Corporate Policy and Strategy Committee

10am, Tuesday, 23 February 2016

Edinburgh Health and Social Care Partnership Strategic Plan

Item number	7.8
Report number	
Executive/routine	
Wards	All

Executive summary

There is a legal requirement for the Edinburgh Integration Joint Board to invite the City of Edinburgh Council and NHS Lothian to comment on the second draft of the Strategic Plan for Health and Social Care prior to the plan being finalised and approved by the Board.

The report summarises the content of the second draft of the strategic plan and makes recommendations on the feedback to be submitted by the Council to the Edinburgh Integration Joint Board.

Links

Coalition pledges	P8, P27, P30, P33, P36, P43
Council outcomes	CO10, CO11, CO12, CO13, CO14, CO15, CO23
Single Outcome Agreement	SO2

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THE CITY OF EDINBURGH COUNCIL

Report

Edinburgh Health and Social Care Partnership Strategic Plan

Recommendations

1.1 It is recommended that the Corporate Policy and Strategy Committee:

i. agree that the proposed response to the invitation from the Edinburgh Integration Joint Board to comment on the second draft of the strategic plan, attached as Appendix A, is submitted on behalf of the Council

ii. note that an Internal Audit report on the Council's planned resourcing of the Integration Joint Board will be submitted to Finance and Resources Committee for consideration.

Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on the Edinburgh Integration Joint Board, along with Integration Authorities elsewhere to:

- produce a strategic plan setting out how it plans to deliver the health and social care services delegated by the City of Edinburgh Council and NHS Lothian in order to deliver the National Health and Wellbeing Outcomes
- establish a strategic planning group to ensure the involvement of key stakeholders in the development of the plan
- invite the Council and NHS Lothian to comment on the plan following consultation with the Strategic Planning Group and prior to the final version of the plan being published

2.2 The Strategic Planning Group was established in February 2015 by the Shadow Edinburgh Health and Social Care Partnership and has collaborated with officers form both the Council and NHS Lothian to produce the strategic plan on behalf of the Edinburgh Integration Joint Board. The Group is chaired by Councillor Ricky Henderson who is also Vice-chair of the Edinburgh Integration Joint Board. Other members of the Group include four citizens with lived experience of using health and social care services and representatives of health and social

care professionals, third and independent sector providers, social housing providers and locality working.

2.3 The first draft of the strategic plan was published in August 2015 and subject to public consultation for a period of three months. The draft plan was presented to the Health, Social Care and Housing Committee in September 2015. A report detailing the feedback received from the period of public consultation and the proposed response was approved by the Edinburgh Integration Joint Board on 15 January 2016.

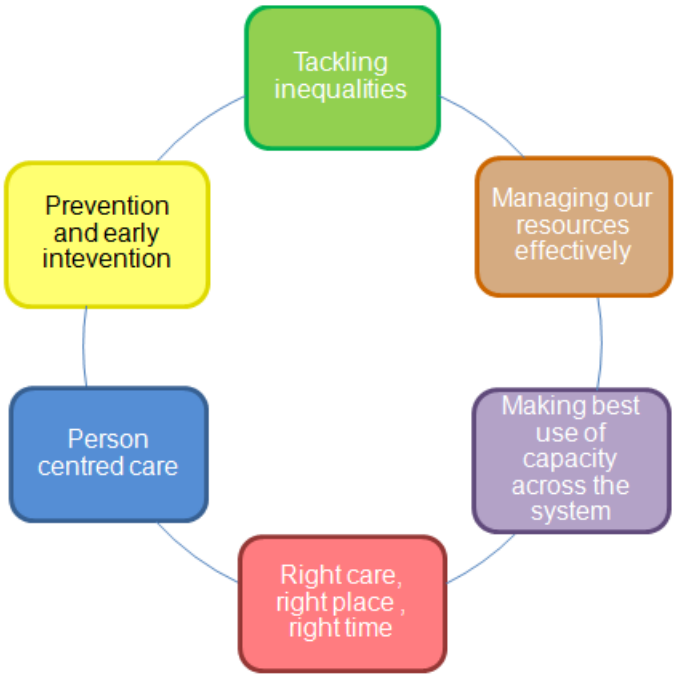
Main report

3.1 The second draft of the Edinburgh Health and Social Care Partnership Strategic Plan, which is attached as Appendix B, builds on the draft plan that was subject to a period of public consultation over the early autumn and the feedback received through that consultation. The plan:

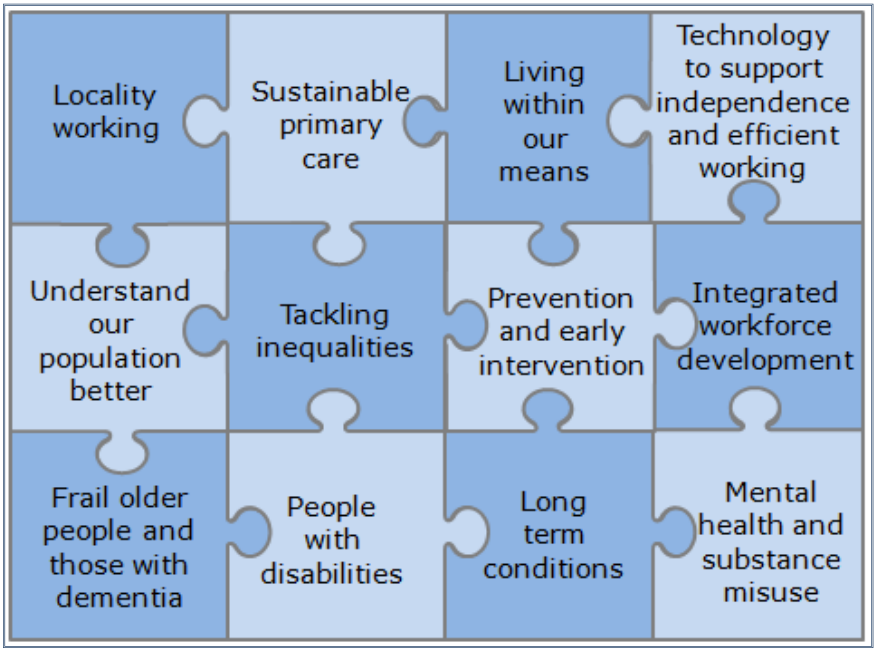
- provides an explanation of health and social care integration and the requirement to produce a strategic plan
- sets out the vision and priorities of the Edinburgh Integration Joint Board
- gives details of the performance arrangements that will support the delivery of the plan
- focuses on 12 specific areas that the Edinburgh Integration Joint Board believes offer the best opportunity to deliver real change

3.2 The vision of the Board is "*People and organisations working together for a caring, healthier, safer Edinburgh".*

3.3 The six linked priorities are shown in the diagram below:



3.4 The 12 areas of focus within the strategic plan are shown in the diagram at the top of the following page. In the same way that there are linkages across and between the six priorities, these 12 areas are interconnected so that actions taken in one area will also impact on others.



3.5 For each of these priorities the strategic plan sets out the case for change and what it is that the Integration Joint Board proposes should be done to deliver that change.

3.6 The vision and priorities set out in the plan align with those of the Council, the Edinburgh Community Planning Partnership and NHS Lothian. The plan contains a diagram on page 18 illustrating these links.

3.7 There is a clear focus on locality working within the plan that mirrors the direction of travel being taken by the Council and other community planning partners through the Transformation Programme. It is essential that the models of locality working developed through the strategic plan and the Transformation Programme are joined up and complementary to avoid duplication, fragmentation and confusion. Specific examples of areas where it is vital that the Integration Joint Board works in partnership with the Council are in meeting

the requirements placed upon both bodies to produce locality plans and the ongoing development of the Joint Strategic Needs Assessment.

3.8 Whilst the move to locality working described in the plan is very welcome it is important that the Integration Joint Board does not lose sight of those who identify with communities of interest rather than geography, the LGBT and minority ethnic communities for example. It would also be helpful to understand how proposals to develop locality approaches for people with mental health problems fit with the overall approach to locality working set out in the plan.

3.9 The plan recognises the importance of tackling inequalities and gives a commitment to "*work with our community planning partners to determine the most effective way of developing and implementing a coordinated approach to tackling inequalities' including health inequalities across the City*". This approach fits well with the Council's desire to see a more streamlined approach to tackling inequalities through the Edinburgh Community Planning partnership.

3.10 The sections of the plan relating to improving care and support for frail older people and those with dementia, ensuring a sustainable model of primary care and plans to achieve integration at a locality level set out a range of proposals for addressing the challenges of building capacity to care for growing numbers of frail older people. Detailed plans for implementing these proposals at pace are now required.

3.11 The section on 'Living within our means' sets out the funding arrangements and the extremely challenging financial position that the Integration Board will be operating in. However, it is not yet possible to give financial plans. These will be available once the overall budget available to the Integration Joint Board from both the Council and NHS Lothian are known.

3.12 From the Council's perspective it is important to ensure that the arrangements for health and social care integration do not lead to another set of silos. NHS and social care services need to integrate with other parts of the Council as well as with one another.

3.13 The issue detailed in paragraphs 3.6 to 3.12 above are the main issues highlighted in the Council's proposed response to the invitation from the Edinburgh Integration Joint Board to comment on the second draft of the strategic plan. The proposed text of the response is contained in Appendix A.

Measures of success

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on the Edinburgh Health and Social Care Partnership to produce an annual performance report assessing performance in planning and carrying out the delegated functions. A performance framework is being which will support the

ongoing strategic planning cycle and allow the Partnership to measure success in relation to the achievement of the key priorities set out in the plan.

Financial impact

5.1 The Edinburgh Integration Joint Board will be responsible for a budget of approximately £575m. The strategic plan provides some high level detail on the make up of the budget and the way in which it is currently utilised across services. The plan also sets out how the Board proposes to change the way in which services are delivered to both improve the health and wellbeing of citizens and address the very real financial challenges. There is a legal requirement for the Integration Joint Board to produce a financial statement annually; the first statement will be produced once the budget to be delegated to the Board by both the Council and NHS Lothian has been confirmed.

Risk, policy, compliance and governance impact

6.1 The Edinburgh Integration Joint Board will be inheriting significant financial challenges from both the Council and NHS Lothian. The strategic plan has been developed in full knowledge of those challenges and represents a genuine attempt to change the way services are delivered to meet the financial challenge and improve the lives of people using health and social care services. However, there are significant risks, particularly as the budget for the Integration Joint Board has not yet been finalised. The Board is well aware of these risks and will adopt a rigorous approach to managing them through the establishment of an Audit and Risk Sub-committee.

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Equalities impact

7.1 Tackling inequalities is one of the key priorities agreed by the Integration Joint Board and also one of then key areas of focus set out in the strategic plan. An Integrated Impact Assessment is being undertaken as part of the preparation of the final version of the strategic plan; this be presented to the Integration Joint Board as part of the process of seeking approval for the plan.

Sustainability impact

8.1 Changing the relationship between public services and citizens and communities to make the best use of capacity and resources across statutory, third and independent sector organisations, citizens and communities in order to develop sustainable solutions to meet health and social care needs is at the heart of the Integration Joint Board's strategic plan.

Consultation and engagement

9.1 The strategic plan has been produced in collaboration with the Strategic Planning Group, established in line with legislative requirements. Membership of this group includes representatives from the Council, NHS Lothian, service users and carers, the third sector, voluntary and independent sector providers, health and social care professionals and providers of social housing.

9.2 The first draft of the strategic plan was subject to a period of three months public consultation from August to October 2015. The feedback received was reported to the Integration Joint Board in January 2016 and has informed the development of the second draft of the plan.

Background reading/external references

Public Bodies (Joint Working) (Scotland) Act 2014

Report to Health, Social Care and Housing Committee on the first draft strategic plan

Report to the Integration Joint Board on Feedback to the consultation

Rob McCulloch-Graham

Chief Officer, Edinburgh Health and Social Care Partnership

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Links

Coalition pledges:	P8 - Make sure the city's people are well-housed, including encouraging developers to build residential communities, starting with brown field sites P27 - Seek to work in full partnership with Council staff and their representatives P30 - Continue to maintain a sound financial position including long-term financial planning P33 - Strengthen Neighbourhood Partnerships and further involve local people in decisions on how Council resources are used P36 - Develop improved partnership working across the Capital and with the voluntary sector to build on the "Total Craigroyston" model

	P43 - Invest in healthy living and fitness advice for those most in need
Council outcomes	CO10 - Improved health and reduced inequalities CO11 - Preventative and personalised support in place CO12 - Edinburgh's carers are supported CO13 - People are supported to live at home CO14 - Communities have the capacity to help support people CO15 - The public is protected CO23 - Well engaged and well informed – Communities and individuals are empowered and supported to improve local outcomes and foster a sense of community
Single Outcome Agreement:	SO2 - Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health
Appendices:	Appendix A **–** Draft response to the invitation to comment on the second draft of the strategic plan for health and social care services in Edinburgh Appendix B - Edinburgh Health and Social Care Partnership strategic plan second draft

Appendix A

Draft response to the invitation to comment on the second draft of the strategic plan for health and social care services in Edinburgh

To the Chair of the Edinburgh Integration Joint Board

Thank you for the opportunity to comment on the second draft of the Strategic Plan for the Edinburgh Health and Social Care Partnership. Our detailed comments are listed below:

1. The Council welcomes the priorities set out within the plan which are closely aligned with those of the Council and, as the illustration on page XX makes clear, those of the Edinburgh Community Planning Partnership and NHS Lothian. The diagram setting out the changes that the Integration Joint Board wants to see over time is clear and again aligns with the changes the Council itself would want to see.

2. The 12 areas of focus are well articulated although there is clearly some overlap between them, which is perhaps understandable given the complexity of the health and social care landscape.

3. The Council welcomes the emphasis on locality working and is keen to see how the proposed approach dovetails with its own Transformation Programme. We expect to see the localities model develop in a joined up way and see the Health and Social Care Locality Managers as key members of the Locality Leadership Teams being developed through the Transformation Programme. As both the strategic plan and Transformation Programme are still at early stages of implementation the lack of detail is understandable. However, we would welcome reassurance that the proposal for locality working set out in the strategic plan will complement rather than duplicate our own plans in this area.

4. The requirement for the Integration Joint Board to produce locality plans at the same time as the Community Empowerment Act introduces a requirement for Community Planning Partnerships to produce local improvement plans, could lead to significant duplication of effort and variation in approach. The Council would welcome reassurance that the Integration Joint Board will work in partnership with the Team supporting the Edinburgh Community Planning Partnership, to ensure a streamlined and joined up approach to the production of locality plans.

5. Whilst welcoming the priority given to establishing locality based working, the Council recognises that many people identify more closely with communities

of interest rather than the area in which they live. Although the strategic plan gives some detail on the way in which it will support some groups of citizens, primarily those who belong to the traditional social care service user groupings; more detail on the approach to be taken to other communities of interest such as the LGBT and minority ethnic communities is required.

6. The Council welcomes the level of recognition given to the importance of tackling inequalities and the commitment to "*work with our community planning partners to determine the most effective way of developing and implementing a coordinated approach to tackling inequalities' including health inequalities across the City*". This commitment chimes well with our desire to see a more streamlined approach to tackling inequalities with a clear strategy, agreed by all members of the Edinburgh Community Planning Partnership, forming the basis for a joined up approach to this key area of work across the city.

7. We are very aware of the challenges in meeting the social care needs of the growing numbers of frail older people in the city and recognise the problem of building sufficient capacity within both social and primary care to meet these needs. For these reasons the Council fully supports *improving care for frail older people* and *ensuring a sustainable model of primary care* as key areas of focus for the Integration Joint Board. The range of proposed actions together with the proposals for locality working, are welcome developments in this area. What is required now is a plan for the delivery of the se proposals at some pace. Whilst the extension of the living wage to staff working for independent providers may help to increase capacity in this area the Council recognises the financial challenge involved.

8. The approach to supporting people with long term conditions set out in the plan is an interesting one. The Council would be interested to know whether a similar systematic approach of identifying those most at risk and taking action to prevent conditions escalating could also be applied in social care.

9. The proposals relating to mental health and substance misuse services make reference to 'implementing the mental health locality partnership model'. Whilst recognising the need to respond differently to different people with differing needs, the Council would like to understand how the proposed locality model for mental health fits with the wider locality model set out in some detail earlier in the plan.

10. The proposals to make increased use of technology to both increase the independence of vulnerable citizens and support more efficient and effective ways of working for staff are very welcome. Clearly there is a reliance on expertise from the wider Council to develop and implement these proposals and the Council will continue to support the Health and Social Care

Partnership in developing these further. The same is true of the ongoing Joint Strategic Needs Assessment. However, the Council would like to consider how work in this area can dovetail with our own plans to make better use of business intelligence, to support improved planning and delivery of services across the city.

11. The Council is keen to ensure that the arrangements for health and social care integration do not lead to another set of silos. We believe that NHS and social care services need to integrate with other parts of the Council as well as with one another. To this end we would like to see more detail in the plan about joined up working with services such as children and families, community safety, education, housing and homelessness.

12. The section on finance (Living within our means) is comparatively brief and contains little detail. Whilst we understand that this is primarily because of the uncertainty about absolute budgetary amounts at this stage, the Council is very keen to be assured of the financial viability of the Integration Joint Board's plans. We assume that a greater level of detail will be contained in the Financial Plan that the Integration Joint Board is required to produce alongside the strategic plan and look forward to seeing this once it is available.

13. In terms of understanding the impact that the Integration Joint Board hopes to achieve through the implementation of the strategic plan, it would be helpful to see more case studies embedded within the plan, illustrating the impact on citizens.

Appendix B

Edinburgh Health and Social Care Partnership

Draft Strategic Plan

2016 – 19

(Version 2)

For comment

February 2016

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

We are delighted to introduce this first Strategic Plan for Health and Social Care, setting out the priorities and actions we need to pursue if we are to achieve our shared vision for a caring, healthier, safer Edinburgh. We are embarking on an exciting journey to ensure we make best use of our joint resources through reshaping services with and around people and communities. We believe our localities based approach to bringing services closer to people in their homes and local communities where possible, will allow us to deliver more joined up care and support, use resources more effectively, and achieve better outcomes for people.

Edinburgh's population of almost half a million, accounts for 9% of the total population of Scotland, and is projected to increase faster than any other area of the country; with a higher rate of growth in some age groups than others. Whilst this growth has many social and economic advantages, it also presents some challenges. Although a relatively affluent city, Edinburgh has areas that experience significant social and economic inequality and one of our key priorities will be to lead on tackling health and social inequalities for the Edinburgh Community Planning Partnership.

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 and housing sectors. Locality working will be able to take account of variations in need, foster improved relationships and understanding, and build on the existing strengths and opportunities in local communities.

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 at the centre of our plans, are supported to live independently by being enabled to look after themselves at home, but also can access the right care and support when needed.

The financial environment continues to be challenging for local authorities and health boards, so we have to do better with limited funds. Over the next five years, the City Council must reduce its operating costs by at least £148 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. We estimate that the partnership itself will have to identify efficiencies of £32m in 16/17. This makes the current way of doing things unsustainable and requires a fundamental re-think of how we work together. We need to use public money, our skilled staff teams,

the capacity and capability of the third independent and housing sectors and of people and communities, to support better health and social care outcomes across the City.

The first draft of our strategic plan consulted on during 2015 was high level, focusing on the six priorities we believe need to be addressed and seeking views on the actions and approach we should take to reshaping services and improving the health and wellbeing of citizens. We have listened to the views expressed through the consultation events and the feedback of those who use our services, our staff and others who provide care, including unpaid carers and community groups in developing our plan for the next 3 years.

This final plan builds on our vision and the six priorities which were endorsed through the consultation, and sets out the actions we now plan to take to transform the health and care landscape in Edinburgh for all our benefit. Many of the changes we propose will take time to fully deliver, but we are keen to make progress and have already put in place devolved management arrangements to enable staff and citizens to work together more effectively in the four localities.

As Chair and Vice chair of the Integration Joint Board overseeing the Edinburgh Health and Social Care Partnership, we look forward to working with all those who use services, those who provide services, and local communities to take the vital steps needed to redesign and reshape our services to deliver the caring, healthier, safer Edinburgh we all want to see.

George Walker

Chair of the
Edinburgh Integration
Joint Board

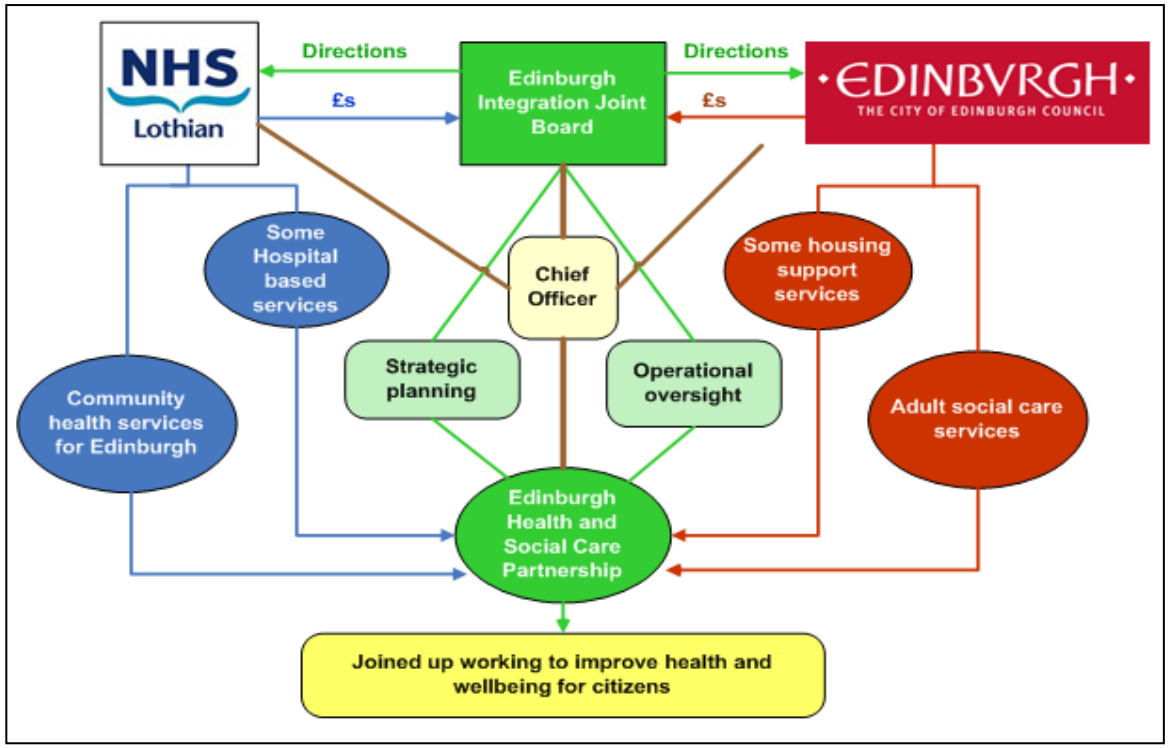
Ricky Henderson

Vice chair of the
Edinburgh Integration
Joint Board

2. Executive summary to be completed following feedback from stakeholders

3. Integrating health and social care services

In 2014 the Scottish Government passed the Public Bodies (Joint Working) (Scotland) Act bringing together the planning and operational oversight for a range of NHS and local authority services for adults in each local authority area under a single body. The purpose of the legislation is to improve the overall health and wellbeing of the population of Scotland by delivering efficient and effective joined up health and social care services. In Edinburgh, the Integration Joint Board is the body responsible for the *strategic planning* of the services delegated by the legislation. The majority of these services are *managed* on a day to day basis by the Edinburgh Health and Social Care Partnership, led by the Chief Officer. The Integration Joint Board will issue directions to the Council and NHS Lothian setting out how services should be delivered. The diagram below illustrates the relationship between the Integration Joint Board, the Health and Social Care Partnership, NHS Lothian and the City of Edinburgh Council.

