Edinburgh Health and Social Care Partnership

Draft Strategic Plan

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

We are pleased to present this first draft strategic plan, setting out the priorities we believe we need to pursue if we are to achieve our shared vision for a caring, healthier, safer Edinburgh.

Edinburgh's population of almost half a million, accounts for 9% of the total population of Scotland, and is growing. Whilst this growth has many social and economic advantages, it also presents challenges. The latest projections indicate that Edinburgh's population will continue to grow faster than anywhere else in Scotland, and some age groups are projected to increase even more rapidly. Although a relatively affluent city, Edinburgh has areas of significant inequality and 'deprivation' and one of our key priorities will be to lead on tackling health and social inequalities.

At the same time the financial environment continues to be challenging for local authorities and health boards. Over the next five years, the City Council must reduce its operating costs by £107 million, while Lothian Health Board needs to make efficiency savings of circa £40m year-on-year to re-invest in services to meet changing needs. This makes the current way of doing things unsustainable and requires a fundamental re-think of how we work together to use public money, our skilled staff teams and the capacity and capability of the third and independent sectors, and of people and communities to support better health and social care outcomes across the City.

A great opportunity now exists to plan and deliver joined up services both at a local level and city-wide. More integrated working through four aligned geographical localities has been agreed across the public sector in Edinburgh, including the Council, NHS, Police and Fire and Rescue services and by the third sector.

At the heart of our plan is the development of a new relationship between citizens and communities, our services and staff, and the many other organisations who contribute to encouraging, supporting and maintaining the health and wellbeing of people who live in our City. We want to ensure that people are supported to live as independently as possible and enabled to look after themselves, but also access the right care and support when needed.

The integration of health and social care services is at an early stage and this first draft of our strategic plan is high level; setting out the priorities we think need to be addressed in order to deliver integrated services that improve the health and wellbeing of citizens. The plan also contains some high level proposals about how these priorities might be addressed. We will be publishing the more detailed final version of our plan at the end of 2015.

We want the final version of our strategic plan, to be as good as we can make it, and we need your help to do so. Over the late summer and early autumn, we will be consulting extensively on this document and developing more detailed plans for the delivery of health and social care services in Edinburgh over the next three years. We are keen to get the views of those who use our services, our staff and others who provide care, including unpaid carers and community groups who can all bring their perspectives to help turn our vision into a set of radical, achievable and affordable actions to transform the health and care landscape in Edinburgh for all our benefit.

As Chair and vice chair of the Board overseeing the newly established Edinburgh Health and Social Care Partnership, we encourage you to participate in the consultation and share your ideas for developing a caring, healthier, safer Edinburgh

George Walker

Chair of the
Edinburgh Integration
Joint Board

Ricky Henderson

Vice chair of the
Edinburgh Integration
Joint Board

Contributing to our plan

You can give us comments on this draft plan at: https://consultationhub.edinburgh.gov.uk/ and you can find out more about the consultation by emailing us at: healthsocialcareintegration@edinburgh.gov.uk or calling: 0131 529 6552.

Executive summary

In line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 the Edinburgh Health and Social Care Partnership has been established to bring together the strategic planning and operational oversight of a range of adult social care services currently managed by the City of Edinburgh Council with a number of community health and hospital based services in Edinburgh currently managed by NHS Lothian. The strategic intention is to improve the health and wellbeing of citizens by joining up the planning and delivery of health and social care services under the governance of a single body, the Edinburgh Health and Social Care Partnership.

The strategic plan:

- sets out the vision and aspirations of the Edinburgh Health and Social Care Partnership (pages 9 to 14)
- provides a high level profile of the overall population of Edinburgh, the four localities within the city that will be used as the basis for the planning and delivery of services and the specific groups within the community that are a major focus of service planning and delivery, particularly for social care services (pages 15 to 23)
- details six key priorities linked to the national health and wellbeing outcomes and the strategic aims of the Edinburgh Community Planning Partnership, NHS Lothian and the City of Edinburgh Council; and uses these priorities to articulate the high level actions that the Edinburgh Health and Social Care Partnership will take in order to use the resources available to it to improve health and wellbeing in Edinburgh. The priorities are:
    - Tackling inequalities (page 27)
    - Prevention and early intervention (page 30)
    - Person centred care (page 33)
    - Providing the right care in the right place at the right time (page 35)
    - Making the best use of capacity across the whole system (page 39)
    - Managing our resources effectively (page 42)

What is health and social care integration?

NHS Lothian and the City of Edinburgh Council have a long history of working in partnership to meet the health and social care needs of the people of Edinburgh. However, it has been recognised both nationally and locally that whilst the health and care needs of individuals are closely intertwined, the services put in place to meet those needs are often disjointed and not as well coordinated as they could be. Experience has shown that where health and social care support is joined up and does work well, this is often because the staff involved may be employed by different agencies, but are managed and work together as part of a single team.

The Scottish Government believes that the most effective way to maximise the benefits of joint working is to bring together the planning, resources and operational oversight for a range of NHS and local authority care services. In Edinburgh, this will be the responsibility of the Edinburgh Health and Social Care Partnership, which is governed by the Edinburgh Integration Joint Board. These arrangements come into effect from 1 April 2016.

The services that will be part of the 'Edinburgh Health and Social Care Partnership' are summarised in the diagram opposite. A full list of delegated services is provided in Appendix A.

What is the strategic plan?

The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Edinburgh Health and Social Care Partnership to produce a strategic plan setting out how the services for which it is responsible will be delivered in order to achieve a set of nationally agreed outcomes, known as the 'national health and wellbeing outcomes'. These outcomes are detailed in the diagram on page 14.

The strategic plan for the Edinburgh Health and Social Care Partnership needs to reflect a range of national and local legislation, policies and strategies, including those of the Edinburgh Community Planning Partnership, the City of Edinburgh Council and NHS Lothian. The diagram on page 14 shows how the draft priorities for the strategic plan link to the strategic aims and priorities of these three bodies. It is also important to recognise that there are a number of existing strategies and plans in place in Edinburgh that include services within the Edinburgh Health and Social Care Partnership, many of which have been developed jointly between the Council and NHS Lothian with involvement from other partners, including people who use health and social care services. As current plans and strategies expire, the opportunity will be taken to streamline the existing range of plans as far as possible whilst continuing to meet national and local requirements.

The diagram in Appendix B sets out the range of national and local legislation, policies and strategies, which have informed the development of the draft strategic plan and will be impacted by the plan at a local level. You can access each of the documents by clicking on the hyperlinks within the diagram.

It is important that the Edinburgh Health and Social Care Partnership Strategic Plan forms part of the community planning structure for the city as a whole. In March 2015, the Edinburgh Community Planning Partnership Board agreed a new community plan for the period 2015/18. Within this plan the Health and Social Care Partnership was recognised as one of eight strategic partnerships in the city; with a lead role for tackling health inequalities, shifting the balance of care and reducing drug and alcohol use. In addition, each of the 12 neighbourhood partnerships published new three year local community plans in 2014, which included specific local health, wellbeing and social care priorities; these have been taken into account in the development of the Joint Strategic Needs Assessment (https://consultationhub.edinburgh.gov.uk/) which supports this draft plan.

How has the draft strategic plan been produced?

The draft plan has been produced on behalf of the Edinburgh Health and Social Care Partnership by officers of the City of Edinburgh Council and NHS Lothian working in collaboration with the Strategic Planning Group (SPG). This is a group of people representing our key partners in the planning and delivery of health and social care services, including people who use those services. The members of the Group are committed to engaging widely within the groups they represent to ensure widespread collaboration and engagement in the production of the plan. The remit of the Strategic Planning Group, membership and the interests represented are detailed in Appendix C.

The process for the production of the strategic plan is set out in the diagram opposite:

The first step in producing the plan was to produce a Joint Strategic Needs Assessment (JSNA), bringing together information held by the Council and NHS in order to identify needs in relation to health and social care services across the city as a whole and in specific localities. Information from the JSNA has been used in developing this draft strategic plan.

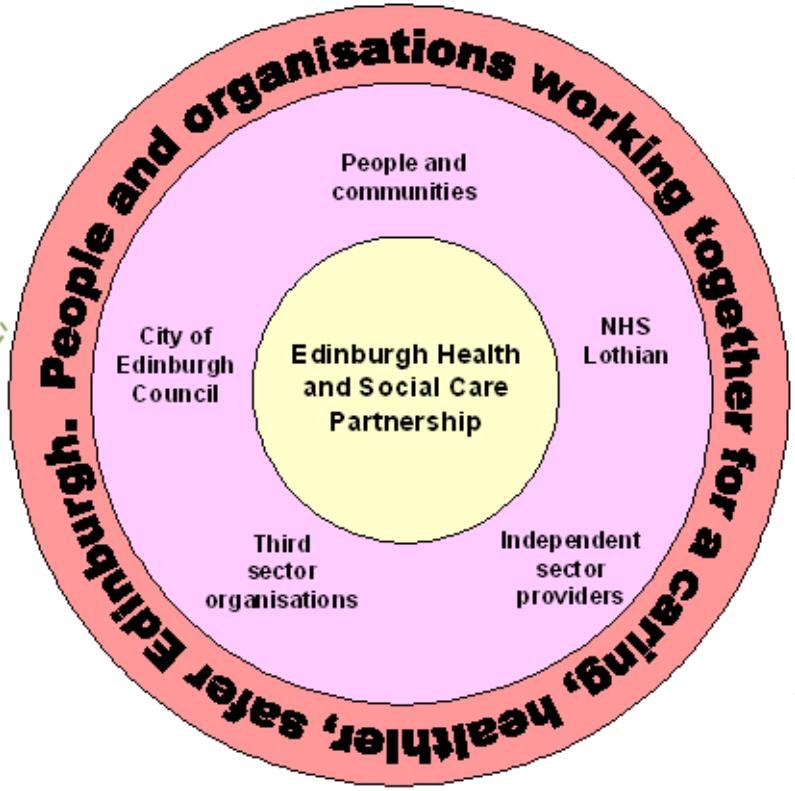
We are continuing to develop the JSNA by talking to a wide range of people to test out whether what we have learned from the data matches the experience of people living and working in the city. We are therefore consulting on the JSNA alongside this draft strategic plan.

Our vision:

People experience improved health and wellbeing; and inequalities including health inequalities, are reduced.

Shared resources will be deployed in the most cost effective way to achieve better outcomes for people, to maximise the efficiencies from coordination of care and to allow public funds to go further to meet demand.

Services will become more focused on outcomes for individuals and will always be planned with and around people and local communities, who will be active partners in the design, delivery and evaluation of these services.



Organisations involved in the delivery of health and social care services will work in partnership with people and communities, using best practice approaches in engagement and involvement, to deliver improved and fully-integrated health and social care services for the people of Edinburgh.

Organisations involved in the delivery of health and social care services will work collaboratively to develop, train and support staff from all organisations to work together, respond appropriately and put the needs of the people we work with first.

