild learning disability which means that he can't read or write. Before attending sessions, he led a very sedentary and isolated lifestyle, staying indoors playing video games and watching films. However, he was keen to make lifestyle changes to improve his mood and continue his weight loss journey.

He started to come along to the Walking Adventures project in Moredun just before COVID ,when these sessions were suspended he joined Zoom catch ups and yoga sessions. When restrictions lifted and the walking sessions resumed, B continued to participate in all the available sessions. He greatly benefitted from meeting new people and the gentle outdoor exercise, forming friendships with other participants, who encouraged him to attend other activities such as the Goodtrees Garden Get Togethers, Move 'n Groove sessions and cycling sessions at Bridgend Farmhouse, both of which he still attends.

This year, B has also begun to attend a programme of Social Cycling sessions with Edinburgh and Lothians Greenspace Trust and joined the new Ambling Adventures walking group in Holyrood Park, which have helped him get to know new parts of the city and whole new groups of people. Whether walking, cycling or jogging, he is now active every single day and recognises the difference that these changes have made to the quality of his everyday life.

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

In 2023/24, 64 projects received funding through the EIJB Grant Programme. In total, we provided £5,043,073 for the continued provision of preventative and early intervention services across the city. These services aim to tackle inequalities by taking action to identify those experiencing the poorest health outcomes in the city and addressing the barriers that they face. The grants awarded through the programme ranged from those addressing social isolation, self-management of long-term conditions, promotion of healthy lifestyles, improved mental health, a reduction in harm from drugs and alcohol misuse and from all forms of abuse and violence, increased income maximisation, reduced digital exclusion and building stronger, inclusive and more resilient communities.

While 2023/24 impact data is not yet available, throughout 2022/23, it is estimated that services funded through the grant programme benefited approximately 50,556 people across the programme's priority outcomes, an increase of 27% from 2021/22. 87% of the targets set were either met or exceeded and the user satisfaction of services provided through the grant programme remains high with an average satisfaction score of 91%. In addition, the following impacts were reported by participants:

- 88% of participants felt less socially isolated
- 84% of participants felt less anxiety and depression
- 86% of participants reported eating more healthy food
- 82% of participants had increased physical activity
- 86% of participants benefitted from increased income
- 71% of participants reported reduced harm from drugs and alcohol misuse

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)

Since May 2023 we have been prototyping open access to mental health and wellbeing support across the city through our Thrive Welcome Teams. Initial data suggests the new open access approach is reducing some pressure on Primary Care Services as well reaching more hard to reach groups, such as males. In addition, staff from across both the Thrive Welcome Teams and Primary Care are delighted with the new ways of working and the feedback from people seeking help has been positive.

Over the last year the Connect Partnership, who are part of our Thrive Collective, have engaged with 1,693 people across Edinburgh with a range of emotional, psychological and social interventions. In terms of Thriving Spaces, this partnership worked with 8,481 individuals, delivering social support, creative opportunities and horticultural activities. Finally, the Physical and Green Space group engaged with 2,657 people. Most of the activities being delivered within this partnership focused on getting people active (e.g. walking groups) and gardening.

The Place to Live framework agreement places strong emphasis on linking people into their local communities, building up a local network of support and accessing community activities. 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. As part of improving our pathway for unscheduled out of hours, we have commissioned Penumbra to host Crisis Navigators who work closely with the Mental Health Assessment Service to help link people to support in the community.

In 2023 we continued with our Thrive Arts programme, which hosts a calendar of events throughout the year, some which coincide with national days, or months, and some which target specific communities of interest or identity. Some of our highlights included Thrive Fest, The Future is Unwritten, Strange Town Touring Company, Bits and Pieces by Saltire Sky Theatre Company, Scottish Mental Health Arts Festival, Pride Youth Space, and Out of Sight, Out of Mind. All these reached out to different communities and invited people to participate, connect, and learn through the arts whilst helping to breakdown the stigma around mental health in our society.

Early in 2023 we hosted an event with over 80 local stakeholders to discuss how we should take forward local delivery of the national suicide prevention strategy *'Creating Hope Together'* and what our local priority areas should be. From these discussions we established a Steering Group supported by four subgroups with themes of data and insights; space/time and compassion; supporting people and supporting our communities.

Through our collaborative Thrive Students initiative, we have been developing and creating ways to build better pathways for students and now have a data sharing agreement in place to allow for easier referral and transfer of information between universities and NHS Lothian, streamlining a student's journey into services. ithrive is

now fully up to date with information on support for students and we have created a link between refhelp and ithrive to help GPs refer more easily.

We continue to support service user research through our partners CAPS Advocacy and Media Education. There are four well established, and two newer active user led research programmes, which help to ensure that service users' voices are at the heart of redesigning and informing our services and support people experiencing first episode psychosis, people who have experienced trauma, people who have attracted a diagnosis of personality disorders and people with eating disorders. The two newer groups are funded through our Thrive Collective and have a focus on LGBTQIA+ and ethnic minorities. CAPS and Media Education are constantly looking at intersectionality in terms of all these themes.

Edinburgh Alcohol and Drug Partnership (EADP)

Work on coproducing the new EADP strategy for 2024-27 has included two large conferences, dozens of focus groups and interviews. Plans for the future development of the strategy include a wide range of activities to hear the voices of lived and living experience.

Other developments have included very substantial progress with the Medication Assisted Treatment (MAT) standards (nationally set targets for the capacity, quality and responsiveness of drugs treatment services). Same day access to assessment for treatment is now available every weekday, many people who are at very high risk of harm are offered outreach support and services provide increasing amounts of evidence-based psychological interventions.

The MAT Implementation Support Team (MIST), a part of Public Health Scotland (PHS), support ADPs to implement MAT and undertake an annual benchmarking exercise to evaluate progress in each area. Progress is expressed in "RAG" (Red, Amber, Green) status, where "green" indicates "fully implemented; and "provisional Green" and "Amber" indicate "partially implemented". EADP's implementation of the MAT Standards was graded as "green" for 1 through to 5 and provisionally green for 6, 7, 8, and 10. We were graded as Amber for MAT 9, Mental Health. More detail on our progress with MAT standards and other activity of the EADP can be found in the EADP Annual Report 2023-24 at this link. It shows significant improvement and degrees of improvement in line with national and local expectations.

Case study: Feniks

The organisations supported through the EIJB programme also support groups most at risk of poor health outcomes. For example, the suicide rate among Polish men in Scotland is almost twice the rate of the Scottish population. As a result, Feniks launched the “Shed your armour, show the scars" campaign, which encouraged Polish men to seek help when struggling with their mental health.

This highlighted the stories of Community Ambassadors such as P, who has become an excellent role model for the Polish community in Scotland. He has contributed to normalising mental health help-seeking by sharing how he's been overcoming challenges and inspiring many Polish men to speak up, show vulnerability and share their difficulties. He has volunteered in various projects, including supporting the Active 50+ group, translation, and event organising.

In his own words he says: 'I took part in this project because I once needed help with my mental health too. I was in a place that seemed impossible. I had one dream: to overcome this and be strong enough to help others. I didn't want anyone to go through the same."

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 assets and strengths, and linking with community networks to achieve positive outcomes. Implementation across our assessment and care management teams continues, with new teams such as our dedicated review teams adopting this way of working to support people more quickly, promote early intervention and prevention and ensure people receive proportionate support.

In response to the joint inspections in 2023, we commenced the one assessment project to provide staff with the relevant guidance and tools to deliver consistent, good quality and robust assessments through the implementation of a single assessment template across all teams. Phase one of the roll out plan commenced in February 2024 to provide new or refresh training in Three Conversations to locality staff. A revised recording process was also implemented January 2024 with all teams using the Three Conversations approach to support consistency and good quality recording.

During 2023/24, an average of 78% of new people who contacted us within the teams using the Three Conversations approach 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 53% in 2022/23, though some of the increase may be attributable to improvements in the recording process. 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. Moving forward it is critical that we build on our experience of implementation and promote a strong culture of continuous improvement within the HSCP and in this regard we will continue to review the application of this model through the lens of strength-based approaches while engaging with front line practitioners in obtaining their views.

Care Inspectorate Reviews

We deliver 35 registered adult care services that are subject to inspection by the Care Inspectorate.

During 2023/24, twenty inspections took place (detailed undernoted), 87% received a grade of 'Good' or above. Overall, the inspections found that in Care Homes, people's health and wellbeing needs were being met, and staff were committed to

helping people achieve their best possible outcomes. Improvements in care planning should continue to promote better care for people. In Homecare services, people were supported to get the most out of life and new technology was being introduced to strengthen quality assurance systems and support improved internal communications and care recording.

