REPORT

Draft Strategic Plan and Formal Consultation Period

Edinburgh Integration Joint Board

17 June 2024

Executive Summary	The purpose of this report is to provide the Edinburgh Integration Joint Board with the draft strategic plan and seek support for formal public consultation which meets the standards for community engagement.

Recommendations	It is recommended that the Edinburgh Integration Joint Board 1. Agree that the draft strategic plan can be issued for public consultation 2. Agree that the formal public consultation will commence on 1 July 2024

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations	No direction required	✓
	Issue a direction to City of Edinburgh Council NHS Lothian	
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

Main Report

1. Edinburgh Integration Joint Board is required by statute to produce a Strategic Plan for health and social care within Edinburgh and to review the Strategic Plan every three years. The current Plan ran from 2019- 2022 and was therefore subject to review in order to have a revised Plan in place by April 2022.

2. The Plan has since been extended through to 2024, most recently to provide the new Chief Officer with time to fully understand the strategic direction of the Edinburgh Integration Joint Board and have confidence in the proposed strategic priorities.

3. The current draft builds on extensive dialogue (detailed in section 21) which began in May 2020 and was initiated to deliver on the commitment in the 2019-2022 strategic *plan "to develop a modern pact between providers and citizens by working alongside formal health and social care agencies, as well as other partners within our communities, to build genuine collaborations which support individuals and communities through co-production".* Two comprehensive reports with recommendations on the Edinburgh Wellbeing Pact detailing the formulation process and related activities were presented and approved by the EIJB in April 2021 and April 2022.

4. The draft strategic plan has a simple vision: **Edinburgh Health and Social Care Partnership, by focusing on people, places and pathways will support and enable people living in Edinburgh to have more good days.**

5. This simple vison statement derived for our co-production process communicates that our Strategic Plan looks beyond service provision to influence the wider social determinates and factors that improve population health and equity for everyone in Edinburgh.

6. The draft Plan proposes four priorities, that we believe are realistic, achievable, and informed by the findings of Joint Strategic Needs Assessments, Improvement Plans, and feedback from our extensive dialogue across the city:

    - **Wellbeing, Prevention and Early Intervention**
    - **Building resilient communities to maximise independence**
    - **Protecting our most vulnerable**
    - **Healthy and valued workforce and using our resources effectively**

7. All the activity which is proposed will be relevant to one or more of the four priorities and will contribute towards meeting the nine national health and wellbeing outcomes.

8. Our Joint Strategic Needs assessments, Integrated Impact Assessments and detailed population health data will ensure that we are reacting to different needs as they emerge. Our focus on people's narratives and experiences through collective advocacy, citizen participation and our new Ellipsis... narrative change programme will ensure that we are always learning and informed by people's experiences.

9. The strategy will inform a whole system planning and prioritisation approach that will identify short, medium, and longer-term phases of delivery over the next three years. This will be a dynamic process that may flex as we evaluate the impact and effectiveness of our actions in improving population health. Delivery plans will be developed, setting out what we intend to do year by year in delivering the aspirations of "More Good Days."

Strategic Priorities	✓	Key points within report that address strategic priorities
Prevention and Early Intervention	✓	The draft strategic plan sets out four new priorities. (See paragraph 6)
Tackling Inequalities	✓	
Person Centred Care	✓	
Managing our resources effectively	✓	
Making best use of capacity across the system	✓	
Right care, right place, right time	✓	

National Performance Indicators

Please note which national performance indicator your report aligns to			✓
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	✓	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.	✓
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.	✓	7. People who use health and social care services are safe from harm.	✓
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	✓	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.	✓
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	✓	9. Resources are used effectively and efficiently in the provision of health and social care services.	✓
5. Health and social care services contribute to reducing health inequalities.	✓	Not applicable	

Implications for Edinburgh Integration Joint Board

Financial

10. The EIJB is addressing significant financial challenges that all public services across Scotland are facing. The challenges over the lifespan of this Strategic Plan may impact

on our delivery of our strategic priorities and this will test our resilience. The risks that are being activity monitored and will be kept under scrutiny and review are:

- Budget pressures affecting preventative and early intervention approaches which lead to escalating demand for crisis services
- Increasing need and complexity of need
- Inability to meet statutory duties
- Inability to recruit, retain and develop a motivated, skilled, and future focused workforce
- Unmet need due to increasing demand and financial challenges.

11. One of the proposed new priorities - *Healthy and valued workforce and using our resources effectively refers to the requirement to build an economically sustainable future* - will be aligned to the Medium-Term Financial Plan.

Risk, legal, policy, compliance, governance, and community impact

12. The IJB is required to produce a Strategic Plan for health and social care services, and to direct the Council and Health Board to deliver those services as per the plan. Legislation prescribes that the plan be reviewed every three years. Completion of the review and publication of a revised Plan enables the IJB to meet its legal obligations. Without an approved Strategic Plan, the IJB will be in breach of its statutory duties.

Equality and Poverty Impact

13. The draft strategic plan was subject to an Integrated Impact Assessment on 4 June 2024 (Appendix 2). A further IIA will be completed following the consultation period informing completion of the final draft prior to this being submitted to the IJB in October 2024.

14. Easy Read and accessible versions of the draft Plan will be available on the HSCP website during consultation.

15. Addressing inequalities, protecting our most vulnerable which includes mitigating against the impact of poverty on health is woven throughout the strategic plan. This suggests a need for targeting of services to geographical areas of deprivation, but this can be stigmatising, and many people affected by inequalities do not live in these areas. A better alternative is to apply **'proportionate universalism'** whereby everyone has access, but with more service provision for populations with greater needs.

16. While Edinburgh IJB has overall responsibility for planning adult health and social care services within the city, it has to consider a variety of other national and local strategies, plans, policies, and legislation to ensure the work of the IJB and the HSCP is consistent with the work of City of Edinburgh Council, NHS Lothian and the national expectations and the priorities and plans put in place by our partners across the city.

17. We will support our key partners – City of Edinburgh Council and NHS Lothian to deliver on their strategic priorities. Our More Good Days approach will enable more

effective input to the City's Community Safety Plan, Children's Services Plan, Alcohol and Drug Partnership Strategy, Housing Emergency Action Plan and Thriving Green Spaces Plan, amplifying aspirations such as embedding the ethos of place making 20-minute neighbourhoods and community wealth building within our actions. We will also align our work with the NHS Lothian Strategic Development Framework to ensure connectivity across pathways for specific programmes of work.

Environment, climate, and sustainability impacts

18. Our ambition is to become an organisation that is environmentally, financially, and socially sustainable whilst delivering high quality, equitable services. Our approach to sustainability will encompass buildings and land, travel, goods and services, care, and communities.

Quality of care

19. The Strategic Plan sets our commitment to deliver safe and effective care, set against the challenges of rising demand and increasing patient expectations. We recognise our shared responsibility for ensuring services in Edinburgh are safe, of good quality and that we are all focused on continuous improvement. We will create the environment for a just culture of openness, transparency, and learning; where safety incidents are reported, reviewed, and learned from and timely improvements are made to continuously progress quality of care.

20. Quality improvement will be informed by people who receive services and frontline staff. We will listen to and involve people to find out what most matters to them and we will empower staff to do the right things for quality improvement. We will establish robust and consistent quality systems, using a quality assurance framework, supported by strong governance within organisations and across the whole system.

Consultation

21. The creation and formulation of the Edinburgh Wellbeing Pact involved robust and meaningful engagement, participation and consultation with Edinburgh citizens, and the workforce in the Health and Social Care Partnership, considerable dialogue with a wide range of stakeholders across the city. We have continued this engagement and participation approach as we developed subsequent drafts of the strategic plan. Table A summarises the engagement and coproduction process to date.

Table A: Summary of Coproduction Activities

Engagement activity	Description	Participants	Sessions held
Third Sector Forums	Voluntary sector forum meetings (From August 2020 onwards)	269	12
Community Interest Groups	Specific community of interest groups including participants from BAME communities, faith groups, and people with specific health conditions (From August 2020 onwards)	238	20
EHSCP Staff Groups	Focus groups with frontline staff and practitioners (From August 2020 onwards)	197	24
PhotoVoice	"Picturing Health" photography (June – July 2020)	115	1
Citizen Survey	Public survey through our HSC Website (June 2020)	355	1
Thought Leaders	23 in-depth interviews with city leaders from the 3rd sector, public sector, elected members, Board members, academia, and private sector (March - April 2020)	23	23
Public events	November 2020 - October 2023 • "The Art of the Possible" • "Anchoring our Thoughts" • "Wellbeing: The Power of our Communities • "On our Way: Formulation to Enactment" • "Checking In: Formulation to Enactment" • "Talking about Transition • "Accelerate" • "Seasons Change • Edinburgh Wellbeing Pact: "Check In" • Update event • Midsummer – Pause, Plan and Reflect • Capacity to Collaborate-Learning event • Prevention and Early Intervention -an opportunity for Edinburgh • Peering in and peering out – exploration of peer support	1,986	17
Summer Season	Events across communities of place, interest, and identity - Summer 2022	3,200	38
Draft Strategic Plan Stakeholder Sessions	Development Session 1 02.02.23 Development Session – 08.03.23	212	2
Draft Strategic Plan	Strategic Planning Committee – Workshop on 11.10.23 Strategic Planning Committee – Workshop 2 on 13.03.23 Wider Leadership Team – Presentation and Discussion - 11.04.23	18 14 14	3

22. The National Standards for Community Engagement are good practice principles designed to improve and guide the process of community engagement. There are seven standards, and these are included in appendix 3

23. Applying the standards in a consistent way will support a process of continuous improvement and earning through the 90-day period.

24. The approach we plan to take to the formal engagement process is multi-faceted and will include:

Survey: Online and paper survey using simple questions with free text input
Focus Groups: Representative groups of stakeholders invited to discuss their views in a small group setting. This will be target on specific themes or topic that emerge through the 90-day period.
One-on-one discussions with key stakeholders may be used to build a deeper understanding of specific concerns or perspectives
Meetings: Utilising current meetings and for a to allow stakeholders to ask questions and share their views
Events: Providing opportunity to communicate face-to-face with a larger group of stakeholders, allowing sharing key information and provide an opportunity to ask questions. We plan to use the city libraries and summer events as focal places.
Social Media: Stakeholders can follow the consultation on social media platforms to stay informed and share their thoughts via comment or message
Consultation Hub: website as a dedicated engagement hub, allowing stakeholders to view information and engagement opportunities in one place

25. A small team to lead on the consultation will be created comprising key EHSCP staff, our 3rd sector interface organisation (EVOC) and our independent sector advisor. It is key that we take this capacity building approach particularly as the consultation will take place through the summer period and peak holiday time.

Report Author

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Background reading / external references

Edinburgh Integration Joint Board Strategic Plan 2019-22

https://www.edinburghhsc.scot/wp-content/uploads/2020/01/Strategic-Plan-2019-2022-1.pdf

National Standards for Community Engagement

https://www.scdc.org.uk/what/national-standards

Appendices

Appendix 1	"More Good Days" – Our strategic plan for health and social care in Edinburgh 2024-2027
Appendix 2	Integrated Impact Assessment
Appendix 3	Community Engagement Standards

Edinburgh Integration Joint Board

More good days

Our strategic plan for health and social care in Edinburgh 2024-27

Contents

Foreword

We are pleased to introduce our new IJB Strategic Plan (2024-27) which seeks to reflect the challenges we anticipate in the coming years while remaining realistic about our ambitions given the significant financial challenges.

Much has happened since the publication of our last strategic plan in 2019. Our city has had to manage unprecedented challenges in facing a pandemic that impacted profoundly on the health and wellbeing of all our citizens. The effects of meeting the challenges posed by COVID-19 whilst felt by all citizens did exacerbate existing inequalities and further marginalised the most vulnerable in our communities.

Addressing these inequalities will remain a challenge and a focus for all of us during the life of this plan and we are committed to working across or communities of identity, interest, and place. For that reason, you will see a focus throughout this plan on the need to strengthen, empower and invest in the ability of those communities of interest, place, and identity to provide people with the supports they need at the right time and in the right place. However, there is also a requirement to redirect our resources as effectively and efficiently as possible to ensure the best outcomes are possible for those in greatest need.

Since the pandemic we have been faced by a cost-of-living crisis, a crisis in housing, reports from statutory bodies highlighting the pressures and gaps in our delivery of care to the city's most vulnerable populations and a financial crisis reverberating across our public services and institutions across Edinburgh, Scotland, and the UK.

We will not meet any of these challenges without people who work across services whether within the HSCP, voluntary or independent sector, to carers who give so much of themselves every day to their loved ones, to those who volunteer and neighbours who support one another in the everyday acts of kindness we see between people and communities.

During the pandemic, people mobilised in streets and localities responding in an agile and adaptative way. Kindness and courage mitigated some of the effects of the pandemic and it is that energy and spirit that we call upon now in this unpreceded financial climate.

We also continue to be amazed by staff across sectors on their ability to create, innovate and help people to see their strengths within themselves. That is why you will see that one of our new Partnership priorities is a thriving and future workforce, acknowledging our greatest asset is our people

At the beginning of Covid we deliberately began a dialogue with Edinburgh citizens asking what health and care meant to people. People spoke of how health is so much more than the absence of illness and that care needs to be kind and compassionate and there when you need it.

We have a vision for a healthier, happier, and fairer city, which will enable people, regardless of their health status, to have more good days. Good health and wellbeing come from all aspects of our lives; our homes and communities, education, employment, and environment and that is why partnership working is a must do if we want to create a healthier, happier, and fairer city for all.

Our primary ambition is to mitigate against the impact of poverty on people's health and reduce health inequalities which currently represent a fourteen-year gap in life expectancy between the most affluent and deprived communities in the city.

The key to achieving this ambition will be continuing to develop our relationship with the people of Edinburgh - harnessing our combined efforts to secure a better quality of life for all. Edinburgh has a distinctive identity and people are intensely proud of their city. We have made some good progress in moving from a paternalistic approach by listening and enabling people to determine what matters most to them at different life stages and experiences and how that is then reflected in our vibrant and responsive communities and our integrated health and social care system.

This draft strategy has been developed through collaboration and coproduction and that will continue as we move forward.

The last 12 months has seen the Integration Joint Board and the Health and Social Care Partnership put in place an ambitious improvement plan to address the significant concerns raised by the Care Commission affecting our most vulnerable citizens.

We have also had to address the significant financial challenges that all public services across Scotland are facing. The challenges over the lifespan of this Strategic Plan may impact on our delivery of our strategic priorities and this will test our resilience. The risks that are being activity monitored and will be kept under scrutiny and review are:

- Budget pressures affecting preventative and early intervention approaches which lead to escalating demand for crisis services
- Increasing need and complexity of need
- Inability to meet statutory duties
- Inability to recruit, retain and develop a motivated, skilled, and future focused workforce
- Unmet need due to increasing demand and financial challenges.

The strategy will inform a whole system planning and prioritisation approach that will identify short, medium, and longer-term phases of delivery over the next five years. This will be a dynamic process that may flex as we evaluate the impact and effectiveness of our actions in improving population health. Delivery plans will be developed, setting out what we intend to do year by year in delivering the aspirations of More Good Days.

Setting our budget is an important part of our strategic planning cycle to begin to implement the changes we need to make. To make the savings requires significant transformational and cultural change, in collaboration with colleagues and partners right across the health and social care system in the city.

We will invite our key partners to adapt their organisational strategies and align resources to come together to deliver at system level. We will also establish mechanisms to hold each other to account, as we need everyone to play their part.

We will continue with **Our More Good Days** dialogue to continue to check in and establish what's important and of value to individuals and communities. These insights will continue to inform future planning and prioritisation in delivering the ambitions contained in the strategy.

We will keep the Strategic Plan under review and make changes where necessary to ensure it is relevant to and reflective of the environment in which we operate.

By nurturing and supporting our staff, empowering communities, and working in partnership to develop innovative solutions to the challenges we all face, we will seek to ensure we continue to have a sustainable health and social care system in this city in the future.

Chair
Edinburgh Integration Joint Board

Chief Officer
Edinburgh Integration Joint Board

Our plan on a page

Change the conversation: change the culture

Thriving and future focused workforce

Partnership working to ensure sustainability

Our values
Kindness
Compassion
Courage
Creative
Inclusive
Inquiring

Supporting people in Edinburgh to have more good days

Our behaviours
Tackle inequalities
Share resources
Involve communities and share power
Invite challenge, take action
Focus on names not numbers
Spread, adopt, adapt, be open

Four priorities

1	2	3	4
Wellbeing, prevention and early intervention	Resilient communities to maximise independence	Protecting our most vulnerable	Healthy and valued workforce and using our resources effectively

Our delivery plans

Wellbeing, prevention and early intervention includes redesign of front door
One Edinburgh
Dementia delivery plan
Primary care improvement plan
Long term conditions plan
Older people's pathway programme
Thrive delivery plan including MH pathways

Workforce strategy
Data and digital strategy
Medium term financial plan

Intelligence and insight – data driven delivery and change

Talking to people and what they said

The commitment to create an Edinburgh offer was one of the key elements of the *Edinburgh Health and Social Care Partnership Strategic Plan 2019-2022*. The plan stated that the Edinburgh Offer would aim to reflect a modern pact between providers and citizens to prevent crisis and support people to manage their health and personal independence at home and be an explicit statement of intent and mutual expectations, with greater definition on the kind of contract the EIJB wished to have with our citizens.

The creation of the Pact was embarked upon during the coronavirus pandemic which posed unprecedented challenges to science, policy, and the interface between the two. The World Health Organisation recognised that how – and how quickly – policymakers, practitioners and researchers reacted to this emerging and complex crisis was making a profound difference to people's lives and livelihoods. The Scottish Government recognised as part of an initiated national conversation that the impact on Scotland has been profound. Internationally a debate has started on whether the adverse health effects of a recession may be greater than the increased morbidity and mortality within the pandemic itself and that the health impacts brought about by greater inequalities may themselves be significant over years to come.