Our values: We will respect the principles of equality, human rights, independent living, and will treat people fairly

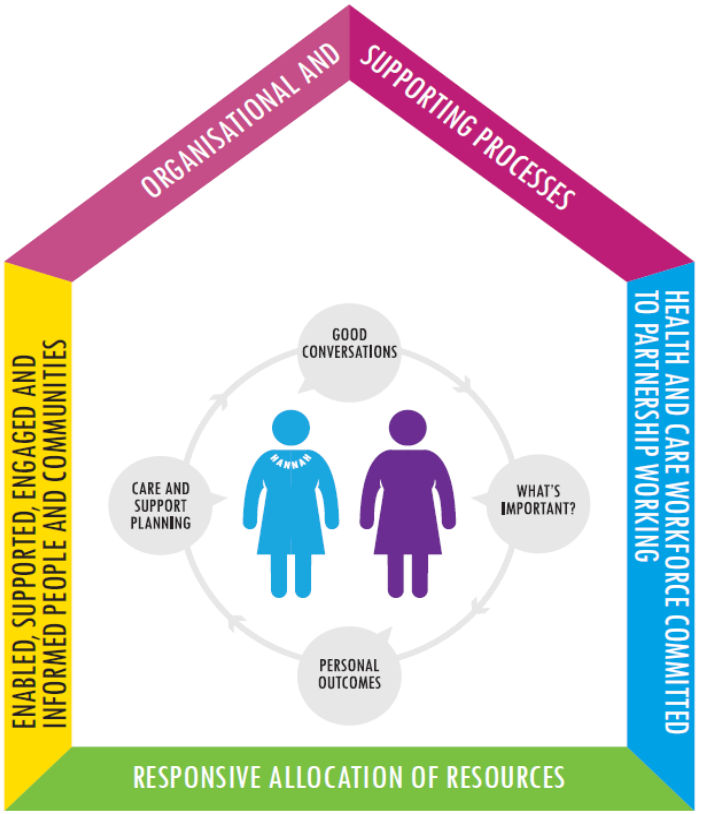
The vision and values of the Edinburgh Health and Social Care Partnership set out the positive impact we believe the integration of health and social care will make, on the way organisations work together and work with people and communities, the way services are planned and delivered and most importantly, on the lives of those living in the city.

Changing the relationship between the people responsible for the planning and delivery of health and social care services, the people who receive them and the communities in which they live is at the heart of our strategic plan. The House of Care model offers a good illustration of the elements that need to be in place if our vision for integration is to be achieved. This model is being developed in partnership between NHS Lothian, third sector organisations, the local authorities in Edinburgh and the Lothians and people who use health and social care services.

The relationship between people who use health and social care services and those providing them is central to our vision; the House of Care model places this relationship at the centre of the 'house'. This relationship is based around the ability to have 'good conversations' with a focus on what is important to the individual (sometimes referred to as their 'personal outcomes').

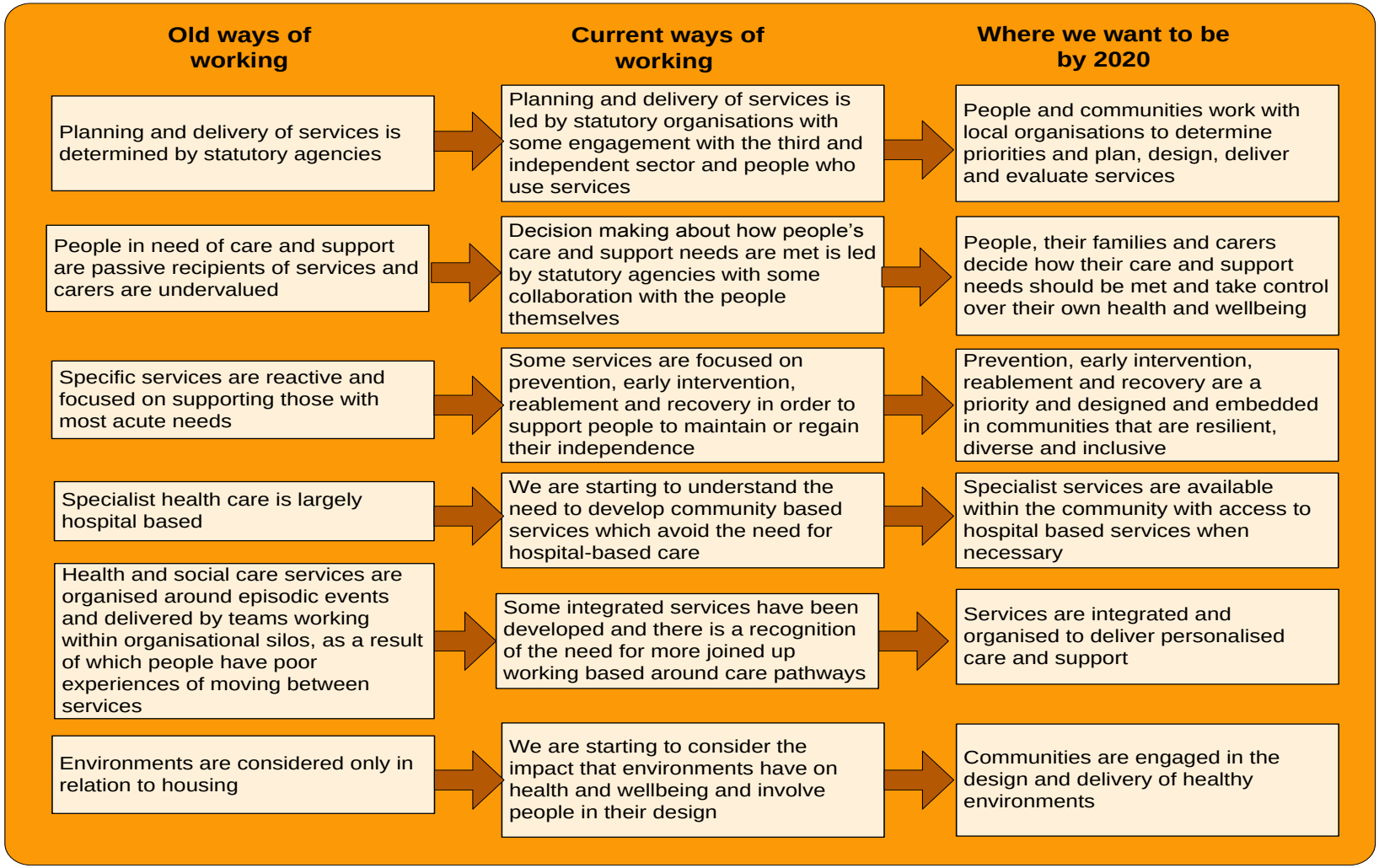
The foundations, walls and roof of the house all need to be in place for the model to work. In the House of Care model these parts of the building represent:

- people and communities engaging meaningfully in 'good conversations' and planning their care and support in collaboration with those working to support them; thinking about what they can do for themselves as well as what services can be provided
- a health and social care workforce that is committed to working in partnership across organisational boundaries and with the people and communities they are working to support
- systems and processes that encourage and support this way of working
- the responsive allocation of resources to meet the needs of the individual or their community, which will change over time



The changes we need to make

If we are to achieve our vision, there are a number of changes we need to make. Some progress has already been made that will help us get to where we want to be. What we need to do now is escalate the pace so that we see real change in the life span of this strategic plan.



Our key priorities

In order to achieve our vision and make the changes set out in this draft strategic plan, the Edinburgh Integration Joint Board has identified a number of key priorities that will drive the work of the Health and Social Care Partnership during the life of the strategic plan:

Tackling inequalities

Working with our partners to tackle the causes of inequality and health inequality by supporting those at greatest risk and focusing on:

- mitigating the health and social consequences of inequalities
- helping individuals and communities resist the effects of inequality on health and wellbeing

Prevention and early intervention

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

Person centred care

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

Providing the right care in the right place at the right time

Delivering the right care in the right place at the right time for each individual, 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 a smooth transition between services
- have their care and support reviewed regularly to ensure these remain appropriate
- are safe and protected

Making best use of capacity across the whole system

Developing and making best use of the capacity available within the city by working collaboratively across:

- the statutory sector
- third and independent sectors
- housing organisations
- communities; and
- individual citizens, including unpaid carers

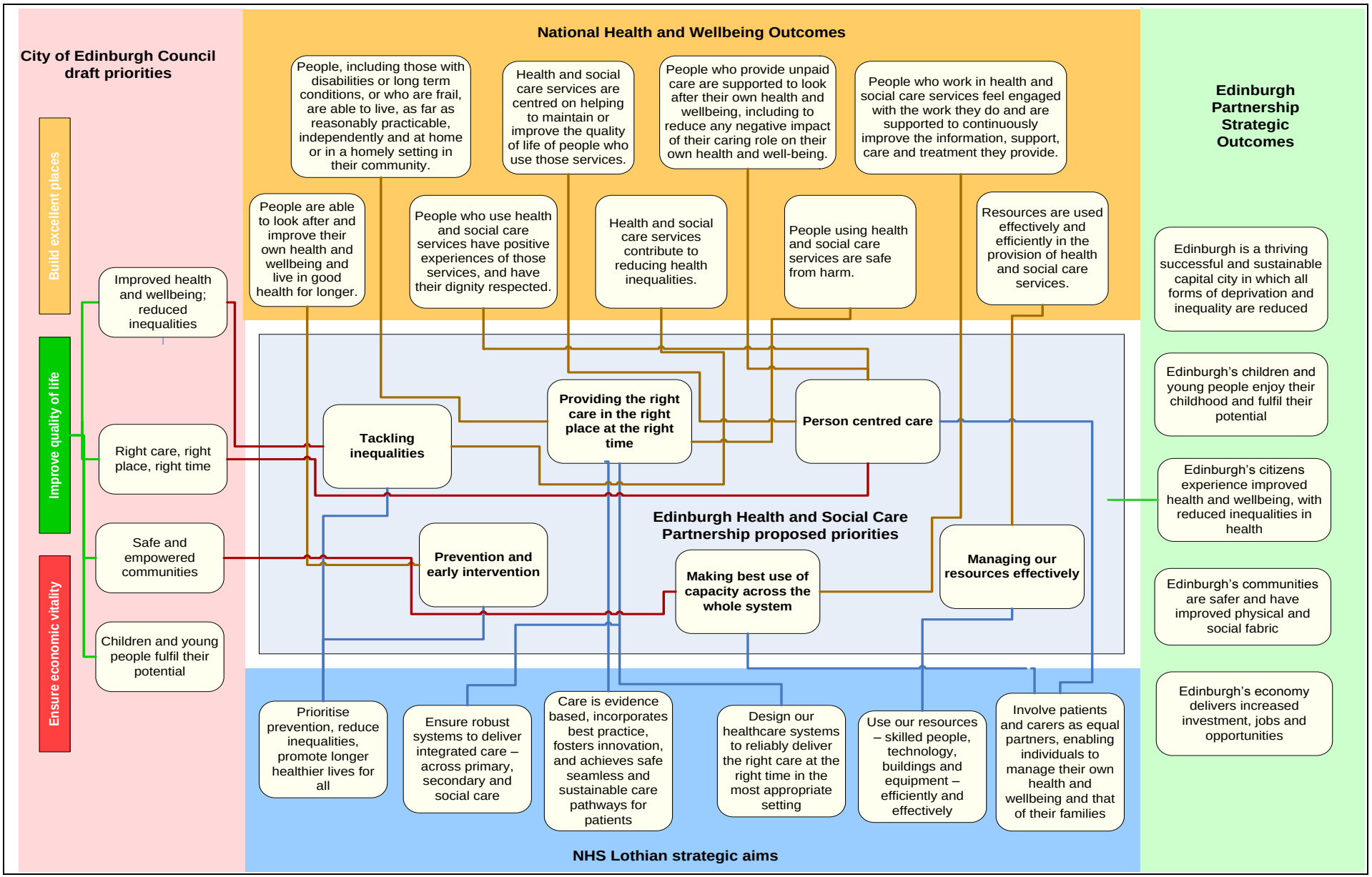
to deliver timely and appropriate care and support to people with health and social care needs, including frail older people, those with long-term conditions and people with complex needs

Managing our resources effectively

Making the best use of our shared resources (people, buildings, technology, information, procurement approaches) to deliver high quality, integrated and personalised services, which improve the health and wellbeing of citizens whilst managing the financial challenge.

