



Edinburgh Health and Social Care Partnership

Draft Joint Strategic Needs Assessment

Working together for a caring,
healthier, safer Edinburgh



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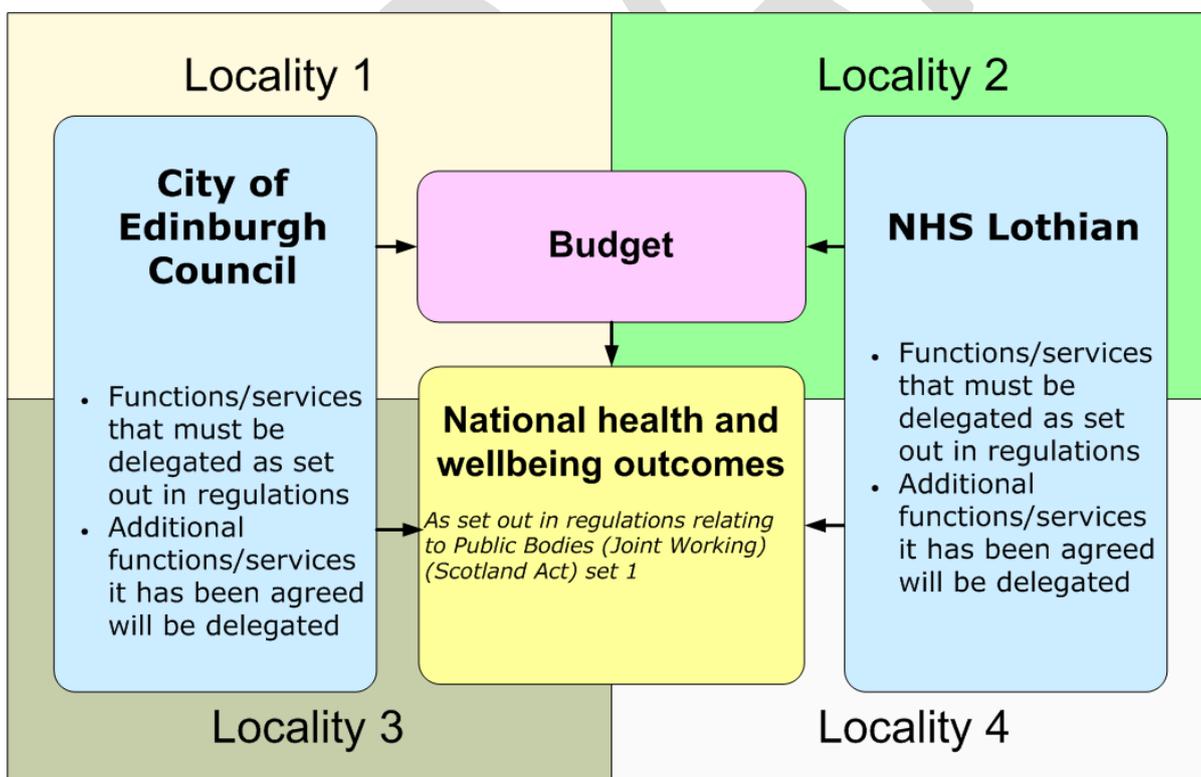
1.0 Introduction

1. Introduction - the integration of Health and Social Care

The integration of health and social care is a key Scottish Government initiative that will bring together the planning of adult social care services, NHS community services and some NHS hospital based services under a single body known as an “integration authority”. The legislation relating to the integration of health and social care is set out in the Public Bodies (Joint Working) (Scotland) Act 2014 and a set of linked regulations. A key requirement of the legislation is that each integration authority must produce a strategic plan that:

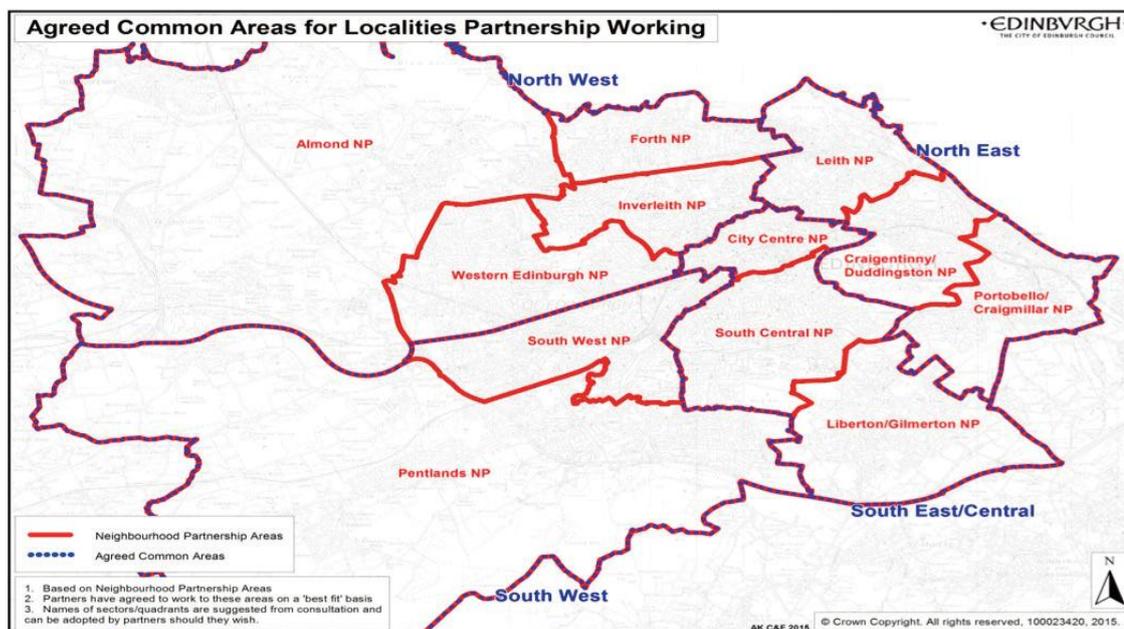
- divides the local authority area for which the integration authority is responsible into at least two localities
- sets out how the functions and services that the integration authority is responsible for will be delivered and how the related budget will be used
- explains how the integration authority intends to achieve a set of outcomes known as the national health and wellbeing outcomes

Scope of the strategic plan for Edinburgh



Defining the localities

The strategic plan for Edinburgh will cover the four localities outlined on the map below:



These localities have been agreed by all members of the Edinburgh Community Planning Partnership as the basis on which all partners will plan and deliver services.

Services to be delegated to the Edinburgh Integration Authority

The services that the City of Edinburgh Council must delegate to the new Integration Authority for Edinburgh are set out in the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Regulations 2014 and include:

- Social work services for adults and older people
- Services and support for people with physical and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Assessment and care management inc. OT services
- Health improvement
- Support for carers
- Residential care
- Care at home, reablement and intermediate care
- Rehabilitation
- Day services
- Respite care
- Telecare
- Local Area Coordination
- Aspects of housing support inc. aids and adaptations

The services that NHS Lothian must delegate to the new Integration Authority for Edinburgh are set out in the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 and include:

Community Health Services

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

*NHS Lothian has also decided to delegate responsibility for these services in respect of under 18's to the integration authority for Edinburgh

Hospital services

- Accident and Emergency
- 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

NHS Lothian has also decided to delegate prison health care services to the Integration Authority for Edinburgh.

National Health and Wellbeing Outcomes

The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected

Outcome 4. 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. Health and social care services contribute to reducing health inequalities

Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

Outcome 7. People using health and social care services are safe from harm

Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services

2. Joint Strategic Needs Assessment

A Joint Strategic Needs Assessment (JSNA) is a key element of the process of preparing a strategic plan, providing an assessment and forecast of needs to enable investment to be linked to all agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

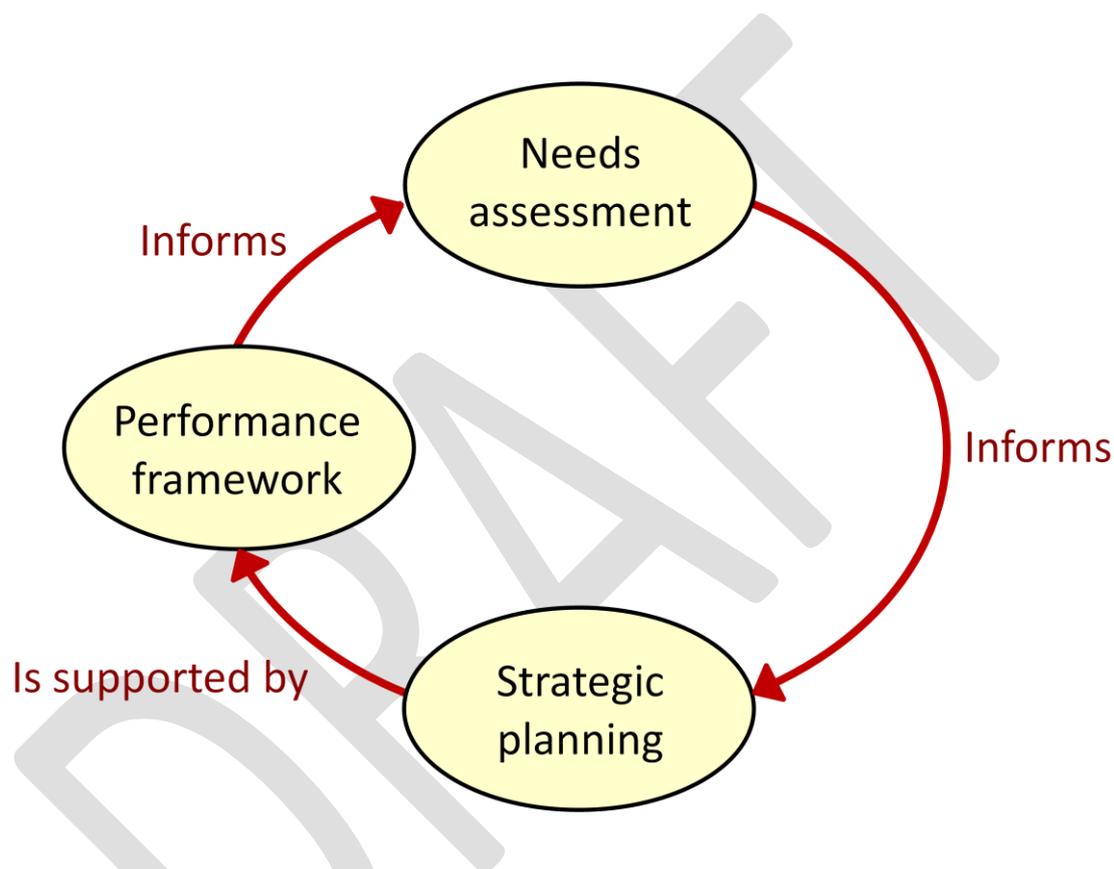
The purpose of the JSNA is to:

- To agree a comprehensive local picture of health and wellbeing needs, using intelligence and analysis to determine:
 - Current and future needs
 - What's working, what's not, and what could work better?
 - What are the major health inequalities and what can be done about them?
 - Unmet needs, including those of seldom-heard populations and vulnerable groups

This will be used to:

- Negotiate and agree overarching priorities on health and wellbeing;
- Influence commissioning and decision making

The JSNA is part of a cycle, which will inform strategic planning, which in turn will be used to develop our monitoring and performance framework.



The needs assessment is being done in two phases. The first phase is a desktop analysis of data, and is the focus of this report. The second phase will involve engaging a wide range of stakeholders in discussing the findings of phase 1, and more broadly, in using their knowledge and experience as clinicians, practitioners, residents, third sector organisations, service providers etc to form a broader and more complete assessment of needs and priorities. Both phases will be needed to meet the objectives of the JSNA as outlined above.

This document presents a desktop analysis of a wide range of datasets. It will cover four broad themes:

- A profile of Edinburgh and its four localities: its population structure – current and forecast, levels of poverty, the labour market, housing, education, children in need and the health of its population
- An overview of the needs of specific groups: older people, people with disabilities, people with mental health problems, unpaid carers, people with addictions, people with complex needs and

people with palliative care needs – current and forecast levels of need are described along with a summary of current priorities for each group

- Profiles of current resource use: spending profiles on NHS and social care services, activity profiles for health and social care, and analyses of specific groups – those people who are at risk of emergency hospital admission, and people who use relatively high levels of support (“high resource individuals”)
- A summary of known pressures within the health and social care system.

This report provides brief overviews of each topic based on more detailed reports, which will be available separately as a series of topic papers (these are listed in Appendix 1).

The JSNA report is being issued in draft form so that stakeholders can provide comments on the report so far, as well as their input about other needs (recognising that there are limitations to the information which is readily available for analysis) and priority areas for action. A number of responses have already been received and many of the suggested revisions are still to be made.

We recognise that this first JSNA will have gaps and that it will raise further questions which will need to be addressed through further analytical work and the ongoing cycle of analyse, plan, do and review.

2. JSNA production

The production of Edinburgh Shadow Health and Social Care Partnership’s JSNA was overseen by a working group, chaired by the Acting Strategic Policy and Performance Manager, which included representatives from the City of Edinburgh Council (Health and Social Care, Business Intelligence, Services for Communities and Children and Families), NHS Lothian and the service user/citizen representative who is a non-voting member of the Shadow Health and Social Care Partnership.

2.0 Profile of Edinburgh

2.1 Edinburgh's Population Structure

Introduction

This analysis summarises population and household data from the 2011 Census, as well as National Records of Scotland (NRS) population projections for local authority areas. Further details will be given in Topic Paper 1 (currently in draft), which will provide links to a range of other documents.

Edinburgh's population – age and gender

The size and age structure of a population are among key determinants of the need for support for universal services such as primary health care and schools, and targeted services - social care, for example.

The Public Bodies (Joint Working) (Scotland) Act 2014, requires integration authorities to divide the area for which they are responsible into at least two localities for strategic planning purposes. The Integration Scheme for Edinburgh proposes four localities within the city, as illustrated below. Population profiles (age and gender) are presented for each locality and for the whole city, using the 2013 Population Mid-Year Estimates (NRS).

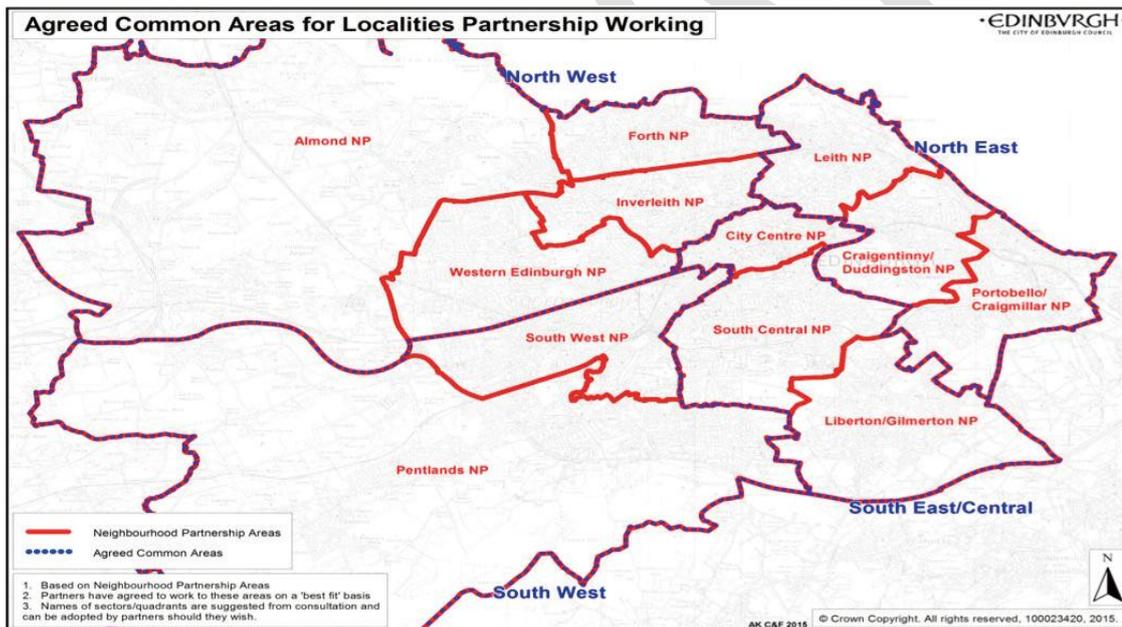


Table 1 shows that the four localities have reasonably similar total population sizes. *North West*, with a population of 138,995, is the largest sector and *East*, with a population of 110,550 is demographically the smallest.

Table 1. Edinburgh's Localities – population profile

Age Group	Males & Females				Edinburgh	Males				Edinburgh	Females				Edinburgh
	North East	North West	S East/Central	South West		North East	North West	S East/Central	South West		North East	North West	S East/Central	South West	
0-15	15,851	24,745	16,149	17,714	74,459	8,037	12,683	8,267	9,124	38,111	7,814	12,062	7,882	8,590	36,348
16-24	11,944	13,658	28,085	15,965	69,652	5,544	6,874	12,844	8,388	33,650	6,400	6,784	15,241	7,577	36,002
25-49	50,640	50,092	45,631	42,404	188,767	25,481	24,172	22,976	21,728	94,357	25,159	25,920	22,655	20,676	94,410
50-64	17,454	26,378	19,375	19,179	82,386	8,714	12,840	9,630	9,490	40,674	8,740	13,538	9,745	9,689	41,712
0-64	95,889	114,873	109,240	95,262	415,264	47,776	56,569	53,717	48,730	206,792	48,113	58,304	55,523	46,532	208,472
65+	14,661	24,122	16,908	16,545	72,236	6,427	10,162	6,999	7,107	30,695	8,234	13,960	9,909	9,438	41,541
75+	7,031	12,087	8,363	7,615	35,096	2,768	4,682	2,994	2,943	13,387	4,263	7,405	5,369	4,672	21,709
85+	1,964	3,428	2,860	1,977	10,229	673	1,140	811	626	3,250	1,291	2,288	2,049	1,351	6,979
Total	110,550	138,995	126,148	111,807	487,500	54,203	66,731	60,716	55,837	237,487	56,347	72,264	65,432	55,970	250,013

Source: NRS 2013 Mid-Year Population Estimates for Datazones. NB: Population data only available in these 5 year age groupings (by gender).

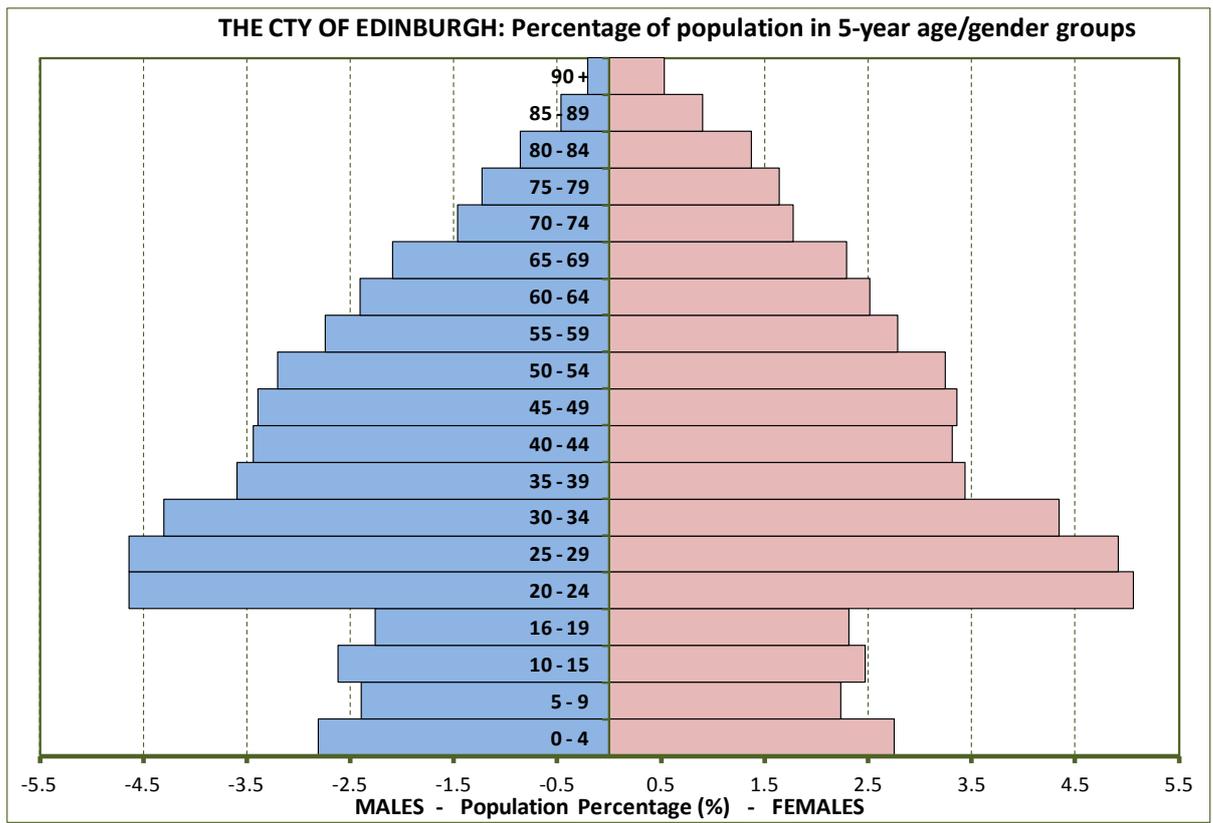
Table 2. Edinburgh's Localities – population profile

Percentage breakdown of age group across the Edinburgh						Percentage breakdown of the locality by age group					
Age Group	Males & Females				Edinburgh = 100%	Age Group	Males & Females				Edinburgh %
	North East	North West	S East/Central	South West			North East	North West	S East/Central	South West	
0-15	21.3%	33.2%	21.7%	23.8%	74,459	0-15	14.3%	17.8%	12.8%	15.8%	15.3%
16-24	17.1%	19.6%	40.3%	22.9%	69,652	16-24	10.8%	9.8%	22.3%	14.3%	14.3%
25-49	26.8%	26.5%	24.2%	22.5%	188,767	25-49	45.8%	36.0%	36.2%	37.9%	38.7%
50-64	21.2%	32.0%	23.5%	23.3%	82,386	50-64	15.8%	19.0%	15.4%	17.2%	16.9%
65-74	23.1%	27.7%	26.3%	22.9%	37,140	65-74	6.9%	8.7%	6.8%	8.0%	7.6%
75-84	20.3%	33.4%	23.4%	22.9%	24,867	75-84	4.6%	6.2%	4.4%	5.0%	5.1%
85+	20.0%	34.4%	23.8%	21.7%	10,229	85+	1.8%	2.5%	2.3%	1.8%	2.1%
Total	22.7%	28.5%	25.9%	22.9%	487,500	Total					100.0%

Key points:

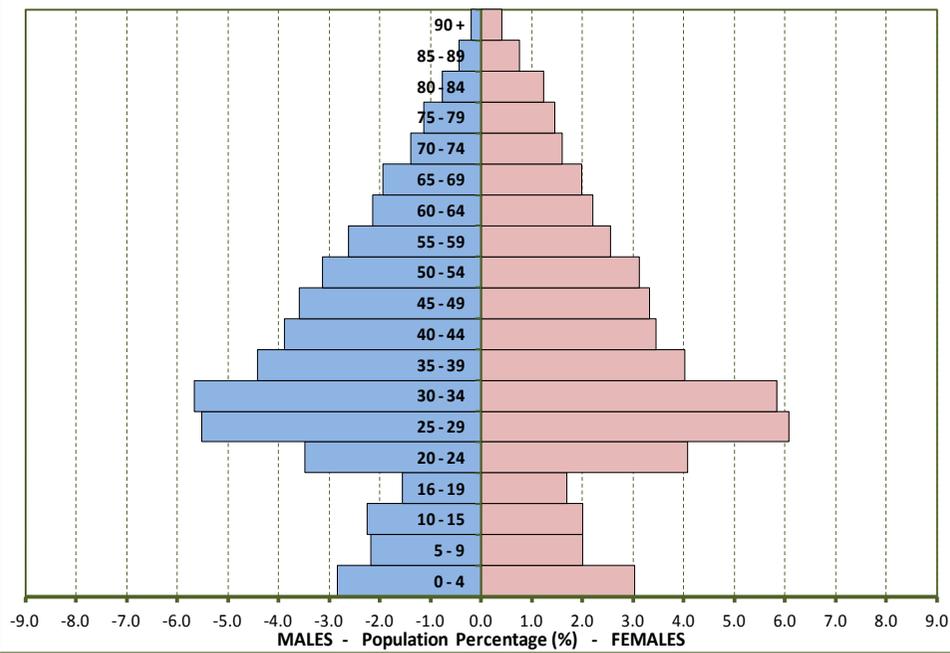
- *North West* includes one-third (33.2%) of Edinburgh's child population aged 0-15 and one-third (33.5%) of the very elderly population aged 85+ (a group which tends to have high levels of need).
- Only 12.8% of *South East/Central's* population is aged 0-15 compared with the Edinburgh average of 15.3% and a large proportion (22.3%) are aged 16-24 (N = 28,085) - many of these will be further education students. The traditional working age population (16-64) is biggest in *South East/Central* (93,091).
- *East* has the lowest proportion of older people (aged 65+) (13.3%); almost half (45.8%) of its residents are younger adults aged 25-49 compared with the overall Edinburgh proportion of 38.7%.
- *South West* and *East* have relatively low proportions of people aged 85+; the working age population is smallest in the *South West* (77,548).

