



Edinburgh Health and Social Care Partnership

# Draft Strategic Plan Summary

Working together for a caring,  
healthier, safer Edinburgh

**NHS**  
Lothian

•EDINBURGH•  
THE CITY OF EDINBURGH COUNCIL

# Welcome to our strategic plan

From April 2016 responsibility for the planning and operational oversight of some services will pass from the City of Edinburgh Council and NHS Lothian to a new body called the Edinburgh Health and Social Care Partnership.

The Health and Social Care Partnership is governed by a body called the Edinburgh Integration Joint Board.

This change is happening across Scotland not just in Edinburgh and is referred to as the 'integration of health and social care'.

As part of the process of establishing the Health and Social Care Partnership we are required to produce a strategic plan explaining how the services we will be responsible for are to be delivered in order to meet a set of nationally agreed health and wellbeing outcomes.

Part of the rationale behind the integration of health and social care is that the current way of delivering these services is no longer sustainable due to:

- an increase in demand – the population of Edinburgh accounts for 9% of the total population of Scotland and is projected to continue to grow more rapidly than other areas
- the challenging financial climate – over the next five years the City of Edinburgh Council must reduce its operating costs by £107 million, while Lothian Health Board needs to make efficiency savings of around £40 million year-on-year to reinvest in services to meet changing needs

The integration of health and social care offers a great opportunity to deliver joined up services both city-wide and across the four localities that we will use as the basis for service planning and delivery.

Integration also gives us the chance to change the relationship between citizens and communities, our services and staff and the many organisations who contribute to 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.

We want our first 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 draft plan and we are keen to get the views and perspectives of as many people as possible to help turn our vision into a set of radical, achievable and affordable actions that transform the health and social care landscape in Edinburgh for all our benefit. Details of how you can comment on the draft strategic plan are given at the end of this document.



**George Walker**

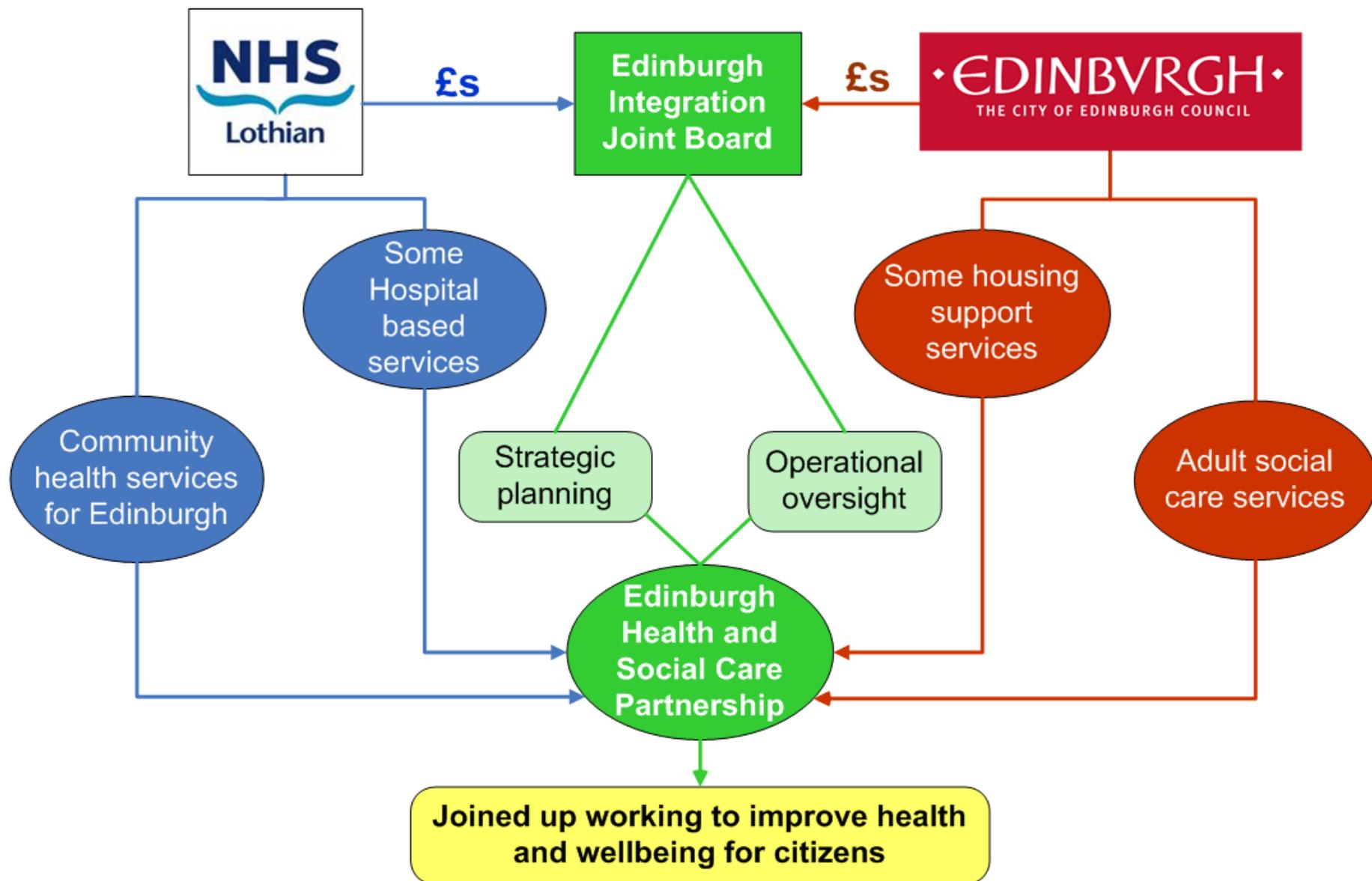
Chair of the  
Edinburgh Integration  
Joint Board



