Edinburgh Health and Social Care Partnership

Annual Performance Report 2017-18

Working together for a caring, healthier, safer Edinburgh

NHS Lothian · EDINBVRGH · THE CITY OF EDINBURGH COUNCIL

Contents

Foreword by the Chair and Vice-chair of the Integration Joint Board

Welcome to the Annual Performance Report of the Edinburgh Integration Joint Board for 2017/18. The report sets out the progress that the Board and the Edinburgh Health and Social Care Partnership has made during the previous year in terms of:

- delivering against the six priorities in our strategic plan 2016-19
- delivering against the National Health and Wellbeing Outcomes
- working at a locality level across North West, North East, South West and South East Edinburgh
- our financial performance.

I think that it is fair to say that our performance over the last financial year has been mixed. We still have significant challenges providing 'the right care, in the right place at the right time' with far too many people waiting far too long to have their needs assessed and start receiving the care and support they need. People are also waiting too long in hospital when they are ready to be discharged. These are both areas we have prioritised for improvement and development and we set out more on that in this report.

However, there are some areas where we perform well; our performance in reducing emergency admissions to hospital and treating people in the community remains strong and when people do receive services, they are generally happy with them. I was particularly pleased to see that the percentage of people who rated the care they received as excellent or good when responding to the Health and Care Experience Survey had increased slightly from the previous survey undertaken two years ago.

We also recognise that the previous year was a challenging one for both the Integration Joint Board and the Health and Social Care Partnership with significant changes in the senior management team having taken place. However, I continue to be impressed by the commitment and dedication of the workforce; and the willingness of our partners in the third, independent and housing sectors to support us in tackling the significant challenges we face in terms of increasing demand for services, financial constraint and recruiting to caring roles in Edinburgh city as a result of virtually full employment. Our new management arrangements will take time to develop but we have a clear focus on the change we want to oversee and the improvement we want to make.

It is also clear to me that whilst our performance is far from where we want it to be there have been some noticeable improvements in the last six months of the last financial year and first three months of the current year in terms of the number of people waiting for assessments and the length of wait. There are also some very

positive developments underway that will strengthen community capacity (Community Link Workers), reinvigorate our approach to self-directed support (good conversations training) and improve support for carers (North West pilot). You can find out more about each of these initiatives as you read through the report.

When the Edinburgh Integration Joint Board met in May 2018, it agreed a 'Plan to alleviate immediate pressure and establish the environment for longer term sustainability'. The plan identifies key areas of focus for the work of the Health and Social Care Partnership going forward:

- a meaningful shift of attention and resources toward prevention and early intervention
- wider cultural change to move away from the traditional model of health and social care to one that is more sustainable and which takes an asset-based approach
- providing the right volume of high quality care and support when people need it
- redesigning traditional high cost services to achieve best value
- developing our workforce
- developing our approach in primary care and making the most of the opportunities set out in our Primary Care Improvement Plan
- ensuring we have adequate business support, processes and ICT infrastructure
- ensuring appropriate professional/clinical governance and quality in an integrated world

These areas will inform our work going forward in 2018/19 and are reflected in the future priorities detailed throughout the plan.

Cllr Ricky Henderson
Chair,
Edinburgh Integration Joint Board

Carolyn Hirst
Vice-Chair
Edinburgh Integration Joint Board

July 2018

Introduction

Since April 2016, the Edinburgh Integration Joint Board (EIJB) has been responsible for the strategic planning, governance oversight, scrutiny and performance management of most community health and adult social care services, together with some hospital based services. These are services that have been delegated to the Integration Board, by both NHS Lothian and the City of Edinburgh Council under the legislation – The Public Bodies (Joint Working) (Scotland) Act of 2014.

The services for which the EIJB has had delegated to it and is responsible for include:

- adult social work services
- community dentistry, pharmacy and ophthalmology
- community nursing
- health and social care services for older people, adults with disabilities, adults with mental health issues and unpaid carers
- health promotion and improvement
- palliative and end of life care
- primary care (GPs)
- services provided by allied health professionals (eg therapists)
- sexual health
- substance misuse
- support for adults with long term conditions
- unscheduled admissions to hospital.

The majority of services for which the Board is responsible are delivered by the Edinburgh Health and Social Care Partnership (EHSCP, or 'the Partnership') which is responsible for its operational delivery. The Partnership brings together staff employed by the City of Edinburgh Council and NHS Lothian to provide integrated services under the leadership of a single Chief Officer. The Chief Officer is accountable to the EIJB and to both the Council and NHS Lothian via both their Chief Executives. In addition, the Council and NHS Lothian are also Directed to commission a range of services on behalf of the EIJB from providers in the third, independent and housing sectors. There are also some services for which the Board has responsibility that are managed directly by NHS Lothian or one of the other Health and Social Care Partnerships in Lothian.

In March 2016 the EIJB published its first Strategic Plan, setting out the strategic vision for community health and adult social care services in the city over the next three years.

Central to this vision is the move to a locality model of working based on the four localities that are used for community planning purposes.

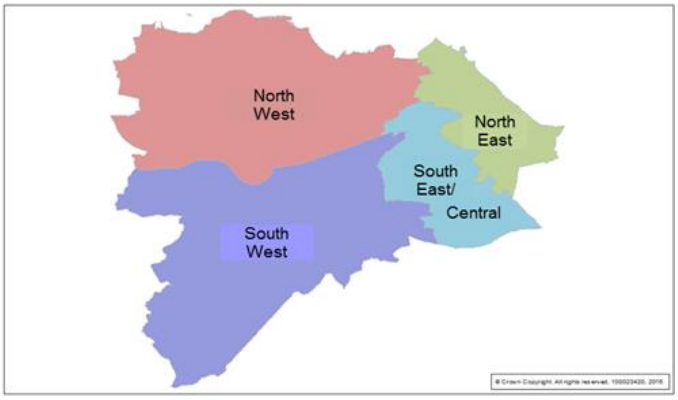

Image 1: locality map

In that Plan we set out six linked key priorities that the Board believed it was important to work towards to improve the health and wellbeing of the citizens of Edinburgh, by meeting the current need for services and managing future demand.