The following population pyramids illustrate the population structure of Edinburgh and the 4 localities:-

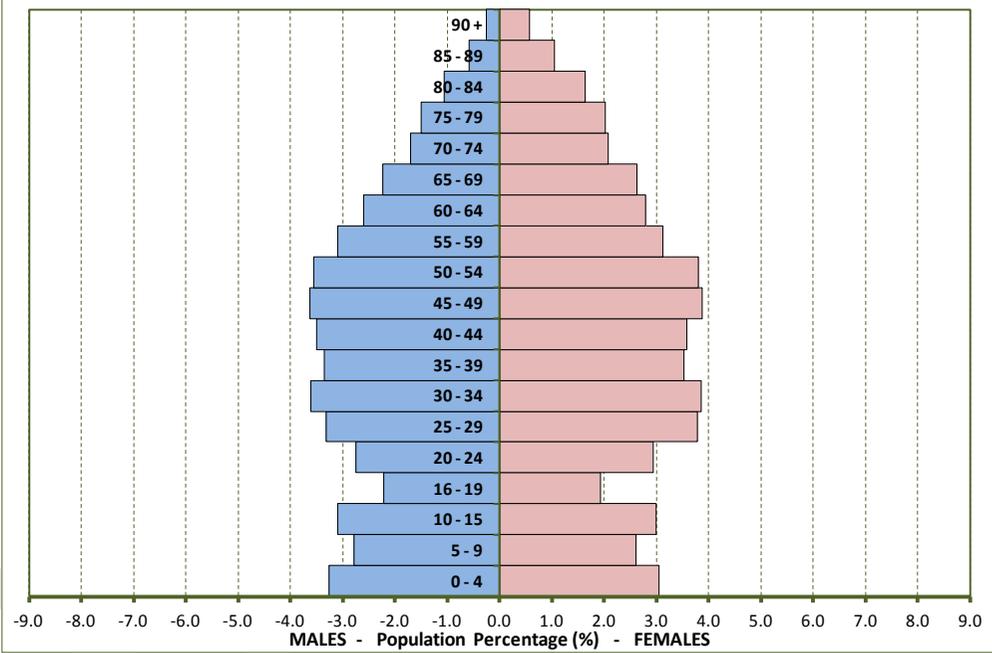


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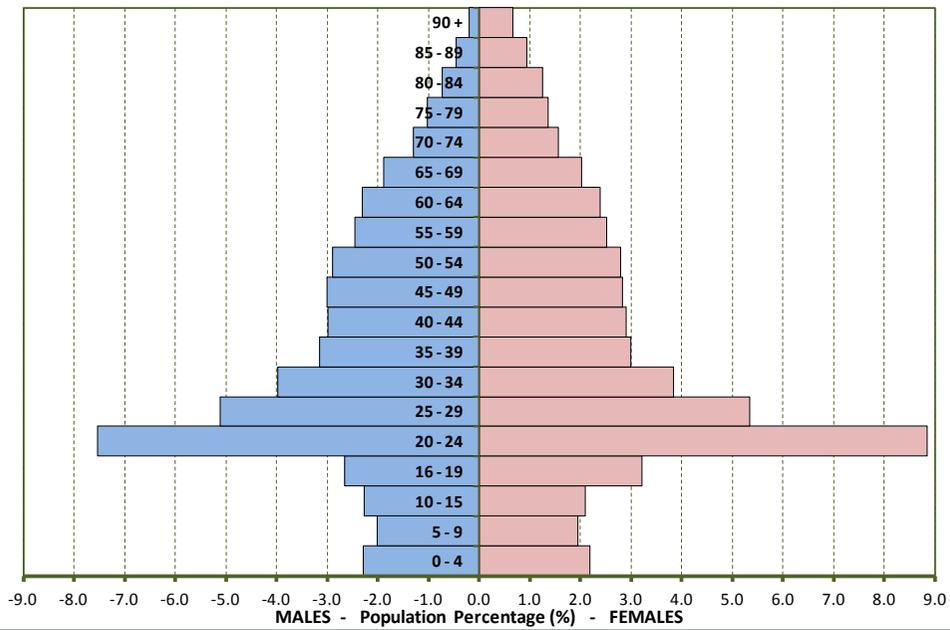
NORTH EAST: Percentage of population in 5-year age/gender groups



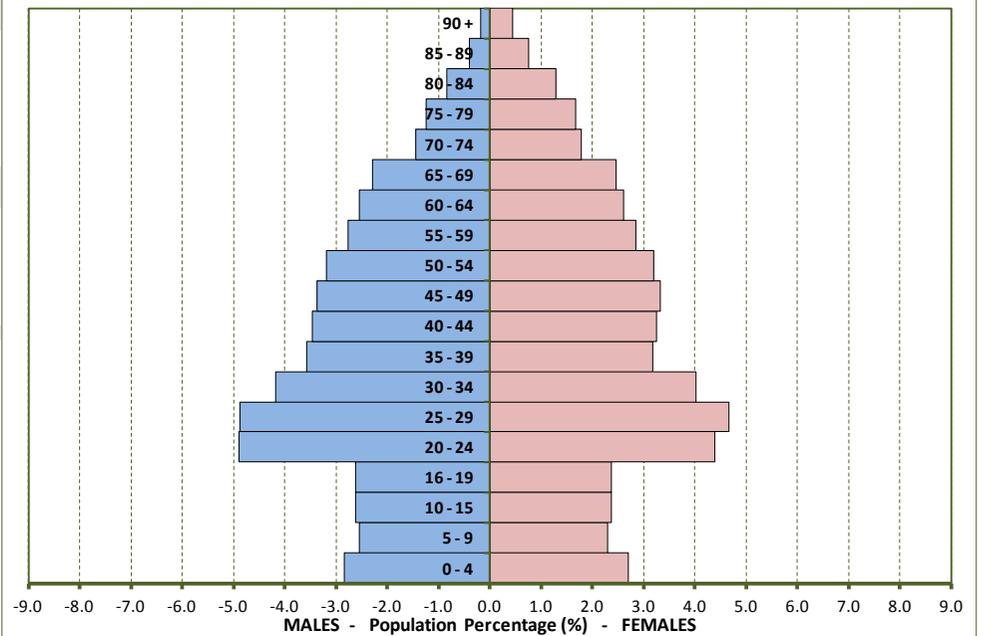
NORTH WEST: Percentage of population in 5-year age/gender groups



SOUTH EAST/CENTRAL: Percentage of population in 5-year age/gender groups



SOUTH WEST: Percentage of population in 5-year age/gender groups



Other characteristics of Edinburgh's population

The results from the National Censuses between 1971 and 2011 tell us that:

- In 2011, 7.8% of Edinburgh's population was "White other" (non British or Irish) – the fifth highest proportion in the UK
- At 2011, among non-White ethnic groups, Chinese was the most common (with around 8,000 people), followed by Indian (just under 6,500), Pakistani (just under 6,000) with other Asian and Black African both having around 4,500 people
- Censuses since 1971 show an increasing proportion of single person households (from 23% to 39%)

Edinburgh's Future Population

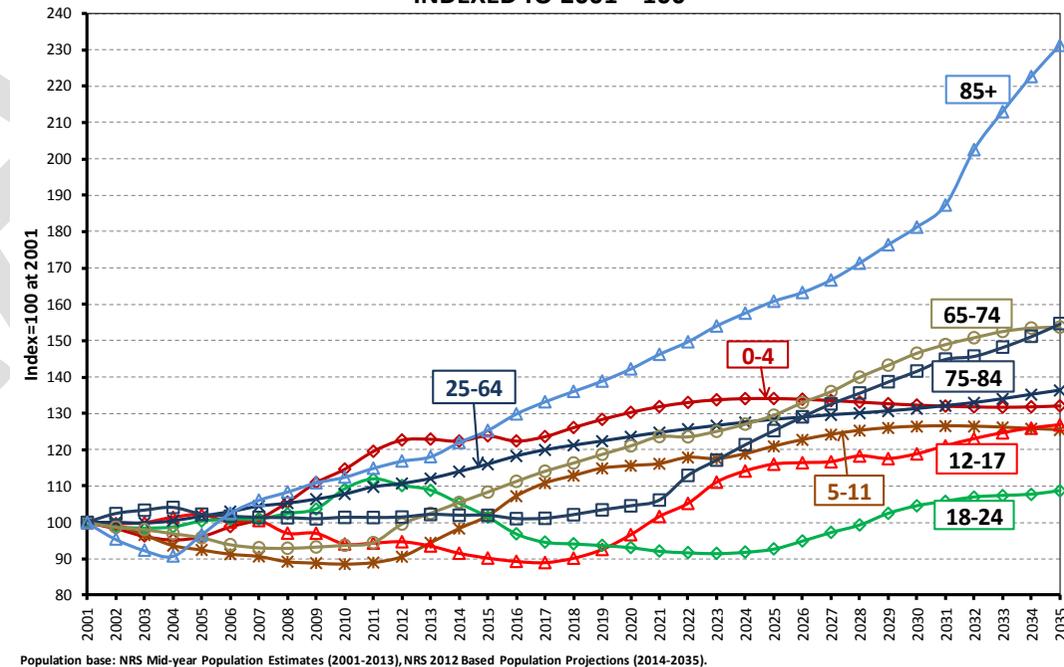
Forecasts of the city's population will help us to estimate future requirements for services, including health and social care services. Edinburgh's population is projected to continue its recent rapid growth, rising from 482,600 in 2012 to 537,000 in 2022 – an increase of 54,400 or 11.3% over the next 10 years. Over 25 years, if recent trends continue, Edinburgh's population would grow by 136,400 or 28.2%, to reach 619,000 in 2037. Over this period, the number of households in Edinburgh is projected to increase by 88,158 from 224,875 to 313,033, which is an increase of 39%. In both numerical and percentage terms, Edinburgh is projected to be home to a faster growing population than anywhere else in Scotland.

Approximately 70% of Edinburgh's future population growth is accounted for by more people coming to live in the city, with remaining 30% resulting from more births than deaths. However, migration is more volatile than births and deaths and therefore difficult to measure accurately. The

numbers shown are projections rather than forecasts, estimating what will happen if recent trends continue but taking no account of future economic changes or policy interventions.

Over the last 30 years male life expectancy in Edinburgh has increased by 7.0 years (to 77.4) while female life expectancy has increased by 5.4 years (to 81.9). Looking ahead, the projections envisage a 28% growth in those aged 85+ between 2012 and 2022, a group that makes more intensive use of care services. The number of people aged 85+ is projected to more than double in Edinburgh by 2037 (110% increase from 10,100 to 21,300).

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



2.2 Poverty and low income

Introduction

This chapter provides a profile of poverty and low income in Edinburgh across wards and localities in the city and evidence of the link between poverty, low income and poor health outcomes. Further details are provided in Topic Paper 2, available separately.

Definitions and measures

The analysis adopts a standard definition of poverty in which people are said to be living in poverty if their *income and resources are so inadequate as to preclude them from having a standard of living considered acceptable in the society in which they live.*

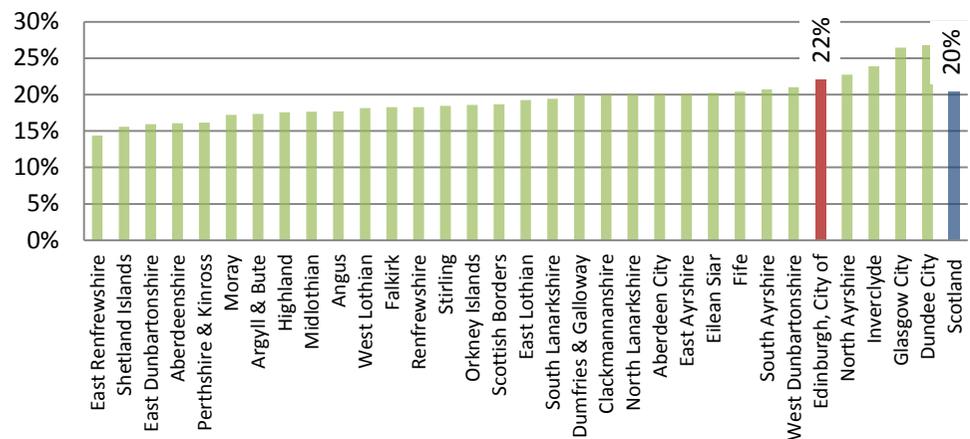
From this definition, the analysis aims to measure the number of households living on incomes below the UK Government defined poverty threshold. Individuals are said to be in relative low income if they live in a household with an equivalised income below 60% of average (median) income of the year in question.

Summary of key findings

- Recent research published by the Scottish Government estimated that 19% of all households in Scotland were living on incomes below the poverty threshold (after housing costs - AHC) in 2012/13. This represents a total of 1 million individuals, a significant increase on 2011/12 and has been driven by recent labour market trends alongside welfare system reforms.

- Recent estimates by the Institute of Fiscal Studies suggest that poverty rates are likely to remain high in the next few years, particularly among working age families and families with children.
- Workless households account for only half of all those on low income. Recent years have shown a steady increase in the prevalence of in-work poverty in Scotland, with 45% of households below the poverty threshold having at least one adult in work.
- Other notable trends highlighted by the research include wide variations in the risk of poverty between different household types. Households at high risk of poverty include – workless households, young households, single parent households, social tenants, ethnic minority households, and households with disabled children.
- A major study of local income patterns across Scotland estimated that some 22% of all households in Edinburgh were living on incomes below the poverty threshold in 2009. On this measure, poverty in Edinburgh is slightly above the Scottish average. Only four other Scottish local authorities record levels of poverty higher than Edinburgh.

% low income households (AHC), by local authority, 2009



Source: Local income modelling project, Improvement Service, 2013

data show that the rate of premature mortality due to Coronary Heart Disease in deprived areas of Edinburgh remains at more than twice the average for the city as a whole. Further information on comparative levels of health across the city is provided in section 3.6

12% of economically inactive residents (aged 16-74) in Edinburgh are unable to participate in the labour market due to a limiting long term illness. This represents the largest single cause of economic inactivity in the city when students and retired residents are discounted. Such rates are particularly high (up to 20%) in low income wards across the city and represent a significant barrier to households ability to increase incomes above the poverty threshold.

- This finding is corroborated by more recent research, which estimates that 21% of all children in Edinburgh were living in low income households in 2013. This again represents a rate close to the Scottish average and indicates poverty levels in Edinburgh significantly higher than suggested by proxies such as the Scottish Index of Multiple Deprivation.
- These average levels mask significant variation in poverty rates across the city. At locality level, poverty rates range from 19.8% in the North West, to almost 23.5% in South East/Central. At a more local level, the proportion of households living below the poverty threshold rises as high as 33% in some areas. This level is comparable to the rate recorded in the most deprived parts of Glasgow and almost double the rate recorded across Edinburgh's least deprived areas. Notably, all localities in the city record areas of high poverty alongside areas of relative affluence.
- The 2010 Marmot Review illustrated a clear link between income inequalities and inequality across a wide range of health outcomes. In Edinburgh, for instance,

Poverty in Edinburgh by locality

	(1) % of Households on low incomes (AHC)	(2) % children who live in low income households (AHC)	(3) JSA claimant rate	(4) Out of work benefits claimant rate
	2009	2013	Aug-14	May-14
North West	19.8%	18.3%	2.1%	10.4%
East	22.4%	26.1%	2.8%	14.4%
South East/Central	23.5%	18.8%	1.6%	9.0%
South West	22.4%	20.0%	2.5%	12.2%
Edinburgh	21.9%	21.1%	2.2%	11.4%
Scotland	20.4%	22.2%	2.7%	14.8%

Sources: (1) Local income modelling project, 2013; (2) Child poverty action group, 2014; (3) DWP; (4) DWP

2.3 Labour Market

Introduction

This section provides a profile of labour market conditions in Edinburgh across wards and localities in the city. The profile also considers trends in labour demand, skills gaps and shortages. Further details are given in Topic Paper 3.

Definitions and measures

Labour supply – refers to the number of people who are working or available to work, otherwise known as the economically active. The alternative to participating in the labour market is to be economically inactive. The reasons for economic inactivity include: being in full-time study, looking after family or home, being long term sick and being retired.

Labour demand – refers to the need for labour by employers to produce outputs or deliver services. It is represented by both the current and forecasted number and type of jobs in an economy.

Summary of key findings

- A total of 345,600 people in Edinburgh are of working age. The working age population has grown more in Edinburgh than in Scotland in the last ten years.
- In terms of Edinburgh locality the working age population is highest in South East/Central (93,200) and lowest in the South West (76,600). North West is second highest (87,600) and East third (78,700).
- The four Edinburgh localities contain different rates of engagement with the labour market. Economically activity rates, or those either employed or unemployed, in the localities vary between 57.5% and 68.6%. Health condition is a barrier to participation in the workforce.

- Locality level averages hide very wide variation in unemployment rates by ward in each area. The North West locality, for instance, contains both the highest and second lowest unemployment rates recorded among all Edinburgh wards ranging from 0.9% (Almond) to 3.7% (Forth).
- Pockets of skill gaps will also present challenges. The proportion of people educated to degree level varies between 38% in the South West to 47% in the South East/Central.
- The health sector is a major source of labour demand and accounts for 45,700 jobs or 15% of total employment in Edinburgh. The sector is expected to grow by 13,000 in Edinburgh, Fife and Lothian regions from 2012 to 2022. This is a higher rate of growth than any other sector.
- Skill shortages and hard to fill vacancies are persisting and growing within the health sector. This presents a number of challenges in this growing and sizable area of employment in Edinburgh.

Labour supply by locality, 2011

	Economic activity	Employment	Economic inactivity
North West	64.8%	60.9%	35.2%
East	68.6%	63.5%	31.4%
South East/Central	57.5%	52.9%	42.5%
South West	63.6%	58.6%	36.4%
Edinburgh	63.4%	58.8%	36.6%
Source: Census 2011			

2.4 Housing

Introduction

This section highlights the key housing issues that relate to health and social care. Further detail and analysis is provided in Topic Paper 4.

The last Housing Needs and Demand Assessment identified that Edinburgh needs an additional 36,000 new homes over 10 years, 16,600 of which need to be affordable.

Homeownership accounts for 58% of households and is the largest tenure in Edinburgh. Private renting is the second largest accounting for 27% of household. 14% of households rent from the Council and registered social landlords (Scottish Household Survey).

The nature of Edinburgh's housing supply brings challenges in terms of accessibility and suitability for adaptations. Edinburgh has a higher proportion of flats than the rest of Scotland (67% compared to 36%) and 50% of Edinburgh's homes were built before 1945, compared to 32% across Scotland (Scottish House Condition Survey 2011/13).