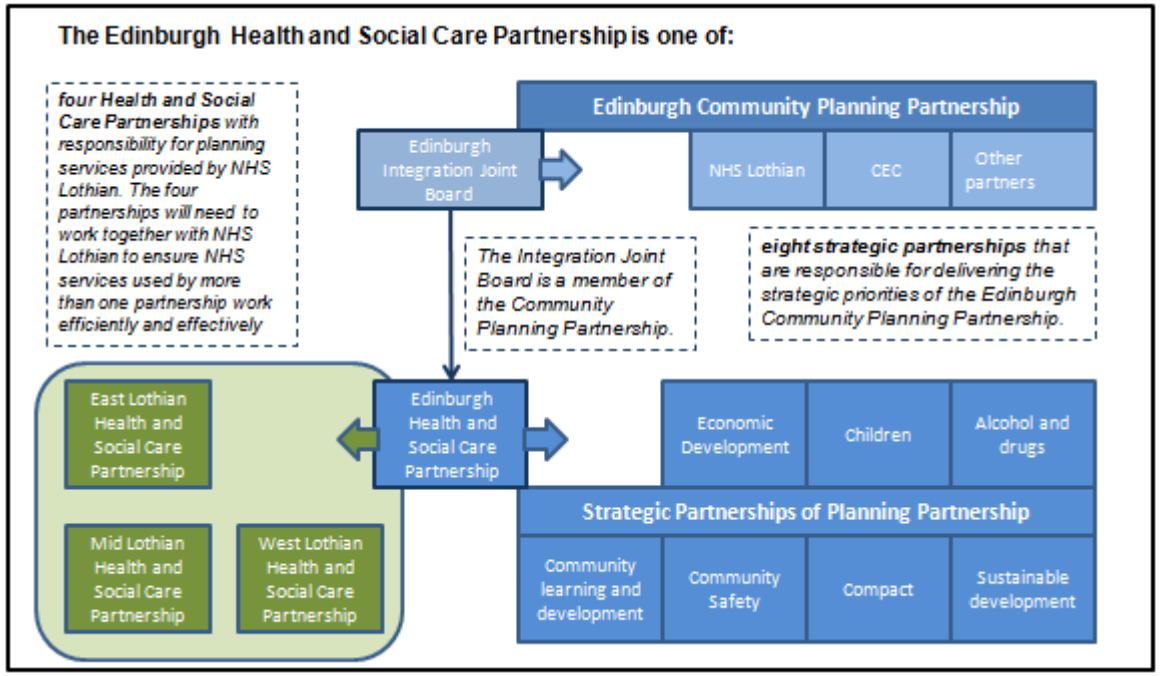


Details of the members of the Integration Joint Board are given in Appendix A.

In order to have a positive impact on health and wellbeing in the city, the Health and Social Care Partnership will need to work closely with its partners including other statutory, voluntary and independent sector organisations and with citizens and communities.

The role of the Edinburgh Community Planning Partnership is to ensure that there is a coordinated approach to planning public services through the development of a community plan for the city. The Integration

Joint Board is a member of the Edinburgh Community Planning Partnership and the Health and Social Care Partnership is one of the eight strategic partnerships that support the delivery of the community plan.



It is important that the strategic plan for the Health and Social Care Partnership takes account of the Edinburgh Community Plan and the local community plans produced by the 12 neighbourhood partnerships; and contributes to the achievement of the aims and objectives set out within those plans.

The diagram opposite sets out the relationships between the Integration Joint Board and Health and Social Care Partnership, the Edinburgh Community Planning Partnership and the other Lothian Health and Social Care Partnerships.

Scope of the Edinburgh Health and Social Care Partnership

Edinburgh is one of four Health and Social Care Partnerships that have responsibility for services previously planned for and still delivered by NHS Lothian, some of which operate on a Lothian wide basis. The other partnerships are East, Mid and West Lothian Health and Social Care Partnerships. Whilst it has been relatively straight forward to transfer resources for some services to individual partnerships in other cases it is much more complicated and agreement has been reached between the four partnerships and NHS Lothian as to how these services should be managed to ensure they operate as effectively and efficiently as possible. As a result, the services that the Edinburgh Integration Joint Board is responsible for planning fall into three groups:

- services that are managed through the Edinburgh Health and Social Care Partnership

- services that are managed by East, Mid or West Lothian or NHS Lothian on behalf of all five organisations – these are referred to as "hosted" services
- services that are managed by NHS Lothian but used by one or more of the Health and Social Care Partnerships where it is not sensible to split the resources available between them without destabilising the service – these are referred to as "set aside" services

The table below summarises the services for which the Edinburgh Integration Joint Board has a strategic planning responsibility. Information about hosted and set aside services is contained in Appendix C.

Adult Social Care Services	Community Health Services	Hospital Based 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	• 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	• 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

Our Strategic Plan

It is a legal requirement that the Integration Joint Board publish a strategic plan every three years setting out how the services and budget it is responsible for will be used to deliver a set of national health and wellbeing outcomes that are detailed in Appendix D and summarised in the diagram on page 18. This first plan has been produced through collaboration between officers of NHS Lothian and the Council and the Strategic Planning Group set up by the Integration Joint Board. Members of the Strategic Planning Group include representatives of those who deliver and receive health and social care services and other key stakeholders; a list of members is given in Appendix B.

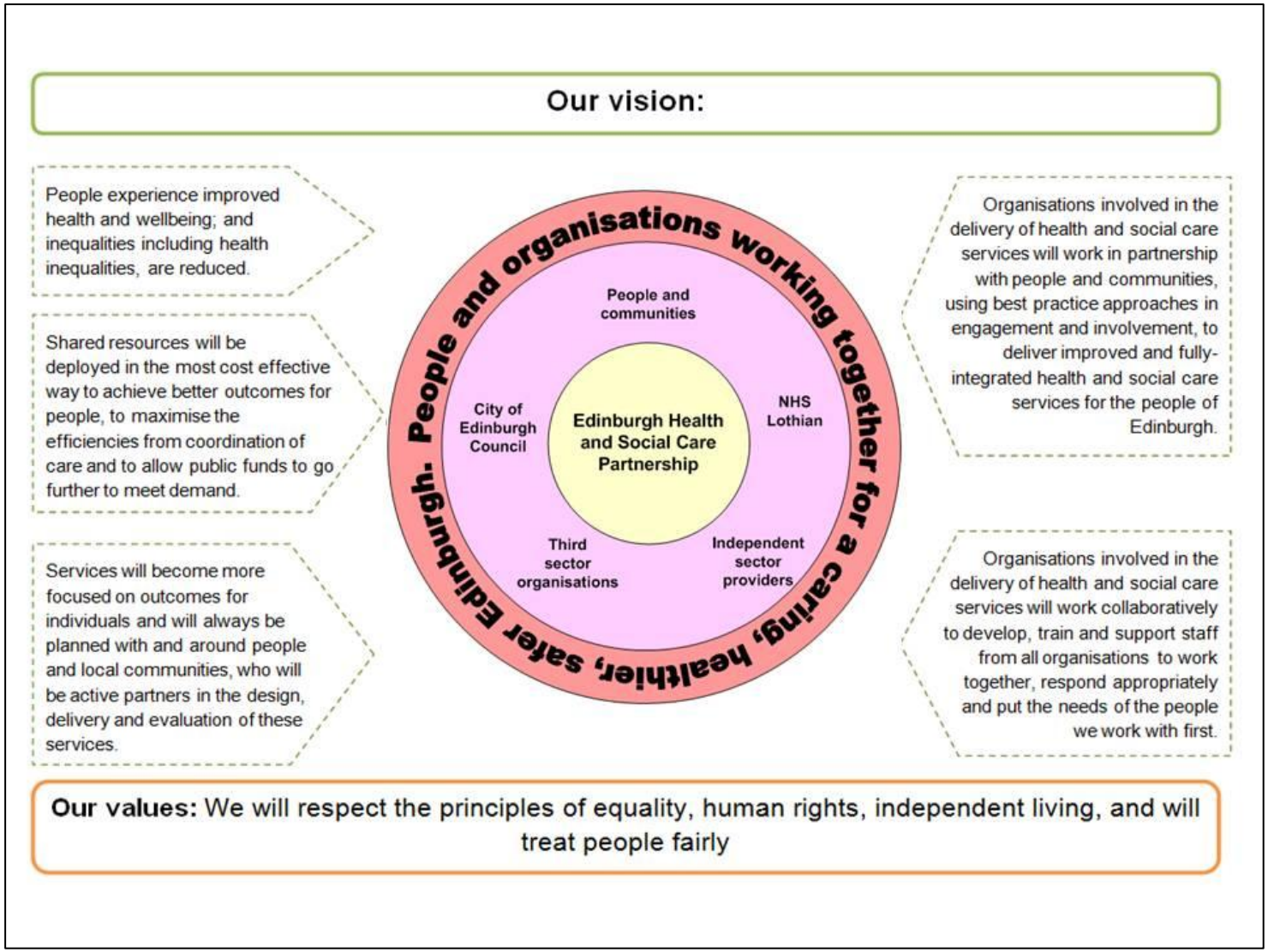
During the autumn of 2015 we asked our partners and the public to provide feedback on an earlier version of this plan. The key things that we learned from the feedback are that:

- people understand the financial pressures that the Health and Social Care Partnership is facing and are concerned about how this will impact on the amount and quality of care available to meet people's needs
- we need to better explain the relationships between NHS Lothian and the four Health and Social Care Partnerships in Lothian and between the Edinburgh Health and Social Care Partnership and the community planning arrangements in Edinburgh
- people are generally supportive of the proposed move to locality working but have some concerns that this could lead to a postcode lottery and that the needs and interests of communities of interest such as minority ethnic and LGBT communities and people with disabilities could get overlooked
- there is strong recognition of the importance of the Health and Social Care Partnership working in equal partnership with the third or voluntary sector, including social housing providers, if we are to deliver the priorities set out in our strategic plan
- primary care services including GPs have an important role to play in helping us achieve our priorities at a local level and need support to undertake this role
- there is an urgent need to ensure our ICT systems are reliable, support staff to work more efficiently and address the need to share data within and across organisations to facilitate effective joined up working

- there is widespread support for our proposed priorities set out on page 15, although there is also concern that these may not be achievable in the current economic climate

We also received suggestions about the actions we need to take to achieve our key priorities. We have taken the feedback we received into account in producing this version of the strategic plan and will ensure that it is also used to inform the development of more detailed future plans and our ongoing engagement with our partners including citizens and communities. More detail about the feedback we received through the consultation and the way in which it will be used is contained in a report considered by the Integration Joint Board in January 2015.

4. Our vision and values

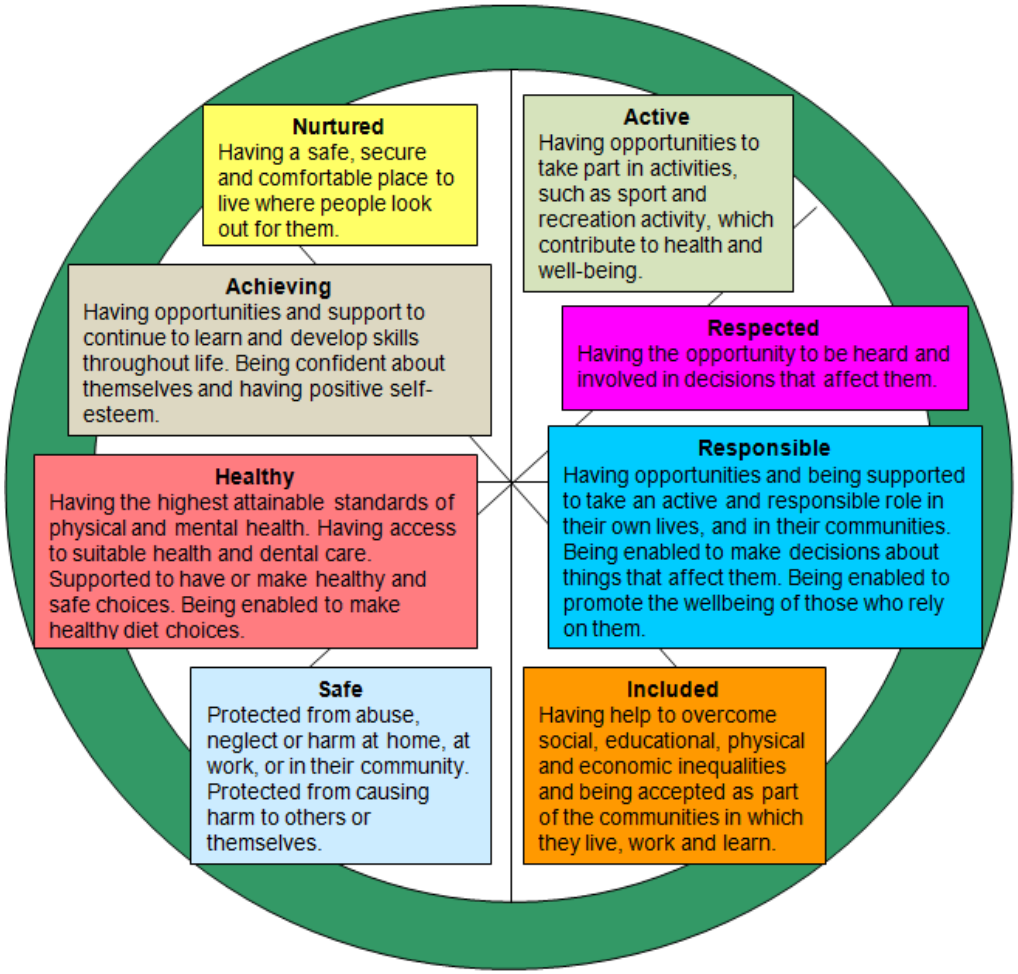


The vision and values of the Edinburgh Integration Joint Board for the Health and Social Care Partnership set out the positive impact we believe the integration of health and social care will make on:

- 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. We are committed to working in person centred ways with citizens to support them retain and regain their independence and take more control over their lives.

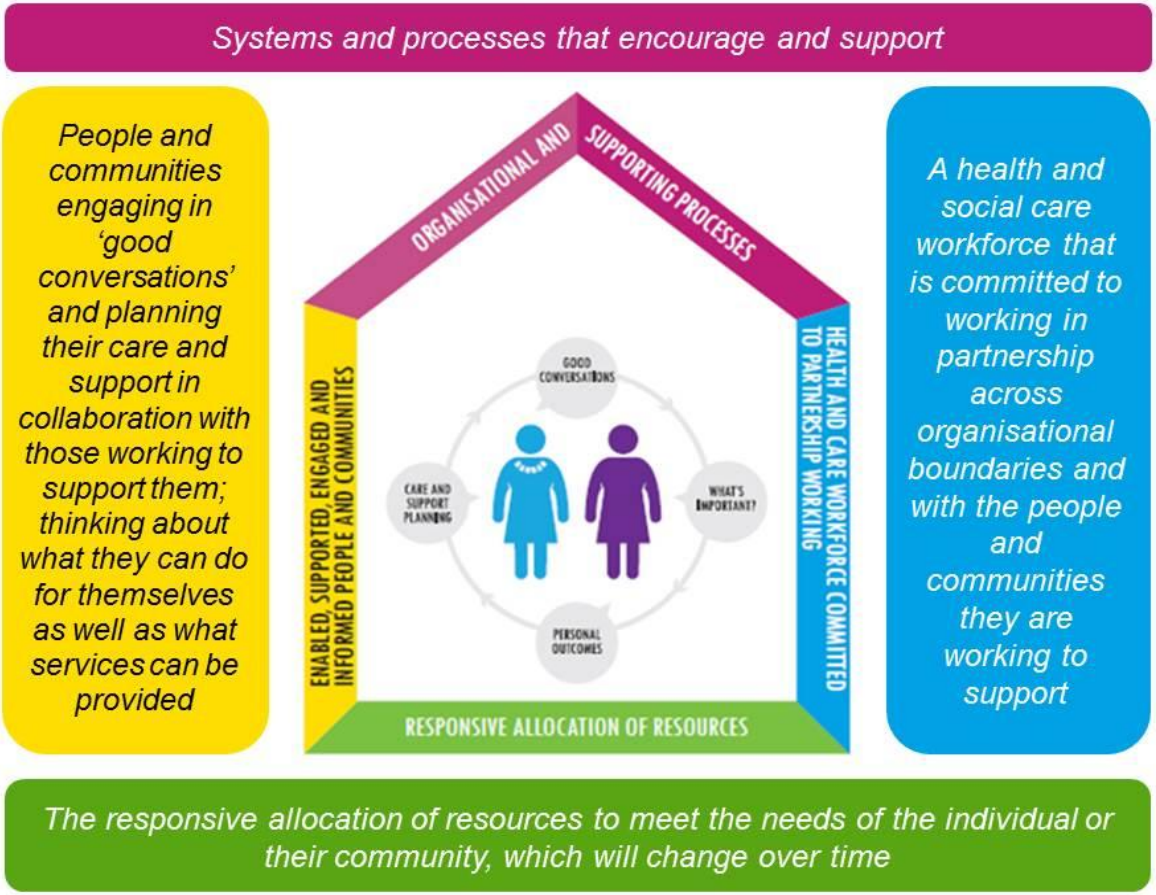
The Wellbeing Wheel opposite sets out the person centred outcomes that the Edinburgh Health and Social Care Partnership seeks to achieve for all citizens in order to improve their health and wellbeing; whilst recognising that the way to achieve them will vary from person to person.



The House of Care model that is being developed in partnership between NHS Lothian, third sector organisations, the Health and Social Care Partnerships in Lothian and people who use health and social care services; offers a good illustration of the elements that need to be in place if our vision for integration is to be achieved.

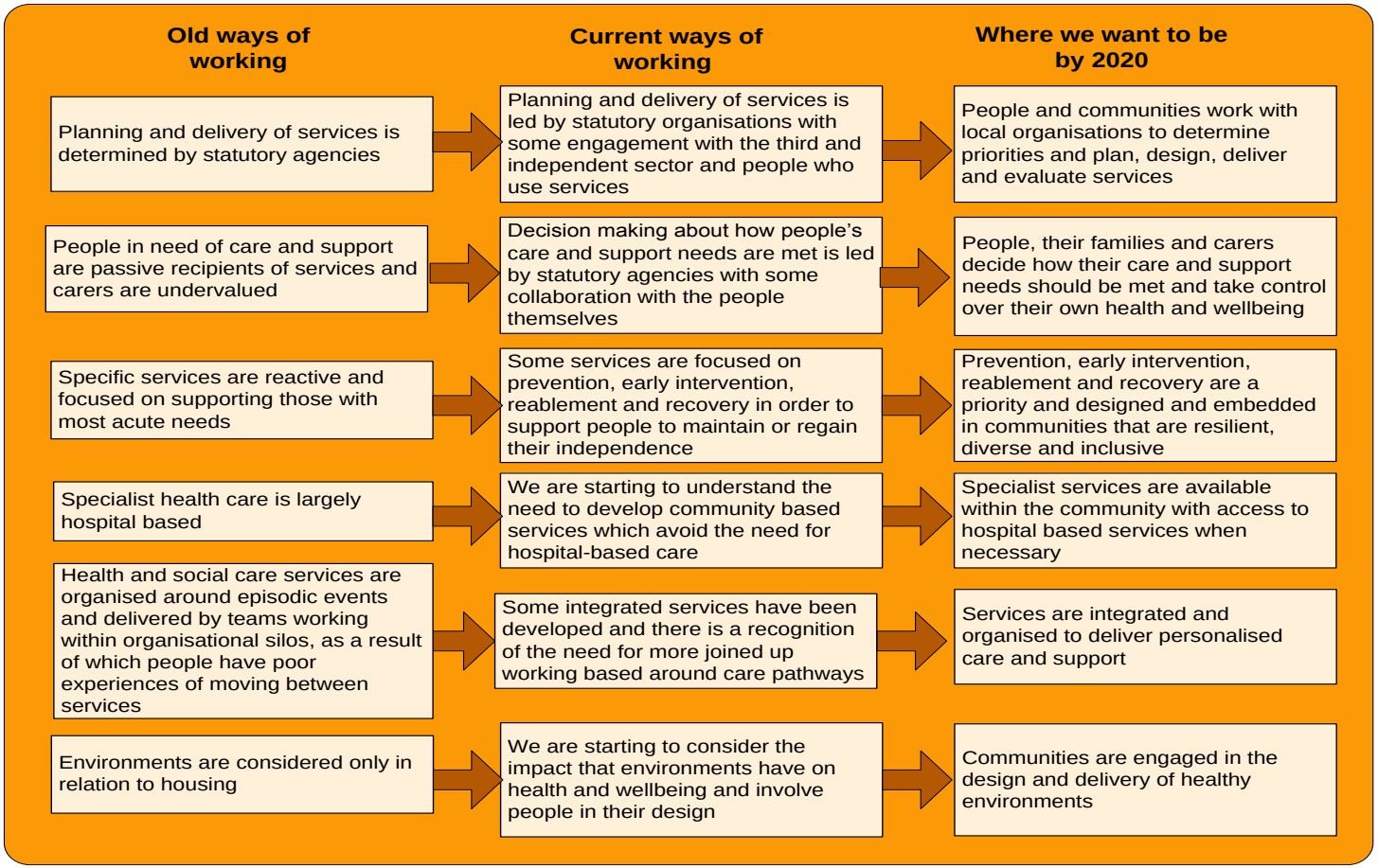
The 'house' where the foundations, walls and roof all need to be in place, provides a good metaphor for the whole systems change we hope to achieve through integration; with relationships and the ability to have 'good conversations' that focus on what is important to the individual at the centre of how we work.

This model will underpin how we work with people, informal carers with communities and with our staff and partners to achieve our vision for a caring, healthier, safer Edinburgh.



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.



5. Our priorities

Along with other public sector organisations in Scotland and the wider United Kingdom, the Edinburgh Integration Joint Board faces three major challenges:

1. An increase in demand for health and social care services that is expected to continue due to a combination of factors including:
    - growth in the number of people living in the city
    - increased life expectancy in the overall population which means that people are living longer but not necessarily healthier lives
    - increased life expectancy amongst people with complex health conditions as a result of advances in medical science
    - an increase in the prevalence of long term conditions in the population overall
2. Changes in social policy and public expectations about the health and social care services that local authorities and the NHS should provide
3. The financial climate which has resulted in the need for both the NHS and local authorities to meet the increased demand for services with less resources in real terms

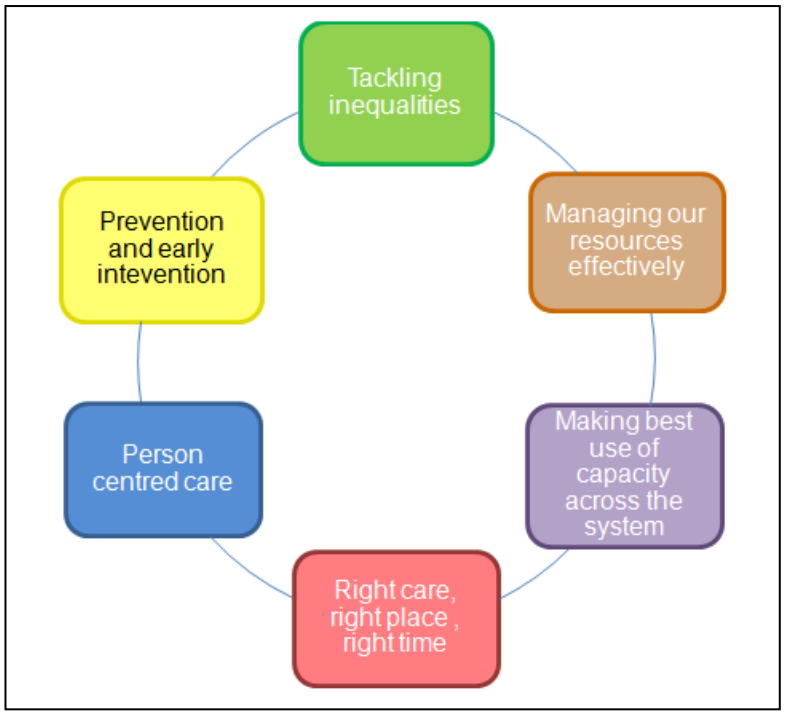
The challenges that are more specific to Edinburgh are set out in our Joint Strategic Needs Assessment which is attached as Appendix H.