The six priorities are:

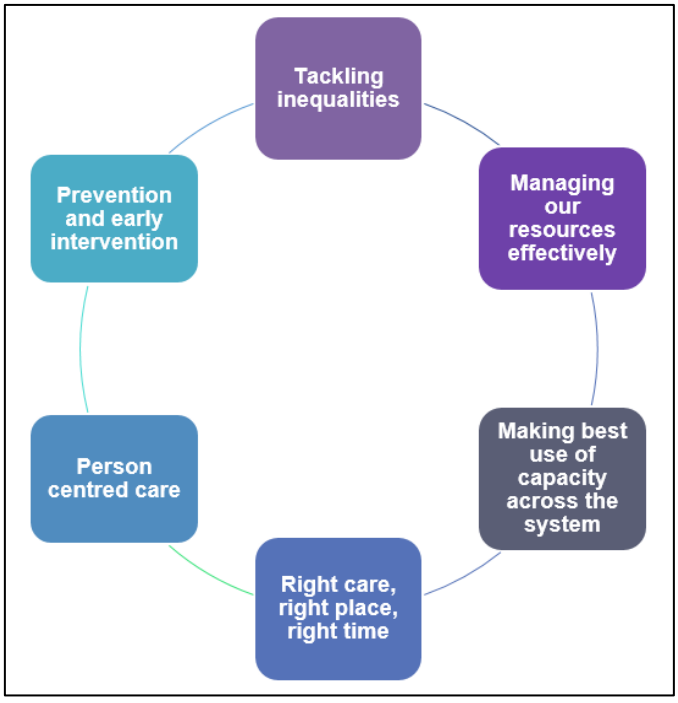

Image 2: our six priorities

- **tackling inequalities** by working with our partners to address the root causes, as well as supporting those groups whose health is at greatest risk from current levels of inequality
- **preventing** poor health and wellbeing outcomes
- practicing **person centred care** by placing 'good conversations' at the centre of our engagement with citizens
- delivering the **right care in the right place at the right time** for each individual
- developing and **making best use of the capacity available within the city** to deliver timely and appropriate care and support to people with health and social care needs
- **making the best use of our shared resources** to deliver high quality, integrated and personalised services, that improve the health and wellbeing of citizens whilst managing the financial challenge.

Our annual report sets out the progress we believe that we have made in working towards these priorities and those set for us by the Scottish Government which are shown in the diagram below. The report also provides details of our performance in managing our budget.

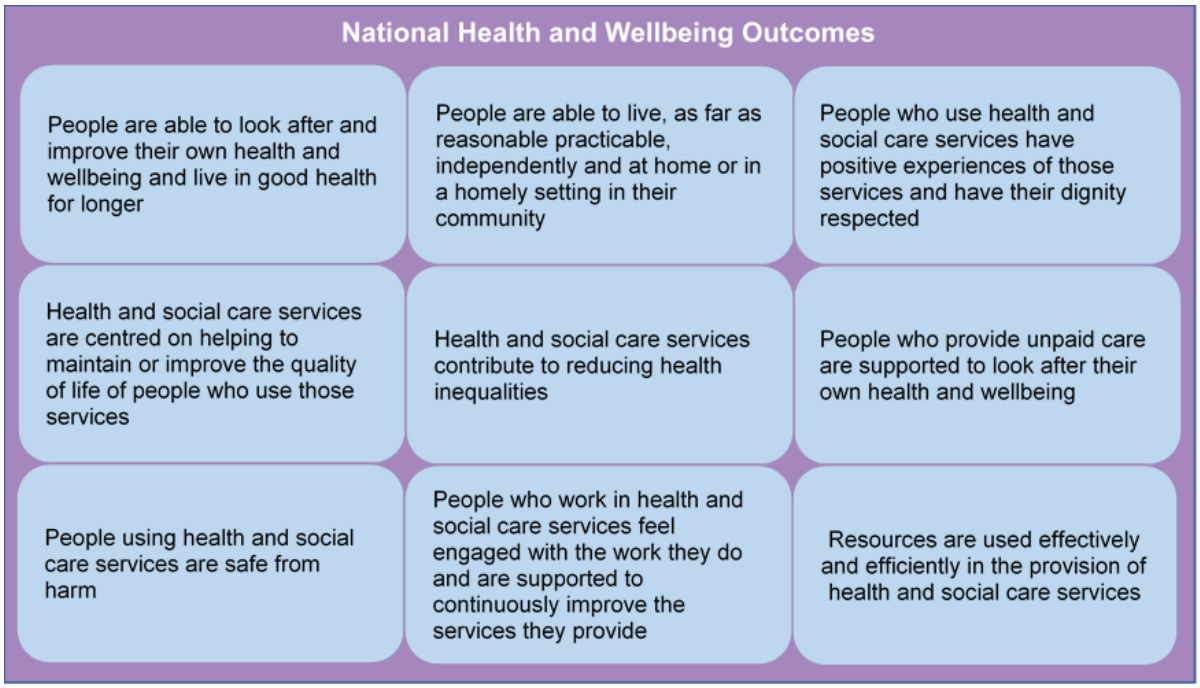

Image 3: The National Health and Wellbeing Outcomes

In producing this report, we have made use of information from a number of different sources, including:

- national indicators, including the 23 indicators to monitor performance against the National Health and Wellbeing Outcomes and the six indicators put in place to assess progress in delivering the benefits of integrations across all 32 integration authorities
- the findings from the National Health and Care Experience Survey which is a postal survey of a proportion of people who use GP services carried out every two years. Overall the satisfaction levels of those who responded to this survey were slightly down since the survey was last carried out in 2015/16. However, the position for Edinburgh largely reflects the picture for Scotland as a whole
- a set of indicators that has been agreed locally to monitor progress against the priorities within the Strategic Plan
- feedback that we have received from other people including compliments, complaints and service inspections
- case studies that help to demonstrate the impact of the way in which services are delivered.

Tackling inequalities

We know that people living in poverty and those who are part of specific social groups experience poorer life chances, reduced health and wellbeing and shorter life expectancy. Tackling the root causes of current levels of inequality as well as reducing the health and social impacts will help us to both improve outcomes for citizens and address the increasing demand for health and social care services. Whilst Edinburgh is often seen as an affluent city. In reality the picture in Edinburgh is very mixed, with areas of affluence and areas of significant poverty existing side-by-side in all four of the localities. We also know that a significant proportion of those experiencing ill health do not live in the areas that are classified as being the most deprived (using the Scottish Index of Multiple Deprivation (SIMD)).