Summary of Key Findings:

- Housing supply is a real challenge in Edinburgh and there is a need to be realistic about the housing options that are available to people.
- The planned re-provisioning of hospitals and public sector property rationalisation programmes, innovative approaches to land use, funding and delivery mechanisms will provide opportunities to create new sustainable communities to meet the needs of the city and its people.
- Often the best option for people is to remain in their current home. Adequate care and support services are needed to help people to remain where they are, whether that is to prevent homelessness or prevent people from going into hospital or care unnecessarily.
- There is an ageing population and we need to ensure there is a sufficient supply of suitable, accessible homes and services to enable older people to plan for their future needs.
- The current approach to preventing homelessness is working, with the number of homeless presentations reducing and the support needs of those presenting also reducing. This is due to targeted housing support for people who need initial support to establish their tenancy and make contacts with health and care services.
- There is a correlation between mental ill-health and drug/alcohol dependency and long term homelessness. Integrated approaches are required to tackle some of the problems faced by people with complex needs, Inclusive Edinburgh and Total Place may assist.
- There is a correlation between areas which traditionally had a high concentration of social rented housing and poverty and deprivation. Although the tenure in these areas has changed in some cases, with an increase in homeownership and private renting, the prevalence of health deprivation remains. This appears to be due to the fact that those living in these homes have limited housing options and are the poorest households. Allocation policies, current legislation and a shortage of homes of all tenures are likely to perpetuate this.
- New joint approaches which seek to match properties to people with Urgent Gold priority for rehousing will help address delayed discharge from hospital, where housing is a key factor. This is a joint approach between the Council's Housing Service, Registered Social Landlords, NHS Lothian and Health and Social Care.
- The cost of energy and fuel poverty is a major issue which affects the lives and health of some of the poorest and most vulnerable households in the city. Through investing in energy efficiency and providing support to help people manage their energy consumption, health benefits can be achieved.

2.5 Children and Families

Introduction

This section highlights the key issues that relate to the integration of health and social care. Further detail and analysis is provided in Topic Paper 5.

We have an increasing number of children in Edinburgh.

The number of children in Edinburgh aged up to two is projected to rise over the next 5 years by around 10%. Funding has been provided by the Scottish Government to significantly increase access to care and learning and this is already being taken forward in the city.

The National Records for Scotland population projections estimate that Edinburgh's primary school roll will rise from the 2014/15 start of session position of 28,010 pupils to an estimated 31,700 pupils by 2020 and then increase further to an estimated 35,400 pupils by 2030. This is largely due to the projected rise in the birth rate from an average of 5,000 per year to 6,000 per year.

This increase has implications for services including schools (school roll sizes, the physical capacity of schools and ratios of staff to pupils), health services, including GPs, health visitors etc, and in the longer term, on adult social care services.

Note that analysis of data at locality level has not yet been carried out as discussions are ongoing with regard to school boundaries.

Demand for targeted services

The projected increase in population will have an effect on both universal and targeted services, including those provided to the most vulnerable in the community (e.g. children and young people who need to be looked after, those with a disability or those requiring additional support).

In Edinburgh, there are around 1,400 children and young people who are looked after at any one time. The numbers have shown a steady increase since 2007 and this increase was projected to continue for the following five years. The proportion of each school population who are looked after at primary school ranges from 0% to 5.6%, at secondary from 0.3% to 7.9% and at special schools (including secure services) from 1.1% to 76.4%.

Outcomes for children and young people

We know that we have more to do to improve outcomes for our most vulnerable or disadvantaged children and young people, including those looked after or with a disability and those who live in deprived areas. The outcomes for these groups can be significantly poorer than those of their peers.

Looked After Children

For children who are looked after, educational outcomes can vary by accommodation type and be even poorer for those looked after at home.

Whilst this is true across Scotland we want to change the picture here in the city. On average a pupil in Scotland who is looked after, compared to their peers, will:

- have lower school attendance, particularly within the secondary and special sectors
- be six times more likely to be excluded
- be almost three times as likely to leave school aged 16 or under
- have an attainment level just over a fifth of other school leavers
- be a third less likely to have a positive destination from school, and
- be less likely to sustain a positive destination

The table below, taken from the Scottish Government Publication 'Educational Outcomes of Looked After Children' published in 2014, shows the average tariff score (attainment measure) and positive destination six months after leaving school of those looked after children in Edinburgh and in Scotland during 2012/13.

% of pupils in most deprived areas gaining 5+ awards at SCQF Level 6 by the end of S6				
	2010/11	2011/12	2012/13	2013/14
Edinburgh	7.4%	7.8%	8.1%	8.7%
National	8.0%	9.0%	10.1%	12.6%
Gap between most deprived areas and the whole population (S6)				
	2010/11	2011/12	2012/13	2013/14
Edinburgh	20.6	21.2	21.6	21.7
National	15	16	15.6	19.4

Children living in deprivation

In general in Edinburgh, school leavers who live in more deprived areas are less likely to enter positive destinations on leaving school than those from the less deprived areas. Leavers who live in the less deprived areas are more likely to enter higher education while leavers from the more deprived areas are more likely to be unemployed. Levels of attainment are also affected by whether a pupil lives in a deprived area. The Local Government Benchmarking Framework published data showing that:

- The attainment of S6 pupils in the most deprived areas has improved since 2010/11, but is lower than the national average.
- The rate of improvement in attainment by the end of S6 in the most deprived areas has increased at a much slower rate than the national average.
- The gap in attainment by the end of S6 has widened in Edinburgh although the rate of increase of this gap is slower than at the national level.

2.6 Edinburgh's Health

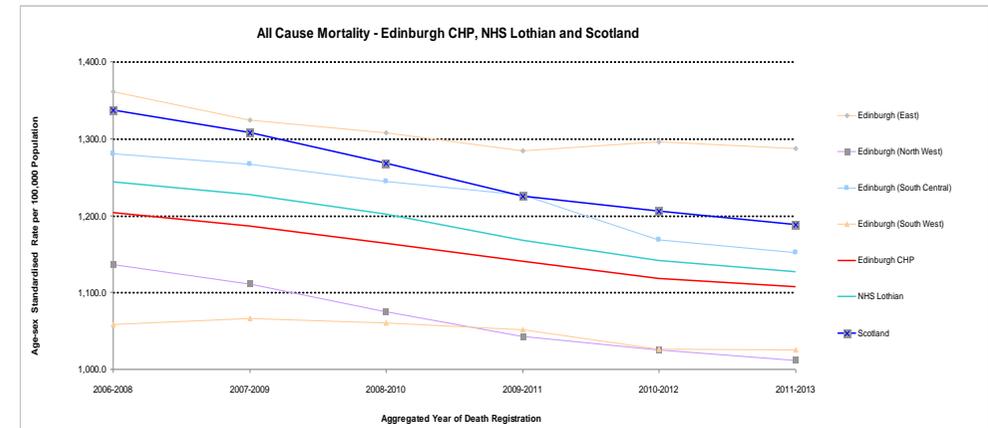
Introduction

This section provides a brief overview of health and life expectancy at Edinburgh and locality level. Further details (including references to research papers etc) are provided in Topic Papers 6a and 6b.

Summary of key points

- Life expectancy has increased steadily in the last ten years in Edinburgh. However, there are pronounced differences within the city, which reflect social and economic inequalities: boys born in Greendykes and Niddrie Mains between 2005 and 2009 had a life expectancy more than 25 years less than girls born in Barnton and Cammo.
- Health is poorest in the East locality, where the mortality rate is the highest in the city, and higher than both the Lothian and Scotland average. Health profiles across the three other localities are broadly similar.
- The East locality has higher death rates for: coronary heart disease, cardiovascular disease, certain cancers, alcohol-related mortality (adjusted for age and sex structure of the area), and early deaths (i.e. before age 75) and, along with South East/Central, suicide (note that caution is needed as

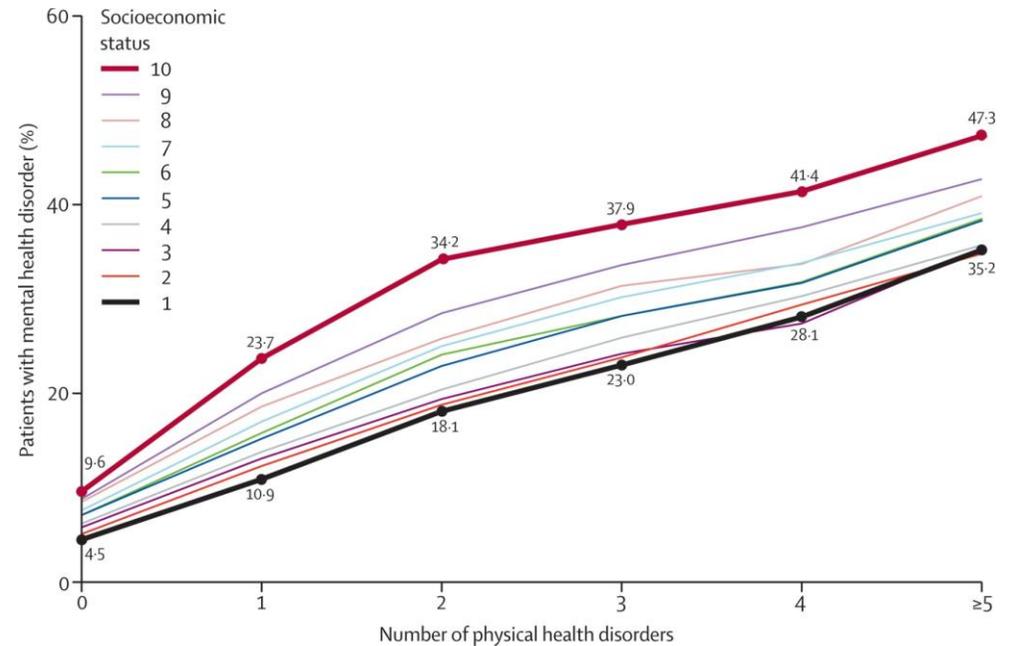
numbers are small for certain categories – see full Topic Report 6a).



- Research shows that people living in areas with higher levels of deprivation also have poorer physical and mental health throughout their lives (see chart below). However, health inequalities are not restricted to areas of multiple deprivation - up to 50% of people experiencing poor health do not live in the most deprived communities.
- There is also very strong evidence of health inequalities associated with social determinants of health. Low income, unemployment and insecure work, homelessness and low educational attainment have particularly strong influences.
- Isolation and loneliness are common health determinants for older people. These are associated with higher all cause mortality for both sexes, as well as lifestyle factors such as poorer dietary intake.

- People who are disadvantaged by race, migration status, disability, gender and other factors also have poorer health.
- Although overall mortality for people from black and minority ethnic populations is similar or better than the white Scottish population, there are aspects of health – notably cardiovascular and diabetes – where access to services and outcomes are worse, particularly for people from south Asian populations.
- People experiencing physical disability also tend to have poorer health. Limiting long term conditions reduce people’s healthy life expectancy i.e. the period of life lived in good health. There is strong evidence that learning disability is associated with very poor health.
- Within the universal service there are often other barriers (including physical, social, environmental, practical and cultural) and lack of capacity where the need is highest. These all contribute to what is termed the ‘inverse care law’ – that quantity and quality of care may be poorest for those with the highest needs. There is evidence in Scotland that resources in our poorest communities are not sufficient for need.
- Edinburgh’s population is increasing. It is estimated that in 2037 the percentage working age population will still be higher than other Scottish local authorities. More GPs, nurses and social care staff will be needed to provide community-based services that serve the population throughout the lifecourse. Filling these key posts will be challenging given the current age profile of these staff groups (see Topic Paper 6.5).

- Edinburgh’s population is *ageing*. An increase in the number of older people will mean an increase in absolute demand for health and care. Diabetes, COPD and dementia are all diagnosed more often among older age groups. Multimorbidity will be the norm for the Edinburgh population.



Physical and Mental Health disorders by socioeconomic status[11], note that socioeconomic status 1 is high

- Current definitions of age, e.g. the working age population being 16-64 years, may change in future as changes to pension eligibility, changing work patterns and longer healthy life expectancy mean that public policymakers need to re-think how to support an older population.

2.7 Summary– Population Characteristics and Needs

1. This section has highlighted the significant disparities in life expectancy, life chances and health and wellbeing among the population of Edinburgh – these exist *between* but also *within* localities. This is directly relevant to two of the national health and wellbeing outcomes:
 - Outcome 1: people are able to look after and improve their own health and wellbeing and live in good health for longer
 - Outcome 5: Health and social care services contribute to reducing health inequalities
2. We know that there are a range of factors which contribute to these disparities in levels of need. These include:
 - **Poverty:** there is a clear link between income inequalities and inequality across a wide range of health outcomes; there are significant pockets within the city; overall, 21% of children were living in low income households in 2013 and Edinburgh has the fifth highest proportion of low income households in Scotland.
 - **Living in an area with high levels of deprivation:** school leavers are less likely to have a positive destination; people are more likely to have poorer physical and mental health throughout their lives; *however, 50% of people experiencing poor health do not live in these areas*
 - **Being in a specific group:** there is clear evidence that being a looked after child, being disabled or being a person aged 85 or more increases the need for support. Looked after children, for example, are less likely to sustain a positive destination after school, increasing the likelihood of living in poverty etc.
3. Other risk factors include social isolation and loneliness which are associated with higher mortality rates among older people – we know that the number of single households in Edinburgh is increasing, and that a substantial proportion of older people live alone.
4. What do we know about the future?
 - Poverty rates are likely to remain high in the next few years
 - There will be an increase in the size of the population – this in itself will lead to an increase in the number of people needing support, even if prevalence rates and economic factors stay the same
 - There will be more older people – again leading to an increase in the numbers of people needing support
5. What are some of the challenges?
 - The “inverse care law” – where the quantity of care may be poorest for those with the highest needs
 - The workforce: the health sector is a major source of labour demand and the sector is expected to grow faster than any other sector. However, there are skill shortages and unfilled vacancies, even at present.
 - Edinburgh has a shortfall in supply of accessible and affordable housing with increased investment needed to meet the needs of an ageing population. Investment in affordable housing also provides housing for workers in the health and social care sector. The Council and its partners have tripled the number of new affordable homes approved for development over the past three years. There is a need to sustain this investment and increase private sector housebuilding to meet the needs of a growing city.

2.8 Locality Overview

This section provides an at-a-glance summary of the key characteristics of the four localities, using information presented throughout the report.

It illustrates the sometimes stark differences between localities in terms of population size, age, health, unemployment etc, which are useful at a broad level for planning. However, as this report also highlights, there are significant differences within localities.

Some key points to bear in mind in considering these summaries:

- Both numbers and rates are used:
 - numbers will give the volume of demand e.g. the largest number of hospital admissions from falls in North West gives us information about the volume of support needed
 - *rates* allow us to make comparisons between the localities e.g. for mortality or poverty, allowing for the different sizes and age structures of the four areas - East having the highest *rate* per 1,000 population (16+) for people being assessed or supported by Health and Social Care, tells us that the underlying level of need is higher compared with other areas
- There are significant differences *within* localities as well as between them, and they are of as much interest for planning – for example, all localities in the city record areas of high poverty alongside areas of relative affluence (see Topic Paper 2).

The information presented below shows the most notable features of each locality. Comparisons of the localities on a like-for-like basis, using a standard set of indicators can be made using the information available separately (in Supporting Info 1 - Locality Profiles).

North West

- Largest population size: 138,995
- One-third (33.2%) of Edinburgh's child population aged 0-15
- A third of the city's population aged 85+
- **Health**
 - Largest **number** of hospital admissions due to falls
 - Highest spend on health (directly related to the size of the area)
 - Highest **number** of persons with:
 - *One or more health conditions* (N = 36,591)
 - *Deafness/Hearing loss* (N = 8,322)
 - *Blindness/Partial sight loss* (N = 2,989)
 - *Physical Disability* (N = 7,032)
 - *Other Conditions* (N = 22,595).
- **Health and Social Care**
 - Highest **number** of individuals supported by Health and Social Care
 - Lowest rate of new legal orders (mental health, adult protection etc) granted
 - Highest proportion of unpaid carers (15.5%)
- **Other**
 - Diverse, containing the wards with:
 - the highest (27%) and lowest (17%) percentage of households on low income in the City
 - the highest and lowest employment rate
 - Lowest percentage of people living alone (35.7%)
 - Lowest percentage of students (4.9%)
 - Highest percentage of retired people (14.2%)
 - 7.7% of its datazones are in the 15% most deprived areas in Scotland

East

- **Population**
 - Total population 110,550 – smallest of the four localities
 - Relatively young: lowest proportion of people aged 65+ (13%)
 - Almost half of population is in the 25 to 49 year old age group
 - Largest number of households from an ethnic minority background
 - Highest concentrations of people with White Polish ethnic origin
- **Health**
 - Poorest health across a wide range of measures
 - Highest percentage of people with long term health problem which limit day to day activity (8%)
 - Highest mortality rate (the only locality with a mortality rate higher than Scottish figure)
 - Largest number of unplanned inpatient admissions
- **Health and Social Care**
 - Highest **rate** per 1,000 population (16+) for people being assessed or supported by Health and Social Care
 - Highest proportion of people supported who are under age 75 years
 - Highest **number** of people supported who have learning disabilities, physical disabilities and addictions with implications for volumes of support needed
 - Highest average size of packages of care (hours per week)
- **Other**
 - Highest level of economic activity and employment (68.6%)
 - Highest percentage of people living alone (43.8%)

South West

- **Population**
 - Total population : 111,807
 - 16+ population : 94,093
 - Smallest 16+ population
- **Health**
 - Relatively low proportion of residents with long term health problems which limits day to day activities
 - Highest percentage of residents economically inactive due to limiting long term illness (15%)
 - Relatively high rates of women with dementia, but low concentration among men
- **Health and Social Care**
 - Highest proportion of Health and Social care open cases in under 24 year age group
 - Low take up of direct payments.
 - Lowest concentration of people providing unpaid care (see map series)
 - Highest concentration of people who cycle to work
- **Other**
 - 12.4% of its datazones are in the 15% most deprived areas in Scotland

South East/Central

- **Population**
 - Total population: 126,148 – second largest
 - 16+ population : 109,999 – 13% of the locality total, compared with 15% across Edinburgh
 - Largest proportion of persons aged 16 – 24 (40.3%) (students)
 - Highest concentration of people aged 85+
 - Highest concentrations of people with Chinese ethnic origin
- **Health**
 - The only locality showing an increase (albeit small) in stroke-related mortality
 - Sharper decline in under 75 year old mortality rates than other localities
- **Health and Social Care**
 - Highest number of individuals in care homes (based on the person's original home address)
 - Lowest rate of unpaid carers provide 50+ hours per week (19.3%)
 - Highest number of people with *Mental Health problems*
- **Other**
 - Largest percentage of households on low incomes (23.5%)
 - Low level of economic activity (due to students?) – 57.5%
 - Highest percentage of students (20.9%)
 - Lowest percentage of retired people (9.6%)
 - 4.8% of its datazones are in the 15% most deprived areas in Scotland

3.0 Care group profiles

This section provides an overview of:

- Current and forecast needs
- Current priorities
- Future use of resources
- Existing strategic plans

This version of the JSNA includes separate chapters for different types of needs. The final version will merge this into a single chapter, to provide a more holistic approach in recognition that people's needs can span several groups.

Further details (including references) are provided in the set of topic reports (7.1 to 7.11) which are available separately.

3.1 Older people

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

[‘Live Well in Later Life’, Edinburgh’s Joint Commissioning Plan for Older People 2012-22](#) (p23) sets out the challenges and opportunities presented by demographic change.

The opportunities include people living more healthily for longer. Almost 90% of those aged 65+ are not in receipt of health or care services. A significant amount of unpaid care is provided by older people and many community assets and activities depend on the voluntary contributions of this age group.

There are also challenges. With increasing age there is also an increase in the number of people living with long-term conditions, disabilities and complex needs. Whilst healthy life expectancy (i.e. the length of time people live in a healthy way) has been increasing, overall life expectancy has been increasing faster. This means people are living longer but are less healthy for longer and are likely to require complex health and social care packages for longer periods than in the past. The number of people aged over 85 is expected to double by 2032 to 19,294. The number of older people requiring intensive levels of support is expected to increase by 61% over the next 20 years due to demography alone. Within 20 years the number of people living with dementia could rise by 61.7 % to 11,548 people.

2. CURRENT PRIORITIES

Unscheduled care – reducing the number of people delayed in hospital and preventing avoidable admissions to hospital is a key priority.

Care at Home services – The demand for care at home services has increased at approx 15% per annum in recent years, which is outstripping the current available supply, leading to significant unmet need of around 5,000 hours per week and unsustainable budget pressures. A Care at Home Commissioning Plan is being developed which sets out the challenges faced, along with proposed actions to address some of these challenges. A new contract will be implemented in April 2016.

Accommodation Strategy – in addition to a lack of capacity in care at home services, another reason for people being delayed in hospital is the lack of a suitable care home or community setting for them to return to if they are unable to manage at home. The accommodation strategy includes

long and short term accommodation options to prevent people being admitted to hospital and enabling them to be discharged when they no longer require hospital care.

Preventing hospital admission – there are a range of work streams underway which aim to support the increasing numbers of frail older people with increasing health care needs in the community thus preventing avoidable hospital admissions.

Preventative services – investment in preventative services was a key focus for the national Reshaping Care for Older People strategy, informed by the Christie Commission report on the future delivery of public services. The Change Fund for Older People provided significant additional investment for preventative services for older people which needs to be considered as this funding ends and partnerships move towards integration.

3. FUTURE USE OF RESOURCES

Addressing the priorities identified above within the very difficult financial context will be a key challenge for the Health and Social Care Partnership.

In line with the national Reshaping Care strategy, 'Live Well in Later Life' is predicated on a shift in the balance of investment to support the shift in the balance of care. With a limited financial envelope, this will require disinvestment in services in order to shift the resource to new models of care and agreed priorities.

Workforce planning and development is another key challenge for delivering health and social care services. The recruitment and retention of

staff is a challenge for all service providers and is a particular issue in Edinburgh due to relatively high levels of employment.

Moving to locality working

Many older people's services already work on a locality basis due to access to these services being through sector teams. Organisations and teams supporting older people already have well established links at a local level and developments such as the LOOPs (Local Opportunities for Older People) initiative aim to strengthen these networks. Mapping work and census data analysis is being used to help understand variations in need, demand and provision across the city. The move to new locality boundaries will undoubtedly be challenging, but will result in coterminous boundaries which will provide the opportunity for improved partnership working in the longer term. Another challenge of a locality focus will be to balance how we meet varying needs of local communities whilst also providing equitable services for those who need them.