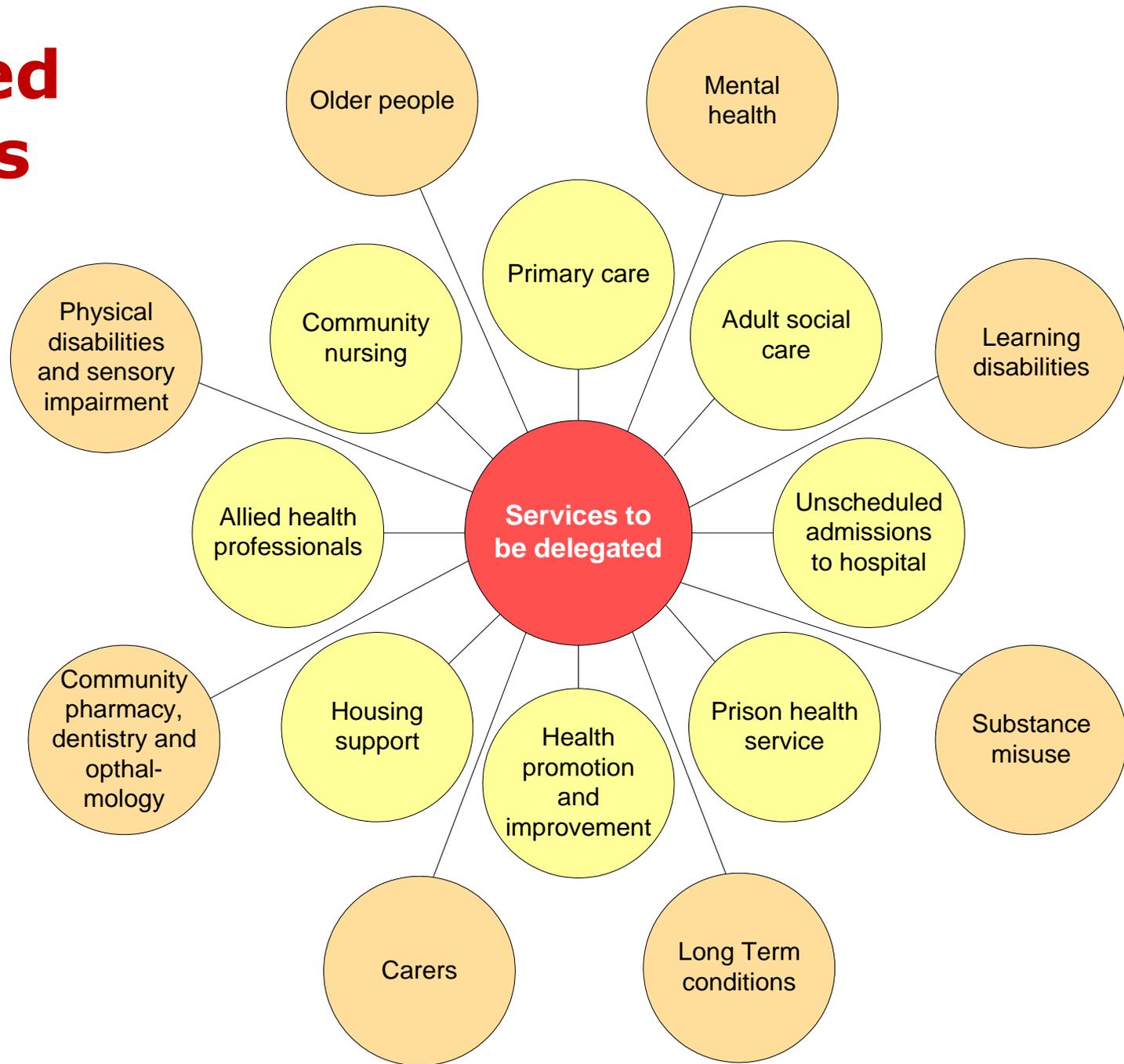
**Ricky Henderson**

Vice chair of the  