It can take a number of years to effect change in levels of inequality. However, the rate of premature mortality, which is used as a national indicator, continued to decrease from 406 in 2016 to 380.4 in 2017, which is the last year for which figures are available. We are working with colleagues in Public Health to develop a more meaningful set of indicators against which our progress in this area can be assessed in future years.

During 2017/18 we have:

- Worked with our partners in the Edinburgh Community Planning Partnership and local people and communities to develop a **Locality Improvement Plan** for each locality. The plans which were published in December 2017 set out:
  - priorities for improving each locality over the next five years
  - actions that will be carried out in the short, medium and long-term
  - a commitment to targeting shared resources in the most effective way to tackle inequality.
- Established four Locality Mental Health and Wellbeing Public Social Partnerships which provide a range of social prescribing, meaningful activities and psychosocial and psychological supports to people experiencing poor mental health including those in crisis on a 24-hour, seven day a week basis, 365 days of the year.
- Invested almost £1.8m in our Health Inequalities Grant Programme which has allowed third sector organisations to support almost 32,000 citizens to achieve better outcomes during 2017/18. On average 84% of participants involved with services who received grants surveyed agreed or strongly agreed that the service had the intended positive impact on them. The table below shows the number of people supported to achieve each outcome compared to the previous year.
- Established a network of 14 **Community Link Workers** employed by third sector organisations and working across 20 GP practices in areas categorised as having

high levels of deprivation. Using ‘good conversations’, Community Link Workers support people to:

- identify problems and issues they are experiencing
- set goals and overcome barriers in order to take greater control of their health and wellbeing
- achieve their goals by enabling them to identify and access relevant resources or services in their community.

Health Inequalities Grant Programme priority outcomes	Number of people supported to achieve outcome in 2017/18	Difference from 2016/17	
		Trend	%
Reduced misuse of alcohol and drugs	173	↑	131
Reduced stigma	368	↑	113
Increased participation in physical activity	1,986	↑	26
Increased social capital	6,416	↑	25
Reduced damage to physical and mental health from all forms of abuse and violence	149	↑	3
Reduced levels of anxiety and depression	1,937	↑	7
Increased income	13,140	↔	0
Increased community capacity	2,459	↔	-1
More people live in healthy environments and use greenspace	1,473	↓	-15
Increased number of people who eat healthily	3,314	↓	-19

Table 1: Health Inequalities Grant Programme priority outcomes

Case study

The Health Agency and local libraries

Walk Scotland challenge

Customers and staff from two local libraries challenged themselves (and had a great time) taking part in a special Walk Scotland step-count, facilitated and funded by Active Steps, during July and August this year.

The team set themselves a target of walking a virtual route around the coast of Scotland of 803 miles, using a poster map to chart its progress. This featured information about various places of interest along the route (so the challenge was informative as well as active).

Around 30 individuals signed up to start the challenge, and were given a pedometer to record their daily step-count, along with a walking diary giving suggestions on how to make gradual improvements to their activity levels and fitness.

Participants included staff, members of the library's Level Up Youth Group, families, and regular attendees of the popular seated exercise classes (which take place twice-weekly at Wester Hailes Library). Those taking part also successfully encouraged several friends, family members and neighbours to join in. Everyone was able to contribute to the challenge and raise their levels of walking activity, regardless of age, disability or fitness.

At the end of the challenge period, when steps were added up, they were delighted to have reached a grand total of 2,971,043 steps between them. This equalled a distance of 1,485 miles, nearly twice the original target.

Case study 1

Priorities for 2018/19

- Complete the review of health and social care grant programmes in collaboration with third sector partners to establish a new single programme focused on prevention, early intervention and tackling inequalities from April 2019
- Implementation of the action plans to deliver the priorities set out in the Locality Improvement Plans
- Evaluate the Locality Mental Health and Wellbeing Public Social Partnerships to inform future commissioning intentions
- Establish the Inclusive Homeless Practice at Panmure St Anne's to provide an integrated housing, health and social care service for people who are homeless and have complex and multiple needs.

Prevention and early intervention

Investing in approaches that prevent problems occurring or stop them getting worse is a key part of our strategy for improving the health and wellbeing of the citizens of Edinburgh and managing future demand for services.

Good quality, effective primary care services are key to helping people look after their own health. GP practices in Edinburgh remain under considerable pressure due to increasing demands from the growing population in the city and a national shortage of people wanting to become GPs. In June 2017, in recognition of these challenges, the Integration Joint Board agreed a 'stability and transformation' programme to support the expansion of 'core' primary care capacity in individual GP practices. There has also been significant investment through NHS Lothian in GP premises. Of those Edinburgh residents who responded to the Health and Care Experience Survey, 84% were positive or very positive about the care provided by their GP practice and 89% felt that they were treated with compassion and understanding.

Many of those seeking support from their GP face a number of challenges that are having a negative impact on their health and wellbeing, including social isolation, concerns about money and stress and anxiety caused by the complex situations they find themselves in. In many cases, the GP is not best placed to help people find solutions and GPs are making increasing use of the wide range of third sector organisations operating in Edinburgh to meet their patients' needs. In some cases, the third sector provide services in GP practices, Community Link Workers and welfare rights for example; whilst in others the GP will refer people on to organisations providing activities in the local community. We currently fund a range of activities carried out by the third sector to help people improve their health and wellbeing through the Health and Social Care Grant Programme.

94% of Edinburgh citizens who responded to the Health and Care Experience Survey agreed that they are able to look after their own health very well or quite well. This is a slight reduction of 2% compared to the previous survey in 2015/16.

Where people do require support services we aim to work with them to ensure they remain independent and that there is as little deterioration in their condition as possible.

Falls can have a serious impact on the health and wellbeing of older people resulting in hospitalisation, long term injury and lack of confidence. The report of the joint inspection of services for older people in Edinburgh carried out by the Care Inspectorate and Health Improvement Scotland recommended that **'***the (Health and Social Care) Partnership should streamline and improve the falls pathway to ensure that older people's needs are better met*.' We have undertaken a range of activities during 2017/18 to address this recommendation, including:

- reviewing and raising awareness of the falls pathway
- broadening the pathway to look at prevention and early intervention in order to address the vicious cycle of minor falls impacting upon an individual's confidence leading to a gradual withdrawal from an active lifestyle; and
- making better use of the total sector's capacity to identify and engage earlier to prevent falls and inactivity created from minor falls.

