Edinburgh Integration Joint Board

Edinburgh IJB Strategic Plan

April 2025 - March 2028

Contents

Foreword

Welcome to Edinburgh Integration Joint Board's (IJB) Strategic Plan.

This plan covers the three financial years running from 1 April 2025 to 31 March 2028.

This Strategic Plan has been produced with extensive input from the citizens of Edinburgh. Also, with the many organisations and teams that serve our communities.

Our purpose as an IJB is to provide the best health and social care services that we can with the resources we have available.

This means working to make Edinburgh a safer, healthier and fairer place to live for everybody.

This Strategic Plan aims to provide a clear and realistic indication of what we believe that we can achieve in each area of the IJB's responsibility over the next three years and how we intend to do it.

This plan outlines the many complex challenges facing Edinburgh's health and social care system and how the IJB plans to use the resources we have available to address them.

This plan has been written in the context of the IJB being in a financially unsustainable position.

When the Edinburgh IJB was first established in 2016, it had an annual funding deficit of around £32M. Despite achieving substantial savings over many years, it has never been possible to close the gap between the funding the IJB receives and the IJB's obligations to provide services.

The increasingly difficult financial climate across Scotland and the UK has reduced the ability of our partner organisations, NHS Lothian and the City of Edinburgh Council, to support the IJB with overspends at the end of each financial year. This has increased pressure on the IJB to be able to live within its means.

The demand for services continues to grow. This means that the IJB has already had to make some difficult decisions about what services it can and cannot afford to

provide. It is expected that further difficult decisions will be need as we work towards a more financially sustainable health and social care system.

Although the financial challenge is more severe in Edinburgh due to our underlying financial deficit, the problem of rising demand and diminishing resources is shared by most of Scotland's IJBs.

This is evidenced by the results of Audit Scotland's 2024 finance and performance report which concluded IJB funding across Scotland was not sustainable.

The priority throughout this Strategic Plan is maintaining the IJB's ability to uphold its many legal responsibilities wherever possible; something that is becoming increasingly difficult to do.

This does not mean that the IJB intends to focus on the provision of statutory services only. It is recognised that investing in other types of provision can help reduce demand on statutory services and be a cost-effective way of supporting the IJB to meets its legal duties.

What it means is that we will take a rigorous approach to evidence-based commissioning. This will ensure that every penny of the IJB's budget is spent responsibly and directly contributes to the IJB's strategic priorities. The IJB is committed to achieving this through a whole system approach. We will work with our partner organisations, NHS Lothian and the City of Edinburgh Council, and with the independent and third sector, as we develop a more collaborative approach to commissioning.

The IJB invites our partner organisations to align their own strategies and resources to those we have committed to in this plan. This will help us to work together across the city to achieve our shared goals. We must also establish clear mechanisms to hold each other to account, as everyone needs to play their part.

This Strategic Plan provides an overview of the IJB's direction of travel for the next three years. It covers what we intend to focus on and why. It should be read in conjunction with our implementation plan, which details how we will do it, our measurement framework which shows how we will know if it is working, and our medium-term financial strategy (MTFS) which shows how we will pay for it.

Chair
Edinburgh Integration Joint Board

Chief Officer
Edinburgh Integration Joint Board

Role and responsibilities of the IJB

In 2014, the Scottish Government passed a law which required local councils and health boards to work together to plan and deliver health and social care.

This law created Integration Joint Boards (IJBs).

The purpose of IJBs is to deliver the national health and wellbeing outcomes. These are:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer
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
3. People who use health and social care services have positive experiences of those services, and have their dignity respected
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5. Health and social care services contribute to reducing health inequalities
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
7. People who use health and social care services are safe from harm
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
9. Resources are used effectively and efficiently in the provision of health and social care services

At heart, our role is to make Edinburgh a healthier, safer and fairer place for everybody to live.

IJBs are funded by both the council and the health board and have responsibility for making decisions and allocating resources to specific areas of delegated responsibility.

Edinburgh's IJB has members from each political party represented on the local council, members nominated from the health board as well as representatives from the third sector, carers and service users.

The Chief Officer of Edinburgh Health and Social Care Partnership (EHSCP) is also a member of the IJB.

The EHSCP is an organisation formed by mutual agreement between NHS Lothian and the City of Edinburgh Council (the Council) to manage and deliver a range of delegated services on behalf of the IJB. Officers from EHSCP produce reports for the IJB and provide advice to members. All decisions are made by the IJB members.

The IJB does not provide services but is responsible for deciding what needs to be done, who is best placed to do it and how much money to give them to do it.

The services are then provided on behalf of the IJB by either the Council, NHS Lothian, EHSCP or from an independent or third sector organisation (TSO).

The IJB then has the responsibility for holding delivery partners to account for performance and value for money.

The IJB must achieve a balanced budget in each financial year. This is becoming increasingly difficult due to the demand for and cost of services rising faster than the budget the IJB has available to spend.

The areas of responsibility delegated to Edinburgh's IJB are:

- Unscheduled care — for example, emergency departments and minor injury units, acute medical wards, general medical wards and hospital at home services
- Adult social care — for example, assessments of social care needs, provision of care at home, supported living placements, care home placements
- Primary care — for example, local doctors' services (GP practices), NHS dentists, optometrists, district nurses
- Pharmaceutical services — for example, community pharmacies and prescriptions
- Rehabilitation — for example, physiotherapy, occupational therapy, dietetics and speech therapy
- Mental health — for example, prevention, early intervention and treatment services, community mental health teams and mental health hospital wards.
- Substance use — for example, addiction prevention and treatment services, harm-reduction services
- Palliative care — for example, hospice and hospice at home services
- Carers support — for example, access to information, advice, and support through personalised plans for unpaid carers

- Sexual health — for example, contraception, prevention, diagnosis and treatment of sexually transmitted infections
- Disability services — for example, learning disability, sight loss and hearing loss support services

The complexity of health and social care means that the work of the IJB often overlaps with that of other organisations.

Some key areas of overlap which affect the work of the IJB and yet are outside of the Edinburgh IJB's areas of delegated responsibility are:

- Housing
- Homelessness
- Refugee services
- Justice services
- Benefits and poverty reduction
- Elective surgery
- Children's services
- Public health.

We will continue to develop our relationships with partner organisations and collaborate to address these complex challenges. We will concentrate our attention and resources on the areas of responsibility that are delegated to the IJB.

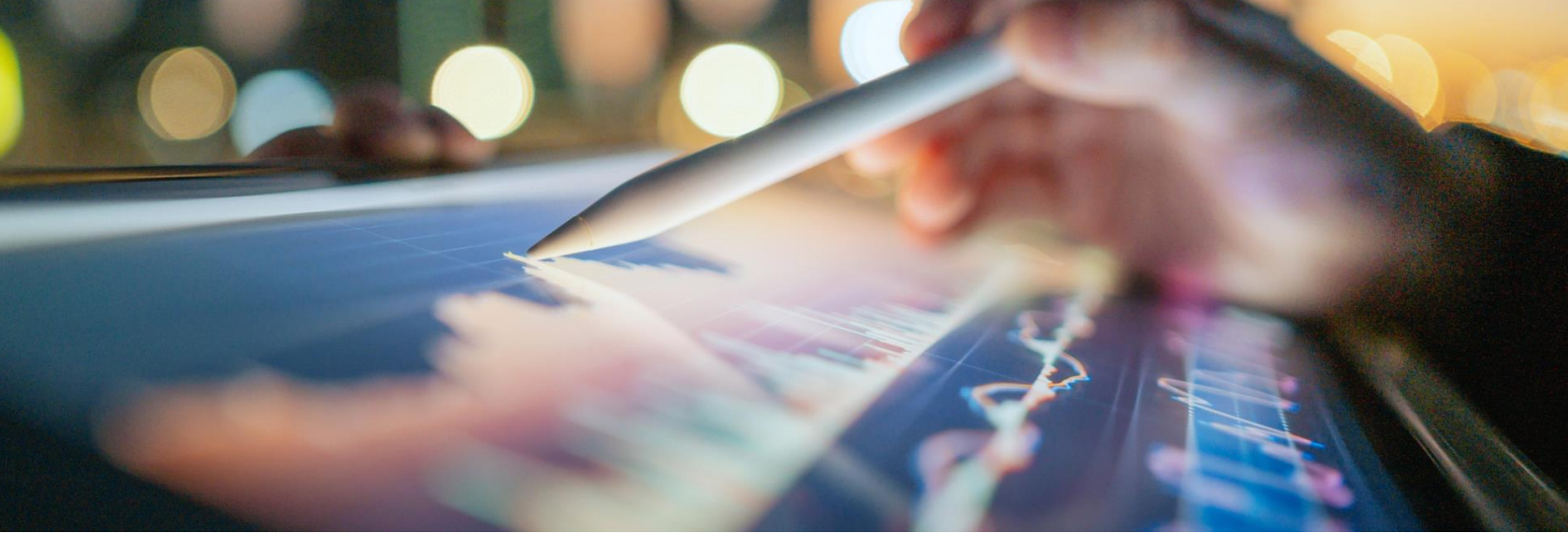
This strategic plan should be read in conjunction with the key strategic documents from our partner organisations:

<u>NHS Lothian</u>

- Lothian's strategic development framework (LSDF)
- LSDF implementation books
- Quality strategy.

<u>City of Edinburgh Council</u>

- City plan 2030
- End poverty Edinburgh delivery plan
- City mobility plan
- Edinburgh children's services plan
- 2030 climate strategy
- Our people strategy
- Living well locally strategy
- Equality and diversity framework.



Development process for the Strategic Plan

This Strategic Plan is being shared almost three years late. It should have been published in 2022.

A lot has changed in those three years, so this plan has also had to adapt to keep up.

What has not changed is the IJB's commitment to provide the best possible health and social care services that we can to the people of Edinburgh with the resources we have available.

To understand what the best possible health and social care services look like, we have:

1. Looked closely at what the law says we **must** provide
2. Looked closely at what best practice guidelines say we **should** provide
3. Listened to the people of Edinburgh about what services you **would like** us to provide through a series of interviews, focus groups and workshops.
4. Considered what services it is going to be **possible** to provide over the next three years with the funding that we have available.

This Strategic Plan summarises the big issues facing different communities within Edinburgh and explains how the IJB plans to help.

A previous version of the Strategic Plan was shared in a public consultation over the summer of 2024.

We received a lot of positive feedback about the plan's principles, although some people also felt it was unrealistic, too vague or too complicated and did not cover all areas of the IJB's responsibility.

This Strategic Plan was produced in response to that feedback. It follows the same principles whilst being clear about what we can afford to do and what this is likely to mean in practice for different communities and service areas.

The title of 'more good days' was also removed in response to feedback that it was not realistic in the current economic climate.

Housing contribution statement

Understanding our population

In developing this Strategic Plan, we analysed a lot of data to improve our understanding of the population of Edinburgh and the type of health and social care services that are most needed. For more detail, please see our joint strategic needs assessment (JSNA).

Key point about the population	Evidence
It's big	In the 2022 census, 512,700 people were recorded as living in Edinburgh.
It's getting bigger	The population has increased by 36,100 people since the last census in 2011. It is expected to grow by a further 9,000 people during the three-year period of this Strategic Plan
It's getting older	Most of the population growth is happening in people over the age of 65.
It's getting more ethnically diverse	In the 2022 census, around 15% of the population recorded their ethnicity as non-white (an increase from 8% in the 2011 census).
It has significant pockets of deprivation and they're growing fastest	16.5% of people living in the North East of the city live in the highest areas of deprivation and this is the area of the city projected to experience the biggest growth.
Most population growth is occurring in the groups that have the highest health and social care needs	There is strong evidence that older people, people from ethnic minorities and people living in deprived areas have greater levels of need for health and social care.

This understanding of our current population and how it is likely to change over the coming years has enabled the IJB to take a more pro-active approach to addressing the growing gap between the demand for services and the resources available.

Meeting this challenge means a greater concentration of our efforts and resources on the delivery of our key strategic priorities as an IJB.

Our strategic priorities

The key strategic priorities for the IJB between April 2025 and March 2028 are:

1. Prevention and early intervention

2. Maximising independence

3. Protecting our most vulnerable

4. Using our resources effectively

Each of our priorities is explored in detail throughout this Strategic Plan.

To make this document easier to read, each priority has been presented individually although a great deal of overlap exists between them.

The theme that unifies each of these strategic priorities and runs throughout this Strategic Plan, is that the IJB is committed to doing the best it can with the resources it has.

Each topic area is presented in two pages. The first page summarises the context in which the IJB is operating and outlines the rationale for the strategic choices we have made. The second page provides a more detailed breakdown of the actions we plan to take, why we believe they will help, and how we will know if they are working.

We chose this format to make it easier for people to navigate to the areas of most interest to them.

The wording of our four priorities has changed slightly from the previous draft of the strategic plan. The underlying principles remain the same.

The changes were made to make this Strategic Plan easier to understand and to make it realistic to implement.

The changes that have been made are:

- The wording of '**Wellbeing, prevention and early intervention'** has changed to '**prevention and early intervention**.'

  This change was made because wellbeing is an outcome we aim to achieve rather than a specific intervention that can be delivered.

  We made this change in response to feedback received which said the previous draft Strategic Plan was too woolly. In this draft, we have tried to be clear about the specific actions that we will take to achieve our goals.

  Improving wellbeing remains our core purpose.

- The wording of '**Resilient communities to maximise independence'** has changed to '**maximising independence**.'

  This change was made because these two concepts are both important but are different enough that they should be explored separately.

  The IJB also has a different level of influence over each.

  Changing the wording of this priority has enabled a more focused approach.

  This will help us to deliver improvement.

  We remain committed to building resilient communities and explore this in depth in the 'using our resources effectively' chapter.

- The wording of '**Valuing our workforce and managing resources**' has changed to '**using our resources effectively**.'

  This change was made to reflect the broader content covered in this section compared to the previous draft.

  We made this change in response to feedback received which said the previous draft Strategic Plan was too narrowly focused and did not consider all areas of the IJB's responsibility. This is corrected in this draft.

  We remain committed to valuing our workforce and explore this in depth within this chapter.

Prevention and early intervention

Prevention and early intervention are concepts that are often discussed and yet, are not always clearly defined.

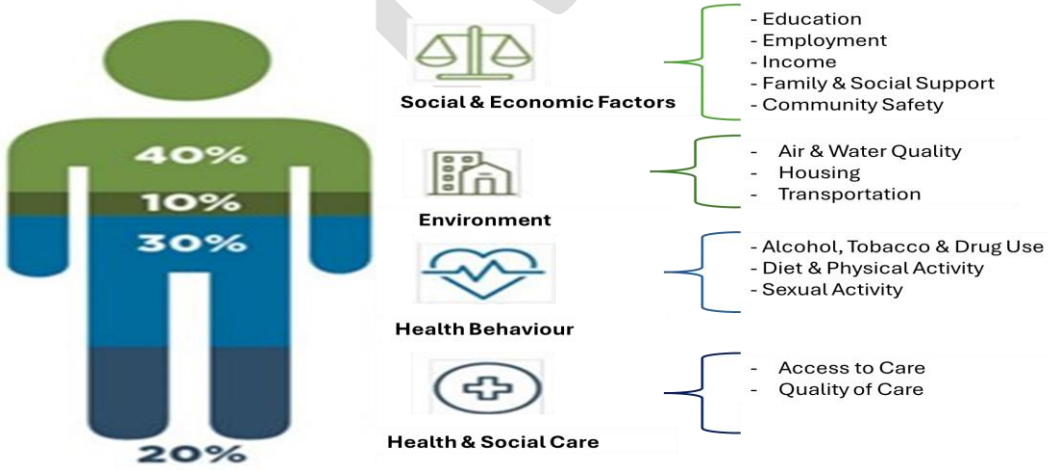
In their most basic form:

- prevention means taking action to avoid something bad from happening
- Early intervention means acting quickly to stop something getting worse.