4. EXISTING STRATEGIC PLANS

['Live Well in Later Life', Edinburgh's Joint Commissioning Plan for Older People 2012-22.](#)

[A Sense of Belonging, a joint strategy to improve the mental health and well-being of the population of Lothian \(2011 - 2016\)](#)

[Commissioning Plan for Social Care Day Services for Older People 2012-17 .](#)

3.2 Mental Health

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS:

Over one in four people (over 120,000 people) in Edinburgh experience a mental health problem. Anxiety and depression are the most common mental health problems, but others include schizophrenia, personality disorders, eating disorders and dementia.¹

Mental ill health is not evenly distributed across society and is more common in socio-economically deprived areas²³. 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 homes⁴. Dementia is far more prevalent in people over 60 with the incidence increasing further with age.

There is some evidence that mental health problems increase during periods of economic recession, low growth and insecurity. There is also some evidence that the welfare reforms are having a significant negative effect on people who receive benefits. However the epidemiology of prevalence of mental ill health and economic recession is being reviewed. Meanwhile the conservative planning assumption is that numbers will increase by an average of 1.4% in line with the annual increase in the adult population.

¹ SPICe briefing, Mental Health in Scotland, May 2014

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

2. CURRENT PRIORITIES:

Redesign of mental health and well being services: We want to move to a new locality based way of developing services based on alliance contracting. This will increase partnership working in meeting the prevention agenda. The plan is to move to a **local partnership model** that will deliver on key principles. These principles are informed by the Joint Improvement Team Health and Social Care Integration – Locality Planning Conversations Report (June 2014) as well as conversations with stakeholder groups and outcomes outlined in the joint mental health strategy 'A sense of Belonging' and the 'Alcohol and Drug Strategy'.

In relation to the redesign of the Council's in-house care and support service, we will be shifting to a reablement model to provide early intervention, prevent hospital admission and to support and facilitate avoidable delays in hospital.

Wayfinder Project: This is a Knowledge Transfer Partnership between NHS Lothian, City of Edinburgh Council and Queen Margaret University to develop evidence based pathway redesign of adult mental health services. This will result in the development of new services to support the redesign of the Royal Edinburgh Hospital.

Delayed Discharges: Delayed discharge within acute mental health wards is a major priority. In the adult under 65 service, currently 25% of inpatients are either waiting for supported accommodation or waiting for an alternative NHS resource. There are, for example, ten to twelve people waiting for a place in the inpatient rehabilitation service. In the last 12

months the overall occupancy has ranged from 104% to 82 %. It normally rises again in summer (particularly August).

3. FUTURE USE OF RESOURCES

NHS Lothian is within the bottom quartile in funding community mental health services in Scotland. The problem of delayed discharge is caused in part by lack of appropriate community services to support people. As is the recent 60% increase over the year in detention rates. There is a need for more investment in the community to prevent people from needing hospital beds.

The recent review of mental health and wellbeing services identified the following key gaps and issues in service provision.

- There is capacity for much greater joint working across third sector organisations. This is partially a result of the way that services are currently commissioned.
- Although all services are moving toward a more personalised method of service delivery, some services are more developed than others.

- There is capacity for much greater use of peer support and peer working.
- The accommodation situation for mental health and well being services may not be sustainable.
- There is a significant barrier to these services offering a fully personalised service as they do not have the capacity to manage an individual budget for a service user.
- Use of these lower level services prevents the need to use more intensive and expensive services.

4. EXISTING STRATEGIC PLANS:

The current joint strategic plan is [A Sense of Belonging](#) which runs until 2016.

In Edinburgh, in consultation with stakeholders, we are developing a commissioning plan to support the implementation of the strategy.

3.3 Disabilities

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

Learning Disabilities

The Scottish Government report, the 'Same as You'⁵ indicated that 2% of the population have a learning disability with the vast majority being unknown to services. NHS Lothian Community Learning Disability teams within Edinburgh are in contact with 1,520 people. City of Edinburgh Council knows of 3,405 people with learning disabilities in the city.

Sensory Impairment

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

Physical Disability

Edinburgh is estimated to have 30,735 adults aged 16-64 with moderate to severe disabilities⁶.

Estimates of Future Demand

Learning Disabilities

The overall prevalence of people with learning disabilities is expected to rise due to (i) Improved neonatal care meaning that more premature babies are surviving with very high likelihood of severe and multiple disabilities. (ii) People with learning disabilities living for longer, including those with profound and multiple learning disabilities. Aside from

⁵ Same as you? A review of services for people with learning disabilities' 2000 Scottish Government

⁶ 'Our Lives Our Way' 2007 NHS Lothian

demographic changes, there is a move to reduce placements outside Edinburgh, for example, young people with extreme challenging behaviour, which requires additional specialist provision within the city.

Physical Disabilities

There is evidence that the number of disabled adults in the population aged 18-64 is increasing due to the greater survival of disabled children and due to all age groups having improved survival from trauma and other causes of disability. However, reliable forecasts are not available. Meanwhile the conservative planning assumption is that numbers will increase by an average of 1.4% in line with the annual increase in the adult population.

Sensory impairment in particular is more prevalent amongst people aged over 60 and this age group is predicted to rise in number.

Autism

The estimated prevalence (Knapp 2009) of people with autism in the Edinburgh population is 1:100, which equates to around 4,850 people, of whom around 2,400 have autism but no learning disability. The Council knows of 450 children aged 0-16 in mainstream provision: these figures reflect the national average. These people may require support from adult services in future. Within Disability Adult Services the number of young adults with a learning disability and autism, and the severity of their care needs has increased over the last few years.

2. CURRENT PRIORITIES

Learning disabilities

The three key messages in the Edinburgh Learning Disability Plan are 'choice and control', 'better local services for people with complex needs'

and 'making the money go further'. There are a wide range of current workstreams which seek to achieve these three key aims. These include:

- 1) As originally stated in the 2008/13 strategy, the delivery of specialist healthcare to people with learning disability is being redesigned in order to shift the delivery of care from hospital to community settings where appropriate. This includes the modernisation of inpatient services within the Royal Edinburgh Hospital campus developments. This will refocus inpatient services on three distinct pathways of care, Autism Spectrum Disorders and intensive behavioural support needs, mental health and forensic support needs, with provision delivered from a single bespoke site on the Royal Edinburgh Hospital site. This will reduce the need for people with learning disability to be supported out of area in order to receive appropriate care and treatment. Further to this there is an intention to redesign services currently delivered at Murraypark, with a remodelled learning disability inpatient service established by 2018/19.
- 2) Earlier intervention in childhood for people with behaviours that are challenging and development of smoother transitions from children's to adult services.
- 3) Strengthening of services that can support people with more complex behavioural or forensic needs in the community.
- 4) Identification of a range of housing and support options for people with learning disability with a particular focus on core and cluster services, particularly for young people with complex needs who require robust housing.
- 5) Reducing the cost of night care by developing a new skype type night support service with the option of on-call responders.

- 6) Adopt an 'Aging in Place' strategy – to promote awareness of disability issues in older people's services and aging issues amongst learning disability services.
- 7) Consult and develop a plan to ensure that the particular needs of people with learning disabilities and their carers from black and minority ethnic communities needs are recognised.

Autism

Key priorities for people with autism (who do not have a learning disability) include (i) Raising awareness of autism amongst front line workers, carers and the public in the city (ii) Development of a care pathway – including early diagnosis and support in the first year of diagnosis (iii) Ongoing advice and information for people with autism including finding and maintaining housing and work, and a focus on individual outcomes for people with autism.

Physical disabilities

The NHS Lothian Physical Disability Strategy 'Our Lives Our Way' (2007) identified key workstreams. Key current priorities taken from these workstreams include (i) increasing the focus on rehabilitation within day care (ii) changing the culture of homecare so that it has a greater focus on building independence and making local connections. Other important priorities include embedding postural management knowledge amongst practitioners and developing an Edinburgh Plan for people with long term conditions.

Sensory Impairment

'See Hear' is the national sensory impairment strategy. City of Edinburgh Council has been awarded £87,000 to implement the strategy through

local partnership networks in 2013/14 and 2014/15. Our local plans focus on developing awareness and improving access to services.

We will implement locally 'The Right to Speak' which concerns people needing assistive augmentative communication aids, and highlights that improvements are needed to ensure that young people in transition are not disadvantaged when moving to adult services and also that low tech communication aids have a significant impact on people's quality of life.

3. FUTURE USE OF RESOURCES

Learning disabilities

The main pressures are the need to plan for:

- 1) The increase in the number of people with learning disabilities, including the impact of people with learning disabilities living longer.
- 2) The need for community services that can support young people with behaviours that challenge from at least aged 16 and sometimes earlier.
- 3) Reducing the number of people delayed in hospital and preventing avoidable admissions to hospital through the provision of services that can support people with more complex behavioural needs in the community

Other areas for further development include:

- 1) Improving planning and delivery around health inequalities, including increasing care givers knowledge and skills in this area.
- 2) Supporting people with a learning disability and end of life care.
- 3) Mental Health First Aid. There is a need to heighten awareness of mental health needs amongst people with disabilities.

- 4) Integrated support with GP practices. There is a need to increase the relationship between Learning Disability teams and GP practices.
- 5) There is a need to develop a plan for people with learning and physical disabilities who are not currently supported by NHS Lothian.

Autism

A focus for this year will be improved access to diagnosis for adults with autism and to improve the nature of, and access to, support in the first year after diagnosis.

Physical disabilities

The main focus is to change the culture towards assisting people to take control over their lives and towards building independence and links with local communities.

Another key aim is to foster more joint working across rehabilitation services with the ultimate aim of shifting the balance of care to community based services.

The first step this year will be to develop a joint strategy that reflects these aspirations and to begin to reshape services in line with this strategy.

Work continues to implement the national 'Right to Speak' Strategy and 'See Hear' strategy in Edinburgh.

Move to Locality working

Learning Disabilities

Community Learning Disability Teams (CLDTs) are well placed to take on the locality agenda as they are currently geographically based in the four social work sectors. Work has started to integrate the CLDTs with the existing social work teams, The developing plans for remodelling care at

home services for people with disabilities include consideration of organisation on a locality/neighbourhood basis.

Autism

The first point of access to diagnosis is via a GP so this fits well with locality provision.

Physical Disability

As we move to a greater focus on rehabilitation in social care services, discussions on shifting the balance of rehabilitation to the community will be done within the context of the locality model. The developing plans for remodelling care at home services for people with disabilities include considering how to organise on a locality/neighbourhood basis. Many of the voluntary organisations are condition specific, for example

Huntington's Association/Arthritis Care, with a citywide remit. We will need to find a way for the localities to engage with them. There are two Council day services for people with disabilities, including a rehabilitation service for stroke. These are already aligned to the north and south of the city.

5. EXISTING STRATEGIC PLANS

[Edinburgh Learning Disability Plan 2011](#)

[Edinburgh Autism Plan 2013](#)

[Our Lives Our Way](#)

[Scottish Sensory Impairment Strategy 2014 – See Hear](#)

NHS Lothian Neurological Care Improvement Plan 2014 – 17.

3.4 Addictions

4. OVERVIEW OF CURRENT AND FORECASTED NEEDS

It is estimated that there are 22,400 people in Edinburgh with dependent drinking. Alongside this there are 5,300 people with problem drug use (using heroin and/or benzodiazepines only). About half of service users are thought to have mental health problems of varying degrees of severity.

In Edinburgh, 64% of the total population of people using heroin are under the age of 25, compared with 51% across Scotland. The rate of drug-related maternities in Edinburgh is almost twice the national average although this is likely to be due to local reporting arrangements than a higher prevalence. Around a third of drug and alcohol users in contact with services in Edinburgh have at least one dependent child.

Estimates of Future Demand

There is some evidence for an increase in addictions during periods of economic recession, low growth or insecurity. However the way that future needs are estimated is being reviewed. In the meantime conservative planning assumptions are that numbers will increase by an average of 1.4% in line with the annual increase in the adult population.

Innovative and new approaches are needed to shift the balance of care from an acute model, which focuses on the first six months of recovery, to one which spans the length of recovery journeys which are reported to last on average five years. This will involve a shift in the focus of existing services, as well as investment in new services further down the recovery journey, with few opportunities for new or extra investment. Alongside this there is a need to develop closer and more integrated arrangements for the commissioning and delivery of services.

5. CURRENT PRIORITIES

Current priorities span new service developments and improvements to the organisation, co-ordination and delivery of services. Current priorities reflect the national and local policy shift away from harm reduction to recovery journeys.

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 service 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.

As a part of the development of a recovery community, consideration is 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 high number of drug related pregnancies remains a challenge. Edinburgh Drug and Alcohol Partnership (EDAP) 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, services need to develop to meet the needs of family members (both children and adults) and to bring focus to family recovery.

Treatment responses to new psychoactive substances are being developed.

In terms of improving the co-ordination of services, EDAP is working to improve links between adult services and children and family services, to improve links with mental health services and to improve arrangements for care co-ordination. In addition, data analysts are currently looking at how to combine data sources from City of Edinburgh Council, NHS Lothian and the Third Sector to give a holistic overview of clients and the ways in which they are moving in and out of services.

Improvements to the underlying knowledge and approach of services is being taken forward through improving understanding of recovery across the collaborative and by developing trauma informed services.

6. FUTURE USE OF RESOURCES

This section identifies the gaps in the current system. In summary the gaps are as follows:

- We do not currently have a coherent approach to preventing problem substance misuse. We need to develop 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 services in preventing relapse, as opposed to focussing on being a first point of access.
- 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 with a shared client group.

6. EXISTING STRATEGIC PLANS

[Treatment and Recovery Group Action Plan](#)

[EADP Commissioning Plan 2012-2015 – Commissioning for Recovery.](#)

3.5 People with complex needs

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

'Inclusive Edinburgh' was set up in 2014 to tackle some of the problems faced by people with complex needs, who may struggle with homelessness, unemployment, drug and alcohol problems, mental or physical ill-health, who sometimes get involved in crime, and who are often the victims of violence. To improve the life chances of this group, the intention is to develop a 'Getting it Right for Everyone' approach: working thematically across service boundaries to achieve positive outcomes for individuals and communities.

Different services have different estimates of who 'this group' are, ranging from 150-5,000 individuals. While the actual number is uncertain, what is clear is the need to make sure that no-one is excluded from receiving appropriate care. The focus of 'Inclusive Edinburgh' is people who struggle to navigate and make effective use of services, and services that struggle to provide effective support to people with complex needs. An estimate from the Access Point a few years ago produced a list numbering approximately 300 homeless people with whom services have struggled to engage in a way that noticeably alleviated poor outcomes. The Scoping work stream will need to complete its work before a more accurate figure can be produced.

While demand for services overall may well increase, through a preventative approach and effective joint working, demand for services targeted at people with complex needs who are multiply excluded should reduce.

Welfare reform and public sector cuts are exacerbating instability in the lives of people for whom navigating and making successful use of a complex and at times unsympathetic service landscape is already a struggle.

1. CURRENT PRIORITIES

There are four workstreams outlined below

Scoping work stream: This work stream has two main components (i) Scoping in terms of data: services, budgets, human and other resources, and volume of need (stakeholders, both known and potential) (ii) Scoping in terms of effectiveness in achieving positive outcomes.

The scoping exercise will analyse the information gathered in order to respond to the following questions:

- What is being done well to deliver positive outcomes for people?
- What needs to be done differently to promote better outcomes?

Stakeholder involvement will inform the thematic analysis of service effectiveness, and subsequently the shape of future services.

Stakeholder Involvement work stream: Based on the identification of the groups (see Scoping work stream), the next step is to involve people in opportunities to redesign local services. The work stream will explore and decide how best to involve people who use – or may need, but do not access – services, in a way that will lead to meaningful engagement.

Access and Inclusivity work stream: Service criteria, policy and practice need to promote an inclusive approach by all parts of the system. Developing a 'Getting it Right for Everyone' approach, with shared principles for practice, and access criteria, which promote engagement, is a key ambition of Inclusive Edinburgh. The project will develop an agreed set of key principles for access to support and for practice. These principles need to be applied consistently by all provider stakeholders and need to be informed by evidence of what works, e.g. trauma-informed practice.

Workforce Planning and Development work stream: Learning opportunities, including training and education will be developed for all staff levels and agencies to promote understanding of the changes required to practice in individual service settings.

2. FUTURE USE OF RESOURCES

The 'Inclusive Edinburgh' review is currently in process.

Moving to locality working

The development of homeless pathways may result in a clear locality perspective. However, this is still being developed. 'A Sense of Belonging' does stress the importance of asset building. 'Inclusive Edinburgh' has a city wide scope and will consider the benefit of the locality approach.

3. EXISTING STRATEGIC PLANS

- City Housing Strategy 2012 – 2017 (includes homelessness strategy)
http://www.edinburgh.gov.uk/info/20222/property_planning_and_housing/1003/housing_strategy

- A Sense of Belonging: current joint strategy for mental health: 2011-2016
<http://www.nhslothian.scot.nhs.uk/OurOrganisation/Strategies/Documents/SenseOfBelonging.pdf>
- Scottish Government 'Choose Life' Suicide Prevention Strategy 2013-2016 <http://www.gov.scot/Resource/0043/00439429.pdf>
There is a significant overlap between the groups considered 'high risk' for suicide and those in scope for 'Inclusive Edinburgh'.

For the 'Inclusive Edinburgh Summary'; 'Inclusive Edinburgh Committee Report' and 'Inclusive Edinburgh Update Report' go to:

http://www.edinburgh.gov.uk/info/20029/have_your_say/948/inclusive_edinburgh

3.6 Carers

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

Without the valuable contribution of carers the health and social care system would not be sustained. Carers, as equal partners in the delivery of care, enable people with illnesses or disabilities to remain at home and in their own communities safely, independently and with dignity. Carers can, for example, prevent avoidable hospital admissions and contribute to people's overall health and wellbeing⁷.

Therefore, as well as there being a strong case for supporting carers based on human rights and quality of care, there is also a compelling economic case. By providing appropriate and timely support to carers resources are saved in the long term⁸.

There are estimated to be 65,084 carers in Edinburgh, or 13.7% of the population. One in five of these carers provides over 50 hours of care a week. It is expected that the numbers of carers will rise due to the rising population, the increasing elderly population and more people living with disabilities due to improved neonatal care meaning more children surviving with severe disabilities.

Against this predicted rise in the number of carers there are uncertainties around funding due to a likely requirement through legislation for all carers to be offered a Carers' support plan and a likely new duty to meet carers' eligible needs following assessment. The Convention of Scottish

⁷ 'Caring Together- the Carer's Strategy for Scotland 2010-2015' (July 2010) Scottish Government and CoSLA

⁸ 'Caring Together – the Carer's Strategy for Scotland 2010-2015' (July 2010) Scottish Government and CoSLA

Local Authorities is currently in discussion with the Scottish Government on whether there will be sufficient additional funding to cover any new legislation as well as the 2014 Self Directed Support Regulations already in force.

2. CURRENT PRIORITIES

- There are six priority areas identified within the strategy for Edinburgh's carers:
 - identifying carers
 - information and advice
 - carer health and wellbeing
 - short breaks/respite
 - young adult carers
 - personalising support for carers

Meeting these priorities will involve undertaking a range of activities to support carers across the city. The impact or effectiveness of these activities can be measured using outcomes.

3. FUTURE USE OF RESOURCES

Work undertaken to develop the Joint Carers' Strategy and the Edinburgh Joint Strategic Commissioning Plan for Carer Support identified some gaps in current support:

- more and better financial and benefits advice for carers
- more locally accessible advice, counselling, advocacy and emotional support
- more flexible short breaks, tailored to individual needs and more breaks for carers from their caring role
- more accessible information on short breaks and respite

- more dedicated young adult carer support (aged 16 to 25)
- improve transition services between young carer and young adult carer support
- continue to provide support to young carers through schools, colleges, community centres and GP surgeries
- drop-ins for carers at GP surgeries
- establish a carers' register
- information packs for carers at social hubs, libraries and GP surgeries
- more district nurses visiting elderly and disabled people in their homes
- provide contact numbers for help in the house and reliable tradesmen
- consider the needs of people from minority ethnic groups and more support for female carers from minority groups
- more funding for support groups.

Carer support providers identified an issue with the sustainability of funding and capacity to develop effective services.

A procurement exercise to meet some of these identified gaps aligned to the six priorities is currently in progress. A carer support grant redesign exercise is also underway and will address some of these gaps. It is envisaged that these exercises will be completed by July 2015 and June 2015 respectively.

Moving to locality working

The recent procurement exercise for carer support will reflect the move to locality working as many of the new services are geographically specific to

one or more of the localities in the city. There is a co-production process underway for carer support grants. Within this we are exploring with grant funded providers how to move to better locality planning.

7. EXISTING STRATEGIC PLANS

[Edinburgh Joint Carers' Strategy for children, young people and adults who provide care to others.](#)

[Edinburgh Joint Strategic Commissioning Plan for Carer Support](#)

3.7 Palliative care

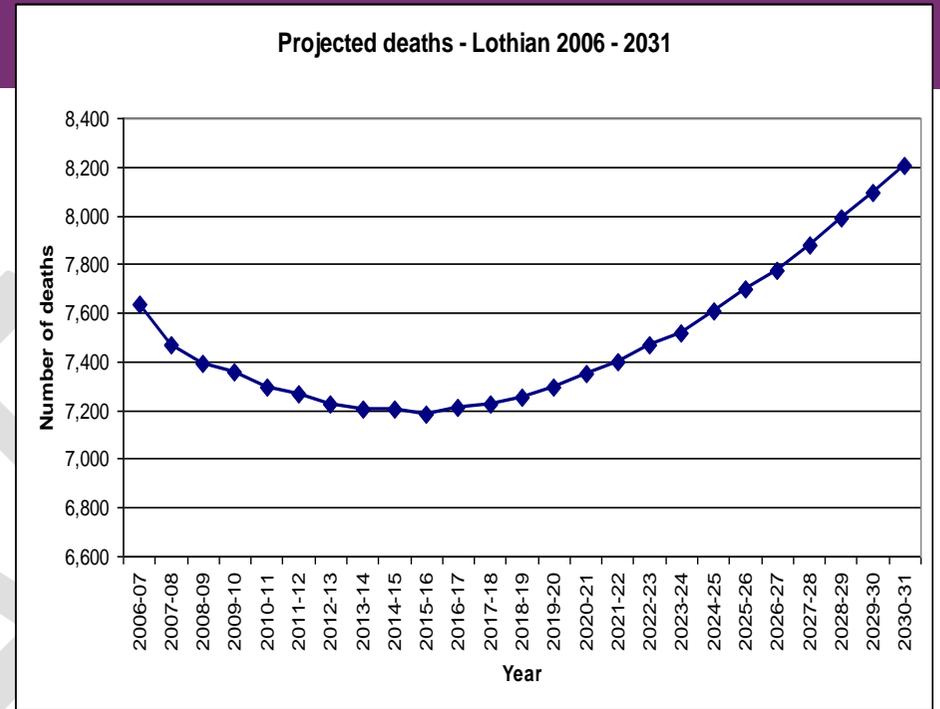
1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

[Lothian's Palliative Care strategy 'Living & Dying Well in Lothian'](#) sets-out strategic priorities aimed at improving care in all settings. It includes a full review of needs assessments undertaken in Lothian and the literature on Palliative Care needs. This can be found here: [Review of Palliative Care needs](#)

In Lothian we face increasing challenges posed by the growth in the number of older people as a proportion of the Lothian population. Increasingly, more people will be living with long term health conditions and will have multi-morbidities. We expect to see a steady incremental rise in the numbers of deaths in Lothian per year from around 2016/17, compared to the level over the last 5 years (chart 1). Future demands on services will be associated not only with a rise in the number of deaths, but also with increased case complexity due to, for example, multi-morbidities and the increasing focus on palliative care for non-cancer conditions.