One service, Royston Court, received grades of weak and adequate and an improvement plan is underway to address the issues raised by the inspectorate.

Service	Date of inspection	How well do we support people's wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting	How well are care and support planned?
Be Able South	01-Mar-23	5	4	NA	NA	NA
North West Hub Re-Ablement Service	16-Mar-23	5	NA	NA	NA	NA
NE Home Care Service Leith	19-Apr-23	5	5	NA	NA	NA
NE Hub - Re-ablement Service	19-Apr-23	5	5	NA	NA	NA
North East Home Care Service East	19-Apr-23	5	5	NA	NA	NA
South West Home Care Service Pentlands	03-May-23	5	5	5	NA	NA
North West Home Care Service Cluster 1	18-May-23	5	5	NA	NA	NA
Sheltered Housing Support Service	29-May-23	4	3	4	NA	4
Marionville Court	13-Jun-23	4	4	4	4	4
Fords Road Home for Older People	14-Jun-23	5	5	NA	NA	NA
Inch View	28-Jun-23	3	4	NA	2	NA
Jewel House	06-Jul-23	4	4	NA	NA	NA
Edinburgh Support Services Community Support	04-Aug-23	4	4	NA	NA	4
Be Able North	21-Aug-23	5	4	5	NA	5
Clovenstone House	18-Oct-23	5	5	NA	NA	NA

Service	Date of inspection	How well do we support people's wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting	How well are care and support planned?
Ferrylee	23-Oct-23	5	5	NA	NA	NA
North Merchiston	17-Jan-24	4	4	4	4	4
Castlegreen	09-Feb-24	5	5	4	4	4
Inch View	26-Feb-24	NA	NA	NA	3	NA
Royston Court	27-Feb-24	2	2	2	3	3

Quality Improvement and Assurance in Care Homes

We have undertaken a large-scale project over the last 12 - 18 months within our internally managed care homes introducing new care documentation. Over 450 staff have been trained in the new documentation, we have developed learning resources for staff training and implemented the new care plans. The idea was to standardise the care documentation across council care homes and introduce documentation which is more person centred. We have also developed new feedback questionnaires for relatives and residents including a dementia friendly questionnaire.

We are currently working on another large project, developing and introducing new assurance documentation which we have tested at Ferrylee care home and are now developing and implementing in Royston with the aim to spread to all the council care homes in 2024.

In the last quarter of 2023/24, we have started a cohort of Scottish Improvement Foundation Skills training specifically for care home staff which is planned to run for 6 months. Within the course there is a member of staff from each care home and the senior nurse for care homes. The projects are specific to the care homes and having a cohort specifically for this staff group will help promote shared learning and ideas for improvement across the care homes through this network of improvers.

Joint inspection of Adult Support and Protection

A Joint Inspection of Adult Support and Protection (ASP) practice in Edinburgh was carried out in the last quarter of 2022 and a full report was published on 14 February 2023. A further inspection of adult social work and social care in Edinburgh was undertaken with the report on this inspection published 21 March 2023. On 13 June 2023 the Edinburgh Integration Joint Board approved a detailed 3 year Improvement plan response to both Inspections.

The year one improvements focused on addressing the root causes of the weaknesses exposed by both inspections by strengthening the fundamental building blocks of good social work and adult protection practice. The plans seek to bring

about a culture change in both operational practices and strategic commissioning, all of which are being progressed at pace. However, the length of time that it will take to fully implement all the necessary improvements and embed cultural change cannot be underestimated, especially while managing high levels of demand and an extremely challenging financial climate.

Work in response to the inspections has been taken very seriously. Some of the key achievements in relation to the improvement plan over 2023/24 include:

- New paperwork in relation to Adult Protection Case Conferences agreed and implemented with clear embedded guidance.
- Resources have been transferred from localities to Social Care Direct to improve access for people at the point of contact and ensure people at risk of harm are identified with the right action taken quickly.
- Undertook staff engagement and consultation on a revised, strengthened professional line management structure.
- Introduced new ASP Investigation processes with specific chronologies and risk assessment.
- Social Work student hub continues to operate effectively to support student placement and transition to permanent appointments as appropriate.
- Improved recruitment and retention - By end of June there was a 38% reduction in Social Worker vacancies from April 2023. When including professional Social Workers Occupational Therapists and Community Care Assistants, reduction is 50%.
- Implemented Quality Assurance audit for effective manager oversight and supervision recording.

Case study: Herbert Protocol

People living with dementia are more vulnerable and at risk of going missing from a variety of settings including their own home, hospitals, care homes, attending day services and community activities/interests. The Herbert Protocol is a UK nationally recognised tool to support someone with dementia who may be at risk of going missing. Completing a Herbert Protocol form[1] in advance means that if someone subsequently goes missing, it assists Police to conduct the missing person search more effectively and quickly.

The Herbert Protocol was launched in Edinburgh in 2019 as a multi-agency partnership approach, with the primary aim that it becomes well-known towards "business as usual" use. Prior to this launch, few people were aware of the Herbert Protocol. Since then, a programme of activities undertaken across the city to raise awareness and promote the form has been completed. Activities undertaken by members of the multi-agency Herbert Protocol Working Group include:

[1] Herbert Protocol form - https://www.scotland.police.uk/what-s-happening/missing-persons/the-herbert-protocol/

- 14 features in print and online social media;
- 10 in-person small group workshops;
- 7 information stalls at community festivals and open days;
- 2 conference presentations;
- 500 plus posters and leaflets distributed to community hubs;
- Herbert Protocol briefing poster circulated to all care homes and care at home providers; and
- 38 joint EHSCP and Police Scotland online information sessions attended by 950 staff from NHS, EHSCP, third and independent sector organisations from Edinburgh and across Scotland, with 94% of attendees reporting that their knowledge of Herbert protocol increased after the session.

Police Scotland Edinburgh Division statistics shows that there has been significant increase in use of the form: in 2019, only 5% of the people missing with dementia had completed a Herbert Protocol form but by 2023 this had increased to 28%. In 2023 the average missing time of those with a completed form was 45 minutes compared to 66 minutes for those without. A survey in March 2024 (84 staff and 8 unpaid carers responded) showed that 66% of staff always recommended use of the form with many examples that it is now included in key processes, and 100% of carers would recommend use with 88% indicating the form helps them feel better prepared if the person cared for goes missing.

EHSCP also had a lead role within Police Scotland's multi-agency national steering group to deliver on national media launch in September 2021 and associated activity. Learning and materials from Edinburgh Implementation were used to support this, including adapting the Edinburgh Herbert Protocol form to one new national form.

It is planned to continue implementation work to early 2026 to ensure Herbert Protocol becomes embedded as part of everyday use.

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. At its meeting in June 2023, the board agreed the medium-term financial strategy (MTFS).

Regular updates on financial performance against this plan and progress with the savings and recovery programme were provided to the Performance and Delivery Committee as well as to the EIJB itself.

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	62,414	60,685	1,729
GP services	101,307	102,482	(1,175)
Prescribing	86,546	87,638	(1,092)
Dentists, ophthalmologists and pharmacies	70,289	70,289	0
Services hosted by other partnerships/NHS Lothian	113,413	111,691	1,722
Hospital 'set aside' services	121,940	129,723	(7,783)
Other	79,904	73,305	6,599
Sub total NHS	**635,813**	**635,813**	**0**
CITY OF EDINBURGH DELIVERED SERVICES			
External purchasing	230,765	236,688	(5,923)
Care at home (*)	28,929	28,906	23
Day services (*)	20,767	17,848	2,919
Residential care (*)	24,974	26,385	(1,411)
Social work assessment and care management (*)	19,365	18,523	842
Other	16,986	13,436	3,550
Sub total Council	**341,786**	**341,786**	**(0)**
Net position	**977,599**	**977,599**	**0**

(*) services provided directly by the Council

Following additional one-off investment from partners, 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 2023/24, as in previous year we relied on one-off measures to achieve balance. The underlying deficit remains and, indeed, increases when we move into 2024/25.

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

- **Externally purchased services,** these are services such as care homes, day services and care at home which are bought by the Council from external organisations. We have seen demographic factors and increases in capacity continuing to drive demand for these services. Whilst an element of growth was factored into the financial plan for the year, this was outstripped by the actual increase. This was most evident with care at home services where a 14% increase in the number of hours of care commissioned. There is a direct correlation between this increase in cost and ongoing performance improvements.

- **Medicines** prescribed by general practitioners (GPs) cost £88 million in 2023/24. 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 both volumes and prices increase.