This Strategic Plan recognises that both prevention and early intervention need to run through everything we do.

This is the right thing to do for our citizens as it is the best way to avoid harm from occurring and minimises the extent of any harm that does occur. It is also the financially responsible thing to do because, when it is done right, prevention and early intervention can reduce the need for more expensive services to be provided in the future.

As shown in figure 1, an individual's heath and their social care needs are affected by many factors.



To maximise the IJB's impact, our efforts and resources will concentrate on factors within our control. This is mainly the availability and quality of our services and to an extent, our ability to positively influence health behaviours of the people we serve.

We know that there are a lot of factors that influence health and social care. We will work with our partners to address these wherever possible. We are also aware that our partners are looking to us to deliver on the areas of work that only we can.

Tackling complex problems like this requires teamwork. This Strategic Plan recognises that the primary role of the IJB on that team is to provide high quality and accessible health and social care services.

We will focus on defining what good looks like in each service we provide. We will make sure that prevention and early intervention are part of everything we do.

A big part of this will be increasing the number of people taking part in vaccination and screening programs. These are some of the most effective ways to prevent people becoming unwell. We know that people from some groups are less likely to access these services currently. This means they are more likely to become seriously ill. To improve this, we will analyse who is and is not taking part. We will then work with the communities that are not taking part to help them to benefit from these services.

We will also be looking to take specific action to improve our prevention and early intervention offer for each of the following groups. To make it easier for readers to follow, we have arranged these in relation to a typical life course.

1. People transitioning from young people's services to adult services
2. People with health or social care needs that are impacting on their ability to work
3. People who are at risk of being unable to continue caring for others
4. People who are dependent or at risk of becoming dependent on substances such as alcohol or drugs
5. People who are at risk of harming themselves or others
6. People with long-term health conditions
7. People with frailty
8. People who have had or are likely to have falls
9. People living in care homes
10. People who are likely to be in their last year of life

Making improvements in these areas will help the people in these groups. It will also save the IJB money. This means that we will be able to help more people.

Our financial position means that we need to prioritise investments that have the biggest impact for our delegated services whilst also producing substantial cost savings in the near term.

We hope that we can extend the window required for return on investment and make more long-term investments in population health in future Strategic Plans once the IJB reaches a more sustainable financial position, but this is not realistic just now.

The next few pages show the opportunity associated with each group and explain where we will focus our prevention and early intervention efforts.

People transitioning from young people's services to adult services

The responsibility for commissioning adult health and social care services is delegated to the IJB but children's services is not. We want to support young people to make the transition to adulthood in a safe, smooth and empowering way.

Each year around 60-70 young people supported by children's services are identified as likely to need support from adult services. At this point, the IJB becomes responsible for their needs. Most of these individuals have significant needs related to an intellectual disability, physical disability or mental health condition (or a combination of these). It is also common for some aspects of their support to be specific to childhood and not suitable for continuation in adulthood.

Support packages for young people are often linked to their schooling or educational needs. They may include accommodation restricted to children and young people, possibly located outside of Edinburgh. In practice, this usually means that transitioning to adult services needs an entirely new package of support, adaptions to the family home or new accommodation. We must also look at what support the individual needs to take on more adult roles within their life. This may involve taking more responsibility for making decisions, managing their finances, directing their care and possibly accessing employment.

People transitioning to adult services often need a lot of support, sometimes for the rest of their life. The financial cost of this pathway is therefore substantial.

It is essential that we help people to be as independent as possible. We also need to improve the efficiency of the support provided. This may include temporarily enhancing support during the transition period whilst new skills are developed, and new routines are established. It may also include capital investment in adapted housing and developing communities on a core and cluster model to realise economies of scale for care providers.

A common frustration we hear expressed by the people we support and their family members is that plans are made too late. This causes unnecessary anxiety.

As one of our key prevention and early intervention priorities, we commit to working with families to begin planning for their transition to adult services from the age of 14.

Our focus throughout the course of this Strategic Plan will be to maximise the independence of people transitioning to adult services as they begin to take on more adult life roles and to develop more efficient models of service delivery.

Primary aim 1: To maximise independence when young people move to adult services, reducing the number of care hours required per person each week.

Primary aim 2: To ensure best value for money, reducing the average cost of care provided per week for people after completing their transition to adult services.

People transitioning from young people's services to adult services		
We will…	**Which will…**	**Measures…**
• Produce accessible information about how to stay well and lead a healthy active life • Encourage people to look after their health by participating in vaccination and screening programmes when and where appropriate • Produce accessible information about adult services • Share information in various formats to suit different people's preferences • Begin working with families to plan for transition from the age of 14 • Work with young people's services to make the transition to adult services as smooth as possible • Get regular feedback about how we can improve the experience for people in the future • Ensure health and social care needs are re-assessed when people transition into adult services • Appropriately involve individuals and their families in all decisions that affect them • Provide rehabilitation services to help people become as independent as possible • Provide enabling equipment to help people be as independent as possible. • Support access to disability-accessible housing were appropriate • Develop additional core and cluster accommodation schemes • Connect people with services that can help them to learn about any benefits they may be entitled to and how to manage their money • Help people to access volunteering opportunities and paid employment	• Enable people to lead healthier lives • Ensure people understand any differences that exist between young people's services and adult services • Ensure people understand how the transition process works • Ensure people receive a holistic assessment of their needs before completing their transition to adult services • Ensure people understand what the transition to adult services will mean for the support they receive • Ensure people are given the best opportunity to take on adult roles in all areas of their lives • Ensure people can be as independent as possible in their day to day lives • Realise economies of scale for care provision • Help people with the ability to progress into employment to do so	• Number of people receiving vaccinations / screening programmes after transitioning to adult services • Positive experiences of the transition process • Number of care hours provided per person for people completing transition to adult services • Average cost of care per week for people completing transition to adult services • Number of people in employment following transition to adult services

People with health of social care needs that are impacting on their ability to work

For many people, having access to work and being able to keep a job is an essential part of living a healthy life.

Working gives many benefits to individuals. The money people make from working can enable them to afford to heat their home. It means they can buy nutritious food to eat and do more of the things they enjoy. It also gives a healthy structure to their week and opportunities to meet people.

Working also has benefits to wider society by providing service to other citizens, reducing the amount of money the government needs to spend on unemployment and sickness benefits and increasing the amount of money generated in taxes. This should ultimately mean that there is more money available to help our city thrive.

It is the role of the Department for Work and Pensions (DWP) to fund job centres. It is the role of the City of Edinburgh Council to fund career coaching or access to work schemes. The IJB's responsibility is to ensure that we minimise any health and social care barriers to people benefiting from these resources.

Our role as commissioner of the city's health and social care services is an important enabler of this work. Just under half of the 5,624 people who accessed employment support services in 2023/24 had a health condition that could affect their ability to work. Within this group, the most common challenges experienced related to mental health conditions which affected 35% of people. This is followed by autism spectrum disorder (ASD) which affected 12%, physical disabilities which affected 10%, and learning disability which affected 7% of people.

It also makes sense for the IJB to focus our attention on helping people to work. There is strong evidence that people who are working are more likely to recover from illness and injury than people who are not working. By doing our part to help reduce barriers to work, we will also save the IJB money by reducing the need for long-term medication and repeated courses of treatment for conditions like chronic back pain.

The focus of our efforts in this area will be to improve the accessibility of our services and strengthening our links with employment support services. This will allow us to work together to overcome obstacles that are preventing people with health conditions from accessing or maintaining employment.

Primary aim: To enable people to access help more easily, increasing the number of people accessing services by self-referral

People with health or social care needs that are impacting on their ability to work		
We will…	**Which will…**	**Measures…**
• Produce accessible information about how to stay well and lead a healthy active life • Encourage people to look after their health by participating in vaccination and screening programmes when and where appropriate • Produce accessible information about what health and social care services we have available • Share information in various formats to suit different people's preferences • Connect people with services that can help them to learn about any benefits they may be entitled to and how to manage their money • Connect people with services that can help them to adapt their work or help them to find new jobs that they may better suit their abilities and circumstances • Enable people to access services such as physiotherapy without having to see their GP first • Routinely ask people who use our services if they are currently working and record this information • Provide access to services outside of traditional weekday office hours	• Enable people to lead healthier lives • Enable people to know what support is available • Help to reduce in-work poverty • Help more people to remain in work for longer • Make it easier for people to get the help they need directly • Help us design better services to support people to remain in work for the future • Help to reduce the impact of health conditions on an individual's ability to work	• Number of people accessing services by self-referral • Number of people giving up employment due to health conditions

People who are at risk of being unable to continue caring for others

We want to support carers to live well and to continue their caring responsibilities.

A carer is somebody who regularly helps (or plans to help) somebody else who could not manage without their support. They are not paid to give this help. People can be carers at any age.

The help that carers give may be the only source of support that a person in need receives. It may be in addition to services they get from people who are paid to help them.

Every carer has the right to an assessment of their needs and to a personalised plan to help protect their wellbeing and to support them to fulfil their caring role. The official definition and legal rights of carers are detailed in the Carers (Scotland) Act 2016. Their importance to the overall system is shown in the National Health and Wellbeing Outcomes framework. This says, '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.'

It is the IJB's responsibility to make sure this happens. Also, that effective support is given to meet their assessed need and in line with our local eligibility framework.

We know that the local data we have on people in unpaid caring roles is not complete. We also know that many people who provide this sort of help to others may not think of themselves as carers. Based on the data we have, we think there are somewhere between 45,000 and 70,000 adult carers in Edinburgh.

The 2022 Scottish Government carers census, which involved a smaller number of carers that were already known to carers centres and HSCPs, estimated that 91% of adult carers provide 20 hours or more of care each week. For Edinburgh, the cost of paying for this number of care hours for all of the people we think do unpaid caring roles would be somewhere between £49 million and £76 million each year.

In recent surveys, 68% of carers reported that their emotional wellbeing was adversely affected by their caring role (2022 Edinburgh carers survey) and 23% did not feel supported to continue in their caring role (2024 health and care experience survey). The Scottish Government's carers census also showed that women were four times as likely as male carers to give up paid work entirely and are also more likely to be in low-paid or part time employment due to their caring responsibilities.

We recognise the contribution that carers make to the sustainability of Edinburgh's health and social care system. Our focus throughout the course of this Strategic Plan will be to improve the support needed to enable carers to continue caring.

Primary aim: To support the health and wellbeing of carers, reducing the number of caring relationships that break down

People at risk of being unable to continue caring for others		
We will…	**Which will…**	**Measures…**
• Produce accessible information about how to stay well and lead a healthy active life whilst caring • Encourage carers to look after their health by taking part in vaccination and screening programmes when and where appropriate • Provide access to replacement care to enable carers to go to medical appointments • Produce accessible information about our carer support services • Share information in various formats to suit different people's preferences • Connect carers to welfare services that can help to make sure they receive any benefits they are entitled to • Provide training to people working in health and social care about the role of carers and how best to support them • Raise awareness of the role of unpaid carers and encourage people to make themselves known to services • Raise awareness amongst employers about how they can support people with caring responsibilities in the workplace • Keep a register of unpaid carers • Undertake a person-centred assessment of the needs and develop an appropriate support plan of each carer known to the EHSCP • Use a validated measurement tool to assess the risk of a carer being unable to maintain their caring responsibilities • Consider the impact on unpaid carers when developing care plans • Provide day services for cared for individuals to reduce strain on carers • Provide access to planned respite and replacement care where needed • Provide rapid access to respite and replacement care to help prevent caring relationships breaking down in crisis situations • Provide access to services outside of traditional weekday office hours • Regularly engage on the best way to support unpaid carers in their role	• Enable carers to lead healthier lives • Enable carers to know what support is available • Help to reduce the financial consequences of providing unpaid care • Make it easier for people to work whilst also providing care for others • Enable more informed judgements to be made about who is providing care for others • Enable us to communicate directly with carers • Enable the risk of caring relationships breaking down to be measured consistently • Enable better decisions to be made about the level of care a person needs • Provide carers with a break from caring • Help to ensure support is accessible when it is needed • Help us design better services to support carers	• Number of unpaid carers taking part in vaccination programmes / screening programmes • Number of people receiving carers allowance • Number of unpaid carers in work • Number of unpaid carers registered with the EHSCP • Number of caring relationships breaking down • Number of people admitted to respite as an emergency • Positive experience of providing unpaid care

People who are dependent on or at risk of becoming dependent on substances such as alcohol or drugs

We want to stop people coming to harm due to using alcohol and drugs unsafely.

The IJB is responsible for commissioning services to help prevent and treat addiction as well as for commissioning mental health services. There is some overlap for certain people we support. The IJB is also responsible for commissioning many of the services that can become necessary due to the harms that sometimes result from substance use. This includes treatment for blood borne viruses, acute hospital stays, physical injuries and psychosis.

For years, Scotland has consistently reported a higher rate of drug-related deaths and other harms than elsewhere in the UK and Europe. In response, the Scottish Government has made reducing the number of drug-related deaths that occur each year a priority and has asked IJBs to do the same.

The Scottish Government also established multi-agency Alcohol and Drug Partnerships (ADPs) with dedicated budgets to help inform and coordinate more strategic action between different organisations. In Edinburgh, the ADP is hosted by Edinburgh Health and Social Care Partnership.

In 2023, there were 111 drug-related deaths in Edinburgh which is about the same as in recent years. This suggests that we are not making much progress in reducing the figure. This is a complicated problem with more than 50 different drugs involved. Most drug users take more than one drug and in more than one way.

Also, in line with the rest of Scotland, Edinburgh has a problem with alcohol-related harms. Although, this has been getting steadily better over the last 20 years. Each year around 90 people in Edinburgh will die of an alcohol-specific condition which is around the same rate that occurs elsewhere in Scotland.

The IJB is responsible for commissioning services to prevent people becoming dependent on substances, as well as to reduce the harms associated with substance use. We also commission rehabilitation services for people wishing to quit or reduce their use of substances.

Fundamentally, preventing harm is the right thing to do. There is also an economic case for the IJB to invest in effective prevention and early intervention for this group. It would reduce the need to treat the avoidable harms that often occur as complications from substance use.

Our efforts will focus on reducing the harms that occur due to substance use. We aim to reduce blood borne virus transmission by helping people at the greatest risk of harm due to homelessness or living in temporary accommodation to access help.

Primary aim 1: To reduce the number of drug-related deaths

Primary aim 2: To reduce the number of alcohol-specific deaths

People who are dependent on or at risk of becoming dependent on substances such as alcohol or drugs		
We will…	**Which will…**	**Measures…**
• Produce accessible information about what services we have available • Share information in various formats to suit different people's preferences • Provide access to drug replacement therapies such as methadone • Provide access to safe injective equipment • Support expansion of the WAND initiative (wound care, assessment of injecting, Naloxone and dried blood-spit testing for bloodborne viruses) • Increase availability of drug testing services • Increase access to hepatitis C treatment in substance use clinics • Provide harm-reduction interventions to people in temporary accommodation, hospitals and residential care settings • Provide access to services outside of traditional weekday office hours • Provide access to specialist services for people using substances that also have a mental health condition. • Support EADP with planning, commissioning and data analysis • Support completion of robust multi-agency drug-related death (DRD) reviews and ensure learning is shared and implemented within our services • Develop a proposal to access additional funding from Scottish Government for provision of safer drug consumption facilities in Edinburgh • Work collaboratively with partners and actively engage in regular multi-agency meetings to give seamless care to the most vulnerable citizens • Provide assertive outreach services to support people with problems related to substance use that have recently been in contact with Scottish Ambulance Service or been to the emergency department • Provide access to residential, outpatient and community-based rehabilitation • Provide a specialist intermediate care service for people with health and social care problems related to substance use • Consistently promote access to harm reduction and recovery support • Regularly engage on the best way to help people who use substances	• Enable people to know what support is available • Make it easier for people to get help • Reduce harm • Ensure people know what substances they are taking • Help identify changes in drug use and inform service planning • Reduce some of the barriers that exist to accessing help • Support the work of the Edinburgh Alcohol and Drug Partnership • Help avoid the same mistakes being made again • Help break the cycle for individuals going from one crisis to another • Give people who want to reduce or stop their use of substances the support they need to do so • Help people to recover from some of the adverse consequences of their substance use • Give people with substance use problems a better chance to lead healthier lives • Help us design better services to support people to remain in work for the future	• Number of people admitted to hospital with drug-related problems • Number of drug-related deaths • Number of alcohol-related deaths • Number of people abstinent of substances six months post rehabilitation • Positive experiences of substance use services

People who are at risk of harming themselves or others

Sometimes, the symptoms of severe mental illness can cause people to harm themselves or others. This harm can take many forms including neglecting to meet essential needs such as eating and drinking, misuse of substances such as taking drugs or drinking too much alcohol, intentionally causing physical injuries, or even attempting to kill themselves or somebody else.