The rate of falls per 100,000 of the population, which is part of the national indicator set, fell very slightly in 2016/17 compared to 2015/16. This is the most recent data available.

Unpaid carers play a significant role in supporting people with health and social care needs, helping them to live as independently as possible in the community whilst minimising their requirements for support from statutory services. The estimated number of unpaid carers in the city is 37,589 (2011 Census). The Integration Joint Board recognises the huge contribution that unpaid carers make and also the importance of supporting them to continue in their caring role.

596 carer's assessments were undertaken during 2017/18 compared to 700 in 2016/17 and only 35% of Edinburgh citizens who responded to the Health and Care Experience Survey and identified themselves as unpaid carers agreed that they felt supported to continue in their caring role. Our approach to the implementation of the Carers Act (Scotland) 2016 involves piloting a new carer's assessment and support planning tool in the North West of the city, that is based around a 'good conversation' to identify what is important to the carer and how they can best be supported. We are planning to move to a position where carer's assessments are carried out by the most appropriate person who may be in a third sector organisation rather than only being undertaken by social work teams. Although the number of carer's assessments completed in 17/18 has reduced from the previous year, we believe that this new approach will increase the number of assessments conducted, improve the quality of assessments, reduce the delay in assessments taking place, respond to identified needs more quickly resulting in better outcomes for carers and address the perceived stigma of needing to approach statutory agencies for help.

During 2017/18 we have:

- ❖ Funded the establishment of an additional 30 full-time posts, including administrators, advanced nurse practitioners, pharmacists and community psychiatric nurses across 30 medical practices. We estimate that this has provided additional medical cover equivalent to 14 additional doctors.
- ❖ Taken an additional 8,000 patients onto GP lists and successfully absorbed 4,000 patients from a practice that closed.

- Relocated Polwarth and Southside medical practices into NHS accommodation avoiding the need for significant capital investment in new premises; commissioned new buildings for Ratho Medical Practice, Allermuir Health Centre and the North West Partnership Centre (Pennywell All Care Centre) which has allowed a new practice to be established creating additional capacity for 5,000 patients; and refurbished a property to accommodate the Leith Walk Medical Practice. We have also developed the business case to co-locate the Access Practice with a range of other services to support homeless people with complex needs.
- Increased the number of referrals from Scottish Ambulance Service for falls assessments as an alternative to taking people to hospital from 12 in April 2017 to 22 in March 2018.
- Used Carer Support Workers and the Carers Hospital Discharge Team to undertake carer's assessments which has both increased the number of assessments undertaken and reduced the amount of time carers wait for the assessment to take place.

Priorities for 2018/19

- Invest £2million in developing a Community-led Support Programme to increase capacity within communities and reduce demand for formal services. This approach, aligned with the grants review focused on primary prevention, will form a key plank of our strategy to improve health and wellbeing and manage future demand.
- Take forward the introduction of the new GP contract by implementing the Primary Care Improvement Plan which details the transformative service redesign required over the next three years to enable GPs to function as expert medical generalists.
- Continue the delivery of prioritised major capital schemes to create additional capacity in primary care, including the re-provision of the Brunton Medical Practice and new primary care provision developing extra capacity in South East Edinburgh, augmented by the ongoing programme of small and intermediate capital schemes to augment capacity
- Provide targeted support to care homes with the management of falls and fractures.
- Increase the number of falls assessments by 20% by March 2019.
- Roll out the new assessment tool and Adult Carers Support Plan following evaluation of the pilot.
- Undertake a test of change exploring the potential to make better use of technology to support people who have had a stroke and increase the confidence of their carers in carrying out their caring role.

- Collaborate with the Strategic Carers Partnership to produce a new Carers Strategy for Edinburgh.

Case study

FreshStart

"I used to cook ready meals and convenience food all the time; it wasn't very healthy and it was expensive too. But then I joined the cooking classes at Fresh Start. They really helped me plan my meals and make my money go further – I am now spending a lot less on my messages. I buy and cook more vegetables and I am a lot more adventurous with my food choices.

"When I finished the cooking course I became a volunteer in the garden and joined the service user involvement group. We talk about issues to do with homelessness and help the staff improve the services. Coming to FreshStart makes me feel part of something.

"The collaboration and sense of belonging has given me confidence to keep going."

Since Tam wrote this he is now volunteering with several other organisations and gardens which he freely admits he would not have been able to do this time last year. He also volunteers and cooks meals for large groups of homeless people on a weekly basis.

Case study 2

Person-centred care

The Edinburgh Integration Joint Board is committed to supporting citizens to live as independently as possible and exercise more choice and control over the way in which their health and care needs are met. We endorse the principles of *Collaboration, Dignity, Informed Choice, Innovation, Involvement, Participation, Responsibility and Risk enablement* that underpin the Social Care (Self-directed Support) (Scotland) Act 2013 and are committed to making self-directed support a reality in Edinburgh. However, we know that we have not made the progress we both need and want to make in respect of this strategic priority.

Whilst 79% of those Edinburgh citizens who responded to the Health and Care Experience Survey and who receive support to live at home agreed that they were supported to live as independently as possible and that the services or support they received had an impact on improving or maintain their quality of life; only 74% agreed that they had a say in how their help, care or support was provided and only 67% felt that health and social care services seemed to be well co-ordinated.

The report of the joint inspection of services for older people also included a recommendation that: '*The Partnership should ensure that self-directed support is used to promote greater choice and control for older people. Staff and multi-agency training should be undertaken to support increased confidence in staff in all settings so that they can discuss the options of self-directed support with people using care services.'*

Achieving our priority of person-centred care and self-directed support being the norm in Edinburgh requires significant culture change. During 2017 we commissioned bespoke training from third sector partners to support staff in the North East of the city, to move from traditional models of assessment and care planning to a model based on 'good conversations'. This approach builds on people's strengths, identifies the things that are important to them and supports them to have greater choice and control over improving their current situation.