Chart 1

Projected number of deaths for Lothian 2006 – 2031 (source: General Register Office for Scotland 2007)



2. PROFILE OF ACTIVITY

Each year around 7,000 – 7,500 people die in Lothian. Approximately 10% of deaths will be sudden or very rapid deaths allowing no time for palliative input, an estimated 40% of all deaths will receive some form of *specialist* palliative care intervention, and almost all people who die (sudden deaths aside) are likely to receive some form of Palliative and End of Life Care in the last year of their life from *generalist* health and social care staff. The majority of activity remains cancer related, however non-malignant activity (for example organ failure, dementia, neurological, and general frailty) is increasing yearly in line with the aims of the Lothian

strategy, and as the reach of specialist palliative care services spread and a palliative approach to care is increasingly taken by generalists.

3. CURRENT PRIORITIES

- To develop and deliver the work-programme of the Lothian Palliative Care Managed Clinical Network.
- To participate in the co-development of the national *Strategic Framework for Action* in 2015
- To exploit current opportunities for further development and innovation: we need to focus on clinical policy, skills development and capabilities in supporting decision making with people, systems of communication and care co-ordination – supported by e-health, and integrated care development including looking forward to opportunities afforded by Health and Social Care Integration
- To complete Lothian Palliative Care Redesign (details are given in the main report – see Topic Paper 4.7)

4. FUTURE USE OF RESOURCES

Resources will go into the programme of priority areas, as outlined above, and will be guided by the new national Strategic Framework for Action.

In addition, commissioning of Lothian Independent Hospices will continue in line with service [guidance](#) for NHS Boards and independent adult hospices on establishing long-term commissioning arrangements, under which 50% of agreed operating costs must be met. In addition, NHS Boards and local authorities must jointly meet 25% of the running costs of the independent children's hospices in Scotland, which provide specialist palliative care and respite services for children with life-limiting conditions.

5. EXISTING STRATEGIC PLANS

- [Lothian's Palliative Care strategy 'Living & Dying Well in Lothian'](#) can be accessed via this link.
- **Emerging national Strategic Framework for Action in Scotland**

The Scottish Government is committed to the development of a *Strategic Framework for Action* in 2015 in order to provide a focus and to further support the delivery of high quality palliative and end of life care for all across all health and care settings e.g. in hospital, at home, in Care and Nursing Homes, in Hospice or any other setting. The strategic framework will set out the structure, the aspirations, objectives and the environment within which more detailed work on planning, design and delivery can take place at a local level. It will set out the key themes and priorities relating to the delivery of high quality palliative and end of life care.

3.8 Sexual Health and Blood Borne Viruses

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

Sexual health data summary:

- **Under sixteens pregnancy rate** in Lothian showed a 22% reduction in 2011 and a further small decrease in 2012.
- **Gonorrhoea:** in 2012 Lothian males had the second highest rate of infection in Scotland, mostly among Men who have Sex with Men (MSM).
- **Syphilis:** there is again a slight rise in cases in 2011 and 2012, with 205 cases in Lothian - the majority of cases are in Men who have Sex with Men.
- **Chlamydia: In Lothian, chlamydia testing rates remain high. Prevalence is highest** in the under twenties and under twenty-five year old age groups.
- **HIV Testing:** testing activity in Lothian in 2013 totalled 35,768 tests, an increase of 14% since 2008.

The total number of people living with HIV in Lothian is 1,479 (March 2014) and the diagnosed prevalence is 1.7/1000 for the whole population, and 2.6/1000 among 15-59 year olds.

There are a variety of **Blood Borne Viruses** (BBV) of which Hepatitis C and HIV have the most serious long term implications. There is no vaccine for either illness. There is no cure for HIV. For Hepatitis C there is a treatment which leads to sustained viral clearance in the majority of patients.

Health Protection Scotland publish BBV data by Health Board but not by Local Authority. During calendar year 2013, 235 cases were newly identified as hepatitis C antibody positive in Lothian. The majority of these are likely to have been infected some years ago. This compares with an average of 203 in the years 2002-2009.

Since testing became available in the late 1980s there have been 4876 persons reported as hepatitis C antibody positive in Lothian (to 31st Dec 2013) of whom 3960 are still alive.

The number of new cases of HIV infection in Lothian has been falling since 2005 and in 2013 totalled 88. However, the prevalence of people with HIV is increasing due to decreased deaths, antiretroviral therapies and new cases being diagnosed. At 31 March 2014 there were an estimated 1,479 people living with HIV in Lothian, up from just over 1,000 in January 2010.

There are around 5,500 people living in Lothian with HIV or Hepatitis C infection. Further planning work is required to estimate the numbers now and in the next five to ten years living in Edinburgh who are likely to require Health and Social Care services.

Late Diagnoses of HIV (Health Improvement Scotland standards 6 & 7): 87 cases were newly reported in Lothian in 2013, 53 of which were new diagnoses for the individuals. 23 cases were late diagnoses. Following a pilot in 2012, it is now policy in Lothian to review all of our HIV late diagnosis cases to identify all healthcare presentations in primary and secondary care of each individual within the 24 months leading up to their diagnoses. This is used to provide learning opportunities in instances where cases have been missed.

2. CURRENT PRIORITIES

- reducing and responding to teenage pregnancy;
- reducing unintended pregnancies for those over 20 years of age;
- increasing uptake of Long Acting Reproductive Contraception in all settings;
- increasing access to early abortion services;
- reducing infection and transmission of Sexually Transmitted Infections and Blood Borne Viruses (primarily HIV and Hepatitis B and C) (This involves implementing Hep C treatment procedure);
- improving gender reassignment services;
- improving sexual health and relationship education in schools and community settings;
- improving our understanding of health needs of men who have sex with men amongst primary care and other staff groups;
- increase access to integrated services in both a central location (Chalmers) and in areas of high deprivation focusing on addressing health inequalities;
- improve efficiencies (eg use of generic drugs)
- develop a clearer pathway into Hepatitis C treatment (social work services)
- develop a post treatment recovery plan. Work with the Third Sector to develop a pathway of ongoing support, including community and residential step up/ step down supports (social work services)

3. EXISTING PLANNING GROUPS

The Sexual Health and HIV Strategy Board is responsible for the strategic direction of sexual health and BBV services. It involves representatives

from health, local authority and the voluntary sector. There are sub-groups working on specific areas of work.

There is also the Hepatitis C MCN (Managed Care Network) that continues to lead the programme of activity designed to reduce the prevalence of Hepatitis C in Lothian.

4. EXISTING STRATEGIC PLANS

National: Sexual Health and Blood Borne Virus Framework (2011-2015)

On 25 August 2011, the Scottish Government brought together sexual health, HIV, hepatitis C and hepatitis B policy into this Framework. It articulates a joined-up approach to improving sexual health and tackling blood borne viruses (BBVs) in Scotland. The Framework built on the success of the *Hepatitis C Action Plan (Phase II)* and *Respect and Responsibility* as well as further developing the *HIV Action Plan in Scotland*.

Lothian: Lothian Sexual Health and HIV Strategy 2011-2016

5. FUTURE USE OF RESOURCES

We will be working to progress the challenges listed above (section 5) and to continue to support the delivery of universal and specialist services within NHS Lothian, CEC and with partners that positively impact on sexual health and wellbeing.

3.9 Alcohol Related Brain Damage

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

In 2013/14, there were 36,206 alcohol-related stays in general acute hospitals in Scotland. In this period, the hospital stay rate was 8.4 times greater for people living in the most deprived areas, compared to those living in the least deprived areas, and Scotland has one of the fastest growing rates of alcoholic liver disease making it one of Scotland's 'big killers'. There are also the social and economic costs of excessive alcohol consumption such as the breakdown of families, crime and disorder and loss of productivity through sickness. It is estimated that alcohol misuse costs Scotland £2.25 billion every year.

Excessive consumption of alcohol can result in a wide range of health problems, such as damage to the liver and brain. Alcohol-related brain damage (ARBD) is the overarching term used to describe the effects and changes to the brain structure and function resulting from long-term alcohol consumption. ARBD usually results from a combination of factors, including the toxic effects of alcohol on brain cells; vitamin and nutritional deficiencies; head injury and disturbances to the brain's blood supply.

Based on data from NHS Lothian's Health Intelligence Unit, the local cost of hospital beds to accommodate those who have ARBD is approximately £2m. This equates to 14 acute beds being occupied over a full year.

2. ESTIMATES OF FUTURE DEMAND

ARBD often remains undiagnosed making prevalence difficult to ascertain. Typically, those who are expected to develop ARBD are men aged 50+ but, with the increased rates of alcohol consumption and a binge drinking culture, younger people, including women, are now developing this

condition. This currently puts pressure on public services, including the NHS and Health and Social Care, in terms of managing a group of people who have cognitive difficulties and other complex needs, for example, by providing healthcare, community supports and accommodation. If rates of alcohol consumption continue to rise, there will be an ongoing demand from this group of service users.

3. PROFILE OF ACTIVITY

The Department of Health and Social Care and NHS Lothian examined the care pathway for people who have ARBD. In order to reduce the number of alcohol-related bed nights, in 2014, a step-down unit was developed at Milestone House of 10 beds, for admissions from the Royal Infirmary of Edinburgh, the Western General Hospital and St John's Hospital. NHS Lothian contributes £650k per annum to the operation of the unit; the Department of Health and Social Care contributed a one-off payment of £177k to the refurbishment of the unit, spends £40k per annum on a dedicated social work post and provides care at home and residential services in the community.

The unit feeds into community residential service provision which consists of 2 care and support services and one care home: Jericho House, 19 Thorntree Street and Forthland Lodge. The total funding to these services from Health and Social Care is £921,744; the total cost to the council is £1.3m. However, the total number of beds available across these services is only 42 and these beds are also required by people in the community. Therefore, it has been necessary to place people with ARBD in services outwith Edinburgh which is costly to the council.

4. EXISTING PLANNING GROUPS

ARBD Executive Group. This is a multi-disciplinary group of professionals which monitors and reviews the work of the step-down unit and has an overview of ARBD service provision in Edinburgh.

5. EXISTING STRATEGIC PLANS

National Plans:

- Changing Scotland's Relationship with Alcohol: A Framework for Action, Scottish Government (2009)
- The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem, Scottish Government (2008)
- Mental Health in Scotland: Closing the Gaps, Making a Difference: Commitment 13 – Scottish Government (2007)
- Care and treatment of Mr H - Mental Welfare Commission (2006)
- Missed Opportunities - Mental Welfare Commission Report (2006)
- A Fuller Life – Scottish Executive (2004)

6. CURRENT PRIORITIES

The ARBD unit is funded until March 2016 and an ongoing evaluation is being carried out. However, the funding priorities of NHS Lothian could affect this timescale and will determine whether or not the unit will continue. The social work post is aligned to these priorities.

Until recently, NHS Lothian and the Edinburgh Alcohol and Drug Partnership funded CARDS, a service from Rowan Alba which provides visiting support service for people with ARBD. The funding from NHS was £79k and the EADP funding is £7k. As an efficiency saving, NHS has disinvested, the council is unable to provide replacement funding and the EADP is considering its position. Consequently, if Rowan Alba is unable to access external funding, this service will cease in September 2015. This will be a loss to the ARBD care pathway as the CARDS service is vital in preventing hospital admissions and keeps people in their own homes and away from alcohol use by providing diversionary activities and support for the service user.

7. FUTURE USE OF RESOURCES

This section identifies the gaps in the current system. In summary, the gaps are as follows:

Additional supported accommodation for people who have ARBD is required. Possible additional provision could be available in autumn 2015 following refurbishment by Services for Communities of a former sheltered housing complex. However, funding will be required to purchase on-site care and support.

In terms of streamlining care pathways, the ARBD pathway will be incorporated into the work pertaining to Inclusive Edinburgh and complex needs.

3.10 People with multiple long term conditions

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

The prevalence of long term conditions can be determined from Quality and Outcomes Framework (QOF) disease registers in primary care. Care must be taken with the definition of some of these registers as they may not be reporting what they appear at face value. Further information on definitions can be obtained at www.isdscotland.org/qof.

Multimorbidity

Multimorbidity is defined as the presence of two or more long term conditions. Lothian's Integrated Resource Framework contains long term condition data based on 16 QOF disease registers derived from the majority of GP practices in Lothian at patient level. This data can be used to describe multimorbidity in Edinburgh.

Key findings

- 38% of patients with a long term condition had 2+ LTCs (Figure 1)
- Proportion of patients with multimorbidity increases with age: 63% of patients aged 75+ with a LTC have multimorbidity
- Proportion of patients with multimorbidity is greater in the most deprived quintile (Q1) compared to the least deprived quintile (Q5) across all agebands from 45-54 to 85+
- Multimorbidity occurs approximately 10 years earlier in the most deprived areas compared to the least deprived
- The numbers of patients with multimorbidity are higher in the least deprived quintiles compared to the most deprived quintiles for Edinburgh, particularly for older patients

- There are many different combinations of comorbidities – the data in IRF can be used to identify the most common and examples of these are given in Figure 2.
- The number of different items prescribed increases with number of LTCs: average 5 different items prescribed for patients with 1 LTC and average of 16 items prescribed for patients with 5+ LTCs

Implications for services

- Deprived areas will have a higher proportion of patients with multimorbidity at a younger age. More patients of working age in deprived areas will experience multimorbidity and will need access to services that may be predominately accessed by older patients in less deprived areas.
- Despite the prevalence of multimorbidity, the current health service model is to focus on single long term conditions. For patients with multimorbidity this can result in multiple primary care appointments, multiple outpatient appointments, and an increased risk of polypharmacy. For health services to be person centred, multimorbidity must be prioritised.

Note

There are caveats regarding these long term conditions data, which are detailed in the topic paper.

Figure 1: Proportion of patients in Edinburgh CHP with 1, 2, 3, 4 and 5+ LTCs in 2012/13. (NB the denominator is patients with at least one LTC). Data source: Lothian IRF 2012/13.

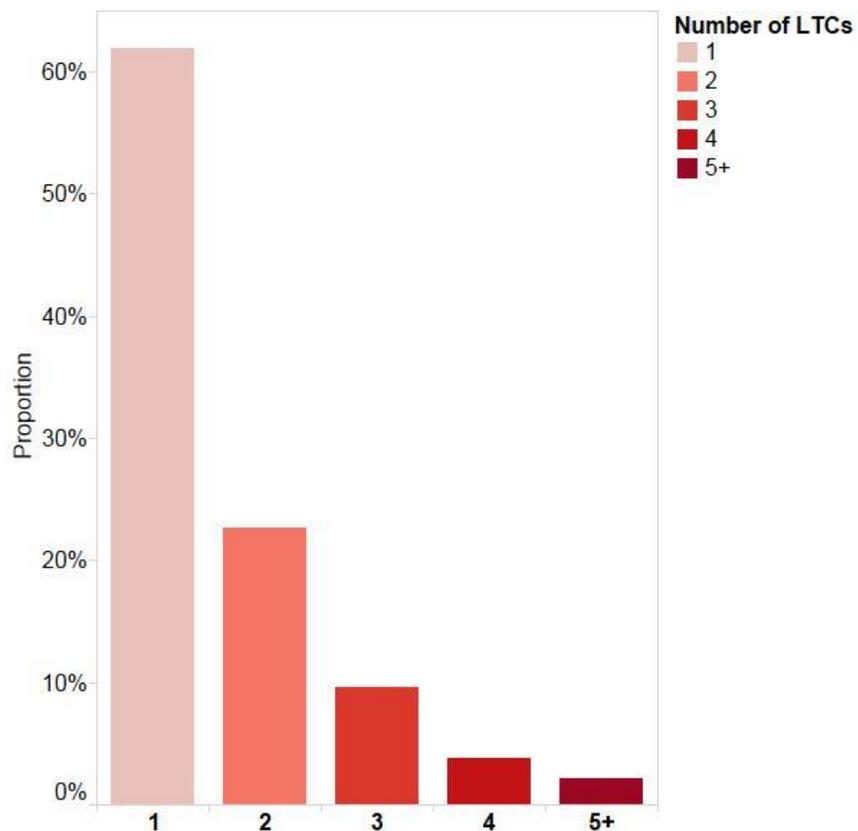
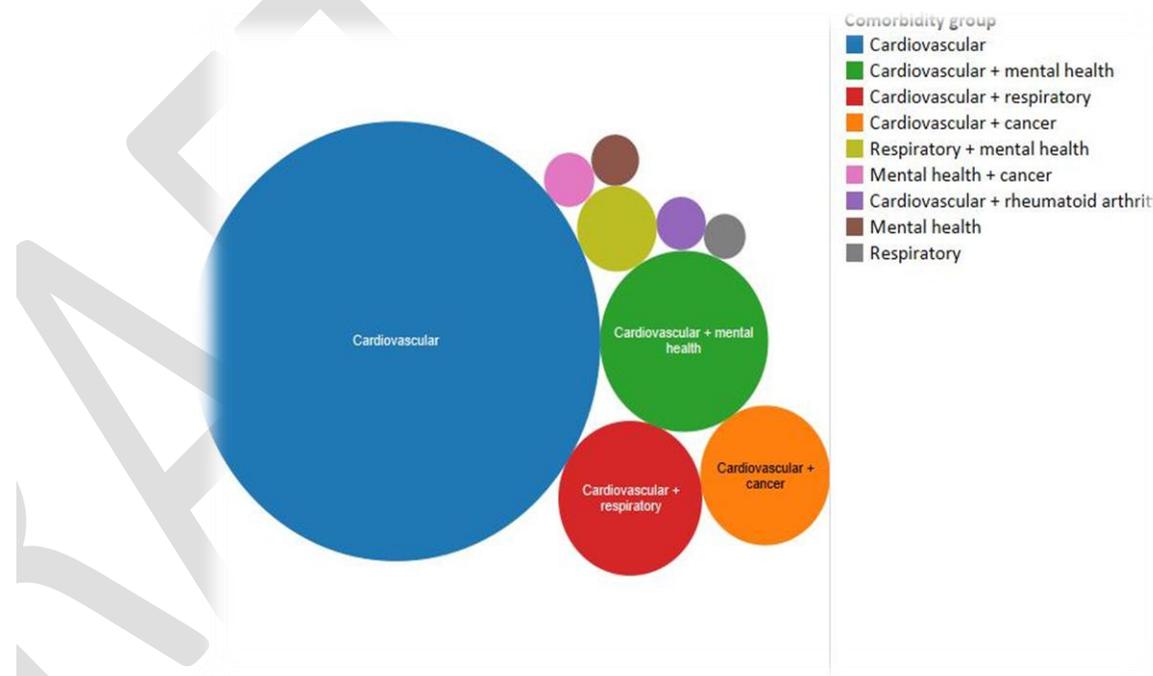


Figure 2: Comorbidity groups based on the most common combinations of comorbidities. The size of the bubbles represents the relative number of patients in each group for Edinburgh CHP (Data source; Lothian IRF 2012/13). (NB Asthma prevalence is lower than expected in Lothian IRF, therefore groups with respiratory comorbidities will be lower than expected).



3.11 Summary: Care Group Profiles – estimates of future need

This section provides a summary of the basis of estimates of future levels of need, extracted from the sections above.

1. Older People

Estimates of future numbers of older people are sourced from National Records of Scotland (NRS) population projections for local authority areas. Of particular interest in terms of anticipated needs for support is the population aged 85 years and over (see section 5 on resource use patterns).

- The number of people aged over 85 is expected to double by 2032 to 19,294
- Within 20 years the number of people living with dementia could rise by 61.7 % to 11,548 people

2. Mental Health

Population growth itself will bring about an increase in demand, assuming that underlying prevalence rates remain the same. However, we know that there are additional factors, including living in areas of socio-economical deprivation, economic factors such as recession, low growth and insecurity, and as noted in section 3.2 on poverty, estimates by the Institute of Fiscal Studies suggest that poverty rates are likely to remain high in the next few years. The epidemiology of prevalence of mental ill health and economic recession is being reviewed. Meanwhile the conservative planning assumption is that numbers increase by an average of 1.4% in line with the annual increase in the adult population.

3. Disabilities

Learning Disabilities

The overall prevalence of people with learning disabilities is expected to increase through improved neonatal care and increased life expectancy including for people with profound and multiple learning disabilities.

Physical Disabilities

There is evidence that the number of disabled adults is increasing, again through improved medical intervention leading to increased survival at birth and in the early years, and for improved survival from trauma. However, reliable epidemiology is not available, and again, we are making a conservative assumption is that numbers will increase by an average of 1.4% per year, in line with the annual increase in the adult population.

Sensory impairment in particular is more prevalent amongst people aged over 60 and so the numbers of people affected will increase in line changes in the population size.

Autism

Assuming the prevalence rate remains the same, the number of people in this category will change along with the size of the population. However, increasing awareness of the condition is likely to lead to increases in diagnosis rates, and potentially the level of demand for support.

4. Addictions

As with mental health, there is some evidence for an increase in addictions during periods of economic recession, low growth or insecurity; and the epidemiology is being reviewed. In the meanwhile conservative planning assumptions are that numbers will increase by an average of 1.4% in line with the annual increase in the adult population.