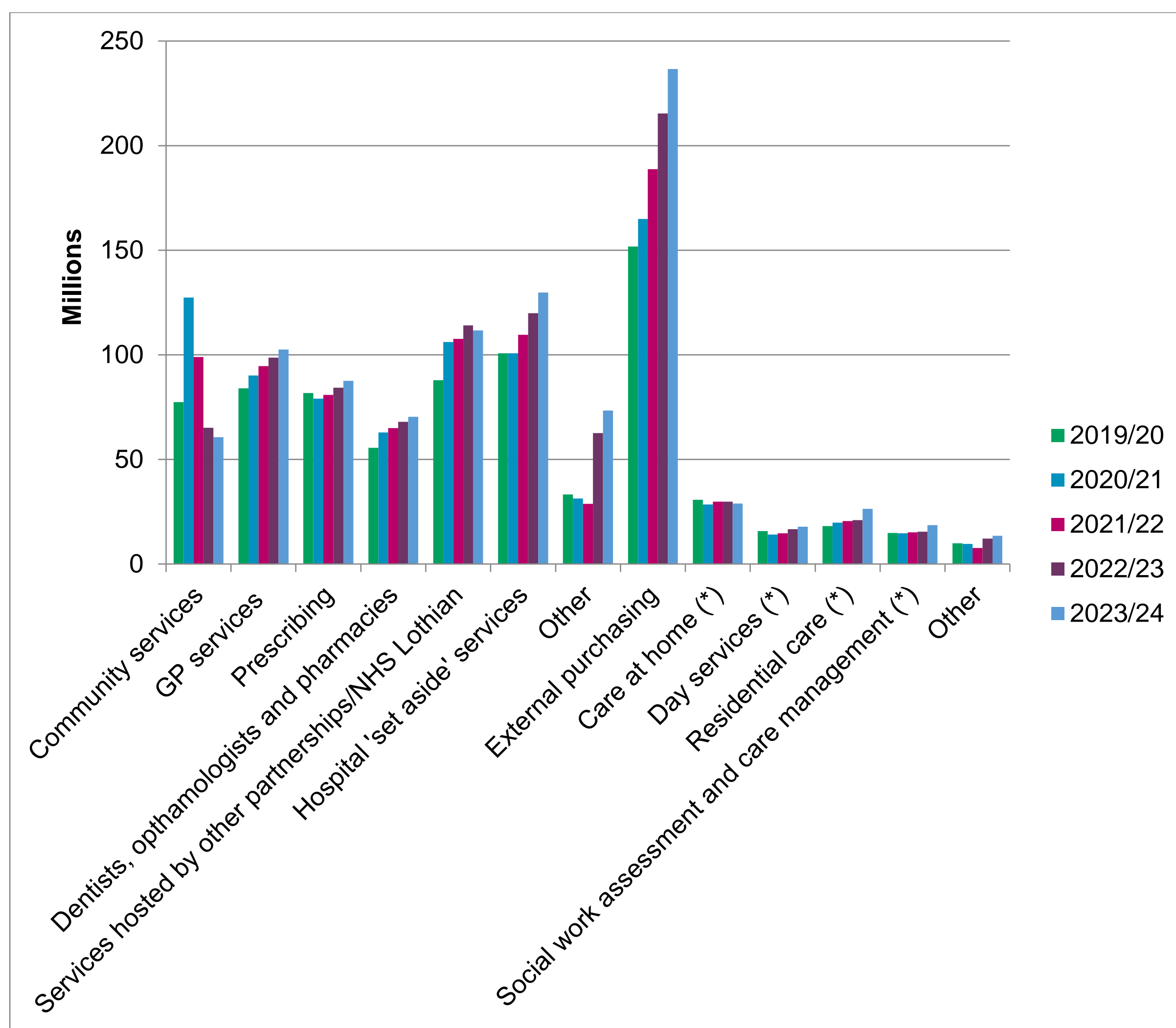
- **General medical services** (the range of healthcare provided by GPs) are experiencing increasing locum costs to cover maternity leave and sickness.

- 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 parallel with the draft strategic plan.

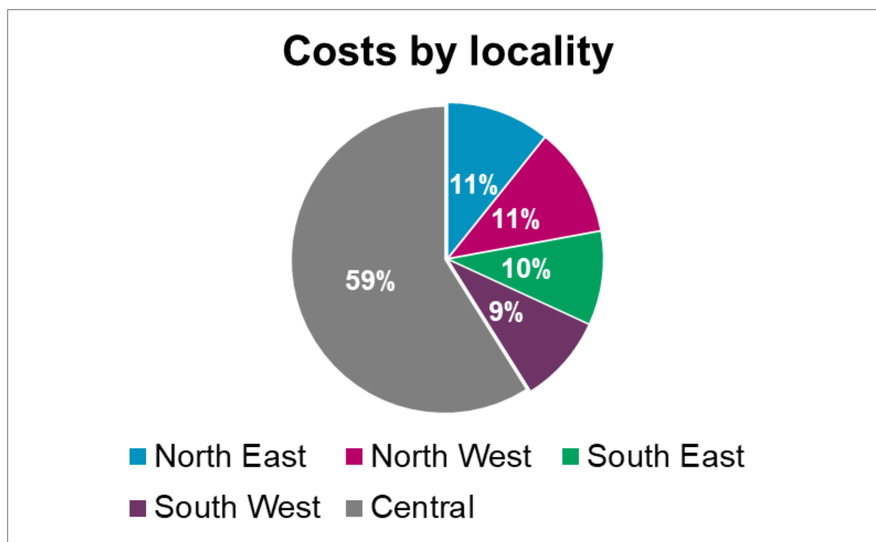
The following chart and table show costs in key areas for the last five financial years:



(*) services provided directly by the Council

Service	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m	2023/24 £m
Community services	77.4	127.4	98.9	65.1	60.7
GP services	84.0	90.1	94.6	98.6	102.5
Prescribing	81.7	79.1	80.9	84.2	87.6
Dentists, ophthalmologists and pharmacies	55.5	62.9	64.9	68.0	70.3
Services hosted by other partnerships/NHS Lothian	87.9	106.1	107.6	114.0	111.7
Hospital 'set aside' services	100.8	100.8	109.5	120.0	129.7
Other	33.3	31.3	28.7	62.6	73.3
External purchasing	151.8	164.9	188.7	215.4	236.7
Care at home (*)	30.7	28.5	29.9	29.8	28.9
Day services (*)	15.7	14.2	14.7	16.6	17.8
Residential care (*)	18.1	19.8	20.6	21.0	26.4
Social work assessment and care management (*)	14.9	14.7	15.1	15.5	18.5
Other	9.9	9.6	7.7	12.1	13.4
Total	**761.6**	**849.2**	**861.9**	**922.8**	**977.6**

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 and table below:



Locality	Proportion of overall costs
North East	11%
North West	11%
South East	10%
South West	9%
Central	59%

Older People Pathways

The Older People's Pathway (OPP) is a strategic review of non-acute hospital and care home services in Edinburgh. The OPP Programme, and the preceding "bed-based reviews," originate in the NHS Lothian's long-standing ambition to close Liberton hospital, which is now owned by the City of Edinburgh Council. The Programme differs from those reviews by increasing the supply of care home beds, mainly by reopening inoperative beds in two Council care homes, for people who currently live in complex clinical care wards in the City's community "PFI" hospitals. We make up for the closure of non-acute hospitals beds by opening more care home beds. This is more affordable than replacing hospital beds in Liberton with similar hospital beds elsewhere. It also makes for better outcomes, with more people living in care-settings that are appropriate for their needs.

By March 2024, the Programme had a well-defined system of change and risk management, given substantial assurance by the Council's internal audit team. It had also completed models of demand, capacity and cost and proposed a reconfiguration of wards in the City's PFI community hospitals and two Council care homes.

Case study: Totalmobile

In partnership with CGI, we have completed implementation of a new scheduling system, including Totalmobile social care app for frontline Homecare and Reablement staff across Edinburgh, which will help to provide more coordinated care across the City. Totalmobile will support the transformation of care to people at home throughout Edinburgh with 650 staff supporting around 800 people with over 6,000 hours of care per week using the new system.

New devices come with the Totalmobile 'Mobilise' app installed, which enables staff to view their visit information, to check in and out of visits, and to more safely and easily navigate around the city. The system's key feature is its dynamic scheduling element, which has made it easier for staff to schedule efficiently and quickly. The innovative new system is reducing time spent on administrative tasks such as journey planning, freeing up staff to spend more time on providing high quality care. Providing frontline workers with smart devices has also meant that they can access online information and training opportunities, and that they feel more connected to the wider Health and Social Care team.