Edinburgh Integration Joint Board is very aware of the challenges we face but we also recognise that they present an exciting opportunity to do things differently, as it is clear that continuing to deliver the same services in the same way is not an option. We have developed a set of linked priorities that underpin our strategic plan, reflect the wider context within which we operate, link to the national health and wellbeing outcomes and are aligned to the strategic priorities of the Edinburgh Community Planning Partnership, the City of Edinburgh Council and NHS Lothian as set out in the diagram on page 18. The range of national and local plans and strategies that impact on or are affected by the strategic plan are set out in the diagram in Appendix E.

Our key priorities are set out below.

Tackling inequalities by working with our partners to address the root causes, as well as supporting those groups whose health is at greatest risk from, current levels of inequality:

- Supporting individuals to maximise their capabilities and have control over their lives
- creating healthy and sustainable communities that can resist the effects of inequality on health and wellbeing
- ensuring that core services are delivered in such a way to reduce, and not exacerbate, health inequality



Preventing poor health and wellbeing outcomes by 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.

Practicing **person centred care by** 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.

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

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

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

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

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

Why these are our priorities

The role of the Edinburgh Integration Joint Board is to plan for the delivery of services that improve the health and wellbeing of the population of Edinburgh. Given the challenges of increased demand and limited resources it is vital that we not only focus our attention on those people in greatest need of health and social care support today but also work to manage future demand. Taking action to tackle the wider causes of poor health and wellbeing and investing in preventative approaches that support people to take more control over their own lives, is an integral part of our strategy. Whilst the provision of care, support and medical services are a key function of the NHS and social care, other partners are better placed to address some of the underlying causes of poor health and wellbeing through the provision of good quality housing, green spaces, social activities, education, good working conditions, accessible information and advice, informal care, support and friendship for example.

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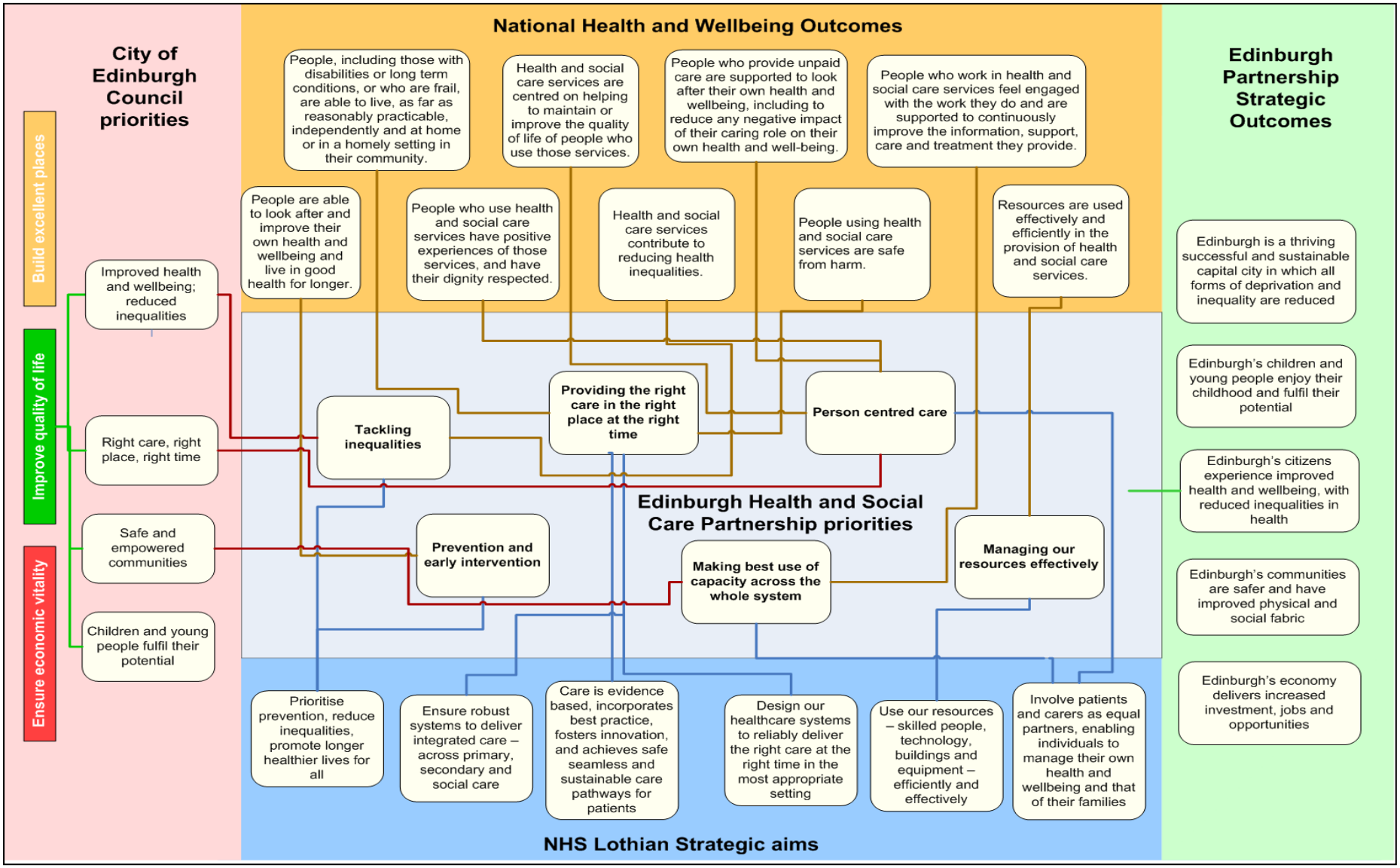
The diagram below illustrates the linkages between the key priorities of the Integration Joint Board, the national health and wellbeing outcomes and the strategic objectives and priorities of the Edinburgh Community Planning Partnership, the City of Edinburgh Council and NHS Lothian.

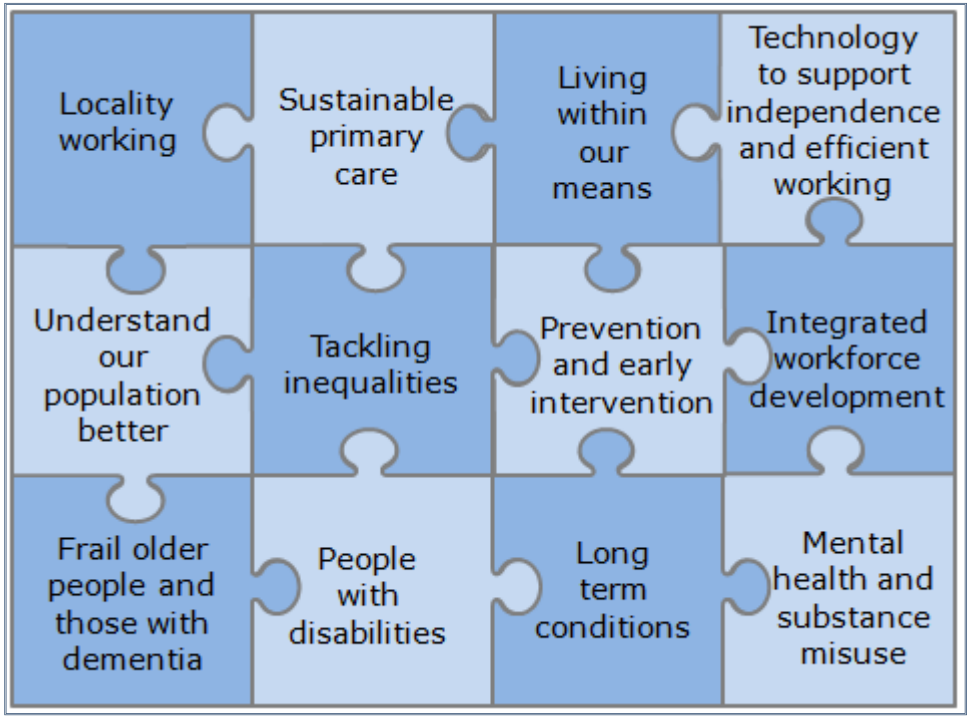

City of Edinburgh Council priorities
Build excellent places
Improve quality of life
Ensure economic vitality
Improved health and wellbeing; reduced inequalities
Right care, right place, right time
Safe and empowered communities
Children and young people fulfil their potential
National Health and Wellbeing 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
Edinburgh Health and Social Care Partnership priorities
Prevention and early intervention
Making best use of capacity across the whole system
Managing our resources effectively
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

Delivering our priorities

To achieve the vision and priorities set out above we have identified 12 areas where we believe we need to focus our attention during the life of this strategic plan, in order to deliver real change. In the same way that there are linkages across and between our six key priorities these 12 areas are interconnected so that actions taken in one area will also impact on others.

The areas on the top row are those where we believe we can and must deliver change quickly. The middle row contains a number of areas that we feel should be golden threads throughout our plan. The bottom row sets out the groups of people that we believe can most benefit from the transformation of services we want to see.

Throughout the plan the actions that we will take to progress our vision and priorities over the next three years are denoted by the italics text in boxes.



6. Our plans to achieve integration at locality level

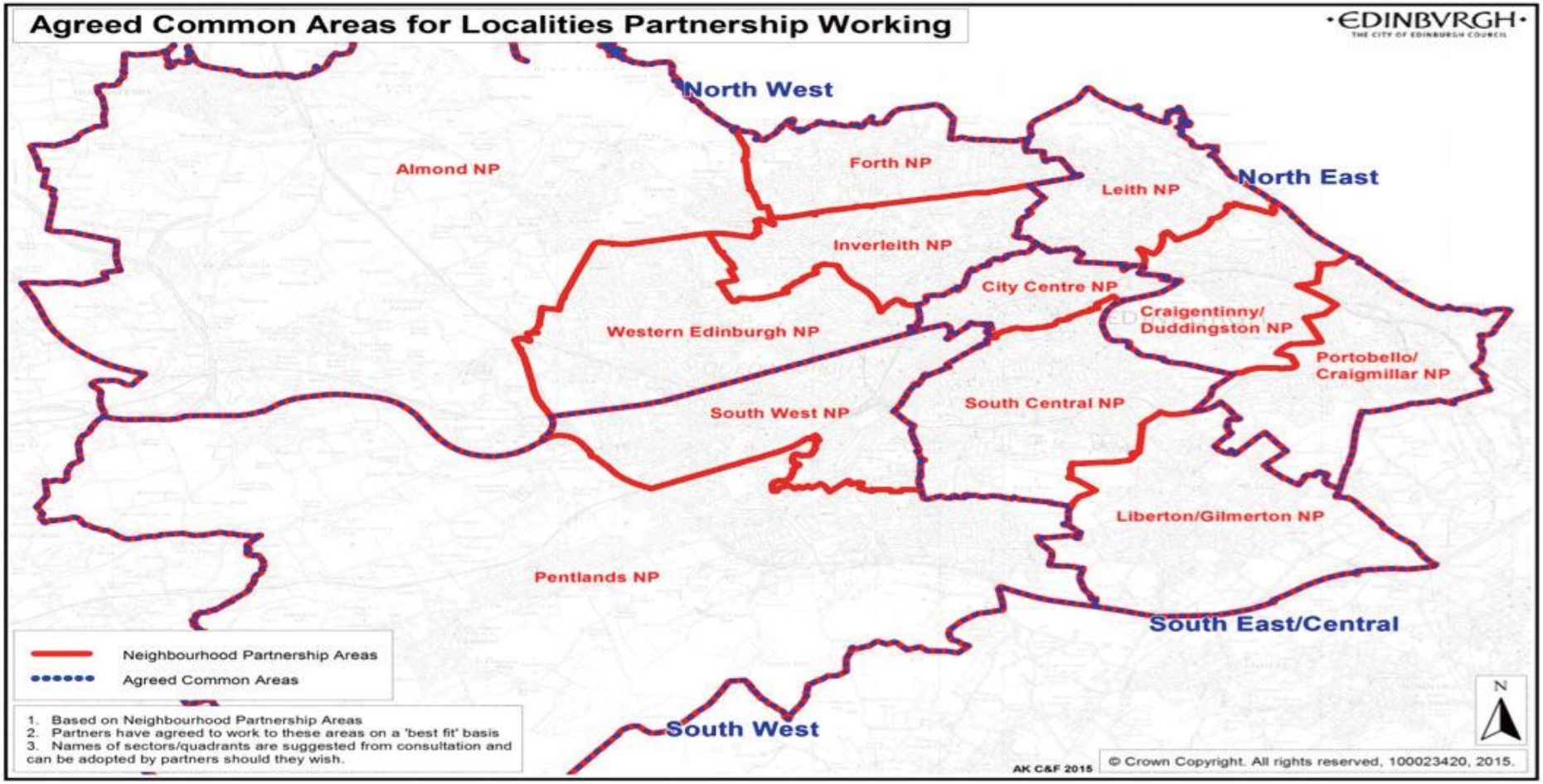
The case for change

There is general recognition at both a national and local level that communities are the engine house for delivering transformation in public services. 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 as locally as possible.

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 City of Edinburgh Council, NHS Lothian and their partners in the Edinburgh Community Planning Partnership, 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.

To achieve this, the organisations that belong to the Edinburgh Community Planning Partnership have agreed that all partners will adopt the same four geographic locality boundaries as the basis for service planning and delivery in the city. The four localities are based around the existing twelve Neighbourhood Partnerships as detailed in the table below and shown on the map on the following page:

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



An initial profile of each locality is contained in the Draft Joint Strategic Needs Assessment contained in Appendix H.

What we plan to do

Bringing health and social care service providers together to work as integrated teams to better meet the needs of people and communities is the core purpose of the Health and Social Care Partnership. To achieve this we have put in place a locality management structure to lead the delivery of most front line services to citizens within the four localities.

The use of common boundaries across partners provides excellent opportunities to integrate service planning and provision not only across health and social care, but across all agencies. A transformation programme is currently underway within the Council, aiming to integrate services such as housing, services for communities, children and families etc at a locality level and similar changes are being considered by Police and Fire and Rescue Services. Edinburgh Health and Social Care Partnership staff will be core participants in the new multi-agency Locality Leadership Teams being established by the Council. Effective joint working with council services and other partners will be vital to help deliver our priorities, in particular greater focus on prevention, early intervention, and tackling inequalities.

The move to managing services at locality level and indeed working below this at neighbourhood level too will enable all partners to build on local knowledge and connections to foster the healthy neighbourhoods and resilient communities that respondents to our Strategic Plan consultation told us they want to see. The focus on localities will help health and social care teams to work more effectively with the existing community groups which support those whose needs are for social networking and healthy living opportunities e.g. lunch clubs, walking groups etc.

From April 2016 we will ensure that local health, social care, voluntary and independent sector care providers, along with carer and service user representatives and other local organisations, are able to work effectively together by establishing local collaborative working arrangements, under the leadership of four Health and Social Care Locality Managers. We will also ensure that links with the housing sector, including social housing landlords, will be strengthened so that people's needs for a warm, affordable and accessible home can be met, and that people can live independently as far as possible.

Bringing existing staff teams together and providing them with the opportunity for more local engagement is also anticipated to support the culture change in our services which many people have identified is needed. We say more about the approach to workforce development in section 16.

We will ensure that while aspects of service delivery may vary according to local circumstances and needs, outcomes will be monitored to ensure that unwarranted variation in support does not develop in different parts of the city, and resources are allocated fairly. There will of course continue to be a need to plan and deliver services at a citywide level where they are focused on meeting the needs of communities of interest or there is limited demand or a reliance on limited specialist facilities.

Locality managers will work with their teams to empower staff to work more flexibly to seek solutions and avoid unnecessary referrals on to another team or service, with the aim of providing more seamless and responsive care and support when needed.

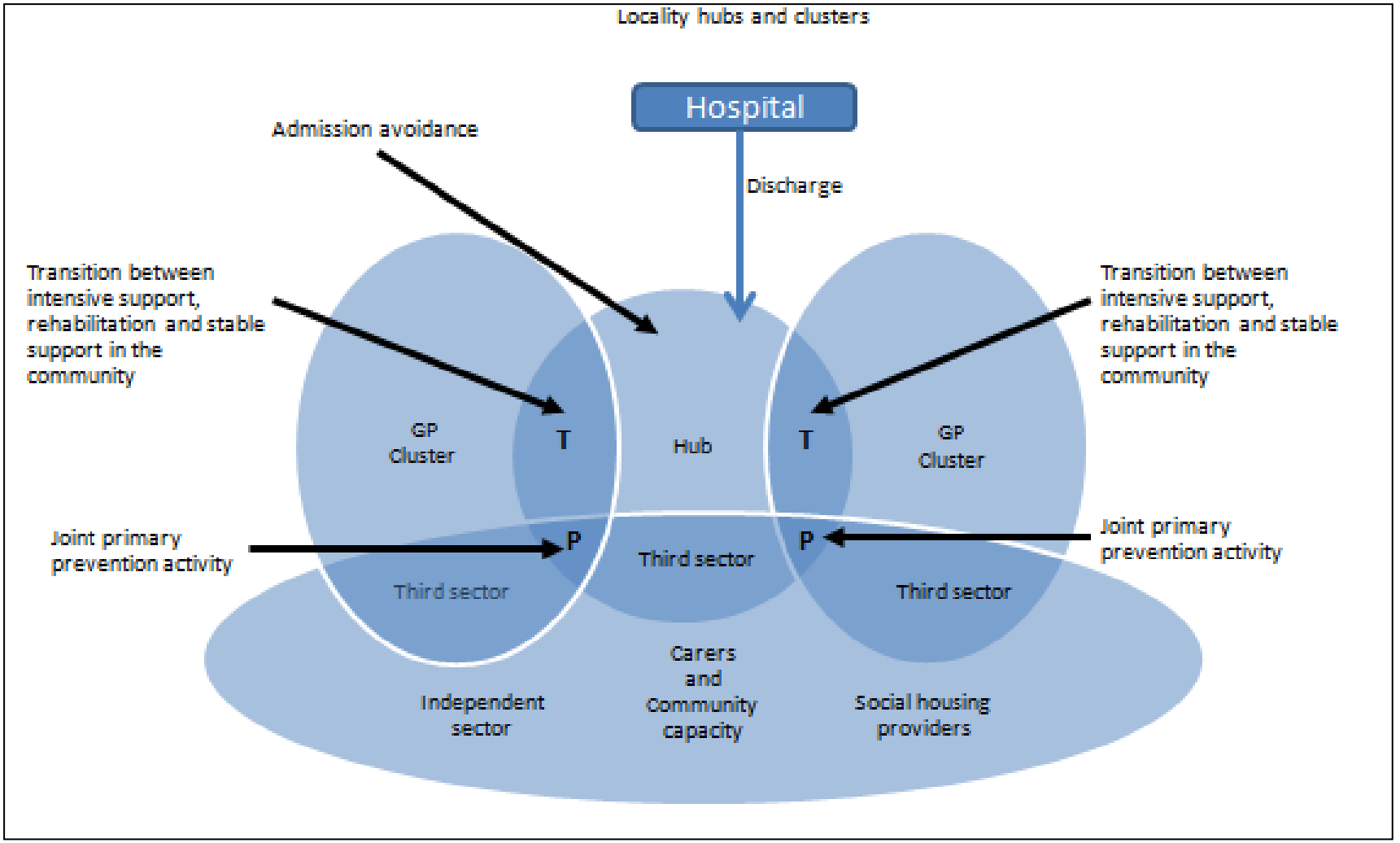
Improving the responsiveness of services when individuals with complex needs require an escalation in care and support, when their health deteriorates, or their normal care arrangements temporarily break down is a priority. We know this leads to people being admitted to hospital when there may be alternatives which could allow people to be cared for safely at home. Even when admission to an acute hospital is appropriate, too many people are unable to get home again in a timely way because community based services such as care at home are not easily restarted.

We will work with colleagues across all sectors to identify people with significant needs who are high users of services and improve anticipatory care planning with the aim of reducing emergency admissions.

The development of locality hubs and clusters is a key part of our approach. The first hub was piloted in South East/ Central locality during the winter of 2015/16 and the learning from this has been shared across the city. Close working with hospital based staff has been established and existing staff teams are being supported to work more flexibly to develop timely plans to meet people's increased needs at home where possible. When individuals are admitted to hospital, information on their care needs is being shared at daily reviews and joint plans developed to allow people to return home with support as soon as their acute care needs have been met.

All four localities will adopt the same team structure: a single hub to manage the transition of patients between hospital and community, and two clusters based on GP practices responding to immediate care need and providing longer term community care support.

The diagram below illustrates the planned interaction between the locality hubs, GP clusters, acute hospitals and community resources



A priority action for the Partnership is to develop hubs within each locality coordinating community resources more effectively in order to:

- *maximise support for independent living*
- *provide a community response to urgent need and care crises*
- *reduce the need for admission to hospital*
- *support timely discharge from hospital*

The vital role Primary Care plays in providing and co-ordinating care at a local level, and the increasing needs and demands which are managed by GP practice teams means they are the foundations of the Clusters and the teams closest to local communities we serve.

A "Total Place" approach to the co-ordination of all public sector and community assets has been adopted in two significant (economically disadvantaged) areas of the City. The two areas are coterminous with two of the eight Clusters, and the Headroom Initiative ensures Primary Care and in particular GPs are able to play an active role in developing this approach. In one of the areas House of Care is also being widely utilised as an approach to person-centred care for people living with long term conditions.

We will support the development of eight integrated health and social care Clusters based on geographical groupings of GP practices within the four localities to support more flexible ways of working in teams with a focus on prevention, early intervention, anticipating and planning for care needs and long term support.

During 2016/17 we will develop locality plans for each of the four localities that complement the locality improvement plans that are a requirement of the Community Empowerment Act

7. Tackling inequalities

The case for change

We know that people living in poverty, and those who are part of specific social groups, experience poorer life chances, reduced health and wellbeing and shorter life expectancy. Tackling the root causes of current levels of inequality as well as reducing the health and social impacts will help us to address the increasing demand for health and social care services.

Although life expectancy has increased steadily in the last ten years in Edinburgh, there are significant inequalities in the health experiences of different groups of people. Poorer health and earlier deaths affect those who face social and economic barriers or disadvantages such as poor housing, lack of employment, low pay or discrimination. At the most extreme, this can mean a difference in life expectancy of more than 25 years between the least and most affluent areas of the city. There are significant pockets of poverty within each of the four localities. People living in the least affluent areas are more likely to develop long term conditions and to develop them at least ten years earlier than their fellow citizens living in the most affluent parts of town; they are also at greater risk of emergency admission to hospital.

- 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.
- 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.

Health inequalities are not restricted to areas classified as experiencing multiple deprivation as defined by the Scottish Index of Multiple Deprivation (SIMD). Up to 50% of people experiencing poor health do not live in communities regarded as experiencing the highest levels of deprivation. Groups, including those with “protected characteristics” under equalities legislation, can also tend

to experience poorer health outcomes. There is evidence that being part of a specific group, for example looked after children, people with disabilities, minority ethnic groups and the LGBT community 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

Our strategic approach

The challenge for the Edinburgh Integration Joint Board is to adopt a strategic approach that is focused on meeting current need by providing the right care in the right place at the right time whilst also seeking to reduce future demand by investing in approaches that seek to prevent needs arising, tackle inequalities and promote independence. Health inequalities can be influenced to some extent by the way in which core services are delivered; however, many of the factors that lead to inequalities in health outcomes are outside the control of the Partnership. It is therefore vital that we work with our colleagues in the Edinburgh Community Planning Partnership to develop and implement a coordinated approach to tackling inequalities across the City. We will have a key role to play in making this happen as the Health and Social Care Partnership is responsible for delivering the following strategic priority within the Edinburgh Community Plan:

> *"Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health"*
> *focusing particularly on shifting the balance of care, reducing alcohol and drug misuse and reducing health inequalities*

Work to coordinate the approach to health inequalities has been undertaken by the Health Inequalities Standing Group, membership of which is drawn from the Council, NHS Lothian and the third sector. This Group has developed a Health Inequalities Framework and Action Plan and also administered the health inequalities grant fund, on behalf of NHS Lothian and the Council.