5. People with complex needs

This group is more challenging to estimate future levels of demand, because there are different definitions of the group, reflected in the range of estimates of the size of the current group being from 150-5,000 individuals. The level of demand may increase through national-level factors such as welfare reform and public sector cuts.

6. Carers

There are estimated to be 65,084 carers in Edinburgh, or 13.7% of the population. It is expected that the numbers of carers will rise in response to the rising population, but social factors such as changes in family composition make numbers hard to predict.

7. Palliative care

Future demand will be linked to death rates as well as the incidence of long term conditions and multi-morbidities, and also with changes in the focus of palliative care to include non-cancer conditions.

8. Blood borne viruses

The number of new cases of HIV infection in Lothian has been falling since 2005 and in 2013 totalled 88. However, the prevalence of people with HIV is increasing due to decreased deaths, antiretroviral therapies and new cases being diagnosed. At 31 March 2014 there were an estimated 1,479 people living with HIV in Lothian, up from just over 1,000 in January 2010.

There are around 5,500 people living in Lothian with HIV or Hepatitis C infection. Further planning work is required to estimate the numbers now

and in the next five to ten years living in Edinburgh who are likely to require Health and Social Care services.

9. Alcohol related brain damage (ARBD)

If rates of alcohol consumption continue to rise, there will be an ongoing demand from this group of service users. As ARBD is often undiagnosed, and prevalence difficult to ascertain, it is not possible to provide estimates of future level with any confidence .

10. Multiple long term conditions

Increasing age and deprivation are associated with multiple long term conditions, so again, demand will increase as the population ages, and also through market factors.

11. In summary

Population growth alone will increase the need for support. A number of wide ranging factors could increase demand further, and these include:

- The economy, levels of poverty and changes in benefits
- Improved medical interventions
- Increases in diagnosis rates

Our conservative estimate of a 1.4% increase in demand each year presents a significant challenge for planners and providers of support.

4.1 Resource Use - Spend on NHS and Social Care Services

Introduction

This section provides an overview of expenditure on NHS and social care services, using data provided by the Information Services Division (ISD), part of NHS National Services Scotland. Topic Paper 5.1 gives more details. The data relate to 2012-13, and are the latest available which include social care as well as NHS (more recent information on NHS spend has been provided by ISD and is summarised in Topic Paper 8).

Summary of key findings

- The area of highest spend for all three areas is “inpatients”, accounting for over a quarter of total expenditure (Table 1)
- Edinburgh’s balance of care, in terms of expenditure, shows a higher proportion of spend on social care services (29%) than the Lothian (27%) or Scottish (26%) totals
- The proportion of total spend attributed to social care services was higher in Edinburgh than across Scotland (28% compared with 26%) (chart 2)
- Spend per head increases with age across the adult groups, with spend for people aged 85+ being around six times the average for the whole population; people aged 85+ form 2% of the population, and account of 12.2% of total spend (chart 3)
- This pattern holds for both NHS and social care spend (chart 4)

TABLE 1: 2012-13 EXPENDITURE PROFILE [%]

	Edinburgh	LOTHIAN	SCOTLAND
Inpatients	27.7	28.1	29.0
Day Care	3.5	3.7	3.8
Other Hospital	12.8	12.9	13.8
Community Based	13.0	13.1	13.0
GP Prescribing	6.7	7.6	8.1
Other Family Health Services	7.3	7.3	6.6
TOTAL NHS	71.0	72.8	74.3
Care Homes	8.3	8.4	7.6
Other accommodation based care	1.3	1.4	2.1
Home Care	7.2	6.0	5.5
Other community based care	12.2	11.3	10.4
TOTAL SOCIAL CARE	29.0	27.2	25.7

Chart 2: Proportion of Total Spend (2012-13) on social care services by Age Group – Edinburgh and Scotland

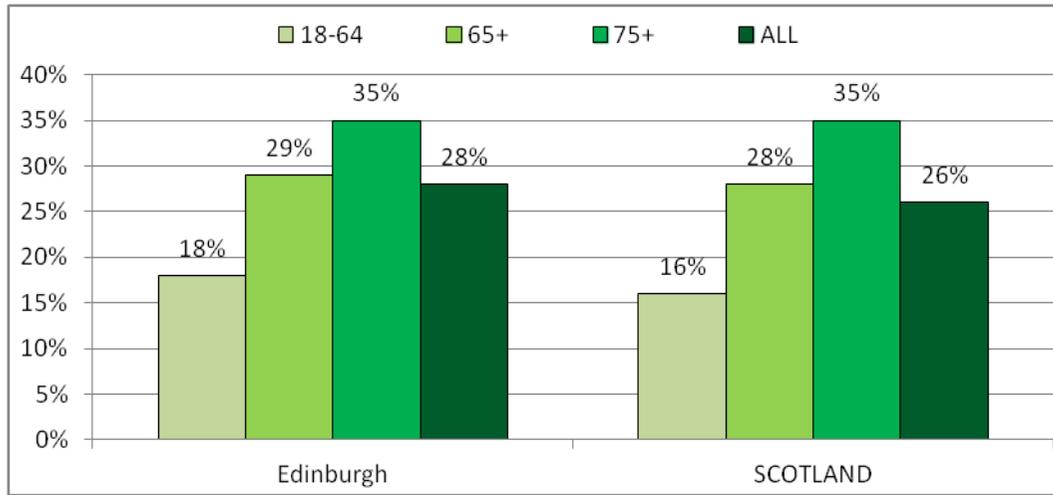


Chart 3: Total NHS and Social Care Spend per Head (2012-13) by Age Group – Edinburgh, Lothian and Scotland

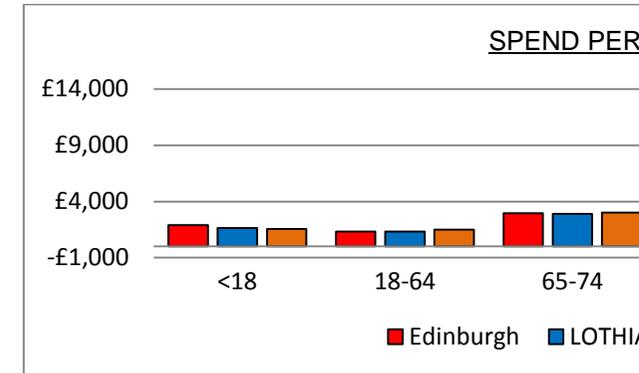
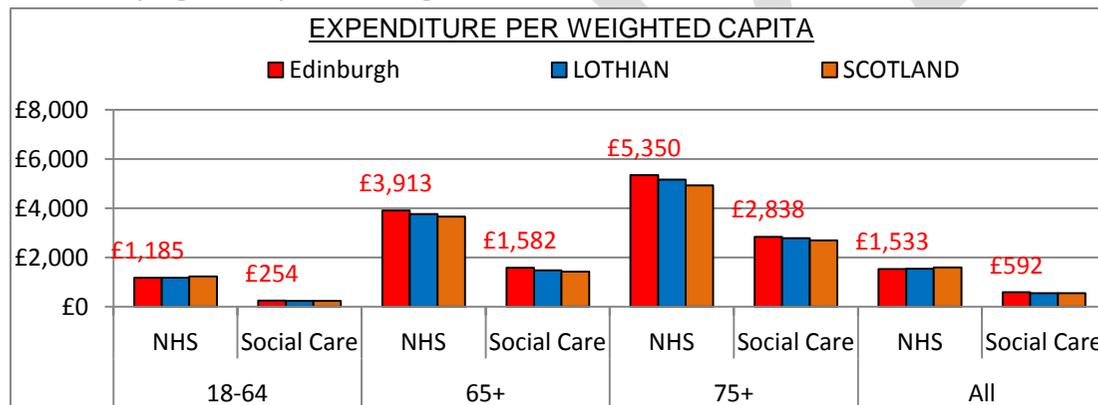


Chart 4: Expenditure per Weighted Capita on NHS and Social Care Services by Age Group - Edinburgh, Lothian and Scotland



4.2 Hospital Inpatient and Hospital Day Case Activity

Introduction

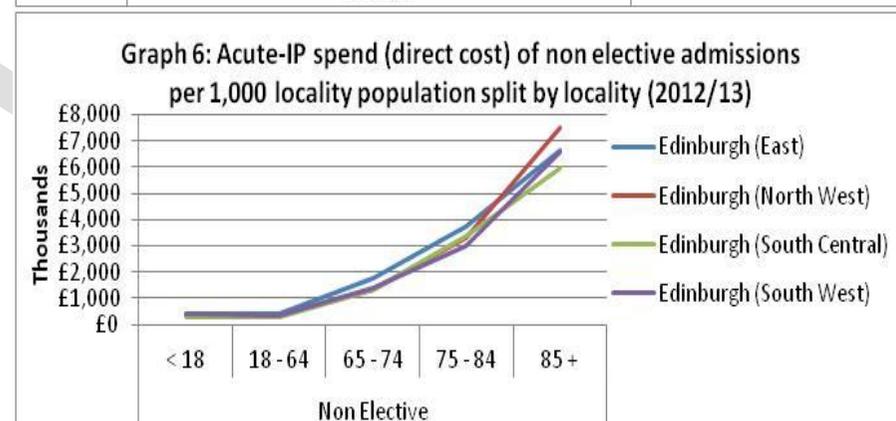
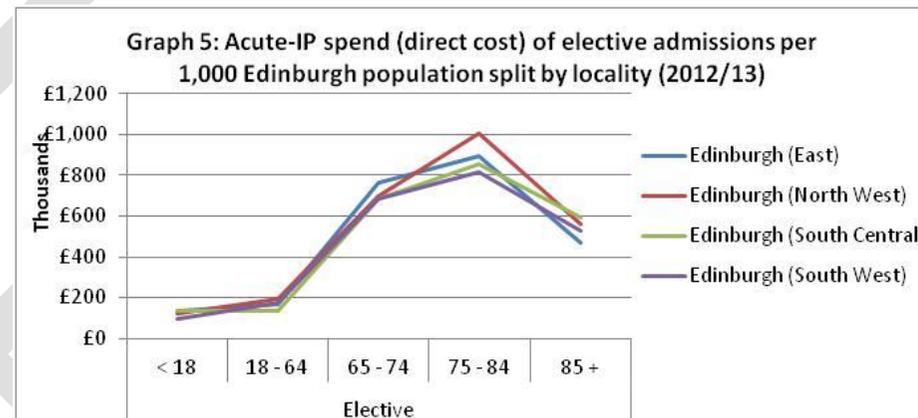
This section presents the key findings from an analysis of a dataset provided by ISD Scotland on NHS Lothian activity and expenditure for the Edinburgh Partnership. A more detailed report is provided in Topic Paper 9.

The data set provides patient level information and costing (PLICS) which has been developed to allow hospital costs to be attributed to patient activity in a very detailed way reflecting key cost drivers such as length of stay. The PLICS methodology is under development and this is being steered by the NHS Scotland Costing Group, and caution is needed in drawing conclusions from the results.

The purpose of this report was to provide a baseline analysis of health expenditure in Edinburgh partnership area.

Summary of key findings

- More has been spent on non elective admissions for Acute inpatient (Acute-IP) than elective (74.2% of the total Acute-IP direct cost).
- Spend is greater in North West Edinburgh for all age groups, as would be expected from it having the largest population.
- Yet, the rate of spend per 1,000 Edinburgh population is very similar across all localities, increasing significantly with age.
- The direct cost of elective admissions per 1,000 population increases with age but drops for the 85+ age group whilst the direct cost of non-elective admissions per 1,000 population continues to rise with age. The charts opposite illustrate cost for the Edinburgh Partnership Area.



4.3 Patients at Risk of Emergency Admission to Hospital

Introduction

The Lothian Integrated Resource Framework (IRF) was used to provide a profile of people who were at risk of admission to hospital. Individuals at risk are identified using the SPARRA risk score (Scottish Patients at Risk of Readmission and Admission). The Lothian IRF dataset contains SPARRA risk scores for patients at March 2013. These scores predict the person's risk of admission for 2013/14. The risk scoring was developed by ISD Scotland, and is based on individuals' previous health care use and demographic factors to create a risk score that predicts a person's risk of an emergency hospital admission in the following year. The tool allows people at risk to be categorised into three sub-groups cohorts: **frail elderly, long term conditions** (LTC - e.g. epilepsy, diabetes, some mental health problems, heart disease, arthritis, asthma and chronic obstructive pulmonary disease (COPD)) and **younger Emergency Department**. Understanding how these groups use the health service provides a useful way of assessing population health needs for people with different levels of risk of hospital admission (not only those at high risk), which accounts for a high proportion of health costs. It also provides us with valuable information about the health of the population in Edinburgh.

Note that there are some caveats with the data, which are described in the full report (Topic Paper 5.3). A key one is that the data in this report does not include psychiatry inpatients or psychiatry outpatients.

- These cohorts are defined by risk of emergency admission in the following year; emergency admission risk is the highest contributor to total health cost for all three SPARRA cohorts.
- Across the three groups, health costs per head increases with the SPARRA risk score.

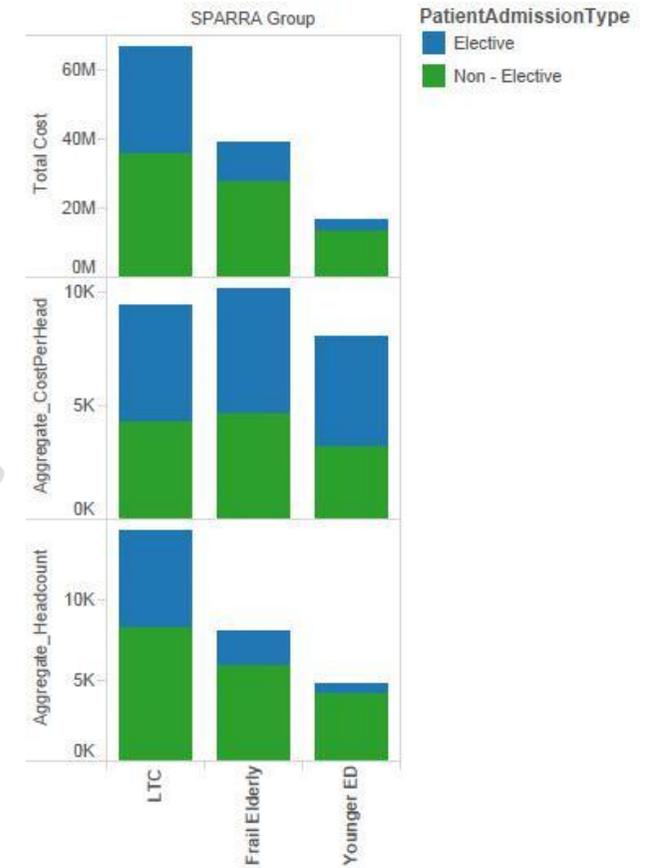
A summary of the main findings from the analysis are described below:

- **The SPARRA LTC cohort (16-74 years):**
 - is the largest of the three (195,440 patients) - 70% of the Edinburgh population aged 16-74 years are in the LTC cohort, and 55% are aged under 50 years; 57% are female
 - 79% of people in areas with the highest level of deprivation (Q1) are in this cohort compared to 67% of people in areas with the lowest deprivation scores (Q5)
 - Almost one third of people in this group that have a record of at least one LTC in primary care have two or more LTCs; 1% have five or more LTCs recorded
 - is responsible for the highest total health cost but the lowest health cost per head
- **The SPARRA frail elderly cohort (75+):**
 - Includes 77% (33,157 patients) of the Edinburgh CHP population aged 75 years and over; 29% are aged 85 years or more; 63% are female
 - 81% of people in the least deprived quintile (Q5) are in this cohort compared to 67% of people in Q1
 - 66% that have a record of at least one LTC in primary care have two or more LTCs and 6% have five or more LTC recorded
 - has the highest total health cost per head
- **The SPARRA younger emergency department (ED) cohort:**
 - Includes 14% (38,476 patients) of the Edinburgh CHP population aged 16-55 years; 56% are aged 35 years or less; 49% are female
 - is the smallest cohort, with the lowest total costs but the second highest health cost per head

- Across all three groups:
 - acute inpatients account for the largest proportion of total healthcare costs
 - Non-elective admissions account for a greater proportion of total cost than elective admissions
 - Long stay inpatients account for the highest cost per head, though they only account for a significant proportion of total cost in the Frail Elderly cohort.
 - Increased risk is associated with an increase in the number of different items prescribed
- A large proportion of the Edinburgh population is in the lowest risk score category (1-20% risk of admission) of the SPARRA LTC cohort and accounts for a large total cost, because the group is large. Reducing the cost of delivering care to this low-risk group could have a significant impact on resources. Early interventions for LTC to prevent people's conditions progressing, and their risk of admission increasing, would be one option for doing this.
- Having multimorbidities (two or more conditions) is accompanied by increased

number of return outpatient appointments, number of different items prescribed, A&E attendance and emergency admissions.

Resource use by SPARRA cohorts



4.4a High Resource Individuals

Introduction

This section presents the key findings from an analysis of another dataset provided by ISD Scotland on “high resource individuals” (HRI). A more detailed report is provided in Topic Papers 9 and 11. The purpose of this analysis is to gain a better understanding of resource use i.e. NHS spend for the Edinburgh Partnership.

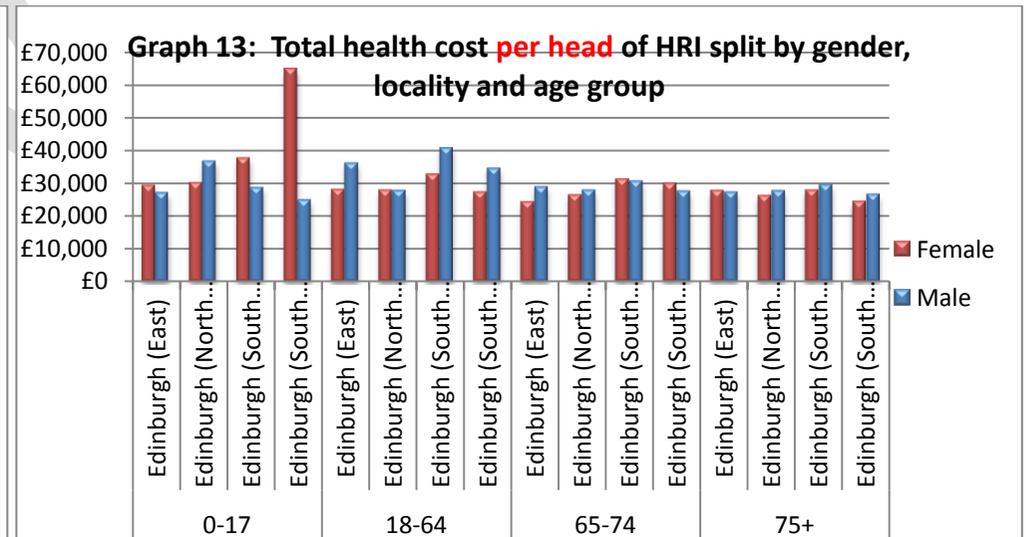
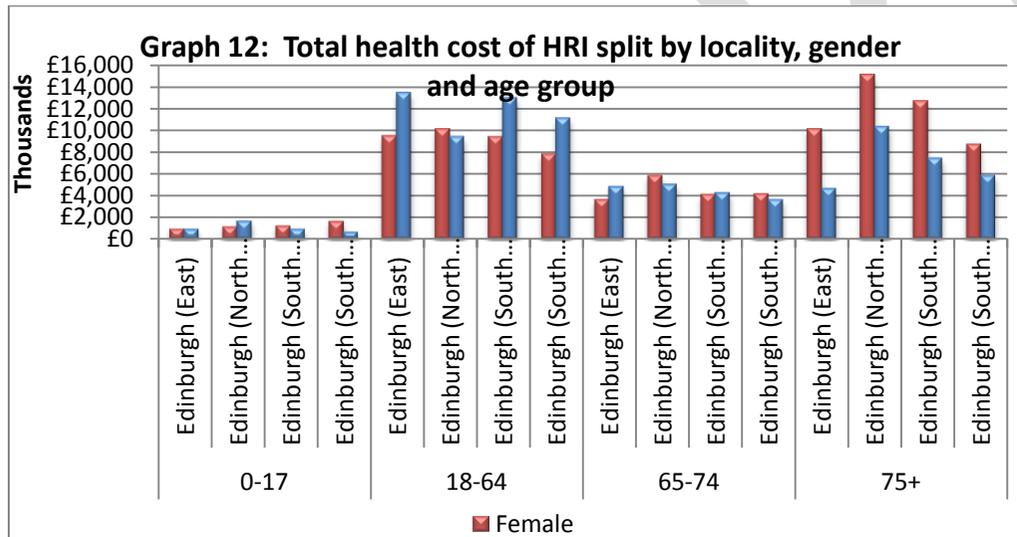
High Resource Individuals were identified by ranking all individuals within a local council area, and then selecting those individuals who fell into the top 50% of the total health expenditure for that area. A separate group is calculated for the whole of Scotland. As the pattern of expenditure varies between areas, an individual identified as 'high resource' in a local area may not be a high resource individual at the national level.

Summary of key findings

- “High Resource Individuals” (HRI) increases considerably with age. Among females, this increased from 3.7 per 1,000 population 0-17 to 80.2 per

1,000 population 75+. Among males, the increase was from 3.9 per 1,000 population 0-17 to 75.9 per 1,000 population 75+.

- Among those aged 75+, there is a greater rate of HRI who are female (84.9 per 1,000) than male (62.1 per 1,000) in East Edinburgh, compared to all other localities. It would be interesting to see the median age of this group of females compared to the males.
- Coronary Heart Disease (CHD) appears to be the most prevalent long term condition for HRI across all localities. Heart failure, dementia and Cardio Vascular Disease (CVD) were also quite high.
- It is important to remember that HRI are only a small proportion of people receiving health care in the Edinburgh partnership area, which can vary from year to year. The analysis would benefit from a longer time series. Caution should be taken with planning and decision making using small numbers.



4.4b Resource Use – High Resource Individuals (Lothian IRF)

Introduction

The Lothian Integrated Resource Framework (IRF) was used to develop a profile of “High Resource Individuals” (HRI), the group of individuals (aged 16 and over) who accounted for half of health or social care spend in 2010-11 (the latest available dataset which includes both health and social care records). The purpose of the analysis is again to develop an understanding of how resources are currently being deployed. A number of caveats apply to the cost data – these are included in the full Topic Report (5.4).