A support planning and brokerage pilot has also been established in the North East of the city that is making use of 'good conversations' to support people to exercise choice over how their care and support needs are met. The early indications are that in at least some cases better outcomes are being achieved at a lower cost, with people having more say in the kinds of support they receive and what makes a good life.

We have also begun to consider ways to transform traditional models of service to free resources to provide people with the means to make genuine choices regarding how their support is designed and provided.

The Adult Carer Support Plan that has been developed and tested in collaboration with unpaid carers and carers' organisations reflects the changes we are trying to

embed through the ‘good conversations’ training. We are exploring the opportunity that this tool offers as the basis for redesigning our adult assessment form in order to support a strengths-based person-centred approach to assessment and simplify our current assessment tool and processes.

As part of our work around supporting people with long term conditions we have recognised the importance of Anticipatory Care Plans (ACPs) in preventing unnecessary admissions to hospital and ensuring that people are supported and treated in line with their wishes. In 2016/17 we carried out a small-scale test of change in the North East Locality to increase the use of ACPs in care homes with the intention of increasing the likelihood that residents receive care that is appropriate to their needs and consistent with their wishes. During 2017/18 we have rolled out this approach across the city. The approach involves asking residents and their families how they would want to be treated in three specific scenarios (a sudden collapse such as from a stroke or heart condition, a serious infection that was not improving with antibiotics, not eating or drinking). The responses are included within the ACP, so that staff can access details of people’s wishes easily and act accordingly.

During 2017/18 we have:

- Increased the number of people choosing self-directed support options 1 or 2 to 850 from 805 in 2016/17.
- Slightly increased the number of people receiving direct payments to manage their own care and support from 1,303 to 1,317.
- Developed a more streamlined payment system, to ensure that carers receive support as near to the completion of the assessment as possible
- Increased the reviewing and updating of ACPs in one care home by 42% and the recording of residents’ wishes and discussion of end of life care in another care home by 65%.

What is good conversations training?

A six-day programme delivered by Thistle Foundation which uses the Lothian’s House of Care model to provide a framework to map change and areas for improvement.

The programme mirrors an asset-based approach in the way it engages with participants. It introduces the good conversations approach and provides participants with a conversational tool box to identify strengths and outcomes with the person and to plan how someone needs can be met.

The face to face training is supported by small group reflective practice which supports practitioners to apply their learning. The programme encourages participants to identify and begin to progress innovation projects in their local teams.

Ico

Case study

Care Home Staff Reflections on Anticipatory Care Planning (ACP)

"A resident had a fall and she had quite a significant bump to her head, but she was fully responsive and everything. She was able to talk, too, so we weren't worried about any immediate serious injury.

"Because it's a bump to the head, when I called NHS 24 they automatically wanted to send her to A&E to get checked over. We knew that would distress her. She would not want to sit down in a hospital and the ACP showed she isn't for hospital admission unless she has a broken bone etc. So we were able to work with NHS 24 on the phone and just talked it through with them and get a doctor to come out here to see her rather than waiting for that length of time.

"I phoned the family and they were happy not to send her to hospital as it said on the ACP. They could have changed their mind if they wanted but they didn't.

"It worked out best for her. It turned out in the end that there wasn't anything to worry about. So, she would have spent six plus hours in A&E on a Saturday night needlessly just to get the okay and say you have been monitored for 24 hours which we would have done here anyway. It was very beneficial for her and for us because we didn't have to send a member of staff away to go to the hospital with her. And her family was quite relieved that they didn't have to go to hospital as well.

"I think the family has a better understanding. It always been an area that people shied away from in the past but now with the paper work and the guidance that we have we are now able to approach it confidently. Once it has been explained to the family, their understanding is much better and because there is a process in place that's made a big difference."

Case study 3

Priorities for 2018/19

- Roll out the 'good conversations' training across the remaining three localities as a means of embedding the ethos of personalisation and person-centred care across the health and social care workforce.
- Continue the support planning and brokerage pilot, evaluate and extend across the city.
- Evaluate the carers pilot in North West Edinburgh and roll out the new tools and approach across the city.

❖ Roll out the use of Anticipatory Care Planning to a further 18 care homes and aligned GP practices.

Right care, right place, right time

The Integration Joint Board's strategic ambition in terms of meeting current need is to deliver the right care, in the right place, at the right time, so that people:

- are assessed, treated and supported at home and within the community wherever possible and are admitted to hospital only when clinically necessary
- are discharged from hospital as soon as possible with support to recover and regain their independence at home and in the community
- experience smooth transitions between services, including from children's to adults' services
- have their care and support reviewed regularly to ensure these remain appropriate
- are safe and protected.

Our progress in delivering on this ambition in 2017/18 is mixed largely due to the challenges we face in creating the capacity within the health and social care system to meet the level of demand for care and support.

We have continued to perform well in terms of avoiding emergency admissions to hospital with a reduction in both the rate of emergency admissions per 100,000 of the population (from 8,723 in 2015/16 to 8,432 in 2016/17) and the rate of bed days being used as the result of an emergency admission (from 121,518 in 2015/16 to 117,759 in 2016/17).

However, we know that too many people are waiting too long, both in hospital and in the community, for their needs to be assessed and support to be provided:

- although the number of people whose discharge from hospital was delayed had reduced towards the end of 2017, there was a significant increase in the first three months of 2018, with 267 people being delayed in March 2018 compared to 176 people in March 2017
- the number of days that people spend in hospital when they are ready to be discharged (per 1,000 of the population) also increased from 1,396 in 2016/17 to 1,509 on 2017/18
- the rate of people being readmitted to hospital within 28 days of being discharged is also relatively high and remains relatively unchanged at 110 per 1,000 of the population.

People in the community are also experiencing similar delays:

- the number of people waiting for an assessment has continued to reduce from a peak of 1,978 in September 2017 to 1,544 people at the end of March 2018, compared to 1,480 in March 2017. The average length of wait has also reduced from 93 days over the period March 2017 to March 2018. Whilst the number of people waiting for an assessment and the length of time they are waiting are both far too high, both figures are moving in the right direction. This is due to the work of the assessment team and the work of locality teams in their new structures
- the number of people in the community who have been assessed as needing a package of care and are waiting for that package to begin has increased significantly over the last year from 381 in April 2017 to 837 in March 2018. This is a result of challenges recruiting to caring roles in Edinburgh city as a result of virtually full employment
- the number of people in receipt of a package of care who are waiting for a review of their needs remains too high. However, there has been a significant improvement between September 2017 and March 2018, when the number of people waiting fell from 6,159 to 5,161.