In developing our key priorities, we have recognised the importance of the wider context within which the Edinburgh Health and Social Care Partnership operates and the need to reflect both national and local priorities. The diagram on the following page shows how the key priorities for the Partnership are linked to:

- the National Health and Wellbeing Outcomes
- the strategic outcomes of the Edinburgh Community Planning Partnership
- the strategic aims of NHS Lothian; and
- the draft priorities of the City of Edinburgh Council


City of Edinburgh Council draft priorities
Build excellent places
Improve quality of life
Ensure economic vitality
Improved health and wellbeing; reduced inequalities
Right care, right place, right time
Safe and empowered communities
Children and young people fulfil their potential
National Health and Wellbeing Outcomes
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.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
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.
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.
People are able to look after and improve their own health and wellbeing and live in good health for longer.
People who use health and social care services have positive experiences of those services, and have their dignity respected.
Health and social care services contribute to reducing health inequalities.
People using health and social care services are safe from harm.
Resources are used effectively and efficiently in the provision of health and social care services.
Tackling inequalities
Providing the right care in the right place at the right time
Person centred care
Prevention and early intervention
Making best use of capacity across the whole system
Managing our resources effectively
Edinburgh Health and Social Care Partnership proposed priorities
Prioritise prevention, reduce inequalities, promote longer healthier lives for all
Ensure robust systems to deliver integrated care – across primary, secondary and social care
Care is evidence based, incorporates best practice, fosters innovation, and achieves safe seamless and sustainable care pathways for patients
Design our healthcare systems to reliably deliver the right care at the right time in the most appropriate setting
Use our resources – skilled people, technology, buildings and equipment – efficiently and effectively
Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families
NHS Lothian strategic aims
Edinburgh Partnership Strategic Outcomes
Edinburgh is a thriving successful and sustainable capital city in which all forms of deprivation and inequality are reduced
Edinburgh's children and young people enjoy their childhood and fulfil their potential
Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health
Edinburgh's communities are safer and have improved physical and social fabric
Edinburgh's economy delivers increased investment, jobs and opportunities

Meeting the needs of localities and communities in Edinburgh

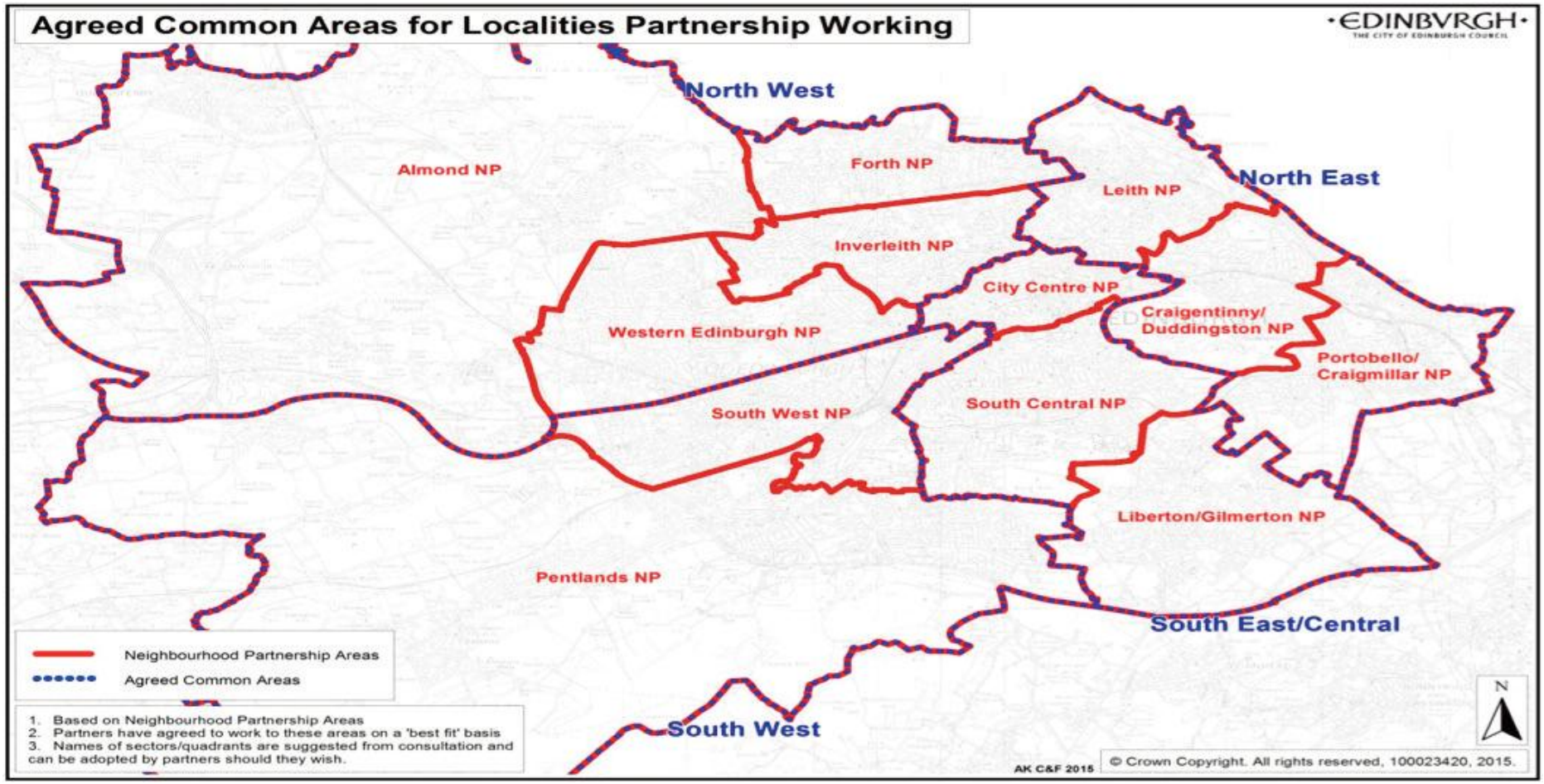
There is general recognition at both a national and local level that communities are the engine house for delivering transformation. If we are to achieve the changes we need to make in order to realise our vision, the planning and delivery of services must take place at a local level.

Edinburgh is a diverse city with many different communities of both geography and interest that have varying levels and types of needs in terms of health, social care and wellbeing. In many cases, these are needs that can best be addressed by a range of services, not simply those that are the responsibility of the statutory health and social care agencies; indeed the most effective way of meeting some needs, loneliness for example, may lie with communities themselves. It is for these reasons that the Edinburgh Health and Social Care Partnership, along with the Edinburgh Community Planning Partnership, the City of Edinburgh Council and NHS Lothian believes that it is right to shift the focus of our service planning and delivery to localities. This will involve working in partnership with and empowering local people and communities, improving the co-location and integration of services and devolving budgets and decision making closer to the point of service delivery.

The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Edinburgh Health and Social Care Partnership to divide the city into at least two localities for the purposes of planning and delivering health and social care services. During the process of the development of the draft strategic plan, the organisations that belong to the Edinburgh Community Planning Partnership have agreed that it makes sense for all partners to adopt the same geographic locality boundaries as the basis for service planning and delivery in the city. Four localities have been agreed based around the existing Neighbourhood Partnerships:

Locality	Neighbourhood Partnerships	Population
North West	Almond, Forth, Inverleith and Western Edinburgh	138,995
North East	Leith, Craigentinny/Duddingston and Portobello/Craigmillar	110,550
South West	Pentlands and South West	111,807
South East/ Central	City Centre, South Central and Liberton/Gilmerton	126,148
	Total	487,500

A brief profile of each locality is given on pages 19 and 20.



The use of common boundaries across partners provides strong opportunities to integrate service planning and provision not only across health and social care, but across all agencies. In particular, links are being made with the Transformation Programme, currently taking place within the Council, which is also seeking to integrate services at a locality level and with similar change initiatives being led by other partners. Whilst the draft strategic plan focuses on the four localities outlined above, we are conscious of the need to work with specific communities of place and interest within and across these localities.

What we know about the population of Edinburgh

The total population of Edinburgh is estimated to be 487,500:

- 51% are female,
- 15% are aged 0-15 years;
- 70% are aged 16-64;
- 15% are aged 65+; 2% of whom are aged 85 years or over.

Census data shows that in 2011:

- 7.8% of Edinburgh's population was "White other" (non British or Irish) – the fifth highest proportion in the UK
- the numbers of people from non-White ethnic groups have been increasing over the past 40 years
- among non-White ethnic groups, Chinese was the most common (with around 8,000 people), followed by Indian (just under 6,500), Pakistani (just under 6,000) with other Asian and Black African both having around 4,500 people
- Censuses since 1971 show an increasing proportion of single person households (from 23% to 39%)

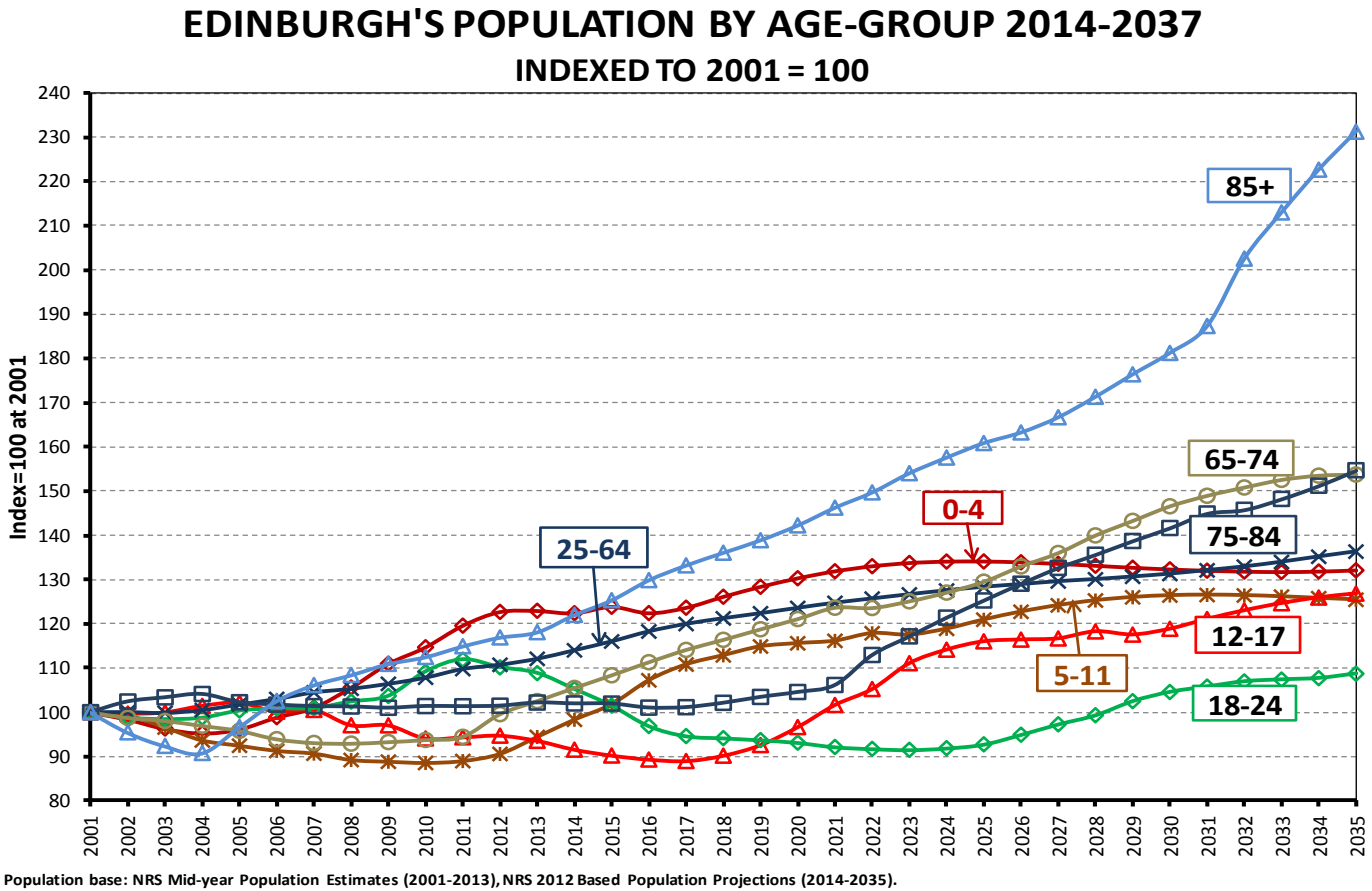
Over the last 30 years, male life expectancy in Edinburgh has increased by 7.0 years (to 77.4), while female life expectancy has increased by 5.4 years (to 81.9).