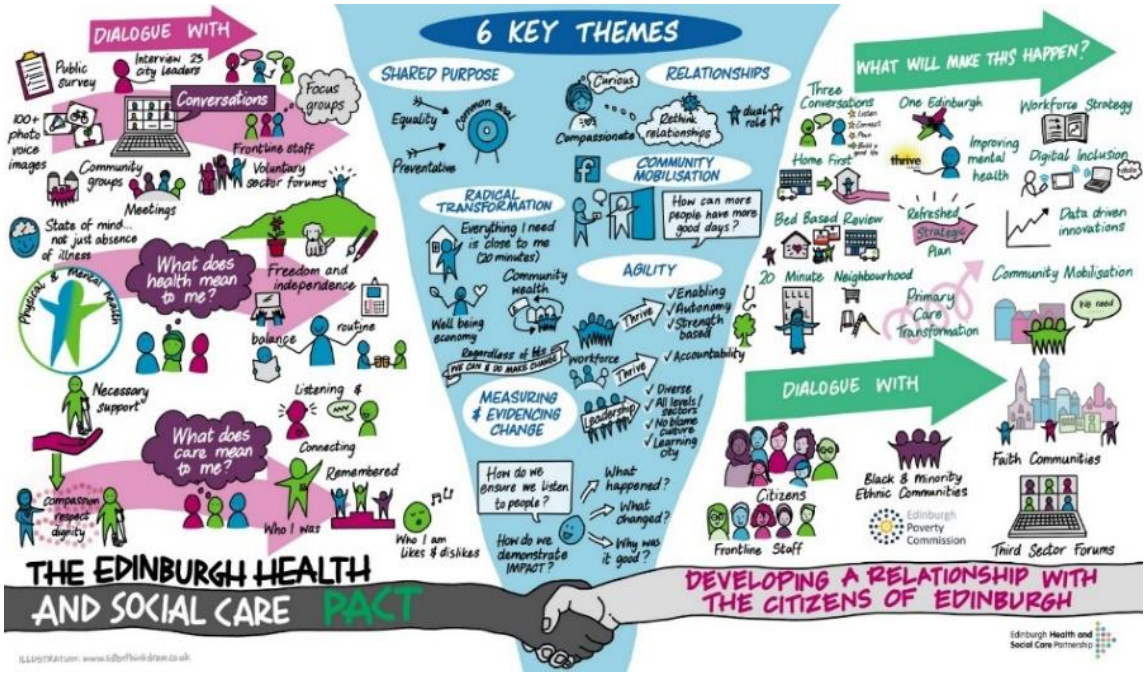
In Edinburgh, citizens, the voluntary sector, public services, academic institutions, and the private sector were collaborating and mobilising to support one another and ensure that those already pushed to the brink and who would be most affected by the pandemic received the help they needed. In Edinburgh with its well-established vibrant 3rd sector and connected public services we seemed to be experiencing a flourishing of relational kindness, connecting across difference and a recognition that some people's needs were greater because of structural disadvantage.

In June 2020, a dialogue with stakeholders beginning with two questions commenced: What does health mean to you? What does care mean to you? Interviews, focus groups and stakeholder workshops enabled the identification of 6 themes which recurred consistently.

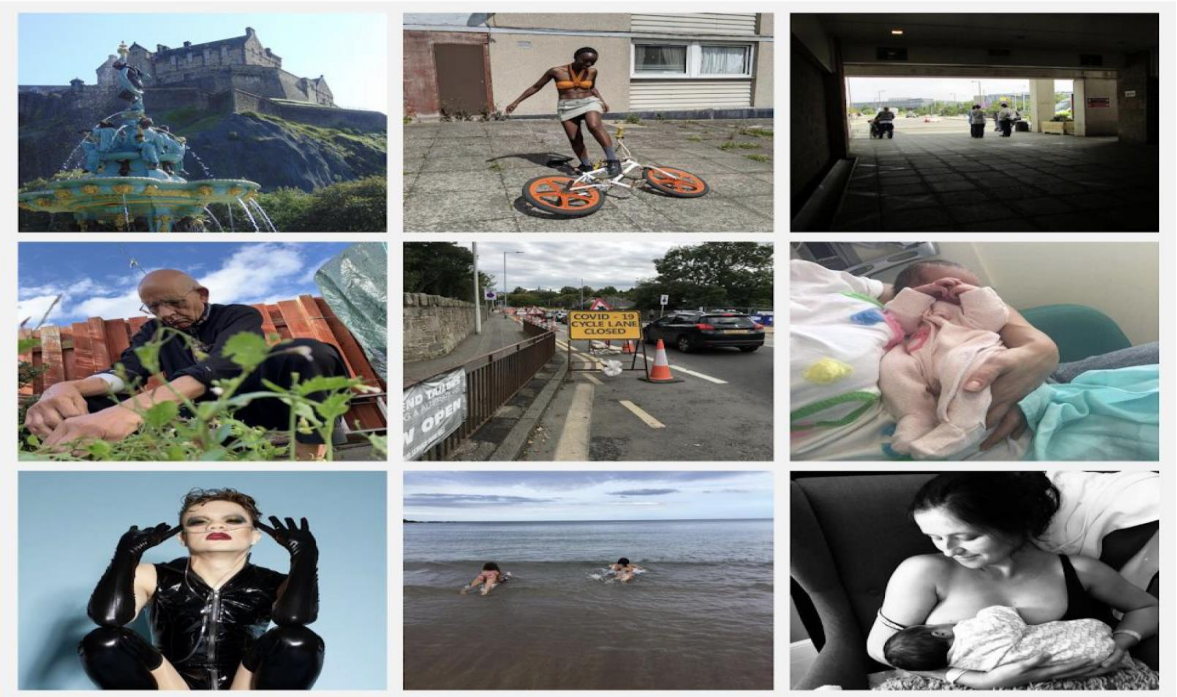
Shared purpose	Relationships	Agility
Radical transformation	Community mobilisation	Measuring change

People talked about heath as being more than the absence of illness but a state of mind you are conscious of; they spoke about being healthy as having the freedom and independence to do what you want to do; live how you want to live. They spoke of the importance of balance and in their life, of having regular routines and people spoke holistically about their physical and mental health rather than separating these two aspects of health. People talked about how it was essential that any care needs to be delivered with compassion, respect and dignity and the importance of being remembered and heard as a person not just set of symptoms or tasks but someone with likes and dislikes and an identity other than being solely one of being cared for.

There was recognition that we cannot experience wellbeing if we are powerless, dependent, and unable to contribute. Wellbeing is something we experience through our relationships with other people. Isolation and loneliness are the biggest threats to wellbeing and although our relationship with people paid to support us is important, much more important is our relationships with our family, friends, and neighbours. Therefore, our wellbeing-based system needs to interact constructively with households, families, and communities as well as with individuals.



“Picturing Health” was commissioned with our partner agency Media Education. Members of the public were invited to submit photographs of what health and care meant to them. 115 images were submitted, creating a rich tapestry of images and a permanent exhibition at Waverley Station with a view to provoking further conversations and interest in developing the Edinburgh Pact.



The combination of social, economic, environmental, cultural, and political conditions identified by individuals and their communities as essential for them to flourish and fulfil their potential led to us talking about a Wellbeing Pact with twin principles of reciprocity and mutuality. Focusing on wellbeing means we will not wait for crisis or emergencies, instead, we will, where possible act early, consistently build resilience and connections, focusing on what's important to people, what skills and attributes they have, the role of their family, friends, and communities and, given all this, what they need to enable them to live as well as possible.

A well-being system cannot be achieved without reorienting existing fragmented models of care towards one that rests on a strong primary health care foundation with an integrated community care component underpinned by the principle of people coproducing health. It requires investment in holistic and comprehensive care, including environments, systems and services that promote good health and wellbeing and prevent the development of illness. It further requires effective referral systems, flexible and multidisciplinary provider networks, and participatory monitoring and evaluation strategies.

We introduced a novel approach of recognizing that if we wanted to move away from competition to collaborative, we need to fund organisations to do this - our *Capacity to Collaborate* funding and conversations generated new solutions and relationship across and between 3rd and public sectors.

Alongside this, EHSCP was continuing to innovate and introduce new programmes such as Discharge without Delay, One Edinburgh, to transform our care at home provision, Three Conversations and Home First, all contributing to building a wellbeing system which focused on prevention and early intervention.

In more recent conversation and dialogue with stakeholders over the last three years people have been consistently talking about similar things:

- Everyday life has become harder for many with the effects of the cost-of-living crisis and what that means for food and fuel security, digital exclusion, housing, and employment security all contributing to poorer health and wellbeing
- People feeling that they have to tell their story several times and it is often only when things reach crisis point people get the support they need.
- Addressing our workforce challenges is the biggest barrier to improving the way we provide health and care for our communities.
- The failure to prevent illness or detecting it too late means that our health and care system is in a cycle of responding to crisis.
- Pressure on public finances and the precarious funding of the third sector
- Additional pressures and challenge faced by unpaid carers supporting their loved ones every day is a concern raised across the city.

We need to talk about the stuff of care itself and we need to start to unpick and reweave our systems in new ways. This is hard. It requires new stories, new ways of seeing and working, and new forms of data and accounting. The table below sets out the story we hear contrasting to the story we want to tell which the new strategy will support us to do.

Table 1: reframing the narrative

The story we hear	The story we want to tell
People being looked after by regulated personal care services with 'life and limb' support delivered by care staff (paternalism)	People of equal worth leading lives of value, that they choose to lead, as part of a reciprocal web of community-based support (mutuality)
Focused on the challenges faced by the 'sector' in delivering care as a service to people	Focused on people and communities benefiting from and contributing to a great health and social care system
Social care is a safety net	Social care is a springboard
People with needs	People with gifts and potential
Social care is in crisis and is broken and funding to maintain the status quo is the only answer	We have great ideas for how to better support people to lead good lives, which require a reformed approach
Plugging the gap/shoring up the system	Financial and environmental sustainability
National government is the only active agent and needs to fund care	Care and support are 'co-produced' and requires time

The story we hear	The story we want to tell
The growing social and financial cost to society of meeting demand for basic social care	The growing value to society of great support
Demand from older and disabled people for social care are a growing and irresolvable pressure on society's resources	By prioritising social care and reforming our approach we can all reap the dividend of living longer lives
Social care is for older, disabled people and vulnerable people	Everyone stands to benefit
People are divided into carers and cared for	Social care can support good, ordinary family relationships
Rooted in paternalism regarding those receiving or requiring support and fairness with respect to questions of funding	Rooted in social justice, equality, and rights

Understanding what we do and deliver

What is health and social care integration?

There is a piece of legislation called the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act). The Act requires Local Authorities (Councils) and Health Boards to integrate the planning of services and functions delivered to adults and older people as a minimum. In Edinburgh this includes community health and social care services provided to adults and older people. The Council and Health Board working together to do this is known as health and social care integration.

What services and functions are integrated in Edinburgh?

The services and functions covered by this Strategic Plan that are planned and delivered by Edinburgh HSCP across four localities and delivered by a range of partners and providers include:

The services we deliver and commission

- Carers Support Services to a subset of the 45,000 and 70,000 adult carers estimated in Edinburgh
- Social Care Assessment and other Social Work Services provided to around 10 - 12,000 people a year
- Care at Home services provided to around 8,000 adults and older people at some point in a year
- Technology Enabled Care provided to around 9 -10,000 people a year
- Around 2,000 people supported through learning disability services
- Dementia Services to support the estimated 8-9,000 people in Edinburgh with dementia
- Pharmaceutical Services
- District Nursing

- GP Services and enhanced primary care services delivered through 70+ GP practices
- Thrive Edinburgh – prevention, early intervention and care and treatment services
- Substance Use services
- Providing health interventions to people who are homeless
- Hospital at Home services
- Services to prevent admission to and support discharge from hospital, with about 5,000 discharges supported each year
- Around 3,500 people supported in care homes and nursing homes across each year
- Sight Loss rehabilitation, access and advice for sight loss, deaf equipment, and deaf social care
- Palliative Care Services

Collaborative working

- We work with our communities of place, identity, and interest to address loneliness and isolation, build connections and combat stigma and discrimination
- We are committed to collaborating with all partners to mitigate against the impact of poverty - this includes our commitment to income maximisation and welfare rights service - and to help the city achieve its' aspiration to end poverty in the city.
- We lead on the city's Suicide Prevention and Self Harm strategies and approaches
- We are working with our partners to mitigate against the housing crisis that was recently declared in the city
- We are part of the city's Alcohol and Drug Partnership providing a wide range of services and support for people
- we collaborate with our colleagues in Children and Families' services with a particular focus on transitions for young people and family-based support
- We are committed to collaborating with our partners in Community Justice and Safety to strengthen our commitment to addressing the health needs of people in our community justice system
- We work closely with our colleagues in acute hospitals and speciality health care services

What is the difference between the Health and Social Care Partnership and the Integration Joint Board?

In Edinburgh, NHS Lothian and City of Edinburgh Council integrated services as Edinburgh City Health and Social Care Partnership (often shortened to the HSCP). The HSCP is the staff from both organisations working in partnership to plan and deliver the services under the direction of the Integration Joint Board (IJB).

The IJB is the formal legal body that makes the decisions about how health and social care services are delivered in the city based on the Strategic Plan. The IJB then directs the City of Edinburgh Council and NHS Lothian to work together in partnership to deliver services. The membership of the IJB is partly defined in the legislation. You can find out more here

Why we have a Strategic Plan

The Act says that each Integration Joint Board in Scotland has to have a Strategic Plan that is reviewed every three years to make sure it is relevant to the needs of the area and the people who live there. The Plan covers health and social care services across the entire city.

Funding for delivery of health and social care services

This is made up of allocations from our two partner organisations, City of Edinburgh Council and NHS Lothian (the partners). Every year the partners provide funding allocations to the HSCP and the IJB is required to approve a balanced budget that details how those financial allocations will be used to deliver health and social care services to the people of the city. The budget needs to demonstrate to the IJB that there are sufficient resources within the budget to deliver services and achieve the strategic priorities of the IJB, which are outlined later in this Strategic Plan. Given the scale of the financial challenges set out in our Medium-Term Financial Savings Plan (MTFS) we must acknowledge that services will be delivered differently because of funding arrangements which are not commensurate with projected growth and demand.

Achieving a balanced budget can involve making some tough decisions about how to prioritise the funding available. Sometimes this means things the IJB would like to do cannot be done, have to be delayed or have to be reduced in their scale.

The IJB's budget for 2024-25 was approved in March 2024 and you can read the report on our website.

The budget report outlined the scale of the financial challenges facing the IJB for the first year of the Strategic Plan (2024-25) and which are expected to continue for the duration of the Plan. The funding allocations from the partners and anticipated funds from the Scottish Government combined resulted in a funding gap of just over £60 million pounds. What this means is that in order to deliver a balanced budget for the IJB, options were required to be presented to fill that gap. Unfortunately, this meant

reducing certain types of services to identify savings that would enable the IJB to deliver health and social care within the funding available.

Reducing services is not something that the IJB ever takes lightly because of the impact this has on people using these services. However due to financial challenges and pressures, this is sometimes unavoidable. We also need to acknowledge that sometimes we have provided too much care, and this has had a negative impact on supporting people's rehabilitation and maximising independence.

The proposed financial savings plans were considered and debated carefully and comprehensively by the IJB before finally being approved on 19 March 2024. Approving a budget that includes reductions in certain services and the use of reserves carries with it a degree of risk. The task for the IJB and HSCP is to identify, minimise and mitigate risk wherever possible. It is important to be honest and transparent about the risks the financial challenges, and the savings plan in place to address those challenges, will bring to the IJB and the impact that might have on the delivery of the Strategic Plan and our Partnership Priorities.

Approving the budget is not the end of the process though. The hard work now begins to implement the savings approved and working to put in place the structures and cultures that are required to deliver health and social care in ways that focus much more on prevention and early intervention. We have strengthened our governance arrangements and are making significant progress on financial grip and control including improvements that are necessary to administer better financial contributions from service users.

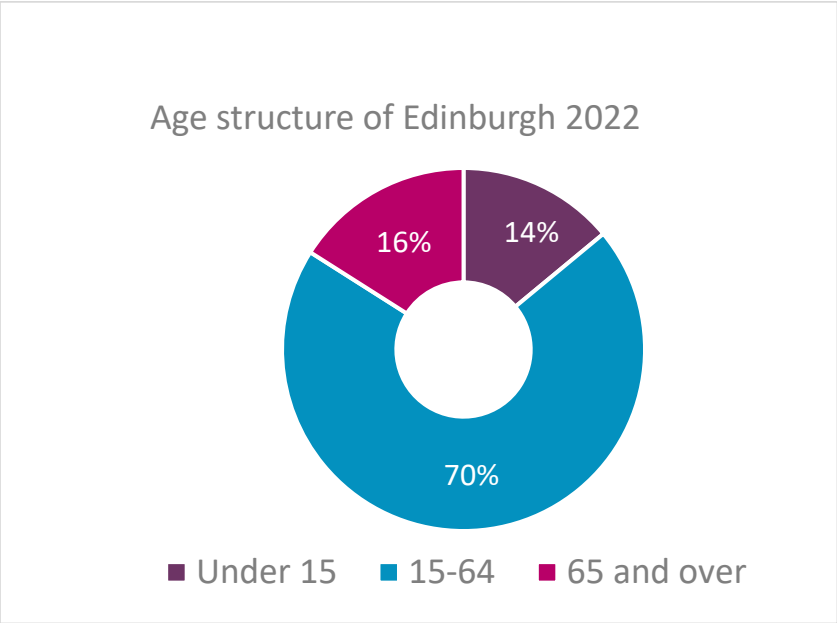
We will actively manage risks and mitigation which will be kept under constant review during the life of this Plan. These risks include:

- budget pressures may affect how we embed prevention and early intervention across our services
- increasing need and increasing complexity of need leading to more demand with decreasing finance
- unable to meet all our statutory obligations
- failure to deliver services and support generating additional pressures elsewhere
- inability to recruit, retain and develop an appropriately skilled and motivated workforce
- unable to respond appropriately to new demands or unexpected external pressures
- ability to deliver a balanced budget.