Homecare staff across the city have shared their thoughts on the rollout:

'It's been such a good day, and the carers have absolutely smashed it. I'm so proud of them!'

'Being a digital champion is an honour. Helping others to develop their own skills from the knowledge you have passed onto them is extremely rewarding'.

'I'm actually surprising myself, but I'm loving it!'

'Thumbs up! I'm enjoying the challenge of trying something new in my work'

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.

Workforce Strategy

'Working Together' is the Edinburgh Integration Joint Board's workforce strategy (2022-25) published in July 2022 Working Together - Edinburgh Health & Social Care Partnership (edinburghhsc.scot). Through engagement groups, surveys and at the direction of our senior leaders, the EIJB committed to building a stronger and more sustainable workforce, driven by four key themes; 'recruitment', 'induction', 'learning' and 'development', in line with the 'Working Together' strategy.

A dedicated Workforce Board, made up of members of our Executive Management Team and other key stakeholders, was established in August 2023 to:

- oversee the monitoring and effective implementation and delivery of the EIJB's Workforce Strategy, 'Working Together'
- provide assurance on all aspects of strategic workforce matters and organisational development relating to staff including equality and diversity, recruitment and retention, staff health, safety and wellbeing and organisational development
- create a positive, open working environment that helps staff do their job to the best of their ability.

This board supported the development of our Workforce Plan which was signed off and submitted to Scottish Government in October 2023. Further work is ongoing to support the next iteration of our workforce plan for publication later in the year.

In addition, a workforce dashboard has been designed as part of our workforce data improvement plan, sharing high level workforce data with the board including data on new starts and leavers, vacancy levels, sickness absence rates and training compliance.

The rescoping of short, medium and long-term priorities is progressing taking into account the current context amidst a partnership-wide restructure, financial savings and ever increased demand with challenges remaining for recruitment and retention. In the short term, a recruitment delivery group was establish in January 2024 to continue to prioritise and focus on sharing resources and collaborating on partnership-wide events and improving onboarding processes.

Shared partnership recruitment events are planned for 2024 focusing on attracting new people to critical frontline roles across health and social care and through central and community based drop-in events.

One Edinburgh: Home-Based Care

In order to deliver our vision of supporting preventative approaches that enable more people to remain independent at home, or in a homely setting, for as long as possible, it is essential that we make best use of capacity within the health and social care system. To achieve this, we know that we need to work differently, to ensure we have enough capacity, in the right place and at the right time, providing access to both reablement and long-term care at home services.

Our ambition is to implement a 'One Edinburgh' approach for all homebased support services, to ensure equity of access to quality support across the city for people and their carers. Our internal service will move to a predominantly reablement offer, so that we can support more people to live as independently as possible.

Similarly, for providers, it is our ambition to shift from competitive, shorter term commissioning models to long term collaboration and partnership commissioning instead. The commissioning of these services will define a modern Edinburgh offer between health and social care providers, support organisations and our citizens.

'One Edinburgh' includes a wide-ranging programme of activities for all internally and externally arranged home-based support. The three key workstreams include:

- **Totalmobile**: We completed successful implementation of Totalmobile in October 2023, the system is now embedded, and consolidation work is underway with the sites to continue to develop the system for our needs. We are working on summarising all the KPIs that have been achieved, and identifying those that will continue to be monitored through the wider One Edinburgh programme. Future developments of the system will now focus on alignment with ongoing plans on reablement.
- **Internal service redesign**: Our transition under One Edinburgh will see reablement become the primary focus for our inhouse staff, where the majority of our internal service provision would be supporting people through reablement, and a small portion providing longer-term care. We currently have approximately 1/3 of staff working to reablement and are now utilising data from Totalmobile to work towards a large-scale and consistent rollout plan of reablement in 2024.
- **External commissioning of home-based support:** Our external commissioning framework was fully approved at the EIJB in September 2023. Assuming successful implementation of our internal reablement model, the key elements of the proposed external commissioning framework will include: up to 50,000 hours commissioned alongside our internal reablement model; a locality-based framework; a sustainable rate; and a transitioning plan to get us there. We continue to work with providers in the external market as we work towards full implementation of our approved framework.

Primary Care (General Medical Services)

Primary care in Edinburgh had another busy year, and GPs and practice nurses delivered around 2.4 million patient appointments. In addition, our population increased again with an additional 9,000 patients offered registration with our medical practices. Our government funded new ‘multi-disciplinary’ workforce delivered over 700,000 treatments, half of which were vaccinations. Edinburgh people continue to come forward for vaccinations and this helps to keep everyone healthy.

We are building a new medical surgery as part of a primary school in the fast-developing Maybury area of the City. A new medical service will open there in early 2025 and we are keen to see whether this new combination of public services is appreciated by local residents.

Edinburgh successfully applied for government funding to further develop the new multi-disciplinary teams in primary care. The project runs from April 2024 to autumn 2025 in the south-east of the city and will allow us to test how we can absorb more people into medical practices.

All medical practices are working very hard to provide as much access to patients as possible and have developed many different arrangements tailored to suit their practice patients. Some make extensive use of remote appointments in the wake of the Covid experience, whilst others use more face to face appointments. Practice systems are under constant review and constructive feedback from patients is always welcome.

Case study: Social work student hub

A Social Work Student Hub has been developed, partly as a specific activity to improve recruitment and retention of Social Workers into Health and Social Care teams across Edinburgh. This also aims to be a centre of excellence for Social Work practice education in Scotland, working closely with the localities, providing exceptional practice learning opportunities for students from universities across the central belt of Scotland.

So far 36 students have been supported through the student hub, with an additional 8 students supported through activities but not directly aligned to the Student Hub. 14 of these participants were final placement students ready for employment, who were supported in job application and interview skills. Of these, 10 secured posts with the City of Edinburgh Council, with 7 of these in EHSCP.

Positive feedback was also received on the Student Hub from students and key stakeholders:

Student Feedback: *“The focus from university is on children and families and I would have struggled with fully integrating theory to practice and understanding the role of a social worker in statutory adult services without the Hub.”*

University Feedback: *"The Student Hub has been a success for our students. When they return for recall days, they are the group who are most positive about their placement experiences."*

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

In a year where the effects of the covid pandemic and cost of living crisis were still to the fore, impact on carers is still being felt and reinforced through the Carer Survey. There continues to be valued support for carers through the contracted provision through our voluntary sector partners, and our internal supports.

The refreshed Edinburgh Joint Carer Strategy for 2023-26 was published in July 2023, and continues the focus across the six key priorities and embrace the five themes identified through the National Carer Strategy. This is the result of collaboration and wide engagement with carers, supported people and other key stakeholders.

Work on refining the documentation for wider implementation of Adult Carer Support Plans (ASCPs), and associated training was completed in July 2023 for contracted voluntary sector partners, who are now able to undertake conversations to complete the plans, which support an outcome-focused approach for carers.

An outcomes-based reporting framework *OutNav,* was further progressed by all carer providers with its application tested in March 2024. This will complement the quantitative data reported upon against the Strategy and provide valuable insight into the difference that our work in Edinburgh is making to the lives of unpaid carers.

Work has progressed through on the Carer Landscape-Edinburgh Action Research (CLEAR), which was designed to capture wider carer supports and contribution to the Carer Strategy beyond the commissioned services.

Home First

We have continued to work with NHS Lothian to embed the Discharge without Delay (DwD) programme. Phase one was particularly successful at the Western General Hospital (WGH) with DwD wards showing a 50% reduction in bed occupancy by patients in delay. This work will be presented at the NHS Scotland Event June 2024 to highlight the positive collaboration between the partnership and NHS. All Edinburgh HSCP intermediate care facility (ICF) wards have been operating Planned Date of Discharge (PDD) since March 2023. This has continued to evidence improvement in length of stay resulting in a greater number of patients accessing our ICF.

During the financial year, the focus of the DwD programme has moved to Early Supported Discharge (ESD). This initiative went live in December 2023 with the aim to reduce hospital occupancy through increasing the numbers of patients discharged within 0-72 hours of admission within the front door. Early data indicates 137 patients identified in the first 3 days of admission as having potential for ESD with a total of 148 new services organised. The team continues to monitor patients who are unable to be discharged within 0-72 hours and ensures opportunities for earlier discharge are explored.