Forecasts of the city's population will help us to estimate future requirements for services, including health and social care services.

- Edinburgh's population is projected to continue its recent rapid growth, rising from 482,600 in 2012 to 537,000 in 2022 – an increase of 54,400 or 11.3%
- By 2037, if recent trends continue, Edinburgh's population will have grown by 28.2%, reaching 619,000. Over the same period the number of households in Edinburgh is projected to increase by 39% from 224,875 to 313,033
- In both numerical and percentage terms, Edinburgh is projected to be home to a faster growing population than anywhere else in Scotland.
- Approximately 70% of future population growth in Edinburgh is accounted for by more people coming to live in the city, with the remaining 30% resulting from more births than deaths. However, migration is more volatile than births and deaths and therefore difficult to measure accurately.

- the number of people aged 85+, a group that makes more intensive use of care services, is projected to increase by 28% between 2012 and 2022 and to more than double by 2037 rising from 10,100 to 21,300 (an increase of 110%)

The graph opposite shows projections rather than forecasts, estimating what will happen if recent trends continue but taking no account of future economic changes or policy interventions.



What we know about the four localities

Although the population of each of the four localities is similar in size, our Joint Strategic Needs Assessment tells us that there are big differences in life expectancy, life chances and health and wellbeing both between and within localities. The information on the following pages provides a summary of the characteristics of the four localities. This information makes reference to both numbers and rates - numbers will give the volume of demand whilst rates allow us to make comparisons between localities.

North West

Population

- Largest population size: 138,995
- One-third (33.2%) of Edinburgh's child population aged 0-15
- A third of the city's population aged 85+

Health

- Largest **number** of hospital admissions due to falls
- Highest spend on health (directly related to the size of the area)
- Highest **number** of people with:
  - *One or more health conditions* (36,591 people)
  - *Deafness/Hearing loss* (8,322 people)
  - *Blindness/Partial sight loss* (2,989 people)
  - *Physical Disability* (7,032 people)
  - *Other Conditions* (22,595 people)

Health and Social Care

- Highest **number** of individuals supported by Health and Social Care
- Lowest rate of new legal orders (mental health, adult protection etc) granted
- Highest proportion of unpaid carers (15.5%)

Other

- Diverse, containing the wards with:
  - the highest (27%) and lowest (17%) percentage of households on low income in the city
  - the highest and lowest employment rate
- Lowest percentage of people living alone (35.7%)
- Lowest percentage of students (4.9%)
- Highest percentage of retired people (14.2%)
- 7.7% of its datazones are in the 15% of areas with the highest levels of 'deprivation' in Scotland

North East

Population

- Total population 110,550 – smallest of the four localities
- Relatively young: lowest proportion of people aged 65+ (13%)
- Almost half of population is in the 25 to 49 year old age group
- Largest number of households from a minority ethnic background
- Highest concentrations of people with White Polish ethnic origin

Health

- Poorest health across a wide range of measures
- Highest percentage of people with long term health problems that limit day-to-day activity (8%)
- Highest mortality rate (the only locality with a mortality rate higher than Scottish figure)
- Largest number of unplanned inpatient admissions

Health and Social Care

- Highest ***rate*** per 1,000 population (16+) for people being assessed or supported by Health and Social Care
- Highest proportion of people supported who are under age 75 years
- Highest **number** of people supported who have learning disabilities, physical disabilities and addictions with implications for volumes of support needed
- Highest average size of packages of care (hours per week)

Other

- Highest level of economic activity and employment (68.6%)
- Highest percentage of people living alone (43.8%)
- 16.2% of its datazones are in the 15% of areas with the highest levels of 'deprivation' in Scotland
- Highest proportion of intensive unpaid care - almost a quarter (24%) of unpaid carers provide 50+ hours per week

South West

Population

- Total population : 111,807
- 16+ population : 94,093
- Smallest 16+ population

Health

- Relatively low proportion of residents with long term health problems that limit day to day activities
- Highest percentage of residents economically inactive due to limiting long term illness (15%)
- Relatively high rates of women with dementia, but low concentration among men

Health and Social Care

- Highest proportion of Health and Social care open cases in under 24 year age group
- Low take up of direct payments.
- Lowest concentration of people providing unpaid care
- Highest concentration of people who cycle to work

Other

- 12.4% of its datazones are in the 15% of areas with the highest levels of 'deprivation' in Scotland

South East/Central

Population

- Total population: 126,148 – second largest
- 16+ population : 109,999 – 13% of the locality total, compared with 15% across Edinburgh
- Largest proportion of persons aged 16 – 24 (40.3%) (students)
- Highest concentration of people aged 85+
- Highest concentrations of people with Chinese ethnic origin

Health

- The only locality showing an increase (albeit small) in stroke-related mortality
- Sharper decline in under 75 year old mortality rates than other localities

Health and Social Care

- Highest number of individuals in care homes (based on the person's original home address)
- Lowest rate of unpaid carers provide 50+ hours per week (19.3%)
- Highest number of people with Mental Health problems

Other

- Largest percentage of households on low incomes (23.5%)
- Low level of economic activity (due to students?) – 57.5%
- Highest percentage of students (20.9%)
- Lowest percentage of retired people (9.6%)
- 4.8% of its datazones are in the 15% of areas with the highest levels of 'deprivation' in Scotland

Meeting the needs of specific groups within the community

Almost everyone living in Edinburgh, including those who work in health and social care will be users of health services. For most people this will be through their GP, pharmacist, dentist or other community health services when the need arises. A much smaller number of people will be in contact with adult social care services and when they are, it tends to be in relation to needs arising from mental or physical ill health, disability or frailty due to old age.

Historically, there has been a tendency within health and social care to see people as part of specific groups, with a common set of needs that can be met by a standard set of solutions. Changes in public expectations and policy, together with changes in the profile of the population, have made it clear that there is a need for a more person-centred approach, which recognises that people's needs are specific to them and do not fit into service or professional silos.

It is also important to note that there is evidence that conditions often associated with old age affect those living in 'deprived' circumstances earlier in life.

People living with long term conditions

Long term conditions are conditions that last a year or longer, impact on a person's life, and may require ongoing care and support. Common long term conditions include epilepsy, diabetes, some mental health problems, heart disease, chronic pain, arthritis, inflammatory bowel disease, asthma and chronic obstructive pulmonary disease (COPD).

The risk of people developing long-term conditions increases with age as does the number of long term conditions that an individual is likely to have.

People with one or more long term conditions have an increased risk of emergency admissions to hospital and place a greater demand on health services generally. 67% of those people that account for the top 50% of health service expenditure have two or more long term conditions.

Those living in 'deprived' circumstances are likely to experience multimorbidity (having more than one long term condition at the same time) approximately 10 years earlier than those in the least 'deprived' circumstances.

People living with long term conditions may also belong to other service user groups and be receiving health and social care services. The challenge is to co-ordinate and integrate their care seamlessly and efficiently to improve outcomes.

Obesity, poor diet and limited physical activity, smoking and excessive consumption of alcohol, are closely associated with long term conditions such as cardiovascular disease and diabetes.

Frail older people and those living with dementia

Almost 90% of those aged 65+ use community health services only and are not in receipt of social care services. Older people also contribute substantially to society. A significant amount of caring for children, adults with disabilities or learning difficulties and older people is provided by people over retirement ages, and many community assets and activities depend on the voluntary contributions of this age group.

However, whilst healthy life expectancy (i.e. the length of time people live in a healthy way) has been increasing, overall life expectancy has been increasing faster. This means people are living longer but in the final years of life are more likely to require support for complex health and social care issues for longer periods than in the past.

The probability of receiving social care services increases dramatically with age, from around 10% at age 75 to over 40% at age 90+ and these people are likely to be living with one or more long term health conditions. The likelihood of developing dementia also increases with age.

The percentage of older people with high level needs who are cared for at home has increased from 14% in 2002 to 35% in 2015. As a result there has been a rise in the average number of hours of care at home services provided, reflecting the increased needs of people living in the community. There has been a similar change in the profile of people living in care homes, with the lowest dependence having almost halved to 22% of the population, whereas those with

People with disabilities

The Scottish Government report, the 'Same as You'[1] indicated that 2% of the population have a learning disability with the vast majority being unknown to services. NHS Lothian Community Learning Disability teams within Edinburgh are in contact with 1,520 people. City of Edinburgh Council knows of 3,405 people with learning disabilities in the city.

The overall prevalence of people with learning disabilities is expected to rise as a result of improvements in medical and social care which mean that:

- more premature babies are surviving with a high likelihood of severe and multiple disabilities, with 97% of those with a disability having a neurological/ intellectual disability
- people with learning disabilities are living for longer, including those with profound and multiple learning disabilities. In 1980 the average age of someone with Down's syndrome was 20 it is now 60. 30% of People with Down's syndrome aged 50 plus develop dementia , this rises to 50% for those aged 60+

In 2007 Edinburgh was estimated to have 30,735 adults aged 16-64 with moderate to severe physical disabilities.

Around 20% of Edinburgh's population experience either hearing loss or significant sight loss. The majority of those with a sensory impairment have hearing loss.

It is estimated that around 4,850 people in Edinburgh are living with autism around 2,400 of whom have autism but no learning disability.

People with complex needs

People with complex needs are those who may be living with a range of needs that adversely affect their health and wellbeing including mental ill health, drug and alcohol problems and homelessness; they may sometimes be involved in crime and are often the victims of violence.

People in this group are often less able to access and make effective use of health and social care services and the services struggle to engage with them.

Over 120,000 people in Edinburgh experience a mental health problem which equates to over 25% of the population. Anxiety and depression are the most common mental health problems, but others include schizophrenia, personality disorders, eating disorders and dementia.

It is estimated that there are 22,400 people in Edinburgh with dependent drinking. Alongside this there are 5,300 people with problem drug use (using heroin and/or benzodiazepines only). 64% of those using heroin in Edinburgh are under the age of 25, compared with 51% across Scotland. The rate of drug-related maternities in Edinburgh is almost twice the national average although this is likely to be due to local reporting arrangements, rather than a higher prevalence. Around a third of drug and alcohol users in contact with services in Edinburgh have at least one dependent child. About half of people receiving support for addictions are thought to have mental health problems of varying degrees of severity.

The local cost of hospital beds to accommodate those who have alcohol related brain damage is approximately £2m. This equates to 14 acute beds being occupied over a full year.

Informal carers

Without the valuable contribution of unpaid carers the health and social care system could not be sustained. Carers, as equal partners in the delivery of care, enable people with illnesses or disabilities to remain at home and in their own communities safely, independently and with dignity. Carers can, for example, prevent avoidable hospital admissions and contribute to the overall health and wellbeing of those they support.