Edinburgh Integration  
Joint Board

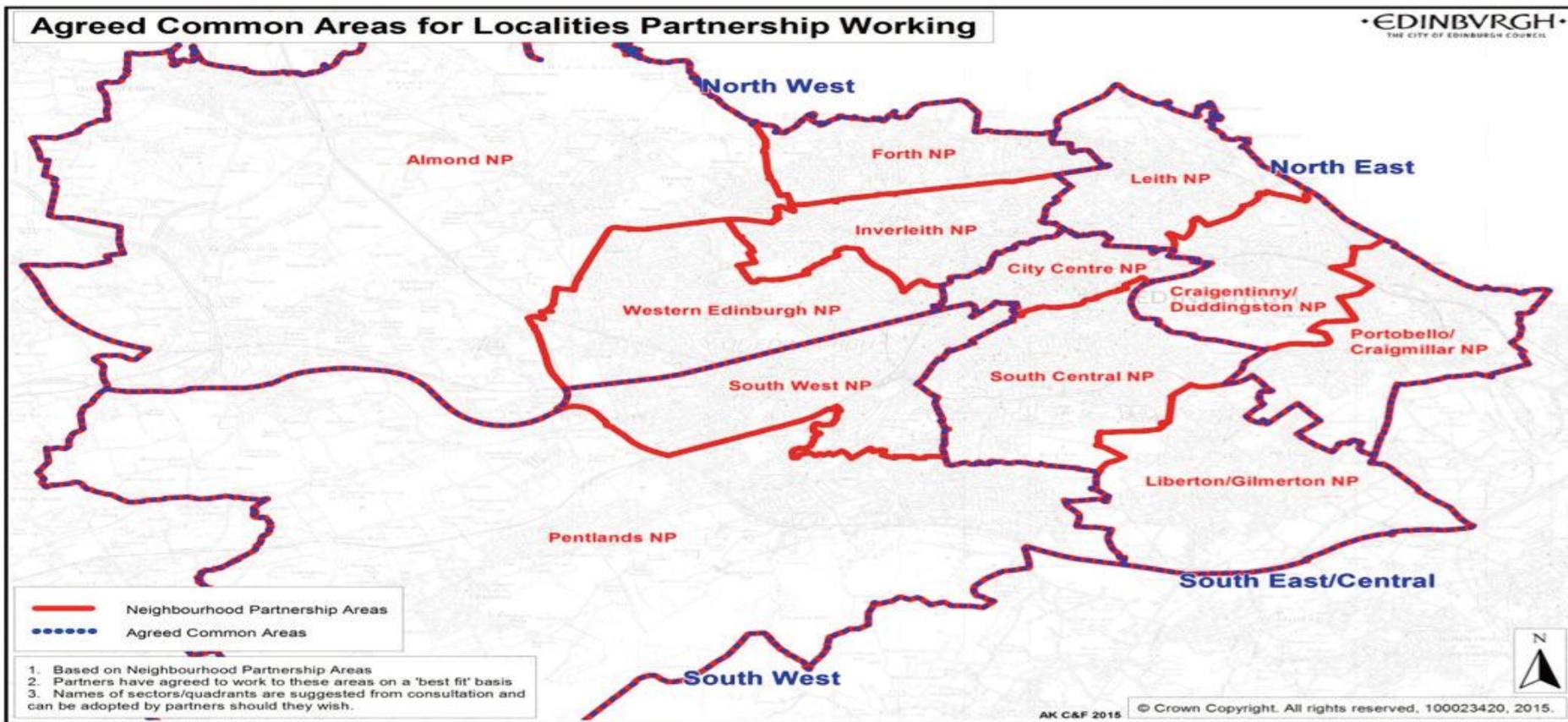
# What is integration?