During 2016/17 we will work with our community planning partners to:

- *determine the most effective way of developing and implementing a coordinated approach to tackling inequalities, including health inequalities across the City*
- *deliver the health inequalities grants programme in line with funding decisions made by the Council and NHS Lothian*
- *assess the impact of the current grants programme on tackling inequalities in order to inform future funding arrangements*

The development of our Joint Strategic Needs Assessment has brought together data and information held by a number of partners and helped us to start to develop a picture of health and social care needs across the city. We have begun to develop a joined up picture of those geographic areas and social groups whose health and wellbeing is most likely to be impacted by the social and economic factors that lead to inequalities. We will continue to work with our partners including Neighbourhood Partnerships, to develop the Joint Strategic Needs Assessment in a way that helps increase our understanding of the strengths and needs of the local population and informs ongoing service planning and delivery at both a local and citywide level.

As an Integration Joint Board working at a strategic level we will:

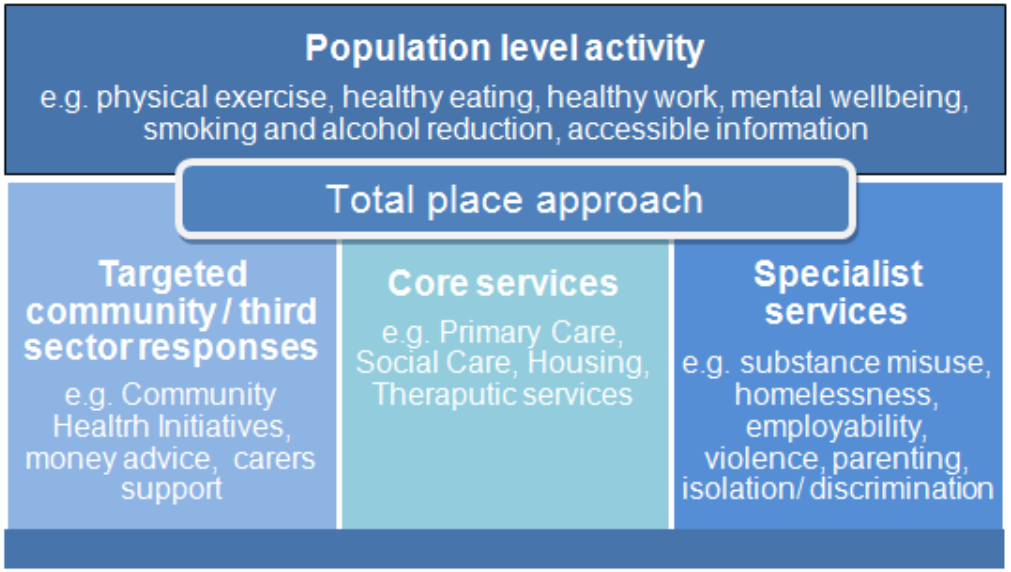
- *improve our understanding of the range and effectiveness of current actions and funding that impact on tackling inequalities in order to inform our future strategic direction*
- *embed tackling inequalities within our strategic and service planning, operational delivery and performance management framework*
- *develop improved intelligence about the distribution of Edinburgh Health and Social Care Partnership services and their uptake by people with protected characteristics, and where possible, by people living in poverty*
- *develop a set of 'equalities outcomes' in line with the Equality Act*

What we plan to do

Activity to tackle inequalities and have a positive impact on people's health and wellbeing takes place at a number of levels. Health promotion activity supports everyone to adopt healthy lifestyles whilst specialist services and initiatives target specific sections of

the population, geographic areas or issues where health inequalities are evident. The diagram below illustrates how we categorise the range of activities involved in taking a joined up partnership approach to tackling inequalities.

The move to locality working will allow us to gain a better understanding of the specific issues that lead to poor health and wellbeing within each locality and help us and our partners work with citizens and communities to develop plans to address these.



We will work with our partners including citizens and communities at a local level to determine our approach to tackling inequalities; these will be set out in the plans we develop for each of the four localities during 2016/17.

The third sector and social housing providers have a major role to play in tackling inequalities across the city through the provision of a wide range of services at a local and citywide level. We will fund a number of these through the Health Inequalities Grants programme in 2016/17 with a particular emphasis on increasing social capital, promoting healthy eating, physical activity and the use of green spaces, maximising incomes, supporting newcomers including refugees and asylum seekers and tackling stigma.

The core services delivered through the Health and Social Care Partnership operate across localities and work with the range of communities of interest in the city and contribute to tackling inequalities by supporting the population as a whole to remain as independent and healthy as possible. We also provide a number of specialist services targeting some of the groups that are most disenfranchised. Nevertheless, for some people inequality results from lack of access to the right care and support. Inclusive Edinburgh is a major initiative started in 2014 to engage all service providers to improve access to services, to provide psychologically informed services and to maintain an integrated response to people no matter the level of need, risk or complexity they present.

A number of initiatives have also been developed with a focus on supporting those who are most economically or socially disadvantaged.

A working group is in place to address health inequalities for people with learning disabilities; membership of the group includes people with learning disabilities and staff from the Council, NHS Lothian and third sector organisations. The aim of the group is to make sure that people with learning disabilities have the same good health as everyone else, are able to access health care when they need it and have accessible information to allow them to better understand their health needs. The group is focusing its efforts on five specific areas: eating healthily, being active, health checks and screening, good mental health and access to health care

In primary care, 17 GP practices have become part of the Headroom initiative which aims to significantly improve outcomes for people in areas with concentrated economic disadvantage. These practices cover 25% of the city's population and 50% of people living in areas of economic disadvantage. Working in partnership with the Council, third sector and other community organisations the Headroom practices are using a range of interventions to test the effectiveness of new approaches. One strong example is social prescribing which involves supporting people to access community based activities as an alternative or to complement prescribing medication or other public services.

We will build on the experience of the Headroom practices and other initiatives to develop the benefits and applications of social prescribing in order to determine where this approach is most effective and how to encourage wider take up as an alternative to traditional health and social care services.

The Patient experience and Anticipatory Care planning Team (PACT) works within the acute hospital setting using data on service usage to identify people who are frequently admitted to hospital and most at risk of emergency admission. The team seek out these individuals whilst in hospital and work with them and the clinicians treating them, to develop a shared management plan to reduce the likelihood of future admissions to hospital. This approach has proved effective in reducing hospital admissions. A significant proportion of the people the team works with are from groups recognised as most likely to be affected by social, economic and health inequalities.

We will support initiatives such as Inclusive Edinburgh, Headroom, the Patient experience and Anticipatory Care Team (PACT),

and the Health Inequalities and Learning Disability Group as part of our approach to better understanding the most effective means of addressing health inequalities in the city

Inequalities, including health inequalities are deep seated within our society and whilst actions taken to address them will deliver some positive results in the short and medium term the real impact of much of the work in this area will take decades to be realised. The Health and Social Care Partnership will engage in targeted activities to address specific health inequalities and work with our partners to support activities intended to address the broader issues of social and economic inequality.

During the life of this plan we will:

- *be an active partner in the locality based multi-agency Leadership Teams designed to tackle inequalities*
- *work closely with NHS Lothian's Public Health service to ensure our approaches to tackling health inequalities are well founded and supported with appropriate evaluations*
- *engage with a wide range of community based organisations at the locality level in a preventative approach which recognises and works alongside community assets*
- *consider the advantage of a training programme or events for our workforce focused on improving our understanding and response to inequalities*

People with protected characteristics

It is imperative that all health and social care services are accessible, appropriate and inclusive of and sensitive to the needs of all and that consideration is given to barriers that can limit access for particular groups. There is detail throughout this plan about how we will support some of these groups, people with disabilities and older people for example; however, our intentions in terms of supporting LGBT people and people from minority ethnic groups may be less clear.

We will continue to raise awareness and understanding of the challenges that LGBT people can face when accessing health and social care services, using the tools developed by projects such as Edinburgh LGBT Age.

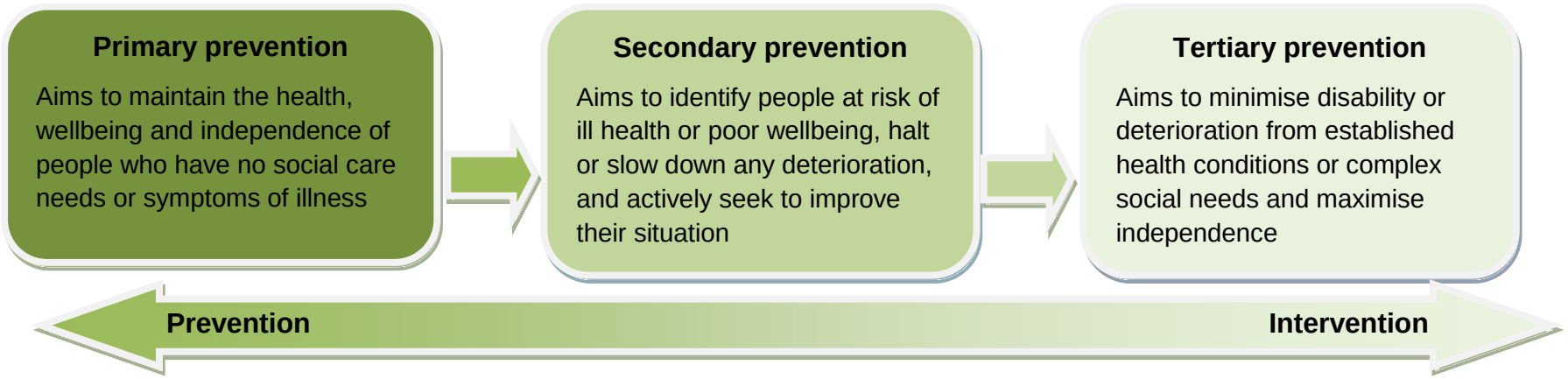
We will work with people with protected characteristics to better understand and meet their needs through the provision of specialist services where appropriate and by improving access to mainstream services.

8. Consolidating our approach to prevention and early intervention

There is a strong link between prevention and early intervention and tackling inequalities, so that actions taken to address one of these issues is also likely to have a positive impact on the other.

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:



- 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.

- 23% of the Edinburgh population 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 around 3% of the population in Edinburgh. 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.

Throughout this plan we give details about our intentions to develop and provide services that fit with the definitions of primary, secondary and tertiary prevention in the diagram above. However, there are a range of other services and initiatives not mentioned elsewhere, that play a crucial role in helping people to improve or maintain their health and wellbeing and retain their independence.

Health screening programmes such as regular dental and eye check ups along with targeted national screening programmes e.g. bowel cancer, play an important role in identifying and treating problems at an early stage. The importance of ensuring that all citizens are able to access these services has already been discussed in the section on tackling inequalities.

Developing a preventative approach is a key theme within 'Live Well in Later Life', Edinburgh's Joint Commissioning Plan for Older People 2012-22. While demonstrating the impact of preventative services can be challenging due to the longer term nature of the changes made, significant evidence of impact is available through qualitative and quantitative evaluation. Some practical examples which show how preventative services are helping people and reducing the demand on health and social care services are:

- *"I go to the hairdressers every week by myself now. The Doctor is taking me off anti-depressants as they weren't helping me"* (Community Connecting)
- *"There was a consensus around the table that, over the period we had been working with the Rita, she had presented at the surgery less. Previously she had frequently visited the surgery, often as a means of social contact, to talk about her low mood."* (Community Connecting)

- *"If the service had not been put in place David would be in a care home and not looking forward to a new sense of freedom"* (Community Alarms Service)

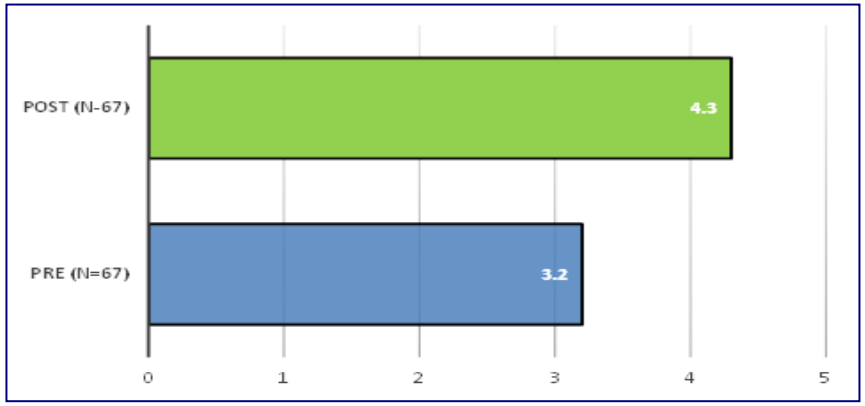
Additional investment from the Reshaping Care for Older People Change Fund (2011-15) supported a range of initiatives across primary, secondary and tertiary prevention. The Integrated Care Fund has enabled some of these to continue and we want to ensure sustainable funding if possible for successful initiatives following the end of this fund in 2018.

Regular physical activity helps prevent over 40 chronic diseases; evidence shows that just 150 minutes of moderate exercise a week reduces the chance of:

- Type 2 Diabetes by 40%
- Cardiovascular Disease by 35%
- Fall, Depression and Dementia by 30%
- Joint and Back pain by 25%
- Colon and Breast Cancer by 20%

There is evidence to suggest regular physical activity can also: improve mental health and well-being, reduce blood pressure and contribute to healthy weight maintenance.

Fit for Health is a physical activity programme designed to improve the health and well-being of people with one or more long term condition including cardiovascular disease, heart failure, respiratory disease, diabetes and peripheral artery disease. We currently work in partnership with Edinburgh Leisure to deliver Fit for Health at five leisure centres in Edinburgh.



Over 468 people have been referred to the Programme since April 2014. People who have participated in the programme are now exercising more frequently – an average of 4.3 days per week – see the graph above which shows the number of days per week participants reported being active for 30 minutes or more. Blue shows before and Green shows after completing the Fit for Health programme. We will continue to work in partnership with Edinburgh Leisure to deliver and develop the Fit for Health physical activity programme for people with long term conditions.

The risk of falling increases with age (30% risk for those over 65 years, 50% risk over 80 years), and with this comes increased risk of fractured bones. It is estimated that *40,000* older people in Edinburgh are at risk of at least one fall per year. The Scottish Ambulance Service responded to *3,626* call outs to a fall in 2014 to people over 65 years, with 77% of these being taken to hospital. In 2014, there were *6,853* falls related presentations to the hospital emergency department.

Edinburgh's falls prevention strategy follows the National Framework for Community Falls Prevention in Scotland. The Falls Service also works in partnership with the Community Alarm Tele-care Service (CATS) who respond to approximately 9,000 calls per year to provide assistance to people who have fallen and carry a personal care alarm.

Following a fall, people can be referred for assessment to either Intermediate Care or Day hospital assessment units. Some people might get referred to community exercise programmes such as Steady Steps (run in partnership with Edinburgh Leisure) or the Be Able and Fit for Life programmes which use a reablement approach to improve personal resilience. In January 2015 alone there were approximately 2,700 referrals to these services

We will:

- *work with partners to map services, assets and resources within localities that could be used to improve people's health and wellbeing*
- *use locality level forums to assist organisations to come together, build relationships, share ideas, and develop collaborative working to meet local needs. There will be key links to the Locality Hubs too to ensure the right people offer the right support*
- *build on the development of the LOOPS (Local Opportunities for Older People) initiative to enhance the opportunities for older people to retain socially connected and independent lives within the localities where they live, and continue to raise awareness across the public, staff and volunteers of opportunities locally*
- *identify local needs, gaps in services and develop co-produced and innovative solutions which build community capacity Priority areas include:*
    - reducing social isolation
    - promoting healthy lifestyles
    - falls prevention
    - supported self management of long term conditions

  - support for unpaid carers
  - technology enabled care and supporting older people to use technology
  - transport options
- continue to work in partnership with Edinburgh Leisure to deliver and develop the Fit for Health physical activity programme for people with long term conditions
- continue to develop a prevention and response service for people most at risk of falling, and work to prevent falls and reduce the number of falls presenting unnecessarily to hospital emergency departments through ongoing partnership working with Edinburgh Community Tele-care Service and the Scottish Ambulance Service
- build on pathways across primary/secondary care, health and social care and third sector interfaces to ensure individuals at high risk of falls receive coordinated management to reduce falls and injury

Support for unpaid carers

Unpaid carers play a vital role in supporting friends and family members with health and social care needs to live as independently as possible. We recognise the importance of supporting carers to both continue in their caring role and look after their own health and wellbeing. The Edinburgh Joint Carers Strategy, co-produced in 2014 between the City of Edinburgh Council, NHS Lothian, carers and carers organisations has a vision that *adult carers are able to live healthy, fulfilling lives and that they will be valued as equal partners in the provision of care and inform decisions about carer support. Carers will be able to sustain their caring role, if appropriate and if they choose it'.* The Health and Social Care Partnership shares this vision and will support the delivery of the action plan to address the following six priority areas set out within the Carers Strategy:

- identifying carers
- information and advice
- carer health and wellbeing
- short breaks / respite
- young adult carers
- personalising support for carers

The Carers (Scotland) Bill is currently being considered by the Scottish Parliament. Once enacted the Bill will place additional duties on public bodies to provide support to young and adult carers and put them at the centre of decision making on how services are designed, delivered and evaluated. Two individuals with experience of providing unpaid care currently sit on both the integration Joint Board and the Strategic Planning Group. The Board will continue to work in partnership with carers during the implementation of this plan and the development of related plans and strategies.

During the life of this plan we will:

- continue to implement the action plan associated with the Edinburgh Joint Carers Strategy 2014-17
- develop a new Edinburgh Integrated Carers' Strategy and establish our new priorities in line with National Carers Policy, New Carers Legislation and the Integration Joint Board's priorities on Prevention and Early Intervention

9. Ensuring a sustainable model of primary care

Why we need to change

The term 'Primary Care' covers the wide grouping of health professions and support staff providing universal first line healthcare advice, diagnosis and treatment in the community and referring to secondary (usually hospital based) health services when needed. These staff include GPs, district nurses, physiotherapists, dieticians, podiatrists (chiropody), pharmacists, dentists and optometrists. The importance of engaging GPs in particular and primary care teams generally in health and social care integration is emphasised in the policy guidance which established health and social care partnerships.

A robust primary care system of GP practices, working well within communities and in partnership with other staff and services, such as wider community teams, social care and the third sector, is crucial to delivering the priorities in the strategic plan. We need to ensure everyone has access to the services of a GP practice in a timely way since GPs are the first point of contact for most people about health and care issues.

It is clear that the GP services in Edinburgh are under substantial pressure. This is due both to increasing workloads and the significant challenges facing GP practices in recruiting and retaining sufficient skilled staff. Workload pressures in primary care arise from a range of factors including population increase, an increasingly older population and the overall strategic direction to shift the balance of care from hospital to the community.

There are common workforce challenges which affect many of the different professional groups who work in primary care mentioned above. These include an ageing workforce, more staff choosing to work part-time, staff numbers not increasing in line with increased population numbers and the more complex needs of people living at home, in care homes and in other community settings.

The ratio of GPs per head of population in Edinburgh has decreased from 1.06 per 1,000 in 2008 to 1.02 in 2013, while workload has increased. GP surveys show a significant level of GPs, particularly trainees, wishing to work part-time or move abroad. This is not unique to Edinburgh and there is an ongoing national challenge in recruiting and retain GPs including within out of hours GP services. Similarly, the core district nursing workforce has not kept pace with population growth and the increasing complexity of

patients living at home. As with GPs, the nursing workforce is ageing with a high proportion of senior and experienced District Nurses over the age of 55.

Integration offers an opportunity to look at community services holistically, including both social care services such as home care, and health services such as district nurses, GPs, physiotherapists etc. It provides an opportunity to redesign how we work and to develop new models of care, especially for frail older people and those with multi-morbidity, which better connects these health, social care and community services and resources around the needs of particular individuals and groups, rather than in professional groupings. We need to look at different workforce models for delivering primary care services in the future including better ways of using the medical expertise of GPs, advanced practice roles for nurses and a strengthening of the pharmacist role. Integral to providing safe and effective care will be ensuring clarity around roles and responsibilities of all those involved.

Integration also offers the potential to simplify the health and social care landscape to make it easier for staff and citizens to access the right care and support in a co-ordinated way. Making it easier for GP practices to access wider resources for prevention of admission and to provide “hospital at home” services is a key objective of the locality hubs. Primary care teams currently negotiate complex local networks to provide support for patients, and we need to design our systems to improve access to appropriate services in a timely way.

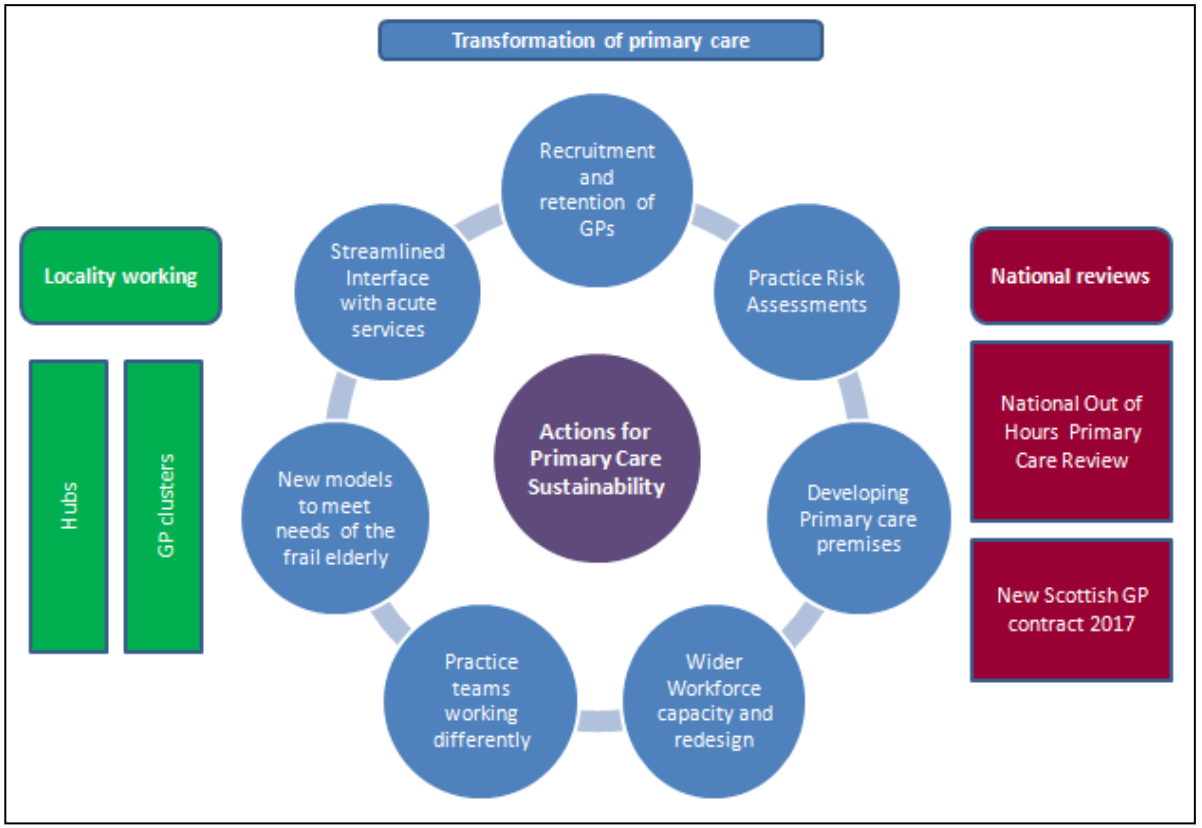
Alongside our local plans, national discussions are underway on a new contract for GPs in Scotland to be implemented in 2017. While not yet agreed, we expect that this change will see a greater focus on using the skills of GPs as “Expert Medical Generalists” who assess health and care needs, develop and coordinate plans with patients and carers and work with extended teams to put these plans in place. This direction of travel fits well with our vision of integrated services. A national review of Out of Hours GP services has recently reported and we will work with East Lothian Health and Care Partnership which hosts this service in Lothian to consider the implications for the Lothian Unscheduled Care Service (LUCS).