Our Discharge to Assess service (D2A) continues to be well utilised pathway with 3,300 referrals received in the 2023/24, which represents an increase of over 800 referrals on 2022/23. Our Hospital to Home (H2H) team is actively involved in prevention of admission for patients in crisis or at end of life. The team also continues to support bridging of care packages to enable people to return home at the earliest opportunity. This service has supported 316 patients from 1st April 2023 to 31st March 2024 with bed days saved per patient ranging from 1-14 days.

A single point of access via the Flow Navigation Centre continues to embed and provide a professional response to requests from healthcare professionals for people who require urgent therapy and/or urgent social care interventions. The establishment of an emergency department frailty team has resulted in increased referrals to Hospital at Home (H@H) services. Weekend admissions to Edinburgh H@H increased from 17 in November 2023 to an average of 36 per month up to end of March 2024, an average increase of 113% from baseline. Edinburgh Community Respiratory Team supported 11,943 clinical contacts during 2023/24 with activity continuing to focus on prevention on admission for people living with Chronic Obstructive Pulmonary Disease.

Assistive Technology Enabled Care 24 (ATEC 24)

ATEC 24 offers a range of preventative and enabling supports to citizens of Edinburgh, which includes Community Alarms; Telecare; Sheltered Housing Support Service; the Assistive Living Team; Children and Families Occupational Therapy Service; 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.

For the past year, the call handling function of our Telecare Service has been temporarily provided by London Borough of Newham Council while we upgrade our Alarm Receiving Centre (ARC) to a digital cloud-based platform in order to continue to deliver our services after the analogue network is switched off in 2025. We have worked collaboratively with the Digital Office and others to onboard the National Shared ARC, and are the first Partnership to do so, with the transition complete and all calls returned to our team in Edinburgh in May 2024. The new ARC will offer greater flexibility in call handling to support quality customer experience and service improvements. In this coming year, we will be working to replace the remaining

analogue devices in customers' homes to digitally capable technologies to minimise the risk to citizens from the analogue switchover.

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. This past year we have recruited two technology practitioners to promote the use of telecare and digital solutions to enable people to live well, at home, for longer.

The Community Equipment Loan Service continues to deliver essential equipment to people through East and Midlothian and Edinburgh Communities. During 2023/24, while there have been some additional challenges with increased demand and changed parking restrictions, we have made significant improvements in our delivery operations by moving to a digital process, and in this coming year we plan to consolidate that as well as increase our recycling and refurbishment programme to deliver improved efficiencies.

In Sheltered Housing, we have introduced three Step Down facilities to support people to be discharged from hospital in circumstances where they cannot immediately return to their current accommodation. This has provided people with improved quality of life, for example, allowing people to return to work, which they would not have been able to do from hospital.

Learning disabilities

The innovation and sustainability review of our Learning Disabilities services continued through 2023/24, with five of the thirteen proposals identified as priorities for additional development. Strategic developments have seen increased focus on savings and efficiencies, due to an ongoing significant gap in the budget for 2024/25. From our existing programme, some elements will be implemented under business as usual, whilst remaining elements have been built into a wider new programme 'Working-age pathways'.

Working-age pathways includes people with life-long conditions of any age who have a condition which limits their ability to live independently (except those who have a main diagnosis of a functional mental illness). This programme will focus on place-based care, accommodation with support, and support at home for people needing the most intensive services.

Performance

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 2023 is used as a proxy for 2023/24 due to the national data for 2023/24 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 2023 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 latest update was received in July 2024 for the results of the 2023/24 survey. Results for indicators 2, 3, 4, 5, 7 and 9 for 2023/24 are not comparable to previous years due to changes in survey wording so previous years have not been reported here.

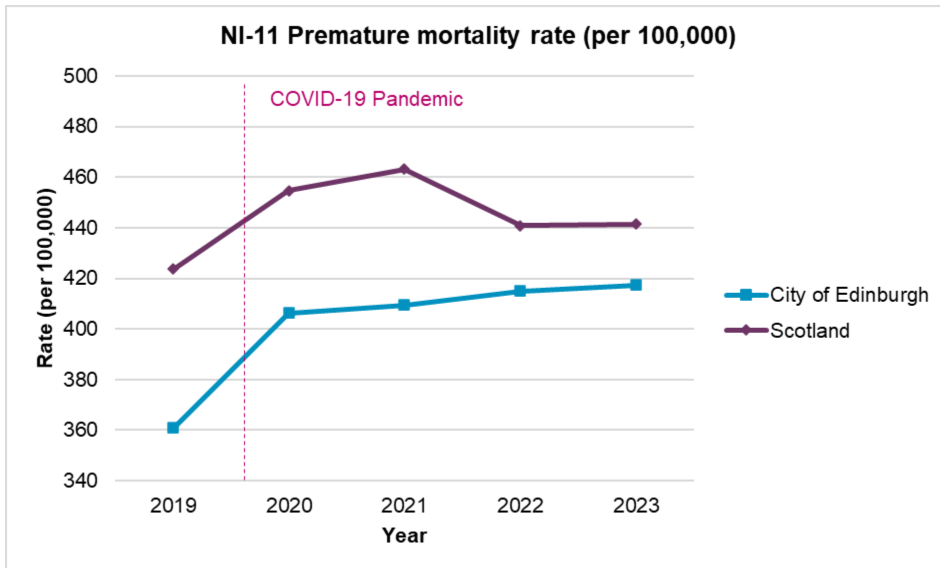
For those that are comparable, we have improved slightly on our 2021/22 results though performance continues to be lower than the last pre-pandemic survey in 2019/20. The Edinburgh result was higher than the Scotland result in all but one of the indicators. Edinburgh performed slightly worse than the national figure on NI3: Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided at 57.2% compared to 59.6% for Scotland.

National Indicator (NI)		2023/24*		2021/22*		2019/20*	
		City of Edinburgh	Scotland	City of Edinburgh	Scotland	City of Edinburgh	Scotland
NI-1	Percentage of adults able to look after their health very well or quite well	91.9%	90.7%	91.6%	90.9%	93.8%	92.9%
NI-2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	75.2%	72.4%				
NI-3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	57.2%	59.6%				
NI-4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	63.1%	61.4%				
NI-5	Total percentage of adults receiving any care or support who rated it as excellent or good	74.1%	70.0%				
NI-6	Percentage of people with a positive experience of the care provided by their GP practice	75.1%	68.5%	73.8%	66.5%	82.5%	78.7%
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	72.0%	69.8%				
NI-8	Total combined % carers who feel supported to continue in their caring role	31.3%	31.2%	30.4%	29.7%	33.0%	34.3%
NI-9	Percentage of adults supported at home who agreed they felt safe	78.6%	72.7%				

Source: Scottish Government HACE surveys *Please note results for indicators 2, 3, 4, 5, 7 and 9 for 2023/24 are not comparable to previous years due to changes in survey wording.

Indicator 11: Premature mortality rate

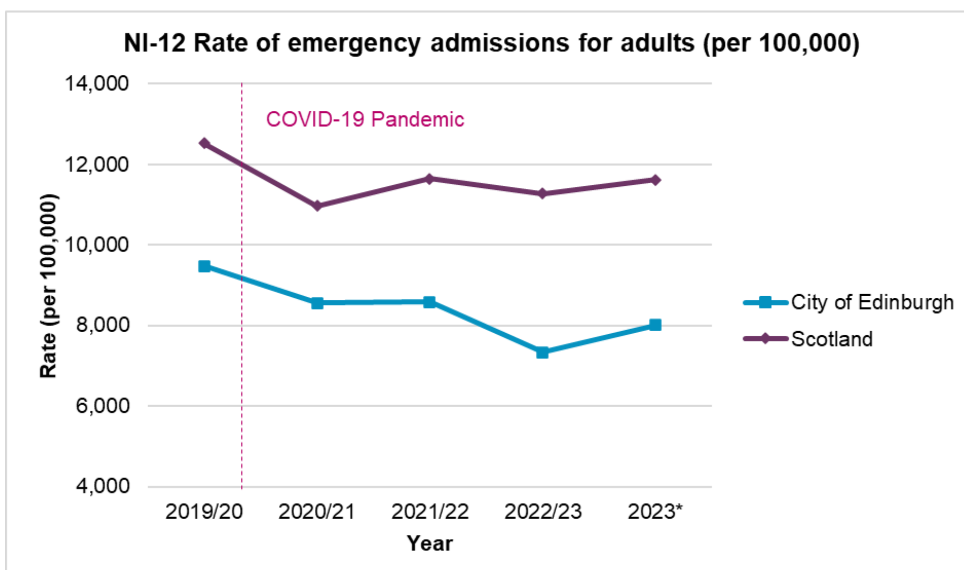
While we remain below the Scottish rate, the rate of premature mortality in Edinburgh continues to remain higher than the levels seen before the pandemic. Edinburgh remains in the top 50% of partnerships but moved from being ranked 14th to 16th out of the 32 areas. The increase in the premature mortality rate has slowed this year though, with only a 0.6% increase between 2022 and 2023, representing a small number of additional deaths.



