Edinburgh Integration Joint Board

More good days

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

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.

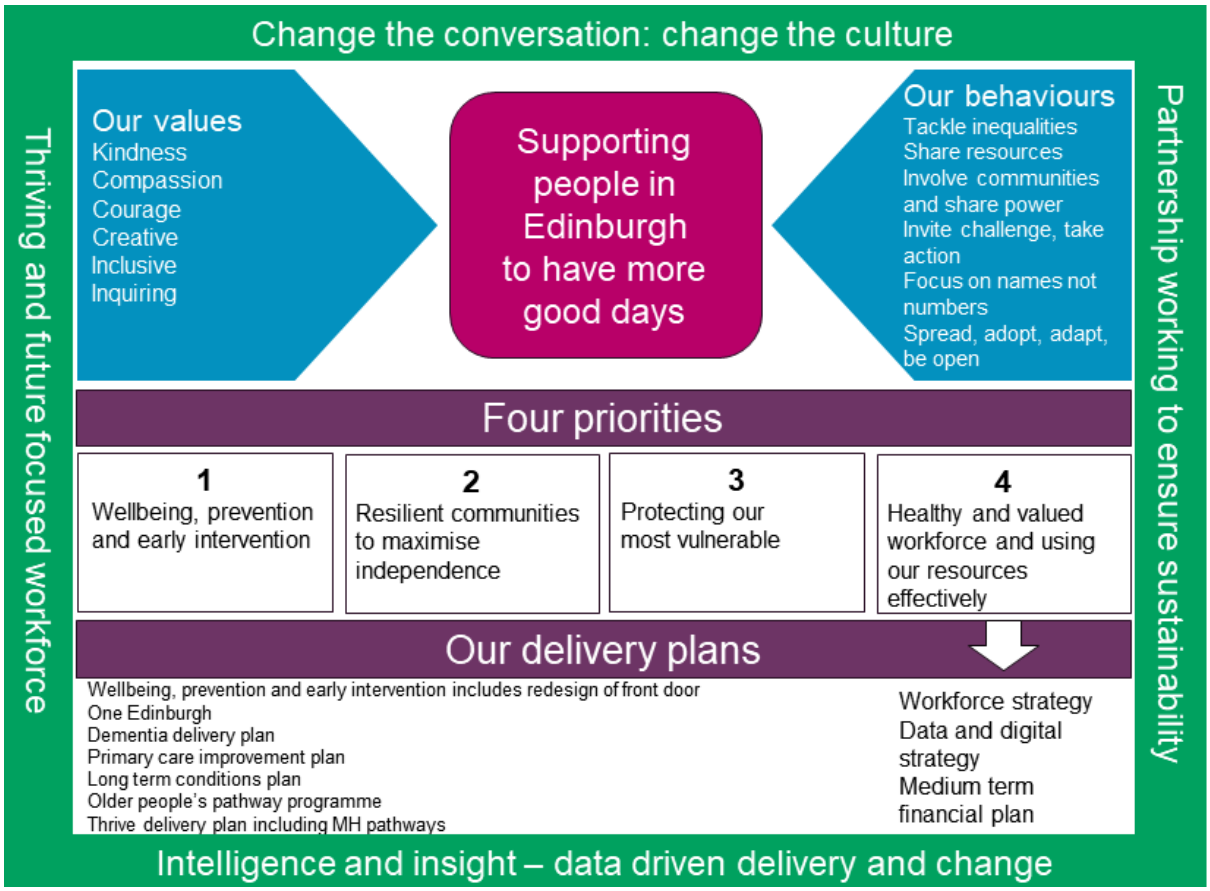
We will continue with **Our More Good Days** dialogue to continue to check in and establish what's important and of value to individuals and communities. These insights will continue to inform future planning and prioritisation in delivering the ambitions contained in the strategy.

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



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:

Carers Support Services	Care at Home services	Dementia Services
Technology Enabled Care	learning disability services	Pharmaceutical Services
Social Care Assessment and other Social Work Services	GP Services and enhanced primary care services delivered through 70+ GP practices	Thrive Edinburgh – prevention, early intervention and care and treatment services for people with mental health problems
Sight Loss rehabilitation, access and advice for sight loss, deaf equipment, and deaf social care	Services to prevent admission to and support discharge from hospital	Providing health interventions to people who are homeless
Hospital at Home services	District Nursing	care homes and nursing homes
Substance Use services	Palliative Care Services	

In Edinburgh, NHS Lothian and City of Edinburgh Council integrated services are known as the 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

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. 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.

Our population

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.

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.

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.

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.

Working in Partnership

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

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Our 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.

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 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.

Improving wellbeing is not just about the design of a great health and social care system. It is about how we create the conditions for more good days. The many challenges we face has galvanised people 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.

Prevent – applied to everyone services, facilities and resources that will help avoid the need for care and support developing

Reduce –targeted at people at risk of developing needs where support may slow this process or prevent other needs from developing.

Delay –aimed at people with established complex health conditions, to minimise the effects, support them to regain skills and to reduce their needs wherever possible.

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."

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.

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.

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 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.

Commissioning differently

Edinburgh Integration Joint Board for Health and Social Care is responsible for planning and commissioning acute health and social care 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.

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

. 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.

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.

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.

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:

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. 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

Digital transformation

We live in a digital world, and it is changing the way we work and provide services for you. We must change the way we think about, plan, and deliver services. Digital transformation is a key focus of the Scottish Government. Good health and social care rely on strong human relationships. Digital technology cannot replace those but can enhance them by transforming how we enable you to monitor and manage your own health, and how we connect and support you to access actionable information and services. It can also help us capture and bring together information about people who use our services in a way that can help us plan and deliver them more effectively.

It is critical that whilst we build on services offered digitally, we consider those who are digitally excluded due to a lack of access, skills, and capabilities. The developing Digital and Data Strategy aims to promote digital inclusion by addressing the barriers to opportunity, access, knowledge, and skills in using technology.

Developing research capability and capacity

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.

Wellbeing, prevention, and early intervention

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.

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.

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.

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
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.
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
Resilient Communities to maximise independence
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 multi-professional Primary Care Teams are operating as efficiently as possible while recognising serious financial constraints and disproportionate growth

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
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.
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.
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
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

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.
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
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.
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 .
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.
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.
The Challenge: People who frequently attend EMERGENCY DEPARTMENT 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.
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
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.
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
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.

Priority 3: Protecting our most vulnerable
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
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.
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
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

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
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.
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.
healthy and valued workforce and using our resources effectively.
he 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

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.
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.
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
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

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