Primary Care Prescribing (by both GPs and non-medical prescribers) for patients in Edinburgh costs around £70m each year, xx% of the Health and Social Care partnership’s budget. This equates to approx £143per person in Edinburgh, which is lower than other parts of Lothian, and the rest of Scotland, reflecting existing good quality cost effective prescribing practice. GPs, the Pharmacy Support Team, and community pharmacists work together to monitor the effectiveness and safety of prescribing in primary care. Primary care teams will continue to work with the public to improve their understanding of the medicines they are prescribed, with

the aim of increasing the health benefits and reducing the risk of harm and avoidable waste from poor compliance with treatments. While in many cases, prescription medicines offer the best treatment for illnesses and long term conditions, for some people and problems, other approaches, including "social prescribing" can offer alternative non-medical sources of support alongside or in place of medication.

What we plan to do

Our key aims are to support the transformation of primary care through 6 workstreams as set out in the diagram opposite.



i. **Work with GPs to improve Resilience of Practices**

It is vital that we support practices in Edinburgh to remain viable and able to care for their registered population. We are already supporting practices and working with them to identify difficulties and risks and find ways to resolve these. We are also committed to implementing measures to make general practice an attractive career, and are implementing a range of measures to improve recruitment and retention of GPs in Edinburgh. This includes offering flexible roles which give GPs the opportunity for combination posts, looking at ways to

encourage retired GPs back into part-time work and the national "GP returner scheme" to encourage those who have left general practice to return.

We will continue to gather information from all practices to develop a better understanding of the workforce and to engage with GP practices on their 'resilience' in order to offer support at an earlier stage where a practice is experiencing staffing or other difficulties.

ii. Supporting practices to work differently

Continuing to work in the same way is not an option. Through the development of localities and in particular the formation of the eight GP practice based clusters across the City we will support general practice, and wider primary care, to be at the centre of discussions on redesign across the system. GP leads from each of the Clusters will be invited to be part of the Locality Management arrangements, ensuring Primary Care is able to influence the Partnership's operational planning and decisions. This will help us to develop more person centred ways of working and to be more integrated, efficient and productive.

We are already working with GP practices and other community staff groups to develop new and creative ways to work. This includes looking at new ways of accessing GP services, e.g. telephone follow up appointments; exploring the use of time saving technologies, e.g. self monitoring of blood pressure by patients; new ways to manage the needs of frail older people (such as locality hubs and new models of support to care homes); developing the skill mix of staff in GP practices; employing pharmacists to manage pharmacy workload and medication reviews and opportunities for shared management and administration resources across practices.

We will encourage and support general practice to examine newer ways of working, to review their own workload and pressures, to look at new ways of working to support practice specific demands, and to encourage redesign of general practice to meet these new demands. We will review the evidence base for social prescribing which offers alternatives to traditional medical approaches and ensure it informs future delivery.

We will continue to support the 17 Headroom practices, which form two of the eight City Clusters, to explore new ways of working with economically disadvantaged communities and to test arrangements which can inform the 2017 GP contract.

iii. Building the wider primary care team capacity and capability

New ways of working are needed not just for GPs and their staff but for the whole primary care workforce so that they are better able to meet future demands. We will review the operation of all our clinical managed services, such as community nursing, pharmacy, and allied health professions e.g. physiotherapists, and redesign and develop these to meet the challenges we are facing. We will work with children's services to ensure effective transitions for children too.

A key priority in developing the primary care workforce will be to take steps to support all professional staff groups to be better integrated around the needs of the people. Through collaboration and innovative approaches, we want to ensure a sustainable and affordable staffing model for primary care and community services and work with acute services to share opportunities for skills development and shared learning.

Many services can be accessed directly without the need for a GP referral. We need to work with national services like NHS Inform to make people aware that they can and should contact an NHS optometrist, dentist, pharmacist, podiatrist or physiotherapist directly for relevant problems, rather than their GP. This would both save time for the patient and reduce the workload of GPs.

We will do this by:

- identifying ways to maximise the contribution of community nurses who support those with healthcare needs, including frail older people living at home, and in care homes, as part of developing a sustainable model of care for this group of people
- continuing and extending medicines reviews for people taking a large number of medicines (polypharmacy) in care homes and in the community, focused on the high risk groups, linked to "Prescription for Excellence" funding

- expanding the primary care pharmacy workforce, salaried and sessional, to work alongside and support GP practices
- testing and rolling out models of "teach and treat" polypharmacy clinics to assist patients to better manage their own medicines
- increasing opportunities for social prescribing for anxiety and depression, for example, as an alternative to prescription medication
- considering better ways to inform the public of how to access directly health services which do not require a GP referral

iv. Developing Premises to meet Population Growth

The population of Edinburgh is growing by around 5,000 each year, so having GP practice premises in the right locations for people to access is important. The Edinburgh Primary Care Premises Strategy has been developed to identify practices and neighbourhoods where expanded or additional GP premises and/ or practices are needed, largely as a result of housing developments, or to replace older buildings which do not meet current standards. Finding sites for new practices to be built in the city will require joint working with Council planners and private developers, to ensure the need for land and resources for new or expanded GP practices is considered alongside the impacts on schools, roads and other amenities. We will continue to explore opportunities to re-use land and premises no longer required by NHS and City of Edinburgh Council for development to meet future needs.

We will work with NHS Lothian to build and expand GP premises to increase capacity, including:

- starting construction of 2 new partnership centres in 2016, incorporating GP practices and community services at Firrhill and establishing a new practice in North West Edinburgh
- building new premises for Leith Walk and Ratho GP practices in 2016/17
- relocating the Edinburgh Access practice (due to tenancy expiring) in 2016
- expanding practice accommodation at Liberton and South Queensferry GP practices during 2016
- exploring opportunities at up to 4 other practices to extend/refurbish practices to increase capacity
- supporting a number of practices to create additional consulting space
- exploring potential development opportunities particularly for incorporating practice reprovision in wider healthy living initiatives

v. New models to better meet the needs of the frail older people at home and in care homes.

The number of frail older people living in the city is growing and we need to ensure that primary care is able to meet their requirements. GPs have a key role in assessing and managing the healthcare needs of the very elderly living at home or in care homes, who are likely to be living with long term conditions and to need access to care and support on a more frequent basis. As set out earlier in this strategy, we want to develop alternative models to support frail older people to remain at or close to home. These need to be designed to make best use of the skills of GPs and the wider primary care workforce, in particular community nurses and pharmacists, and with easy access where required to more specialist expertise, including Medicine of the Elderly and Old Age Psychiatry. The Hospital at Home model aims to bring services and staff skills to the patient where possible, rather than transporting a frail older person unnecessarily to an acute hospital.

Integrated community health and social care teams and locality hubs will be designed to enable a more joined up approach, making it easier for GPs to access the range of services and supports needed for their patients. Taking account of the learning from the Behaviour Support Service and Care Home Liaison pilots, we will develop alternative models of support to care homes to ensure primary care and specialist teams engage effectively to allow people to avoid unnecessary hospital admissions. We will deliver the recommendations of “Promoting Continence in Lothian” report to improve community based support for individuals.

vi. Improving the interface between primary and secondary care

We need to ensure that primary and secondary care work well together, so that people can have as streamlined a healthcare journey as possible, with information easily shared about medical history, current medicines and care arrangements to ensure patient safety and so that people do not need to repeat their story again and again.

When people do need the services of acute hospitals, especially in an urgent (unscheduled) situation, the process of referral and assessment at the hospital front door should be as simple to navigate for primary care as possible, and the acute

hospital should be able to develop plans for treatment and aftercare with input from the patient and their carers, and the support of community health and social care teams, which avoid delays in discharge.

We want to shift the balance of care so that more care and support is provided at or close to home, and GPs and the wider primary care team have a key role in co-ordinating care and providing the continuity of care people value. We say more about our approach to this is relation to older people and those with long term conditions elsewhere in this plan.

Providing good quality palliative care which supports people as they near the end of life is important too and the recent National Strategic Framework for Action for Palliative and End of Life Care will influence our plans in this area, along with the local redesign programme developed in partnership with Marie Curie.

To help achieve integration of care pathways at a locality level we will work with other Lothian Integration Joint Boards and acute hospital division to develop a single model for acute unscheduled care services across the city, including early assessment at hospital front doors, and approaches which provide alternatives to admission, and which work effectively with local community services in Edinburgh.

We will work with primary and secondary care colleagues to improve processes for care across the interface and transition between primary and secondary care to improve efficiency and safety, e.g. medication reconciliation and discharge planning.

10. Improving care and support for frail older people and those with dementia

Why we need to change

The transformation of services for older people and people with dementia is key to delivering the vision and aims of the Strategic Plan, and improving these care pathways is one of the most urgent areas for attention if we are to provide the right care in the right place at the right time. 25% of the total health and social care budget relates to spend on older people's services and demographic change means that the rate of increase in the over 85 age group is predicted to be greater than for any other age group.

Most people want to live healthy independent lives for as long as possible. People in Edinburgh are generally living longer which is a cause for celebration, and older people make a very significant contribution to our communities as unpaid carers of both young and old, as volunteers and community leaders and through continuing as part of the paid workforce beyond traditional retirement ages.

However our ageing population also presents challenges for health and social care services, as people are increasingly likely to develop more complex long term health conditions, including dementia as they get older. Fundamental changes are required in how our services operate to make them more responsive and focused on maximising independence, early intervention to prevent deterioration, promoting rehabilitation and supporting people at end of life with dignity and respect.

While this section focuses on older people, we know that living with frailty and long term conditions can also affect younger people, and people with disabilities. We recognise that the care and support needs of individuals should take account of their unique circumstances, and therefore services need to work across traditional client group boundaries and silos.

Our key aims are to:

i. Shift the balance of care from hospitals to community based settings
ii. Develop whole system capacity plans to provide the right mix of services
iii. Improve support for people with dementia through integrated services which the provide the right support at the right time
iv. Embed rehabilitation, reablement and recovery approaches to maximise independence and support self-management
v. Develop preventative services and activities that improve health and wellbeing and prevent or delay access to more intensive services and support

i. Shifting the Balance of Care

There has already been a significant shift in the balance of care from hospitals to community. The percentage of older people with high level needs (10+ hours of care per week) who are cared for at home has increased from 14% in 2002 to 35% in 2015. The average number of hours of care at home provided to individuals has also risen, reflecting increased needs. Within care homes, the proportion of people with lower dependency levels has almost halved to 22% of the resident population, whereas those with the highest needs has increased from 8% to13%. In order to sustain the current balance of care and shift this further, a redirection of resources and new ways of working are required to enable community services to meet increasing demand and provide quality care for people living in the community with increasingly complex conditions.

We know that hospitals are not a good environment for providing longer term care for people whose needs could be met at home. At October 2015 in Edinburgh there were 149 people delayed in hospital. While reasons for delays can be complex, in the majority of cases it is because the level of care needed to allow the person to leave hospital is not in place.

While the number of older people waiting in hospital for a care home place fell at the beginning of 2015 and has remained relatively stable since, the number of older people waiting in hospital for a package of care at home has increased throughout 2015. Care at home services provide essential care and support to help people maintain independence and live at home for as long as possible. The number of hours of care provided each week has increased from 34,000 in 2012 to 40,000 in 2015 and the average size of packages has increased from 12.2 to 14.5 hours per week, reflecting the increased needs of people being supported at home.

However, demand still exceeds the capacity available by a shortfall of between 4,500 and 5,000 hours of care a week in November 2015. This results in people remaining in hospital longer than necessary or waiting in the community, increasing stress on unpaid carers and increasing the risk of an unplanned admission to respite care or hospital. Workforce availability is a key factor limiting the available capacity, influenced by low pay rates for care work, along with council budget funding constraints.

We have established the Older People Service Redesign Executive to bring together those responsible for delivering assessment, treatment, care and support along the frail older people and people with dementia pathways as a focal point to plan and deliver change. We are working with support from Healthcare Improvement Scotland to increase our understanding

of drivers of demand, identify how we can better use our current capacity and capabilities and develop plans to rebalance the system and address key gaps and barriers through optimising the use of our core resources and bridging change with support from Scottish Government.

From October 2016 we will commission care at home on a locality basis through new contracts with the independent and third sector, ensuring that local care providers can work closely with local homecare organisers and engage with the locality hubs to maximise flexibility and capacity to meet care needs.

We will also support the development of alternative delivery models across market sectors to deliver cost effective and good quality care at home, through a potential third sector collaborative for example

We will work with housing providers and the council housing strategy team to identify future needs and support the development of more accessible and affordable housing to meet the needs of frail older people and those with dementia, and develop housing options to meet these needs

ii. Developing whole system capacity plans to provide the right mix of services

The partnership recognises the importance of developing our plans to ensure we can provide the right mix of service capacity if we are to provide the right care in the right place at the right time. We will continue to develop whole system mapping of capacity and demand, with support from Healthcare Improvement Scotland, to help achieve the optimum patient pathways and determine the resources we need to ensure seamless transitions for individuals from home to hospital when required and back to home or homely settings whenever possible.

Building sufficient capacity in primary and community care core services to support growing numbers of older people with increased levels of need in the community, including people living in care homes, is vital. A focus on prevention and anticipatory care is required across all services. Our plans to develop a sustainable model in primary care, set out in section 9 above, are key to improving care and support to help people live at home as long as possible.

At the same time we need to work with colleagues in acute hospitals to ensure that the transfer of care between GPs and hospital staff is effective, and that older people are able to get timely access to urgent care including specialist assessment and support from specialists in the care of older people, including specialist skills in dementia when required.

Resources currently spent keeping people in hospital beds could be better spent providing the right kind of care and support to people at home, and we will be working with the other Partnerships in Lothian and the acute hospital division to deliver alternative care models which will allow the resources currently tied up in Liberton Hospital, and the Royal Victoria Hospital site to be redirected. Work is already underway to identify the longer term need for Hospital Based Complex Clinical Care in the city, taking account of recent Scottish Government guidance, and consider options to ensure that patient facilities and staffing profiles meet these needs. This will incorporate learning from the Healthcare Improvement Scotland review of Hospital Based Complex Clinical Care in Edinburgh which is expected to report in April 2016.

We will:

- *consider the longer term needs for interim care beds currently being provided at Gylemuir House and determine the future model of delivery for this service during 2016*
- *update our capacity plans for long stay nursing and residential care home places, including those which care for older people with behaviours that challenge, and provide specialist dementia care, alongside our capacity planning for those whose needs cannot be met anywhere but a hospital during 2016.*
- *develop alternative models of support to care homes to ensure primary and community services and specialist teams engage effectively to avoid unnecessary hospital admissions and allow people to receive the care they need*
- *explore the opportunities to use the resources and assets associated with the Royal Victoria and Royal Edinburgh Hospital sites*
- *evaluate the need for the development of an Integrated Care Facility model to meet our capacity requirements for the care and support of older people, as part of the Hospital Based Complex Clinical Care review, and work with the council housing team to deliver homes for older people with higher needs*
- *support the implementation of the palliative care redesign programme in partnership across Lothian*
- *work with neighbouring IJBs and the Acute Division of NHS Lothian to allow the closure of Liberton hospital and release resources for reinvestment in community based services*

iii. Improving Support for People with Dementia

In Edinburgh, it is estimated that 7,823 people have dementia, over 95% of whom are aged over 65. People living with dementia are very likely to require high levels of health and social care support as their illness progresses. It is estimated that the average cost of dementia care and support per person is £27,647 per annum. A Scottish Government performance target introduced in 2013 requires that all people newly diagnosed with dementia have a minimum of one year's post-diagnostic support coordinated by a link worker. The partnership has provided a Post Diagnostic Support service for all those newly diagnosed with dementia since 2014, funded through the Integrated Care Fund. The service is coordinated by six Link Workers employed by Alzheimer Scotland, who deliver support to 300 people recently diagnosed with dementia.

The incidence of dementia is increasing and it is important that those working in all sectors of health and care are trained to work effectively with people with dementia.

We will:

- *develop an improved pathway for people with dementia from assessment, diagnosis, and post- diagnostic support, including effective engagement between Medicine for the Elderly and Old Age Psychiatry Services, to ensure individuals get the specialist support they require in a timely way*
- *develop a plan in response to the intended reduction in old age psychiatry in hospital beds at the Royal Edinburgh Hospital to ensure adequate capacity to provide appropriate discharge planning and personalised care and support in the community for people with mental health problems including dementia*
- *build on learning from the Behaviour Support Service and Care Home Liaison pilots to develop an improved model to support care homes to care for people with dementia and those with complex needs*
- *provide training for staff in all sectors working with people with dementia*
- *continue to develop the award winning Dementia Friendly Edinburgh programme*
- *work with housing providers to support the development of more dementia friendly housing*

iv. Embedding Rehabilitation, Reablement and Recovery Approaches

There are many examples of services for older people that have been designed around the principles of rehabilitation, reablement and recovery which have been shown to deliver better outcomes for individuals whilst also making best use of resources. These services aim to provide intensive short term support to maximise the independence of people, supporting rather than doing things for them, and focus on what is important to the individual. We want to ensure that everyone who can benefit has access to this opportunity and that this approach is embedded in all care pathways. Examples of such services supporting older people are:

- Re-ablement
- Intermediate Care
- Be-able
- Falls prevention
- Mental health recovery

We know that a significant number of people have been unable to access reablement in the last two years due to blockages in our system and we are already taking urgent action to address this. Our overall capacity planning work will help us understand the reablement and rehabilitation capacity we need to deliver timely and appropriate care in the longer term.

We are temporarily increasing the level of care at home capacity to be able to offer timely access to reablement to match needs, and ensure that people can move on from reablement with their longer term needs met, so that the reablement capacity is released to support others who can benefit from this service.

We will plan for the right balance of reablement and rehabilitation within our overall capacity planning work and ensure this is a core accessible support service within the locality Hub model going forward.

Jenny's Story – how the locality hubs can make a difference

Jenny is 86 years old and lives alone.
She:
- copes okay with good support from her family who call in everyday.
- Receives 5 hours care at home a week to help her get up and dressed
- Attends a local lunch club run by a third sector organisation

In January 2015 Jenny's son, Bob, calls on her and find her in a very confused state, she has fallen and hit her head which is bleeding.

Bob calls Jenny's GP who comes out to visit her. The GP diagnoses that Jenny has a urinary tract infection, is dehydrated and has a very high temperature.

In the past the GP would probably have arranged for Jenny to be admitted to hospital. However, now he contacts the new Locality Hub.

Staff at the Hub decide that a community nurse is the best person to visit and coordinate support for Jenny.

The community nurse talks to Jenny and her family and decides that she can be cared for safely at home. To enable this to happen he arranges:
- a visit to the Day Assessment Unit so that Jenny can be rehydrated; and
- additional care at home hours and additional support from the family to make sure that Jenny is eating, drinking, taking her medication and generally keep an eye on her to get her back on her feet

A volunteer from the lunch club also pops round to see Jenny and keep her up to date with what is happening at the club

After 10 days Jennie's condition is back to normal. The additional care hours are no longer needed and she can get back to the lunch club .

The introduction of Locality Hubs will increase the chances of Jenny and others like her being cared for in their own homes rather than admitted to hospital. This is better for her as she is able to maintain her independence and is happier. It is also a much better use of scarce resources to support Jenny at home and means that hospital beds are available when needed for those who cannot be cared for at home.

11. Transforming services for people with disabilities

There has been a welcome increase in the life expectancy of people living with a range of physical, complex and learning disabilities. In part, this is due to the greater survival rate of children with disabilities and improved support and rehabilitation for people with progressive conditions. At the same time, there has also been a change in social attitudes that recognises people with disabilities as friends, relatives and colleagues who have a valuable contribution to make to the life of their communities. In terms of health and social care this has led to a drive to support and enable people with disabilities to live as independently as possible, taking as much control over their lives as they wish and ensuring that they have access to services available to other sectors of the community.

Learning disabilities, autism, many physical disabilities, complex conditions and sensory impairments are life long conditions. However, responsibility for the provision of care and support for people with disabilities from both the NHS and social care changes at the point of transition to adulthood, with different services and budget regimes coming into play. This transition can cause significant difficulties for the young person, their families and carers. Detailed planning with families for their sons and daughters to live independently from them has been successful in significantly reducing the need for crisis placements. Early intervention in childhood with families of children with behaviours that challenge, recognition of the strengths of the person and the contribution they can make would improve transition to adult services.

We will work with partners to establish options for developing a cradle to grave service for people with learning disabilities in Edinburgh to improve support for the transition to adulthood by March 2017.

The Health and Social Care Partnership will continue to develop models that help people with disabilities live more independent lives, reduce dependence on services by improving the response to families with children with disabilities, minimise breakdowns in service at points of transition, reduce dependency on night time services and reduce hospital admissions by enhancing community based services.

It is also important to recognise that some people may be living with a number of different disabilities, be aged over 65 and have experience of mental health problems. The Health and Social Care Partnership recognises the need to move away from working in

silos based around services or conditions and develop a way of working that is person-centred and focuses on the strengths, needs and aspirations of the individual. We believe that the move to locality working will help us make this shift.

Services for people with learning disabilities

The Scottish Government strategy the 'Same as You' indicated that 2% of the population have a learning disability with the vast majority being unknown to health and social care services. The City of Edinburgh Council knows of 3,405 people with learning disabilities in the city, 480 of whom are aged over 60. It is anticipated that the number of older people with learning disabilities will increase threefold over the next decade.

The main thrust of the Scottish Government's strategy for improving the quality of life for people with learning disabilities 'The Keys to Life', is about improving access to health care and support to achieve outcomes related to healthy life choices so that people's human rights are respected and upheld. We have already made reference to the fact that people with learning disabilities are more likely to experience health inequalities than the majority of the population. Supporting people with learning disabilities to live as independently as possible in the community is central to delivering on both the Government's ambitions and the vision and priorities set out in the strategic plan.

40% of people with a learning disability have communication difficulties and within this group 80% with severe learning disabilities do not acquire effective communication. The provision of information and advice in easily understandable formats such as easy read can greatly enhance people's ability to engage in ordinary activities. Supporting people with learning disabilities to take part in regular health checks enables them to be more involved and, where desired, take more control over their own health and wellbeing.

People with mild learning disabilities need support to navigate health and social care services and are particularly vulnerable to issues of adult or child protection and falling into debt, yet they struggle to access any support services. Welfare reform has dramatically affected people with disabilities, who need assistance to claim and support to argue for basic benefit entitlements when they are reviewed.

Approaches that focus on building confidence, skills, travelling independently and friendships are crucial to changing the service dependency culture in learning disability services.

The modernisation and redesign of hospital based learning disability services is dependent upon the development of integrated community services leading to a reduction in the need for inpatient learning disability beds. This fits well with the Health and Social Care Partnership strategy to transform services for people with disabilities by shifting investment from hospital to community based support. As many of these services are provided on a Lothian-wide basis and not just for Edinburgh, this will involve working in partnership with NHS Lothian and the Integration Joint Boards for East, Mid and West Lothian via the Lothian Learning Disability Collaboration, to agree both the allocation of funding released through the redesign of hospital services and to co-ordinate detailed plans for this to take effect.

Services for people living with autism

It is estimated that around 4,850 people in Edinburgh are living with autism, approximately 2,400 of whom do not have a learning disability. Whilst the diagnosis of autism in children is now more accessible, many adults have gone through childhood without their condition being diagnosed.

The Edinburgh Autism Plan for people with autism who do not have a learning disability was developed in 2013, in partnership between the City of Edinburgh Council, NHS Lothian, third sector organisations and people living with autism. The plan sets out six priority areas for action:

- development of a care pathway to ensure that people get the right service at the right time
- ensuring the wellbeing of children with autism
- providing better support on housing matters and the right kind of housing
- increased support in finding and keeping employment
- improving people's quality of life
- better training to increase awareness of autism in services and amongst carers

The Health and Social Care Partnership is committed to the ongoing delivery of the Autism Plan.