There are estimated to be 65,084 unpaid carers in Edinburgh, or 13.7% of the population. One in five of these carers provides over 50 hours of care a week. There are proportionally more carers in North West (15.5%) than in South Central (11.7%). Just over 1 in 5 (21.1%) of carers provide 50+ hours per week and this rate was highest in North East (23.7%) and lowest in South Central (19.3%).

The Scottish Government's publication "Scottish Carers" (2015) presents evidence of the impact of providing care on people's health and wellbeing. Those in more complex and demanding caring situations are most at risk of experiencing poor mental and physical health. Additionally, there can be an impact on employment and income: caring can result in carers reducing the hours they work or leaving employment.

What will working at a locality level mean?

Edinburgh's 12 Neighbourhood Partnerships demonstrate the benefit of locality working, in meeting the aspirations and needs of local communities across all issues that affect people's lives, whether education, employment, health, housing, safety, transport and the environment. They enable individuals and communities to work together with the public, voluntary and business sectors to support the design and delivery of services. The success of this approach provides a basis for realising the vision set out in this draft strategic plan as demonstrated by the examples below. More information and other examples can be found at www.edinburghnp.org.uk

Reducing inequalities

A support service has been established for a group of migrant workers in Leith. The individuals faced significant challenges relating to issues of homelessness and alcohol and substance misuse and were increasingly the subject of complaints in the area for anti-social behaviour. Working directly with the group to understand and respond to their needs, the Council, third and community sector organisations developed a programme of support, including English classes, housing and welfare advice and employability services. The programme has realised positive outcomes for the individuals involved through achieving English language qualifications, securing jobs and moving in to secure tenancies. The project has now been mainstreamed into partner services.

Working with communities

In Pentlands funding has been provided for events and activities that support access to healthy spaces and wellbeing. These include funds to purchase equipment to plant and maintain the trees provided by the Friends of Hailes Orchard and Woodland, and for Harmeny Wood Group to provide educational walks, including bat walks, for all ages in Juniper Green. These activities complement other local environmental action such as the development of new friends of parks groups in the area, community led events to support a new recycling service and the development of the Union Canal as a community asset.

Making better use of resources

Neighbourhood Partnerships have been at the forefront of citizen involvement in decision making on the use of devolved budgets, through the Community Grants Fund and Neighbourhood Environment Programme budget. These funds both enable communities to participate in the decision making process, and support grass roots development. Many of the Partnerships use participatory budgeting to allocate funds, which has proven extremely successful in strengthening local understanding of public budgets and supporting communities to develop solutions to local issues.

A range of partners including NHS Lothian, the Council, Fire and Rescue Service and third sector have developed a collaborative and proactive approach to address levels of alcohol-related harm amongst elderly residents in the West. This included the provision of Alcohol Brief Intervention training events for front line staff, from across partner agencies and the community, and the production of a toolkit which provides advice on alcohol awareness and misuse, adaptable to different client needs. The success of the approach has led to it being rolled out more widely across the area, including to local pharmacies, libraries and GP practices.

Creating collaborative approaches to reshaping services

An innovative project led by Alcohol Focus Scotland, in partnership with the Edinburgh Alcohol and Drug Partnership is being delivered in Leith, to identify actions that can reduce alcohol harm and the negative impact of alcohol in the area. This includes an educational initiative, co-produced with pupils of Drummond Community High School. External evaluation has shown young people are more aware of how they are targeted by alcohol marketing through social media. The next steps include the potential to deliver the educational programme in a community youth setting in or around Leith.

Aligning services to community needs

In Almond the community, NHS Lothian, third sector and the Council have worked together to provide additional facilities in the community for people suffering from dementia. This includes the development of a dementia-friendly 'sensory' garden, providing a place where dementia sufferers can access and interact with memorabilia and remain physically active and socially engaged. Work to explore the feasibility of creating an indoor drop-in facility is currently underway within the community.

Strategic enablers

Budget

A major function of the strategic plan is to ensure that the resources available to the Health and Social Care Partnership estimated to be in the region of £0.5 billion are aligned with the strategic priorities set by the Integration Joint Board. Reference is made throughout this draft strategic plan to the challenge of managing increased demand within limited financial resources and the very challenging financial positions of both the Council and NHS Lothian make careful financial planning and management an absolute priority. Work is currently underway to determine the budget for the Health and Social Care Partnership from April 2016 onwards, through a process of due diligence. The final budget will also be subject to the budget setting processes of NHS Lothian and the Council. It is therefore not possible to give any detailed information about the budget available to the Health and Social Care Partnership at this stage, more detail will be contained within the final version of the strategic plan.

Performance management

An important role of the Integration Joint Board will be to oversee the performance of the services for which it is responsible. A key element of this will be to ensure that the national health and wellbeing outcomes and the priorities set out in this draft plan are delivered. A draft performance management framework is under development to ensure that the Board has the necessary information to manage performance effectively. Details of how performance will be managed will be contained in the final version of the strategic plan.

Other strategic enablers

In addition to the financial statement and content of the performance management framework, the final version of the strategic plan will contain details of the following plans for the Edinburgh Health and Social Care Partnership:

- communications and engagement
- workforce and organisational development
- risk management
- Information and Communication Technology

The final version of the plan will also contain a housing contribution statement.

Delivering our priorities

The following section of this plan focuses on our key priorities and sets out why we believe they are a priority, the evidence for this, what we are already doing, the opportunities that we believe integration offers to do things differently and finally, a set of high level actions that we believe we need to take. The final version of the strategic plan will contain a more detailed set of actions backed up by plans for delivery within defined timescales.

Tackling inequalities

Please note: *We have used the term 'deprived' in this document to indicate people or areas of the city that experience a range of problems that arise due to lack of resources or opportunities.*

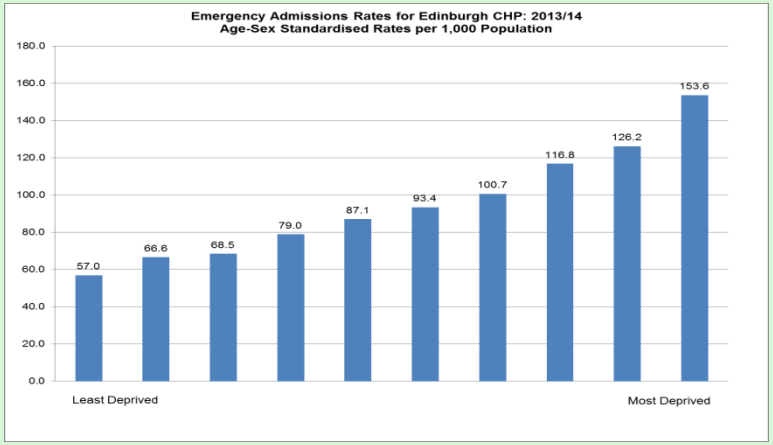
Why is it a priority?

There is strong evidence to suggest 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 than the rest of the population. If we are to address the increasing demand for health and social care services and support people to take more responsibility for their own health and wellbeing, we need to take action to prevent, mitigate and reduce the severity and impact of health and social inequalities.

What do we know?

- Life expectancy has increased steadily in the last ten years in Edinburgh. However, there are pronounced differences within the city; at the most extreme, this can mean a difference in life expectancy of more than 25 years between the areas of the city experiencing the lowest and highest levels of deprivation.
- People living in the most 'deprived' areas of the city are more likely to develop long term conditions and to develop them at least ten years earlier than people living in the least 'deprived' areas. They are also at greater risk of emergency admission to hospital as illustrated in the diagram on the following page.
- In 2013, 21% of children in Edinburgh were living in low income households, which is the fifth highest proportion of low income households in Scotland.
- There are significant pockets of poverty within the city and within each of the four localities. However, health inequalities are

not restricted to areas of 'multiple deprivation', as up to 50% of people experiencing poor health do not live in the communities experiencing the highest levels of deprivation.



- There is evidence that being part of a specific group, for example looked after children, people with disabilities, minority ethnic groups, the LGBT community and people aged 85 or more can increase the likelihood of poor life chances.
- Poor mental health with depression affects one in five older people living in the community and two in five living in care homes. Older members of the LGBT community are 2.5 times more likely to live alone and 10 times more likely to indicate they have no-one to call on in times of crisis.
- Difficulties in communication can be a significant barrier to accessing services for many people from minority ethnic groups and people with disabilities.
- Many unpaid carers who are unable to work due to their caring role are living on low incomes and experience poor physical and mental health as a result of the strain of their caring responsibilities.
- 12% of residents in Edinburgh aged between 16 and 74 who are not in work are unable to participate in the labour market due to a limiting long term illness. This is a significant barrier to increasing incomes above the poverty threshold.
- The cost of energy and fuel poverty is a major issue, which affects the lives and health of some of the poorest and most vulnerable households in the city. Health benefits can be achieved through investing in energy efficiency and providing support to help people manage their energy consumption.
- Edinburgh contains the top 10 practices in Lothian with most patients living in areas of the most acute 'deprivation'. Although the funding for GP practices is weighted for 'deprivation', there is a strong view that this does not reflect the cost of the additional support required.

What are we already doing?

- The Health Inequalities Standing Group, which is a sub-group of the Edinburgh Community Planning Partnership, has

produced an Integrated Framework and Action Plan to tackle inequalities. Actions include: funding local community health initiatives to build community capacity and increase people's social capital, increasing healthy eating through skills training and local food co-operatives and community cafes, increasing physical activity through walking and cycling groups, active commuting and sport, creating healthier environments through better design and opportunities to use green space and take part in "growing" activities.

- Building stronger and more resilient communities through specific initiatives such as 'Headroom' that is taking place in specific GP surgeries in the East and South West of the city.
- Removing barriers to access and effective use of health and social care services for all citizens.

What opportunities does integration offer?

- Consolidation of all funding and other resources dedicated to tackling inequalities across the Health and Social Care Partnership.
- The opportunity to influence the approach to tackling inequalities across the Edinburgh Community Planning Partnership.
- Better targeting of effort and resources to tackle issues of inequality within specific localities and communities working collaboratively with citizens and communities.

What are the next steps we need to take?

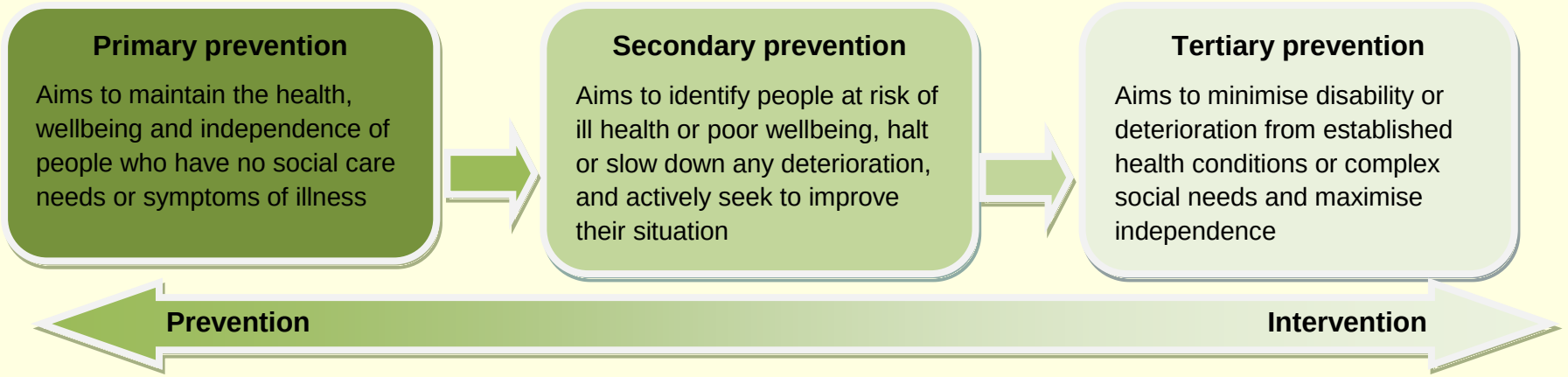
- Review the current structures and approaches to tackling inequality, including the remit and membership of the Health Inequalities Standing Group. It is anticipated that this group will become a sub-group of the Edinburgh Health and Social Care Partnership.
- Review the priorities for tackling inequalities from 2016/17 developed by the Health Inequalities Standing Group in collaboration with voluntary sector organisations and Lothian Community Health Initiatives Forum.
- Consolidate the funding available across health and social care to tackle inequalities and determine how this should be allocated once current grant commitments expire.