If these situations are not managed well when they arise, the consequences for the individuals affected and those around them can be devastating. At its most severe, it can lead to premature deaths and the development of new life-long disabilities. It is also strongly linked to high usage of other health and social care resources such as emergency department attendances, hospital admissions and detentions under the Mental Health Act (MHA). The cost of not providing good prevention and early intervention for this group of people is high on a human level and in financial terms.

The IJB is responsible for commissioning many of the services these people already use or would benefit from using. These services include where they may go to reach out for help such as their local GP surgery, Thrive welcome team, community mental health team or social work. It also includes, the treatment they may need such as medication, therapy and peer support or a stay in a specialist hospital. We also commission the services that currently deal with the consequences of our system not being able to prevent these harms occurring, for example, emergency departments, general hospitals and social care.

This gives us a lot of scope to make positive change. There is also a strong economic case for the IJB to invest more in effective prevention and early intervention for this group of people. Doing so would avoid the need for prolonged hospitalisation and the need to treat complications from avoidable harms.

Another priority for improvement for this group is to increase the level of support we can provide in the community. This will reduce our reliance on prolonged hospital admissions. It will also give people with mental illness the best opportunity to recover in their own homes and with the support of their friends and family around them.

The focus of our efforts in this area will be to reduce the harms that occur due to severe mental illness.

This will mean tailoring our support for individual groups, such as for men, who accounted for 46 of the 58 probable suicides that took place in Edinburgh in 2023, and for young people aged 18-24, who are significantly less likely than other adult age groups to ask for support from health professionals when they need it.

Primary aim 1: To provide effective support to prevent people from attempting to take their own lives, reducing the number of deaths recorded as probable suicide.

Primary aim 2: To support people with mental illness to live well in the community, reducing the number of people in the Royal Edinburgh Hospital.

People who are at risk of harming themselves or others		
We will…	**Which will…**	**Measures…**
• Provide a holistic and timely assessment of needs for people with symptoms of severe mental illness and review it regularly • Enable care agencies to provide support in a more flexible way to meet the changing needs of people with mental illness • Enable people with mental illnesses to see the same team of people each time to help them manage their condition effectively • Work closely with the Council and housing providers and to ensure that the living situation of people with mental illness is as good as it can be • Ensure that community teams respond quickly to individuals in crisis • Increase the capacity of community services to be able to help more people to receive the treatment they need without needing to go into hospital • Identify people most at risk in the community and intervene early to prevent prolonged stays in hospital becoming necessary • Ensure access to mental health teams within emergency departments • Commission enough mental health hospital beds to meet our demand • Ensure all treatments with the highest standard of evidence are provided • Work closely with City of Edinburgh Council and housing providers to maintain tenancies when people with mental illness get admitted to hospital so that they have still have their home to get back to • Enhance our mental health rehabilitation services to enable people to recover more quickly and be less reliant on others • Ensure everybody has been given a fair chance to return home before any decisions are made about their long-term care needs • Ensure everybody has access to independent advocacy services to support them to make big decisions when they are unwell • Increase access to supported living accommodation for people with complex needs • Regularly engage on the best way to support people with mental illness	• Get people help they need quickly • Enable more personalised care • Increase availability of help • Increase people's ability and confidence to manage their health effectively • Help stop little problems becoming big problems. • Ensure people are only admitted to hospital when they need to be • Ensure a robust assessment of risk Is undertaken by specialists • Ensure people start on the right treatment for them as soon as possible • Ensure hospital beds are available for people when they need them • Ensure people only remain in hospital for as long as they need to • Enable people to recover from mental illness more quickly • Enable people to be as independent as possible • Ensure everybody is given the best opportunity to return home • Enable people to live the best lives they can • Help us design better services	• Number of deaths recorded as probable suicide • Number of people attending the emergency department with self-harm related injuries • Number of people admitted to hospital for mental illness • Number of people with mental illness staying in hospital • Number of people with mental illness experiencing delays in their discharges from hospital. • Number of beds occupied in hospital. • Number of people returning home from hospital

People with long-term health conditions

We want to support people with long-term conditions to live healthy lives in the community.

A long-term condition is a health problem that needs ongoing support from health professionals. These can develop at any age and may occur on their own or along with other problems.

Edinburgh's ageing population means more people are living with at least one long-term health condition. This trend is set to continue. As well as being linked with age, long-term conditions are also linked to health inequalities and social deprivation.

The Scottish Government named care for people with long-term health conditions as a public health priority in 2018. It has also called for collective action to reduce the differences that exist in life expectancy between different areas of Scotland.

Living with a long-term condition can put people at risk of developing other problems. If they are not well controlled and planned for, it can lead to a snowball effect. This means little problems become big problems. For example, long-term conditions account for most prolonged hospital stays.

Long-term condition*	Approximate number of citizens affected in Edinburgh	Impact on hospitals
Respiratory conditions	31,000 people with asthma 9,000 people with other breathing problems	On average each day, 18 people are admitted to hospital with breathing problems and use around 127 hospital beds.
Heart Disease	80,000 people live with high blood pressure or other heart-related problems	On average each day, 24 people are admitted to hospital with heart problems and use around 87 hospital beds
Neurological conditions	6,000 live with epilepsy 9,000 people live with stroke	On average each day, 6 people are admitted to hospital with neurological problems and use around 84 hospital beds.

*Other long-term conditions of particular interest will be dementia, learning disability and diabetes. Our data on these conditions is currently incomplete.

We recognise the scale of missed opportunity to support people with long-term conditions to live healthier lives. Our focus throughout the course of this Strategic Plan will be to reduce the dependence on acute hospitals and support more people with long-term conditions to live well in the community.

Primary aim: To intervene early to prevent long-term conditions worsening, reducing the number of hospital beds occupied by people with specific long-term health conditions

People with long-term health conditions		
We will…	**Which will…**	**Measures…**
• Produce accessible information about how people can manage their own condition more effectively • Produce accessible information about what services we have available • Share information in various formats to suit different people's preferences Commission locally enhanced services to enable primary care to focus more resources on people with long-term conditions • Provide access to specialist multi-disciplinary teams for people long-term conditions • Ensure that all individuals with long-term conditions have advanced care plans (ACP) reflecting their preferred treatment choices for predictable exacerbations and deterioration in their condition • Provide support for people with long-term conditions to plan for future progression of their conditions to prevent crises from occurring • Develop specific strategies for dementia, respiratory conditions, heart failure, neurological conditions and learning disability. • Provide access to rehabilitation services to improve recovery from exacerbations • Provide home care and assistive technology where required • Assess and adapt people's home environments when required • Provide equipment to help people move around safely in their homes and the community	• Enable more people to manage their condition effectively • Enable people to know what support is available • Make it easier for people to get the help they need directly • Ensure people receive medical care that is in their best interests • Provide continuity of care and enable more holistic oversight of different episodes of care • Ensure access to pro-active preventative care • Help people with long-term conditions to recover from illness as quickly as possible • Help people with long-term conditions to recover their ability to do things for themselves as quickly as possible after illness or injury • Ensure people with long-term conditions are able to benefit from the right services for their needs at the right time • Help us design better services to support people with long-term conditions in the future	• Number of people admitted to hospital with dementia / respiratory conditions / heart failure / neurological / learning disability • Number of hospital beds occupied by people with dementia / respiratory conditions / heart failure / neurological / learning disability • Number of people delayed in hospital with AWI

People with frailty

We want to help people to live well in the community and avoid crisis.

Frailty is the term used to describe when people are more likely to get hurt or become ill and will find it harder to recover afterwards. What this means is that things that may be a relatively minor issue for somebody else, such as a urinary tract infection or constipation, can become a big problem or even a life-changing event for somebody living with frailty.

Frailty can develop at any age, sometimes because of another illness. It is becoming more common as people live longer. Frailty is not part of the normal ageing process and is often avoidable or reversible.

The increase in levels of frailty is a national challenge. Current data indicates that more than 55% of people in Scotland over the age of 65 live with some level of frailty (35% are mildly frail, 15% are moderately frail, and 5% are severely frail).

There is a lot of good collaborative work going on at a national level, with NHS Lothian and with the other Lothian IJBs. Edinburgh IJB will continue to contribute. One area of focus for this work is using GP records to identify people with frailty so that support can be given in a more proactive and preventative way.

People with frailty have high levels of health and social care needs. This is because they are more likely to get sick, they take longer to get better, and they are less likely to make a full recovery than people who are not frail. Frailty increases demand on care at home, care home placements, hospital care, providing medications and delivering primary care.

We want to prevent people from developing frailty and to reverse it when it develops. We must also adapt our services to the needs of people with frailty. This would improve outcomes and experience for people using our services. It would reduce crowding and waiting lists in all areas of the system. It would also save money.

A lack of consistent and compassionate forward planning and a lack of availability of appropriate community services, can mean people with moderate to severe frailty get admitted to acute hospitals. They can then remain for prolonged periods of time, even when it is not medically beneficial and is against their wishes.

Addressing these issues is an enormous task and will need to be done in stages.

Our focus over the course of the three years covered by this Strategic Plan will be to improve our ability to identify people living with frailty and to reduce the number of people with frailty admitted to acute hospitals for prolonged stays.

Primary aim 1: To support people to receive the care and support they need, increasing the number of people over the age of 65 with a clinical frailty score recorded

Primary aim 2: To enable people to spend more time at home, reducing the number of hospital beds occupied by people with frailty

People with frailty		
We will…	**Which will…**	**Measures…**
• Produce accessible information about what services are available. • Share information in various formats to suit different people's preferences • Provide access to community link workers that can support people to access activities in their local communities • Provide training to enable teams to recognise, assess and manage frailty • Use the clinical frailty scale to measure frailty • Use the clinical frailty scale to inform conversations and decisions about health care management at all stages of the patient journey • Ensure people with moderate to severe frailty receive a comprehensive geriatric assessment (CGA) and anticipatory care plan (ACP) • Commission locally enhanced services to enable primary care to focus more resources on identifying and supporting people with frailty • Increase capacity in our community teams working with people with frailty • Improve coordination of community teams working with people with frailty • Provide access to medical day hospital and outpatient services as an alternative to hospital admission • Provide access to hospital at home services as an alternative to hospital • Provide access to rehabilitation services to help solve problems and keep people as independent as possible • Provide access to social care support to help people with the essential things they cannot manage for themselves anymore • Provide rapid access to health and social care services • Provide rapid access to therapy and reablement services in the event of a deterioration in function • Consistently use a 'home first' approach • Provide timely access to frailty specialists for people living in the community, attending emergency departments, in hospital and in care homes • Regularly engage with people with frailty on the best way to support them	• Enable people to know what support is available • Help connect people to resources and activities within their local communities • Make it easier for people to get the help they need directly • Ensure frailty is assessed and recorded in a consistent way • Ensure people with frailty receive medical care that is in their best interests • Provide continuity of care and enable a more holistic oversight of different episodes of care • Ensure access to pro-active preventative care • Help people with frailty to recover from illness as quickly as possible • Help people with frailty to recover their ability to do things for themselves as quickly as possible after illness or injury • Ensure people with frailty are able to benefit from the right services for their needs at the right time • Help us design better services to support people with frailty	• Proportion of people aged over 65 with a clinical frailty score recorded • Proportion of people over the age of 65 with a CGA and ACP completed • Number of unscheduled hospital admissions for people over the age of 65 • Number of hospital bed days used by people over the age of 65

People who have had or are likely to have falls

Preventing falls is one of the IJB's biggest opportunities to improve the lives of the citizens of Edinburgh.

The consequences of a fall can be devastating for people. They may also lead to serious physical and psychological harm as well as a permanent loss of independence.

Falls are also one of the most expensive and yet largely avoidable challenges facing the health and social care system. The IJB is responsible for funding much of the treatment for falls. This includes emergency department attendances, hospital admissions, rehabilitation, and for the social care needs of people who do not make a full recovery and require life-long support afterwards. We can afford to invest in falls prevention because reducing falls would save the IJB a lot of money.

Edinburgh has work to do. We consistently rank in the bottom ten IJBs in Scotland for our number of hospital admissions that result from falls. In the year 203/24, there were 2,866 hospital admissions due to falls, 72% of which were in people over the age of 65. This is relatively high with 24.9 out of every 1,000 over 65s being admitted to hospital after a fall each year in Edinburgh compared to the Scottish average of 22.4 per 1,000. On average each day, three people over the age of 65 will be admitted to hospital with a broken hip, broken leg or broken forearm and they will occupy 65 hospital beds each day.

The financial cost to the IJB of managing these serious injuries and of providing the necessary rehabilitation and social care support afterwards is significant. Much of it could be avoided by reducing the number of people experiencing falls.

Strong evidence exists to tell us what works to prevent falls and how to do this cost-effectively. We want to put these measures in place. We will be taking some of this work forwards in partnership with NHS Lothian and the other Lothian IJBs. Some of this work will be specific to Edinburgh.

Our focus over the course of the three years covered by this Strategic Plan will be to get better at identifying people at risk of falls and preventing them from coming to harm. We will also reduce the number of people admitted to hospital with an injury following a fall and the number of hospital beds occupied by people admitted with an injury resulting from a fall.

Primary aim: To prevent people coming to harm, reducing the number of people admitted to hospital following a fall with a fractured neck of femur, lower leg or forearm.

People who have had or are likely to have falls		
We will…	**Which will…**	**Measures…**
• Produce accessible information about how people can identify when they are at risk of falls and reduce their own risk • Produce accessible information about what services we have available • Share information in various formats to suit different people's preferences • Provide training and guidance to enable everybody coming into contact with people at risk of falls to know how best they can help • Use a consistent screening tool across all community services to identify people at risk of falls • Commission locally enhanced services to enable primary care to focus more resources on people at risk of serious injury from falls • Use a consistent assessment tool to identify the reasons that individuals are at risk of falls • Assess and adapt people's home environments when falls risks are identified • Provide equipment to help people move safely around their homes and the community • Provide access to physiotherapy and occupational therapy services • Review medications in people identified to be at risk of falls to reduce the likelihood of falls and the likelihood of falls leading to serious injury • Provide home care and assistive technology where required. • Commission falls prevention exercise and education programmes for people to go to in local communities • Provide bespoke support to prevent falls occurring in care homes • Ensure all staff working on hospital wards have completed falls awareness and prevention training • Focus our falls-prevention efforts on the people most likely to benefit • Continuously monitor the data to determine if our approach is being effective in preventing falls	• Enable people to take their own reasonable precautions • Enable people to know what support is available • Make it easier for people to get the help they need • Identify people at most risk of falls • Enable the right interventions to be provided to the right people at the right time • Enable people to be more physically active and less reliant on others • Help people overcome specific issues that make them more likely to fall • Reduce risk of falls occurring in unfamiliar environments • Enable us to adapt our approach for maximal benefit	• Number of people attending the emergency department with falls • Number of people admitted to hospital following a fall • Number of beds occupied in hospital following admission with a fall • Number of people admitted to hospital with a fractured neck of femur • Number of falls in hospital

People living in care homes

We want people living in care homes to lead happy and healthy lives and to have access to the services they need to do so in their familiar surroundings.