During the life of this plan we will:

- *Work with NHS Lothian to modernise the learning disability inpatient facilities and develop forensic and positive behaviour support services in the community focused on prevention of admission to hospital*

- *reach agreement with Lothian partners on the allocation of NHS resources as hospital services are redesigned*
- *realign existing internal day support services for people with learning disabilities into two streams; complex care and community based support*
- *work with all providers of day support to develop a framework agreement for these services*
- *evaluate a model of working collaboratively across the NHS, social care, third sector and families to prevent admission to hospital, from either supported accommodation or the family home*
- *take action to raise awareness of autism amongst front line workers, carers and the public in the city*
- *develop a care pathway to improve access to diagnosis and post diagnostic support in the first year for adults with autism who do not have a learning disability*

Services for people with physical disabilities

In 2007, there were estimated to be 30,735 people aged between 16 and 64 living with moderate to severe physical disabilities in Edinburgh, this figure is predicted to increase by 1.4% a year based purely on predictions about increases in the size of the overall population. There is a higher prevalence of disability amongst those aged over 65 which is largely explained by the fact that the likelihood of developing a disability increases with age.

The Scottish Government have recently released their public consultation setting out their Delivery Plan 2016 – 2020, for implementing the UN framework, to remove barriers and enable people with disability to enjoy equal citizenship throughout Scotland. The four main outcomes of the draft national delivery plan are that disabled people, including disabled children, have equal and inclusive access to:

- the physical and cultural environment, transport and suitable, affordable housing
- health care provision and support for independent living
- education, paid employment and an appropriate income and support whether in or out of work
- the justice system without fear of being unfairly judged or punished, and with protection of personal and private rights

Whilst the Health and Social Care Partnership, as part of the Edinburgh Community Planning Partnership, will have a role to play in ensuring that all of these objectives are delivered, it is clearly the requirement in relation to access to health care and support for

independent living that is of the most direct relevance. Our strategic approach is to assist people to build on their abilities to be as independent as possible. Through maximising support to promote and enable self management we will work in partnership with people to manage their conditions. Integration offers significant opportunities for collaboration to further enhance the delivery and provision of community support for and with people with physical disabilities, within the four localities and across the city.

The provision of accessible homes for people with disabilities is essential to promote independence and self-management and the housing sector are key partners in delivery of this. The Housing Contribution Statement in Appendix G sets out how housing agencies and Edinburgh Council Housing Team will work with the partnership to develop, allocate and adapt homes to meet needs.

The Health and Social Care Partnership is keen to foster more joint working across rehabilitation services and supports for people with disabilities with the ultimate aim of shifting the balance of care to local community based services wherever appropriate. The re-provisioning of the Royal Edinburgh Hospital involves the redevelopment of MacKinnon House to provide outpatient and administrative services, plus the transfer of a range of Lothian-wide services currently provided at the Astley Ainslie Hospital to the new Royal Edinburgh Hospital campus. The services that will be relocated include:

- cardiac and stroke rehabilitation
- rehabilitation for traumatic and acquired brain injury
- rehabilitative and clinical care for people with progressive neurological conditions
- services for people who have experienced amputation
- services for younger trauma patients requiring a period of orthopaedic rehabilitation

NHS Lothian's Neurological Care Improvement Plan 2014 – 2020 sets out the case for change across tertiary, secondary and primary care with the aim of developing universal pathways of healthcare across Lothian and across a range of conditions. Having a neurological condition is the most likely reason for people aged under 65 experiencing complex and physical disabilities. The NHS ambition is to ensure people receive effective healthcare, appropriate to their presenting condition from the most appropriate clinical area, and are supported to be as well and as self managing as possible. Key stakeholders in the delivery of this ambition include third sector organisations and people with neurological conditions themselves. The initial clinical areas being prioritised to lead this service transformation are services for people with Parkinson's disease, headache and epilepsy.

During the life of this strategic plan we will:

- *continue to develop the approach in day and home care services for people with physical disabilities across the localities, moving from long term support to focus on rehabilitation and life style management, building confidence, independence, local connections and support for carers*
- *re-align existing day support for people with physical disabilities to move from two sites to one. Develop the single site into a physical disability hub that will focus on rehabilitation, Edinburgh Community Stroke Service, prevention and condition specific intervention*
- *work with people with physical disabilities to develop a joint strategy, informed by the review of Hospital Based Clinical Complex Care, with a clear focus on supporting people to help them manage their conditions, build confidence and increase their independence.*
- *develop the business case for the re-provision of specialist and complex rehabilitation services (hosted for Lothian at the Astley Ainslie Hospital) within phase 2 of the Royal Edinburgh Hospital Campus development*
- *work with Primary Care and the acute hospital sector to support the implementation of the Neurological Care Improvement Plan to support early intervention, self-management where possible, and planned access to specialist services when required in a timely way*
- *within the framework of the Neurological Care Improvement Plan, continue to progress the redesign of services for people with progressive neurological conditions such as Multiple Sclerosis and Huntington's Chorea, provided through the Lanfine Unit, to include a smaller in-patient provision for those who require this, a Lothian wide community outreach team and options for flexible breaks from caring*
- *implement the redesign of the amputee rehabilitation service with the support of the housing sector*
- *further develop the stroke rehabilitation service to improve outcomes for those post- stroke to engage in a range of activities including returning to work*
- *work with other Lothian Integration Joint Boards and the acute hospital division to reconfigure stroke services to improve patient outcomes including discharge support*
- *set up a new contract for the delivery of independent living services in the city, that includes information and advice about Direct Payments*

Services for people with sensory impairments

Around 20% of Edinburgh's population are living with a hearing or sight loss. These conditions are most prevalent amongst people aged over 60, whilst sight and hearing loss often goes unnoticed amongst people with learning disabilities, people with dementia and minority ethnic communities.

The Government's See Hear strategy published in 2014 sets out a framework for improving awareness, access and treatment for people with a sensory impairment. The British Sign Language (BSL) (Scotland) Act 2015 places a duty on public bodies to produce plans to increase the profile of BSL and its use in the delivery of services. The Scottish Government has committed to producing a national plan by 2017 with the expectation that other public bodies, including local authorities and the NHS, will produce local plans within the following 12 months.

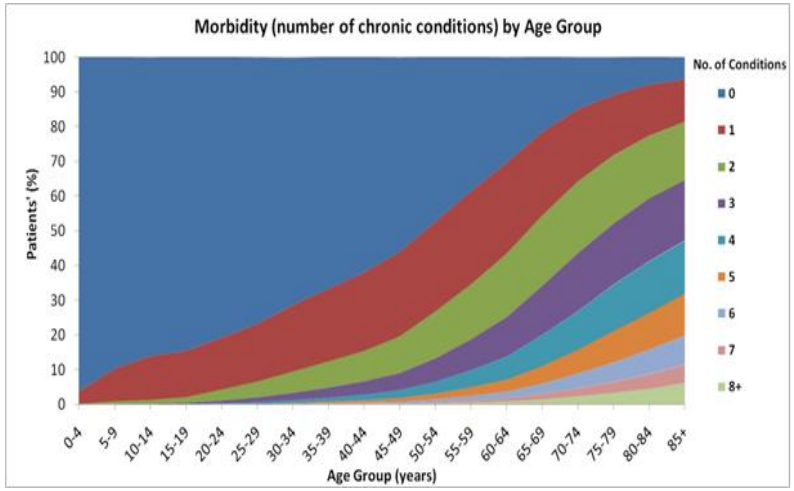
During the life of this strategic plan we will:

- *implement a new contract for the provision of social work care management and assessment service, specialist equipment and rehabilitation for people with a sensory impairment. Ensure the service includes an assessment of those people with sensory impairment at risk of fire and in need of particular fire alarms*
- *work jointly to improve the pathway to audiology services focussing particularly on access for those people with hidden hearing loss and improve co-ordination of social support to people at diagnosis*
- *determine how early identification of and intervention with people with sight and hearing loss can improve the pathway for eye care services*
- *establish how the Scottish Government's sensory awareness training tools can best be rolled out in the city to improve quality of life*
- *respond to the requirements of the British Sign Language (BSL) Scotland Act 2015 building on the work of the sensory champions*

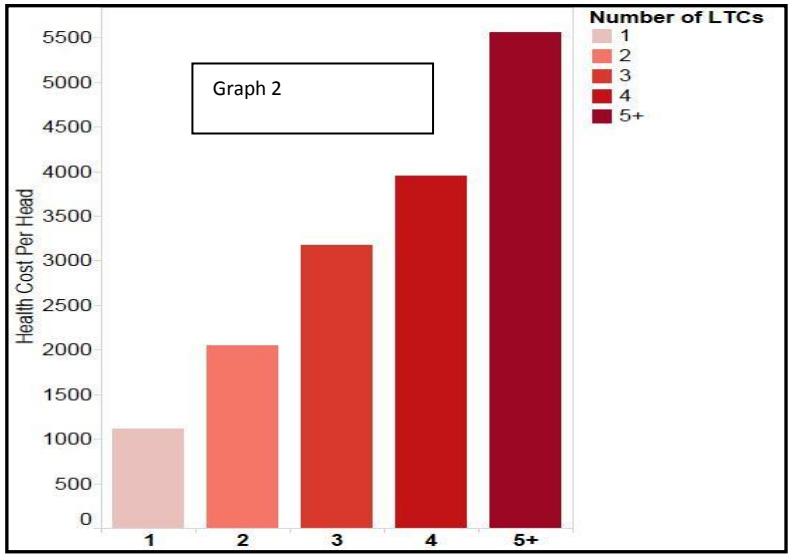
12. Supporting People living with Long Term Conditions

The case for change

People in Scotland are living longer and long term conditions are increasingly common. Many more people are living with more than one long term condition than ever before. (Common long term conditions include epilepsy, diabetes, heart disease, arthritis, chronic pain, asthma and chronic obstructive pulmonary disease). In Edinburgh we recognise that 23% of people have at least one long term condition and 38% of these people have multiple (two or more) long term conditions, known as multi-morbidity. Much of the health service is designed to care for each condition in isolation. People with multiple long term conditions often experience disjointed services and have a high 'burden of treatment' from the various professionals they interact with to manage their conditions.



Long term conditions become more prevalent with age. We know that as people get older they develop more long-term conditions and their use of health and social care services increases and becomes more expensive (hospital admissions, out patients appointments, prescribing costs and use of primary care services). The top graph opposite illustrates the increased prevalence of long term conditions with advancing age. People with long term conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionately longer, and account for over 60 per cent of hospital bed days used. People with multi-morbidity account for 78% of consultations in primary care**.** The graph opposite shows the health costs per person for people with one or more long-term condition.



Many people with multiple long term conditions will require support from beyond health services including from the voluntary sector and local authority housing, social care and employability services. Far greater integration and signposting is needed between these and health services.

'Many Conditions, One Life - Living Well with Multiple Conditions', is the national action plan to improve care and support for people living with multiple conditions in Scotland by adopting a Whole Person, Whole Team and Whole System approach:

- Whole Person: changing the conversations and shifting the relationship between the person and the professional in every consultation;
- Whole Team: new ways for health and care professionals to work together, and with volunteers and community supports, around the GP practice;
- Whole System: improving the way the care and support is planned and co-ordinated across the whole pathway between home and hospital

The vision of Edinburgh's Health and Social Care Partnership is to deliver integrated services using the House of Care model detailed on page 13 which offers many benefits to people with multiple long term conditions, allowing them to have 'good conversations' focused on what is important to them and have their care planned in a collaborative way.

Edinburgh's Long Term Conditions Programme has focussed on improving the care for people with long term conditions by developing integrated care service models that use technology, prevention, anticipatory care and supported self-management approaches to support people to have more information about and better control over their condition. We have identified people who are most likely to be admitted to hospital because of their long term condition(s) and in recent years created five specialist community based health teams to support these people by providing more complex care in the community, preventing avoidable hospital admissions, embedding anticipatory care and self-management approaches and driving down inconsistencies.

To date, the programme has primarily focused on (with the exception of anticipatory care planning and physical activity) people with a single long term condition and our challenge is to capitalise on the opportunities that an integrated health and social care partnership present to better support people with multiple conditions to self-manage their condition and reduce health inequalities.

What we plan to do

The Long Term and Multiple Condition Programme aims to deliver the key components of the 'Many Conditions, One Life' Action Plan to not only improve the care of people with long term/multiple conditions but also to transform their use of health and care services and enhance personal resilience and community capacity. We will continue to improve our understanding of the strengths and needs of the local population.

We will respond to the Scottish Government's Many Conditions, One Life – Living Well with Multiple Conditions Action Plan using a risk approach based approach to:

- *proactively identify and target patients most at risk of hospital admission/readmission*
- *support patients to be discharged from hospital at the earliest opportunity*
- *support individuals to self-manage their condition and provide care to enable individuals to stay at home during acute illness episodes*
- *embed robust anticipatory care planning, medication reviews into the patient care pathways*
- *embed digital solutions to support health and well being, including engagement of physical activity, and self-monitoring of conditions*

Identification and Risk Stratification

The Scottish Patients at Risk of Readmission and Admission (SPARRA) database predicts the risk of emergency admission to hospital in the following year for patients in Scotland. It looks at previous use of health services by analysing activity such as number of drugs prescribed by GPs, Emergency Department attendances, hospital admissions and out-patient appointments. Patients are allocated a risk score of between 1% and 100% depending on their previous use, which predicts the likelihood of an emergency hospital admission within the next year.

The Long Term and Multiple Condition Programme will continue to use risk predictor tools including SPARRA and data produced by GP practices, hospitals and community health teams to identify people who are most at risk and would benefit from support. We

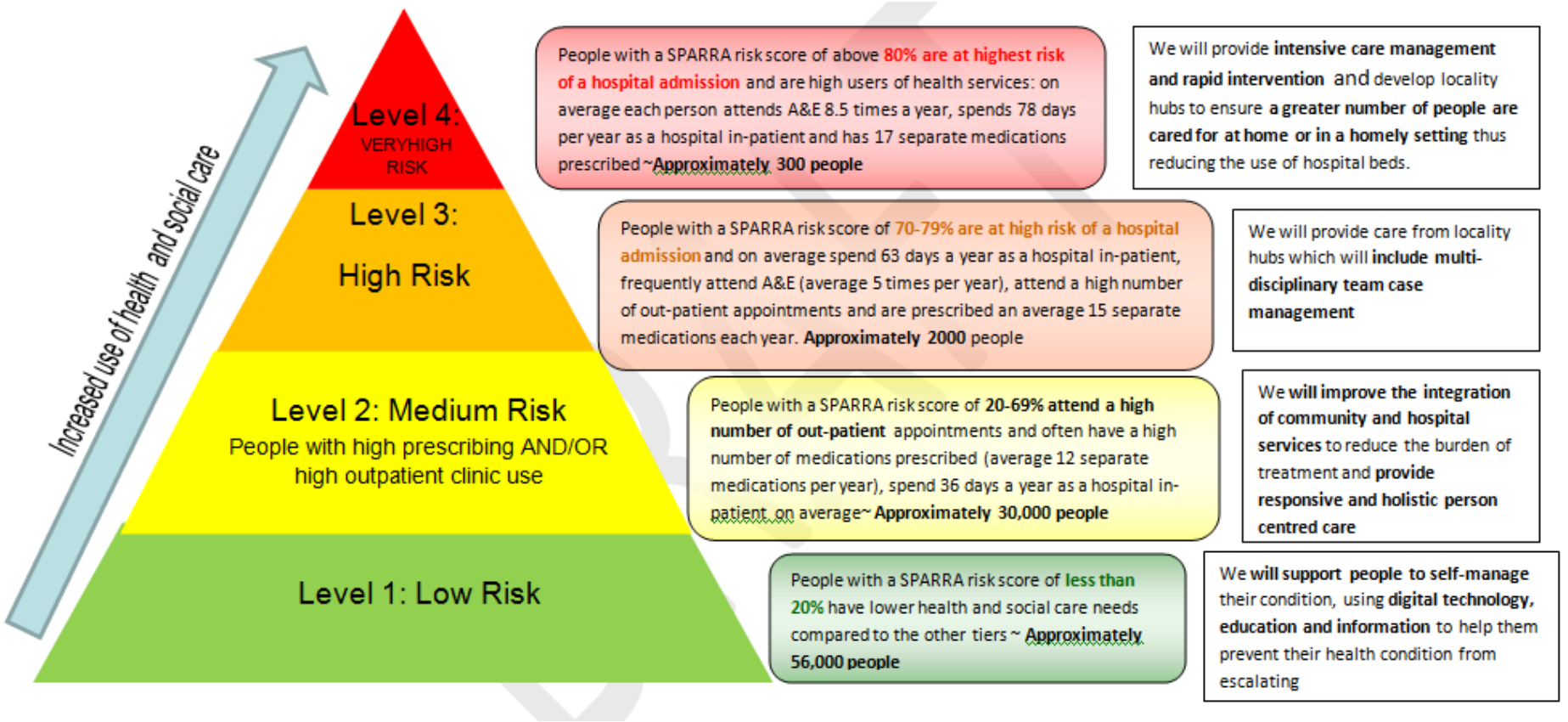
have identified three overlapping groups of people with long term conditions/multi-morbidities for whom we will design a tiered approach to improve their care:

1. People with long term conditions/multi-morbidities who are high users of hospital in-patient beds
2. People who require improved condition specific management (e.g. COPD, Diabetes, Heart Failure) to reduce their risk of becoming high users of hospital beds as well as improving their resilience to self-manage and reduce their reliance on statutory services
3. People with long term conditions /multi-morbidities who will benefit from supported self-management and use of technology to improve their ability to use services efficiently and prevent early progression of their condition.

The diagram on the following page illustrates the tiered care approach on a pyramid using Scottish Patients at Risk of Admission and Readmission (SPARRA) 2014/15 data.

Health and Social Care services within the programme will work together in an integrated way to develop Edinburgh locality based services that provide targeted support for people within each tier of the pyramid.

This tiered approach requires the development of a range of services which include at one end (most at risk) intensive case management, to (at the lower end of risk) provision of information, anticipatory care plans, self-management plans and increased use of technology. We will develop Self Management Champions, drawn from professionals and people with lived experience. We will continue to scale up the use of home monitoring and digital platforms like *Living it Up* so that people with long term conditions can benefit from online support to help them stay well and contribute to the community. We understand health literacy is not about people's reading and writing ability but how we help people to play an active role in their health, healthcare and treatment and it is crucial for patient safety, person centred care, tackling health inequalities and informed decision making. We will work in partnership with the third sector to develop support for people to understand and self-manage their conditions to improve their health and resilience and reduce their reliance on statutory services.



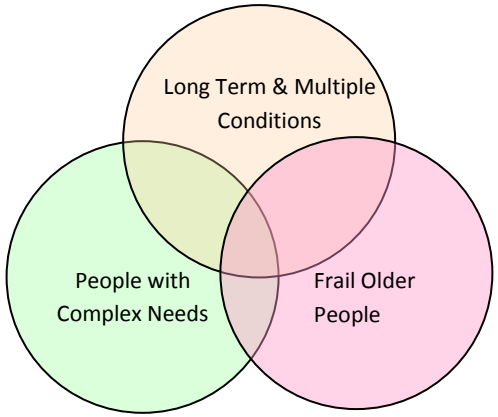
We will continue to use SPARRA and other health and social care data to identify high risk individuals.

We will work with locality based hubs to deliver holistic, person-centred care for people with complex multiple conditions to effect reductions in hospital bed days, improved anticipatory care planning, self-management and medicines management. This will include multi-disciplinary reviews led by advanced practitioners providing expert clinical advice. Multi-disciplinary reviews will include pharmacy input to rationalise medicine regimes of people with packages of care to limit the need for visits – such as medication prompting.

In partnership with the third sector and NHS Lothian's House of Care Collaborative we will deliver an integrated model of self-management, social prescribing and peer support for people with long term conditions.

We will signpost people to digital platforms like Living It Up to benefit from online support to help them stay well and contribute to the community.

We recognise there is overlap with the Long Term and Multiple Conditions programme and other care groups including 'Frail Older People' and 'People with Complex Needs' and we plan to work with these groups to co-ordinate the care of those people at highest risk of a hospital admission through the locality hubs. The main focus will be on the reduction of hospital bed days (prevention of admissions and early supported discharge); to provide comprehensive anticipatory and palliative care planning; and to provide support for people to self-manage their conditions using digital technology where possible.



Integrated care for people with Chronic Obstructive Pulmonary Disease (COPD)

Building on the success of our Chronic Obstructive Pulmonary Disease (COPD) model, we will continue to develop integrated care models and adopt a Whole Team approach with our internal and external partners including the Scottish Ambulance Service, Managed Clinical Networks, Lothian Unscheduled Care Service and the third sector. We have created a virtual community based Respiratory Hub which brings together specialists from nursing, physiotherapy, occupational therapy, pharmacy, psychology and respiratory medicine to work together with our partners to support people.

By working in an integrated way, the community respiratory hub delivers consistency to the way people with COPD in Edinburgh are cared for both during the day and at night. The service has been recognised nationally through a number of awards for innovation, team working and person-centred care. This integrated multi-agency community based respiratory hub creates an environment for choosing well, ensuring patients have access to the right service at the right time in the right place in line with the Partnership's vision.

We will continue to develop the multidisciplinary/multiagency COPD integrated care model to target patients most at risk of hospital admission/readmission, to extend the reduction in hospital bed days and to use transferable learning in the development of services for complex patients with multi-morbidity in locality based hubs.

Managing the increasing number of people living with diabetes

An increasing concern for health of our population is the rising number of people living with diabetes. 16,430 people in Edinburgh have diagnosed with diabetes (3.32% of the population). While lower than the Scottish rate of 4.6%, we know that the numbers are expected to increase dramatically. The treatment and care of patients with diabetes is estimated to equate to 10% of total NHS costs,[1] while in Edinburgh more than 8% of the primary care prescribing budget is spent on medication and monitoring of diabetes.

Section 8 above emphasises the opportunities for the prevention of diabetes, through encouraging people to take more exercise and support for weight management. During 2015 GP practices have already been encouraged, through an Enhanced Service Fund, to put in place care plans for newly diagnosed type 2 patients whose care can be managed in primary care, and diabetes specialist nurse posts have been piloted in North and South Edinburgh.

Over the life of this plan we will work with the Lothian Diabetes Managed Clinical Network to implement the national Diabetes Action Plan to put in place improved and consistent pathways for people with both type 1 and type 2 diabetes, and to increase public awareness of the risks and consequences of this condition.

Anticipatory Care Planning - use of Key Information Summaries (KIS)

Anticipatory care plans allow people to have greater choice and control by recording their wishes about care and support in the event of future deterioration. They also contain vital health and social information that will help healthcare professionals to make decisions on the most appropriate care for that person based on their wishes.

Anticipatory Care Planning will be further developed in each Edinburgh locality to help people with multiple long term conditions to 'think ahead' and to have greater control and choice over their care and support. An improved anticipatory care approach will

[1] Scotland. Scottish Government Health Department. Diabetes Action Plan 2010 – A Summary. Scottish Diabetes Group. August 2010. Diabetes UK.

support people at all levels of risk and will bring most benefit to people who are high users of health and social care services. We will continue to work with hospitals, general practices and community based teams to increase the number of staff who routinely create and access electronic Key Information Summaries (KIS) so that they make decisions based on the person's wishes and preferences.

We will increase the quantity and quality of (new and existing) anticipatory care plans, ensuring these are created and shared using electronic Key Information Summaries (KIS) and contain information based on the person's wishes including preferred place of care. We will achieve this through integrated working and by providing training to health and social care professionals.

13. Redesigning Mental Health and Substance Misuse Services

Mental Health Services

The case for change

Our mental health is just as important as our physical health to overall health and wellbeing. We know that over 25% of the population in Edinburgh, more than 120,000 people, will experience a mental health problem at some point in their lives. Anxiety and depression are the most common mental health problems, but others include schizophrenia, personality disorders, eating disorders and dementia.

Mental ill health is not evenly distributed across society and is more common in socio-economically disadvantaged areas[23]. Being old is also a risk factor for poor mental health with depression affecting one in five older people living in the community and two in five living in care homes[4].