Prevention and early intervention

Why is it a priority?

There is a strong link between this priority and that of tackling inequalities. In 2001, the Christie Commission on the 'Future Delivery of Public Services' suggested that around 40 – 45% of expenditure on public services in Scotland was spent on addressing issues that could have been prevented if action had been taken earlier. Shifting the balance of investment in favour of services and approaches that prevent problems occurring or stop them from getting worse, can improve outcomes for citizens, reduce future demand for services and make more effective use of available resources.

The Edinburgh Community Planning Partnership has produced a Prevention Strategic Plan, which recognises a continuum of prevention:



What do we know?

- It is estimated that the projected increase in the population of Edinburgh will lead to an increase in demand for health and social care services of 1.4% per year
- 70% of the Edinburgh population aged between 16 and 74 have at least one long term condition, which increases their risk of emergency admission to hospital. Although the individual cost to the NHS of people in this group is relatively low, the size

of the group means they account for a significant level of expenditure. Consequently early interventions to prevent people's conditions progressing, and their risk of admission increasing, could have a significant impact on resources

- Currently 27% of the adult Scottish population is obese; this is predicted to increase to 40% by 2020. Diabetes currently affects more than 5% of the population. If obesity prevalence continues to increase, the prevalence of type 2 diabetes will also rise, which has significant implications for health and social care resources.
- Loneliness has been shown to be as harmful to long-term health as smoking 15 cigarettes a day. It can also put people at risk of developing dementia, high blood pressure and depression.

What are we already doing?

Current activity to improve health and wellbeing through prevention and early intervention is focused on:

- raising awareness of health and wellbeing issues and encouraging and supporting citizens to adopt more healthy lifestyles for themselves
- encouraging citizens to improve the health and wellbeing of others they interact with as an employer, service provider or member of the community
- strengthening capacity and resilience within communities to support citizens with health and social care needs; encouraging people to engage in community activities to combat loneliness and isolation
- improving screening for a range of health conditions through primary care
- reablement approaches that provide intensive support for short periods of time allow people to regain their confidence and independence after a period of ill health
- promoting new projects with housing providers, such as prescribing new heating boilers to people with health and well-being problems that can be alleviated by being able to heat their homes efficiently
- encouraging and supporting self management for people with long term conditions including the use of telehealth
- reducing the risk of falls and fractures through evidence based falls prevention programmes
- embedding recovery approaches for people with mental ill health and problems with drugs and alcohol and maximising

opportunities to invest in peer support from people who have lived experience of these conditions

- using technology such as fall detectors and pendant alarms to support people to continue to live independently

What opportunities does integration offer?

The integration of health and social care provides the opportunity to:

- embed prevention and early intervention in mainstream activity across health and social care, responding to the principles and priorities within the Edinburgh Community Planning Partnership Prevention Strategic Plan
- develop a shared understanding of the pattern of current resource use in order to consolidate the specific resources available for investment in preventative activity
- take an evidence based approach to agreeing specific priorities for future investment in prevention and early intervention across the partnership and in collaboration with community planning partners, citizens and communities

What are the next steps we need to take?

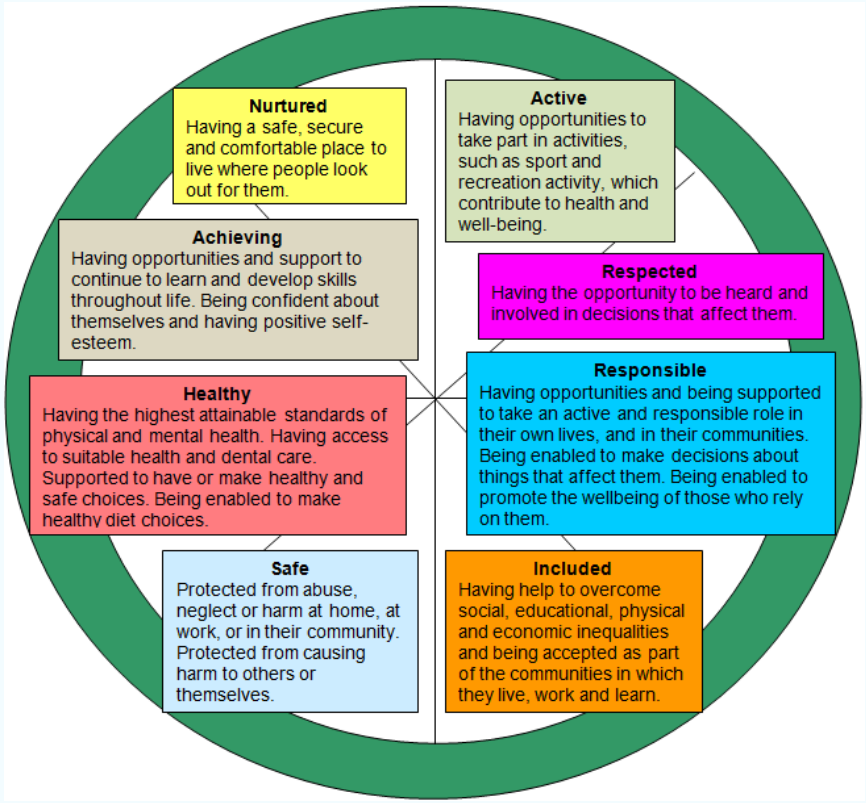
- Consolidate our understanding of those health and social issues where prevention and early intervention can have the biggest impact and the approaches that are most effective.
- Encourage GPs and housing providers to use the data available within the JSNA at neighbourhood level to jointly identify and support people at risk.
- Produce a prevention and early intervention strategy and action plan setting out the:
    - specific outcomes we are seeking to achieve
    - actions we will take
    - timescales for delivery
    - resources required
    - how we will know we have been successful

Person centred care

Why is it a priority?

Changing public expectations about public services over the years have led to recognition that “one size does not fit all” and that the most effective way of meeting people’s needs is to see them as a whole person with goals and strengths; rather than just seeing the condition or problem with which they need support. Increasing demand for services together with limited resources means that the relationship between health and social care services and the people who use them needs to change, so that citizens are no longer passive recipients of services but become active partners in making decisions about and managing their own needs based on what is important to them and their community.

The Wellbeing Wheel opposite sets out the person centred outcomes that the Edinburgh Health and Social Care Partnership seeks to achieve for all citizens in order to improve their health and wellbeing, whilst recognising that the way to achieve them will vary from person to person.



What do we know?

- The environment within which people live has a significant impact on their health and wellbeing and must be taken into consideration in planning to their meet their needs.

- We are all experts in our own lives and our views are therefore vital in reaching informed decisions about our health and wellbeing.
- Care and support that takes account of the things that are important to us and helps us to achieve our goals and live our lives in ways that we choose, is likely to be more effective and improve our mental and physical wellbeing.
- We all have our own strengths, which we can contribute to improving the lives of our communities.
- Enabling people to exercise more choice and control over their lives by deciding how their social care needs might be met and managing their support through a direct payment or adopting self management approaches to long term conditions, has the potential both to improve people's overall wellbeing and make more effective use of scarce resources.
- Many people want to play a more active role in their health care, and there is growing evidence that approaches to person-centred care such as shared decision making and self-management support can improve a range of factors, including patient experience, care quality and health outcomes.
- Involving carers and family members in decisions about the best way to meet needs can lead to better outcomes.

What are we already doing?

- We have implemented outcome focused assessments within adult social care that encourage a conversational approach to identifying people's needs and the personal outcomes that are important to them.
- Self-directed support enables people to exercise more choice and control about how their social care needs are met and managed.
- Exploring new ways to meet and manage people's needs such as service user owned cooperatives.
- Engaging with patients in primary care in more person centred ways through approaches such as Headroom and House of Care.
- Supporting people who need to move home to help them live independently by recognising this as a priority in the allocation system for council and housing association tenancies in Edinburgh.
- Working collaboratively with citizens in the planning, development and evaluation of services.

What opportunities does integration offer?

- Integration and the move to locality based working offers significant opportunities to shape health and social care services around the needs of specific communities, engage with those communities in the planning and delivery of services and strengthen the capacity and resilience of communities.

What are the next steps we need to take?

- Embed the principles of person centred care across the health and social care workforce through our workforce development plan.
- Ensure that citizens have access to information, advice and support to make informed decisions about their health and wellbeing and are enabled to manage their own care where they choose to do so.
- Invest in approaches such as self management, self-directed support and technology enabled care that increase independence and allow people to take more control over their lives.
- Establish clear mechanisms through the development of the strategic plan that embed collaboration with citizens and communities in service planning and delivery.
- Maximise opportunities to coordinate care delivery to reduce the number of times people have to tell their story.

Providing the right care in the right place at the right time

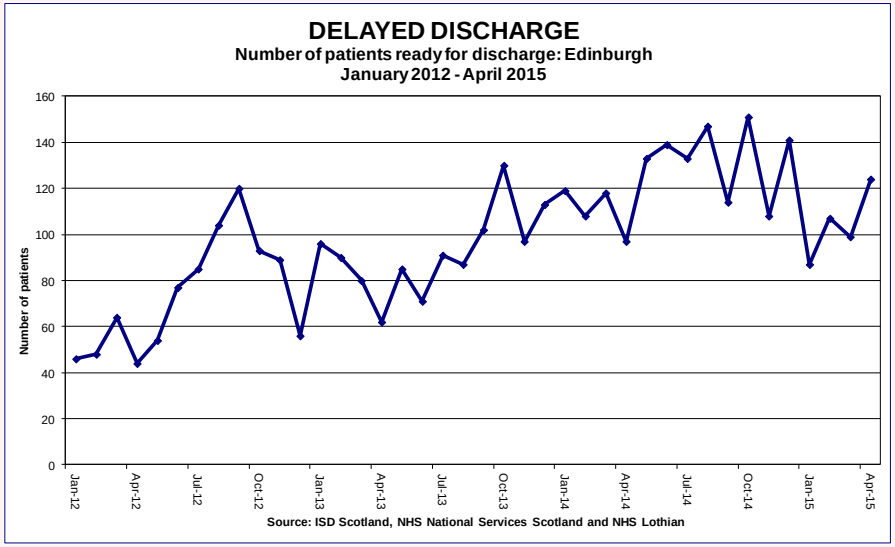
Why is it a priority

Most people want to live healthy, meaningful, independent lives for as long as possible, and if they do need support they would prefer to be looked after at home or in a homely setting, and to die there if possible. We know that hospitals are not a good environment for providing longer term care when the needs of the individual could be met in a community setting. We therefore need to change our systems to be able to respond to people's needs in a more timely and person centred way that is focused on promoting wellbeing and living well, preventing deterioration, maintaining independence and providing people with a positive

experience of health and social care services. Where it is necessary for people to receive treatment in hospital, their admission should be planned if possible, and their discharge well managed to ensure they can return home safely without any unnecessary delay.