We believe that transformational change is required, and our More Good Days Strategy focuses on the positive and transformative actions that the health and care system will take together and with the people of Edinburgh to improve population health and reduce health inequalities.

There is a multitude of health data which demonstrate the challenges, these are set out in the Joint Strategic Needs assessments that have been completed for the city. Key facts about our city are set out below:

- The population of Edinburgh in 2022 was 512,700. 16% of the population of Edinburgh are 65+.

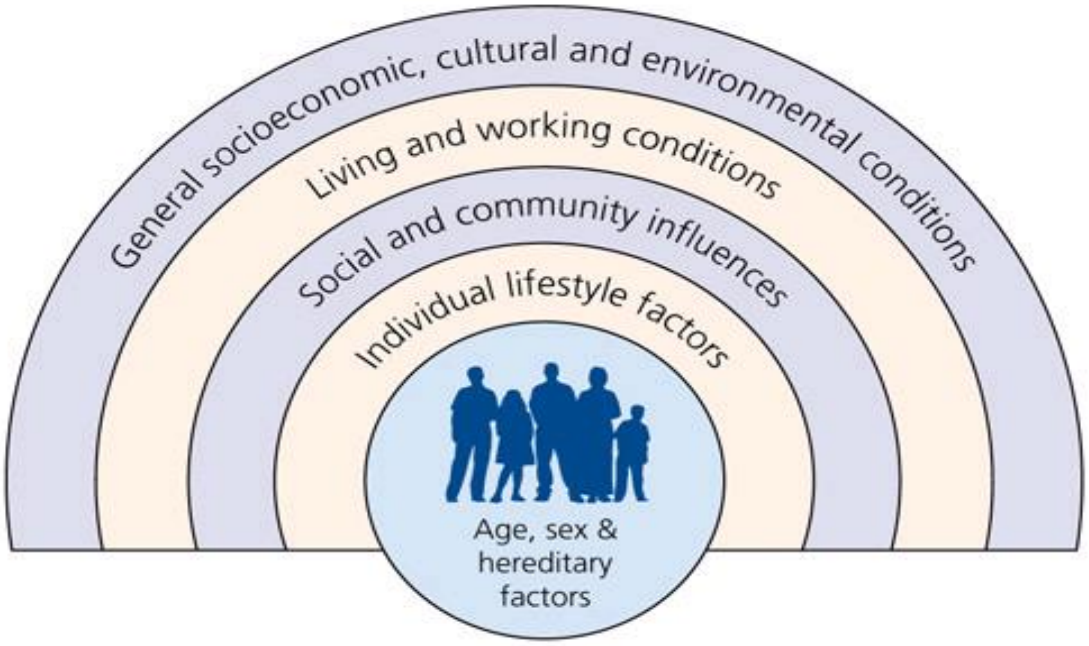


- Scotland's population is projected to continue to increase until around mid-2033 peaking at 5.53m then projected to fall by 0.6% to 5.49m by mid-2045. Scotland's population is projected to age, with over 65s to grow by nearly a third by mid-2045, with children and people aged16-64 projected to fall (20% and 3% respectively).
- But the overall population of Edinburgh is expected to grow by 7.7% between 2018 and 2030.
- Each of the older population age groups in Edinburgh and Scotland are expected to grow by at least a fifth.
- The largest growth is expected in the North East locality.
- Just over 2 in 5 people (43.5%) in Edinburgh live in the 20% least deprived areas of Scotland.
- Over half of the population in both North West and South East live in the 20% least deprived datazones in Scotland.
- North East has the highest proportion living in the most deprived datazones.
- Two fifths of households in Edinburgh are single person households.
- Biological, social, and environmental determinants interact to influence people's health and wellbeing.

Measures of health must consider age, gender, geography, socio economic position, occupation, education, and other determinants to capture the full range of health needs – and differences — across the population.

Health inequalities cannot be attributed to a single clinical or behavioural risk factor. Biological, social, and environmental determinants interact to influence people's health and wellbeing. Health will improve if people are supported to be physically active, eat and drink healthily and not smoke. However, these behaviours are significantly shaped by social circumstances such as income, housing, education, employment, spatial planning, and transport all of which impact on people's ability to exercise healthy choices.

Figure 2: Dahlgren and Whitehead: the social determinants of health[1]

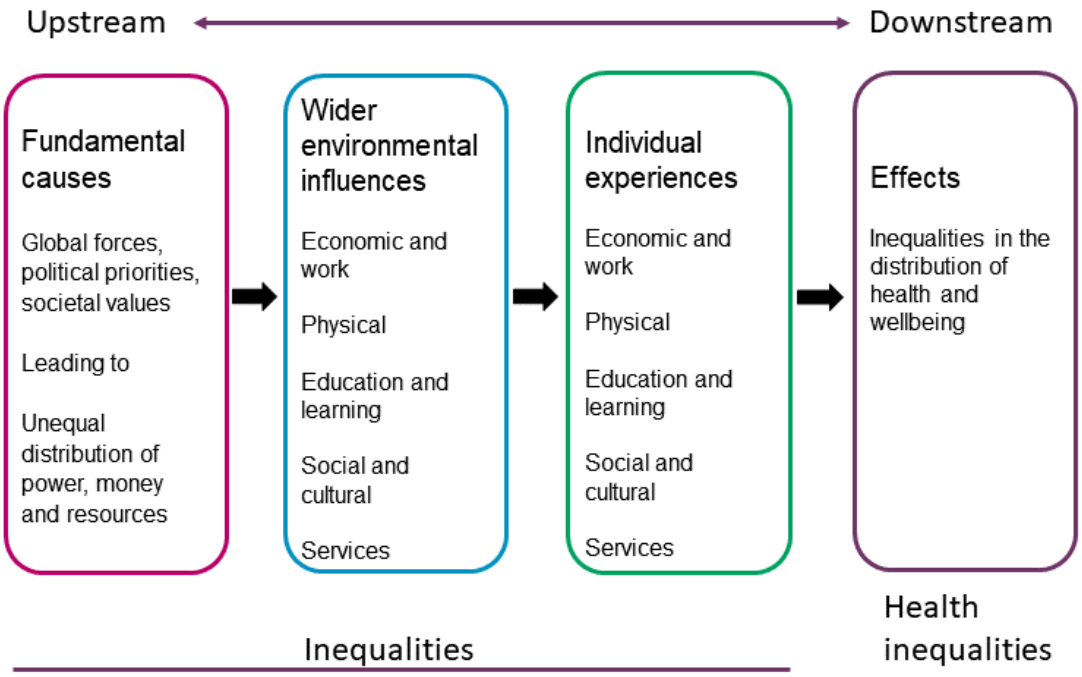


Loneliness and isolation and widening social inequalities are placing increased pressures on primary care and 3rd sector services. There is evidence of increasing numbers of people seeking support for mental health issues, much of which is associated with loneliness, isolation, and distress due to money, employability, and housing worries. Mental ill health is a more common problem for people living in more deprived communities. As people live longer, they live with chronic conditions. People with multiple health concerns and illnesses will become the norm for the Edinburgh population.

Inequalities develop over a life course as the result of systematic, unfair differences in the health of the population that occur across social classes or population groups. The fundamental causes of health inequalities such as power and wealth affect the distribution of wider environmental influences such as the availability of jobs, good quality housing, education and learning opportunities, access to services, social status.

[1] https://www.health.org.uk/evidence-hub

Figure 3: Fundamental causes of health inequalities



Edinburgh is more affluent than other parts of Lothian and its population has better health. But health inequalities in Edinburgh remain a concern, with those in the most deprived areas experiencing significantly poorer health outcome that those in less deprived areas[2].

This suggests a need for targeting of services to geographical areas of deprivation, but this can be stigmatising, and many people affected by inequalities do not live in these areas. A better alternative is to apply 'proportionate universalism' whereby everyone has access, but with more service provision for populations with greater needs.

[2] ScotPHO profiles (shinyapps.io)

Local and national influences

We are aware that we live in a policy rich landscape, and we need to be able to respond in an agile way to changing priorities and focus. Local implementation of national strategies for mental health, dementia, learning disabilities, cardiovascular disease, diabetes, chronic obstructive pulmonary disease **(**COPD), and cancer will all benefit from a planned approach for population health management, which segments the diverse and multiple needs of different population groups and responds with joined up, personalised approaches across prevention, early intervention, assessment, treatment, and care.

While Edinburgh IJB has overall responsibility for planning adult health and social care services within the city, it has to consider a variety of other national and local strategies, plans, policies, and legislation to ensure the work of the IJB is consistent with the work of City of Edinburgh Council and NHS Lothian and the national expectations and the priorities and plans put in place by our partners across the city.

We will support our key partners – City of Edinburgh Council and NHS Lothian to deliver on their strategic priorities. Our More Good Days approach will enable more effective input to the City's Community Safety Plan, Children's Services Plan, Alcohol and Drug Partnership Strategy, Housing Emergency Action Plan and Thriving Green Spaces Plan, amplifying aspirations such as embedding the ethos of place making 20-minute neighbourhoods and community wealth building within our actions. We will also align our work with the NHS Lothian Strategic Development Framework to ensure connectivity across pathways for specific programmes of work.

In Scotland, in partnership with other Wellbeing Economy Governments around the world, including Iceland, Finland, Wales, and New Zealand, policies are focussed on building a wellbeing economy which prioritise human, social, planetary, and economic wellbeing, which constitute the wellbeing "capitals." These include important assets such as trust, social cohesion, participation, environmental sustainability, and quality employment, which are crucial for developing healthy, fairer, and prosperous societies where people can thrive.

Promoting population wellbeing is key to reducing the burden on health systems, to enable sustainable and resilient health care. This cannot be achieved in silos and requires many sectors of our society working together to support each other. The move to create a wellbeing economy should help ensure economic policies contribute to achieving health and social outcomes in an equitable way. EIJB can play an important part in this by commissioning appropriate, high-quality health services to populations with the poorest health, making full use of its potential working with anchor institutions, and with partners to help address the underlying fundamental causes.

Some (but not all) of the key local and national influences are detailed below.

National legislation

- Public Bodies (Scotland) Act 2014
- Carers (Scotland) Act 2016
- Community Empowerment (Scotland) Act 2015
- The Equalities Act 2010
- Fairer Scotland Duty
- National Care Service (Scotland) Bill
- Social Care (Self-directed support) (Scotland) Act 2013
- The Mental Health (Care and Treatment) (Scotland) Act 2003
- Adults with Incapacity Act (Scotland) 2000
- Review of Mental Health Law in Scotland 2020
- Child Poverty Act

National polices and strategies

- Scotland's Digital and Health Strategy
- Independent Care Review (the Promise)
- Primary Care Improvement Programme Scottish Government
- Public Health Scotland's Public Health Approach to Prevention and the role of NHS Scotland
- NHS Scotland Climate Emergency and Sustainability Strategy
- Ending Homelessness 2040
- National Mental Health and Wellbeing Strategy 2022
- Dementia in Scotland Everyone's Story – Scotland's National Dementia Strategy 2023-33 and associated National Delivery Plan 2024-2026
- Tackling food insecurity - Scottish Government's 'Cash-First - towards ending the need for food banks in Scotland: plan' (2023)
- A Connected Scotland: our strategy for tackling social isolation and loneliness and building stronger social connections' (2018)
- See Hear Strategy, meeting the needs of people with a sensory impairment (2014, refreshed version to be published 2025)

National frameworks and standards

- Health and social care standards
- Planning with People Community Engagement Guidance
- National Health and Well-being outcomes
- Medication Assisted Treatment (MAT) standards

Local strategies and plans

- NHS Lothian Strategic Development Framework
- Primary Care Improvement Plan
- Edinburgh City Plan 2030[3]
- City of Edinburgh Business Plan
- City Vision 2050
- Edinburgh IJB Workforce Strategy
- Edinburgh IJB Data and Digital Strategy (in development)
- Edinburgh Poverty Commission's 'A Just Capital - Actions to End Poverty in Edinburgh' 2020
- Edinburgh Partnership Community Plan 2022-28 (commonly referred to as the LOIP)
- Edinburgh Partnership Learning and Development Plan 2024
- City of Edinburgh Council BSL Plan 2024-30

During the term of this Plan there will be many more strategies, plans and programmes of work that emerge. Some of these will be in response to local issues and priorities, some in response to national bodies such as the Mental Welfare Commission or Care Inspectorate and others will be in response to national priorities and expectations. Given the financial challenges we must remain focused on the impact of any new policy and/or legislative changes and assert a strong position where we believe this could have a detrimental effect on service delivery and our commitment to core statutory responsibilities and protecting our most vulnerable.

One major development through the life course of this plan will be the development and implementation of a **National Care Service.** The Scottish Government has begun a coproduction process to establish a National Care Service which would be one of the most ambitious reforms of public services since the creation of the National Health Service. It is necessary to deliver the consistency and quality of care and support across Scotland that people deserve and reinforces the commitment to Scotland's people to take long term action to change society and make it a fairer and more equal place to live.

The aims of the National Care Service are to deliver a care system that is genuinely accountable to people; promotes best value across care and support by driving up quality; embeds human rights-based approach; recognises the breadth of value in the workforce; develops preventative strategies and avoids crisis interventions; smooths artificial transitions; builds strong and resilient communities; and supports

localism and partnership. The development of the National Care Service will ensure that the social care and social work workforce are valued along with the healthcare workforce. The role of unpaid carers, including young carers must also be recognised for the essential contribution they make to the lives of others and also the economy. Throughout the National Care Service development, there is a commitment to work together with people with experience in accessing and providing community health and social care support and those who deliver social work and community healthcare and unpaid carers, including young carers.

The IJB will review how our activity complements and contributes to other relevant strategies and plans against a context of increasing cost of living and the increasing budgetary pressures being felt across the public sector paying particular attention to Edinburgh specific issues such as the Housing Crisis and the consequential impact of positive asylum-seeking decisions on core services.

The EIJB will continue to work with our key stakeholders and people with lived experience to plan, design and deliver these priorities and will share details of future work, including opportunities to get involved, on our website.

Understanding our population

There are wide and growing inequalities in Edinburgh with the most deprived areas having 7% lower life expectancy than the City of Edinburgh as a whole and for males a 9-year difference between SIMD 1 and SIMS 5. Mortality and morbidity especially early mortality, increase with greater deprivation.

Early mortality rates are the number of deaths of people under 75 years observed over a specified time period; in effect, this subset of the overall death rate captures unfulfilled life expectancy. The Edinburgh premature mortality rate is consistently lower than the Scotland rate from 2009 to 2019. There has been a greater decline in the premature mortality rate in the most deprived communities, but the rate remains almost three times higher than seen in least deprived communities.

There is, however, significant inequality in mortality rates between people living in the most and least deprived areas in the city, with people living in the most deprived communities are dying at almost double the rate of people in the least deprived communities.

A significant component of early mortality are deaths associated with conditions such as poor mental health, and alcohol and drug use. These deaths can be more likely to affect people who fall under an inclusion health definition or who hold protected characteristics under the Equality Act' socially excluded populations, including the homeless, people with substance use disorders, sex workers, and prisoners.

Drug related deaths are a particular concern in Scotland. The most recent data relate to 2022. Drug related deaths in Edinburgh continue to rise, with an increase from 118 deaths in 2021 to 121 deaths in 2022. These deaths are concentrated in the 35-54 age group and more common among males than females. The drug related death rate (age standardised death rate per 100,000 people) for the City of Edinburgh (2018-2022) was 19.6, lower than the Scottish rate at 23.4 deaths per 100, There is a clear link to deprivation. Multiple drug use is an increasingly common cause of death, but this population also experiences a wide range of chronic health conditions which will also contribute to early mortality. Deaths in these populations are driven by wider social determinants of health

Harm from alcohol use is also a significant concern within Edinburgh. Alcohol use can lead to a range of short and longer-term health harms, for individuals, families, and communities. Short-term problems such as intoxication can lead to risk of unintentional injury as well as being associated with violence and social disorder. Over the longer term, excessive consumption can cause irreversible damage to parts of the body such as the liver and brain. Alcohol can also lead to mental health problems, for example, alcohol dependency and increased risk of suicide. In addition, alcohol is recognised as a contributory factor in many other diseases including cancer, stroke, and heart disease. The most deprived areas in Edinburgh have the highest rates of alcohol-specific deaths. Alcohol-specific deaths across the city would be 55% lower if the levels of the least deprived areas were experienced across the whole population.

We need to pay particular attention and focus our efforts on people who are at risk of experiencing multiple disadvantages as well as socially excluded populations. The coproduction works now underway on the city's Alcohol and Drug Partnership Strategy and the refresh of Thrive Edinburgh's commissioning and delivery plan and our renewed focus on health and homelessness will enable us to better connect and streamline our responses for this population group.

The Scottish Government recently published the Creating Hope Together – Suicide Prevention Strategy and EHSCP has been leading work with our partners to develop and deliver a comprehensive action plan to deliver on this national suicide prevention strategy.

To seek to address the difference in life expectancy between the wealthier and poorer population we need a particular focus on population groups and the parts of our city that have the worst health outcomes. This aspiration will be evidenced through reductions in the premature mortality rates of our city's biggest killers - cancer, circulatory and respiratory disease, which account for almost 7 out of 10 early deaths.

Joint Strategic Needs Assessments (JSNAs) which draw on local and national data sets enables us to have a greater understanding of Edinburgh's population health which in turn will enable us to target initiatives and programmes for those most at risk of developing health conditions or whose lives are being greater impacted by poor health due to protected characteristics, impact of social determinates of health and access to resources to mitigate the impact of these.

Social factors that contribute to health care needs for people from black and ethnic minority populations include racism and hate crime, social isolation and low income and unemployment. Evidence and research emphasise the need for staff training including cultural sensitivity, recognition of the role of the Third Sector in supporting people from ethnic minority communities, effective community engagement and the importance of effective approaches to prevention including overcoming isolation.