	2019	2020	2021	2022	2023
City of Edinburgh	361	406	410	415	417
Scotland	424	455	463	441	442

Indicator 12: Rate of emergency admissions for adults

Edinburgh has the lowest rate of emergency admissions in Scotland. The rate has increased slightly from 2022/23 into 2023, likely linked to increased flow through the hospital system.

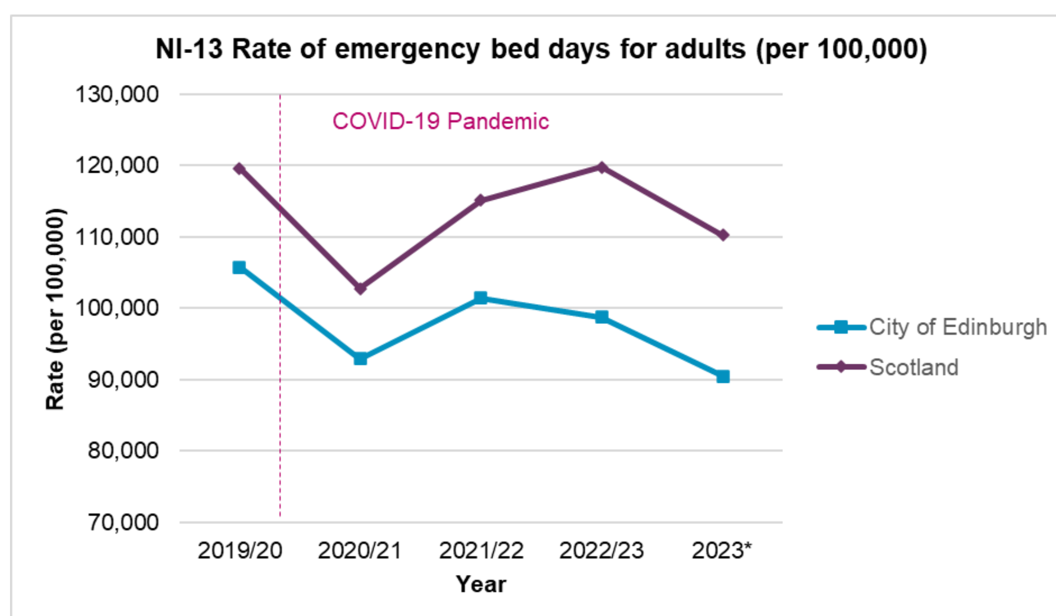


The rate of emergency admissions varies across our localities, but all are below the national rate, as per the table below:

	2019/20	2020/21	2021/22	2022/23	2023*
City of Edinburgh	9,482	8,564	8,592	7,340	8,038
Scotland	12,529	10,964	11,643	11,276	11,707
North East	10,235	9,133	8,898	7,407	8,315
North West	9,963	9,282	9,270	8,225	8,529
South East	8,001	7,070	7,379	6,189	6,998
South West	9,946	8,956	8,922	7,600	8,424

Indicator 13: Rate of emergency bed days for adults

Edinburgh has the fifth lowest rate in Scotland and the rate is the lowest it has ever been. The slight increase in emergency admissions shown in indicator 12 is not seen here, suggesting we continue to improve on length of stay in hospital. This is supported by local data collected through our Early Supported Discharges and Discharge without Delay initiatives, described in the Home First section above.



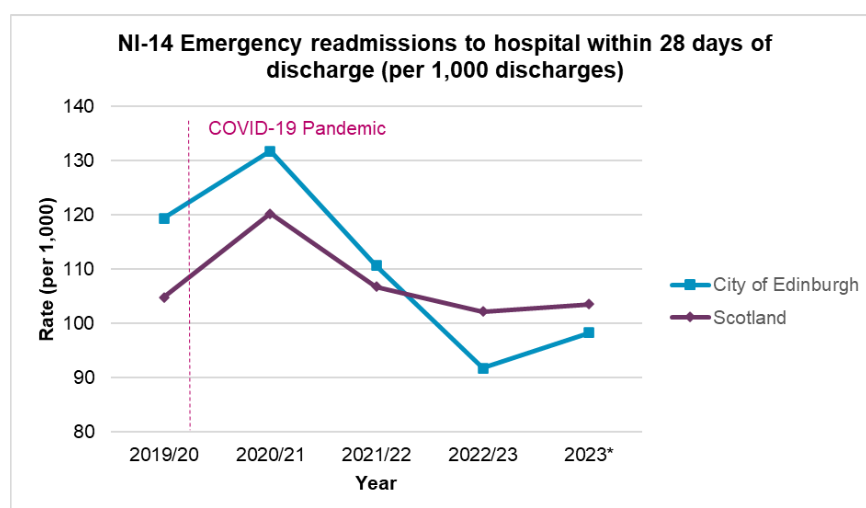
As with emergency hospital admissions, performance varies across our localities depending on demographics, but remains below the national rate in all areas:

	2019/20	2020/21	2021/22	2022/23	2023*
City of Edinburgh	105,746	93,246	101,781	98,783	92,171
Scotland	119,753	102,875	115,308	119,806	112,883
North East	101,361	90,378	98,768	98,421	94,044
North West	108,557	95,676	106,652	101,228	95,629
South East	105,906	96,907	99,585	97,957	86,250
South West	106,807	88,644	101,775	97,121	92,072

Indicator 14: Readmissions to hospital within 28 days of discharge

Edinburgh has increased slightly in the rate of emergency re-admissions to hospital within 28 days of discharge, however we are still below the Scottish rate. In 2021, we asked the Local Intelligence Support Team (LIST) at Public Health Scotland to undertake a deep dive analysis into the reasons behind the higher readmissions rate in Edinburgh. This found a change in admissions practice at the Edinburgh Royal Infirmary was contributing to an increase in admissions for people who had a length of stay of less than 1 day. It also found particularly high rates of readmissions in certain cancer specialities due to admission practices and for reasons related to poisoning (which is believed to include certain aspects of alcohol and drug misuse). These were linked to patients with multiple admissions, a key area of focus for our Home First team.

In 2023, in light of the significant reduction in readmissions rates, in Edinburgh LIST reran this analysis. This found that the higher rates of readmissions among cancer and poisoning specialities remained, as did the higher number of people with multiple admissions, but that the changes at the Edinburgh Royal Infirmary which had led to the increasing rate was no longer a factor, suggesting a further practice change in admissions for short periods. When the admissions through this route are removed, the readmissions rate in Edinburgh is steady over the past five years, suggesting that there has not been a wider trend in readmissions or a change in the needs of the population. The slight increase in 2023 is also to be expected in light of Indicator 12 and the increased flow through the system.

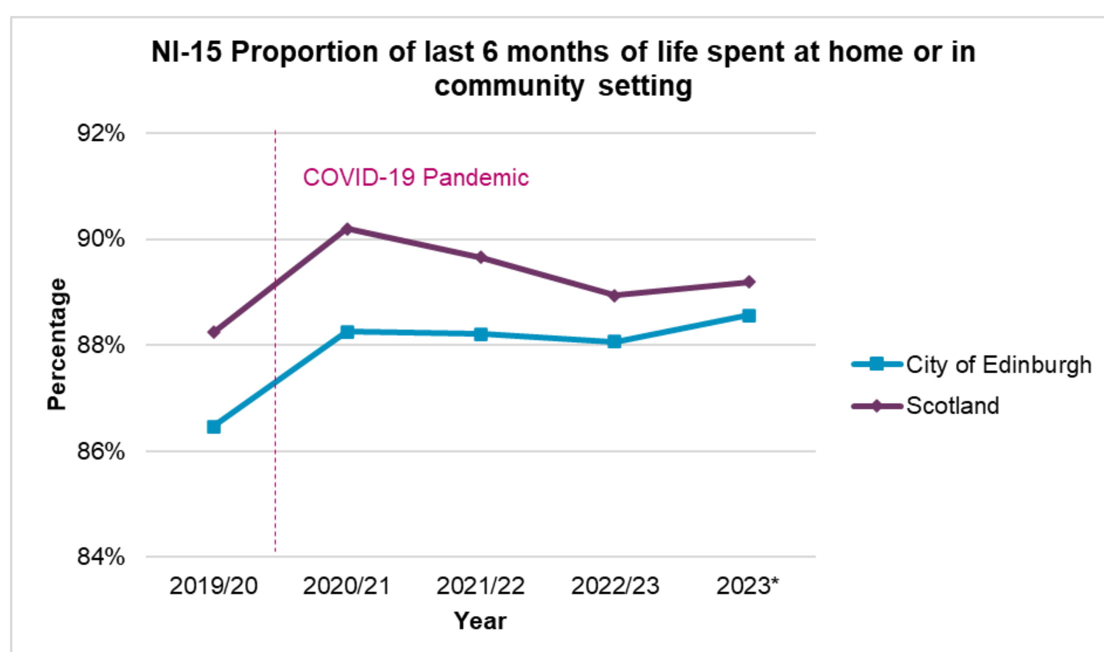


Performance of this indicator varies by locality:

	2019/20	2020/21	2021/22	2022/23	2023*
City of Edinburgh	119	132	111	92	98
Scotland	105	120	107	102	104
North East	124	134	113	94	102
North West	112	137	110	93	95
South East	119	119	104	86	99
South West	124	135	117	95	97

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 21st but there are minimal differences between rates in different partnerships on this measure. As outlined in the section on our Older People's Pathway programme, we are currently undertaking a review of our non-acute hospital and care home services in Edinburgh, including Hospital Based Complex Clinical Care (HBCCC) provision, where we currently have one of the highest bed rates in the country, to ensure that people are able to live in the most appropriate setting for their needs and are not unnecessarily treated in this hospital setting when there could be a more appropriate community setting for them. The changes as a result of this review would likely have an impact upon this end of life measure.



The breakdown by locality is as follows:

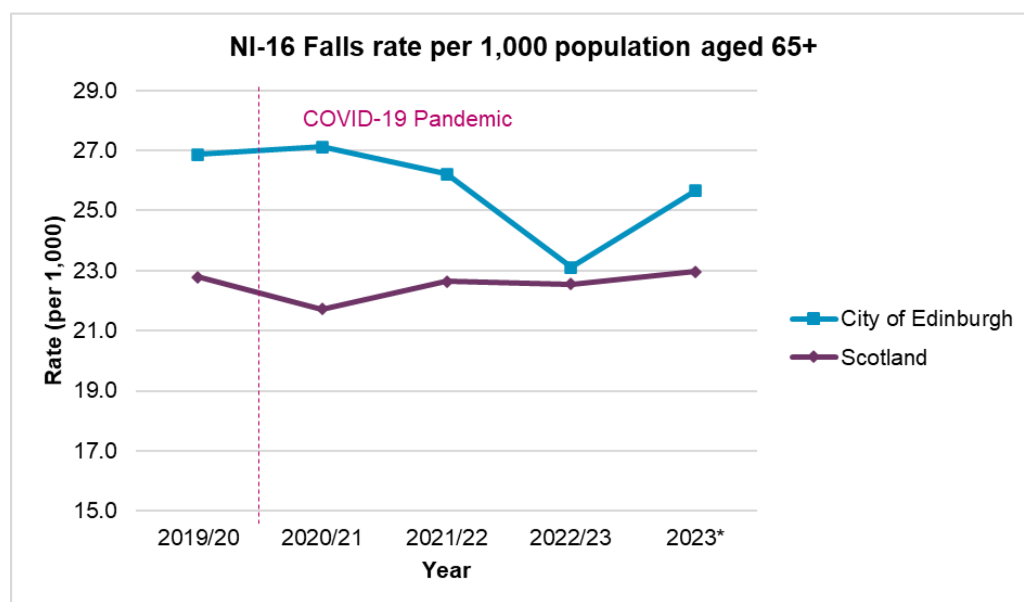
	2019/20	2020/21	2021/22	2022/23	2023*
City of Edinburgh	86%	88%	88%	88%	88%
Scotland	88%	90%	90%	89%	89%
North East	87%	88%	88%	88%	89%
North West	85%	87%	88%	87%	88%
South East	88%	89%	89%	88%	89%
South West	87%	89%	89%	89%	88%

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

Edinburgh saw a drop in the rate of emergency admissions for falls in 2022/23 but this has increased again in 2023. Analysis by LIST at Public Health Scotland on behalf of Edinburgh showed that the change in rate in 2022 was linked to a further

change in admission practice at Edinburgh Royal Infirmary, as described under indicator 14. Again when we remove the changes that led to this peak and drop between 2019 and 2022, the rate in Edinburgh evens out, suggesting that there has not been an underlying change in the falls rate or severity of falls. We will continue to explore the data to identify the underlying causes of the increase in 2023.

With a rate of 25.7 per 1,000 over 65's in 2023, we are above the Scottish figure of 23 and rank 25th out of all the partnerships.

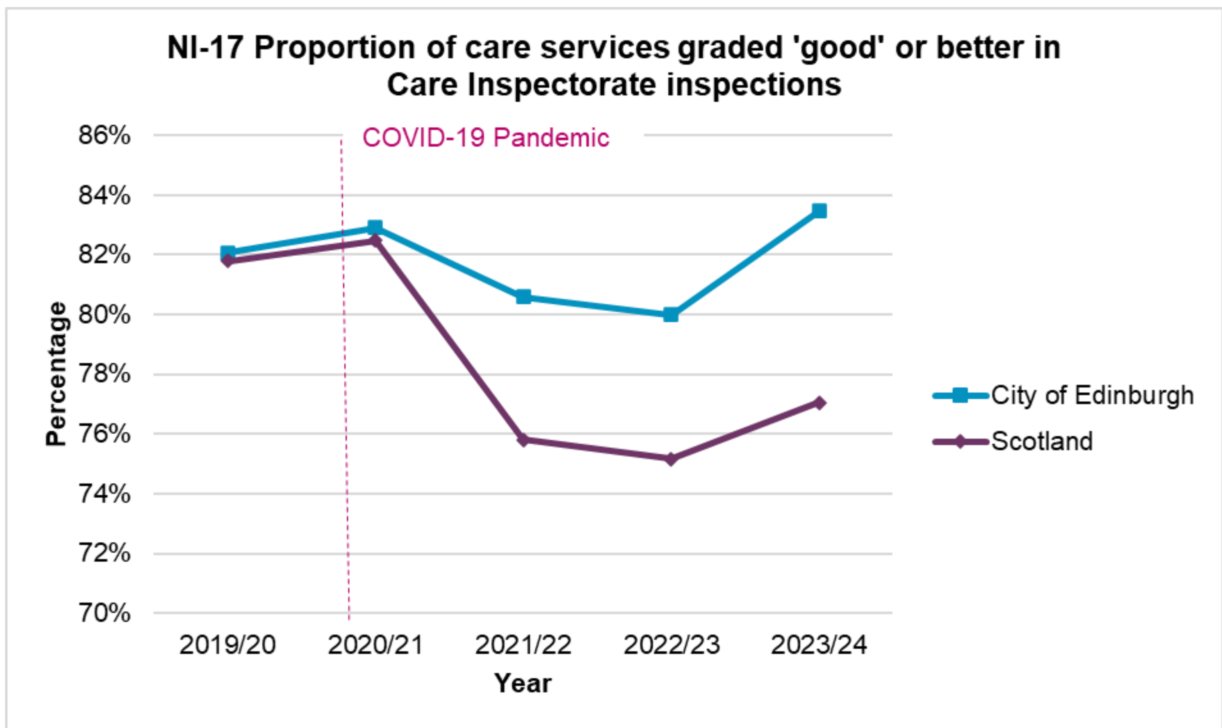


The breakdown by locality is as follows:

	2019/20	2020/21	2021/22	2022/23	2023*
City of Edinburgh	27	27	26	23	26
Scotland	23	22	23	23	23
North East	30	28	28	22	29
North West	27	29	27	24	23
South East	28	27	26	24	26
South West	23	24	24	21	26

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. 2023/2024 is the highest in the last five years at 83.5%, 6 percentage points above the figure for Scotland as a whole.