What do we know?

- We are spending a great deal of public money to keep people in the wrong place through delaying their discharge from hospital and having to make use of high cost placements outside Edinburgh, due to a lack of appropriate resources. There are particularly long delays in discharge to appropriate community aftercare for people with mental health problems, i.e. those with dementia, brain injury and learning disabilities.
- Remaining in hospital once acute care needs have been addressed is bad for people's overall wellbeing, resulting in loss of confidence and independence.
- The predicted increase in the size of the population in Edinburgh will lead to an increase in demand for services across health and social care.



- GPs and other community health services, such as community nursing, occupational therapy, physiotherapy, and podiatry play an important part in helping the majority of people to stay well, and able to look after themselves and their families. These services are under severe pressure, with rising workloads and significant workforce challenges.
- The demand for care at home services has been increasing by around 15% each year, leading to waits for care, a current service gap of around 5,000 hours per week, and unsustainable budget pressures for social care.
- Changing the models of care and support across the system is a priority to meet current and future care needs. Evidence from elsewhere shows that a more integrated network of preventative community services providing timely access to health and care support could avoid a proportion of admissions to acute hospital and be more effective in supporting people to recover and keep

well.

- Many people experiencing crisis and those involved in supporting them do not know which services can meet their needs or how to access them. As a result, there are delays in getting access to the right care and some groups of people are more likely to reach crisis point before accessing services.
- There are inconsistencies in the pathways and models of care for people with long term conditions/multi-morbidities.

What are we already doing?

- The third and independent sectors, housing organisations and communities are delivering a wide range of services to help people to live as independently as possible at home, and connect with their local communities.
- Developing ways of working that bring together local resources around the needs of local people, particularly those who find it difficult to engage with statutory services as they are currently provided.
- Developing a redesign programme called “Improving Older People’s Care in Edinburgh” which aims to develop community health and social care capacity for older people in Edinburgh and would lead to the withdrawal from out-dated hospital facilities such as Liberton and the Royal Victoria Hospitals.
- Redesigning mental health services to support more people in their own home and community, including the redevelopment of the Royal Edinburgh Hospital.
- Introducing innovative Locality Partnership Models for mental health and substance misuse services, which will promote open access and self referral within locality settings.
- Developing a redesign programme for specialist learning disability services, which will allow more people with complex needs to live in community settings, and reduce the need for hospital based care.
- Working with housing providers to design the right housing and care solutions within neighbourhoods.
- Evaluating a range of recent pilots and short-term funded projects which aim to improve the interface between communities, primary and community services and specialist hospital based support for older people.
- Evaluating the impact of pathway redesign for people with long term conditions, which includes anticipatory care planning and

supported self management along with joint team working between hospital and community staff to meet patients' needs at home, reducing emergency admissions and promoting timely discharge.

- Exploring new models of housing provision for older people under the Edinburgh Housing Strategy.
- Using our adaptations budgets to help people live at home as independently as possible.

What opportunities does integration offer?

- Integration provides the opportunity to develop a shared set of priorities and a shared understanding of the right models of care for people and communities, and where, when and by whom care and support should be provided in order to inform shared decisions about the use of available resources.

What are the next steps we need to take?

- A high priority is to agree an improved and consistent service model for frail older people and those with dementia, which anticipates and plans for needs, is responsive, makes community and home-based care the norm, avoids unnecessary admissions to hospital, and promotes timely healthcare, social care and reablement to maximise independence.
- Develop a strategy and action plan in relation to long term conditions to support the delivery of 'Many Conditions, One Life – Living Well with Multiple Conditions'.
- A critical part of modernisation and redesign of NHS Lothian learning disability services is the development of community services for people with forensic needs, autism and behaviours that challenge leading to a reduction of hospital admissions.
- Develop an integrated approach to technology enabled care/eHealth across the Health and Social Care Partnership.
- Implementation of a locality partnership model for the delivery of recovery orientated mental health services.
- Work with partners, including people and communities to establish the four localities detailed in this plan, as the basis for service planning and delivery at a community level.

Making best use of capacity across the whole system

Why is it a priority?

Increasing demand and severely limited resources make the current system of providing health and social care services in Edinburgh unsustainable. We can only deliver our priorities of tackling inequalities, preventing poor health and promoting wellbeing through early intervention and delivering the right person centred care, in the right place, at the right time, by working collaboratively with our partners (citizens, communities, statutory agencies, housing providers and the third and independent sector) to make the best use of all our skills and resources.

What do we know?

- Primary care, social care and community health services, such as community nursing, physiotherapy, and podiatry are under severe pressure with rising workloads and significant workforce challenges. These include an ageing workforce, staff numbers not increasing to match population growth, and in some cases, decreasing to meet cost reductions.
- General Practitioner (GP) numbers have not kept pace with the growth in population and recruitment of doctors into primary care is an urgent problem in Lothian as it is across Scotland.
- Unpaid carers are a vital resource in meeting health and social care needs and must be appropriately supported to maintain their own health and wellbeing whilst carrying out their caring role.
- The third sector plays a critical role in strengthening community resilience and supporting people to take more control over their own lives through adopting self management approaches, for example.
- Having a warm, dry, safe and affordable place to live has a significant impact on people's wellbeing.
- Independent sector providers deliver 70% of care at home services in the city to those aged 65+.
- Many of the issues that impact on health and wellbeing can be more effectively addressed by universal and non specialist

services; however, GPs, social workers and others working with people to identify the best way of meeting their needs are often not aware of services and support available locally within the community or through the third sector.

What are we already doing?

- Working with a range of partners to plan, deliver and evaluate services collaboratively.
- Identifying and implementing a range of measures to manage and address the lack of capacity within primary and social care.
- Working with the third sector to pilot innovative ways of supporting people to maintain their independence and wellbeing through specific funding streams such as the Reshaping Care and Self-directed Support Innovation Funds.
- Making good use of adaptations and of housing support to help people remain independent and living at home.
- Making links between the Health and Social Care Partnership and the wider Community Planning Partnership and between work taking place to implement the integration of health and social care with initiatives such as the Council's Transformation Programme and the Health Board's efficiency and productivity agenda to achieve integration across the whole system.
- Providing support to unpaid carers by funding a range of open access information and advice services and providing specific tailored services, such as support to carers when the person they care for is discharged from hospital and involving the carers and families of people with learning disabilities and complex needs in planning their future care.
- Developing peer support approaches, which involve people with lived experience in supporting others with mental ill health and complex needs through recovery.
- Working with partners to develop opportunities for volunteering, which can improve the wellbeing of both the volunteer and the person they support.
- Engaging with initiatives that are developing multi-agency approaches to community based working.

What opportunities does integration offer?

- The recognition of the importance of integrated service planning and delivery at a locality level across the Edinburgh Community Planning Partnership represents a significant opportunity to improve the health and wellbeing of citizens beyond the integration

of health and social care, through the development of ways of working that break down organisational, professional and budgetary silos and actively involve local people, providers and communities.

- The focus on localities, neighbourhoods and communities of interest should allow better identification of those at risk of loneliness and social isolation and identification of local opportunities for social connections which help individuals to build personal resilience.

What are the next steps we need to take?

- Further develop our understanding of the characteristics and needs of locality and neighbourhood populations, and as locality working develops, consider how this already is and can further be met by the range of resources within the statutory, third and independent sectors and local communities themselves.
- As part of our organisational development plan, engage with staff, wider stakeholders and the public to improve communication and shared understanding across those involved in planning, commissioning and delivering care, and consider the new ways of working needed by all to deliver the benefits of integration and locality working.
- To work with GP practices to ensure they are able to sustain services and build on work already underway to improve the recruitment and retention of GPs as the core community based medical decision-makers, so that people in Edinburgh can get access to local primary care services in a timely way.
- Work with the three other partnerships in Lothian to review community nursing, recognising this as a vital core workforce, which complements general practice in helping people to remain living independently at home.
- To progress the establishment of clinical pharmacists in GP practices in line with the Prescription for Excellence.
- Work with communities, the third sector and housing providers to identify and develop ways of supporting people to remain independent within communities, accessing and using formal health and social care services only where necessary.
- Understand how the capacity available under the local Housing Strategy can contribute to the outcomes for Health and Social Care.

Managing our resources effectively

Why is it a priority?

When faced with increasing demands for services and limited resources with which to meet those demands, it is essential that we make every penny count. Delivering the right care in the right place at the right time requires us to shift the balance of care from hospital to home in the community and ensure that our resources are deployed accordingly, in order to deliver on our priorities and improve the health and wellbeing of the citizens of Edinburgh as set out in this draft plan.

What do we know?

- Meeting avoidable demand is not an effective use of resources. Examples of avoidable demand currently in our system include the impacts of poverty and unhealthy lifestyles, delayed discharges, blockages in reablement due to a lack of suitable community based services, a proportion of falls, and of emergency hospital attendances and admissions.
- If people are to remain living independently for as long as possible, they need affordable and accessible homes to live in. However such housing stock in Edinburgh is in short supply, which is also an issue for the health and social care workforce, many of whom are on relatively low incomes.
- The projected increase in demand for services cannot be met through existing service models. Current recruitment difficulties in both health and social care indicate that the numbers of additional staff required are not available, even if such increases were affordable.
- Expenditure on NHS Lothian services accounted for 71% of total health and social care expenditure in 2012/13 with expenditure on “inpatient” care accounting for 27.7% of the total budget.
- 75% of hospital inpatient care is accounted for by emergency/unplanned admissions, although the rate of such admissions remained constant over the 5 years 2009/10 to 2013/14.
- 2.4% of Edinburgh residents account for 50% of total health care costs and 8.4% of residents account for 50% of social care expenditure.
- Significant increases in the number of people choosing to manage their own social care support through the use of direct

payments suggests that more people are willing to take control over the way in which their social care needs are met.

- Changes to welfare reform will impact negatively on health and wellbeing.

What are we already doing?

- One of the most effective ways of reducing the number of people staying in hospital for longer than medically necessary is to reduce the number of people being admitted to hospital unnecessarily. The fact that the rate of hospital admissions has remained steady in the face of increasing demand should be seen as an achievement, although we must strive to do better.
- The third sector organisations working in partnership with NHS Lothian are supporting people with long term conditions to manage those conditions themselves.
- Supporting community based staff to provide person centred end of life care, that allows people to die at home or in a homely setting, rather than being admitted to hospital unless medically necessary.
- Exploring opportunities to address the capacity issues in particular service areas and professions, such as GPs, by reshaping the roles of other members of the workforce.

What opportunities does integration offer?

- Pooled budgets provide the opportunity to release resources tied up in out-dated hospitals to invest in better community based care and support.
- The planned reprovisioning of hospitals and public sector property rationalisation programmes, innovative approaches to land use, funding and delivery mechanisms may provide opportunities to create new affordable homes in sustainable communities.
- Better planning and coordination of services at points of transition between child and adulthood and between hospital and community based support.
- Locality focused working should enable more effective care planning for the relatively small number of people at any one time, who are high users of health and care services and who account for 50% of total resource use.
- Collaboration between partners has the potential to foster new ways of working that make best use of the differing skills and expertise of all partners.

What are the next steps we need to take?