# Delegated functions and services



# Four localities



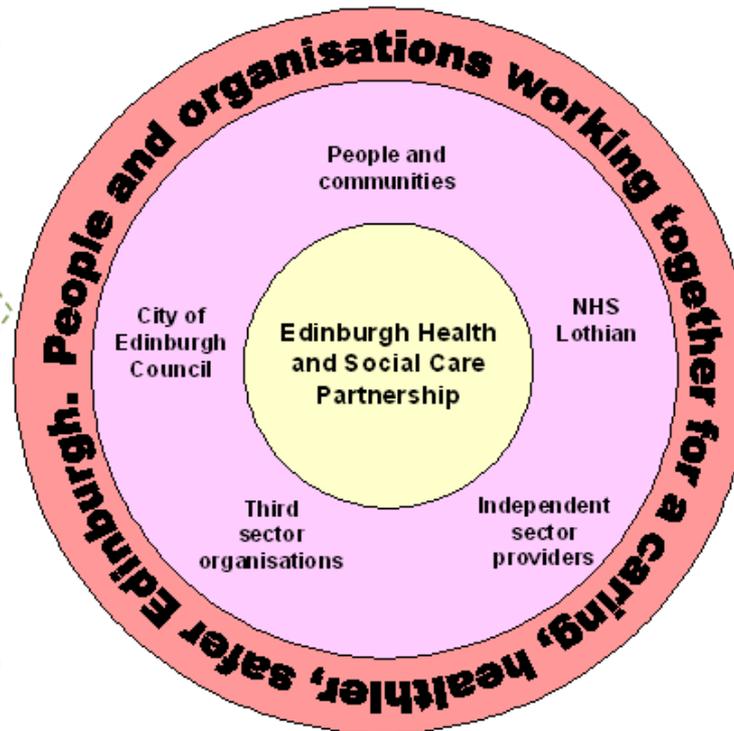
| Locality                   | Neighbourhood Partnerships                                 | Population     |
|----------------------------|--|----------------|
| <b>North West</b>          | Almond, Forth, Inverleith and Western Edinburgh            | 138,995        |
| <b>North East</b>          | Leith,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

## 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.

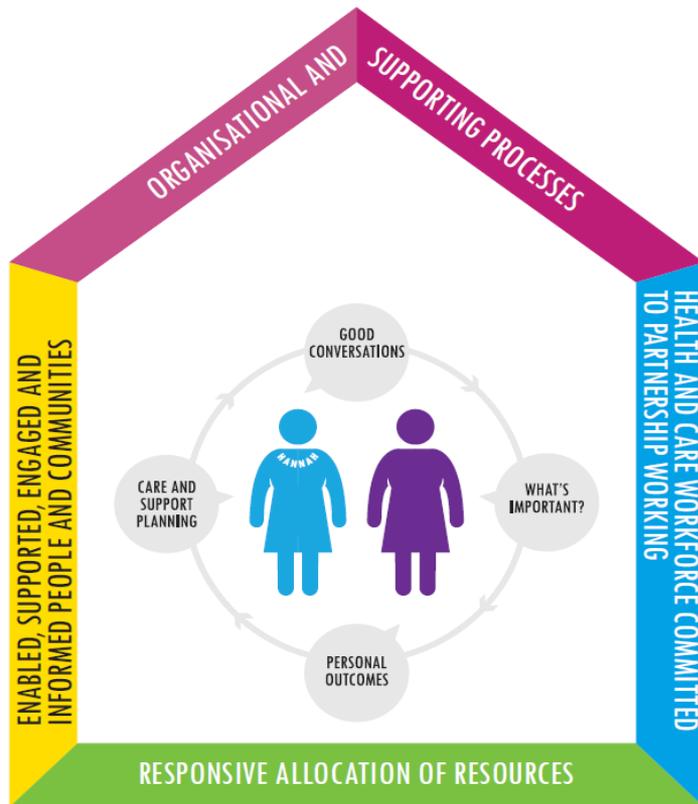


Organisations involved in the delivery of health and social care services will work in partnership with people and communities, using best practice approaches in engagement and involvement, to deliver improved and fully-integrated health and social care services for the people of Edinburgh.