There also clear links between mental health problems and substance misuse problems; some people will experience both of these and may require complex and coordinated responses from treatment and support services. Some of the determinants for poor mental health and substance misuse are similar with both problems more prevalent in less affluent areas. The key components of recovery are also similar and involve reducing isolation, helping people to connect with their communities, reducing stigma and supporting people into employment and meaningful activities.

The four key priorities in the Joint Lothian Mental Health Strategy A Sense of Belonging 2011-2016, still represent the key aims we need to pursue to improve the health of our population. These are closely aligned with the key priorities on which this Strategic Plan is based:

- Tackling health inequalities
- Embedding recovery and living well
- Building social capital and wellbeing

[2] SPICe briefing, Mental Health in Scotland, May 2014
[3] Scotland's Mental Health, October 2012, NHS Health Scotland
[4] Adults In Later Life with Mental Health Problems, Mental Health Foundation quoting Psychiatry in the Elderly, 3rd edition, Oxford University Press, 2002

- Improving services for people

A great deal has happened to progress these priorities, with a well established Recovery Network, shifts in the balance of care as a result of investment in community services and resources, and a focus on building personal resilience through enabling people to engage with their local community resources. Specialist services for people suffering from post-traumatic stress, for new mothers with mental health problems and for those with eating disorders have been put in place in recent years. Alongside this the number of acute hospital beds has been reduced, with intensive home treatment and crisis care and support providing alternatives to hospital.

However we know that more needs to be done to improve mental health and wellbeing. The integration of health and social care provides the opportunity to further develop local, integrated services which provide easy access, early intervention, prevent admission where possible and support early discharge from hospital.

The first phase of development of the Royal Edinburgh Hospital, which opens in December 2016, will reduce the provision of bed based hospital care for people with mental health problems. At present too many people are unable to move on from a stay in acute mental health wards because the alternative care and accommodation they need is not available; this has to be a major priority to address. Currently 25% of hospital inpatients aged under 65, are either waiting for supported accommodation or waiting for an alternative NHS resource such as the inpatient rehabilitation service. The problem of delayed discharge is caused in part by historically lower levels of investment in community mental health services in Edinburgh than the Scottish average. More community services including more supported community places therefore need to be developed.

The recent review of progress with “A Sense of Belonging”, and consultation on Edinburgh’s mental health and wellbeing commissioning plan, identified the following priorities which we are developing plans to address:

- improved access to services
- prevention and early intervention
- delivery of personalised services to support recovery
- support to keep people safe and well
- improved health and wellbeing

Improving Access to Services

We want to move to a new locality based way of developing services which make better use of local assets to improve access for individuals and prevent the need for hospital admission. This will include exploring how we can join up physical and mental health care so that people can access support via a single point. We will learn from and build on the initial work of the locality hubs described in section 6, and work closely with third sector partners and service users to design more integrated and personalised responses to meet people's needs.

We need to work together with our partners to transform the delivery of our operational mental health services integrate health and social care staff into more effective teams, provide care and support closer to home, and make use of innovative technology.

We will:

- *implement the agreed mental health locality partnership model beginning in North East Edinburgh with a focus on the communities of Craigmillar, connecting to Total East and Leith, and maximising the opportunities of the "GameChanger" Public Social Partnership being developed with a range of partners focused on the population of this locality which we know has the highest percentage of people with long term health problems*
- *review the current service model with inpatient service teams to ensure that there is a coherent and effective model of care across community and hospital services in place prior to the opening of the new acute facilities in the phase one redevelopement of the Royal Edinburgh Hospital in December 2016*
- *continue to work with colleagues across Lothian to reduce the waiting times for people who require specialist psychological therapies to meet the Government standard of 18 weeks, including identifying opportunities through our locality model to work more effectively with third sector partners who can offer a wider range of support*
- *through our locality partnership model, seek to maximise the opportunities for shared premises with health and social care, other public sector agencies and the third sector in each of the localities to make it easier for people to access a range of supports in one place*

Prevention and early intervention

We know that there is opportunity for much greater use of peer support and peer working, which can be very valuable to people on their recovery journey. We have evidence that this approach works from models in place in mental health, substance misuse and other services and we want to ensure it is part of our holistic support and service model.

There is capacity for much greater joint working across third sector organisations, and consultation on the health and social care commissioning plan in 2014 has resulted in a decision to take forward future commissioning through a co-production process, which will allow joint planning and delivery of a more responsive and appropriate range of services and support. This will include exploring the opportunities for greater self-directed support which enables individuals to have more control over their lives and take more personal responsibility where possible. We do need to take actions to live within our means, however we believe that the co-production approach will allow us to maximise benefits from spend through third sector partners which will achieve better outcomes overall.

We will continue to work with partners to reduce the number of suicides in Edinburgh with a particular focus on those groups who are at most risk: younger men and men aged between 40 and 55. This will include training for partner agencies and specific initiatives.

During 2016 we will redesign wellbeing and preventive services by using approaches that engages citizens, service user and carer groups and all other partners to focus on co-designing services that meet identified needs. A range of commissioning options will be considered for co-produced and delivered services to be in place by April 2017.

Delivery of personalised services to support recovery

As part of the overall service model we will work with NHS Lothian to ensure improvement in the therapeutic environment, culture and rehabilitative focus of inpatient services at the Royal Edinburgh Hospital campus, as the hospital is redeveloped. This will include acceleration of the “green space; art space” Public Social Partnership which will create volunteering and employment opportunities for service users.

Health and social care community teams will be integrated to focus on reablement, recovery and personalised approaches, providing early intervention to prevent hospital admission and to support and facilitate timely discharge from hospital if admission is necessary

We will support NHS Lothian to develop a business case to put in place provision for those who require relational, procedural and environmental security, to comply with legislation and ensure that people are not cared for in conditions of excessive security.

We will support NHS Lothian to develop a business case to commission and deliver a service for women with multiple and complex needs to enable more women to receive appropriate care and support closer to home.

The partnership will:

- *significantly improve the rehabilitation pathway for those who have longer term needs for care and support, including the urgent production of a business case to commission and deliver up to 15 community places with 24/7 support, in time for the completion of phase 1 of the Royal Edinburgh Hospital. This builds on the Firrhill development recently commissioned which provides 6 places as part of the Wayfinder Programme.*
- *explore other opportunities for community provision for those with 24/7 community support needs*
- *deliver the new Rivers Centre Public Social Partnership which will provide a new centre for the treatment of people of all ages who lives are adversely affected by the impact of trauma by Spring 2016*

Support to keep people safe and well

We know that recovery from mental health problems requires ongoing access to care and support for many people, and that avoiding social isolation and having a warm and secure place to live is essential to keep people safe and well.

We will work with partners from the Edinburgh Affordable Housing Partnership, the Housing Strategy Team in the Council, third, independent and statutory sector partners to ensure we maximise the potential for people to live well in community settings with timely access to inpatient care when required.

Improved health and wellbeing

We will continue to commission and support independent and collective advocacy provision to meet statutory requirements and to mitigate the impact of compulsory (legal) measures, on those individuals with mental health problems and mental illness. A review of current provision is planned commencing March 2016 which will take account of the updated Mental Health Care and Treatment Act 2015.

We will continue to engage with and use the learning from the Wayfinder Project Knowledge Transfer Partnership between NHS Lothian, the City of Edinburgh Council and Queen Margaret University to develop the evidence base for the pathway redesign of adult mental health services, learning from best practice examples nationally and internationally.

Substance Misuse Services

The case for change

It is estimated that there are 22,400 people in Edinburgh with dependent drinking. Alongside this there are 6,600 people with problem drug use (using heroin and/or benzodiazepines only). More than half of service users are thought to have mental health problems of varying degrees of severity.

In Edinburgh, the estimated number of young people between the ages 15 and 24 with problem drug use went from 520 in 2009/10 to 730 in 2012/13, an increase of 40.4%. Over the same period in Scotland as a whole the numbers in this age group decreased from 7,900 to 6,600, a reduction of 16.5%.

The reported rate of drug-related births in Edinburgh is almost twice the national average, and a third of drug and alcohol users in contact with services in Edinburgh have at least one dependent child.

Edinburgh Alcohol and Drug Partnership (EADP), one of the eight Strategic Partnerships within the Community Planning Partnership, leads on the planning of responses to substance misuse, alongside and on behalf of the Integration Joint Board. For adult treatment and recovery services, health and social care services and the third sector are key members alongside, Police Scotland, Criminal Justice Social Work, HMP Edinburgh and people with lived experience of substance misuse. EADP's current

priorities span new service developments and improvements to the organisation, co-ordination and delivery of services and reflect a national and local policy shift towards helping people through recovery journeys as well as reducing harm.

The development of a recovery community has started already in Edinburgh, creating a social focal point for people who have achieved abstinence. The peer support component within treatment and support services is being developed to encompass all areas of delivery. Peer support workers will be well trained and supervised to ensure they sustain their own recovery whilst supporting others. Consideration is also being given to how people who continue to use methadone (and are therefore in treatment) can be seen as a part of the recovery community.

The impact of parental alcohol and drug use on children remains a challenge, including the impact during pregnancy. EADP commissions a specialist service (Prepare) that brings together maternity services, health visiting and alcohol and drug treatment services to support pregnant women who do not effectively engage in mainstream services. Alongside this, there are specialist family support services for children and their families affected by these issues. There is recognition that adult treatment and recovery services need to develop to meet the needs of family members (particularly adult carers) through a focus on family recovery.

New psychoactive substances, also known as legal highs, are a recent challenge and responses are being developed in collaboration with acute hospital services.

The EADP has developed a locality based model through Recovery Hubs. This brings together social work, nursing and the third sector to provide an integrated response to people with alcohol and drug problems. Recovery Hubs are located in the most disadvantaged areas of the city where drug/alcohol problems have a greater impact. Alongside this many people receive their drug treatment through their GP, enabling them to access treatment alongside general healthcare.

The partnership is actively working to improve links between Recovery Hubs and services for children and families, to improve links with mental health services and to improve arrangements for care co-ordination. In addition, the potential to combine data sources from City of Edinburgh Council, NHS Lothian and the third sector is being examined to seek a more holistic overview of the way clients move in and out of services.

The key priorities the EADP have identified are to:

- develop a coherent approach to preventing problem substance misuse, starting with a framework for investing in prevention
- develop more trauma informed services and focus on relationships to maximise effective engagement and minimise relapse
- develop a clear role for counselling and other psychological therapies to address underlying issues which may cause relapse
- invest in a broader range of aftercare services that focus on preventing relapse
- develop a "stepped care" approach to prescribing opiate replacement therapy (methadone and other opiate replacements) in primary and secondary care to ensure people receive an intervention which meets their recovery needs
- redesign services to increase the availability of detox in the community
- clarify and shift roles and responsibility between practitioner groups to create greater efficiency
- integrate with Mental Health and other services to jointly plan around a shared client group

The integration of health and social care provides the opportunity for greater integration between the planning of substance misuse services and wider approaches to improving health and wellbeing. As locality working is developed, engaging a wide group of partners across the statutory, third and independent sectors, along with people and communities, to create a more joined up approach to prevention, early identification and engagement with those at risk, and greater local access to services is envisaged.
Substance misuse pathways include specialist treatment and recovery services including the pilot service for those with Alcohol Related Brain Damage and we will work with Lothian partners to review the outcome of this pilot. The community services which the Health and Social Care Partnership directly manage, and the hospital based services managed by NHS Lothian, will work together with other EADP partners to further design and deliver integrated pathways which achieve the priorities of prevention and recovery, using resources as effectively as possible.

We will:

- *review the treatment and recovery pathway for people with substance misuse issues including inpatient and community programmes (Ritson Clinic, Lothian and Edinburgh Abstinence Project (LEAP)) in line with Royal Edinburgh Hospital campus re-development*
- *consider the recommendations arising from the business case associated with the pilot Alcohol Related Brain Damage unit by June 2016*
- *implement a model of care within the Recovery Hubs including concepts of key working, lived experience peer supporters,*

and effective group work programmes

- *explore new harm reduction and recovery approaches based on evidence and experience elsewhere to better engage those who receive drug treatment through their GP*
- *develop a stepped care approach to residential and community based rehabilitation programmes to ensure that people receive the right service to support their recovery*
- *develop and implement a stepped care approach to psychosocial and therapeutic interventions across recovery services, to ensure that services are able to support underlying trauma issues as part of the recovery journey when needed*
- *support the development of the recovery community by creating networking opportunities for people in recovery*
- *work with other Alcohol and Drug Partnerships in Lothian to manage and mitigate the impact of new psychoactive substances on health*
- *work with community planning partners to reassess the availability of alcohol and the link with alcohol related harm within the city to inform Licensing Board Policy*

14. Using technology to support independent living and efficient and effective ways of working

Increased use of technology offers significant opportunities to support citizens to live more independently and enable our workforce to work more efficiently and effectively. It should be seen not simply as a way of automating current practice but as a driver of different ways of care, and as a facilitator of improved quality and safety.

The term Technology Enabled Care refers to the range of technological solutions that allow us to deliver care and support in new ways in combination with or without more traditional services, in order to enable people to live more independently. These solutions are sometimes referred to as Telecare and Telehealth and include the following:

- online advice and information, through Living it Up for example
- community alarms which provides a 24/7 alarm receiving and response service to support people in an emergency
- enhanced monitoring systems such as fall detectors, or motion detectors that raise alerts if there has been no movement in a person's home within a given time period
- home automation that includes sensors to detect floods and gas leaks, automated night time lighting and environmental control systems that allow people with severe disabilities and life limiting degenerative conditions such as Multiple Sclerosis and Motor Neuron Disease to control their heating, close their curtains or simply change the station on their TV
- clinical monitoring systems that allow blood pressure and diabetes blood sugar readings, for example, to be transferred directly from a meter, via a smart phone to a database. This provides doctors with much more usable data and supports the self management of long term conditions
- remote consultations using video conferencing technology which can remove the need for people to attend their GPs surgery or hospital outpatients clinics

Effective use of Technology Enabled Care has the potential to:

- reduce social isolation by enabling people to stay connected via technology to family and friends
- help people to feel more safe and secure living at home

- improve people's self confidence in self managing their health and wellbeing
- increase access to specialist hospital appointments and professional advice and support by using videoconferencing facilities, thus reducing unnecessary travel time
- reduce the need for GP appointments, visits to hospital and emergency admissions
- reduce adverse outcomes

Although some use is currently made of technology to meet health and social care needs through the Community Alarm Telecare Service, the Occupational Therapist led Assistive Technology Service and the environmental controls provided by the Bio Engineers at the SMART Centre; services are not joined up, usage is at a small scale and the full potential of technology to increase independence and meet needs more effectively has not been realised.

In 2016/17:

- *we will improve our understanding of the extent to which Technology Enabled Care is currently utilised within the Health and Social Care Partnership and by our other partners including housing providers*
- *explore further options for increasing the use of Technology Enable Care linked to the development of care pathways*
- *undertake further horizon scanning to support service delivery across all service areas*
- *explore the options for better coordinating the staffing and financial resources available to deliver Technology Enabled Care*
- *work with our partners to develop a strategy for the delivery of Technology Enabled Care in Edinburgh*
- *produce business cases in respect of developments to be implemented in each of the three years from 2016/17 onward; opportunities include:*
    - *an increase in the use of pendant alarms*
    - *the use of technology for overnight support*
    - *automated medication prompting and daily wellbeing checks*
    - *video conferencing within care homes*
    - *scaling up the use of home monitoring for people with long term conditions*
    - *explore the potential of MyGov technology to support person held records*

- *make funding applications through the Scottish Government Technology Enabled Care Programme and other available funding sources to support the increased use of technology to both increase independence and support effective and efficient ways of working*

If we are to truly integrate our services and embrace joined up working we need to provide our workforce with effective and reliable ICT systems that allow them to:

- access all relevant information to allow them to support the person they are working with as effectively as possible at the time and place it is needed – 'right information, right place, right time'
- share information about citizens quickly and securely to aid decision making and ensure that citizens need only tell their story once, with appropriate regard to privacy
- share and access information across different partners regardless of location
- work on the move using technology that makes it easy for staff such as nurses and home care staff working in people's homes to remain in contact with their base without having to physically go into the office
- produce the data and information needed to meet the performance management reporting requirements of all stakeholders as a by-product of operational record keeping

We will also make it a fundamental principle that any change to ICT systems needs to be an integrated part of changes to care pathways.

In addition to these general requirements many of the developments and change programmes detailed within this plan will have specific implications for ICT requirements. ICT systems are also central to ensuring that appropriate mechanisms are in place to underpin the performance management framework that is required to allow the Integration Joint Board to monitor the impact of this strategic plan.

ICT support for the Health and Social Care Partnership will be provided through NHS Lothian and the City of Edinburgh Council. ICT Teams within the two organisations have been working together for a number of years to develop solutions to support joint working. This has allowed staff from different agencies to be co-located within the same building and access their own systems, share email address books and through the interagency portal, to view a subset of data about individual people receiving services

from each others systems. Building upon this experience and following engagement with managers and frontline staff involved in delivering health and social care services, the ICT Teams have produced a joint road map focused on six key areas and underpinned by six overarching assumptions for joint working:

Areas of focus	**Assumptions for joint working**
• A more streamlined approach to **Information governance** with the integration of services and improved outcomes for people at its heart; underpinned by improved information governance training and clarity for staff; a better model for patient/service user 'consent' and joint training to make best use of technology that is currently available; • Improved **connectivity** to networks and wifi to enable mobile and co-located working; • Responsive **mobile technology** for staff to help improve productivity in the field and cope with increasing demand; • **A 'pathways' approach** to information and systems access: so that relevant patient/service users data is accessible to appropriate people at the right time in their pathway through the care system. (Including the person being cared for); • Access to **real-time patient/service user information** wherever possible to ensure accuracy of decision-making for patients/service users and for responsive service operations; • A **joined up approach to electronic communication** between NHS Lothian and the Council for staff, such as contact and emails information, intranets, shared workspace and policies and procedures.	• Business information requirements (e.g. operational delivery, performance/management information) are supported by ICT **not** ICT driven • A whole system approach is required looking at: Primary Care, Community Health, Social Care and Secondary Care • There will be more integrated teams and more co-located teams as we move forward • There is a requirement for more sharing of personal data along people's pathway of care • We must work with and maximise the benefit from existing ICT systems – rather than create new ICT systems for the Health and Social Care Partnership • ICT support services need to work together at the highest level to support the integrated functions

In addition to the need for ICT systems to support joint working across the Council and NHS Lothian it is also important to consider the need to integrate and align with the systems used by other partners including service providers if we are to truly make best use of capacity across the whole system.

The Integration Joint Board will give clear directions in relation to its ICT requirements to both the Council and NHS Lothian and will welcome guidance on the best technological solutions. In recognition of the importance of technology in helping the Health and Social Care Partnership address current challenges and transform the way services are planned and delivered, the Integration Joint Board has nominated one of its members to act as an ICT champion to work with the managers of ICT services in the Council and NHS Lothian to develop a shared understanding of and approach to meeting the needs of the Health and Social Care Partnership.

During 2016/17 we will work with the ICT services in NHS Lothian and the Council to:

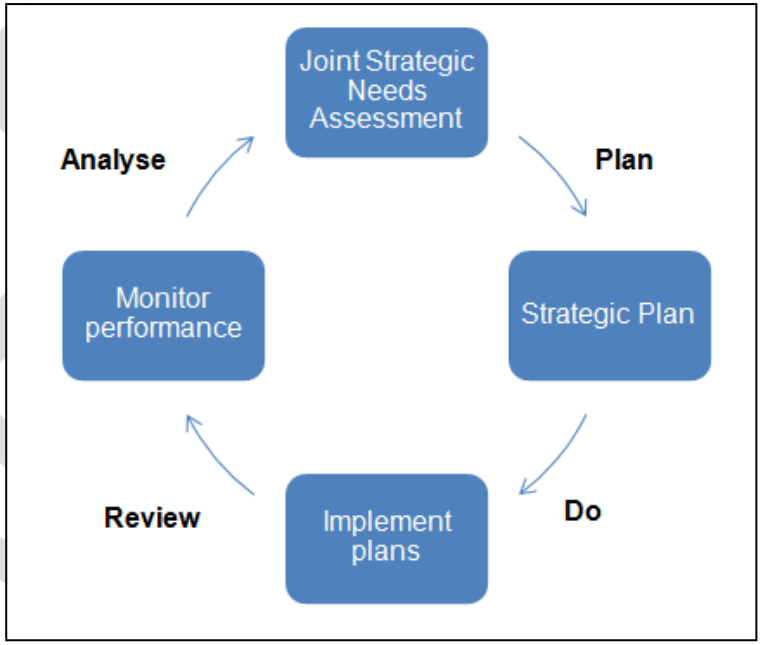
- *understand the implications of the strategic plan in relation to ICT and wider technology which will allow us to develop an ICT Strategy and implementation plan for the Health and Social Care Partnership*
- *develop a delivery plan in respect of the roadmap based on the areas of focus and assumptions for joint working set out above*
- *ensure that any business cases developed in relation to the strategic plan clearly set out any ICT implications.*

Whilst increased use of technology undoubtedly offers very significant opportunities to increase independence for citizens and support our staff to work more efficiently and effectively, the benefits will only be fully realised if we recognise that many citizens and staff have not fully embraced technology and do not have the skills and knowledge to make best use of the systems available to them. A key plank of our strategy around increased use of technology must therefore include steps to increase skills, knowledge and understand and access to technology across both our workforce and the population as a whole.

15. Improving our understanding of the strengths and needs of the local population

A good understanding of the strengths and needs of the local population is essential to support effective strategic planning in order to help us identify:

- current and future needs
- what is working well and what could work better
- the major health inequalities and what can be done about them
- needs that are not being met, including those of seldom-heard populations and vulnerable groups



The production of a Joint Strategic Needs Assessment (JSNA) is part of a cycle of analyse-plan-do-review that both informs and helps monitor the impact of the strategic plan over time. It therefore needs to be developed and updated on an ongoing basis to ensure that emerging issues or patterns of need can be identified.

The Joint Strategic Needs Assessment is intended to provide a sound basis for decision making about the deployment of resources. To do this, it needs to be comprehensive, up to date, accessible and easy to use.

Edinburgh's first Joint Strategic Needs Assessment of health and wellbeing in the city was developed by people from across the Council, the NHS, the voluntary and independent sector, neighbourhood groups and citizens. It provides an overview of Edinburgh's population and circumstances; including the labour market, poverty and inequality and housing; the needs of specific groups; patterns of resource use across NHS Lothian, the City of Edinburgh Council, the voluntary sector and the independent sector; pressures and unmet need. Information at locality level is available for a range of topics.

This first assessment is attached as Appendix H and will provide a baseline against which we can measure local changes in relation to health and social care and inform future iterations of our strategic plan.

The development of the Assessment revealed a number of gaps in our current knowledge and further gaps were identified through consultation with our partners and the public which will address in future iterations.

Ongoing development of the Joint Strategic Needs Assessment is needed to:

- develop more detailed locality profiles in order to support the move to locality working, recognising that there is as much variation within localities as there is between them
- enable the identification, monitoring and assessment of emerging issues, for example, the use of legal highs and the health and support needs of people who are obese
- support the identification of trends and shifts in resource use and unmet needs
- understand the needs of people from minority ethnic groups who have mental health problems, disabilities, frailty etc
- further investigate methods of forecasting needs among specific groups; at present, forecasts are based largely on population growth
- consider alternative indicators in areas such are inequalities and identify indicators for mental health

We will continue to develop the Joint Strategic Needs Assessment to provide a range of information to support the Edinburgh Health and Social Care Partnership and wider Community Planning Partnership to better understand the needs and strengths of the population at both locality and citywide levels. In doing so we will take the following actions during the financial year 2016/17:

- *review the membership of the Joint Strategic Needs Assessment Sub-group to ensure that we benefit from the knowledge, experience and information held by our partners including local people*
- *take account of feedback obtained through consultation on the first iteration of the Assessment*
- *work closely with those leading change work streams identified elsewhere in the strategic plan to incorporate areas for further or more detailed assessment arising from their work*
- *embed the Joint Strategic Needs Assessment within the broader needs assessment and profiling of localities within Edinburgh as part of the Council's Transformation*
- *move the Joint Strategic Needs Assessment from the current paper format to be a web based tool that supports access to data at a number of levels*

16. Integrated workforce development

Achieving the vision and priorities set out in our strategic plan will require significant culture change for the Council, NHS Lothian and our other partners, for the workforce delivering health and social care services across the city, for the people who use those services and the wider population.