Summary of key findings

Resource use (cost) is heavily skewed, with a small proportion of people accounting for a high proportion of costs:

- 2.4% of CEC residents account for 50% of total health care costs
- 8.4% of CEC residents account for 50% of all social care costs

Four groups have been identified among Edinburgh’s population, based on their health and social care resource use – the first three account for 50% of total health and/or social care costs, while the 4th accounts for the remainder:

1. Those with high health care costs and high social care costs – “HRI health and HRI SC”
2. High healthcare costs only (not high social care costs) - “HRI health”
3. High social care costs only (not high health care costs) – “HRI SC”
4. People who have low costs for both – “Non-HRI”

Overall resource use

- People who are high users of both health and social care have the highest cost per head but lowest total costs
- Those who are high users of health care only have a lower cost per head than those who are high users of social care only, but higher total cost
- The group which do not make high use of either have the lowest cost per head but highest total costs (being a very large group)

Table 1: Total Lothian IRF health and social care costs and costs per head by resource group for CEC resident 2010/11

	Headcount	Cost Per Head	Total Cost
HRI health and HRI SC	188	£68,619	£12,900,295
HRI health	7,181	£29,764	£213,736,667
HRI SC	1,702	£48,731	£82,940,828
Non HRI	300,704	£882	£265,092,228

Characteristics of the resource groups

Age

- In the three HRI resource groups the highest proportion of patients are in age bands 76-84 years and 85+ years (see chart 1).
- HRI social care only group has the highest proportion of clients aged 85+.

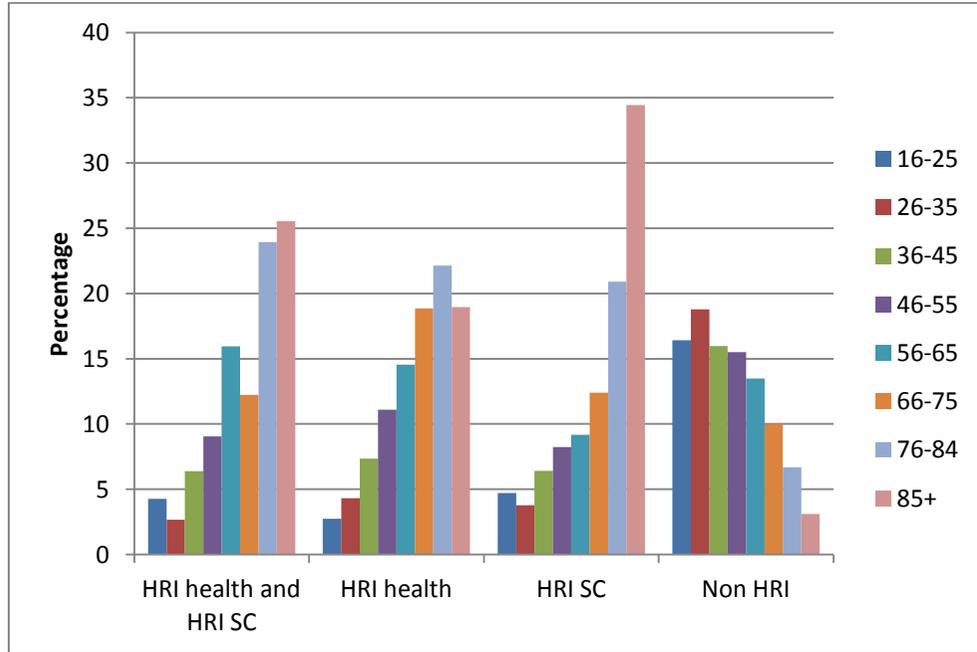
Gender

- Higher proportion of females than males in all groups

Deprivation

- The three HRI groups have a higher proportion of residents in Q1 and Q2 (most deprived quintiles) compared to the non-HRI group

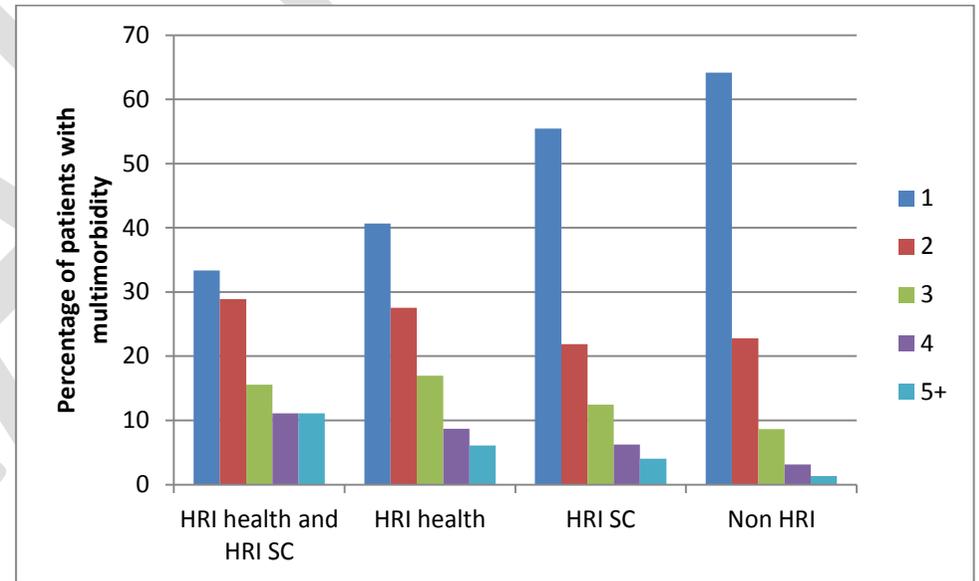
Figure 1: Age profile of the four resource groups for CEC residents for 2010/11



Multimorbidity

- The 'HRI health and HRI SC' and 'HRI health only' groups have a higher proportion of patients with multimorbidity than the other two groups.
- 67% of patients with a record of a LTC have two or more LTCs in the 'HRI health and HRI SC' group.

Figure 2: Proportion of patients in each resource group with 1, 2, 3, 4, or 5 or more LTCs for CEC residents in 2010/11.



4.5 Adult Social Care - Activity Profile

Introduction

The purpose of this report is to give an outline of the provision of Adult Social Care services across Edinburgh and the four localities. The aim is to show the *actual volume* of activity for those social care services which will be delegated to the Edinburgh Integration Joint Board, numbers of people being supported) *as well as rates* of the localities' populations, which enable comparisons to be made about provision levels. Full details are provided in Topic Paper 12.

Summary of key findings (note: all rates are per 1,000 population aged 16+)

- Over the 12 month period (Dec 2013 – Nov 14), almost 23,000 individuals were in contact with Health and Social Care to have their needs assessed or being supported, a rate of 55 per 1,000 population (16+). The **East** locality had a *higher rate* than the other three localities, while **North West** had the highest *number of individuals*.
- The **East** locality shows the highest rate of assessment requests, while South East/Central had the lowest.
- Across localities, there is a clear pattern of increasing numbers with age, up until around 80 years. The average age of people receiving support from Health and Social care was 69, with all four localities supporting people over the age of 97
- Older people formed the largest group of people being supported (60% of the total in the **East** rising to 74% in the **North West**).
- The main client group of the open cases for the under 65 population in the four localities varied, with **East** locality having the highest *number* of people with learning disabilities, physical disabilities and addictions and **South East/Central** having the highest *number* of people with mental health problems.

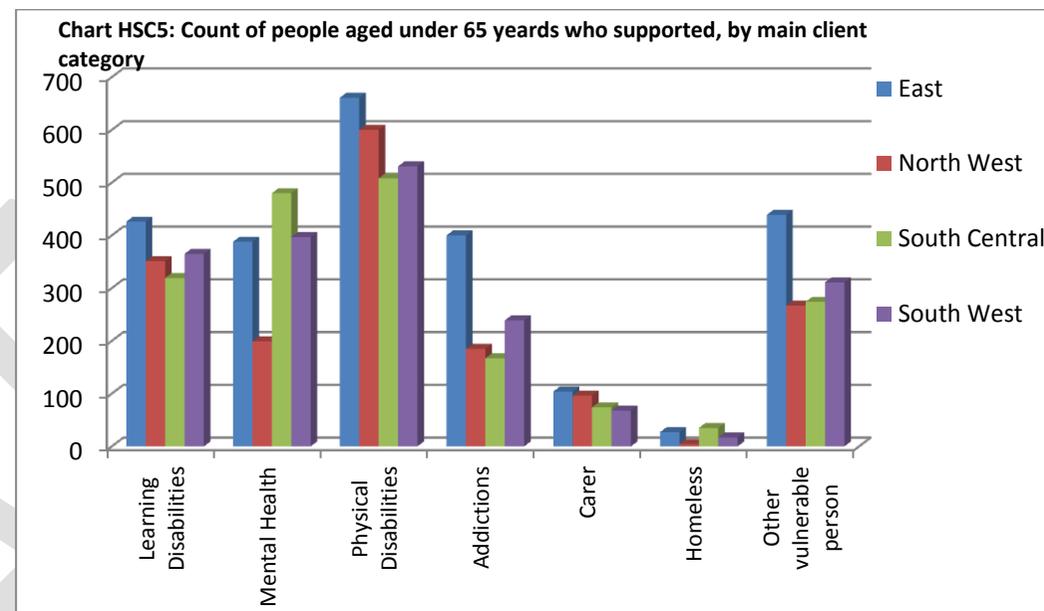


Table 1: Domiciliary service provision (30 November 2014)

	People receiving service	Hours provided per week	Average Package of Care (hours per week)	Weekly hours - rate per 1,000 population (16+)
East	1,082	25,796	23.8	272.4
North West	1,264	23,257	18.4	203.6
South East/Central	1,056	19,416	18.4	176.5
South West	987	18,431	18.7	195.9
Total	4,389	86,900	19.8	210.4

- Table 1 above shows that the *average size* of a package of care to support someone at home was largest in the **East** (24 hours per week compared with the City-wide average of 20).
- Profiles of support vary between localities. For example *the rate* of people receiving direct payments is lower in South West than the other localities, and the number of people in care homes in South East/Central is higher.
- The large increases in direct payments over the last few years suggests that people are willing to take more choice and control over the supports they receive to support their social care needs. This shift in Health and Social care support is developed further by the implementation of Self Directed Support legislation. This shift in control of arranging support and the types of support available in the community needs to be monitored and the impact on future commissioning of services considered.
- The use of legal orders for individuals who have mental health issues, capacity issues and those at risk of abuse varies between localities, with **North West** having a relatively low rate of new orders granted compared to the other three localities, which are fairly similar as shown in Table 2 below.

Table 2: A count of legal orders granted between December 13 and November 14.

	Adult support and protection	Adult without capacity	Mental Health	Grand Total	Rate per 1,000 population (16+)
East		31	179	210	2.2
North West	1	35	127	163	1.4
South East/Central		41	205	246	2.2
South West	1	28	168	197	2.1
No fixed abode			14	14	
Grand Total	2	135	693	830	2.0

- Increases in the overall size of the population and in the number of older people (see Topic Paper 1), shifting the balance of care and reducing delays for people ready for discharge from hospital (see delayed discharge paper) suggest that the pressures on Health and Social Care will increase in the future.
- Chapter 6 provides a summary of pressures and unmet need across health and social care.

4.6 Primary Care

Introduction

'Primary Care' is a 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. In this first needs assessment the most detailed analysis has been concentrated on GPs due to their significance in the policy guidance which established health and social care partnerships, and due to the significant GP workforce challenges.

1. DEMAND AND FORECASTED NEEDS

Edinburgh currently has 73 GP practices. The average number of GPs in each practice is seven. £68million is available to pay for the running costs of the 73 practices. Demand for primary care services is affected by the factors outlined below.

1a. Population Growth and Change

Population increase had accelerated to around 5,000 per year since 2007 and this rate is expected to continue until 2035 and possibly thereafter. Approximately 20 new GP surgeries are required by 2030. Eight new practices and one upgrade are currently planned within the next couple of years⁹.

The older population is increasing. People are living longer, but are also less healthy for longer and are likely to require complex health and social care packages for longer than in the past¹⁰. Older people with complex needs require more and lengthier consultations¹¹. In terms of the need for GP support, there are no longer significant differences in morbidity and hence healthcare needs

⁹ Population Growth and Primary Care Premises in Edinburgh 2014-2019 (April 2014) NHS Lothian

¹⁰ John Appleby, 'Spend on health and social care in the next 50 years' King's Fund 2013

¹¹ Care of the Frail Elderly and 2020 Vision: Lothian GP sub-committee 2015

between three groups of frail elderly - those in nursing homes, those in care homes and those who housebound. In the past, the highest levels of need were found in nursing and residential homes. Now, people in all three settings could be considered as having equivalent levels of need in planning terms¹².

Although increasing numbers of older people will lead to increased workload in the primary care sector, and hence increase pressure to spend more on health and on social care, the scale of this pressure will not be as important as either changes in national income or in technology (such as new drugs and treatments)¹³.

1b. Shifting the Balance of Care

The 2020 Vision reinforces the policy of 'Shifting the Balance of Care' which has already moved activity out of the acute sector and into Primary and Community Care sectors. This policy direction increases demands on primary care services.

1c. Deprivation levels and inequality

People in deprived areas have a far higher prevalence of serious ill-health which impacts the workload of GPs based in areas of deprivation. Edinburgh contains all of the top ten most deprived practices in Lothian¹⁴. Whilst deprivation is reflected in the allocation of funding to General Practices, there is a strong view that it is not sufficiently weighted.

1.d Health Predictions

Currently 27% of the adult Scottish population is obese¹⁵ and this is anticipated to increase to 40% by 2020. Diabetes currently affects more than 5% of the population. If obesity prevalence does increase, type 2 diabetes prevalence will

¹² Care of the Frail Elderly and 2020 Vision: Lothian GP Sub-committee 2015

¹³ John Appleby, 'Spend on health and social care in the next 50 years', King's Fund 2013

¹⁴ Our Health, Our Care, Our Future 2014-2024, Appendix 3: NHS Lothian Primary Care Strategy, Demand, Capacity and Access an overview

also increase. The ill health effects of both of these conditions has significant health and social care resource implications.

2. CAPACITY

2a Spend on Primary Care services

Against the above mentioned pressures, nationally there have been real term decreases in spend in two key areas of primary care: GP practices (reduced by 2.5% between 2009/10 and 2013/14) and district nursing (reduced by 13%).

2b. Primary care Workforce in Edinburgh

2bi - GPs

The actual, not whole time equivalent (WTE) number of GPs in Edinburgh has increased by 10% to 508 from 2006 to 2014¹⁶. However, numbers of actual GPs per 1,000 population in Edinburgh increased between 2006 to 2008, before falling sharply to below 2006 levels by 2013. The situation improved slightly in 2014. There is no robust data on changes to numbers of WTE GPs, although there is a widespread perception that the well evidenced increase in female GPs (up by 24% since 2006) in Edinburgh has led to an increase in part-time working. A BMA UK survey¹⁷ (UK wide) found that almost one in five (17%) of GPs intend to move to part-time working within five years and that a third of GP trainees want to work part-time within five years.

In 2014, of GPs whose age is recorded (10% are not recorded), 65% of GPs are aged under 50, 18% aged 50-54 and 12% aged 55-59. 5% are aged 60 and over. These percentages are almost identical to those in 2006. It should be noted that all GP trainee positions have been filled in South East Region each year since

2010¹⁸ and there has been an overall increase in numbers of performer registrars/ specialist trainees between 2006 and 2014 (from 42 to 58).

Another way to measure workload pressure and access to GPs would be to look at GP practices with full or restricted lists. In 2013 there was a dramatic increase to 19 practices with restricted lists and at June 2015, 26 of the 73 practices in Edinburgh (36%) had some type of restriction on patients joining the practice list. GPs themselves report high work pressures. A BMA UK wide survey of GPs (2015) asked GPs to rank the factors that negatively impact on their personal commitment to general practice. Workload came our strongly on top at 71%, followed by inappropriate and unresourced transfer of work to general practice (54%) and insufficient time with each patient (43%).

In terms of the effect of GP pressures on patient access to GPs, Edinburgh is not meeting the national targets, but performs as well as Lothian and Scotland¹⁹. Edinburgh patients' reported ability to be able to access a GP or Nurse within 48 hours stood at 85% in 2013/14. This is the same as the Lothian and the Scottish figure of 85% although lower than the Scottish Standard of 90%.

GP Employment type

There have been striking changes in the balance of GP employment types in recent years, with a substantial increase in salaried GPs (as opposed to those who are partners in a practice) from 11% in 2006 to 21% in 2014. There has also been an increase in trainee GPs. All trainee positions have been filled in South East region each year since 2010²⁰.

Lothian Unscheduled Care Services

There is an ongoing national challenge in GP staffing within out of hours services. This is related to the pressures that GPs are experiencing within their day time

¹⁵ Scottish Health Survey 2013

¹⁶ ISD

¹⁷ British Medical Association survey of GPs ;The Future of General Practice 2015': a report by ICM for the BMA

¹⁸ NHS Education for Scotland

¹⁹ Health and Social Care Experience Survey

²⁰ NHS Education for Scotland

practices as well as changes to working patterns, pension changes and increasing complexity and workload during the out of hours period.

Effect on GP Practices

The pressures on GP practices are coupled with the supply of locum doctors no longer matching demand difficulties for practices in attracting candidates to become partners. This means that GP partners are under pressure to work more as earnings fall and the associated administrative burden increases. This is making general practice less attractive to medical students and newly qualified doctors. Consequently, in Edinburgh there are around six practices considered to be 'unstable' at any one point.

Meeting the Challenge

An action plan is currently being developed in Edinburgh which outlines a range of initiatives to increase capacity in the GP workforce by either increasing numbers of GPs or decreasing GP workload. Essentially work which is currently undertaken by GPs will need to be undertaken by other health care professionals, such as nurses and pharmacists.

A Note on GP Workforce Data

Despite the firm view that the GP workforce is in crisis, it is challenging to get data on the GP workforce to robustly evidence this. This indicates a need to improve data collection to enable effective workforce planning in the future.

2bii – CAPACITY WITHIN OTHER PRIMARY CARE PROFESSIONALS

The workload of General Practice, is directly affected by resources to support GPS from other primary care professionals. The reduction or lack of these services will lead to increased demand for general practice.

District Nursing

The picture for the GP workforce is similarly replicated with regard to the community nursing profession, which has not kept pace with population growth.

The district nurse workforce is ageing, with many staff approaching retirement age. This is a particular issue for band six nurses.

The reduced capacity in the service has led to a reduction in the range of services delivered by these staff. This reduction is particularly noted in the care of patients who are frail, have multiple morbidity or palliative care needs where spare capacity is required to manage unexpected clinical events. This will have a domino effect upon Out-of-Hours services and, inevitably, on A&E services and unscheduled admissions. Preparedness for Vision 20:20 would indicate a need for more, rather than fewer community nurses, particularly to meet community palliative care needs²¹.

Physiotherapists

All branches of physiotherapy have seen a rise in referrals. For the musculoskeletal service and domiciliary service this rise has been compounded by a reduction in whole time equivalent staff. The effect has been particularly pronounced in the domiciliary service, which sees the frailest people, which has seen a rise of 16% over the last three years yet a drop of 3.5% in whole time equivalent staff. As with GPs and district nurses, the workforce is ageing. As with GPs, there is a move to more staff working part-time.

Dietetics

The staffing level in Edinburgh has been maintained through skill mix to absorb the impact of budget cuts. The main reasons for referrals are being malnourished, obese or diabetic, with the latter two being conditions projected to increase in prevalence. The increase in the elderly population with multi-morbidity will also significantly impact on this service.

Podiatry

NHS Lothian podiatry service has the smallest share of podiatry staff relative to population (0.66%) compared to other Scottish regions. The workforce is declining due to posts being released in 2014/15 to meet savings targets. The age

²¹ Our Health Our Care Our Future 2014-2024– appendix 1 Demand, Capacity and Access' NHS Lothian

profile of staff may present a challenge over the next 10-15 years as staff retire. Increasing numbers of older people will impact on podiatry which sees large numbers of older people with long term conditions. The main workforce implications relate to an increase in demand for diabetes related foot services.

Community Pharmacy Services²²

There are no known capacity issues, for Community Pharmacy Services, within Lothian.

General Dental Services²³

There are a known number of practices who are taking on new NHS patients but, at the current time, no capacity issues have been identified.

General Ophthalmic Services²⁴

There are no known capacity issues, for Ophthalmic Services, within Lothian

²² 'Our Health Our Care Our Future 2014-2024– appendix 1 Demand, Capacity and Access' NHS Lothian.

²³ 'Our Health Our Care Our Future 2014-2024– appendix 1 Demand, Capacity and Access' NHS Lothian.

²⁴ 'Our Health Our Care Our Future 2014-2024– appendix 1 Demand, Capacity and Access' NHS Lothian

4.6 Summary of Resource Use

This section of the JSNA has been to provide a baseline overview of spend and activity patterns. Key points to emerge are listed below. The relevant chapter of this report is shown in brackets

Summary

- The highest proportion of NHS and social care expenditure is on inpatient care, which accounted for a quarter of the total in 2012-13 (5.1)
- Three quarters of the acute inpatient care is on non elective (unplanned) admissions (5.2)
- Spend per head across localities is similar (5.2)
- Among adults, spend per head increases with age – spend for people aged 85+ was on average 6 times the average for the total population (5.1, 5.4)
- Risk of emergency admission to hospital increases with the level of deprivation (5.3)
- A large proportion of the Edinburgh population is in the lowest risk category for long term conditions group, but, because of the size of the group, it accounts for a large proportion of the total cost. There is scope, through early interventions for people with long term conditions, to reduce this total cost (5.3)
- Resource use (cost) is heavily skewed, with a small proportion the Edinburgh population accounting for a high proportion of costs (5.4b):
 - 2.4% of the population account for 50% of total health care costs
 - 8.4% of the population account for 50% of all social care costs
- The group of people who make intensive use of both health and social care services have an average annual cost of around £68,600 (although there were only 188 people in this category) (5.4b)
- Those people who make intensive use of social care services only (N=1,702), cost on average around £49,000 per person each year (5.4b)
- As noted elsewhere in this report, population size, old age and deprivation are key drivers of the need for social care: the **East** locality had a *higher rate* of people supported than the other three localities, while in volume terms, the North West (the biggest sector) had the largest *number* (5.5).
- Similarly, older people formed the largest group of people being supported by social care services (60% of the total in the **East** rising to 74% in the **North West**) (5.5).
- The main client group of the people being supported by Health and Social Care for the under 65 population in the four localities varied, with **East** locality having the highest *number* of people with learning disabilities, physical disabilities and addictions and **South East/Central** having the highest *number* of people with mental health problems.