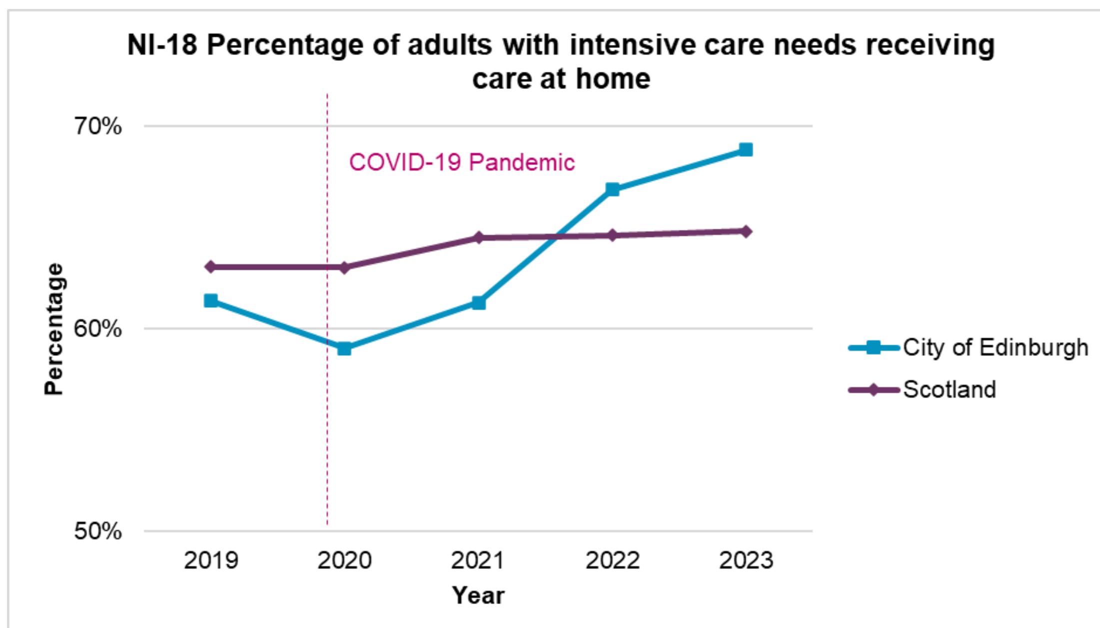


	2019/20	2020/21	2021/22	2022/23	2023/24
City of Edinburgh	82%	83%	81%	80%	83%
Scotland	82%	82%	76%	75%	77%

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 Hospital Based Complex Clinical Care (HBCCC), has increased again in 2023, so we remain higher than the Scottish average. 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 is 13th out of 32 partnerships, moving us into the second quartile.

This is likely linked to our progress in reducing our unmet need list for care at home combined with difficulties in arranging care home placements in the external market due to current high costs if care. Currently the only beds available for people requiring a nursing or dementia care home bed, are at prices significantly higher than the national care home rate, making them unaffordable, particularly within the current financial climate. Our Older People's Pathway programme, outlined above, has a range of workstreams to address this issue, primarily an independent analysis to benchmark the cost of care and a proposal for a care bookings service to streamline the process of negotiating and arranging a care home placement.



	2019	2020	2021	2022	2023
City of Edinburgh	61.4%	59.0%	61.3%	66.9%	68.8%
Scotland	63.0%	63.0%	64.5%	64.6%	64.8%

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

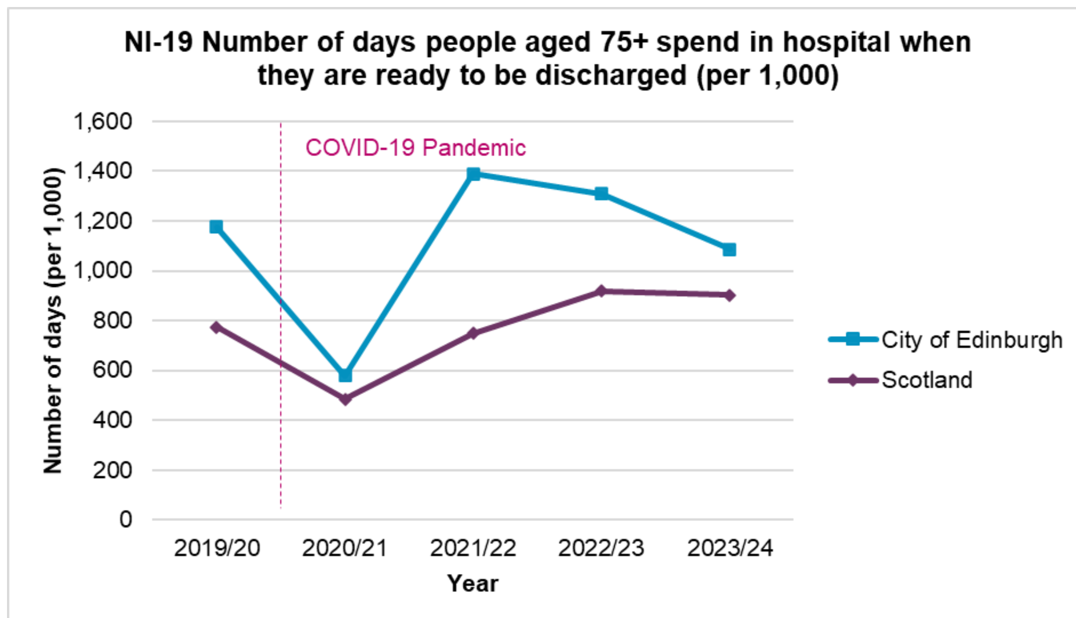
We continue to see substantial improvement in delay levels and our 2023/24 rate is the lowest level we have seen, excluding the pandemic year of 2021/22. We have seen a 17% reduction over 2023/24 compared to a 2% decrease nationally and our delays bed days rate is now lower than it was before the pandemic. For 2023/24 as a whole, we rank at 23rd in Scotland, compared to 26th out of 32 in 2022/23.

However, we know the pressure that delays can have within our hospital system so we are continuing our focus on improvement in this area. Care home placements for those with complex needs has been a challenging area in Edinburgh for some time. While the external care at home market continues to be responsive to our demands and prioritises support for those in hospital, there continues to be some instability within the external market with a small number of our commissioned care at home providers currently suspended, subject to enhanced monitoring and/or controlled growth, which is affecting our waitlist figures.

These issues are long-standing and intractable, and will take significant shifts within the system to fully resolve, however some of the actions we are taking to support this include:

- Implemented minimum of twice weekly huddles to review the position of each of our services to support discharges (currently daily due to increased number of people delayed).
- Implemented a brokerage team to facilitate flow to packages of care at home.

- Implemented a nursing model at three of our internal care homes to provide for residents with more complex needs.
- Undertaking a strategic review of care home services in Edinburgh.
- Moving our internal service to a reablement model to support more people to live as independently as possible.
- Shifting our external care at home market from competitive, shorter term commissioning models to long term collaboration and partnership commissioning.
- Ongoing work through the Home First project on implementing a Planned Date of Discharge will also support more proactive discharge planning.



	2019/20	2020/21	2021/22	2022/23	2023/24
City of Edinburgh	1,175	579	1,388	1,310	1,087
Scotland	774	484	748	919	902

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: Geriatric Long Stay

Indicator	2017/18 Baseline total	Desired direction of travel	Latest available figures	Achieved Direction of travel	Latest Period
A&E Attendances	103,986	↓	103,720	↓	2023/24
Unplanned Admissions	35,597	↓	34,491	↓	2023
Emergency Occupied Bed Days:					
Acute	330,759	↓	302,875	↓	2023
Geriatric Long Stay^	22,324	↓	23,980^	↑	2023
Mental Health	122,841	↓	121,285p	↓	2023
Delayed Discharges	76,933	↓	61,519	↓	2023/24
Last 6 months of life spent in a community setting	85.7%	↑	88.5%p	↑	2023
Balance of Care: at home#	95.6%*	↑	96.0%	↑	2022/23

^ 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 2024/25 will be on the delivery of the budget savings programme agreed by the EIJB in March 2024 and Inspection Improvement Plan agreed by the EIJB in June 2023. These initiatives will support us to improve services for the people of Edinburgh while also working towards financial sustainability by cutting the structural deficit in a manageable way over the next three years. However, this may also mean that we maintain rather than continue to improve upon our performance against the core indicators, as we balance the financial challenges we face with our performance ambitions.

We will also be consulting on a refreshed EIJB Strategic Plan, which has a focus on four key priorities:

- wellbeing, prevention and early intervention,
- building resilient communities to maximise independence,
- protecting our most vulnerable, and
- valuing our workforce and managing resources.

By evolving our strategic change 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. Some of the key strategic change projects we will be progressing in 2024/25 are a redesign of our 'front door', i.e. the ways that service users are able to access our services, and continuing our key pathways programmes. We will also be developing a new Digital and Data Strategy and implementing a new case management system that will cover our adult social care work.

We will continue to engage with, and respond to, work undertaken by our partners in the wider health and social care landscape, including proposals for the 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.