Poverty is a significant contributor to poor health and health inequalities. The latest available data shows that an estimated 17% of people in Edinburgh were living in poverty in the period to 2022, including 20% of all children. In line with national patterns these data indicate that poverty rates have remained relatively unchanged in recent years, despite the impact of the pandemic and the early months of the cost

of living crisis in 2022. Within the health and care system it is recognised that people's income problems can impact the health and care system by resulting in delayed discharges, inappropriate use of clinical staff time, and increased recovery period and risk of readmission. Provision of, and referral to, income maximisation services results in increased financial gain for people, which can in turn improve health and wellbeing reduce impact on services.

Smoking is one of the leading causes of preventative illness and premature death. It causes significant harm to individuals, families, the NHS, and the economy. Smoking prevalence is significantly patterned by socioeconomic position and is a significant contributor to health inequalities. Referrals by health professionals of people who actively want to stop smoking have high chances of a successful quit, so ensuring pathways to smoking cessation are clear and effective is essential. Smoking rates have fallen nationally Edinburgh is one of the local areas that are most behind on meeting the national target to support smokers living in the most deprived 40% of SIMD to quit, so this is a huge priority from public health perspective.

Cardiovascular disease, type 2 diabetes, and obesity - Cardiovascular disease caused the greatest burden of disease in NHS Lothian and across Scotland in the Scottish Burden of Disease study, 2019. Type 2 diabetes is affecting an increasing number of individuals, families, and communities because of increasing levels of obesity and an ageing population. Prevention has a key role in tackling the health burden from cardiovascular disease type 2 diabetes and opportunities to strengthen preventative action across care pathways for these diseases should be explored, Obesity, the main modifiable risk factor for type 2 diabetes, is a complex issue and is rooted in inequalities. Population-level approaches, including action to address socio-economic and environmental factors, are required to disrupt the current upward trajectory for both obesity and type 2 diabetes.

Immunisation is the most cost-effective intervention for saving lives and improving the health of the population. Immunisations help protect the population against serious vaccine preventable illness. Concerted effort is required to improve, and reduce inequalities in uptake of vaccinations, using the learning from our Covid 19 programmes.

Screening - National screening programmes are evidence based and can identify individuals who may be at future risk of a particular medical condition or disease or detect early indications of disease or conditions with the aim of intervening to reduce their risk. Screening uptake needs to be maximised across all population groups to ensure programmes are effective and efficient, and to maximise population health gain.

Falls prevention - Falls are estimated to cost the NHS more than £2.3bn per year. Morbidity from hip fracture contributes to the demand on health and social care services. Given the ageing population, this burden is likely to increase further over the coming years. Implementation of evidence-based interventions which are effective in preventing and reducing future risk of falls is progressing well.

Working together, we will identify individuals and groups that without intervention will go on to become unwell. This means working in a different, but much more effective way. We will use population health management approaches, using data and local

insight, to identify “at risk” individuals and groups. In any population, a relatively small number of people account for a disproportionately large use of healthcare services. We will prioritise these population segments for prevention, early intervention, and care in Edinburgh across the life course: Managing population health in this way will enable partners to focus on preventing illness upstream, to address a mounting affordability gap and tackle poor health outcomes.

As part of a wider Health and Social Care system, Edinburgh will work towards:

- reducing premature cancer deaths
- reducing premature circulatory disease deaths
- stabilising premature respiratory disease mortality
- reducing deaths from alcohol and drugs
- reducing deaths by suicide.

We acknowledge transformational change work is challenging, time consuming and difficult. Redesign does not start within the current system. It starts with this very different understanding of the role care plays within human and natural world systems. This in turn provides the different principles that can guide and govern the creation of those new systems. professionals – the ones who know – and the reliance on data and indicators, which officially tell us what is happening – whether the home is clean, and the residents are ‘cared’ for, but in fact exclude most what we want to know: how people are feeling, the quality of human interactions, the balance of power between those in need of support and those paid to offer support. Our performance framework will pay attention to these key aspects.

Our vision, behaviours, and priorities

Edinburgh Health and Social Care Partnership, by focusing on people, places and pathways will support and enable people living in Edinburgh to have more good days.

This simple statement clearly communicates that our Strategic Plan looks beyond service provision to influence the wider social determinates and factors that improve population health and equity for everyone in Edinburgh.

We will achieve our vision by:

- Recruiting, developing, and retaining a competent, confident, and valued workforce
- Working with our partners to create stronger communities that build on people's strengths and support them the way they want to be supported
- Adopting a life course approach
- Making full use of the city's rich and diverse community assets.
- Broadening and deepening our partnerships with the voluntary and community sector, private and academic sectors
- Improving access to services and supports throughout the community for people who need them and are available when they need them most
- Talking to people about what they need to have more good days, and about how we can support them to achieve these
- Enabling people to take control of their health and wellbeing
- Focussing on prevention and early intervention to achieve health improvement and reduce health inequalities
- Understanding and addressing the impact that financial challenges and poverty (including fuel and food poverty) have on people's health and well-being
- Responding to all of a person's assessed needs - physical, psychological, and social

- Simplify our complex system so people receive the right care in the right place at the right time
- Embedding quality and safety in everything we do
- Ensuring equity across physical and mental health
- Breaking down and removing the barriers to integrated care
- Ensuring equal access to supports by valuing diversity and inclusion when designing services
- Working in partnership with housing partners to reduce the impact of low quality or inadequate access to housing
- Maximising the value of the Edinburgh Health and Social Care pound, in line with an Anchor Institutions approach
- Making strong connections to the city's vision and regional deal
- Striving for innovation and trying new things, even if they are difficult and untested, including making the most of technology
- Evaluating new and existing systems and services to ensure they are delivering the vision and priorities and meeting the needs of communities
- Using clearly defined and transparent performance monitoring to ensure continuous improvement and accountability
- Focussing decisions and taking innovative approaches based on evidence of what works, the desired outcomes of individuals and risk accepted and managed rather than avoided, where this is in the best interests of the individual

Our behaviours - how we will work together:

- **Understand and tackle inequalities -** Act at individual, team, organisation, and system levels, informed by data, to understand and tackle inequalities.
- **Share risk and resources -** Set out our expectations of each other, share data effectively, support joint working with shared resource and create a culture of collaboration. This must happen at every level and in every place.
- **Involve communities and share power -** Consistently take a strengths-based approach with co- design, co-production and lived experience as fundamental ingredients.
- **Spread, adopt, adapt -** Share best practice effectively, test, learn and celebrate success, with supportive governance and resources. Adapt and implement best practice locally, in organisations and across systems.
- **Be open, invite challenge, take action -** Be open, honest, consistent, and respectful in working with each other. Work on the boundaries and differences that we have in a constructive way, to support effective change.
- **Names not numbers** - Ensure we all listen to people, putting them at the centre, and personalising their care. This will involve rapidly increasing the level of integrated neighbourhood and locality working that connects all partners and communities who can contribute to improving health and tackling inequalities.

This will move us to a stronger model of collaboration, ensuring more consistent and standardised responses to systemic challenges.

To ensure we play our part in delivering our shared vision we will capitalise on both:

- The connection with neighbourhoods and communities that locality working offers – to integrate health and care with wider public services and tackle the root causes of poor health
- The scale that our integrated partnership organisation offers – to drive consistent improvement, reduce unwarranted variation and make the best use of our collective resources.

Partnership priorities

We have identified four Partnership Priorities for Edinburgh IJB / HSCP and its partners in delivering health and social care in Edinburgh which we believe are realistic, achievable, and informed by the findings of our JSNA and feedback from our extensive dialogue across the city:

- wellbeing, prevention, and early intervention
- building resilient communities to maximise independence
- protecting our most vulnerable
- healthy and valued workforce and using our resources effectively.

To achieve the priorities of the IJB and its partners a range of activity is planned or underway. During the life of the Strategic Plan there will be further activity that emerges which the HSCP will deliver with its partners.

All the activity which is progressed will be relevant to one or more of the Partnership Priorities and will contribute towards meeting the 9 national health and wellbeing outcomes.

Our Joint Strategic Needs assessments and detailed population health data will ensure that we are reacting to different needs as they emerge. We will continue to listen and discuss with people what is important to them. Our focus on people's narratives and experiences through collective advocacy, citizen participation and our new **Ellipsis** narrative change programme will ensure that we are always learning and being informed by people's experiences.

Priority 1 – wellbeing, prevention, and early intervention

Improving wellbeing is not about the design of a great health and social care system that patches up the gaps where real life should be. It is about turning this thinking on its head. We must think first how to create the conditions for more good days which means the ability to support and care for one another, across the life span

The state of health in the city, and the fact that many of our outcomes are deteriorating rather than improving, has galvanised the health and care system to come together around a shared vision for better health, working in partnership with the people of Edinburgh and applying **three approaches to prevention** across our communities and formal systems of care and support.

What do we mean by prevention - It is important that we have a common understanding and consistency of approach to prevention. True prevention should run all the way through every contact in whatever form it takes. From people using universal services and community groups, to an initial request for information and advice, to assessment, care and support planning, and reviews, and beyond to strategic plans and service development.

Prevention isn't a standalone principle, but one which links closely with wellbeing, empowerment, and partnership. It should be an ongoing consideration, rather than something that happens only once before people develop more significant needs. The duty to prevent needs from developing or increasing is distinct from the duty to meet eligible needs. The responsibility applies to all adults:

- Those with no care and support needs
- Those with care and support needs, whether those needs are eligible or met by the local authority
- Carers, including those about to take on a caring role, those with no need for support and those whose support needs are not met by the local authority.
- Young carers may have some distinct and different needs from adult carers

Prevent – primary prevention/promoting wellbeing
This approach should be applied to everyone, encompassing a range of services, facilities and resources that will help avoid the need for care and support developing. It could include information and advice, promoting financial wellbeing, and healthy and active lifestyles, reducing loneliness and isolation as well as promoting uptake of preventative and early detection opportunities such as vaccination and screening.

Reduce – secondary prevention/early intervention
This approach is targeted at people at risk of developing needs where support may slow this process or prevent other needs from developing. It could include smoking cessation, cardiovascular and type 2 diabetes care pathways, carer support, falls prevention, housing adaptations or support to manage money.

Delay – tertiary prevention/formal intervention
The third approach is aimed at people with established complex health conditions, to minimise the effects, support them to regain skills and to reduce their needs wherever possible. This could include rehabilitation/reablement services, meeting a person's needs at home, and providing respite care, peer support, emotional support, and stress management for care.

The different approaches with robust evidence are[4]:

Advice and guidance: promoting self-management and behaviour change

Physical activity promotion: there is strong evidence of the impact of promoting exercise and movement, and the role of social care in this work should be further explored.

Social prescribing: growing evidence base for assessing their effectiveness.

Reablement: there is evidence to support that reablement improves health-related quality of life and improved service outcomes.

Asset-based approaches: the complexity of this approach makes forming conclusions from the different types of evidence difficult, but there is potential in developing this approach and our knowledge on the role and impact of health and social care.

Strengths-based models of practice (such as Three Conversations)

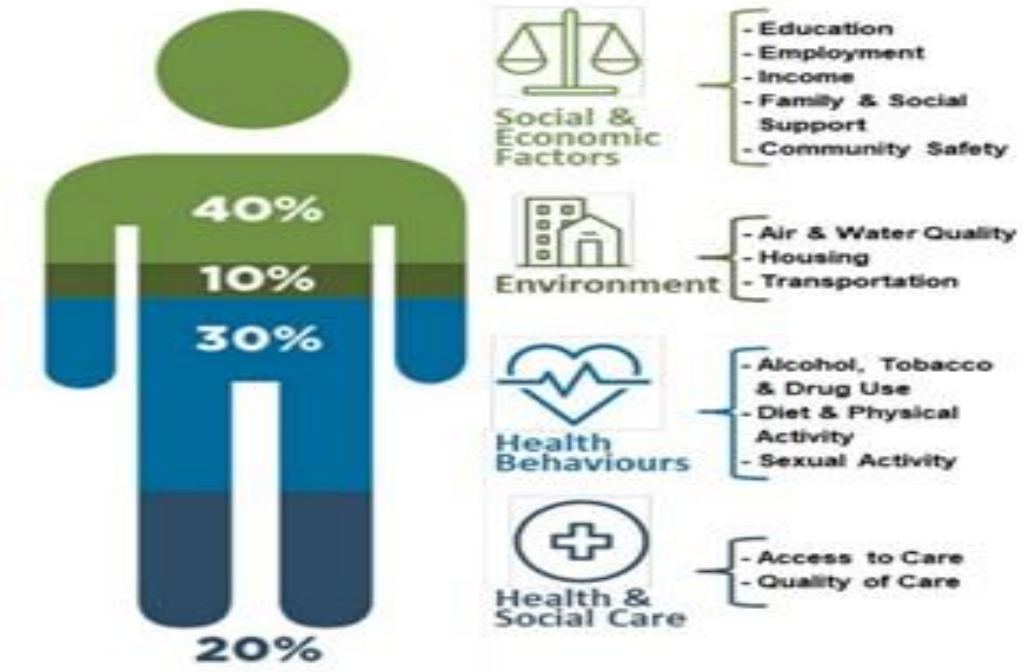
Approaches to social networking and building community capacity (such as Local Area Coordination)

Mobilising the resources of family and personal networks (through approaches such as Family Group Conferencing, peer support or Community Circles)

Targeted 'upstream' use of personal budgets.

[4] Skills for Care Wavehill Social and Economic Research, 2019

Our health is determined by a complex combination of social and economic factors. Where we live, our work conditions, our housing and education are fundamental building blocks in influencing our health and wellbeing. As Figure 1 below illustrates, healthcare is important, but other factors have a significant impact on health. This means we need to take action to support improvement in wellbeing across the building blocks of health and not focus on health and social care in isolation.



Evidence of cost-effectiveness and effectiveness in prevention is challenging not only due to the lack of a shared understanding of what prevention is, but also because of the difficulties in demonstrating whether it was the interventions that caused the outcomes. Other key challenges in economic evaluations include the long timeframes required for observing the full consequences of preventative investments, the lack of experimental evidence and the challenges involved in disentangling the effects of services and needs.

That is why we will consider our three strands of preventative work with our strategic partners. This will be detailed further in our Prevention and Early Intervention delivery plan– “A Sense of Belonging**.”**

We are committed to working with a wide range of partners across the city to improve health and well-being and prevent ill-health and social isolation among the people of Edinburgh wherever possible. This includes meeting the challenges of poverty and financial insecurity, increasing healthy life expectancy, and reducing health inequalities

This will be done by supporting communities to shape and deliver services where they are needed most and where they will make most impact. We will continue to promote positive health and well-being through prevention and early intervention, and by promoting physical activity or other ways of building social connections,

strength, and resilience in communities. This is part of our commitment to fostering a healthy start to life for people and improving their physical, mental, and emotional health. We will seek to ensure people get the advice and support they need at the right time to maintain their independence in the right place, including from community or third sector supports rather than HSCP services where this is better for individuals.

Why this is a priority

- Loneliness and isolation and widening social inequalities are placing increased pressures on primary care services.
- There is evidence of increasing numbers of people seeking support for mental health issues much of which is associated with loneliness and isolation and distress due to money, employability, and housing worries.
- As people live longer, they live with chronic conditions. Multimorbidity will become the norm for the Edinburgh population.
- Poor mental health is a more common co-morbidity for people living in more deprived communities.

  Preventive actions can ensure people live healthily in their own homes rather than frequenting hospitals and other acute care services.

The Challenge: How to mitigate against the wider social determinates of health on individuals and communities' health
What we will do: We will contribute to the development of neighbourhoods with clean air access to green spaces where communities can come together to improve and enjoy their local environment benefitting their physical and emotional health by supporting City of Edinburgh Council spatial and transport planning policy. We will work with city partners to ensure that places are age inclusive and that older residents can contribute to and benefit from sustained prosperity and a good quality of life to ensure they can age well. We will contribute and play our part in Community Wealth Building and as an Anchor Institution – contribute to a people centred approach to economic development where everyone can participate in local economic life; where local resources and wealth are redirected into the local economy and where local people have more control.
How will we know we are making a difference: Our approaches and programmes will recognise and mitigate the dis-empowering consequences of poverty and discrimination wherever possible.
The Challenge: Mistaking dependency for dependable
What we will do: We will work in neighbourhoods, involving multi-disciplinary teams and community and 3rd sector organisations, to inspire, encourage and support more people to help themselves. This will include inspiring through promoting strength-based stories; creating a strength-based culture; moving from a 'helping' to a facilitating culture and building the capacity of local organisations to help people, to address loneliness and social isolation. We will contribute to the development of evidence-based interventions and insight-led campaigns to tackle the key factors in the city that drive ill-health − smoking, healthy weight, alcohol, and physical inactivity. There will be a focus on how we scale up and systemise brief interventions, such as Making Every Contact Count, across all settings of care, with shared principles and training for front-line staff.
How will we know we are making a difference? Staff trained in asset focused conversations. No of campaigns and reach**.**

The Challenge: Increasing number of people who are lonely and socially isolated which is a significant public health issue
What we will do: support inclusive services, groups and activities exist in their local area that can help prevent and address loneliness and isolation, and how they can be promoted more widely, identify further opportunities to act on loneliness which may arise from needs assessments and carers assessments; ensure practitioners are able to offer the right information and advice on support and local initiatives to address loneliness and isolation.
How will we know we are making a difference? We will gain a deeper understanding of the disproportionate impact that ill-health, isolation, and loneliness have on certain groups and work to identify ways to address it.
The Challenge: Our current Social Care Direct system directs people into statutory provision before considering how a person could be supported in other ways
What we will do: Connect people and those they care for to the right supports, in the right place and at the right time through developing the new single point of access (currently operating as Social Care Direct), which will provide more straightforward and timely signposting and information for those looking for support within their communities
=How will we know we are making a difference: Our staff will be skilled in supporting people to identify and build on their strengths when discussing how to support them to thrive. There will be earlier, realistic, and honest conversations with people we will reduce the need for formal health and social care supports in some situations, so people can access services when required, rather than waiting until a point of crisis in their lives. The HSCP will use relevant data to understand need, predict demand and identify where resources should be directed to provide approaches which promote early intervention and prevention, and signpost to community supports where suitable. We will be collaborating with partners to ensure community assets are being used effectively, resulting in more people being supported within their own communities. Formal requests for services will reduce and support to meet more complex needs will be more manageable through community prevention and access to alternative forms of support.