People living in care homes are often frail or else they are likely to have another health condition that makes them vulnerable to becoming unwell. This means that people living in care homes are more likely to be admitted to hospital in an emergency than people who do not live in care homes.

As with the rest of the population of Edinburgh, the IJB is responsible for commissioning health services for people living in care homes. This includes, primary care, community teams such as hospital at home and physiotherapy, as well as some services in acute hospitals.

Edinburgh is starting from a position of relative strength when it comes to health provision for this group. Although people living in care homes in Edinburgh are about as likely to attend the emergency department as people living in care homes elsewhere in Scotland, they are around 34% less likely to be admitted and typically stay in hospital for about 30% less time than the national average.

We believe this is likely to be due to our investment in community services for people living in care homes. Services like our care home support team and our hospital at home service, as well as our emergency department frailty team. This service gives a comprehensive assessment to people showing frailty and aims to use community-based alternatives to hospital admission wherever appropriate.

Whilst we are performing well in relation to other IJBs, there is still scope for improvement. Around 4 care home residents go to the emergency department and occupy an average of 28 hospital beds each day. Given this population's level of vulnerability, it remains an area of focus for the IJB. We will do all we can to avoid having to take care home residents into busy and crowded emergency departments where they may experience a prolonged and uncomfortable stay or become disorientated by being admitted to hospital unless necessary.

There is also an economic case for supporting care home residents to access health care in their own environment. Often the IJB is already paying for the care home bed anyway.

The IJB's priority over the course of this Strategic Plan will be to maintain what is evidently working well already to support this population. We will also build on this success by continuing to develop our community-based alternatives to hospital care. We will promote their use whenever possible so that more people living in care homes can receive the health care they need in the safety and comfort of familiar surroundings.

Primary aim: To ensure peoples' health needs are met within care homes, reducing the number of hospital beds occupied by people living in care homes

People living in care homes		
We will…	**Which will…**	**Measures…**
• Produce accessible information about what services we have available. • Share information in various formats to suit different people's preferences • Ensure that everybody receives a Comprehensive Geriatric Assessment (CGA) and Anticipatory Care Plan (ACP) when they first get admitted to a care home • Ensure that CGAs and ACPs are reviewed and updated on an annual basis • Provide access to training to help all care home teams identify the early signs of a deterioration in a resident's health and to know what to do • Provide community nursing support to pro-actively review the health of people living in care homes and identify early signs of deterioration • Provide access to rehabilitation services for people living in care homes • Provide care homes with direct access to a senior clinical decision-maker who can make decisions about the medical management of residents overnight and at weekends • Provide access to Hospital at Home services • Regularly engage with people working in care homes on the best way to support them • Regularly engage with people living in care homes on the best way to support them	• Enable people to know what support is available • Make it easier for people to get the help they need • Ensure that every individual's needs are identified, and a plan is put in place to mee them • Help stop little things becoming big things • People are actively involved in decisions about their own health • Ensure that all health care interventions provided are in the individual's best interests • Enable care home residents to benefit from hospital-level care without leaving their care home • Help us design better services to support people working in care homes • Help us design better services to support people living in care homes	• Number of care home residents attending the emergency department • Number of care home residents being admitted to hospital • Number of hospital beds occupied by care home residents • Positive experience of working in Edinburgh's care homes • Positive experience of living in Edinburgh's care homes

People who are likely to be in their last year of life

We want to help everybody spend as much time as possible with the people they love, in the places they feel most comfortable.

The provision of effective and compassionate end of life care is an important responsibility of the IJB. We commission the services that provide the support that adults need to achieve a comfortable and dignified death.

The services we commission can take place in a person's own home, in a care home, in a hospice or in hospital. The choice about a preferred place of death is an important and deeply personal one for an individual and their family. This decision should be based on what is right for them. All too often this decision is influenced by where we have the capacity to provide care.

This can often mean people spending more of their last months of life in hospital than they would choose to do and more than is medically beneficial for them.

The Scottish Government has established a national steering group for palliative and end of life care and has a draft strategy currently out for consultation. This strategy aims to ensure everybody receives well-coordinated, timely and good quality palliative care as well as promoting forward planning around serious illness, dying, death, and bereavement.

This is a priority area for Edinburgh because national benchmarking shows that our citizens typically spend more of their last six months of life in hospital than people do elsewhere in Scotland.

One key area of focus will be to identify people who are likely to be in their last year of life and support them and their family to plan for the death they would want. This supports the principles of realistic medicine by enabling more personalisation and involving people in decisions about their care.

Another key area of focus will be to develop the capacity needed to meet demand for services in the community. This will reduce our reliance on hospitals to meet end of life care needs.

Primary aim: To support people to spend more time with the people they love and where they feel most comfortable, increasing the proportion of the last six months of life people spend at home or in a community setting

People likely to be in their last year of life		
We will…	**Which will…**	**Measures…**
• Produce accessible information about what services we have available • Share information in various formats to suit different people's preferences • Ensure that everybody identified as likely to be in their last year of life has a holistic care plan including their medical, social, cultural and spiritual needs • Provide access to training to help people recognise the early signs of a deterioration, know what to do to help and where to access support • Ensure that an anticipatory are plan (ACP) is completed for everybody identified as likely to be in their last year of life • Consistently ask individuals identified as likely to be in their last year of life where their preferred place of death would be and record this preference • Make every effort to fulfil an individual's wishes on preferred place of death • Consistently record obstacles that prevent people from being able to die in their preferred place of death, identify trends and work to prevent recurrence • Provide access to community teams to enable people with low complexity needs to die in their own homes when this is their preferred place of death • Provide access to specialist community palliative care teams to enable people with highly complexity needs to die in their own homes when this is their preferred place of death • Provide access to hospital-based palliative care teams to advise ward teams how best to meet the end-of-life needs of individuals in their care. • Provide access to hospital at home services • Commission hospices to provide inpatient, outpatient and domiciliary-based support to people with highly complex palliative care needs • Provide home care and assistive technology where required • Provide access to rehabilitation services to reduce reliance on other services and improve quality of life • Regularly engage with people receiving end of life care on the best way to support them	• Enable people to know what support is available • Make it easier for people to get the help they need • Enable provision of person-centred care • Enable the right interventions to be provided to the right people at the right time • Enable more people to die in their preferred place of death • Help to inform our future service planning • Help us design better services to support people in their last year of life	• Number of people with preferred place of death recorded • Number of people dying in their preferred place of death • Number of days spent in hospital in the last year of life • Experiences of people receiving palliative care

Maximising independence

The population of Edinburgh is getting bigger, older, more frail and less healthy as inequalities widen and a growing proportion of people live with one or more long-term health condition.

Demand for health and social care services already exceeds capacity in many areas. The population changes that are already underway mean that this pressure is likely to continue to grow for at least the next decade or more.

In 2019 Audit Scotland estimated that by 2034, Scotland would see a rise in demand for care at home by a staggering 33%. This represents a significant challenge to all IJBs.

As has been a consistent feature throughout this Strategic Plan, finance is the main constraint affecting the IJB's ability to meet demand. Whilst we are not without our own workforce challenges, Edinburgh is in the fortunate position of having a greater availability of care at home than most other areas of Scotland. This means that unlike most other IJBs, we are likely to run out of money to pay for care before our local care providers run out of capacity to provide it.

In many ways this is a positive position to be in compared to other areas, but it does reaffirm the need for the IJB to stay financially prudent. In the context of rising demand and reducing financial resources, traditional models of care are not financially sustainable.

The IJB is embarking on an ambitious redesign of what services we provide and how we deliver them. Throughout this process we will be placing a strong emphasis on maximising independence.

We believe that it is the right thing to do to support people to be as independent as possible and the evidence also tells us that it is more cost-effective too.

This section outlines the specific actions we plan to take in relation to the rehabilitation and reablement services that we commission.

Rehabilitation

‘Rehabilitation’ is a broad term. It describes a systematic approach to helping people to make the best of their situation and to lead the most fulfilling life they can. This can mean different things in different situations.

The form that rehabilitation takes will vary depending on the circumstances. It usually involves undertaking a comprehensive assessment to understand what an individual hopes to achieve and what is standing in their way. Then using the scientific knowledge of an expert to understand if this is likely to be possible and if so, how to do it. Rehabilitation involves carrying out a deliberate series of actions to achieve a person’s goals by some combination of reducing the impact of problems such as pain, increasing what an individual can do for themselves, finding new ways to overcome problems, or adapting the task or the environment to better suit the individual’s capabilities.

The IJB is responsible for commissioning some of the rehabilitation services that take place in hospitals and in communities that help adults affected by physical illness or injuries as well as for mental health conditions, learning disability and addiction. Rehabilitation services that help people recover from planned surgery such as hip and knee replacements are outside of our scope of responsibility.

The IJB is committed to developing our rehabilitation services in line with the Scottish Government’s national strategy ‘rehabilitation and recovery – a person-centred approach.’

In Edinburgh, we know that we do not have the capacity we need in our rehabilitation services. This means that people often need to remain in hospital after their medical needs are resolved because we do not have the capacity in our community teams for the level of rehabilitation they would need to recover in their own homes. This is costly for the IJB. Delays in accessing rehabilitation and insufficient intensity and duration of rehabilitation can also mean that people do not reach their full functional potential. This can lead to the IJB incurring avoidable costs such as larger care packages over the long term.

Our focus for the next three years will be to increase the capacity of our community rehabilitation services to enable more people to be discharged home from hospital as soon as they are medically ready to do so. We will provide the level of rehabilitation they need to maximise their recovery in their own homes.

Primary aim: To support people to recover at home, reducing the number of people in hospital that do not meet the criteria to reside with a day of care audit code of ‘AHP rehab ongoing’.

Rehabilitation		
We will…	**Which will…**	**Measures…**
• Develop a whole-system rehabilitation strategy with clear pathways • Apply a consistent risk assessment to inform decisions and access to therapy services in all areas of the system • Provide access to therapists in primary care, outpatient clinics, online, in hospitals and in people's own homes • Provide early access to rehabilitation during the acute stages to illness in the community and in hospitals • Provide access to specialist rehabilitation for people with complex needs • Ensure access to therapy is based on need rather than location • Take a 'home first' approach to rehabilitation whenever possible • Increase the capacity of community therapy teams to deliver more frequent sessions when needed • Undertake a regular series of day of care audits of hospital sites to identify the number of people remaining in hospital due to ongoing rehabilitation needs that cannot be met in the community. • Provide responsive services which are able to start at short notice • Provide access to rehabilitation for all conditions which impact on function • Consistently use strengths-based assessment which looks at what people can do rather than what they cannot • Work with service users to set and achieve meaningful goals • Develop and deliver person-centred treatment plans • Consistently use validated outcome measures to record level of function • Align our services with third sector organisations and community resources • Standardise the use of equipment and provide additional support for clinical reasoning where required • Develop a clear competency framework for working in rehabilitation • Regularly engage on how best to support people providing rehabilitation • Regularly engage on how best to support people undergoing rehabilitation	• Help people know where best they can access rehabilitation • Make it easier to get help • Minimise functional decline and accelerate recovery • Reduce barriers to access • Improve chances of recovery • Enable resources to be targeted where they will do the most good • Enable more people to leave hospital as soon as they are medically ready to do so • Prevent unnecessary admissions to hospital • Provide person-centred care • Help people to do more for themselves • Help people to lead the lives they wish to • Reduce variation in equipment provision • Improve cost-effectiveness of equipment provision • Ensure a consistently high standard of rehabilitation is provided • Help us develop better services to support people recovering from illness and injury	• Number of hospital beds occupied • Number of people in hospital recorded as 'AHP treatment ongoing' on day of care audits • Number of people waiting for inpatient rehabilitation beds. • Length of stay in inpatient rehabilitation beds. • Proportion of therapy provision occurring in non-bed-based settings • Experience of providing rehabilitation • Experience of receiving rehabilitation

Reablement

Reablement is a model of supported and short-term care. It is delivered in people's homes and is person-centred and outcome driven. The service helps a person identify goals they want to achieve and then works towards realising these. It typically lasts up to six weeks.

The IJB is responsible for commissioning reablement services which are provided by EHSCP. The EHSCP has delivered a reablement service for several years. It typically sees around 1,000 people a year. The service has achieved good outcomes including managing to reduce hours of care at home required from initial referral by 44%. It does this by effectively supporting people to recover after illness or injury.

In line with our prioritisation of maximising independence as part of this Strategic Plan, we are significantly expanding our reablement service. We will also be taking a 'reablement first approach' for all care at home. This means that with only a small number of exceptions, such as for people with advanced dementia or end of life needs, anybody identified as needing a new package of care at home will first undergo a period of reablement. This will be with a specialist team with close alignment to our rehabilitation services and give people the best opportunity to recover their independence. We anticipate that the number of people receiving reablement will rise from around 1,000 people to around 3,500 people each year.

After a period of reablement, people with longer term care needs will be transferred to a long term care provider. This will maintain capacity within the reablement service and improve continuity of care for people.

The EHSCP will remain the 'provider of last resort' to maintain the safety of our citizens. This means EHSCP will be able to step in to provide support in emergencies such as a care provider going out of business, or the breakdown of relationship between a service user and their care provider. Once stability is restored, people with long-term care needs will transfer back to an independent care provider.

We believe that our reablement approach will help us to achieve the national health and wellbeing outcome, '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.'

Our focus throughout the next three years will be to complete the transition to a reablement first approach, to develop the skills of our reablement teams and ensure a seamless relationship between our rehabilitation services and reablement services. This will ensure everybody has the best opportunity to recover their independence. It will also save money by reducing the number of care at home hours the IJB needs to provide in future years.

Primary aim: To enable people to be as independent as they can, reducing the average size of new packages of care provided following reablement

Reablement		
We will…	**Which will…**	**Measures…**
• Use a consistent assessment tool minimise barriers to access • Provide a responsive service which can start at short notice • Provide a period of reablement for all new hours of care for people with the potential to recover and do more for themselves • Consistently use strengths-based assessment which looks at what people can do rather than what they cannot • Work with people we support to set and achieve meaningful goals • Develop and deliver person-centred recovery plans which focus on exercise and functional task practice • Provide support at the frequency and duration required to maximise recovery of function • Consistently use validated outcome measures to record level of function • Alignment of community therapy, nursing and primary care teams • Align services with third sector organisations and community resources • Regularly review function and increase / decrease support as required • Transfer all long-term care hours from the partnership's internal service to external providers to maximise capacity for reablement • Consistently apply the criteria for critical and substantial need before transferring to a long-term care provider • Connect people to alternative services that do not meet criteria for care • Provide access to equipment, assistive technology and telecare to help people to be more independent • Develop a clear competency framework for working in reablement • Provide an intensive and ongoing training programme to all reablement staff • Use TotalMobile to improve efficiency of visit scheduling • Develop a framework that supports providers to deliver proportionate care • Regularly engage on how best to support people providing reablement • Regularly engage on how best to support people undergoing reablement	• Ensure everybody with the potential to become more independent is given the chance to do so • Maximise opportunities for recovery • Provide person-centred care • Help people to do more for themselves • Maintain flow and availability of reablement for others who need it • Mean long-term care is only provided when it is essential and only at the level required • Ensure a consistently high standard of reablement service is provided • Help us develop better services to support people recovering from illness and injury	• Waiting list to access reablement • Number of new hours of long term care provided per person per week • Number of people waiting for long-term care (unmet need) • Number of long-term care hours provided by EHSCP teams • Experience of providing reablement • Experience of receiving reablement

Protecting our most vulnerable

This Strategic Plan has been explicit about the severity of the financial challenge facing the IJB. Also, about the fact that things will continue to get harder because of the way that the city's population is changing.