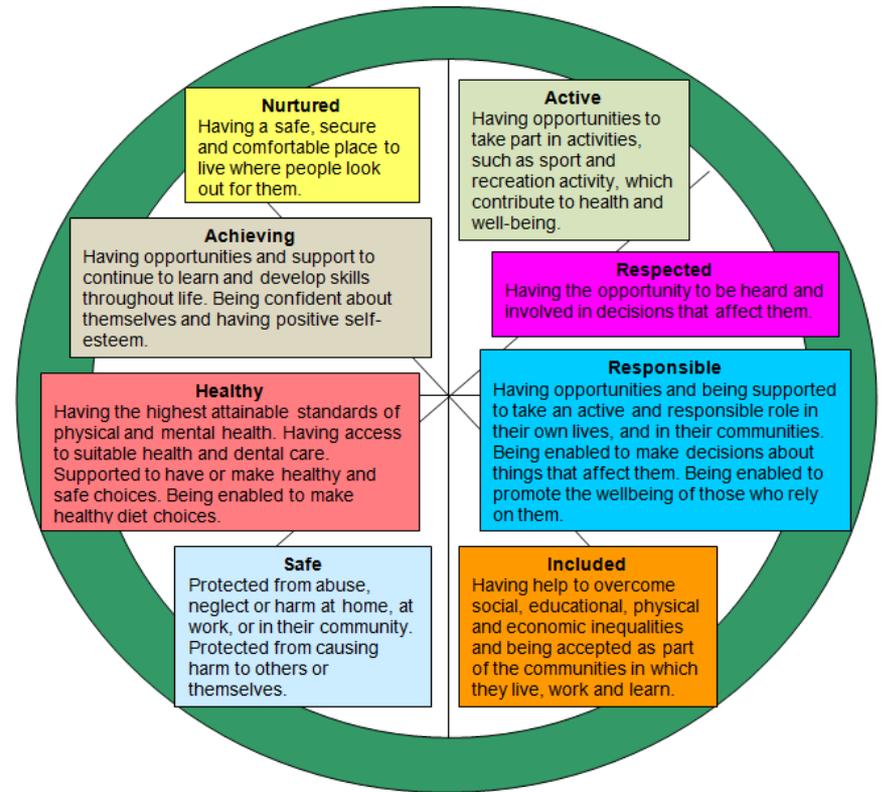
Organisations involved in the delivery of health and social care services will work collaboratively to develop, train and support staff from all organisations to work together, respond appropriately and put the needs of the people we work with first.

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

## Relationships are at the heart of integration



## The outcomes we want for people



# Changes we need to make

## Old ways of working

## Current ways of working

## Where we want to be by 2020

Planning and delivery of services is determined by statutory agencies



Planning and delivery of services is led by statutory organisations with some engagement with the third and independent sector and people who use services



People and communities work with local organisations to determine priorities and plan, design, deliver and evaluate services

People in need of care and support are passive recipients of services and carers are undervalued

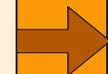


Decision making about how people's care and support needs are met is led by statutory agencies with some collaboration with the people themselves



People, their families and carers decide how their care and support needs should be met and take control over their own health and wellbeing

Specific services are reactive and focused on supporting those with most acute needs

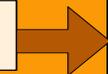


Some services are focused on prevention, early intervention, reablement and recovery in order to support people to maintain or regain their independence

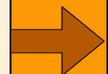


Prevention, early intervention, reablement and recovery are a priority and designed and embedded in communities that are resilient, diverse and inclusive

Specialist health care is largely hospital based

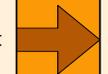


We are starting to understand the need to develop community based services which avoid the need for hospital-based care



Specialist services are available within the community with access to hospital based services when necessary

Health and social care services are organised around episodic events and delivered by teams working within organisational silos, as a result of which people have poor experiences of moving between services

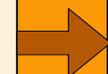


Some integrated services have been developed and there is a recognition of the need for more joined up working based around care pathways