The Challenge: Ensuing we are commissioning a range of evidence-based interventions which mitigate against the impact of poverty and address health inequalities across the city and communities of interest, identity, and locale.
What we will do: Co-design and co-deliver with 3rd sector partners a range of programmes to reduce and mitigate the impact of poverty and health inequalities in the city, focussing on falls prevention, income maximization and welfare rights, social prescribing and community connecting.
How will we know we are making a difference? Increased uptake of programmes from different communities.
Challenge: Increasing number of people ending their lives by suicide
**What we will do: **deliver the Edinburgh Creating Hope Together Action Plan which has been developed to meet the outcomes of the national Suicide Prevention Strategy
How will we know we re making a difference Reduction in the number of suicides**.**

Priority 2 - resilient communities to maximise independence

Our vision for people in Edinburgh is to help them live at home for longer by retaining their independence, supported by professionals, families, and the wider community. The needs of an ageing population, particularly supporting people living with dementia, multiple medical conditions (known as co-morbidity) and frailty, also place a significant demand on primary and community care services. People who develop complex multiple health problems also appear to be at greater risk of frailty in old age. Loneliness and social isolation can have a serious effect on both physical and mental health.

People with long term conditions may have unplanned hospital admissions. Many of these hospital admissions are potentially preventable. Potentially preventable admissions are defined as conditions that can be managed with timely and effective treatment in outpatient and community settings. There are 19 conditions defined as ‘potentially preventable’, such as COPD, angina, and diabetes complications. There are more than 7,000 potentially preventable hospital admissions in Edinburgh annually.

In June 2023, the Board directed a strategic commissioning exercise on older people’s bed-based care. Edinburgh has comparatively few care homes for its population. The city has about six care home beds per thousand of its population compared with eight for Scotland as a whole.

Edinburgh’s “balance of care” is exemplary. The city manages with comparatively few care home beds because it has a large, thriving market for care at home. According to the national local authority spending statistics, in 2022-23 the Partnership spent 10% more supporting people at home than in care homes.

Demographic change in Edinburgh will create more demand for health and care services. NH Lothian recently undertook a comprehensive demand forecast programme which, in addition to hospital services, included forecast of demand for care homes in the City of Edinburgh until 2043. The review used projected

demographic changes based on the most recent population projections from 2018 - more up to date projections, reflecting the 2022 Census are expected in 2025 and may shift the longer-term trends. The impact of demographic change only, assuming a similar need to the current, suggests significant growth in Care Home numbers of 50% from the 2022 baseline of 2,633 occupied care home beds, or 1300 care home places by 2043.

Integrating and sustaining health and care services across primary, community, acute and specialist settings of care is a complex challenge which requires a new level of collaboration amongst health and care partners. Population growth in adults and growing demand, increasing public expectations, new technologies and workforce challenges against a backdrop of major financial pressures all call for a new approach. We know that individuals and families with the most complex needs experience multiple contacts from different services and agencies and yet they often don't get what they need. All too often we offer services in isolation and our care system is very difficult to navigate, particularly at times of crisis. We will address these weaknesses by integrating and personalising services to better meet peoples' needs, focusing particularly on those with complex needs. We are developing alternatives to traditional care, including extra-care housing, harnessing digital innovation, and strengthening access to support networks.

In their contact with people, practitioners will take a **strengths-based approach** and, through genuine conversation, establish a holistic picture of the person's life. Our workforce will look at their strengths, ambitions, and priorities; their support networks; their needs and risks; the available community and voluntary groups and resources, and start to answer the question, 'What does a good day look like for you and how can we work together to achieve it?'

The conversation should enable the practitioner to establish:

- what is a problem now
- what may become a problem
- what can be done to prevent, reduce or delay the likelihood of those needs developing.

The resulting care and support plan should list all the needs that have been identified, whether they are eligible, and detail:

- how the person's eligible needs will be met
- how their non-eligible needs can be addressed to reduce or delay them becoming more significant.

This requires a shift to working in preventative ways and frontline practitioners are well placed to do so at both an individual and community level. They play a key role in promoting independence, enabling people to live the life that they choose, and recognising people's strengths and the importance of family, friends, and communities. These can reduce the risk of health problems and/or delay the need for care and support. Practitioners now need, at every contact, to consider which needs

can be prevented; which could be reduced; which might be delayed; and which need support now.

Social innovation - traditionally, our focus has been in providing clinical and social care. We will explore the development of a social innovation model which provides one single point of access to a range of health enhancing and supporting services, including antipoverty, wellbeing, economic inclusion, rapid response, crisis resolution and workforce development. These services will be delivered with improved efficiency and will be based on the principle of providing just enough care and no more ensuring our previous resources are utilised as best as possible.

Why this is a priority

- Re-admissions to hospital within 28 days of discharge per 1,000 admissions was 94 in 2020/21 compared to 111
- 88% of people in 2020/21 spent the last 6 months of life at home or in a community setting, compared with 88% the previous year
- % Edinburgh's older people aged 65+ who have high levels of care needs, live at home. This is 65.7% compared to 63.5% Scotland overall.
- In 2019 an estimated 8,065 Edinburgh citizens (includes 281 under 65 years) were living with dementia. 2024 projected figures are 8,790.
- 79.2% of adults supported at home agree that their services / support is improving / maintaining their quality of life (78.1% for Scotland).
- 91.6% of adults are able to look after their health very well or quite well (90.9% for Scotland).
- 79.2% of people receiving a home care service feel the service makes them feel safe and improves their quality of life.
- adult support and protection services, with around 3,000 duty to inquire assessments completed each year
- The rate of emergency admissions per 100,000 adults is 7,472
- The rate of emergency bed days per 100,000 adults is 93,387

The Challenge: Sustainable Primary Care - Primary care is the cornerstone of the NHS; GPs are local, accessible, and offer a personal response to people's needs. However, demand for primary care continues to rise and it is becoming more of a challenge to manage demand. As general practice transforms, we will retain the very best in how it currently operates, whilst finding ways to reduce variations in access, quality, and scope of services
What we will do: Further develop the model of care for primary care, ensuring that that GPs and other professionals are operating as efficiently as possible while recognising serious financial constraints and disproportionate growth.
How will we know we are making a difference? Performance measured through again the Primary Care Improvement Action Plan
The Challenge: Increase awareness and understanding of the impact of trauma on people's lives and ability to sometime make use of the help and support available
What we will do: Implement a psychologically and trauma informed practice approach and support staff to deliver trauma informed support through the rollout of the Scottish Trauma Informed Training.
How will we know we are making a difference? Monitoring the KPIs developed as part of the Trauma Informed Delivery Plan**.**
The Challenge: Carers not being recognised, feeling overwhelmed and under supported
What we intend to do: We will accelerate the actions set out in the City's Carers strategy to ensure that carers receive the personalised support they need to feel fulfilled, independent and to lead healthy lives. We will pay attention to the gendered aspect of the caring role.
How will we know we are making a difference: Where people receive a life changing health diagnosis, carers will be identified early in their caring role where necessary and provided with the support and information they need to help maintain and improve their health and well-being so that they can continue to care, if they so wish, and have a life alongside caring. We will monitor our performance with the KPIs identified in the Carers Strategy.

The Challenge: Frailty can restrict and impede healthy ageing and increase risk factors for other health conditions
What will we do: Develop and implement an integrated pathway for falls and frailty, focused on prevention and early identification to improve outcomes and to reduce the upstream costs of treating frailty.
How will we know we are making a difference: Measuring performance against a key set of indicators identified through the integrated pathway. Reduction in the number of falls resulting in admission to acute hospitals.
The Challenge: Too many people being seen in crisis
What we intend to do: Utilise population health management tools to anticipate care needs and provide support and preventative care before crises occur. Integrating local urgent care to provide an urgent community response and reduce the need for people to need ambulance or hospital support
How will we know we are making a difference: Reduction in emergency admissions
The Challenge: Supporting people to live at home or the place they call home for as long as possible
What we intend to do: Continue to expand the access to and use of technology-based supports to enable people to live independently in their own homes with supports appropriate to their needs.
How will we know we are making a difference: More people returning home following admission to hospital; Reduction in people delayed in hospital

The Challenge: Increasing individual's sense of control and agency over the support they receive to manage their conditions
What we intend to do: Identify opportunities to improve the HSCP's Self-Directed Support (SDS) policies, processes, and procedures to increase the effectiveness of SDS in empowering individuals to have a greater say and greater control in the services they access to meet their personal outcomes.
How will we know we are making a difference: No of people receiving SDS Options
The Challenge: More people living with one or more long term condition
What we intend to do: Ensure there are clear pathways focusing on prevention, early intervention and care and treatment for all long-term conditions.
How will we know we are making a difference: Use population health data to monitor and track changes in health outcomes.
The Challenge: Edinburgh like other parts of Scotland has a large number of services and sites where people access urgent and emergency healthcare; public engagement has highlighted how confusing the current services are for patients.
What we want to do: Establish integrated community based urgent care services which offer better access, simplicity, reduced duplication, and a greater range of services closer to home, thereby reducing demand on our Emergency Department and ambulance services.
How will we know we are making a difference: Reduced presentations to A & E.
The Challenge: Ensuring that more people can be supported to live in their own home with specialist care to support them and we have enough care and nursing homes for those who require them.
What we want to do: Strengthen our pathways for people focusing on maximising independence and further developing our multi-professional approach and model of care / nursing home provision .
How will we know we are making a difference: No of people supported at home: No of people moving into care / nursing homes

The Challenge: More people waiting for and receiving a diagnosis of dementia
What we intend to do: Work with partners to improve the experience for people living with dementia, and unpaid carers who provide support, through improvements and developments in the following areas: timely diagnosis, post-diagnostic support, access to information on services and community resources, dementia training, dementia friendly communities, support developments in wider workstream on dementia and complex clinical care.
How will we know we are making a difference: Through progressing an Edinburgh dementia delivery plan (where all these areas are included) we will capture progress, improvements, developments, and associated impact, which will be aligned to the national health and well-being outcomes.
The Challenge: More people experiencing poor mental health, mental health problems and mental illness
What we will do: Use our learning from Thrive Welcome Teams to meet dynamically changing needs of younger people, adults and older people with common mental health problems, severe mental illness, and those with very complex needs who require ongoing support and treatment by developing further our multi-disciplinary teams that connect to neighbourhood and community-based care and are strengths based, provide easier access to evidence based clinical interventions, psychological therapies, and social support.
How will we know we are making a difference: We will monitor performance against the KPIs set out in Thrive Edinburgh Adult Health and Social Care Delivery Plan.
The Challenge: People who frequently attend A & E whose needs may be meet in a different way
What we will do: Introduce and consolidate working up alternative solutions and responses for people who frequently attend our Emergency Department services.
How will we know we are making a difference: Reduction in number of people frequently attending A & E; Reduction in repeat attendances

The Challenge: Improve our support, care, and treatment for people with learning disabilities
What we will do: Redesign our enhanced community living services for adults with a learning disability and adults with mental health problems to support people to be discharged from hospital care
How will we know we are making a difference: We will monitor performance against the KPIs set out in the Learning Disabilities Delivery Plan.
The Challenge: More people being investigated for and / or receiving a diagnosis of cancer
What we will do: Continue the work of the Improving Cancer Journey team in co-producing unique care plans with people affected by cancer, focussing on what matters to them most, and by ensuring that through timely conversations individuals play an active and meaningful role in making decisions about the care and support they receive.
How will we know we are making a difference: Number of people accessing range of support services
The Challenge: People's discharge from hospital being delayed due to lack of appropriate supports in community settings
What we will do: Focus on a range of initiatives which support people leaving acute settings who are able to return home or to care/ nursing home with the appropriate supports in place
How will we know we are making a difference: Reduction in number of people delayed. Sustainable care homes.
The Challenge: Support people to die well
What we will do: Seek wherever possible to enable people to spend more time in their communities in the final years of their life, rather than in hospital settings, to support our commitment to enable and empower people to die well in their communities if that is their choice.
How will we know we are making a difference: More people receiving palliative care at home

Priority 3 – Protecting our most vulnerable

Poverty in the city drives substantial health inequalities in our city. The Health of the Nation report highlights the unmet healthcare needs of our population following the COVID-19 pandemic. These impacts will disproportionately affect people and communities most at risk and will increase future health inequalities if not addressed.

It is important that efforts to address pressure on services and help us catch up with backlogs also recognise the needs of the communities we care for and address barriers to care. We can do this by practising Realistic Health and Social Care. In doing so we can direct resources away from services that are wasteful, less cost-effective, cause harms, are not valued by the people we care for and do not reduce inequalities.

Addressing the existing inequalities means delivering health and social care in accordance with need. Currently, health and social care services are either accessed equally across social groups despite differences in need, or disproportionately by those whose needs are lower. There are many reasons for this, including:

- people not feeling worthy of NHS and social care resource
- barriers to obtaining appointments and accessing services
- a fading trust in services and providers
- cost, time, caring or employment barriers; and,
- communities with the greatest health and social care needs often have poorer access to resources and more stretched in areas with greater needs
- services often inadvertently cause health inequalities as a result of the factors listed above, which may make it harder for those who would benefit most from the services to access them, especially those services that are delivering prevention and early intervention.

There are some good examples in the city of coordinated actions to tackle the upstream determinants of health. For example, the Edinburgh Partnership Community Plan Priorities of Enough Money to Live On; Access to Employment and A Good Place to Live. By viewing every theme and critical action to deliver on in the *More Good Days* strategy through an inequalities lens with interventions to be systematically delivered at scale and intensity we can contribute to this collective and collaborative effort.

People experiencing severe and multiple disadvantages – there needs to be a greater focus on changing lives for those experiencing multiple disadvantages and struggling with the complexities of drug, alcohol, mental health, and associated problems

People with learning disabilities and those with severe mental illness experience poor health and die on average 15-20 years younger than the general population.

We will work in partnership with communities and other services to ensure that people, particularly the most vulnerable adults and older people, are kept safe from harm and that risks to individuals or groups are identified and managed appropriately.

We accept that not all risk can be avoided, and, in some cases, we will be required to provide protective interventions to keep people safe and in order to meet the public protection responsibilities of the HSCP. However, risk of harm can be reduced through integrated and partnership working, and risk can be managed effectively through good public protection practice, safety planning shared learning and reflecting collectively to keep people safe. By developing stronger communities, we aim to reduce harm and safeguard and protect vulnerable people and communities.

Person-centred care supports people to develop the knowledge, skills, and confidence to effectively manage and make informed decisions about their own health and care. Legislation, including early plans for the National Care Service strengthen the rights of people who need care and support by promoting more personalised care and shifting the focus from providing services to supporting individuals to achieve the outcomes that matter to them. We will work with people to help them develop their own strengths and capabilities, and signpost them to support from their wider networks or within their community to help find better ways, beyond the provision of care and support, to improve their health, wellbeing, and sense of control.

We are committed to listening to what people who use our services, and their carers tell us about the lives they can and want to live. We will support them to identify and understand the options available to them and empower them to actively participate in and take responsibility for decisions about how they will live their lives and achieve the outcomes they identify. By working with people to identify and understand their needs and options, we will support them to make informed decisions about the supports they choose to receive where it is safe and appropriate to do so.

We will work with The Edinburgh Poverty Commission to address their agreed objectives that:

- no one feels stigmatised, abandoned, or treated with less respect by the city as a result of their income or their wealth
- no one has to go without the basic essentials they need to eat, keep clean and safe, and stay warm and dry
- fewer than one in ten children and fewer than one in ten adults are living in relative poverty at any given time
- no-one lives in persistent poverty.

We also need to be planning for how we will protect out populations from future threats, including the health impacts of climate change, which we will increasingly experience, even as we continue our efforts to reduce greenhouse gas emissions - this will include work to ensure our infrastructure, services and communities are adapted and resilient in relation to these impacts - as per the Climate Ready Edinburgh Plan[5]:

Why this is a priority

- An estimated 17% of people in Edinburgh were living in poverty in the period to spring 2022, accounting for over 80,000 individuals including over 17,000 children, or 20% of all children in the city.
- 12% of all Edinburgh residents had been living in poverty for three of the past four years.
- In 2022/2023 a total of 24,260 people received social care services compared to 22,390 in 2021/2022.
- In 2021/2022 19% of service users in Edinburgh received a Direct Payment.
- In 2022/2023, 65.7% of Edinburgh adults aged 18+ who have high levels of care needs, are cared for at home or have a direct payment for personal care. This is higher than Scotland at 63.5%.
- The percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided (68.9% compares with the national figure 75.4%.
- In 2022 Home Care Survey, 89.43% respondents ‘always’ felt they were treated with dignity and respect.
- In the same survey, 63% respondents were satisfied with the way their complaints to the service were handled
- 30.4% of carers who feel supported to continue in their caring role.

[5] Draft Climate Ready Edinburgh Plan -City of Edinburgh Council

The Challenge: Increasing gap of dying younger and having fewer years lived depending on where you live in the city
What we will do: We will direct greater resources to people and communities with the greatest need, embedding equity into how we allocate resources by adopting the principle of proportionate universalism. Where applicable the IJB /HSCP will contribute to the four priority areas of the Poverty Commission: Reduce the cost of living; Maximise support from social safety nets; Increase income from work and opportunity to progress and make it easier to find help
How will we know we are making a difference: Frontline staff trained and supported to engage in strength-based conversations rooted in the principles of asset-based approaches, whole person assessments and motivational interviewing.
The Challenge: Increasing number of adults subject to Adult Protection and Mental Health Act legislation
What we will do: Ensure that staff and stakeholders understand that the public protection responsibilities of the HSCP mean that sometimes interventions may not be welcome but are in the best interests of individuals or the wider community to prevent harm to that person or others. We will work with people who receive support and organisations that provide it to understand what communities need to enable and empower people to make informed choices about services and supports to meet their needs. Shared decision making - We will ensure that people are supported to make decisions that are right for them, with clinical and care staff supporting people to reach a decision about their treatment and/or care. These conversations will bring together the clinical and care staff's expertise, such as treatment options, evidence, risks and benefits and the person's preferences, personal circumstances, goals, values, and beliefs. Continue to progress the city's commitment to the reduction of domestic abuse and gender-based violence.
How will we know we are making a difference? People living in the city will feel safe and will know how to seek support if they or someone they know is experiencing harm. The risk of harm to individuals and communities is reduced as far as is possible, recognising that harm prevention is not possible in all cases Provide the information and supports required to those who are experiencing or are at risk of experiencing harm in our city to ensure protection from harm. We achieve an appropriate level of risk management, which empowers staff to understand and be enabled to assess and manage risk according to their professional assessment and judgement with people encouraged, supported, and enabled to take responsibility for decisions affecting their lives and how they manage risk. Number of people subject to Adult Protection and MH Act Legislation. No of people accessing independent advocacy who are subject to legislation.