There is evidence to suggest that where people do receive services, those services are generally of a good quality:

- 80% of Edinburgh citizens who responded to the Health and Care Experience Survey and receive care and support rated those services as good; which is an increase of 3% from 2015/16
- 88% of registered services were graded 4 (good) or better in Care Inspectorate inspections, which is an increase of 4% from 2016/17.

The Care Inspectorate undertook 28 inspections of services operated by the Edinburgh Health and Social Care Partnership during 2017/18. Following these inspections:

- 25% (7) of services were downgraded in relation to the previous inspection
- 39% (11) were graded the same with requirements/recommendations for improvement
- 7% (2) were upgraded in relation to previous inspection
- 7% (2) received a mix of upgrades and same grades across the inspection criteria with recommendations and requirements for improvement
- 21% (6) retained their grades with no recommendations or requirements.

The Joint Inspection of services for older people in Edinburgh highlighted that the processes and procedures in respect of adult support and protection were not being applied consistently. In 2017/18 we received 2,057 referrals where adult protection concerns were raised, an increase of 72% on the previous year. Of these, 543 (26.4%) led to further work being undertaken under the adult support and protection

legislation and 1,393 (67.7%) led to further action being undertaken outwith of the adult support and protection process. 350 cases underwent adult support and protection investigation of which, 143 (41%) had longer term adult protection plans put in place.

The percentage of citizens who agreed that they 'felt safe' when responding to the Health and Care Experience Survey fell from 82% in 2015/16 to 77% in 2017/18.

During 2017/18 we have:

- Agreed to invest £4.5m on a non-recurring basis to address immediate priorities around people delayed in hospital awaiting care home placements and people waiting in the community for assessments. This was used to fund:
  - 50 additional care home places
  - a temporary team established in March 2018 to address the assessment waiting lists of approximately 750 cases. The team used a person-centred and asset-based approach and have shared learning with locality teams. The main impact of the work of this team will be seen in 2018/19.
  - a wide scale programme of process redesign work to ensure key business processes are lean and effective and make best use of available resources. Processes for the screening and allocation of cases have already been redesigned to ensure cases are picked up as quickly as possible.
- Produced outline strategic commissioning plans for learning disabilities, mental health, older people and physical disabilities setting out the current position together with our aspirations and priorities for the future. Each plan is supported by a clear action plan with timescales for delivery.
- Fully established our locality working model based around two GP clusters within each of the four localities. In each locality there is:
  - a single Hub team focused on avoiding hospital admission, supporting timely discharge and supporting people to live as independently as possible. Each Hub team has a Multi Agency Triage Team daily morning meeting which has a focus on supporting early discharge from hospital
  - two Cluster teams aligned to a GP cluster with a focus on providing longer term care and support
  - a mental health and substance misuse team.
- Each locality has undertaken tests of change to address their own particular challenges, these include:
  - the establishment of a Palliative Care Team in the North East focused on working with people who have a life expectancy of six to eight weeks

- exploring a model for improving respiratory support and management for anyone with acute respiratory infection in the community in the North East Locality
- a ‘Hospital Release Scheme’ using proactive approaches to ‘pull’ people out of hospital in the South West
- the increased use of Anticipatory Care Plans within care homes in the South East.

- A Sustainable Community Support Programme has been initiated to address capacity challenges in the provision of community based support services and design the future model. The programme will assess options to improve the current Care at Home contract (which is due to expire in October 2019) to increase capacity and make greater use of external capacity for the provision of home based care.
- Initiated a project to test the use of provider-led reviews of existing packages of care, recognising that providers are often best placed to understand the needs of the service user and how best to deliver successful outcomes.
- Negotiated with colleagues in the housing sector for people with mental health problems who are ready for discharge from hospital or to move on from supported accommodation to be given priority (gold) status for the allocation of tenancies.
- Supported 15 people with profound and multiple learning disabilities to move from Murray Park to placements within the community.
- Created additional supported placements within the community for people with mental health problems as part of the work around the re-provision of the Royal Edinburgh Hospital.
- Developed a new service specification to meet the needs of people requiring post-diagnostic dementia support and awarded the contract for the delivery of this service.
- Strengthened the adult support and protection procedures by undertaking a full evaluation of the Electronic Interagency Referral Discussion Review Group, resulting in improved recording of decision making, escalation procedure, greater scrutiny of operational decision making and the effectiveness of safety planning.

Run five locality-based adult support and protection workshops for managers and senior social workers, focusing on practice standards, barriers to improved performance, support and expectations, thresholds, screening decisions and the need for accurate record-keeping.

Case study

Multi Agency Triage Team (MATT) meetings

The RIE Hub Discharge facilitator was on the ward when the consultant for patient AC was doing his ward round. She was able to tell the consultant that there was already a plan in place in the community, which had been set up through the MATT meeting. This prevented the need for another care plan to be created and ensured that there was a clear plan for discharge.

When the discharge facilitator spoke to AC's wife about the plan, she was concerned about being able to manage at home, as she still worked two days per week and wanted to maintain this.

The discharge facilitator discussed putting Mrs C in touch with the community LOOPS worker, to see if there were community supports that she could link in with to enable her to continue working.

Case study 4

Priorities for 2018/19

- Review and redesign the end-to-end business processes to support the delivery of asset-based and person-centred care whilst taking advantage of opportunities reduce unnecessary bureaucracy.
- Continue the Sustainable Community Support Programme to develop sustainable models of care at home that will deliver additional capacity.
- Work with housing providers to deliver on the commitment within the Housing Contribution Statement to ring-fence 3,000 affordable homes for people with health and social care needs.
- Work with care home providers in the independent sector to increase the capacity across the city by 240 beds.
- Deliver an additional 16 community placements at St Stephen's Court for people with mental health problems.
- Work with providers in the third, independent and housing sectors to review and transform our current approach to delivering night time support.
- Complete the development of the strategic commissioning plans for learning disabilities, mental health, older people and physical disabilities with a focus on service transformation to address current and future challenges.
- Implement the related delivery plans.