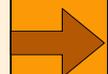


Services are integrated and organised to deliver personalised care and support

Environments are based on the need for housing



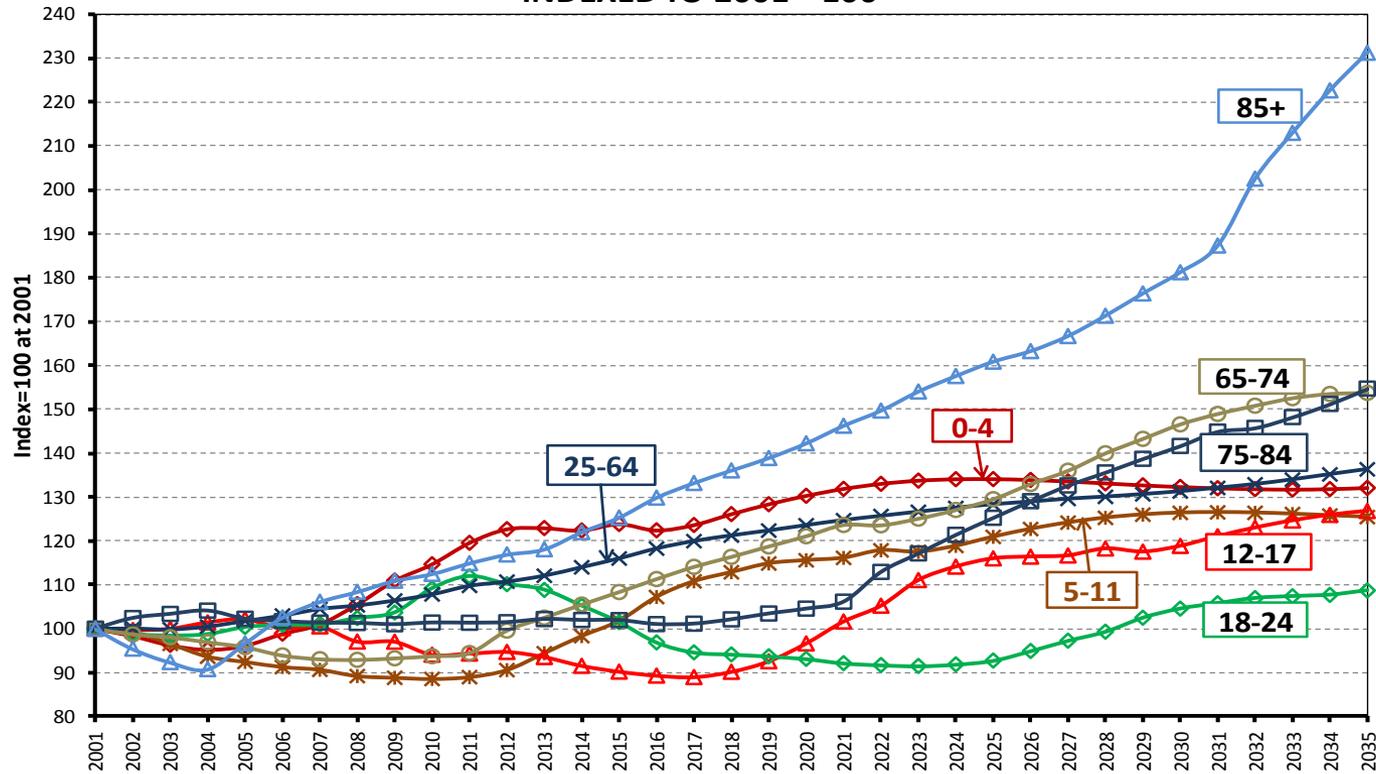
We are starting to consider the impact that the environment has on health and wellbeing and involve people in their design



Communities are engaged in the design and delivery of healthy environments

# Understanding our population

EDINBURGH'S POPULATION BY AGE-GROUP 2014-2037  
INDEXED TO 2001 = 100



Population base: NRS Mid-year Population Estimates (2001-2013), NRS 2012 Based Population Projections (2014-2035).

# Understanding our localities

## South West

### Population

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

### 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

- Second largest population: 126,148
- Largest proportion of persons aged 16 – 24 (40.3%) (students)
- Highest concentration of people aged 85+

### 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 (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

## 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 (36,591) with one or more health conditions

### 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%)
- 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

- Smallest population size: 110,550
- Almost half of population is aged 25 to 49
- Largest number of households from a minority ethnic background

### Health

- Highest percentage of people with long term health problems that limit day-to-day activity (8%)
- Highest mortality rate
- 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
- Highest average size of packages of care (hours per week)