The Challenge: Responding better to people whose lives are impacted upon by structural inequalities
What we intend to do: We will develop the health and social care workforce through a revised training and development plan to ensure they have the knowledge, skills and understanding about how to identify, anticipate and respond to need and inequalities
How will we know we are making a difference? People will have better and more personalised care plans, so they can achieve better outcomes and feel they have been treated with dignity, trust, and respect. No of people with personalised care plans including safety plans in place. People will feel seen and recognised as fully rounded individuals, with a range of strengths that can be developed, instead of only focussing on the areas where they need support
The Challenge: Aligning our resources to improve how we respond to people with multiple and complex needs
What we intend to do: We will use the evidence base to create sustainable change in how we work with people who are experiencing multiple and severe disadvantages
How will we know we are making a difference: A set of indicators will be developed to support this ambition.
The Challenge: Improve uptake of screening programmes and immunisation
What we will do: Identify those at greatest risk and supporting early detection and therefore earlier treatment and support. reducing health inequalities and addressing differences in uptake among different groups. Improve awareness of, and access to, immunisation; early detection and screening programmes, particularly targeting areas of the city and groups where uptake is low .
How will we know we are making a difference: Uptake in screening and immunisation from different community groups defined by identity, interest, or locale.

The Challenge: Poverty of aspiration and hope
What we intend to do: We will adopt an asset-based approach to reducing inequalities by strengthening local communities and networks. The health and care system will expand on the Capacity to Collaborate initiatives into our delivery within neighbourhoods, particularly for communities of locale, interest and identity experiencing greater inequalities. We will support community development and initiatives, including building capacity for local people to be involved as community champions or connectors.
How will we know we are making a difference: Increase in community champions / connectors actively engaged in service redesign and community mobilisation.
The Challenge: Increasing number of drug related deaths and alcohol in the city
What we will do: Support the Scottish Government's ambition to enable the consistent delivery of safe, accessible, high-quality drug treatment and deliver initiatives and priorities to tackle the harm caused by alcohol and drugs in the city, through implementation of the Edinburgh Alcohol and Drug Partnership Strategy 2024-27.
How will we know we are making a difference: Delivering on the priorities set out in the refreshed strategy. Reduced number of drug related deaths; Reduction in number of deaths and illness related to alcohol use and dependency

Priority 4 – valuing our workforce and managing resources

As an Integrated Care Partnership, we need to take action to create the conditions to allow our people to provide the best possible care – including our paid and unwaged workforce. We also have responsibility as an anchor Institution to identify opportunities for upstream action to reduce health inequalities, including supporting people to access and remain in good quality employment.

Our intention is to ensure we have more people choosing health and care as a career of choice, and that they feel supported to develop and stay in the sector. We want a cultural shift to create a more compassionate and inclusive leadership culture, bolstering a culture of collaboration and a culture where wellbeing matters.

Our actions will demonstrate the value we place on those providing care across health and care and our commitment to support, retain, develop, and enable wellbeing in our workforce, as well as at home for unwaged carers. Edinburgh has many advantages that support our workforce ambitions, our young population profile, the concentration of educational establishments

These are extremely challenging times for our health and care services as we face significant financial pressures and a workforce crisis. National recruitment challenges across all care sectors are challenging. At the same time, we recognise the enormous pressures faced by carers, making life harder for the people they are trying to support.

We will seek to develop and retain a workforce that is suitably and highly skilled, trained and supported to deliver the highest standard of service to the city's people in keeping with the strategic priorities set out on our workforce plan. By having a workforce that feels engaged, valued, and highly trained we can ensure that our staff are ready to meet the challenges and opportunities of delivering health and social care services and are confident in the value placed on their own health and well-being.

We will identify the investments, and cultural and organisational change, we require to make with our leadership teams and wider staff group to overcome the recruitment

and retention challenges facing the sector and ensure a flexible, supported, resilient and sustainable workforce that can adapt to changing demands and opportunities placed on and available to the service.

Our workforce

What we know

- As of September 2023, of the 4,817staff working within the HSCP 2,397 are employed by City of Edinburgh Council and 2,420 are employed by NHS Lothian. 46% of HSCP staff are over 50 (Social Work 54% and NHS, 39%) (Sept 2023).
- In the 2023 annual employee engagement survey we found from those that responded that:
    - 1,350 HSCP staff reported that they are treated fairly, consistently, with dignity and respect in an environment where diversity is valued. 1311 agreed that they are provided with a working environment that promotes the health and well-being of staff, patients, and the wider community.
    - Average score for the statement ‘I am given the time and resource to support my learning growth’ was 75.
    - Average score for the statement ‘I feel my direct line manager cares about my health and well-being’ was 89.
    - Average score for the statement recommending the HSCP as a ‘good place to work’ was 75.
    - Average score for the statement ‘I have sufficient support to do my job well’ was 81.

The Challenge: Recruiting to our Workforce
What we will do: Implement plans to predict vacancies and recruit as early as possible. Develop a strategy for promoting the attraction of candidates from a range of backgrounds. Link with external partners such as colleges and job centres to explore opportunities for placements and pre-employment courses
How will we know we are making a difference? Staff will feel inspired, valued, supported, and equipped to do their job Staff will work in a mentally healthy workplace where discussions about mental health and well-being are part of routine support
The Challenge: Retaining our Workforce
What we will do: Succession planning to ensure natural staff turnover does not negatively impact on our ability to deliver services. Ensure accessibility and raise awareness of mental health and well-being resources available to all HSCP staff. Support staff who are absent from work and are experiencing Long Covid and other health conditions. Provide regular protected time for staff development and ensure all HSCP staff have career development conversations. Ensure staff are trained to deliver on the commitment to plan and deliver services within a human rights-based approach.
How will we know we are making a difference? Staff will have access to resources and supports that enable them to manage and improve their health and well-being. We will have a workforce that is committed to training and continuous development, and we will be matching that commitment with the relevant investment to provide training and development opportunities
The Challenge: Developing our workforce to deliver on our strategic priorities
What we will do: Develop and implement a programme of culture change, staff engagement and development to create the conditions required to deliver a new approach to delivering a sustainable health and social care service. The workforce will continue to be developed to ensure we have a digitally literate workforce. we will be engaging with staff to ask them what they need to support healthy working lives and manage change. Ensure staff are trained to deliver on the commitment to plan and deliver services within a human rights-based approach.
How will we know we are making a difference: Staff will work within an environment characterised by collaborative and compassionate leadership

Managing our resources

The health and care system continue to face unprecedented financial challenge, which drives the need for both commissioners and providers to deliver improved productivity and to ensure that resources are targeted for maximum value.

We need clarity to enable the local system to plan and to ensure rigorous and disciplined financial management in order to achieve financial balance. Achieving financial sustainability for the health and care system can be described as 'living within our means' and ensuring that expenditure does not exceed income.

As previously highlighted, our system has a deficit because spending has been higher than income due to unprecedented growth in demand and a requirement to improve service performance. Action has been taken to address the drivers of both cost and demand in the system to achieve a balanced position and this is set in our **Medium-Term Financial Plan.**

In the prevailing financial climate, it is clear that major change is necessary to support financial sustainability across all public services. This position is particularly acute in the case of Edinburgh Integration Joint Board, evidenced in part by the structural deficit which the IJB inherited from partners. Since its inception the IJB has routinely faced an underlying budget gap which we are unable to bridge on a sustainable basis. The MTFS offers an opportunity to redesign services over a 3-year period in a way which maximises alignment with the strategic plan.

Despite the stated intent to identify and deliver savings which are congruent with our strategic intent, it is clear that size of the budget deficit will require some decisions which reduce services and impact negatively on the lives of the people we provide services for. In taking these decisions the IJB will strive to protect the most vulnerable and the statutory duties of our partners in the City of Edinburgh Council and NHS Lothian. Officers will have to be responsive to these challenges, moving at pace and communicating widely to reset expectations

Maximising value

In order to improve population health, a greater proportion of resources need to shift from treating people for specific diseases to proactive management of their overall health and wellbeing. We will move from counting activity to a value and outcomes-based approach, making best use of the Edinburgh health and care pound. This will include:

The Challenge: Ensuring we have fit for purpose structure to deliver on our strategic priorities
What we will do: Complete the restructuring of Edinburgh Health and Social Care Partnership, ensuring that our organisational structures reflect our strategic priorities and delivery intentions
How will we know we are making a difference: Restructured services aligned to strategic priorities.
The Challenge: Balancing ambition with realism within an ever-changing landscape
What we will do: We will be ambitious but also realistic when planning services with our partners to ensure we do not over-promise and under-deliver, We will ensure we use our resources, including finances, our workforce, and other resources effectively and where they will make most impact to achieve value for and have strong and reliable health and social care services, not just now, but for future generations too. We will be honest and transparent in our de We will have and be acting on good data and projections of need that enable us to mobilise and target resources in a responsive and flexible way. Decision making in relation to what we can and can't feasibly do within the resources available and have honest conversations with our partners and stakeholders if we require to make difficult decisions in relation to existing or planned services
How will we know we are making a difference: We will have and be acting on good data and projections of need that enable us to mobilise and target resources in a responsive and flexible way.
The Challenge: Ensuring evidence informs our delivery plans
What we will do: We will use best practice, evidence, and national guidance to find ways locally to innovate to achieve better population health outcomes. The challenges of financial constraints require innovative, whole system approaches, which take a long-term approach to reducing demand and recognise the connection between population health and a vibrant economy. We will be investing in services based on good information and projections to ensure services are designed and delivered in ways that enable them to react to changing demands and pressures
How will we know we are making a difference: Staff will feel valued and involved in decision-making and developing local plans and strategies. We will understand the models of support required of our staff and ensure training and development opportunities are tailored to ensure they can deliver the high levels of care they are passionate about delivering

Building a sustainable future – city-wide contributions to environmental sustainability

Our ambition is to become an organisation that is environmentally, financially, and socially sustainable whilst delivering high quality, equitable services. Delivering this priority will focus on several key areas:

- sustainable buildings and land
- sustainable travel
- sustainable goods and services
- sustainable care
- sustainable communities.

Our work to support sustainability will focus both on *mitigation* - reducing our greenhouse gas emissions to reduce the future impact of climate change - and *adaptation* - ensuring that our infrastructure, services, and communities are adapted and supported to be resilient to the existing impacts of climate change, including extreme weather events and changing patterns of disease.

Some of the key areas of work that we will continue or begin to undertake during 2024-2027 are:

- Working closely with NHS partners to influence the design of sustainable and climate emergency structures to lead on planning for the future.
- Supporting our staff to consider how they plan their journeys, make green choices, and reduce travel where possible.
- Support and continue the Fleet Strategy Programme to provide electric vehicles and ensure the appropriate infrastructure is in place.
- Pilot of electric vehicles with Care at Home services as part of the home care fleet.
- Roll out electric vehicles to other social work teams with a goal for all fleet vehicles to be.
- Build sustainable procurement into commissioning practices to encourage partners to share sustainable values.
- Increase the number of home carer staff group employed within their local community and cover their visits on foot or public transport.
- Increase the number of posts filled by local candidates to reduce travel.
- Design and implement actions to improve community resilience to climate change, targeting disadvantaged and vulnerable groups.
- Design and implement actions to improve the health and care sector's ability to adapt, including improving the resilience of health and care service infrastructure and services through planning and business continuity arrangements.

Our enablers – what will help us to achieve our vision and priorities

Edinburgh HSCP does not and should not operate in isolation. Planning and delivering quality health and social care requires a range of different people, organisations, professionals, and groups (our partners) to share the responsibility of maximizing people's independence, promoting early intervention and prevention and ensuring people receive the types of support they need, where they need it and at the appropriate point in time.

Central to this will be working with the people who know the services best. People who have used services have a unique perspective on how they need to evolve to meet the needs of people throughout the city. These people are often referred to as people with "lived or living experience."

People with lived or living experience are one of a range of different partners that have a role in implementing the approach to service delivery in the city.

The key partners we will work with to plan and deliver health and social care services include the following:

- people with lived experience (including patients, service users, carers, and families)
- local communities (individual citizens and community organisations and groups)
- voluntary (or third) sector service providers
- independent sector service providers
- other services and teams within the Council (e.g., Housing, Education)
- providers of housing services
- community planning partners
- equalities-led groups and organisations
- academic partners.

Our work on developing the Edinburgh Wellbeing Pact demonstrated that opening up two-way engagement and dialogue channels enables us to understand our health and care needs, experiences, and aspiration. Engagement and involvement will give us essential insight to help people self-care, inform service improvement and improve quality and patient experience. Collectively we will ensure that we are accountable, and services are shaped by the people who use them. User involvement will move from the margins to the mainstream to inform planning, commissioning, and providing our health and social care services.

Our objectives for engagement and involvement include:

- Determining local need and aspirations − listening to people in order to understand what matters to them
- Promoting health and reducing inequalities − involving people in shaping ways to help them to take better control of their own health and wellbeing
- Improving service design − using insight from people's experiences to improve services and care.
- Improving quality of care – systematically gathering data and insight to learn and
- Understanding what is working well and areas for improvement and action.
- Strengthening local accountability and improving transparency − demonstrating that we listen and respond.

We will widen the scope and intensity of engagement and involvement; sharing information widely, offering opportunities for face-to-face conversations and using a wide range of channels to seek views. We will co-ordinate our efforts in a 'do-once' approach. We will:

- Adopt a single set of principles for co-design.
- Develop engagement leadership, skills, capacity, and collaboration to support effective involvement.
- Establish an integrated engagement infrastructure to support the do-once approach, utilising best practice and diverse channels
- Widen involvement methods such as citizen panels and utilising local democratic infrastructure, community champions
- Involving communities of interest and identity on specific themes
- Harnessing the expertise and leadership of frontline staff in co-production and engagement
- Increase opportunities to listen to patients, families, and communities

Integrated Impact Assessments

Integrated Impact Assessments (also known as IIAs) are a keyway for us to influence designing services and making decisions in ways that take account of the impact on and feedback of diverse groups across the city. IIAs are our way of considering what the impact will be of what we are considering doing on certain

groups of people (referred to as people with protected characteristics). These characteristics include age, disability, gender reassignment, pregnancy and maternity, race, religion or belied, sex, and sexual orientation. There is also a requirement under the Fairer Scotland Duty to consider socioeconomic disadvantage. Other groups on whom impacts may be considered, although here is not a statutory requirement to do so, include carers, care experienced people, refugees, and asylum seekers.

The HSCP acknowledges that further activity and commitment is required to fully implement a culture where timely and detailed consideration is given to how diverse groups will be affected by decisions being taken by the IJB. The HSCP is increasingly aware of the importance of understanding and considering the combined impact of multiple characteristics. For example, the combined effect for people with a disability who are female. Or on people who are in older age groups and from black or minority ethnic backgrounds. The interconnected nature of social categorisations such as race, class, and gender as they apply to a specific individual or group can have the effect of creating overlapping or magnified experiences of discrimination or disadvantage. We refer to this as “intersectionality” and this will be actively considered as part of the decision-making process with partners.

Taking an equalities-informed and equalities-sensitive approach will be central to our work to ensure we are not increasing inequalities. Equality impact assessments have a strong human rights element and help us to identify and reduce or remove negative impacts.

How we will know involvement is meaningful

- We will be working in partnership with a network of voluntary and independent health and social care providers, groups and individuals and people with lived experience of health and social care services (our stakeholders)
- People with lived experience will feel that the IJB recognise the value of involving them in decision-making processes
- Stakeholders will feel that they are working together towards joint goals
- Decisions about health and social care services will be influenced by our stakeholders, both within and external to the HSCP
- Where appropriate, specific stakeholder groups will be identified and encouraged to be involved
- Stakeholders will be respectful of one another’s views and feel that their views are being listened to and acted upon
- New services and changes to existing services will be designed jointly (co-produced) with our stakeholders
- Opportunities to be involved will be open to all relevant stakeholders, with any specific barriers to involvement identified and overcome wherever possible
- We will seek to involve family members of those who face barriers to involvement

- Stakeholders will recognise their input and suggestions in the decisions that are taken, irrespective of the outcome

Healthy and vibrant partnerships

We have come together as a health and care system in a way we have not experienced before to create a platform for transformational change. Our ethos is one of collaboration rather than competition with a strongly held commitment to do the right things and encourage the people of Edinburgh to become key partners for change. experience more good days. We will create the environment and give space for health and social care professionals to become even more actively involved in strategic leadership and transformation. We will achieve our outcome ambitions through scaled up prevention and early detection, offering better and integrated services and working in a targeted way with the people Edinburgh so they feel entitled to seek better health. Partnership working between the voluntary sector, local government and the NHS is crucial to improving care for people and communities. Voluntary sector partners are key agents in delivering the most effective social and economic support for people in communities. By working closely with the voluntary sector, we can be absolutely ensuring we are addressing the needs of people and communities.

Focusing on quality

We will work together to deliver safe and effective care, set against the challenges of rising demand and increasing patient expectations. We recognise our shared responsibility for ensuring services in Edinburgh are safe, of good quality and that we are all focused on continuous improvement. We will create the environment for a just culture of openness, transparency, and learning; where safety incidents are reported, reviewed, and learned from and timely improvements are made to continuously progress quality of care.