Making the best use of capacity across the whole system

The Edinburgh Health and Social Care Partnership cannot tackle the twin pressures of limited resources and increased demand for services alone. At the heart of our strategic plan is changing the relationship between statutory services, citizens, communities and our partners in the independent, third and housing sectors, so that we make best use of the capacity available within the city.

The move towards asset-based approaches that focus on the strengths of individuals to take control of their own lives and the current pilot of Family Group Decision Making, based on empowering the widest possible network of extended family members and friends to participate in decision making about an individual, are good examples of the changes we want to make in our relationship with citizens.

We are also proactively engaging partners from the independent, third and housing sectors in the development of our strategic commissioning plans for learning disabilities, mental health, older people and physical disabilities. We believe that this will assist us to develop outcome focused and innovative plans that result in improved health and wellbeing for the citizens of Edinburgh.

During 2017/18 we have:

- Worked with adult and young carers and the organisations that represent them to develop the Adult Carers Support Plan and Young Carers Statement. We are currently piloting these in the North West of the city with a view to expanding the range of people who can undertake carer's assessments.
- Established a steering group to take forward the review of health and social care grants programmes with membership from third sector and housing providers as well as colleagues with expertise in public health and procurement. Following successful engagement events with the wider third sector we have also agreed to set up a number of forums and short life working groups to continue to develop a collaborative approach to the development of the new grants programme.
- Worked with independent sector providers to identify ways to increase care home capacity in the city.
- Worked with colleagues in the Edinburgh Community Planning Partnership to develop Locality Improvement Plans based on a shared understanding of the priorities within each locality and the additional benefits that can be achieved through taking a partnership approach to addressing these.
- Established a pilot project to test the Family Group Conferencing model in adult services. Recognising that family members and friends can have a life-long commitment to each other and an intimate knowledge of family history, the model encourages and enables family members and extended networks to bring a wide range of their own resources to developing support plans.

Case study

Hospital Discharge Carer Support Service

AD contacted Edinburgh Carer Support Team for advice as her husband had collapsed in Glasgow and been admitted to hospital there. AD stated she was struggling financially with the cost of travelling to see him and had to borrow money to enable her to visit him. AD sounded extremely stressed and queried if there was any help towards these costs. Once a follow up call was made, AD confirmed her husband had been discharged home. The carer advised she has been caring for five years as her husband has multiple health issues including throat cancer and stroke. AD was interested in completing an Adult Carer Support Plan (as part of the North West Carer Pilot) to determine if there were other underlying issues in her caring role that could be addressed as she had no other supports in place. Through a one to one meeting with a Carer Support Worker (CSW) the following outcomes were agreed:

AD would like to learn how to swim as she is looking for an activity to maintain her health wellbeing. She also wanted to set up an achievable goal to work towards as she feels she is lacking motivation and positivity in her day to day life. Her friends also go swimming and as she can't go with them this isolates her further

To have a weekend away with her husband to help to maintain their positive relationship. AD also described she would "Just like to run away, even for little while, from our usual routine."

AD also had concerns about what would happen if she was unwell and who would then be able to care for her husband. With recent hospital admissions, the CSW also encouraged AD to think about looking at matters such as Power of Attorney (POA).

Case study 5

Priorities for 2018/19

- Continue to work with colleagues in the Edinburgh Community Planning Partnership to implement the Locality Improvement Plans.
- Continue to work with our partners in the third, independent and housing sectors to shape the care and support market and address current gaps in capacity.
- Improve our engagement with all stakeholders through the development of the Strategic Plan 2019-22 to ensure that there is a coherent and shared vision for health and social care services across the city in which everyone plays their part.

Managing our resources effectively

The Integration Joint Board recognises the importance of maximising opportunities to share resources with our partners to deliver high quality, integrated and personalised services that improve the health and wellbeing of citizens whilst managing the financial challenges that we all face.

During 2017/18 we have:

- Supported the LOOPS Hospital Discharge project to ensure that our third sector partners are represented at the daily Multi-Agency Triage Team (MATT) meetings that take place in each of the locality Hubs. This allows us to identify people who are fit to leave hospital and could be supported in the community by third sector organisations then refer on appropriately.
- 57 of the 72 GP practices in the city have benefited from small scale investment through the Primary Care Tech Fund, which has enabled them to implement technological solutions such as self-service check in, patient texting and ulcer assessment kits.
- Utilised the expertise of the Thistle Foundation to deliver good conversations training as a key plank of our strategy to reinvigorate our approach to self-directed support.
- Established a Workforce Development Steering Group that includes representation from the third, independent and housing sectors along with the Volunteer Centre and unpaid carers.
- Worked with Blackwood Housing to build a ‘smart house’ at Longstone Resource Centre to allow citizens and staff to ‘try’ a range of technological solutions in a simulated domestic setting, that may address some or all of their care and support needs.

Priorities for 2018/19

- Roll out the Good Conversations training out over the remaining three localities.
- Complete the development of the multi-agency workforce development strategy.
- Complete the work on the ‘smart house’.
- Maximise the opportunities for making use of technology to support improved health and wellbeing.
- Progress the proposed Community Led Support Programme to increase community capacity and reduce demand on formal services.

Our financial performance

Financial information is a key element of our governance framework with financial performance for all delegated services reported at each meeting of the IJB. Budget monitoring of IJB delegated functions is undertaken by the finance teams in the City of Edinburgh Council and NHS Lothian, reflecting the IJB's role as a strategic planning body which does not directly deliver services, employ staff, or hold cash resources. However, it is important that the IJB has oversight of the in-year budget position as this highlights any issues that need to be accounted for when planning the future delivery of health and social care services.

The financial plan sets out how we ensure our limited resources are targeted to maximise the contribution to our objectives. Whilst in 2017/18 we delivered a surplus of £4.7m this entirely reflects 'ring fenced' money we have carried forward to meet costs which will be incurred next year. Getting to this position was only possible because both the City of Edinburgh Council and NHS Lothian agreed additional one-off contributions to the IJB: £7.2m from the Council and £4.9m from NHS Lothian. These additional payments reflected some of the significant and long standing financial pressures we face, notably:

- **care at home,** which continues to be the single most significant financial challenge facing the IJB with a reported in year overspend of £7m
- **prescribing,** short supply and the cost of high value drugs gave rise to an in year overspend of £2.1 million on the GP prescribing budget. Similar pressures are evident across Scotland
- delivery of **savings and recovery plans** remains a challenge with only a marginal contribution was made towards the Council's transformational savings in 2017/18. Equally, NHS services did not fully deliver the required level of savings
- NHS Lothian **set aside** budgets overspent by £2.4m in the year. Junior doctors are the most significant contributory factor where non-compliant rotas are driving costs upwards.