### Other

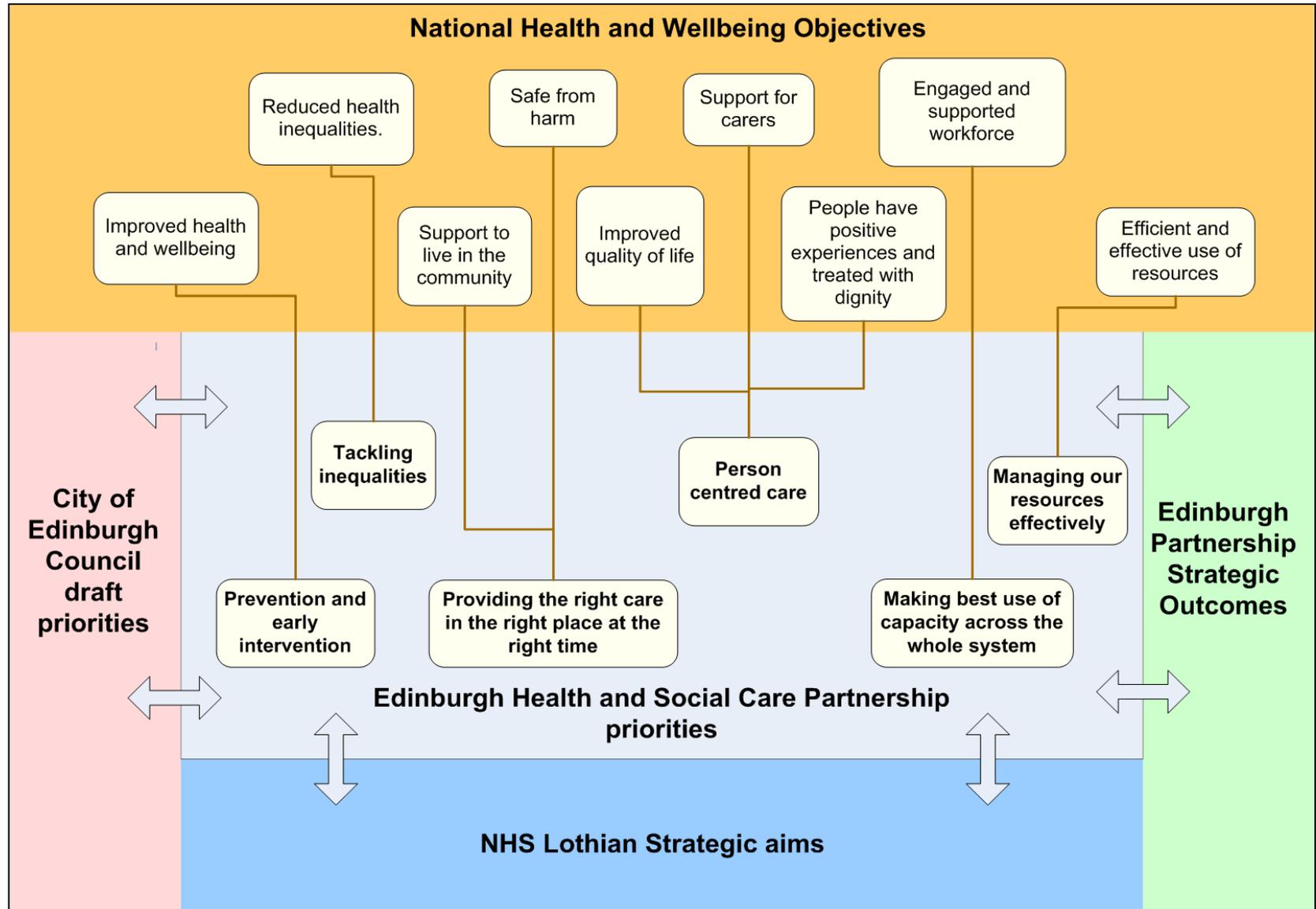
- Highest level of economic activity and employment (68.6%)
- Highest percentage of people living alone (43.8%)
- Highest proportion of intensive unpaid care
- 16.2% of its datazones are in the 15% of areas with the highest levels of 'deprivation' in Scotland

# Understanding our care groups

The vast majority of the population of Edinburgh makes use of health services at some time. This is usually through primary care services such as their GP, pharmacist, dentist or other community health service.

A much smaller number of people make use of social care services and when they do it tends to be because they have needs arising from mental or physical ill health, disability, addictions or frailty due to old age.

# Our key priorities



## What we know:

In Edinburgh, 50% of people experiencing ill health do not live in the areas with the highest areas of deprivation

Target resources more effectively through working collaboratively with citizens and communities at a local level

## What we plan to do:

People living in areas experiencing high levels of deprivation are at risk of:

- dying at a younger age
- developing long term conditions 10 years earlier than those in less deprived areas

Many carers experience poor physical and mental health

In Edinburgh, 12% of people aged 16-74 are unable to work due to a limiting long term illness

Communication difficulties can make it harder for many people from minority ethnic groups and people with disabilities to access services

## 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

Review the remit, membership and priorities of the Health Inequalities Standing Group and consolidate funding available across health and social care to tackle inequalities

Prioritise actions that increase physical activity, and promote healthy eating, healthier environments and better use of green space

Provide information on keeping healthy in an accessible easy read format for people with communication difficulties

## What we know:

Around 40 – 45% of public expenditure is spent of addressing preventable issues

Embed prevention and early intervention in mainstream activity across health and social care

## What we plan to do:

70% of Edinburgh's population has one or more long-term condition, which increases the risk of emergency admission to hospital if not managed

## 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.

Use the data available within the Joint Strategic Needs Assessment to identify and support people at risk

Loneliness has been shown to be as harmful to health as smoking 15 cigarettes a day

Develop a shared understanding of the pattern of current resource use in order seek opportunities to invest in preventative activity that will have the most impact

27% of the population of Scotland is obese (predicted to rise to 40% by 2020) leading to increased risk of diabetes, stroke and coronary heart disease

Produce an evidence based prevention and early intervention strategy and action plan for health and social care

Falls are the leading cause of accident related death in older people - 30% of people over 65 and 50% of those over 80 fall each year

Encourage GPs and housing providers to use the JSNA to jointly identify and support people at risk.