We have not shied away from the uncomfortable truth that this means we will need to stop some services and reduce others to save money.

We want to be equally explicit that **we will protect the most vulnerable** citizens of Edinburgh as we make the necessary changes.

In practice, this means prioritising resources or services that provide essential support to the most vulnerable members of society. In the challenging financial context, this is not a controversial position and had universal approval during this Strategic Plan's first public consultation.

What was previously left unsaid though, was who are 'our most vulnerable'?

Without a clear definition to work with, it is not possible to have a shared understanding of what we mean when we say that we will prioritise protecting our most vulnerable. Everybody would have their own interpretation of what that meant.

After much consideration, the fairest and most practical thing to do was to look at how the law defined the most vulnerable. We identified four key pieces of public protection legislation and used these to come to our definition.

By 'our most vulnerable' we mean:

1. People supported under the Adult Support and Protection (ASP) legislation
2. People supported under the Mental Health Act (MHA)
3. People supported under the Adults with Incapacity (AWI) Act
4. People affected by health inequalities

In practice, overlap can exist between these groups, but our key strategic actions have been presented individually to make this document easier to read.

People supported under adult support and protection (ASP) legislation

The Adult Support and Protection (Scotland) Act 2007 (ASP) is a law passed by the Scottish parliament which the IJB has specific responsibilities to uphold. The ASP Act is designed to protect adults who are at risk of harm because they are unable to protect themselves or their interests due to physical or mental illness or disability.

The ASP Act requires all public bodies to work together to safeguard the wellbeing, rights and property of adults who are unable to look after their own interests.

In Edinburgh, ASP is coordinated through EHSCP although the legal responsibility to ensure compliance with the ASP Act remains with the City of Edinburgh Council.

In 2023/24, we managed 2,870 adult protection cases which was slightly higher than the number the previous year. This resulted in 1,329 case conferences being completed. The most common risks managed were physical harm at 26% of cases, followed by financial harm at 24% of cases. We currently complete just under 70% of duty to inquire assessments within the target timescales which leaves significant room for improvement.

In February 2023, the Care Inspectorate, Healthcare Improvement Scotland (HIS) and His Majesty's Inspectorate of Constabulary Service (HMICS) published a joint report following their earlier inspection of EHSCP. This, detailed serious failings in how we delivered ASP services within Edinburgh. In response, we developed and implemented an extensive improvement programme.

Many of these failings resulted from long-standing issues and will need consistent effort over several years to fully address. However, we are encouraged by the findings of our more recent follow-up inspection which was published in November 2024. This concluded that 'significant progress' had been made in four out of seven of the priority areas for improvement, and 'some progress' had been made in another two. We are particularly assured that the joint inspection found that significant improvement had been made in relation to ensuring 'there is consistent, competent, effective adult support and protection practice that keeps adults at risk of harm safe and delivers improvements to their health and wellbeing'.

There was only one area of our improvement plan where the joint inspection team concluded that minimal progress had been made. This related to involving people with lived experience in our local ASP committee. Addressing this failing and maintaining the momentum we have achieved on the rest of our improvement plan will remain a strong area of focus for us throughout the next three years of this Strategic Plan.

Primary aim 1: To increase the proportion of duty to inquire (DTI) assessments completed within target timescales

Primary aim 2: To increase representation from people with lived experience on the ASP committee

People supported under Adult Support and Protection (ASP) legislation		
We will…	**Which will…**	**Measures…**
• Increase the amount of training available to our staff in relation to ASP • Produce guidance to complement our inter-agency procedures on specific areas of practice • Have dedicated ASP recording templates and processes within our new case recording system • Have a robust and reliable dataset and reporting mechanism for ASP • Share the outcomes of learning reviews and make improvements in practice where needed • Support consistent practice across the city • Develop competency framework for working in ASP • Include service users and their informal carers in understanding and managing risk of harm • Maintain an up-to-date and relevant ASP improvement plan that is regularly reviewed • Work collaboratively with partner agencies and the third sector to support the delivery of ASP • Have clear communication with our communities in relation to ASP	• Ensure our staff are confident and competent in the delivery of ASP • Ensure that we meet our statutory obligations in relation to this key piece of legislation • Make people and their informal carers feel included in plans • Enable us to analyse trends and areas for development • Ensure that we create a learning culture • Deliver continuous improvement • Make our service efficient and effective • Improve our engagement with communities • Support inter-agency working	• Number of people protected from risk of harm • Number of people affected and their informal carers feeling involved and included • Number of ASP concerns with appropriate response within mandatory time periods • Number of staff with appropriate awareness of ASP requirements and processes • Number of staff that feel safe and confident delivering ASP

People supported under Mental Health Act

The Mental Health (Care and Treatment) (Scotland) Act 2003 (updated 2015) (MHA) is a law passed by the Scottish parliament which the IJB has specific responsibilities to uphold.

The MHA gives the legal basis for detaining somebody at risk to themselves or others due to a mental illness in hospital and for compelling them to receive essential medical treatment for which they do not have the capacity to provide or withhold consent. The MHA contains important standards and safeguards to protect the rights of individuals with mental illness.

The IJB is the commissioning body for mental health services within Edinburgh. This includes inpatient hospital services and community teams looking after people with serious mental illness, where detentions and compulsory treatment under the MHA are needed regularly. Additionally, the IJB is responsible for commissioning emergency care, acute medical services and geriatric medical services where it also needs to administer treatment under the MHA. The IJB also commissions social work services from EHSCP, which includes mental health officer (MHO) provision to ensure that the needs of individuals supported under the MHA are appropriately identified and their legal rights respected.

Both of our partner organisations, NHS Lothian and the City of Edinburgh Council, retain the legal accountability to comply with the MHA for the staff they employ and the services they deliver on behalf of the IJB.

Upholding our responsibilities with respect to the MHA is a challenge for the IJB. This is evidenced by Edinburgh having the third lowest rate of completions for social circumstance reports in Scotland. These are a mandatory requirement. Our poor performance is due to persistent challenges with our MHO capacity.

There are also signs that our system may have an unusually high demand for MHO activity. For example, in Edinburgh, the rate that short-term detention certificates (STDCs) and compulsory treatment orders (CTOs) are used are both about 60% higher than the national average. These have both been increasing over the last ten years. It is also noticeable that people living in areas of deprivation are more likely to be detained under the MHA. This is cause for concern given that the city's population is growing most quickly in areas of deprivation.

This is an area we need to improve over the course of this Strategic Plan. Our focus will be on ensuring consistent compliance with all our legal responsibilities for the MHA. This is likely to involve developing our community mental health services to increase the availability of alternatives to detention and increasing the capacity of our MHO service.

Primary aim 1: To reduce the rate of Short-term detention certificates (STDCs) and compulsory treatment orders (CTOs)

Primary aim 2: To increase the number of social circumstance reports completed within agreed timescales

People supported under Mental Health Act (MHA)		
We will…	**Which will…**	**Measures…**
• Employ enough qualified mental health officers to give a consistent and resilient service that meets our statutory obligations • Continue to make sure that any person subject to detention under the MHA has an allocated mental health officer • Have dedicated MHA recording templates and processes within our new case recording system • Improve our performance in producing social circumstances reports • Have a robust and reliable dataset and reporting mechanism in relation to MHA • Make sure that advocacy services are available to any person subject to detention under the MHA • Respond to any national changes that need our services to adapt and learn • We will ensure that we have multi-agency frameworks in place to support the work of our teams • We will ensure that alternatives to detention under the MHA are made available wherever possible • Work collaboratively with partner agencies	• Ensure that we meet our statutory obligations in relation to this key piece of legislation • Make people feel that their voice is included in plans relating to the care and treatment • Ensure that important and relevant background information is available to the multi-disciplinary team to support care, treatment and recovery • Make our service efficient and effective • Allow us to understand the demand on our service and plan for the future • Make sure that we are compliant with any new policy and legislation • Ensure that teams are able to work together to improve outcomes • Ensure that the MHA is only utilised where there are no alternatives available • Support inter-agency collaboration	• Number of assessments not completed within statutory timescales • Number of people detained under MHA to receive input from a MHO • Experience of managing people detained under the MHA • Experience of being detained under MHA • Proportion of people detained under MHA to access advocacy

People supported under Adults with Incapacity (AWI) Act

The Adults with Incapacity (Scotland) Act 2000 (AWI) is a law passed by the Scottish parliament which the IJB has specific responsibilities to uphold.

The AWI Act gives the legal basis for making decisions on behalf of somebody that does not have the capacity to make such decisions for themselves. This is usually because of a cognitive impairment like dementia or due to a severe mental illness. The AWI Act applies to decisions that affect health and wellbeing. This can include, whether to consent to a particular medical treatment, or to decisions about personal finance and property, such as whether an individual should leave their home to move into a care home.

Under the AWI Act, the court can appoint a 'guardian' to make decisions on behalf of an individual who has been assessed as lacking capacity. A guardian may be somebody who the individual knows well such as a relative, friend or carer. Alternatively, the court may appoint the local council's chief social work officer to act as guardian on behalf of the individual.

The legal duty to comply with the AWI Act remains with our partner organisations, usually with NHS Lothian for decisions regarding health and with the City of Edinburgh Council for decisions regarding finances and property. As such, the IJB has a responsibility to work with our partners to ensure appropriate professional governance is in place for all services and pathways that we commission.

On average each day, Edinburgh has around 28 people delayed in hospital awaiting the appointment of a guardian to make a decision about their discharge destination. This is lower than most other areas in Scotland. The IJB has limited scope to reduce this as most of the time spent in the guardianship appointment process is due to constraints in court process. We will continue to pursue incremental improvements to the process wherever possible within the services we commission.

At the end of 2023/24, there were over 1,100 people with guardianship orders in place in Edinburgh, which is about 22% below the Scottish average. Most guardianships are in place to make decisions on behalf of people with a learning disability or dementia.

There is a substantial backlog in completing guardianship reports for people outside of hospital that are protected under the AWI Act. This is due to a lack of capacity within our mental health officer (MHO) service. The system we use to manage and track this activity also needs improvement. Each of these areas will be a focus over the next three years of this Strategic Plan.

Primary aim 1: To reduce the number of outstanding guardianship reports

Primary aim 2: To increase the number of guardianship reports completed within mandatory timescales

People supported under Adults with Incapacity (AWI) Act		
We will…	**Which will…**	**Measures…**
• Employ enough qualified MHOs to give a consistent and resilient service to meet our statutory obligations • Develop and implement a plan to make sure we address the number of outstanding requests for MHO reports to accompany private guardianship reports • Ensure that all CSWO guardianship orders have an allocated worker • Effectively utilise our resources to support and supervise private guardians including dispensing with supervision where appropriate Have dedicated AWI recording templates and processes within our new case recording system • Have a robust and reliable dataset and reporting mechanism in relation to AWI • Respond to any national changes that require our services to adapt and learn • Ensure that our staff have access to relevant training including 'crossing the acts' between inter-related pieces of legislation • Prioritise progress of AWI reports where there is identifiable risk of harm, to facilitate lawful hospital discharge and to support transition to adult services • Promote the use of a power of attorney	• Ensure that we meet our statutory obligations in relation to this key piece of legislation • Ensure that adults who lack capacity to make decisions have the necessary legal framework in place • Focus staff time and resource where it is needed most • Enable us to understand the demand on our service and plan for it • Make our work more efficient • Make sure that we are compliant with any new policy and legislation • Ensure that our staff feel confident in applying relevant legislation • Increase the number of people with a power of attorney in place	• Number of AWI reports outstanding • Number of AWI reports not completed within mandatory timescales • Number of people delayed in hospital with AWIs • Number of people being looked after 'in the right place, at the right time' • Number of people requiring guardianship orders to be in place to make some decisions on their behalf

People affected by health inequalities

Health inequalities is the term used to describe when some groups of people experience a different standard of health or care due to systematic reasons that are unfair and avoidable. The Equality Act 2010 makes it a legal requirement to ensure that people receive the same standard of care no matter what their personal characteristics are.

Perhaps the starkest example of the impact of health inequalities is that men living in the most affluent areas of Edinburgh typically live 14 years longer than men living in the most deprived areas of the city. The same pattern emerges in almost every area of health and social care that it is possible to measure. People in minority groups and those with fewer social and economic advantages consistently do worse.

The impact that inequality has on health is widely recognised and a lot of research has been done to understand what can be done to help.

Research has shown that non-medical things account for half of a person's long-term health outcome. These include things like how well a person did at school, whether they have a job, how much money they make, and the quality of the house they live in. This is why the IJB previously spent a lot of money in trying to address these non-medical issues in the hopes of improving the health of the city's population.

We still believe that investment in these areas is important and necessary. However, the severity of the IJB's financial position means that continuing to spend money in this way would mean having to make further deep cuts to essential frontline health and social care services to pay for it. This is counterproductive for the IJB.

Improving the health of the population is a big job and needs a team effort. Organisations such as the IJB, NHS Lothian, the City of Edinburgh Council, third sector organisations, Scottish Government, UK Government and the business community all need to play their parts. To fulfil our role on that team with the limited resources we have, the IJB needs to focus on our key areas of responsibility which is commissioning the health and social care services that are delegated to us.

The availability and quality of health and social care services account for a smaller proportion of what drives health inequalities and overall population health compared to non-medical factors. However, that is the bit that only we can do. Our teammates are counting on us to do that and to do it well.

Our focus throughout the course of this Strategic Plan will be to improve access to our services for people living in deprived communities and from other disadvantaged groups. We will have a particular focus on increasing uptake of evidence-based preventative interventions such as vaccinations. We know we need to improve how we record data on personal characteristics such as ethnicity and outcomes. This will help us to better understand who our current services work well for. Perhaps more importantly, it will tell us who they don't work well for so that we can improve.

Primary aim: To promote equity of access to our services and outcomes, reducing the gap between different groups of the population

People affected by health inequalities		
We will…	**Which will…**	**Measures…**
• Provide opportunities for people at risk of poor health outcomes to live healthier and more active lives each time we see or speak to them • Enable people to get more of the help they need closer to where they live • Base more of our services alongside other community assets such as libraries and shopping centres where good transport links exist • Make it easier for people with more than one problem to get the help they need from the same place and at the same time • Ensure people do not wait longer for what they need depending on where they live • Use a 'no wrong door' approach to access all our services • Work closely with the Council and with housing providers to help make people's homes healthier places to live • Help connect people living in poverty to the services that can make sure they are getting all the money they are entitled to • Identify people and communities most at risk of ill health and design our approaches to them specifically (for example, vaccinations and screening programmes) • Involve people from groups most likely to have poor outcomes in the design of the services that affect them • Ensure that a robust integrated impact assessment (IIA) is conducted on all proposed changes to services so that the impact on inequalities is fully understood • Improve data collection and reporting capabilities on protected characteristics • Formally report on health inequalities to the IJB's performance and delivery committee	• Give more people the support they need to lead healthier lives • Make it easier for people to access the help they need • Reduce the number of different appointments people need to attend • Enable more personalised care • Ensure access to services is fair • Reduce the impact of poor housing on health and social care needs • Help reduce the number of people living in poverty • Ensure the services we provide meet the needs of the people we serve • Ensure that the impact of all decisions on health inequalities is fully understood • Inform a more robust understanding of how inequalities impact on health and social care	• Number of people who stop smoking • Number of people recovering from alcohol addiction • Number of people recovering from drug use • Number of people undertaking regular exercise • Variation in waiting lists between different parts of the city • Number of people living in poverty referred for income maximisation services • Variation in life expectancy between different areas of the city

Using our resources effectively

The context of the IJB having insufficient resources to meet the city's full demand for health and social care services and our assessment that the gap between capacity and demand will continue to grow over the next few years has run throughout this Strategic Plan.