5.1 Pressures and Unmet Need

Introduction

This section provides a brief overview of existing and future pressures in the health and social care system, including: delayed discharge, unscheduled care, waiting lists and staffing profiles.

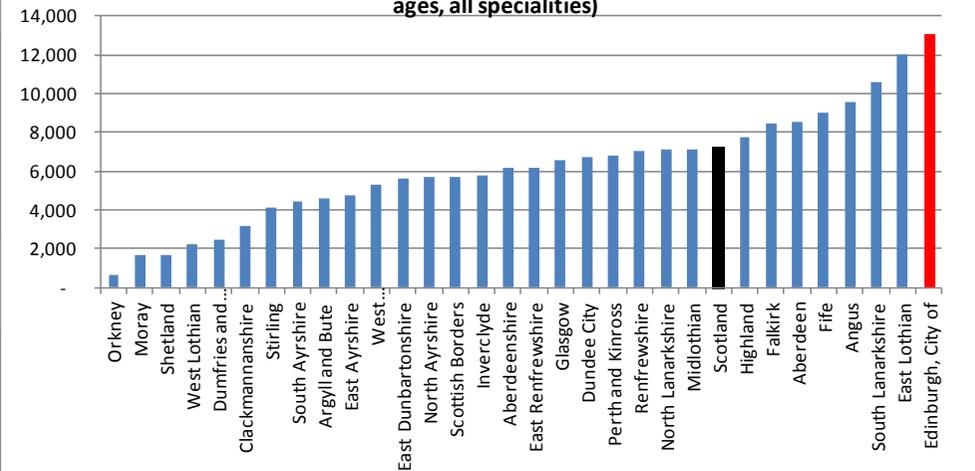
5.2 Delayed Discharge

Summary of key points (see also Topic Paper 13)

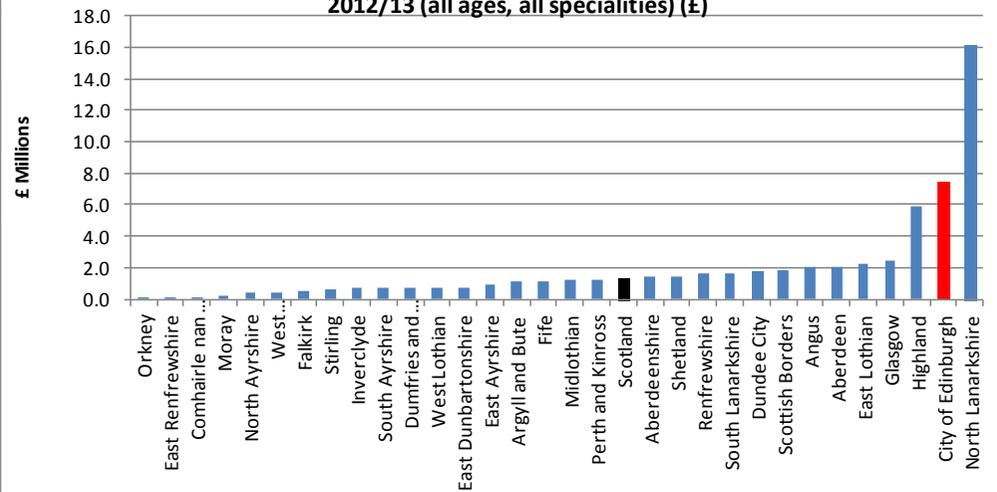
The information summarised in the section includes an overview of delayed discharge levels and costs for 2012-13, provided by ISD through their Integrated Resource Framework (IRF). This is the first time that the costs of delayed discharge have been calculated, and 2012-13 is the most recent analysis available. More recent (uncosted) trends in Edinburgh are also shown.

- Edinburgh's rate of bed days occupied by delayed discharges per 100,000 population was the highest of the 32 local authorities in Scotland - 13,065 bed days occupied per 100,000 population in 2012/13 (all ages) (see the first chart opposite).
- The rate of delayed discharge was highest among the 75+ age group
- The total cost of delayed discharge in Edinburgh (as a rate per 100,000 population) ranked second highest with a total cost of £7.4 million per 100,000 population in 2012/13 (see the second chart).
- The total cost arising from delayed discharges in Edinburgh increased by 13% over 2012/13, lower than the Scottish increase of 23%. Over two thirds of this cost in Edinburgh is associated with the 75+ age group.
- The number over 6 weeks was 31 and the number over the national standard of 4 weeks was 47 – the target for both is zero. The number waiting for over 2 weeks, the standard from April 2015, was 64.

Graph 9: Rate of bed days occupied per 100,000 population in 2012/13 (all ages, all specialities)



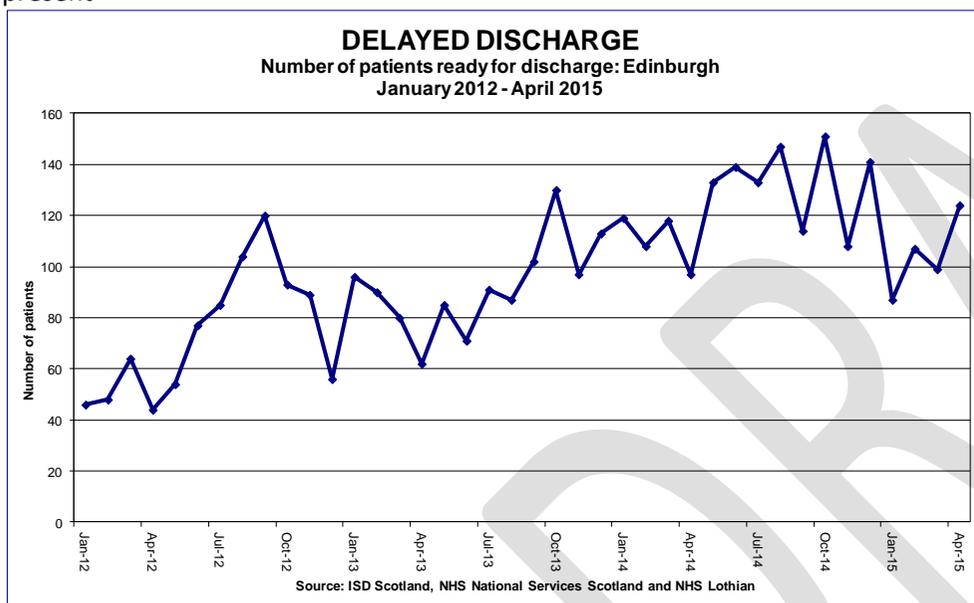
Graph 14: Rate of total resource consumption per 100,000 population in 2012/13 (all ages, all specialities) (£)



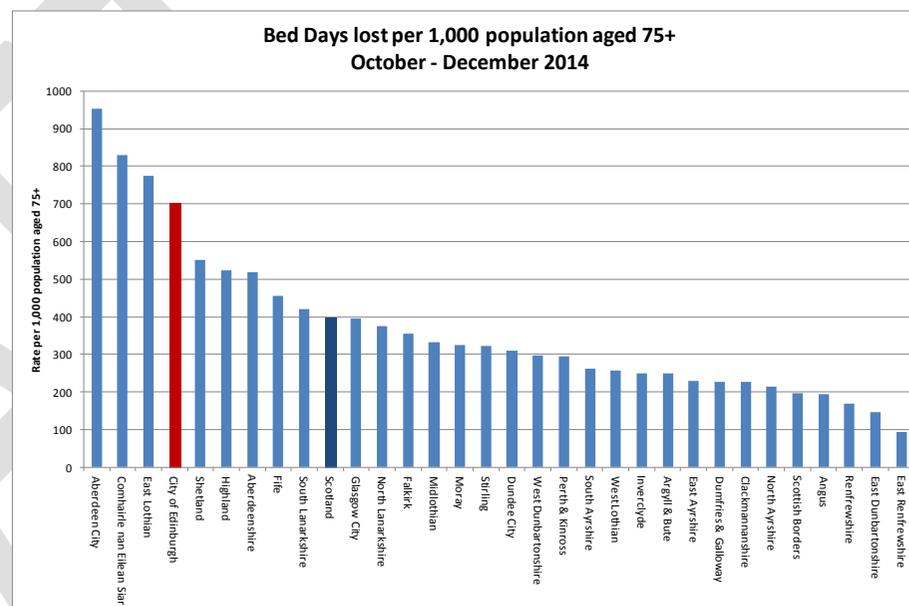
Current position: the total number of delays for Edinburgh recorded on the ISD census in April 2015 was 124 against a local target of 78. However, the number over 6 weeks was 29, the number over 4 weeks was 33 and the number of the new national standard of two weeks was 59.

Graph 3 below illustrates the fluctuating, but generally increasing level of delayed discharge of Edinburgh patients since January 2012.

Graph 3: Edinburgh Patients who were ready for hospital discharge – 2012 to present



Graph 4: Bed days lost to delayed discharge – rates per 1,000 population 75+ for each partnership



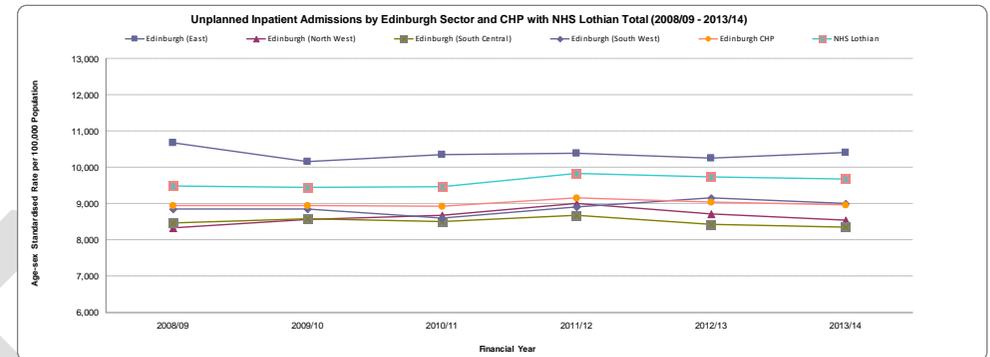
Graph 4 shows that Edinburgh’s rate of bed days lost in the quarter October – December 2014, the latest available. The number of bed days lost was 24,657, 14.6% of the Scottish total. As a rate per 1,000 population aged 75+, Edinburgh ranked 4th, behind Aberdeen, the Comhairle nan Eilean Siar and East Lothian.

5.3 Unscheduled Care

Summary of key points (see also Topic Paper 6 Public Health)

Emergency admission rates have remained consistent over the five years. Deprivation is associated with highest admission rates so Edinburgh East has most residents being hospitalised in this way. Edinburgh has fewer unplanned hospital admissions than other parts of Lothian.

Figure 1: Age-standardised Unplanned Inpatient Admissions by Edinburgh Locality



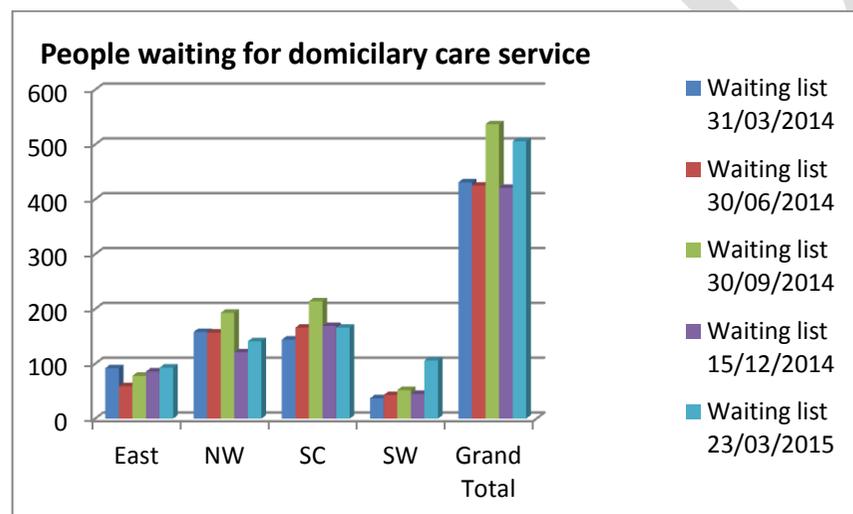
5.3 Domiciliary Care

Summary of key points (see also Topic Paper 12)

People may be waiting at home or in hospital while their package of support is arranged. Pressures arise when the time taken to do this is protracted. The chart and table below provide a series of snapshots of the levels of unmet need – these are typically higher in number (people waiting) in the North West and South East/Central, while the average number of hours of support people are waiting for is higher in East (this is in line with the larger average size of packages provided there).

Table 1: Average size of package on waiting list by locality

	Waiting list 31/03/2014	Waiting list 30/06/2014	Waiting list 30/09/2014	Waiting list 15/12/2014	Waiting list 23/03/2015
East	12.9	12.6	12.9	16.4	11.7
NW	10.9	12.5	9.6	10.9	7.5
SC	10.4	11.6	9.3	9.8	9.9
SW	13.2	11.0	12.4	9.7	14.7
Grand Total	11.3	12.0	10.2	11.5	10.6



5.4 Staffing

Summary of key points (see also Topic Papers 6 – Public Health; 3 – Labour Market)

An increase in population size will require additional staff, including general practitioners, community nurses and social and care workers, if current staffing ratios are to be maintained. Supporting people with higher levels of need in the community, rather than in hospital, will add to the need for skilled staff.

The analysis of the labour market in Edinburgh Topic paper shows:

- Skills shortages were highlighted in health sector as vacancies become harder to fill. In 2013, 24% of vacancies in the health and social care sector (nationally) were hard to fill, up from 13% in 2011.
- Given that future demand is expected to be concentrated in health and social care professionals, challenges in recruitment for non graduate roles, attracting new applicants, and addressing the ageing profile of the sector workforce will persist and increase in the future.

Population growth, including the growing number of frail elderly people, and the shift in the balance of care to the community, is placing increasing pressure on primary care professionals. Whilst the number of GPs has increased, the numbers are not keeping pace with the population: since 2009 the number of GPs per head of population has fallen sharply. Although numbers on whole-time equivalent GPs are not robustly gathered, it is widely accepted that more GPs are working part-time due to a, well evidenced, proportional increase in the number of female GPs. All of this is placing increasing pressure on GPs, and making general practice an unattractive option for medical students.

Whilst the number of whole time equivalent community nursing staff (health visitors, community nurses and school nurses) has increased by 1.34 between 2009 and 2013, practice list size has increased by 3%.

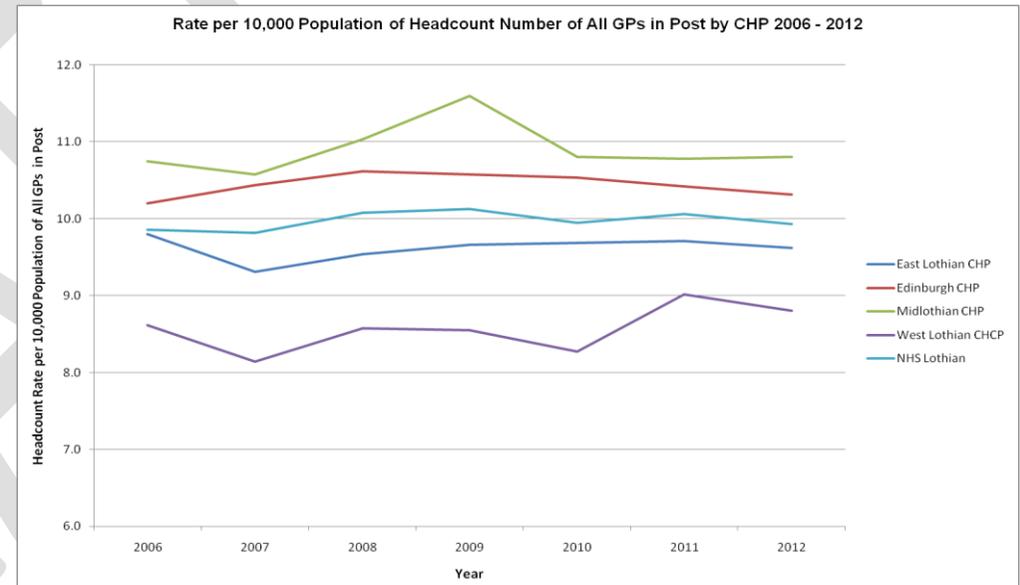


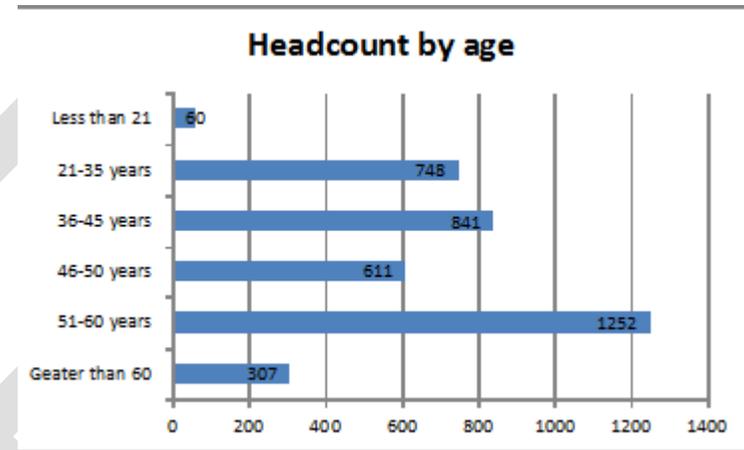
Figure 22: GP headcount rates for Lothian

There is a similar difficulty with the information available about the number of practice nurses, which is available only for 2007, and with a response rate of about 74% of practices across Lothian. Again, only headcount information is available.

A recent profile of the Health and Social Care workforce showed the following.

- As at 31 December 2014, 3,819 people were employed in Health and Social Care within the City of Edinburgh Council
- Each year, an average of 7.9% of Health and Social Care staff leave the employment of the Council
- The highest area of turnover is care workers employed with the Home Care service and Residential Care for Older People

- The age profile of staff is shown in the diagram below. It highlights the need for succession planning



DRAFT

Appendix 1 – List of Topic Papers

	Topic Paper	Report status	Authors
1	Edinburgh's Population	Draft (not ready to be circulated)	Russell Morris, Senior Research and Information Officer, Health and Social Care, City of Edinburgh Council Steven Di Ponio, DA to the Convener of Health, Wellbeing & Housing, City of Edinburgh Council
2	Poverty and Low Income	Final	Chris Adams, Senior Business Intelligence Officer, Corporate Governance, City of Edinburgh Council Louise Wright, Social Inclusion Team, Health and Social Care, City of Edinburgh Council
3	Labour Market	Final	Chris Adams, Senior Business Intelligence Officer, Corporate Governance, City of Edinburgh Council Gareth Dixon, Business Intelligence Officer, Corporate Governance, City of Edinburgh Council
4	Housing	Draft (not ready to be circulated)	Gillian Campbell, Senior Project Manager, Housing and Regeneration, Services for Communities, City of Edinburgh Council Ada Yiu, Project Manager, Housing and Regeneration, Services for Communities, City of Edinburgh Council
5	Children and Families	Final	Karen Brannen, Performance Manager, Children and Families, City of Edinburgh Council
6	Health Profiles	Final (but amendment needed to make chart readable)	Dr Dermot Gorman, Martin Higgins, Public Health and Health Policy, NHS Lothian Duncan Sage, Lothian Analytical Services, NHS Lothian
7a	Older People	Final	Caroline Clark, Planning and Commissioning Manager (Older People) Jamie Megaw, Strategic Programme Manager for Older People, NHS Lothian.
7b	Mental Health	Final	John Armstrong, Pathway Manager Mental Health, City of Edinburgh Council Linda Irvine, Strategic Planning Manager for Mental Health, NHS Lothian.
7c	Disabilities	Final	Helen Morgan, Commissioning Manager Disabilities, City of Edinburgh Council Rona Laskowski, Strategic Programme Manager Disabilities, NHS Lothian.
7d	Addictions	Final	Nicholas Smith, Joint Programme Manager, Edinburgh Alcohol and Drug Partnership
7e	People with Complex Needs	Final	Alan Laughland, Pathways Manager, Inclusive Edinburgh

7f	Carers	Final	Jacque Robertson, Planning and Commissioning Officer- Carers, City of Edinburgh Council Gordon Dodds, Planning and Commissioning Officer - Carers, City of Edinburgh Council.
7g	Palliative Care	Final	Peter McLoughlin, Strategic Programme Manager, Cancer, Diagnostics of Palliative Care
7h	Blood Borne Viruses	Draft (not ready to be circulated)	Colin Beck, Senior Manager Mental Health, Criminal Justice & Substance Misuse Mairi Simpson, Strategic Programme Manager - Drugs, Alcohol, Sexual Health & BBV
7f	Alcohol Related Brain Damage	Final	Pauline McKinnon, Pathways Manager (Criminal Justice, Substance Misuse), Health and Social Care, City of Edinburgh Council
7g	People with Multiple Long Term Conditions	Draft (not ready to be circulated)	Leonie Hunter, Senior Public Health Researcher, NHS Lothian
8	Spend on NHS and Social Care Services	Final	Mary Smyth, Best Value Officer, Health and Social Care, City of Edinburgh Council
9	Hospital Inpatient and Hospital Day Case Activity	Final	Yvonne Gannon, Research and Information Officer, Health and Social Care, City of Edinburgh Council
10	People at Risk of Emergency Admission to Hospital	Draft (not ready to be circulated)	Leonie Hunter, Senior Public Health Researcher, NHS Lothian
11	High Resource Individuals	Draft (not ready to be circulated)	Yvonne Gannon, Research and Information Officer, Health and Social Care, City of Edinburgh Council Leonie Hunter, Senior Public Health Researcher, NHS Lothian
12	Adult Social Care Activity Profile	Final	Catherine Stewart, Senior Performance and Information Officer, Health and Social Care, City of Edinburgh Council
13	Delayed Discharge	Final	Yvonne Gannon, Research and Information Officer, Health and Social Care, City of Edinburgh Council Philip Brown, Senior Research and Information Officer, Health and Social Care, City of Edinburgh Council

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