Our financial performance for the year is summarised in the table on the following page.

	Budget	Actual Expenditure	Variance
	£k	£k	£k
NHS delivered services			
Community services	33,942	33,476	466
General medical services	80,167	81,049	(882)
Mental health	35,116	34,556	560
Learning disabilities	8,569	9,161	(592)
Prescribing	80,072	82,172	(2,100)
Reimbursement of independent contractors	49,623	49,623	0
Services hosted by other partnerships	47,282	45,769	1,513
Hospital 'set aside' services	96,975	99,410	(2,435)
Other	50,691	43,750	6,941
Council delivered services			
External purchasing	115,623	124,670	(9,047)
Care at home	34,652	34,616	36
Day services	13,912	12,698	1,214
Residential care	20,905	22,457	(1,552)
Social work assessment and care management	11,336	10,452	884
Other	13,400	12,184	1,216
Sub total	**692,265**	**696,043**	**(3,778)**
Additional contributions	12,130	0	12,130
Reserves brought forward	(3,690)		(3,690)
Total	**700,705**	**696,043**	**4,662**

Table 2: Financial performance for the year

It will be important moving forward to 2018/19 and future years that expenditure is managed within the financial resources available and this will require close partnership working between EIJB as service commissioner and the City of Edinburgh Council and NHS Lothian as providers of services. Like many other public sector organisations, we face significant financial challenges and, due to the continuing difficult national economic outlook and increasing demand for services, will need to operate within tight fiscal constraints for the foreseeable future. Pressures on public sector expenditure are expected to continue, both at a UK and Scottish level, meaning NHS Lothian and City of Edinburgh Council will face continued funding pressures for the foreseeable future. This in turn will impact on

their ability to resource the functions delegated to the IJB. In this financial climate, we recognise that returning to a balanced position will require major redesign of services, radical changes in thinking and approach, and the involvement of all partners and stakeholders.

Many of the considerable challenges we face have significant financial consequences and we face a complex landscape of interconnected risks. Examples include:

- increased demand for services alongside reducing resources
- impact of demographic changes
- delays in accessing appropriate services, including social care assessments, reviews and timely discharge from hospital
- impact of welfare reform on the residents of Edinburgh
- impact of the living wage and other nationally agreed policies
- risk that the savings programme does not deliver within the required timescales or achieve the desired outcomes
- costs associated with meeting new legislative requirements without adequate resources being put in place.

Our performance against the 23 core national indicators

The purpose of this table is to provide a summary of performance since the Edinburgh Integration Joint Board and Health and Social Care Partnership were established in April 2016. However, where data is not available for 2017/18, data for 2015/16 has been included for comparison purposes.

Indicator	Title	Low= good Y/N	Edinburgh score 2015/16	Scotland score 2015/16	Edinburgh score 2016/17	Scotland score 2016/17	Edinburgh score 2017/18	Scotland score 2017/18	Edinburgh Current Quartile (Scotland-wide comparison)	Edinburgh performance against previous year	Scotland performance against previous year
NI - 1	Percentage of adults able to look after their health very well or quite well	N	96%	94%	N/A	N/A	94%	93%	Top	↓	↓
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	N	81%	84%	N/A	N/A	79%	81%	Third	↓	↓
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	N	77%	79%	N/A	N/A	74%	76%	Third	↓	↓
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	N	71%	75%	N/A	N/A	67%	74%	Fourth	↓	↓
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	N	78%	81%	N/A	N/A	80%	80%	Third	↑	↓
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	N	87%	87%	N/A	N/A	84%	83%	Second	↓	↓
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	N	83%	84%	N/A	N/A	79%	80%	Third	↓	↓
NI - 8	Total combined % carers who feel supported to continue in their caring role	N	37%	40%	N/A	N/A	35%	37%	Fourth	↓	↓
NI - 9	Percentage of adults supported at home who agreed they felt safe	N	82%	84%	N/A	N/A	77%	83%	Fourth	↓	↓
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work		N/A	N/A	N/A	N/A	N/A	N/A			

Indicator	Title	Low= good Y/N	Edinburgh score 2015/16	Scotland score 2015/16	Edinburgh score 2016/17	Scotland score 2016/17	Edinburgh score 2017/18	Scotland score 2017/18	Edinburgh Current Quartile (Scotland-wide comparison)	Edinburgh performance against previous year	Scotland performance against previous year
NI - 11	Premature mortality rate per 100,000 persons	Y			399	440	380	425	Second	↑	↑
NI - 12	Emergency admission rate (per 100,000 population)	Y	8,723	12,346	8,432	12,297	8,214	N/A	Top	↑	↑
NI - 13	Emergency bed day rate (per 100,000 population)	Y	121,518	127,965	117,759	126,302	98,929	N/A	Top	↑	↑
NI - 14	Readmission to hospital within 28 days (per 1,000 population)	Y	108	97	110	100	103	N/A	Third	↓	↓
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	N	84%	87%	85%	87%	87%	88%	Fourth	↑	↑
NI - 16	Falls rate per 1,000 population aged 65+	Y	23	21	22	21	22	22	Third	↑	→
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	N			84%	84%	88%	85%	Second	↑	↑
NI - 18	Percentage of adults with intensive care needs receiving care at home	N	61%	61%	62%	62%	NA	NA	Third	↑	↑
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	Y			1,396	842	1,509	772	Fourth	↑	↓
NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	Y	24%	24%	24%	25%	21%	N/A	Third	↑	↑
NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	Y	N/A	N/A	N/A	N/A	NA	NA			
NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	N	N/A	N/A	N/A	N/A	NA	NA			
NI - 23	Expenditure on end of life care, cost in last 6 months per death		N/A	N/A	N/A	N/A	NA	NA			

Note: the data in this table is produced by the Information Services Division of NHS Scotland and is the most up to date available.

Table 3: Our performance against the 23 core national indicators