In response, we have developed our four strategic priorities, which sum up how we believe we can do the best we can with the resources we have.

Our first two priorities are **Prevention and Early Intervention** and **Maximising Independence**. Both focus heavily on doing the right thing for the people in our care whilst also helping money stretch further by avoiding the need for more expensive costs elsewhere in the system.

Our third priority is **Protecting Our Most Vulnerable.** This highlights some of our most critical legal obligations. It also makes it clear what actions we need to take to ensure that the IJB continues to fulfil its core purpose as the financial challenge continues to grow.

This final section of the Strategic Plan explores our fourth priority, **using our resources effectively**. This will detail how we intend to address the challenges and opportunities facing each area of responsibility delegated to the IJB.

Inevitably, there are some areas of overlap with previous sections. This reflects our firm intention for all four of our strategic priorities to run through every service the IJB commissions.

To make this document easier to read, we have tried to keep areas of duplication to a minimum.

Building resilient communities

Resilient communities are better able to prepare for, respond to and recover from emergencies in a way that complements emergency responders. Resilience does not happen by accident and needs conscious and consistent effort to achieve.

In 2019, the Scottish Government issued the 'building resilient communities' guidance. This included access to useful resources such as the guide to emergency planning for community groups, links to examples of good practice and a toolkit for measuring how effective community resilience initiatives are.

In response to the national emergency caused by the outbreaks of Covid 19, we saw communities rally together to support each other. Charities, local clubs, private businesses and individual citizens took it upon themselves to help make a difference to somebody in need. This illustrates all that is best about communities.

Some of the most important learning from this experience was the power of connections, trusting relationships and information sharing. Where the community response worked best, it worked because different groups worked together, each sharing their knowledge, expertise and resources for the common good.

It is important that we do not lose this valuable learning. We need to do what we can to maintain and build on these relationships and channels of communication to help us respond to the next emergency. To keep these channels of communication open, we will continue to contribute to groups such as the Edinburgh Partnership. We will also work closely with the third sector reference group that is being established to support the representation of third sector organisations (TSO) on the IJB.

Edinburgh's communities need to be prepared for the wide range of other emergencies that may arise. For example, the impact of climate change means that extreme weather events such as heatwaves, cold snaps, floods and severe snow are likely to become increasingly common.

To minimise harm, it is important to understand the dangers, to know who is most at risk, where they are and how to help them. It is also important to understand what resources we have available to work with.

Building community resilience is a whole-city responsibility and does not sit entirely with the IJB, however, we have a responsibility to play our part.

Community resilience planning can be informed by our existing joint strategic needs assessment (JSNA) process. This involves working with NHS Lothian and the City of Edinburgh Council to carry out a detailed analysis of the city's population. We use this information to inform the strategic planning for the services we commission. It makes sense for this information to be used to inform community resilience planning too.

Primary aim: To inform resilience planning by working with partners to complete a risk assessment for the most likely emergencies to affect different communities.

Building resilient communities		
We will…	**Which will…**	**Measures…**
• Actively participate in the Edinburgh partnership's, the city's community planning partnership • Regularly engage with the third sector reference group • Complete a risk assessment of most likely emergency events using the JSNA process • Provide training to our teams on how to advise vulnerable people they are working with about where they can prepare for emergencies and where they can access help • Actively participate in any multi-agency resilience simulation training that takes place • Maintain a risk register for how each of our services would be affected in different emergency scenarios • Develop and maintain action cards for how our teams should respond to different emergency scenarios • Share our action cards with community organisations and ask them to share theirs with us • Consistently record on Trakcare / Mosaic when individuals have identified risk factors which could need special precautions or actions in the event of an emergency • Provide training and support for our staff to improve their own resilience • Engage in evaluation processes and debriefs following emergency preparedness simulations and real-life events	• Ensure a holistic approach to planning across the city • Maintain relationships and channels of communication with community organisations • Inform preparations for emergencies • Empower individuals at risk to take action to protect themselves from harm in the event of an emergency • Enable us to improve the resilience of health and social care services • Help us to avoid working in silos • Enable us to identify people at risk of harm in an emergency quickly • Enable a culture of learning and continuous improvement	• Number of risks areas of IJB service covered by risk assessment for common emergencies • Number of services covered by business continuity action cards • Feedback from teams and community groups on our action cards (gap analysis of response) • Feedback on training provided

Right care, right place, right time.

The IJB commissions a wide range of services across the health and social care system. An important part of commissioning effective services is making them easy to access and navigate so that people can get the help they need quickly. The issue is that our current system is not easy to navigate.

People access our services in lots of different ways. These include call centres, online, face to face with professionals, from hospitals or in offices. We have multiple front doors into services and no integrated approach across health and social care.

Because of this, people accessing our system from different entry points may end up on different pathways, end up receiving different services and have different outcomes or experiences. This does not produce the best outcomes for our service users and is not cost-effective for the IJB as a commissioner.

As Edinburgh's integrated commissioner for both health and social care services, the IJB has a good opportunity to put a robust system in place. This would reduce this variation and make it quicker and easier for people to get the help they need no matter where they are.

We will produce clear information to ensure people know where they should go to get the help they need. We will also ensure we have good links across our system. This will involve commissioning an ambitious programme to develop an integrated front door which gives a consistent assessment to enable every person to get to the right place, first time, every time.

We will improve our website and develop a user-friendly self-management platform to give our citizens with another means of accessing high-quality information and another route into our services. This will standardise our assessment tools and simplify referral pathways. It will also align with the Scottish Government's 'digital front door' strategy.

Our new processes will support other improvements in our pathways. An example of this is implementing our reablement first approach to care at home.

We also know that the process of making referrals to services within our system can be time-consuming and cumbersome for our teams and needs to be simplified.

We will use the opportunity that this redesign gives us to improve our understanding of the interdependencies that exist between different parts of our system and the demand for specific services by collecting capacity and demand data in a consistent way across all areas.

Primary aim 1: To agree and implement a standard assessment tool which can be used at any entry point to the system which consistently determines the most appropriate service for an individual's needs

Primary aim 2: To implement a consistent method of counting capacity and demand data for all services

Right care, right place, right time		
We will…	**Which will…**	**Measures…**
• Produce accessible information about what services we have available and the best place to go to get help in different situations • Share information in various formats to suit different people's preferences • Provide advice on healthy active lifestyle and signposts to relevant services via our self-management platform • Have a single point of access for all services we commission • Develop a standard assessment tool which can be used at any entry point to the system which consistently determines the most appropriate service for an individual's needs • Use a 'no wrong door approach' • Use a consistent method of counting capacity and demand data for all services • Consistently work to reduce bottlenecks and queues • Provide easy to navigate referral pathways to all services we commission • Make more community services accessible by self-referral • Encourage use of community-link workers to act as single point of access for non-medical services • Provide services for a range of accessibility needs and preferences including, online, telephone and in person • Provide responsive community services • Enable paramedics access community services as an alternative to hospital • Strengthen referral pathways from primary care and NHS Lothian flow navigation centre (FNC) to community services, day hospitals, same day emergency care and hospital at home • Promote access to pharmacy first and physiotherapy • Ensure people at risk of deterioration have anticipatory care plans in place • Provide specialty professional to professional advice lines • Regularly engage on the best way to support people looking for help	• Enable people to know what support is available • Help connect people to resources and activities within their local communities • Make it easier for people to get the help they need • Make it easier to access the resources that are available • Help us to know how many of each type of staff we need • Help to reduce waiting times • Make it easier for GPs to access specialist advice to enable them to better support their patients • Help build relationships across the whole system • Help us design better services	• Number of active users on self-management platform • Number of people accessing help from Pharmacy First • Number of people accessing physiotherapy with self-referral • Waiting times for accessing appointments • Number of speciality professional to professional advice calls • Number of times ambulances convey people to hospital • Experience of using our services

Primary care

Primary care is often called the ‘front door’ to the NHS because it is where most people go to get the help that they need most of the time. Primary care includes most health services that take place outside of hospital that the public can access without needing to be referred by a professional first. Around 90% of all contact the public has with a health professional occurs in primary care.

The full list of primary care services is wider although the most frequently used are local doctor’s surgeries (also known as general practice or GP for short), dentists, optometrists for eye care, community pharmacies, district nursing and physiotherapy.

Whilst primary care counts for a relatively large proportion of the IJB’s overall spend each year, the IJB has less discretion over its use than with other parts of our budget. This is because we must abide by the general medical services (GMS) contract that is agreed between the Scottish Government and the Scottish general practitioners committee (SGPC) of the British Medical Association (BMA).

A lack of capital money to modernise buildings is also a problem. While the IJB does not have our own buildings or capital money to invest, we will continue to support NHS Lothian and the Council to prioritise how they use theirs. We have had some success with this in recent years and hope to build on it.

Although less well publicised than the pressures facing hospitals, the demands on primary care are substantial and rising sharply. The rise in demand is primarily driven by the rapid growth of Edinburgh’s population and the increasing complexity of care needed due to more people living with long-term conditions. Capacity has grown substantially in recent years through a combination of increased investment, improved efficiency and local innovation, but demand has risen more quickly.

In primary care, people usually either have a new problem that they are concerned about and need advice, investigation or treatment or they have a long-standing problem that they need long-term support to manage. For new problems, the priority is usually getting help as quickly as possible. People with long-standing problems tend to do better if they regularly see the same person who knows their history.

To make it easier to get an appointment, we will focus on getting more people to access services such as physiotherapy and pharmacy without going to see their doctor first. This will mean quicker access to help. It will also free up the doctor to see people that need help for more complex medical issues more quickly.

Our other area of focus will be to enable GPs and their teams to spend more time with people with complex long-term conditions. We will provide funding for NHS Lothian to commission locally enhanced service (LES) contracts with GP practices. These will prioritise preventative management and advanced care planning for people at risk of prolonged hospital stays. We expect this to achieve cost savings by reducing the need for more expensive care in hospital.

Primary aim: To improve care for people at risk of prolonged hospital stays, increasing GP contact time and continuity of care

Primary care		
We will…	**Which will…**	**Measures…**
• Produce accessible information about what services we have available • Share information in various formats to suit different people's preferences • Provide advice on healthy active lifestyle and signposts to relevant services via our self-management platform • Provide easy to navigate referral pathways to all services we commission • Have a single point of access for all services we commission • Make more community services accessible by self-referral • Encourage use of community-link workers to act as single point of access for non-medical services • Provide services for a range of accessibility needs and preferences including, online, telephone and in person • Provide responsive community services • Provide primary care colleagues with direct access to day hospitals, same day emergency care and hospital at home • Promote access to pharmacy first and physiotherapy • Provide funding for NHS Lothian to commission locally enhanced services • Support people from different teams to discuss complex cases • Ensure people at risk of deterioration have anticipatory care plans in place • Promote GP partnership model (i.e. 17J practices rather than 2c practices) • Improve general practice premises and co-locate with other community assets wherever possible • Support people to transition to mainstream primary care services • Provide specialty professional to professional advice lines • Increase community geriatrician support available to primary care • Extend quality improvement support to colleagues working in primary care • Regularly engage on the best way to support people working in primary care • Regularly engage on the best way to support people accessing primary care	• Enable people to know what support is available • Help connect people to resources and activities within their local communities • Make it easier for people to get the help they need • Make it easier to access the resources that are available • Reduce demands on primary care • Enable primary care colleagues to spend more time working with the people most likely to benefit • Increase capacity to provide appointments in the future • Give GP's more control over their work • Enable people with complex needs to build long-term relationships with primary care • Make it easier for GPs to access specialist advice to enable them to better support their patients • Help to make continuous improvements • Help build relationships across the whole system • Help us design better services	• Waiting times for accessing an appointment • Number of people accessing services by self-referral • Number of people with long-term conditions admitted to hospital as an emergency • Number of days people with long-term conditions spent in hospital • Number of GP practices run by GP partners • Number of people without a long-term GP • Experience of working in primary care • Experience of using primary care

Home first

The term ‘home first’ describes the principle that people should be enabled to stay in their own homes whenever possible.

This is something we are extremely passionate about and the IJB commissions a wide range of services to help people to live well in their own homes. When we talk about home first, we are usually talking about services in a person’s own home or as an outpatient that prevent them from needing to be admitted to hospital or services which help them return to their own homes from hospital more quickly when they still have some ongoing needs.

Home first aims to prevent life-changing decisions being made when people are in an acute crisis and to support people to have more control over their lives, their health and their care. One example of the home first approach in action is our discharge to assess (D2A) team which received 3,300 referrals in 2023/24. This team assesses people that have just returned home from hospital to see if they need any support. This gives a more accurate reflection of a person’s capabilities than trying to figure out how they are likely to cope at home while they are in an unfamiliar environment like a hospital ward.

Home first embodies the Scottish Government’s longstanding ambition to shift the balance of care from hospitals to the community. While we have made some progress against this goal, we need to go a lot further and a lot faster.

We believe that home first is the right thing to do as most people want to be in their own home. It is also a financially prudent thing to do because it is often cheaper to provide care in the community than it is in hospitals.

There is a significant amount of urgency to this. Our hospitals are already full and yet our population continues to grow and is becoming older with more people living with frailty and other long-term conditions. It is not realistic to think that we could keep up with the changes in the population by continuously building more hospitals. So, we need to increase our ability to do some of the things that would previously have been done in hospital in people’s own homes.

There is scope to achieve this. Each day in Edinburgh, an average of 19 potentially preventable admissions to hospital occur and several hundred hospital beds are occupied by people who could be managed in the community.

To make the shift needed and continue to develop our home first approach, we need to increase capacity in our community services. This will give a consistent alternative to hospital care and raise awareness of these services so that referrers and the public have confidence that we can meet their needs in their own homes.

Priority aim: To enable people to live well in their own homes, reducing the number of people in hospital that do not need to be there

Home first		
We will…	**Which will…**	**Measures…**
• Provide information to help people with long-term conditions to manage their conditions effectively • Produce accessible information about what services we have available • Share information in various formats to suit different people's preferences • Provide access to services which help identify problems and intervene early • Provide responsive community services for both health and social care issues • Minimise barriers to access by using self-referral and trusted assessment models for community services • Provide access to co-ordinated multi-disciplinary teams for people with complex needs living in the community • Work with people with conditions that are likely to deteriorate to develop anticipatory care plans • Provide access to hospital at home and day hospitals as alternatives to hospital admission • Increase capacity in community rehabilitation services • Consistently apply the principles of the discharge without delay programme • Undertake regular day of care audits to identify the common reasons preventing people from leaving hospital when they are ready to do so • Use the results of day of care audits to plan changes needed within community services to prevent recurrence of hospital discharge delays. • Ensure people are given the opportunity and support they need to recover from illness or injury before being assessed for long-term care needs. • Ensure assessments for long-term care needs take place in person's own home whenever possible. • Provide easy access to assessment and community services through a single point of access	• Help people to live healthier lives • Reduce demand on services • Enable people to get the help they need quickly • Help stop little problems becoming big problems • Give people more control over their health care • Ensure people are only admitted to hospital when they are likely to benefit and want to • Enable people to leave hospital as soon as they are medically well enough to do so • Give everybody the best chance to live the life they want • Enable people to be as independent as possible • Reduce demand for long-term home care	• Number of people admitted to hospital • Total occupied bed days in hospital • Number of people remaining in hospital for more than 14 days • Total occupied bed days for people remaining in hospital for more than 14 days • Number of people delayed in their discharge from hospital • Number of people in hospital whilst not meeting the criteria to reside

Unscheduled care

The term ‘unscheduled care’ is used to describe the range of health services that respond to an unplanned need for medical care.

The IJB is responsible for commissioning unscheduled care services provided by GP practices, pharmacies, community services such as district nursing, minor injury units, emergency departments, acute medical wards and geriatric medical wards.