Quality improvement will be informed by people who receive services and frontline staff. We will listen to and involve people to find out what most matters to them and we will empower staff to do the right things for quality improvement. We will establish robust and consistent quality systems, using a quality assurance framework, supported by strong governance within organisations and across the whole system. Our critical actions will include:

- Listening to people that use our services and staff to improve quality
- Reducing unwarranted variation in health and care outcomes and people's experience
- Ensuring improvements agree evidence based; informed by people and front-line staff
- Working together for safe, consistent, and reliable care.
- Learning from good practice and take lessons from sub-optimal care
- Embedding an approach of continuous improvement, driven by intelligence

Commissioning differently

Edinburgh Integration Joint Board for Health and Social Care is responsible for planning and commissioning acute health and social cere services in the city. Some services are operationally managed through NHS Lothian (Acute Division or Royal Edinburgh and Associated Services) on behalf of the IJB. The IJB sets directions to partners (Council and NHS Lothian) with key performance indicators and standards. The 3rd sector and independent sector will through commissioning and procurement have either contracts, grant awards or Service Level Agreements in place which are routinely monitored by EHSCP staff. Our commissioning principles are:

- **Community informed**: people and communities should be an integral part of deciding what they need to thrive.
- **Collaborative**: working together to identify and agree strength-based approaches to improving health and wellbeing of our people and communities. Application processes will be designed in a way that enables collaborative bids and working.
- **Learning focused**: all grants, contracts, other forms of commissioning and related outcomes will prioritize collective learning, using the learning to improve and adapt to needs of our communities.
- **Ethical** (as defined by Scottish Government): ensuring that all eight ethical principles are woven through every aspect of commissioning:
    - person-centered care first
    - human rights approach
    - full involvement of people with lived experiences
    - fair working practices
    - high quality care
    - climate and circular economy
    - financial transparency and commercial viability
    - shared accountability.

One Edinburgh, which is an innovative approach to care at home provision. is a current example of our commissioning principles in action.

Becoming a learning organisation

NHS and local authority leaders, alongside the voluntary sector and wider strategic partners, have recognised that we must collaborate rather than compete. Leaders across the health and care system need to embody future-focused, inclusive leadership qualities to improve overall performance and better population health. We will create a leadership climate and culture that lays the foundations for transformation across the Edinburgh health and care system.

New governance arrangements have been established to underpin an integrated health and care system and there is currently a restructuring underway.

In complex environments, which are characterised by variety and change, continuous learning should drive performance improvement. Continuous learning

enables workers' practice to improve – through experimentation, gathering data, sense-making and reflective practice, Management is required to create learning environments and to monitor their effectiveness. Performance depends on managers nurturing (and recruiting for) workers' sense of intrinsic motivation, rather than the extrinsic motivation of reward/punishment for hitting targets. In complex environments, continuous learning is required because there is no such thing as "what works" at a programme level – there is no standardised programme which is "best practice" for all times and in all places. In complex environments "what works" is the continuous process of learning and adaptation.

Our learning partner approach to working with partners is to:

- Embrace complexity.
- Develop and nurture relationships with empathy and respect.
- Embrace learning and experimentation.
- Renegotiate our identity - What are people holding on to that is holding them back? What is preventing us from being truly innovative and doing what we feel is right.
- Lean into discomfort -Being comfortable can be a barrier to change, even when we have permission to do things differently. Alliances and networks lie at the heart of mobilisation concerning social change, and these networks of everyday life harbour a multitude of resources which can be tapped. This ongoing awareness to the importance of being agile in responding to an ever-changing context has resulted in a more dynamic and fluid plan and building an increasing social movement across the city with a shared narrative of achieving more good days for everyone.

Monitoring performance

Edinburgh IJB and HSCP have been developing well defined performance management arrangements to monitor, report on and scrutinise the performance of health and social care services. The Performance Framework enables the HSCP and IJB to monitor performance and outcomes routinely and regularly in relation to delivery of the Strategic Plan and against a range of local and national performance measures, known as Key Performance Indicators (or KPIs).

Progress is regularly reported in Quarterly and Annual Performance Reports, which can be accessed on the HSCP website. Detailed Quarterly Performance Reports include a wide variety of performance measures and provide information on how services are responding to areas of under-performance.

All performance indicators have been aligned to the priorities set out in the Strategic Plan and to the Scottish Government's National Health and Well-being Outcomes. The quarterly performance reports are shared with and scrutinised by HSCP senior management groups and teams and are presented to relevant IJB Committees,

In addition to the Quarterly Reports, we publish an Annual Performance Report (APR) in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. Within the APR we highlight progress in delivering the Strategic Plan commitments and consider performance and outcomes over a longer period of time, including in relation to the Core Suite of National Integration Indicators which have been published by the Scottish Government to measure progress in relation to the National Health and Well-being Outcomes.

The IJB and HSCP management teams also regularly receive updates on delivery of our Strategic Plan commitments through individual service reports, as well as financial updates on budgetary performance and the delivery of agreed savings programmes.

As part of defining the Partnership Priorities above, this Plan outlined some general suggestions for what success will look like. We will be able to monitor progress and demonstrate success for some of these measures through the formal and established performance monitoring arrangements outlined above. Others are not so straightforward to measure or quantify.

Where data is not available or is not currently captured, the HSCP will work with our stakeholders to identify how to measure success in achieving our priorities, for example through case studies or the testimonies of people with lived experience of services and supports. A priority for the HSCP will be to identify where the impact of our activity is having an effect in terms of reducing the numbers of people seeking supports and reducing need in the city. How we do this and the success we

experience will be reported back through the relevant governance and strategic planning groups for consideration and action.

Harnessing our economic strength as anchor institution through community wealth building

As two of the city's largest employers, NHS Lothian and the City of Edinburgh Council can directly influence inequalities by collaborating in targeted approaches to create employment and stimulate economic growth through regeneration and procurement:

- We will work together to maximise our economic contribution to support the most disadvantaged in our communities so they can share in the city's economic growth and social development.
- We will adopt shared principles for equality and diversity in employment practices and processes.
- Playing our part with our key partners organisation commitment to being anchor organisations
- Providing greater access to paid employment, including apprenticeships and initiatives that target residents who are unemployed, economically inactive or in low paid, insecure work. Also offering pre-employment programmes and volunteering
- Actively promoting workplace wellbeing through a range of evidence-based initiatives, delivered at scale and consistently
- Adopting procurement policies that support local investment and employment

Best use of our estate

Edinburgh is fortunate to have health and social care estates infrastructure with some good quality facilities. Our goal is the city's whole public estate is to be fit for purpose and able to meet future needs. Despite investment, there are a significant number of challenges: under-utilisation, a legacy of high levels of maintenance, some estate which is no longer fit for purpose and opportunities for capital release through surplus land and property.

The IJB does not have a capital budget we therefore need to collaborate with our Council and NHS Lothian partners to focus on improvement and full utilisation of all our assets. This needs to also to focus on community assets which will support delivery and expansion of our integrated locality teams

Our critical actions will include:

- Work with our partners to innovate to ensure that our shared assets are utilised to maximum effect and are flexible to meet the changing needs of services as they are redesigned and integrated.

- Identifying and planning provision with a particular focus on primary and community care in response to changes in geographical distribution of population.
- Open up our buildings to support communities providing activities and engagement.
- Invite our partners in the private and academic sectors to open up their buildings to communities to promote health gain.

Digital transformation

People today expect to have effective and convenient digital access to services, records, appointments, and self-help. Digital innovation and smart solutions also have the potential to improve services, efficiency, and health outcomes. We will ensure that we align with the actions emerging from the developing EIJB Digital and Data Management Strategy and our critical actions will include:

Empowering People - We will extend and improve digital access for patients, including appointments, prescriptions, test results and personal health records. Health and wellbeing information and signposting will be accessible using apps and we will extend Edinburgh's remote telemetry service.

Boosting quality, capability, and efficiency - We will provide digital assistance to enable an agile and flexible health and care workforce, including providing virtual access for GPs to obtain specialised expertise and using advanced data analytics to identify people most at risk of poor health.

Innovation, sustainability, and economic growth - We will continue to develop Edinburgh's health and care sector to enable innovative solutions and share best practice, working closely with the Edinburgh Futures Initiative.

Improving infrastructure and security - We will ensure that our digital system is interoperable, paper-free, resilient, and secure. We ae replacing our Social Care System. We will move to cloud-based services to enhance resilience and establish infrastructure

Harnessing research capability and capacity

We need to maximise and capitalise on the wealth of clinical and academic assets within our city to tackle mortality and ill health through research, innovation, and education.

We want to unite the city's academic institutions around our strategic aims to harness the strengths and opportunities for improving population health and economic productivity through research, innovation, and education.

Each programme should have a strong "theory of change," from research through to implementation, which provides assurance that our strategy will have long term impact and the significant involvement of our workforce will ensure that theory is grounded in the reality of front-line delivery.

Glossary

Adult at risk: An adult who is in need of extra support because of their age, disability, or physical or mental ill-health, and who may be unable to protect themselves from harm, neglect, or exploitation

Asset based approach: A way of helping people by looking at what they have, rather than what they lack. This approach helps people make use of their existing skills, knowledge, and relationships. It is also called a 'strengths-based approach' and can be used as a way of improving local areas, by promoting what is good about an area rather than focusing on problems. See also co-production

Autonomy: having control and choice over your life and the freedom to decide what happens to you. Even when you need a lot of care and support, you should still be able to make your own choices and should be treated with dignity.

Care pathway: A plan for the care of someone who has a particular health condition and will move between services. It sets out in a single document what is expected to happen when, and who is responsible. It is based on evidence about what works best to treat and manage your particular condition.

Circle of support: Sometimes also called a 'circle of friends', this is a group of people who act as a community around a person who needs help and support. The person themselves remains in control. The group may include the person's family, friends, and other supportive people from the community they live in. They are not paid, and their role is to help the person do the things they want to do and plan for new events in their life.

Clinical outcomes: Specific changes in your health or quality of life, as a result of the health treatment or care you receive

Collaborative commissioning: When several organisations, such as local councils and health organisations, work together to plan specific care services and share funding.

Community wealth building - a people centred approach to economic development where everyone can participate in local economic life; where local resources and wealth are redirected into the local economy and where local people have more control. Where we maximise the contribution of public services through our social value framework and our contribution as local economic anchors in relation to employment, procurement, building and land use, and our environmental impact.

Community Wellbeing: An approach that looks at the health and wellbeing of the whole community, focusing on a wide range of things that can affect how people feel. This approach recognises that being well is about more than just not being ill: social and emotional factors are important too.

Co-morbidity: When you are living with more than one health condition at the same time.

Complex needs: You may have complex needs if you require a high level of support with many aspects of your daily life and rely on a range of health and social care services. This may be because of illness, disability or loss of sight or hearing - or a combination of these. Complex needs may be present from birth or may develop following illness or injury or as people get older.

Co-production: When you as an individual are involved as an equal partner in designing the support and services you receive. Co-production recognises that people who use social care services (and their families) have knowledge and experience that can be used to help make services better, not only for themselves but for other people who need social care.

Delayed discharge: When you are well enough to leave hospital after an illness or accident, but you have to stay there while the care you need in your own home or in another place is arranged.

Direct Payments: Money that is paid to you (or someone acting on your behalf) on a regular basis by your local council so you can arrange your own support, instead of receiving social care services arranged by the council. Direct payments are available to people who have been assessed as being eligible for council-funded social care. They are not yet available for residential care. This is one type of personal budget.

Discharge planning: If you go into hospital, this is the process of planning when you will leave, where you will go, what you are likely to need once you are out of hospital, and how your needs will be met. You should expect discharge planning to begin as soon as you go into hospital. You should also expect to be part of these discussions and to know what is happening.

Discharge to assess (D2A): If you are ready to leave hospital but still need some care and support, you may be able to go home with care provided in your home for a short period while discussions take place about the care and support you may need in the longer term. This means you can continue your recovery at home, rather than having to stay in hospital while your future support is worked out. It also means that

your needs can be assessed in your own home, where you may be able to do things for yourself differently than in hospital.

Early intervention: Action that is taken at an early stage to prevent problems worsening at a later stage. It may apply to children and young people, or to help that is offered to older people or people with disabilities to enable them to stay well and remain independent.

Equality impact assessment: A process of considering the effect a new policy or project will have on all groups of people, and making sure that no-one is left out or worse off. The aim is to see whether changes to the way things are done will have a good or bad result for people from particular groups, such as disabled people, older people, and people from ethnic minority groups.

Frailty: A condition that may develop as you get older, and your body becomes less able to recover from illness or injury. It makes you more likely to become ill and to spend time in hospital. It is not an illness in itself, and is not the same as physical disability, although disability and frailty may overlap with each other.

Health inequities - Health inequities are the unfair and avoidable differences in health outcomes between different groups in society. Health equity acknowledges the unfair gap in opportunities and seeks to address it by distributing resources, and/or designing services based on need, so everyone can have the same chance to thrive.

Home care: Care provided in your own home by paid care workers to help you with your daily life. It is also known as domiciliary care. Home care workers are usually employed by an independent agency, and the service may be arranged by your local council or by you (or someone acting on your behalf).

Home First: A service offered in some areas when you are well enough to leave hospital, but still need some support. The planning for your future support takes place in your own home rather than in hospital: an assessment of your needs is carried out in your own home on the same day as you leave hospital. This service may also be used to help you avoid going into hospital, by providing the care and support you need at home.

Independent living: The right to choose the way you live your life. It does not necessarily mean living by yourself or doing everything for yourself. It means the right to receive the assistance and support you need so you can participate in your community and live the life you want.

Joint strategic needs assessment: The process of identifying the future health, care and wellbeing needs of the population in a particular area, and planning services to help meet those needs. This process is led by your council, working with the NHS and private and voluntary organisations in your area.

Long-term condition: An illness or health condition that you live with, that cannot be cured but can usually be managed with medicines or other treatments. Examples include asthma, diabetes, arthritis, epilepsy, and other things.

Multi-agency working: When different organisations work together to provide a range of support for people who have a wide range of needs.

Multidisciplinary team: A team of different professionals (such as doctors, nurses, therapists, psychologists, social workers, and others) working together to provide care and support that meets your needs. The team brings together many different types of knowledge, skills, and expertise, and should look at you as a whole person.

Natural support: Support that may already be there for you, provided informally by your family or friends. It exists 'naturally' and in the relationships you have and does not have to be formally planned or commissioned.

Outcomes: In social care, an 'outcome' refers to an aim or objective you would like to achieve or need to happen - for example, continuing to live in your own home, or being able to go out and about. You should be able to say which outcomes are the most important to you and receive support to achieve them.

Outcomes framework: A way of measuring how good services are at delivering results for people and comparing results in different areas.

Participation: Taking part in decisions about things that affect you and other people. This may be about your own day-to-day life, such as what to eat or how to spend your time, or about how a service or organisation is run. It is more than consultation: you should not just be asked your view but should be able to have an influence over the final decision.

Performance indicators: Ways of checking that an organisation is doing what it is supposed to be doing, by measuring progress towards particular goals. An example of a performance indicator might be how long people have to wait after requesting an assessment.

Peer support: The practical and emotional help and support that people who have personal experience of a particular health condition or disability can give each other, based on their shared experience. People support each other as equals, one-to-one or in groups, either face-to-face, online or on the telephone.

Place-based commissioning: When organisations work together to plan, develop, and pay for services to meet the needs of people in a single local area. The aim is to improve the health and wellbeing of the population of a particular area, and to focus on this rather than on the organisations that provide services.

Prevention: Any action that prevents or delays the need for you to receive care and support, by keeping you well and enabling you to remain independent.

Preventive services: Services you may receive to prevent more serious problems developing**.** These services include things like reablement, telecare and befriending

schemes. The aim is to help you stay independent and maintain your quality of life, as well as to save money in the long term and avoid admissions to hospital or residential care.

Population health: An approach that aims to improve physical and mental health outcomes, promote wellbeing, and reduce health inequalities across an entire population. It reflects the whole range of determinants of health and wellbeing, many of which are separate to health services. It's about creating a collective sense of responsibility across organisations, individuals, and communities

Population health management: A way of improving the health of people in local communities by looking at which groups in the local population are most likely to become unwell and working out how to prevent and treat ill-health.

Safeguarding: The process of ensuring that adults at risk are not being abused, neglected, or exploited**,** and ensuring that people who are deemed 'unsuitable' do not work with them. If you believe that you or someone you know is being abused, you should let the adult social care department at your local council know. They should carry out an investigation and put a protection plan in place if abuse is happening.

Screening tool: A test that is carried out to work out whether someone has, or is at risk of developing, a particular condition or illness. It may be a physical test or a questionnaire or checklist, depending on what is being tested for.

Self-directed support: Support services that help give people with a disability the confidence and wellbeing to live independently and become an active member of the community.

Self-management: An approach that encourages people with health and social care needs to stay well, learn about their condition and their care and support needs, and remain in control of their own health.

Service redesign: Changing the way that health, care, and support services are provided in a local area to reflect the changing needs of people in that area. Services often need to change as people live longer, and as more people live with ongoing health conditions.

Service specification: A description given to an organisation that provides a service by the organisation that is paying for the service. The description says what the service should look like, what should be provided to people and what the outcome**s** should be.

Social capital: The connections that are made between people who live in the same area or are part of the same community, and who are able to do things with and for each other. Strong neighbourhoods, clubs and groups help create a sense of community, enabling people to trust each other, work together and look out for each other.

Social care: Any help that you need, such as personal care or practical assistance, to live your life as comfortably and independently as possible, because of age, illness, or disability

Social determinants of health - Sometimes referred to as the 'causes of the causes,' these are the social, cultural, political, economic, and environmental factors that shape the conditions in which people live. For example, our access to a good education or prospects for decent employment. This strategy gives primary focus to the social determinants of health.