- Address issues of demand and capacity and our financial position, which cannot meet current, let alone future demand, through a robust needs assessment and strategic commissioning plan with an aligned financial plan.
- Work with our other strategic partners in the Edinburgh Community Planning Partnership to establish the four localities as a basis for locality planning and delivery, which makes the best use of the resources of all partners, including local communities and the people who live in them.
- Review the profile and skill mix of our workforce in the light of the opportunities to work with our partners in different and a more joined up ways through integration.
- Explore the opportunities offered by working at a locality level to meet the needs of citizens through supporting them to access community assets rather than formal services.
- Take an integrated approach to workforce development across all partners.
- Co-ordinate and integrate the care and support offered to those living with multiple long term conditions seamlessly and efficiently to improve outcomes, rather than within condition specific silos.
- Build on the development of the Joint Strategic Needs Assessment to embed a joined up approach to data collection, sharing and analysis across the Health and Social Care Partnership and its partners.
- Explore the opportunities to integrate and share resources including accommodation, wherever possible and appropriate.
- Explore the full potential of technology not only to support people to live independently and remove the need for more intensive support, but also to support efficient and effective integrated and joined up working.
- Ensure that commissioning and procurement approaches are collaborative, proportionate, locality and neighbourhood focused, do not act as a barrier to small specialist organisations entering the market and deliver best value.
- Explore new models of housing provision for older people under the Edinburgh Housing Strategy.
- Using our adaptations budgets to help people live at home as independently as possible.

Appendices

Appendix A	Delegated functions and services diagram
Appendix B	Strategic planning framework
Appendix C	Membership of the Strategic Planning Group

Appendix A
Services that are part of the Edinburgh Health and Social Care Partnership

Adult Social Care Services

- Assessment and Care Management-including Occupational Therapy services
- Residential Care
- Extra Care Housing and Sheltered Housing (Housing Support provided)
- Intermediate Care
- Supported Housing-Learning Disability
- Rehabilitation-Mental Health
- Day Services
- Local Area Coordination
- Care at home services
- Reablement
- Rapid Response
- Telecare
- Respite services
- Quality assurance and Contracts
- Specialist Services-Sensory Impairment, Drugs and Alcohol

Community Health Services

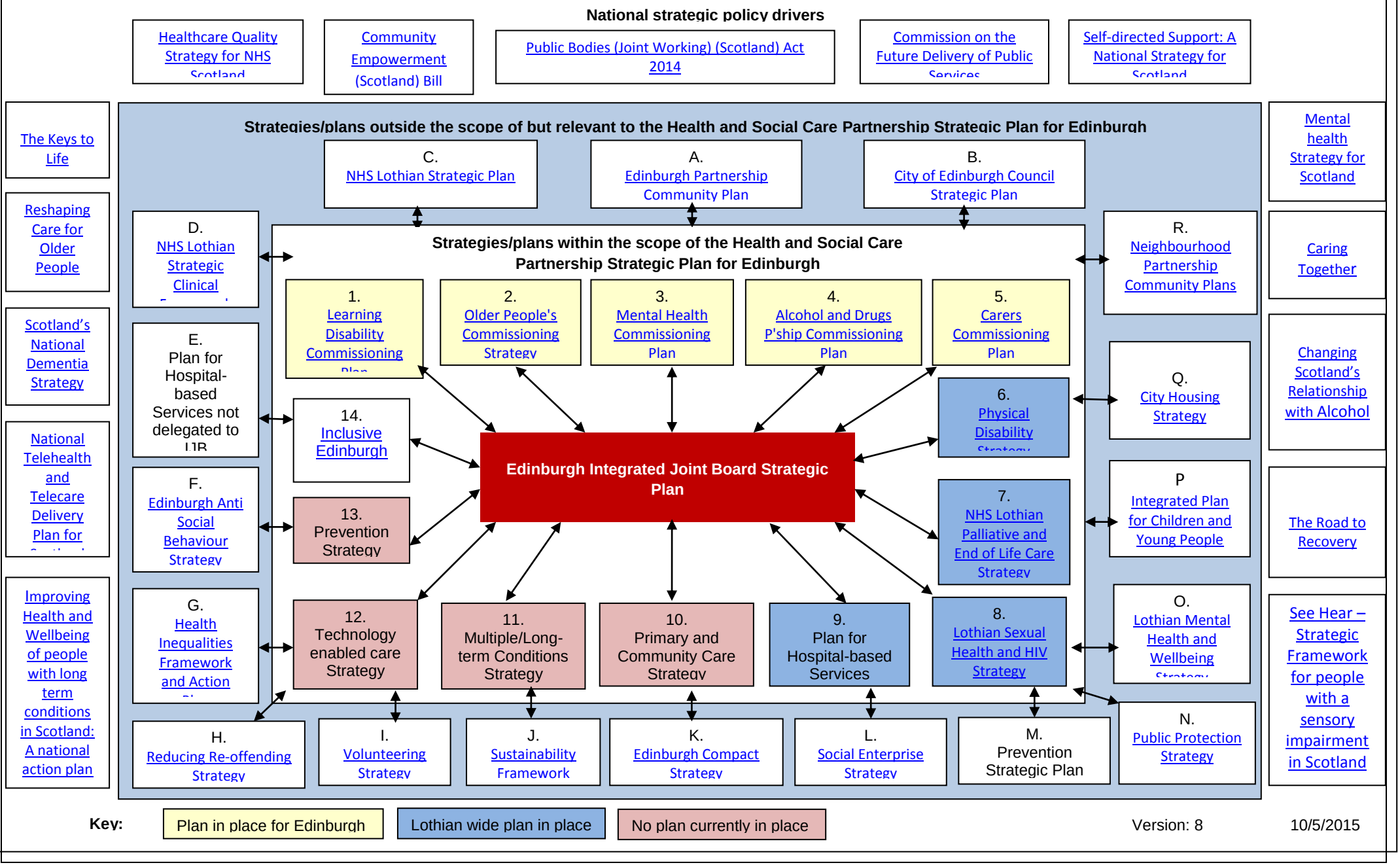
- District Nursing
- Services relating to an addiction or dependence on any substance.
- Services provided by AHPs
- Public dental service
- Primary medical services (GP)*
- General dental services*
- Ophthalmic services*
- Pharmaceutical services*
- Out-of-Hours primary medical services
- Community geriatric medicine
- Palliative care
- Mental health services
- Continence services
- Kidney dialysis
- Prison health care service
- Services to promote public health

*Includes responsibility for those aged under 18

Hospital Based Services

- A&E
- General medicine
- Geriatric medicine
- Rehabilitation medicine
- Respiratory medicine
- Psychiatry of learning disability
- Palliative care
- Hospital services provided by GPs
- Mental health services provided in a hospital with exception of forensic mental health services
- Services relating to an addiction or dependence on any substance.

Appendix B


National strategic policy drivers
Healthcare Quality Strategy for NHS Scotland
Community Empowerment (Scotland) Bill
Public Bodies (Joint Working) (Scotland) Act 2014
Commission on the Future Delivery of Public Services
Self-directed Support: A National Strategy for Scotland
The Keys to Life
Reshaping Care for Older People
Scotland's National Dementia Strategy
National Telehealth and Telecare Delivery Plan for
Improving Health and Wellbeing of people with long term conditions in Scotland: A national action plan
Strategies/plans outside the scope of but relevant to the Health and Social Care Partnership Strategic Plan for Edinburgh
C. NHS Lothian Strategic Plan
A. Edinburgh Partnership Community Plan
B. City of Edinburgh Council Strategic Plan
D. NHS Lothian Strategic Clinical
E. Plan for Hospital-based Services not delegated to
F. Edinburgh Anti Social Behaviour Strategy
G. Health Inequalities Framework and Action
Strategies/plans within the scope of the Health and Social Care Partnership Strategic Plan for Edinburgh
1. Learning Disability Commissioning
2. Older People's Commissioning Strategy
3. Mental Health Commissioning Plan
4. Alcohol and Drugs P'ship Commissioning Plan
5. Carers Commissioning Plan
6. Physical Disability
7. NHS Lothian Palliative and End of Life Care Strategy
8. Lothian Sexual Health and HIV Strategy
9. Plan for Hospital-based Services
10. Primary and Community Care Strategy
11. Multiple/Long-term Conditions Strategy
12. Technology enabled care Strategy
13. Prevention Strategy
14. Inclusive Edinburgh
Edinburgh Integrated Joint Board Strategic Plan
H. Reducing Re-offending Strategy
I. Volunteering Strategy
J. Sustainability Framework
K. Edinburgh Compact Strategy
L. Social Enterprise Strategy
M. Prevention Strategic Plan
R. Neighbourhood Partnership Community Plans
Q. City Housing Strategy
P Integrated Plan for Children and Young People
O. Lothian Mental Health and Wellbeing
N. Public Protection Strategy
Mental health Strategy for Scotland
Caring Together
Changing Scotland's Relationship with Alcohol
The Road to Recovery
See Hear – Strategic Framework for people with a sensory impairment in Scotland
Key:
Plan in place for Edinburgh
Lothian wide plan in place
No plan currently in place
Version: 8
10/5/2015

Appendix C

Strategic Planning Group – remit and membership

Remit

The legal requirement to review and refresh the strategic plan every three years means that the planning process will be ongoing throughout the life of the plan. The Strategic Planning Group will have an ongoing role once the first plan for Edinburgh has been produced. The remit of the Strategic Planning Group will be to:

- collaborate in the preparation of the strategic plan, including:
  - developing recommendations about the content
  - developing the plan itself, including being part of sub-groups working on aspects of the plan
  - consultation on the plan within the groups they represent and through wider public consultation
- act as a critical friend to the Integration Joint Board when consulted on any decisions that need to be made outside the strategic planning framework or when consulted on any other matter

Membership

SPG Member	Role	Group to be represented	Arrangements for appointment of representative
Councillor Ricky Henderson (Chair)	Vice Chair of Edinburgh Integration Joint Board	City of Edinburgh Council	
George Walker (Vice chair)	Chair of Edinburgh Integration Joint Board	NHS Lothian	
Alex McMahon	Director of Strategic Planning, Performance Reporting & Information	NHS Lothian	Nominated by NHS Lothian
Angus McCann	Non voting member of Edinburgh Integration Joint Board (Citizen representative - users of health and social care services)	Users of health and social care services	Non voting members of Edinburgh Integration Joint Board

SPG Member	Role	Group to be represented	Arrangements for appointment of representative
Beverley Marshall	Non voting member of Edinburgh Integration Joint Board (Citizen representative - users of health and social care services)	Users of health and social care services	
Christine Farqhar	Non voting member of Edinburgh Integration Joint Board (Citizen representative - carer)	Carers of users of health and social care services	
Sandra Blake	Non voting member of Edinburgh Integration Joint Board (Citizen representative - carer)	Carers of users of health and social care services	
Colin Beck	Senior Manager Mental Health, Criminal Justice and Substance Misuse	Social care professionals	Nominated by the Professional Advisory Committee
Angela Lindsay	Allied Health Professionals Manager	Health professionals	
Rene Rigby	Independent Sector Development Officer, Scottish Care	Commercial providers of social care	Nominated by Scottish Care
Graeme Henderson	Director of Services and Development, Penumbra	Non-commercial providers of social care	Nominated by Edinburgh Voluntary Organisations Council (EVOC)/ Coalition of Care and Support Providers in Scotland (CCPS)
Blackmore, Lesley	Strategic Development Manager. Lothian Community Health Initiatives Forum	Non-commercial providers of health care	
Fanchea Kelly	Chief Executive, Blackwood Housing Association	Non-commercial providers of social housing	Nominated by Edinburgh Affordable Housing Partnership
Ella Simpson	Non voting members of Shadow Health and Social Care Partnership/IJB representing the Third Sector	Third sector organisations carrying out activities related to health or social care	Non voting members of Edinburgh Integration Joint Board
Michele Mulvaney	Community Engagement Manager	Localities	Nominated pending establishment of representation
Henry Coyle	Neighbourhood Manager	Localities	

SPG Member	Role	Group to be represented	Arrangements for appointment of representative
Anna Herriman	Participation and Information Manager	Localities	for proposed four localities