## What we know:

The relationship between health and social care services and citizens needs to change

Establish clear mechanisms that embed collaboration with citizens and communities in service planning and delivery

## What we plan to do:

The most effective way of meeting people's needs is for them to be active partners in making decisions about and managing their own health and wellbeing

## 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.

Engage with staff to embed the principles of person centred care in everything we do

Ensure that citizens have access to information, advice and support to make informed decisions about their health and wellbeing and manage their own care where they so choose

Involving unpaid carers and family members in decisions about the best way to meet needs can lead to better outcomes

There is growing evidence that approaches to person-centred care such as shared decision making and self-management support can improve people's experience, care quality and health outcomes

Reduce the number of times people have to tell their story by better co-ordination of care

Invest in self management, self-directed support and technology enabled care to allow people to take more control over their lives

## What we know:

Changing models of care and support is a priority to meet current and future care needs

Develop an integrated approach to technology enabled care/eHealth

## What we plan to do:

### Right care, right place, right time

Most people want to live independently for as long as possible, and if they do need support, would prefer to be looked after at home or in a homely setting, and to die there if possible

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 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

Agree an improved and consistent service model for frail older people and people with dementia

Development of community services for people with learning disabilities with forensic needs, autism and behaviours that challenge

Implementation of a locality partnership model for the delivery of recovery orientated mental health services

Develop a strategy and action plan in relation to long-term conditions

Remaining in hospital once acute care needs have been addressed is bad for people's overall wellbeing, resulting in loss of confidence and independence

GP and other community health and social care services that help keep people at home, are under severe pressure

## What we know:

Unpaid carers are a vital resource and must be supported

Work with communities to identify individuals at risk and help them build personal resilience

## What we plan to do:

# Making best use of capacity across the whole system

Increasing demand, limited resources and workforce challenges make the current system of providing health and social care services unsustainable

The third sector has a vital role to play in strengthening community resilience and supporting people to remain independent

More good quality, affordable and accessible housing is essential to maintain health and wellbeing

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

The independent sector provides 70% of care at home services to those aged 65+

Develop ways of working that break down organisational, professional and budgetary silos and actively involve local people, local providers and communities

Develop our understanding of the resources and strengths within the four localities and how all partners can collaborate to meet needs

Work with all partners to ensure that community-based health services, including GP practices can be sustained and developed

Understand how the capacity available under the local Housing Strategy can contribute to the outcomes for Health and Social Care

## What we know:

When faced with increasing demands and limited resources it is essential we make every penny count

Collaborative locality and neighbourhood focused commissioning

## What we plan to do:

### Managing our resources effectively

Expenditure on NHS services accounted for 71% of total health and social care expenditure in 2012/13

75% of hospital inpatient care is accounted for by emergency/unplanned admissions

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

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

There is avoidable demand currently in our system, which if managed differently, would free up resources to be used to address our priorities

Take an integrated approach to workforce development, which allows us to work in different and more joined up ways with our partners and reduce unnecessary duplication

Use the ongoing development of the JSNA to embed a joined up approach to data collection, sharing and evaluation

Explore the full potential of technology to both support individuals to live independently and enable integrated and joined up working

Work with our strategic partners to establish the four localities as the basis for service planning and delivery that makes the best use of the resources of all partners, including local communities assets

# Strategic enablers

The following plans will be part of our final more detailed plan to be published at the end of 2015:

- Financial plan
- Performance framework
- Communication and engagement strategy
- Workforce and organisational development plan
- Risk management plan
- Information and Communication Technology (ICT) strategy
- Housing contribution statement

# Contributing to our plan

You can give us comments on the draft plan at:

<https://consultationhub.edinburgh.gov.uk/>

You can find out more about the consultation by emailing us at: [healthsocialcareintegration@edinburgh.gov.uk](mailto:healthsocialcareintegration@edinburgh.gov.uk) or

calling: 0131 529 6552