In Edinburgh, as in the rest of Scotland, the unscheduled care system has been under sustained pressure for many years and is struggling to cope with rising demand.

Unscheduled care is a priority for the Scottish Government. It has commissioned the national teams for primary care, unscheduled care and social care to support health boards and IJBs with their improvement efforts. The national strategy is to focus on improving community pathways, optimising flow navigation centres, improving access to hospital at home, optimising assessment in emergency departments and promoting early and effective discharge planning. We will continue to work with the national teams and with NHS Lothian and the other Lothian IJBs to progress improvement work in all these areas.

One of the biggest challenges facing unscheduled care in Edinburgh is that we are working with a relatively small number of hospital beds. We do not have enough capacity within our community services to enable people to move through them quickly enough to maintain flow.

Our focus throughout the next three years of this Strategic Plan will be to reduce the number of people in hospital. This will create the space that is needed for people to be admitted when they need to be. We will do this by investing more in our community services to reduce our reliance on hospital beds in two main ways.

Firstly, as is true elsewhere in Scotland, most of our hospital beds are occupied by the relatively small number of people who stay in hospital for a long time. These individuals are typically living with severe frailty or have one or more long-term condition. They are usually well-known to their GP and other community services. By investing in more focussed care planning and support for these individuals, we can prevent the need for prolonged hospital admissions.

Secondly, our data has highlighted that many people remain in hospital even after becoming well enough to go home because they need more rehabilitation than our community teams have the capacity to provide. This is inefficient because it usually costs more to keep somebody in hospital for rehabilitation than it would cost to do it in their own home. We will therefore increase the capacity of our community services to enable people to leave hospital when they become well enough to do so and receive the help they need to recover in their own homes.

Primary aim: To enable people to live well in the community, reducing the number of people staying in hospital for more than 7 days

Unscheduled care		
We will…	**Which will…**	**Measures…**
• Increase the number of people accessing the care they need directly from specialist services such as pharmacy, physiotherapy and mental health welcome teams rather than requiring GP referral. • Enable people with long-term conditions that put them at risk of needing prolonged hospital stays to see the same team of people each time to help them manage their condition effectively. • Identify the people most at risk in the community and intervene early to prevent their health deteriorating to the point where a prolonged stay in hospital becomes necessary. • Enhance the multidisciplinary frailty team at the front door of hospitals • Build capacity in community-based alternatives to hospital care so that more people can get the care they need closer to home. • Increase the use of direct admission to wards for people already under consultant care in the community when needed to ensure only people requiring emergency medicine attend the emergency department. • Continue to develop our early supported discharge (ESD) service to enable people appropriately admitted to hospital and at risk of a prolonged stay to get the care they need and return home within 72hours of admission. • Ensure we provide the right number and the right type of beds for people who need to be in hospital. • Increase access to occupational therapy and physiotherapy in hospital to help people recover from illness/injury more quickly and to be able to do more for themselves when they leave hospital. • Increase access to community rehabilitation to enable people to leave hospital as soon as they are well enough to do so and can recover at home. • Ensure everybody has been given a fair chance to recover at home before any decisions are made about their long-term care needs.	• Get people the help they need more quickly. • Improve access to GP appointments for people with more complex medical needs. • Enable more personalised care • Increasing peoples' ability and confidence to manage their health • Help stop little problems becoming big problems. • Ensure people are only admitted to hospital when they need to be. • Ensure hospital beds are available for people when they need them. • Ensure people who need to be in hospital are on the right type of ward for their needs. • Ensure people only remain in hospital for as long as they need to. • Enable people to recover from illness or injury more quickly • Enable people to be as independent as possible. • Ensure everybody is given the best opportunity to return home from hospital. • Enable people to live the best lives they can.	• Waiting times for GP appointments. • Waits for ambulances. • Waiting times in the emergency department. • Number of people staying in hospital for more than 14 days. • Number of people in hospital each day. • Number of people on the wrong type of hospital ward • Number of people experiencing a delayed discharge from hospital. • Performance against the 4hour emergency access standard • Number of people returning home from hospital.

Mental health

The term ‘mental health’ describes a person’s capacity to lead a fulfilling and enjoyable life. It is broader than just the absence of mental illness and changes over time in response to a wide variety of factors.

The IJB is responsible for commissioning all mental health services for people experiencing problems with their mental health. The only exception is secure forensic hospitals which remain the responsibility of NHS Lothian.

We commission different services to meet different needs. We have already shared how we intend to help people at risk of harming themselves or others earlier in this plan (pages 21-22). We have also shared how we will help people supported under various pieces of safeguarding legislation (pages 39 – 44). To avoid repeating ourselves, this section only covers mental health needs not discussed earlier.

Mental health problems are extremely common. In 2023/24, 88,000 people were prescribed medication for the treatment of anxiety, depression or psychosis. This was around 17% of the city’s population. The long-term trend across Scotland is towards an increasing proportion of people being prescribed medication for mental health problems.

Anti-depressant and anti-anxiety medication is a safe and effective treatment which can provide a vital support for many. Consequently, we should not directly equate the rising numbers of people taking such medication as a bad thing because this could potentially mean that more people are accessing help rather than living with untreated symptoms. It does however illustrate the substantial and growing demand that mental health conditions place on the health and social care system.

The IJB spends a lot of money on these services. This includes funding GP time to assess, prescribe and monitor medication. We fund pharmacies to give out medications as well as counselling, psychological therapies and a wide variety of support services provided by third sector organisations.

Feedback from people who use mental health services tells us that services do not always feel joined up and that waiting times are too long.

Our focus over the course of this Strategic Plan will therefore be to streamline mental health pathways and to reduce waiting times. We will do this through co-production with service users and service providers. The IJB’s financial position means that there will not be any more money available to do this, so we will need to identify efficiencies and savings to pay for these improvements.

Primary aim 1: To increase the proportion of people reporting a positive experience of accessing mental health services.

Primary aim 2: To reduce waiting times for mental health services

Mental health		
We will…	**Which will…**	**Measures…**
• Provide information to help people with managing their own mental health • Produce accessible information about what services we have available • Share information in various formats to suit different people's preferences • Provide access to services which help identify problems and intervene early • Minimise barriers to access by using self-referral and trusted assessment • Commission community-link workers to act as a single point of access for non-medical services to provide alternatives to medical management • Provide access to non-pharmacological treatments for depression and anxiety including counselling, cognitive behavioural therapy and exercise • Provide access to co-ordinated multi-disciplinary teams • Provide responsive community services for health and social care • Provide services for a range of accessibility needs and preferences including, online, telephone and in person • Increase the capacity of community services to be able to help more people receive the treatment they need in the community • Work with people who use and provide our services to co-produce a more streamlined pathway • Assess capacity and demand in all services with long waiting times • Ensure all treatments with the highest standard of evidence are available • Disinvest in treatments and services that are not supported by evidence of effectiveness and cost-effectiveness • Regularly engage on the best way to support people with mental illness	• Help people to live healthier lives • Reduce demand on services • Provide help more quickly • Help stop little problems becoming big problems • Give people more control over their health care • Ensure a holistic offer of evidence-based treatments are available • Enable people to be as independent as possible • Enable flexibility so people can access help at the time they need it • Help us design better services to support people with mental health needs	• Waiting times for mental health services. • Experience of accessing mental health services • Mental health outcomes • Number of people prescribed anti-depressant and anti-anxiety medication

Learning disability

A learning disability (LD) is a lifelong condition where an individual is born with a reduced intellectual ability and has difficulty learning new skills. This can make everyday tasks harder, such as self-care, managing money and socialising.

Learning disabilities vary in severity and can affect different people in different ways. The IJB is responsible for providing a range of services to this community. This ranges from information and advice to hands-on support to help them to meet their essential needs and enable them to live more independently.

People with LD often experience poor health and have an average life expectancy around 20 years lower than the rest of the population. Over 95% of people with LD have at least one other health condition, with many having both physical and mental health problems. There is a wealth of evidence that people with LD have worse outcomes when admitted to general hospitals for medical and surgical problems. This is due to a lack of appropriate adaptation for the specific needs of people with LD. In response to these challenges, in 2021, the Scottish Government published an action plan called ‘towards transformation’, which aims to ensure that the human rights of people with LD are protected and that they are empowered to live as independently as possible.

The IJB commissions support for people with LD directly from EHSCP as well as from a range of specialist care at home and day service providers. Each year our services support around 2,000 people with LD.

A lack of suitable housing for people with LD is a chronic challenge. This leads to poorer outcomes for people and higher costs for the IJB.

Firstly, it can lead to people with LD who have high levels of need remaining in hospital for years at a time even though they are medically well. This is because there is no suitable environment for them to be discharged to.

Secondly, it can lead to increased costs for care at home. Particularly, when individuals with specialist care needs are spread out over too wide of an area and care teams need to travel a lot. There are some excellent examples of housing schemes which provide a good standard of living for people with LD. These also enable economies of scale for care providers but there are not enough of them.

In line with our commitment to maximising independence, we will also be focusing on helping people with LD to develop their self-care skills and, where possible, reduce reliance on care services and access employment. We also intend to commission a new overnight care service for people with intermediate level needs which will bridge the gap between our existing remote-only and overnight sleepover services.

Primary aim 1: To enable people with LD to live well in the community, reducing the number of people with LD in hospital for more than 12 months

Primary aim 2: To ensure best value for money, reducing the average cost of care at home for people with LD

Learning disability		
We will…	**Which will…**	**Measures…**
• Ensure that people with a learning disability requiring social care receives a holistic assessment of their needs in a timely way and that this is reviewed regularly • Implement a new framework to enable care agencies to provide support in a more flexible way to meet the needs of people in their care • Enable people with a learning disability to see the same team of people each time they need help from health services • Provide access to annual health checks for people with a learning disability. • Work with individuals to develop and follow a health improvement plan where risks are identified • Ensure that community health and social care teams respond quickly to an individual's needs in times of crisis • Increase the capacity of community health services to help more people with LD to receive the treatment they need without going into hospital. • Provide support to people with LD to an acute hospital • Enable people without a medical need to be in hospital to be supported in the community and close the long-stay hospital beds once vacated • Consult on the optimum model of acute hospital care for people with LD • Re-focus the EHSCP care team on enablement to help people with learning disability to be as independent as possible • Commission a new overnight care service for people with intermediate level of need to bridge the gap between the two service options we currently offer • Transition people with long-term care needs to third sector providers • Increase the supply of supported living environments • Provide access to independent advocacy to support decision-making • Ensure that commissioned day services promote enablement • Support access to volunteering and employment opportunities • Regularly engage on how best to support people with learning disability	• Enable more personalised care • Mean more help is available when needed • Help stop little problems becoming big problems • Ensure people are only admitted to hospital when they need to be • Ensure hospital beds are available for people when they need them • Enable people to be as independent as possible • Enable people to live the best lives they can • Help keep people safe at home overnight • Create a most cost-effective option to meet the needs of some individuals with overnight needs • Provide greater access to social activities for people with a learning disability • Enable delivery of care more cost-effectively • Help us design better services to support people with a LD	• Level of participation of people with LD in society • Number of people with LD with an unplanned admission to hospital • Number of people with LD in hospital • Cost associated with overnight care provision • Number of people with LD accessing volunteering opportunities • Number of people with LD in hospital for more than 12 months • Number of people with LD in paid employment • Experience of living with a Learning Disability

Care homes

Care homes give long-term support for people 24 hours a day when they are no longer able to live in their own home due to their high level of social care needs.

The IJB is responsible for funding placements for people with an assessed need for a care home who cannot afford to pay for it themselves.

EHSCP currently operates seven care homes on behalf of the City of Edinburgh Council, looking after around 300 people each day. This accounts for only around 13% of all care home residents in the city. The other 2,200 live in privately-owned care homes that charge the IJB (or the resident themself) for each bed used.

The Scottish Government works with care home providers to decide how much IJBs should be charged for care home beds and agrees the national care home contract (NCHC) rate. Although this agreement exists, as private businesses, each care home can set their own prices.

It is our policy to pay the agreed NCHC rate, but not enough care homes are willing to sell us enough beds at this price to meet demand. This causes long waiting times.

There are several reasons for this. Firstly, Edinburgh has fewer care home beds than would be expected for a city of our size which means there is less availability. Secondly, it is expensive to build in Edinburgh due to high land prices which can deter people from developing new care homes. Finally, questions have been raised about whether the NCHC rate accurately reflects the cost of providing care.

In response, in 2023/24, we commissioned an external consultant to undertake a cost of care evaluation and advise the IJB on whether we should agree an alternative price to the NCHC rate for Edinburgh. Despite robust safeguards for the protection of commercially sensitive data, the exercise failed due to insufficient engagement from providers. This idea will therefore not progress.

Due to the way the population of Edinburgh is changing, the demand for care homes is only going to grow. Modelling completed on behalf of NHS Lothian has forecast that Edinburgh will need an additional 60 care home beds each year to keep up with population changes over the next twenty years. Even more challenging than this, to be financially viable, we need these additional beds to be sold at NCHC rate.

Our focus over the period of this Strategic Plan will be to increase the supply of care home beds sold at the NCHC rate. We will do this by continuing our policy of only purchasing beds at this rate, by investing capital for the development of new care homes and by working with the Council to incentivise private developers to build more care homes in Edinburgh.

Our other focus will be to make better use of the Council's care homes by increasing our specialisation on people with the most complex needs such as people with challenging behaviours due to dementia.

Primary aim: Reduce the number of people waiting for a care home

Care homes		
We will…	**Which will…**	**Measures…**
• Focus the EHSCP's internal care homes on caring for people with complex needs • Close some of the EHSCP's internal care homes that are not financially sustainable • No longer fund residential or nursing homes above national care home contract (NCHC) rate • Block purchase more care home beds with at NCHC rate • Provide funding at NCHC rate to continue placements in the event that somebody who has been self-funding runs out of funds • Work with the Council to restrict the sale of some areas of council land for the purpose of care homes • Develop new care homes • Work with external providers to develop new contractual agreements to purchase a proportion of their beds at NCHC rate. • Develop a brokerage function to centrally coordinate access to publicly funded care home placements • Prioritise access to care homes based on individual need and risk • Ensure that everybody entering a care home receives a comprehensive geriatric assessment (CGA) and anticipatory care plan (ACP) • Support care home providers to identify and respond to deteriorating health • give specific falls-prevention advice and training to care home operators • give care home residents with direct access to clinical decision makers in the event of a resident becoming unwell • Give care home residents direct access to hospital at home. • Focus Council care homes on provision of care for people with complex needs and dementia • Regularly engage on how best to support care home residents • Regularly engage on how best to support care home providers	• Ensure availability of support for people with complex needs. • Improve the financial sustainability of residential and nursing care provision • Increase the supply of care home beds at NCHC rate • Ensure that available care home places are used to help the people who need them most • Help stop little problems becoming big problems • Ensure that care home residents have appropriate access to health care interventions that are in their best interests • Provide people with complex needs and dementia with high quality care homes at an affordable price • Help us to develop better services to support care home operators • Help us develop better services to support people living in care homes	• Reduced number of people waiting for care homes • Reduced number of people in residential care homes with fees paid above NCHC rate • Reduced number of people in nursing care homes with fees paid above NCHC rate • Positive experience of operating care homes • Positive experience of living in care homes

Care at home and day services

The IJB is responsible for commissioning care at home and day services for people assessed as having a critical or substantial social care need. The criteria for what needs count as critical and substantial are defined in law. These mainly relate to help needed for essential tasks without which, people would come to harm in the near future. Most commonly, this involves assisting people with things such as getting washed, dressed, preparing meals, eating and drinking, taking medications and getting in and out of bed.

We call it 'care at home' when this support is provided within the person's own home. A 'day service' is when the individual travels to another location to receive support. Day services are also used as part of a holistic care package to support people to keep active, give opportunities to socialise with other people and to give unpaid carers a break.