Social exclusion: When individuals or groups do not have the same rights and privileges that most people in society have, such as employment, adequate housing, health care or education. This is often because of poverty, disability or because they belong to a minority group of some kind.

Stakeholders: People or groups who have an interest in what an organisation does, and who are affected by its decisions and actions.

Strength-based assessment: An assessment that looks at your strengths and what you are able to do, rather than on your weaknesses. The focus is on your abilities, and on what keeps you well and helps you remain independent.

Supported decision-making**:** Getting the support you need to make decisions for yourself, or to express your wishes or preferences if someone is making a decision for you.

Systems change: A way of changing the way a system works (such as the way that social care is planned and delivered) by looking at causes of problems, and at how different things affect each other. The aim is to change the way things work in order to produce a different result.

Tertiary care: Highly specialist health care requiring particular expertise and equipment, which is available only in specialist hospitals. Examples include cancer treatment, heart surgery and other things.

Universal services: Services such as transport, leisure, health, and education that should be available to everyone in a local area and are not dependent on assessment or eligibility.

User involvement: The involvement of people who use services in the way that those services are designed, delivered, and run. It may be an opportunity to use your experiences to make a particular service work better, and to be involved in decisions about things that affect you. User involvement takes different forms in different organisations, from voicing your opinion to getting actively involved in the way a service is run.

Values-based recruitment: A way of finding people to work for an organisation who have the beliefs, principles, and behaviour that the organisation thinks is important, as well as the right skills to do the job.

Value for money: A way of working out whether a person or organisation has received the maximum benefit for the money they have spent on something. This applies to your own money as an individual, as well as to public money spent by councils and other public sector bodies.

Vulnerable adult: An adult who may need care and support because of their age, disability, or illness, and may be unable to protect themselves from harm, neglect, or abuse.

Wellbeing: Being in a position where you have good physical and mental health, control over your day-to-day life, good relationships, enough money, and the opportunity to take part in the activities that interest you.

Whole systems approach: Looking at every aspect of how a system works – such as the health, social care, and housing system – and understanding what each part does, where the connections are and how it all fits together. Looking at the system in this way should help show how things can be done differently and better.

Integrated Impact Assessment – Summary Report

Each of the numbered sections below must be completed
Please state if the IIA is interim or final

1. Title of proposal

Interim IIA for the draft EIJB strategic plan: *More Good Days – Our strategic plan for health and social care in Edinburgh 2024 – 2027'*

2. What will change as a result of this proposal?

The implementation of actions as part of the EIJB strategic plan.

'Much has happened since the publication of our last strategic plan in 2019. Our city has had to manage unprecedented challenges in facing a pandemic that impacted profoundly on the health and wellbeing of all our citizens. The effects of meeting the challenges posed by COVID-19 whilst felt by all citizens did exacerbate existing inequalities and further marginalised the most vulnerable in our communities.

Addressing these inequalities will remain a challenge and a focus for all of us during the life of this plan and we are committed to working across or communities of identity, interest, and place. For that reason, you will see a focus throughout this plan on the need to strengthen, empower and invest in the ability of those communities of interest, place, and identity to provide people with the supports they need at the right time and in the right place. However, there is also a requirement to redirect our resources as effectively and efficiently as possible to ensure the best outcomes are possible for those in greatest need.'

' *A vision for a healthier, happier, and fairer city, which will enable people, regardless of their health status, to have more good days. Good health and wellbeing come from all aspects of our lives; our homes and communities, education, employment, and environment and that is why partnership working is a must do if we want to create a healthier, happier, and fairer city for all.*

Our primary ambition is to mitigate against the impact of poverty on people's health and reduce health inequalities which currently represent a fourteen-year gap between the most affluent and deprived communities in the city.'

3. Briefly describe public involvement in this proposal to date and planned

- Extensive public engagement and participation
- Strong voluntary sector engagement
- Edinburgh Community Health Forum – voluntary sector discussions
- EVOC engagement
- Shared through executive management.

Engagement activity	Description	Participants	Sessions held
Third Sector Forums	Voluntary sector forum meetings (From August 2020 onwards)	210	9
Community Interest Groups	Specific community of interest groups including participants from BAME communities, faith groups, and people with specific health conditions (From August 2020 onwards)	238	20
EHSCP Staff Groups	Focus groups with frontline staff and practitioners (From August 2020 onwards)	197	24
PhotoVoice	"Picturing Health" photography (June – July 2020)	115	1
Citizen Survey	Public survey through our HSC Website (June 2020)	355	1
Thought Leaders	23 in-depth interviews with city leaders from the 3rd sector, public sector, elected members, Board members, academia, and private sector (March - April 2020)	23	23
Public events	November 2020 - October 2023 • "The Art of the Possible" • "Anchoring our Thoughts" • "Wellbeing: The Power of our Communities • "On our Way: Formulation to Enactment" • "Checking In: Formulation to Enactment" • "Talking about Transition • "Accelerate" • "Seasons Change • Edinburgh Wellbeing Pact: "Check In" • Update event • Midsummer – Pause, Plan and Reflect • Capacity to Collaborate-Learning event • Prevention and Early Intervention -an opportunity for Edinburgh • Peering in and peering out – exploration of peer support	1,986	17

Summer Season	Events across communities of place, interest, and identity - Summer 2022	3,200	38
Draft Strategic Plan Stakeholder Sessions	Development Session 1 02.02.23 Development Session – 08.03.23	212	2
Draft Strategic Plan	Strategic Planning Group – Workshop on 11.10.23 Strategic Planning Group – Workshop 2 on 13.03.23 Wider Leadership Team – Presentation and Discussion - 11.04.23	18 14 14	3

5. Date of IIA

Monday 3rd June 2024

6. Who was present at the IIA? Identify facilitator, lead officer, report writer and any employee representative present and main stakeholder (e.g. Council, NHS)

Name	**Job Title**	**Date of IIA training**
Rhiannon Virgo (Facilitator)	Project Manager - Innovation and Sustainability	
Dr Linda Irvine Fitzpatrick (Lead Officer; Report Writer)	Strategic Programme Manager, Thrive Edinburgh and Substance Use SRO, Edinburgh Wellbeing Pact, Community Mobilisation, Prevention and Early Intervention	
Susan Shippey	Strategic Planning and Commissioning Officer (Sensory Loss)	
Stef Milenkovic	Senior Development Officer, EVOC	
Stephanie-Anne Harris	Strategic Development Manager Edinburgh Community Health Forum	
Susan Robertson	Strategic Planning and Commissioning Officer for Physical Disabilities	
Paul Powrie	Public Health Practitioner (South)	
Nikki Conway	Locality Manager, SE Edinburgh `	
Karina O'Rourke	Long Terms Condions Lead, EHSCP	
Karen Thom	Strategic Planning and Commisisoning Officer, EHSCP	

7. Evidence available at the time of the IIA

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
Data on populations in need	edinburgh-by-numbers-2023 Population and demographics - Edinburgh Health & Social Care Partnership (edinburghhsc.scot) Household data Census 2022 Edinburgh Integration Joint Board - Joint Strategic Needs Assessment – Dementia (2022) https://www.edinburghhsc.scot/the-ijb/jsna/dementia/	Provides current and projected data on the wider population in the City of Edinburgh In 2019 an estimated 8,065 Edinburgh citizens (includes 281 under 65 years) were living with dementia. 2024 projected figures are 8,790.From the most recent population projections available (2018 based), it is projected that by 2034 the number of people in Edinburgh living with dementia will rise by 26% (11,077). 1 in 4 people at any one time in acute hospitals will be living with dementia[1]
Data on service uptake/access	National Benchmarking data https://www.edinburghhsc.scot/moregooddays/	2021/22 LGBF data shows an increase in the number of people supported to live as independently as possible.

[1] Scottish Government (2023) Dementia in Scotland - Everyone's Story

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
Data on socio-economic disadvantage e.g. low income, low wealth, material deprivation, area deprivation.	*Joint Strategic needs Assessment City of Edinburgh HSCP (2020)* https://www.edinburghhsc.scot/the-ijb/jsna/ Tackling Inequalities to reduce mental health problems – Mental Health Foundation (Jan 2020) Edinburgh poverty commission report – A just capital: Actions to end poverty in Edinburgh Hard Edges Report -Scotland Public Health Scotland (May 2024) Dementia Post Diagnostic Support Local Delivery Plan Standard. Figures 2021/2022	Provides current and projected data on the demographics within Edinburgh
Data on equality outcomes	JSNA-Health-Needs-of-Minority-Ethnic-Communities-Edinburgh-April-2018.pdf (edinburghhsc.scot) NHS Health Scotland - Dementia and Equality - Meeting the challenge in Scotland	Provides data on demographics of minority ethnic communities
Research/literature evidence	thetriangleofcare-thirdedition.pdf (nhslothian.scot) Prevention and Early Intervention Research to support the Final Report of the Evaluation of the Social Services and Well-being (Wales) Act 2014 (gov.wales) Prevention and Early Intervention Research to support the Final Report of the Evaluation of the Social Services and Well-being (Wales) Act 2014 (gov.wales)	
Public/patient/client experience information	Evidence reports from Capacity to Collaborate projects	

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
	Evidence of unmet needs through Community Mental health Fund research Thrive Summit Report (May 2024) Alzheimer Scotland Charter of Rights for People with Dementia and Their Carers 2010 Scottish Government Standards of Care for Dementia in Scotland June 2011	
Evidence of inclusive engagement of people who use the service and involvement findings	Complaints/ compliments	
Evidence of unmet need	Edinburgh Integration Joint Board Strategic Plan (2019-2022)	Details the health needs and priorities for the people of Edinburgh Strategic-Plan-2019-2022-1.pdf (edinburghhsc.scot)
Good practice guidelines	Principles of Inclusive Communication: Principles of Inclusive Communication: An information and self-assessment tool for public authorities - gov.scot (www.gov.scot) Fair Work Action Plan 17. The Real Living Wage - Fair Work: action plan - gov.scot (www.gov.scot) SIGN 168 - Assessment, diagnosis, care and support for people with dementia and their carers. National Clinical Guideline (Nov 23) https://www.sign.ac.uk/our-guidelines/dementia/	Detail of how to include everyone fairly in communications – self audit

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
	Scottish Government (2015) National Health and Wellbeing Outcomes Framework Healthcare Improvement Scotland (May 23) Quality Framework for Community Engagement and Participation	
Carbon emissions generated/reduced data	N/A	
Environmental data	2030-climate-strategy (edinburgh.gov.uk) Delivering a net zero, climate ready Edinburgh	Looking to net zero in Edinburgh focused on reducing impact of climate change
Risk from cumulative impacts		
Other (please specify)	The Impacts of Covid 19 on Equality in Scotland	
Additional evidence required		

8. In summary, what impacts were identified and which groups will they affect?

Equality, Health and Wellbeing and Human Rights	Affected populations
Positive The draft plan provides opportunities to be less siloed and work across themes as part of the new strategy. The group highlighted as we have an increasingly more diverse community we need to consider intersectionality - people don't just exist with one identity Remember age isn't always the determining factor for someone needing support from partnership.	All Population

Equality, Health and Wellbeing and Human Rights	**Affected populations**
There is an opportunity in the plan to consider transition points for people. These are extremely essential and vulnerable points in life and the support has to be there to help ensure these are meaningful and fulfilling experiences. In particular the group highlighted the impact transitions have on young people. There are opportunities to think about transition points for young people into adult services, particular focus on CAMHS into adult MH, also transition into becoming a new young carers The plan provides opportunities to consider how we deliver services to cultural diverse/international communities in terms of if they are locality or city wide based, and to think about how accessible they are for people. There are opportunities to consider cultural diversity, cultural norms for across international communities. How do we address and deliver services that meet their needs? Also consider if we do indeed have any unintentional cultural/structural racism. The group discussed how we allow our communities to understand better about their health and what they need or are able to get to help them. The plan offers an opportunity to consider health literacy and how we improve our communications. Consider developing a communication strategy alongside the plan. Alongside improvement in our communications there is an opportunity for us to get a shared terminology which is respectful and should give people dignity. We have an opportunity to review the data we gather and to consider if we are collecting the right data that will help us improve our response for vulnerable populations and international communities. The new plan encourages opportunities for income maximisation to help people experiencing poverty, inequalities, and vulnerabilities. There is an opportunity, through better look at data for the plan to identify populations in more need – look at how the system currently works for them, the gaps, challenges, and opportunities.	Young People Minority ethnic people (includes Gypsy/Travellers, migrant workers, non-English speakers) Refugees and asylum seekers Disabled people (includes physical disability, learning disability, sensory loss, long-term medical conditions, mental health problems) Those face poverty, people on benefits, homelessness, vulnerable populations Vulnerable populations as above, criminal justice
Negative People who experience sensory loss, need to think about health literacy for strategy, accessibility of information around the strategy.	

Appendix Two: Interim Integrated Impact Assessment

Equality, Health and Wellbeing and Human Rights	Affected populations
The plan may not consider specific circumstances and for example falls prevention and frailty, how does the strategy support this.	Older People
Transitions are extremely essential and vulnerable points in life and the support has to be there to help ensure these are meaning	
More female carers, generally more negative impact	Young People
Need for a engagement plan for people living in areas of deprivation, poverty and facing inequalities. If not specifically addressed will impact vulnerable families who current seek and require support from organisations.	Women
Similar to above - need to have an engagement plan for people who are harder to reach, living alone, not seeking help, or those with no fixed address.	Vulnerable families
With evidence from community resilience team showing people leaving care settings need 'basic needs' helped with, such food and heating – can impact on delayed discharge from hospitals.	Vulnerable, lone people, people facing homeless
Young carers – how do we support to become and to be a young carer whilst trying to transition through into adulthood.	Vulnerable families, people leaving hospital
Communications:	Young People/Carers
Effective, inclusive and accessible information and communicatins are required could mitigate the sense of isolation and exclusion, and possibly encourage collective peer support and community of interest cohesion.	All
May impact on communities out with city centre area more rural if organisations get reduced finance which causes closures – further understand of where may be impacted.	
Closures – further understand of where may be impacted.	Rural/Geographic communities
Need to consider access to places and spaces for more rural communities.	Rural/Geographic communities
Need to consider transport and local transport networks – access to services and supports.	Rural communities
	Rural communities

Environment and Sustainability including climate change emissions and impacts	**Affected populations**
Positive Opportunities to align actions to Edinburgh Climate Strategy which shows future impact of climate change	All
Negative	

Economic	**Affected populations**
Positive Opportunities for supporting staff wellbeing and impact on staff retention. Staff and people renumeration	Staff Staff/volunteers/Peers
Negative	

9. Is any part of this policy/ service to be carried out wholly or partly by contractors and if so how will equality, human rights including children's rights, environmental and sustainability issues be addressed?

10. Consider how you will communicate information about this policy/ service change to children and young people and those affected by sensory impairment, speech impairment, low level literacy or numeracy, learning difficulties or English as a second language? Please provide a summary of the communications plan.

Identified an opportunity to use the good practice in:

Principles of Inclusive Communication:
Principles of Inclusive Communication: An information and self-assessment tool for public authorities - gov.scot (www.gov.scot)

Consider communication strategy alongside strategic plan

11. Is the plan, programme, strategy or policy likely to result in significant environmental effects, either positive or negative? If yes, it is likely that a Strategic Environmental Assessment (SEA) will be required and the impacts identified in the IIA should be included in this. See section 2.10 in the Guidance for further information.

Need to consider Edinburgh Climate Strategy: 2030-climate-strategy (edinburgh.gov.uk)
Delivering a net zero, climate ready Edinburgh

12. Additional Information and Evidence Required

If further evidence is required, please note how it will be gathered. If appropriate, mark this report as interim and submit updated final report once further evidence has been gathered.

13. Specific to this IIA only, what recommended actions have been, or will be, undertaken and by when? (these should be drawn from 7 – 11 above) Please complete:

Specific actions (as a result of the IIA which may include financial implications, mitigating actions and risks of cumulative impacts)	Who will take them forward (name and job title	Deadline for progressing	Review date
Complete further IIA as part of formal public consultation process	Dr Linda Irvine Fitzpatrick	September 2024	

14. Are there any negative impacts in section 8 for which there are no identified mitigating actions?

These are to be reviewed as part of any future IIA

15. How will you monitor how this proposal affects different groups, including people with protected characteristics?

- More localities provider meetings to improve communication knowledge, sharing and capacity building
- Improved data collection of protected characteristics and sharing the collated information with providers

16. Sign off by Head of Service

Name

Date

17. Publication

Completed and signed IIAs should be sent to:
integratedimpactassessments@edinburgh.gov.uk to be published on the Council website www.edinburgh.gov.uk/impactassessments
Edinburgh Integration Joint Board/Health and Social Care
sarah.bryson@edinburgh.gov.uk to be published at
www.edinburghhsc.scot/the-ijb/integrated-impact-assessments/

Appendix 3: Community Engagement Standards

- **Inclusion** - How well did we involve the people and organisations that are affected by the engagement? For example, did we think about those excluded from participating due to disadvantage relating to social or economic factors?

- **Support** - How good were we at identifying and overcoming any barriers to participation? For example, were actions taken to remove any barrier to participating in engagement activities?

- **Planning** How clear were we about the purpose for the engagement? For example, was there a clear engagement plan in place? Was there enough time and resources to support an effective engagement process?

- **Working Together** How well did we work together to achieve the aims of the engagement? For example, were roles and responsibilities clear and understood for all those involved? Did the methods of communication during the engagement process meet the needs of all partners?

- **Methods** How good were our methods of engagement? For example, did we use a variety of methods of engagement to ensure that all voices are heard? Did we make use of creative approaches to encourage participation and effective dialogue? Did we obtain feedback on the methods to ensure that we are learning and adapting?

- **Communication** How well did we communicate with the people, organisations and communities affected by the engagement? For example, was information clear and accessible? Did we provide feedback to the community on the engagement process, options which have been considered and any decisions and actions which have been agreed and the reasons why?

- **Impact** How well did we assess the impact of the engagement and use what we have learned to improve our future community engagement? For example, is the community more involved and influential in decision making, have local outcomes or services improved as a result of the process?