Our overarching workforce strategy setting out the future staffing models required to deliver sustainable and affordable high quality health and social care services that keep people safe will be developed during 2016/17, based to a large extent upon the requirements identified through this strategic plan.

We will bring together the specific actions within this plan that are related to or have implications for our workforce in order to inform the development of our overarching workforce strategy and plan which will be developed in 2016/17.

Effective workforce development is central to helping us deliver the shift in culture required and can provide a model for the integrated working between partners, each of whom have their own skills, knowledge, experience and ideas to bring to the table; we hope to harness these to develop a truly integrated approach to workforce development making best use of capacity across the whole system.

We already have some good examples to build on such as the Dementia Training Partnership through which the Council, Scottish Care, NHS Lothian and Edinburgh Voluntary Organisations Council (EVOC) are working together to role out the Promoting Excellence in Dementia care framework across all providers. The Council and NHS Lothian have previously involved people with experience of using health and social care services in the delivery of training activities. These are examples we hope to build on and see developed further through the Health and Social Care Partnership.

We have already made a start on embedding an integrated and collaborative approach to workforce development through our participation in the *Playing to your strengths* leadership training programme which has brought together senior leaders from across health & social care and the third sector in the four Lothian Health and Social Care Partnerships. The outcome from *this Programme* is the creation of strengths based personal development plans that will support successful leaders use their strengths and develop complementary competencies to enhance their leadership. The collaboration with the other Health and Social Care

Partnerships in Lothian is intended to support the development of networks and relationships which will foster further joined up working in the future.

In 2016/17 we will establish an Integrated Workforce Development Planning Group with membership drawn from key partners including as a minimum the NHS, the Council, third and independent sectors and people who use health and social care services in order to develop and oversee the implementation of an integrated workforce development strategy and action plan.

Staff need to feel empowered to:

- contribute to the development of a new culture and understand their role within it, which may involve opportunities to change the way in which they work
- broaden their understanding of the people we work with and the issues they face as well as the range of services available to them
- develop new working relationships
- take on new roles and responsibilities
- look after their own health and wellbeing

In addition to helping our workforce to embrace the new culture, more specific training needs are identified throughout this plan ranging from increasing awareness across the workforce of specific conditions such as autism or dementia to developing skills to increase the number of staff able to undertake particular roles.

17. Living within our means

Financial context

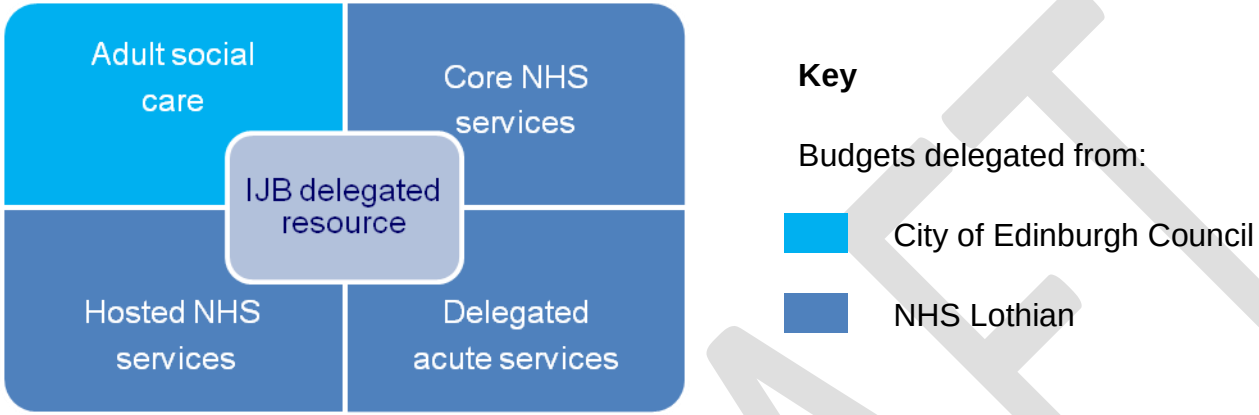
In an environment of increasing demographic pressures and a growing financial challenge, the ability to redesign services in ways that make the best use of scarce resource will be critical. Aligned with this is the rising expectation from the general public that health and social care services should be able to deliver the increased capacity required to fully meet changing needs.

Earlier in the plan (page 52) we gave the example of Jenny and how changing the way she accesses services and aligning these to best meet her needs resulted in a better outcome for Jenny at lower cost. This is the key to the financial challenge for all Integration Joint Boards, how we use our money wisely to support redesign at the same time as maintaining good outcomes for people.

How we get our money

Functions are delegated to the Edinburgh Integration Joint Board from the City of Edinburgh Council and NHS Lothian and the resources associated with these functions form the budgets for the Integration Joint Board. It then becomes the responsibility of the Board to deploy these resources in support of the strategic plan. As such the Board can choose to spend the money differently. One example of this would be the Integration Joint Board's ability to disinvest in hospital services, using the money released to invest in services designed to maintain people in their own homes and wider communities.

There are 4 component parts to the resources delegated to the Integration Joint Board as shown in the diagram below:



An explanation of each of these component parts is included in section 3 above along with a list of each of the services in each category. During 2015/16 we have been working closely with NHS Lothian and the City of Edinburgh Council to agree which elements of budget will transfer to the partnership. For hosted and delegated acute services this has required the agreement of a mechanism to share budgets currently held on a Lothian wide basis equitably between the four Lothian Integration Joint Boards.

Whilst hosted and delegated acute services will be operationally delivered by other parties (e.g. NHS Lothian or one of the other three Health and Social Care Partnerships), the Edinburgh Integration Joint Board will have the responsibility for planning these services. We therefore require any material changes to these services, either investment or disinvestment to be discussed and agreed in partnership.

These discussions have helped the Edinburgh Integration Joint Board shape a financial plan which shows the level of resource available as well as the savings which will require to be delivered.

Our financial plan

As the resources available to the Integration Joint Board flow through the City of Edinburgh Council and NHS Lothian, the financial constraints facing these organisations are equally relevant for the Board. There is no doubt, given the financial constraints the City

of Edinburgh Council and NHS Lothian face, both now and in the medium term, that the Board will have a significant financial challenge to address. In this environment achieving financial balance will require a focus on service redesign within the overall financial envelope.

The City of Edinburgh Council formally agreed a 3 year budget on 21st January 2016. NHS Lothian are not yet in a position to finalise their financial plans as further work is required to fully understand the impact of the Scottish Government's recent budget announcements on the resources available. The draft financial plan for the Integration Joint Board is therefore based on the best information currently available.

The initial assessment of the financial plan for 2016/17 identified a budget for the Integration Joint Board of £554 million with an associated savings target of £32 million, or 6%. This level of efficiency, set against a background of increasing pressure on services, is clearly a challenge for the Integration Joint Board. The figure below summarises the position:

	CEC	NHSL	Total
	£k	£k	£k
Projected 15/16 expenditure	**195,133**	**364,581**	**559,714**
Changes in 16/17			
Increases in costs	4,651	22,454	27,105
Savings	(15,018)	(17,417)	(32,435)
Social care fund		20,180	20,180
Net budget change	**(10,367)**	**25,217**	**14,850**
Projected 16/17 budget	**184,766**	**389,798**	**574,564**
% change in budget	**-5.3%**	**6.9%**	**2.7%**

We will continue to work with City of Edinburgh Council and NHS Lothian to develop sustainable plans to achieve financial balance, including delivery of savings plans to be implemented from April 2016.

The scale of this challenge will require us to use our money wisely and to make sure we make the most of any funds available for investment as well as target any disinvestment appropriately. This includes the new Social Care Fund referred to above as well as any time limited or specific sources of funding such as the Integrated Care Fund. To support this we will need clear criteria and a methodology to assess and prioritise proposals.

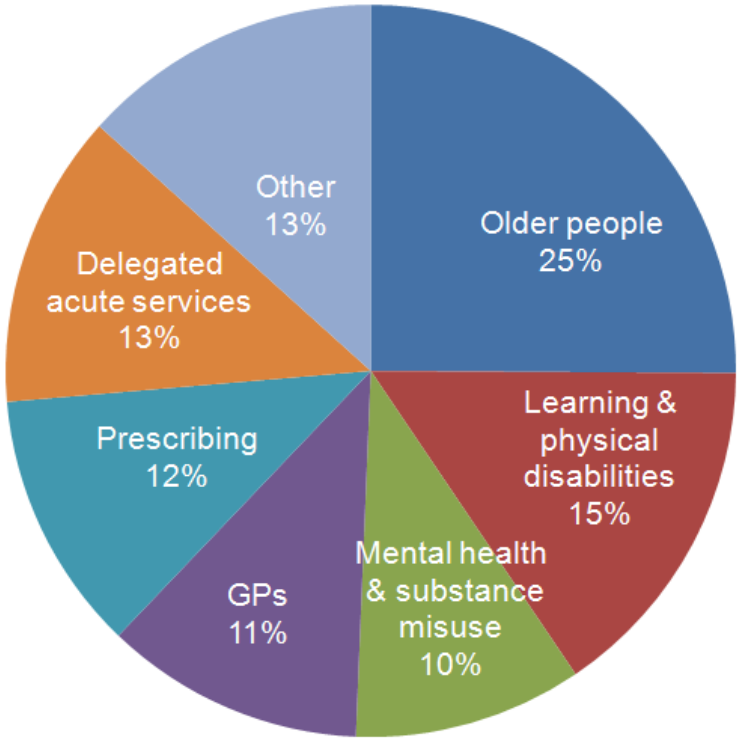
We will develop a robust decision making framework which captures and assesses risk and supports both investment and disinvestment decisions.

How do we spend our money?

The diagram opposite shows how much of our money is spent on each of the different functions delegated the Integration Joint Board.

The opportunities

In this challenging financial environment integrating services brings opportunities to deliver efficiencies by making better use of our resources. Examples include: avoiding duplication; reducing management costs; avoiding admissions to hospital and unnecessarily long stays which don't provide the best outcomes for people; using our resources wisely by commissioning services which keep people well and independent; making better use of the skills and networks of the third and independent sectors; and closer working with affordable housing sector.



18. Performance – its role in the Strategic Planning Cycle

Progress against the priorities and actions outlined in the Strategic Plan will be monitored through the Edinburgh Partnership's integrated performance framework.

The scope of the performance framework includes:

- Performance against targets e.g. LDP (formerly the NHS HEAT targets)
- Quality
- Finance
- Stakeholder experience (e.g. staff and the people who receive support)

The framework will support:

- **Operational oversight** – through a small group measures which will be reported and considered relatively frequently e.g. monthly
- **Strategic planning and commissioning**

It will help us to assess whether:

- we are doing what we set out to do
    - *By monitoring progress against the strategic planning priorities and actions.*
- We are moving towards our local and national priorities
    - *By using the suite of national indicators as well as local indicators and by getting feedback from key stakeholders*
- we are delivering the support we intended to at the right place and at the right time. Is it safe, timely, effective, efficient, equitable and person-centred?
    - *By using measures, performance indicators, assessing costs and processes and by using feedback from staff and the people we support*
- we are changing the way we use resources over time
    - *By comparing spend on hospital based and community provision, for example*

- the profiles of localities have changed over time
    - *Ongoing work to develop needs profiles will provide this information. We are particularly interested in looking at changes in measures of health and wellbeing*

The diagram on the following page provides a summary of our performance framework.

The Lothian Integration Dataset group, which has members from NHS Lothian and the four Health and Social Care Partnerships within Lothian, has been working to identify a range of measures of interests to the four Integration Joint Boards. The aim is to provide a dataset for shared use by the four partnerships, which can be augmented by each with local measures. The proposed indicator set is shown in Appendix F.

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Integrated Performance Reporting

Reporting progress:

1. Indicators and measures
2. Action plans
3. Feedback and experience
4. Finance

Integrated Performance Management Framework

Project plan content:

1. The case for change
2. Current performance and challenges*
3. What we plan to do
4. Resource implications
5. What will success look like?*
6. We will collaborate with partners in this programme by …
7. We will collaborate with citizens and communities on this programme by …
8. Delivering our key priorities
9. Key milestones

*Performance indicators

Our key priorities:

1. Tackling inequalities and helping people to stay healthy
2. Prevention and early intervention
3. Person-centred care
4. Right care, right place, right time
5. Making best use of capacity across the whole system
6. Managing our resources effectively

Appendix C

Appendices A to F

to the Strategic Plan for Health and Social Care

Appendices to the strategic plan

A	Membership of the Edinburgh Integration Joint Board	
B	Membership of the Strategic Planning Group	
C	Hosted and set aside services	
D	National Health and wellbeing outcomes	
E	Local and national drivers	
F	Proposed indicator set	
G	Housing Contribution Statement – not yet available	
H	Joint Strategic Needs Assessment – available on request	

Appendix A

Members of the Edinburgh Integration Joint Board

The Public Bodies (Joint Working) (Act) 2014 sets out who should be a member of the Board and which members should have a vote.

Responsibility for chairing the Board rotates between the Council and NHS Lothian every two years.

Voting Members	
George Walker (Chair)	NHS Lothian non-executive board member
Ricky Henderson (Vice Chair)	City of Edinburgh Council elected member
Elaine Aitken	City of Edinburgh Council elected member
Shulah Allan	NHS Lothian non-executive board member
Kay Blair	NHS Lothian non-executive board member
Joan Griffiths	City of Edinburgh Council elected member
Sandy Howat	City of Edinburgh Council elected member
Alex Joyce	NHS Lothian non-executive board member
Dr Richard Williams	NHS Lothian non-executive board member
Norman Work	City of Edinburgh Council elected member
Non-voting members	
Rob McCulloch-Graeme	Chief Officer Health and Social Care Partnership
Ian McKay	Clinical Director
Michelle Miller	Chief Social Work Officer
Maria Wilson	Chief Nurse
Moira Pringle	Interim Chief Finance Officer
Dr Andrew Coull	Clinical Director Acute Medicine
Wanda Fairgrave	NHS Staff representative

Kirsten Hey	Council Trade Union Representative
Sandra Blake	Citizen member
Christine Farquhar	Citizen member
Angus McCann	Citizen member
Beverley Marshall	Citizen member
Ella Simpson	Third Sector Representative
Dr Carl Bickler	Chair Professional Advisory Committee
Dr Gordon Scott	Vice-chair Professional Advisory Committee

Appendix B

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	Users of health and social care services	Non voting members of Edinburgh Integration Joint

SPG Member	Role	Group to be represented	Arrangements for appointment of representative
	representative - users of health and social care services)		Board
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 organisations carrying out activities related to health or social care	Non voting members of Edinburgh Integration Joint Board

SPG Member	Role	Group to be represented	Arrangements for appointment of representative
	Third Sector		
Michele Mulvaney	Community Engagement Manager	Localities	Nominated pending establishment of representation for proposed four localities
Henry Coyle	Neighbourhood Manager	Localities	
Anna Herriman	Participation and Information Manager	Localities	

Appendix C

Hosted and set aside services

Hosted Services

Edinburgh
- Rehabilitation
- Sexual health
- Substance misuse

East Lothian
- Complex care
- Unscheduled care

Mid Lothian
- Art therapy
- Dietetics

West Lothian
- Clinical psychology
- Community dentistry
- Podiatry

NHS Lothian
- Hospital based learning disability services
- Hospital based mental health

Set aside Services

NHS Lothian
- Accident and Emergency
- Cardiology
- Diabetes
- Endocrinology
- Gastroenterology
- General medicine
- Geriatric medicine
- Infectious diseases
- Rehabilitation medicine
- Respiratory medicine
- Therapies

Appendix D

National health and wellbeing outcomes

as set out in the Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014

Outcome 1: improve health and wellbeing

People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2: support to live in the community

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.

Outcome 3: positive experiences and treated with dignity

People who use health and social care services have positive experiences of those services, and have their dignity respected.

Outcome 4: quality of life

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 5: reduce health inequalities

Health and social care services contribute to reducing health inequalities.

Outcome 6: support for carers

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.

Outcome 7: safety

People using health and social care services are safe from harm.

Outcome 8: engaged and supported workforce

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.

Outcome 9: use of resources

Resources are used effectively and efficiently in the provision of health and social care services.

Appendix E - 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 Scotland

Improving Health and Wellbeing of people with long term conditions in Scotland: A national action plan

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

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 Framework

Q. Neighbourhood Partnership Community Plans

Strategies/plans within the scope of the Health and Social Care Partnership Strategic Plan for Edinburgh

1. Learning Disability Commissioning Plan

2. Older People's Commissioning Strategy

3. Mental Health Commissioning Plan

4. Alcohol and Drugs P'ship Commissioning Plan

5. Carers Commissioning Plan

E. Plan for Hospital-based Services not delegated to IJB

14. *Inclusive Edinburgh Strategy*

6. Physical Disability Strategy

P. City Housing Strategy

Edinburgh Integrated Joint Board Strategic Plan

F. Edinburgh Anti Social Behaviour Strategy

13. Prevention Strategy

7. NHS Lothian Palliative and End of Life Care Strategy

O. Integrated Plan for Children and Young People

G. Health Inequalities Framework and Action Plan

12. Technology enabled care Strategy

11. Multiple/Long-term Conditions Strategy

10. Primary and Community Care Strategy

9. Plan for Hospital-based Services

8. Lothian Sexual Health and HIV Strategy

N. Lothian Mental Health and Wellbeing Strategy

M. Public Protection Strategy

H. Reducing Re-offending Strategy

I. Volunteering Strategy

J. Sustainability Framework

K. Edinburgh Compact Strategy

L. Social Enterprise Strategy

Key: Plan in place for Edinburgh | Lothian wide plan in place | No plan currently in place

Version: 7 20/4/2015

Appendix F

Proposed indicator set

National Health and Wellbeing Indicators

Ref	Indicator
	Outcome indicators based on survey feedback, to emphasise the importance of a personal outcomes approach and the key role of user feedback in improving quality. While national user feedback will only be available every 2 years, it is expected that **Integration Authorities' performance reports will be supplemented each year with related information that is collected more often.**
NI.1	Percentage of adults able to look after their health very well or quite well.
NI.2	Percentage of adults supported at home who agree that they are supported to live as independently as possible.
NI.3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
NI.4	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
NI.5	Percentage of adults receiving any care or support who rate it as excellent or good
NI.6	Percentage of people with positive experience of care at their GP practice.
NI.7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
NI.8	Percentage of carers who feel supported to continue in their caring role.
NI.9	Percentage of adults supported at home who agree they felt safe
NI.10	Percentage of staff who say they would recommend their workplace as a good place to work.*
	Indicators derived from organisational/system data primarily collected for other reasons. These indicators will be available annually or more often.
NI.11	Premature mortality rate.
NI.12a	Rate of emergency admissions for adults - SMR01
NI.12b	Rate of emergency admissions for adults - SMR04
NI.13	Rate of emergency bed days for adults.*
NI.14	Readmissions to hospital within 28 days of discharge
NI.15	Proportion of last 6 months of life spent at home or in community setting.
NI.16	Falls rate per 1,000 populations in over 65s
NI.17	Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
NI.18	Percentage of adults with intensive needs receiving care at home
NI.19	Number of days people spend in hospital when they are ready to be discharged

NI.20	Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency
NI.21	Percentage of people admitted from home to hospital during the year, who are discharged to a care home
NI.22	Percentage of people who are discharged from hospital within 72 hours of being ready
NI.23	Expenditure on end of life care.*

Local Delivery Plan Indicators

Ref	Indicator
LDP.1	People diagnosed and treated in 1st stage of breast, colorectal and lung cancer (25% increase)
LDP.2	31 days from decision to treat (95%)
LDP.3	62 days from urgent referral with suspicion of cancer (95%)
LDP.4	People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support
LDP.5	12 weeks Treatment Time Guarantee (TTG 100%)
LDP.6	18 weeks Referral to Treatment (RTT 90%)
LDP.7	12 weeks for first outpatient appointment (95% with stretch 100%)
LDP.8	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation
LDP.9	Eligible patients commence IVF treatment within 12 months (90%)
LDP.10	18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)
LDP.11	18 weeks referral to treatment for Psychological Therapies (90%)
LDP.12	Clostridium difficile infections per 1,000 occupied bed days (0.32)
LDP.13	SAB infections per 1,000 acute occupied bed days (0.24)
LDP.14	Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)
LDP.15	Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings
LDP.16	Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas
LDP.17	48 hour access or advance booking to an appropriate member of the GP team (90%)
LDP.18	Sickness absence 4%
LDP.19	4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
LDP.1	Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement

Additional Hospital Indicators

Ref	Indicator
AHI.1	No. patients age over 75 in hospital with unscheduled admission
AHI.2	No. patients (adults) in hospital with unscheduled admission
AHI.3	Occupied bed days (OBD) in week for patients aged over 75 with unscheduled admission
AHI.4	Occupied bed days (OBD) in week for patients (all adults) with unscheduled admission
AHI.5	A&E four hour waiting time (Lothian, Hospital Site)
AHI.6	Unplanned admissions as % of all admissions
AHI.7	Hospital admission rate over 75 (replication of 12. for National Indicators, but for aged 75+)
AHI.8	Over 75 LOS –median/average/90th percentile for patients discharged in month
AHI.9	Adults LOS – median/average/90th percentile for patients discharged in month
AHI.10	Rate of emergency bed days for adults
AHI.11a	Delayed Discharge a. No. patients waiting over 3 days on census
AHI.11b	Delayed Discharge b. No. occupied beds days lost from delayed discharge over two days
AHI.11b	Delayed Discharge c. No. patients waiting over 2 weeks on census
AHI.12	No. admissions from a care home
AHI.13a	Time of admission: a. No. Unscheduled Admissions to hospital within hours (all adults)
AHI.13b	Time of admission: b. No. Unscheduled Admissions to hospital within hours (75+)
AHI.13c	Time of admission: c. No. Unscheduled Admissions to hospital OOH (all adults)
AHI.13d	Time of admission: d. No. Unscheduled Admissions to hospital OOH 75+)
AHI.14e	Medical Readmission rate within 7 days
AHI.15	Medical Readmission rate within 28 days
AHI.16	A&E activity – number and rate per 100,000
AHI.17	Beds closed by infection
AHI.18a	A&E attendances converted to admission: a. (all adults)
AHI.18b	A&E attendances converted to admission: b. (75+)
AHI.19a	Alternatives to hospital admission: a. Hospital@Home prevention of admission i. No. referrals in month
AHI.19b	Alternatives to hospital admission: b. Redirection at hospital front door i. No. referrals to SPOC by bed bureau to urgent clinic, H@H, day of medicine, day hospital
AHI.20	Adverse events in hospital with serious harm

AHI.21	Patient falls with harm
AHI.22	No. grade 2 or above pressure ulcers
AHI.23	Potentially preventable admissions (ISD indicator available through Discovery)

Social Care Indicators

Ref	Indicator
SC.1	Number of domiciliary care hours provided in the snapshot week for people aged 65+
SC.2a	Total number of people 65+ who are supported in a care home
SC.2b	Number and % of people supported in a care home who are receiving FPNC (free personal and nursing care payments) only
	Number of people waiting for a domiciliary care package who are waiting:
SC.3a	- in hospital
SC.3b	- at home in the community – with no domiciliary care service in place
SC.3c	- at home in the community – where the person is already receiving a domiciliary care service but needs additional hours
	For people waiting for domiciliary care in the following locations, number of hours of support needed:
SC.4a	- in hospital
SC.4b	- at home in the community – with no domiciliary care service in place
SC.4c	- at home in the community – where the person is already receiving a domiciliary care service but needs additional hours
SC.5	Number of people aged 65+ who are waiting in hospital for a care home place