As the commissioner, the IJB has a role in helping to shape the market by working with providers to agree prices and other terms and conditions.

The amount of care we buy is driven largely by demand. This is because we have a legal obligation to provide services to anybody assessed as having a critical or substantial need. We are not legally required to provide care for needs that do not qualify as critical or substantial. Therefore, like most IJBs, our policy is not to provide such services due to the costs involved.

We typically pay for around 100,000 hours of care at home each week to care for just under 8,000 people a year. Benchmarking data tells us that we have historically provided larger care packages than most other IJBs. This has significant financial implications.

We are actively working on reducing demand for care at home through our maximising independence approach. Also, by reviewing existing care packages to ensure that they do not exceed the person's assessed need. We are also implementing a new framework to pay for care at home which will increase the resilience of care providers and reduce costs through improved efficiency.

We are exploring opportunities to make sure the IJB recovers all money it is entitled to for providing social care. Personal care to help with essential tasks such as washing and dressing is free at the point of use in Scotland. However, councils can charge people for some or all of the help they get with other tasks if they have been assessed as being able to afford it. An example would be help with housework. We know that the income we recover from charging is lower than you might expect compared to other areas. We will be working with the Council to try to ensure that everybody who can afford to contribute towards the cost of their care does so.

Primary aim 1: To support people to be as independent as possible, reducing average hours of care provided per person

Primary aim 2: To increase money recovered in line with the council's charging policy

Care at home and day services		
We will…	**Which will…**	**Measures…**
• Provide a period of reablement for all new hours of care • Transfer all long-term care hours from the EHSCP's internal service to external providers to maximise capacity for reablement • Screen all individuals that are identified as having a new social care need for health-related causes that could respond to treatment • Provide access to rehabilitation services to help people recover from illness or injury • Use a strengths-based assessment which looks at what people can do rather than what they cannot • Consistently apply the criteria for critical and substantial need • Help connect people not meeting the criteria for care provision with alternative community services • Provide access to equipment and assistive technology to help people to be more independent in their homes and when accessing the community • Provide access to telecare and technology-enabled care. • Review all existing packages of care and day services to ensure people receive the service they need but no more than they need • Be responsive in providing extra help in times of crisis. • Enable care providers to have more flexibility in how they provide care • Commission a range of day services • Consistently apply the Council's charging policy for housing support and day services • Continue to develop the One Edinburgh framework to support care providers to build capacity within specific regions of the city • Develop and maintain a quality assurance framework for care providers which focuses on service user outcomes • Regularly engage with people with frailty on the best way to support them	• Enable people to be as independent as possible • Help stop little problems becoming big problems • Ensure the Council maintains its legal duties • Mean care is available for people who need it when they need it • Help prevent crises • Mean that everybody who should pay for the services they receive does so • Help us develop better services to support people requiring care	• Number of new hours of care provided per person per week • Number of people waiting for care (unmet need) • Costs recovered on provision of service • Experience of providing day services • Experience of providing care at home • Experience of accessing day services • Experience of receiving home care

Sexual health

The term ‘sexual health’ describes a person’s ability to engage in consensual sexual activity, their access to appropriate precautions to minimise their exposure to potential harm and their access to treatment for any harms that do occur.

The Scottish Government’s ‘sexual health and blood borne virus action plan: 2023 to 2026’ outlined the priorities for providing services. These are, diagnostic testing, access to contraception, services for young people, sexual wellbeing, the elimination of hepatitis C and the elimination of HIV transmission.

The IJB is responsible for commissioning sexual health services for the city of Edinburgh.

Sexual health services are delivered by East Lothian Health and Social Care Partnership on behalf of all four Lothian IJBs through an arrangement called a ‘hosted service’. This arrangement gives economies of scale for services that may be too small to be efficient and resilient if run separately in the four areas.

We retain the responsibility for commissioning the sexual health services on behalf of the citizens of Edinburgh. The hosted services arrangement also means that we need to consider the impact of any decision we make on the viability of sexual health services for the other Lothian IJB areas.

East Lothian IJB, alongside all IJBs, are experiencing significant financial challenges and are exploring all opportunities to make cost savings. This work has highlighted that the cost of providing some parts of sexual health services on behalf of Edinburgh and the other Lothian IJBs exceeds the funding they receive to deliver those services. This is not sustainable.

We therefore have a responsibility to work with the other Lothian IJBs to support the East Lothian team to realise cost savings. This may include having to make decisions about reducing or even stopping some parts of the service. Or, if unable to agree sufficient cost savings, we will need to spend more money to maintain existing services. Inevitably, this would mean us having to make additional savings elsewhere to find the money.

When taking part in these discussions with the other IJB areas, our four strategic priorities will be in the forefront of our minds. These are, prevention and early intervention, maximising independence, protecting our most vulnerable and using our resources effectively.

Our focus in this area will be in trying to avoid a situation where reducing sexual health services would increase costs elsewhere in our system or risk increasing health inequalities.

Primary aim: To Work with all Lothian IJBs to implement a plan that makes sexual health services good quality and financially sustainable without increasing Edinburgh IJB’s overall expenditure across all our services.

Sexual health		
We will…	**Which will…**	**Measures…**
• Provide advice on healthy lifestyle and signpost to relevant services via our self-management platform • Produce accessible information about what services we have available • Share information in various formats to suit different people's preferences • Provide training to primary care teams on best practice diagnosis and management of sexual health issues • Provide accessible professional to professional advice to people working in primary care on sexual health issues • Provide specialist sexual health services for young people and to LGBT+ young people • Provide access to specialist advice and treatment for women going through menopause • Provide an accessible gender service • Provide access to personalised advice on contraception and a diverse range of contraceptive options • Provide access to specialist support for people with unwanted pregnancy • Provide access to abortion care • When required, provide access to an abortion procedure that takes place within two weeks of self-referral to abortion services. (HIS standard 10) • Ensure people that need it are offered an assessment for sexually-transmitted infection testing within two working days of self-referral (HIS standard 4). • Promote awareness of HIV and other blood borne viruses to at risk groups and provide practical advice on how to reduce risk • Provide local access to PrEP, HIV testing and post-diagnostic support • Provide specialist psychosexual therapy services for people with a diagnosis of sexual dysfunction	• Enable people to make informed choices about their health • Enable people to access the right services for their needs at the right time • Help stop little problems becoming big problems • Reduce barriers for at risk groups accessing sexual health services • Ensure everybody has access to best practice in sexual health diagnosis and treatment • Enable access to specialist support for people experiencing gender-related problems • Enable people to find the contraception that works best for them • Enable people to make informed decisions about their unwanted pregnancies • Comply with national quality standards • Reduce risk of HIV and blood-borne viruses spreading • Improve wellbeing for individuals and couples affected	• Incidence of serious harms related to sexually transmitted infections • Proportion of people to receive an initial assessment from gender services within 18 weeks of referral • Number of unintended pregnancies • Number of sexual relationships subject to coercion or harm • Number of people living with HIV and other blood borne viruses • Experience of accessing sexual health services • Mental wellbeing assessment score

Workforce

It is often said, and for good reason, that our workforce is our most important asset. This is true because nothing can be achieved without the people to do it.

The NHS Act 1978 and the Health and Social Care Staffing (Scotland) Act 2019 make it a legal requirement to have a workforce plan. The duty to comply with this legislation remains with our partner organisations, NHS Lothian and the Council.

The IJB does not employ staff. We commission services from employing organisations such as NHS Lothian, the Council, third sector organisations and independent businesses. Nevertheless, we are responsible for ensuring we have enough people with the right skills to deliver our delegated functions.

In 2022, the Scottish Government published the national workforce strategy for health and social care in Scotland. This emphasises the need for workforce planning to be aligned with operational planning and financial planning.

These areas are highly interdependent. To know how many people and what skills are needed (workforce planning), we need to understand what we are trying to achieve and how (operational planning). We also need to be able to afford it (financial planning). Whenever one area changes, the other two need to adapt.

Our current workforce strategy ends in March 2025. Our new workforce strategy will build on the progress made and help us to implement this Strategic Plan.

The recurring theme throughout this Strategic Plan, has been the severe financial challenges facing the IJB and the rising demand for services caused by our growing population, increasing levels of frailty and deprivation. To meet this demand, we would inevitably need more people. The extent to which we can afford that, will depend on how successful we are at saving money elsewhere.

Another substantial risk is that a large proportion of our workforce in some professions are approaching retirement at the same time. This is a national problem and reflects the historic ‘boom and bust’ of training placements and employment trends. It means we will lose many of our most experienced staff at the same time.

Adapting to increasing demand when we have less money to work with, means our teams need to be ever more imaginative in how they work. We know they will need help to broaden their skills. We know that the people who do the work are often best placed to improve it, and we are committed to supporting them to do so. We will work closely with trade unions to achieve this. This is likely to involve providing protected time, access to relevant data, training opportunities and coaching for improvement.

Our focus throughout the next three years will be to ensure that our workforce plan aligns to our strategic objectives, local service plans, and is affordable. Achieving this is likely to need substantial work on skills development within our workforce.

Primary aim: To support people to realise their potential, increasing the number of people accessing training opportunities for expanded roles

Workforce		
We will…	**Which will…**	**Measures…**
• Have a fully costed workforce plan which covers the three-year period of this Strategic Plan • Strengthen our governance arrangements to support the implementation of the workforce plan • Work in partnership with trade unions on service design • Develop oversight groups within professional discipline areas to inform strategic planning and implementation • Ensure robust lines of professional and operational accountability • Maintain reasonable ratios of direct reports for line managers • Ensure people are clear about what we are trying to achieve and what is expected of them in their role • Utilise quality improvement leadership and coaching capacity to support implementation of the workforce plan at both directorate and service levels • Engage widely when developing our workforce plan • Use feedback from service users and analyse complaints received to identify any changes needed to our workforce plan • Use data to inform our workforce plan including from joint strategic needs assessments to show how workforce needs are likely to change in the future • Use feedback from exit interviews to inform improvement planning • Develop competencies and associated training packages for each role in the organisation • Maintain high levels of compliance with mandatory training • Consistently apply the HR policies of NHS Lothian and the Council • Regularly engage with trade unions on changes that affect our staff • Develop more internal opportunities for career progression and succession planning • Use integrated posts whenever practical to give people the choice of whether to be employed on NHS or council terms and conditions.	• Ensure compliance with our legal duties • Provide a clear direction for us to follow • Ensure people feel supported in their roles • Enable robust financial and service planning • Help us deliver our strategic plan • Ensure robust governance • Increase our chances of successful implementation • Align our workforce with the needs of the populations we serve • Help us to adapt to the changing needs of our population • Ensure that our teams have the skills needed to work at the best of their ability • Improve the experience of working in our services • Help to retain experienced people within our services • Maximise opportunities for people	• Number of posts vacant in each service or professional group • Post turnover rate for each service or professional group • Compliance against statutory responsibilities • Proportion of people with valid mandatory training • Number of days safe staffing levels are not met • Number of days effective staffing levels are not met • Number of people accessing training opportunities and coaching for expanded roles • Compliance against HR policies

Quality

The term ‘quality’ refers to how good something is. In relation to health and social care, it means services that are **safe**, **effective and efficient** and **person-centred**.

Quality does not happen by accident, it needs conscious planning, ongoing management and continuous improvement.

Many of the services commissioned by the IJB must comply with legal standards of quality. They are inspected by regulators such as Healthcare Improvement Scotland, the Care Inspectorate and the Mental Welfare Commission.

Inspections from external regulators are an important element of ensuring the quality of services but they are not enough on their own. To manage quality effectively, we need to be proactive, and we need to be constantly looking for ways to improve.

To achieve this, we will ensure that each service we commission has a clear vision of what it is trying to achieve, an explicit and evidence-based plan for how it is going to do it, robust measures in place to track how well they are doing and to quickly identify when things go wrong, and the skills to fix them when they do.

To ensure consistency of approach, we will use a standardised template called a ‘target operating model (TOM),’ to capture this information. We will hold regular peer-review sessions throughout the year for teams to learn from each other, and to provide feedback and suggestions for improvement.

We will use these TOMs and the data they contain as the basis for quality planning and reporting within EHSCP, with NHS Lothian and the City of Edinburgh Council as well as with the IJB and its various groups and committees.

There can sometimes be a tension between best quality and keeping costs down, but these two ideals can also be compatible. What does not get talked about enough is that poor quality is expensive, particularly when it leads to duplication of effort or creating extra work for another part of the system.

The four priorities in this Strategic Plan, prevention and early intervention, maximising independence, protecting our most vulnerable and using our resources effectively are just different ways to approach improving quality. Every action to which we have committed is intended to make our services more safe, effective, efficient or person-centred.

Our focus throughout this Strategic Plan will be to increase the capacity and capability of our teams to plan, manage and improve quality. We will do this by developing a specialist quality function within EHSCP with responsibility for an integrated total quality management system across all services commissioned by the IJB.

Primary aim 1: To increase the capacity and capability of teams to undertake total quality management

Primary aim 2: To develop target operating models for all service areas

Quality		
We will…	**Which will…**	**Measures…**
• Adopt a total quality management approach encompassing planning, assurance, control and improvement to develop an improvement workplan • Strengthen our quality planning function to ensure that our decisions are data led, and evidence based • Develop target operating models for all services to clearly define the key priorities and aims in line with strategic and operational priorities • Use target operating models to align our resources to our priorities • Adopt a consistent and standardised approach to change • Make data informed decisions and use data over time to evaluate the impact of improvement • Develop a measurement framework to ensure all change leads to improvement for internal and external services • Develop a robust assurance framework to produce regular reports for the attention of the clinical and care governance committee and the IJB • Develop a quality function ensuring appropriate executive and senior level sponsors are identified • Embed a risk management framework aligned to ones used by NHS Lothian and the Council to ensure risk is managed consistently at all levels • Provide access to QMS and QI training for all staff within the EHSCP • Use a combination of qualitative and quantitative data to measure what really matters and encourage a more holistic approach to improvement • Ensure there is support for people to access, interpret and understand data to identify and drive improvement • Develop a quality network and community of practitioners for QI • Develop more mechanisms to encourage service user feedback and engagement to drive improvement • Drive, track and measure improvement activity • Embed a clinical and care governance framework	• Enable a systematic and standardised approach to quality and safety • Ensure quality remains a priority • Help keep improvement activity on track • Provide a single accurate version of the health and social care system • Allow us to concentrate our efforts on areas of concern and adopt a preventative rather than reactive approach to change management • Make our resources go further • Create the conditions for improvement • Ensure sufficient scrutiny and oversight of safety and quality of care	• Achievement of SMART goals • Visibility of performance and quality • Capacity and capability for QI within the EHSCP • Audits of the use of and understanding of data for service design • Number of complaints being responded to within timescale • Staff experience measures • Service user outcomes • Service user experience measures

Co-production

Co-production is an evidence-based method of working together to solve problems. It involves the people who are responsible for providing services working with the people who will use them to develop joint solutions.

Co-production is recognised as best practice and is supported by the Scottish Government which commissions the Scottish community development centre to help organisations make it a reality.

There are excellent examples where co-production has been used to develop services that we commission. These include our Thrive welcome teams for people seeking help for their mental health and in some of our drug and alcohol services.

By working together with communities, we can ensure that the IJB's resources are used to best effect by providing the services that they need rather than what somebody else thinks they should have.

We are committed to making this our normal practice in all our service areas.

Developing a culture of co-production is a long-term goal and needs a sustained investment in training and support to develop the necessary knowledge and skills. We are committed to putting the resource in place to achieve this.

For co-production to work, there needs to be a shared understanding of the problem and the context in which solutions need to be delivered.

This is why this Strategic Plan has been so explicit about the severity of the financial challenge facing the IJB and the absolute necessity to abide by our legal duties. Honesty and transparency are critical to creating the conditions for co-production. So, we want to share the full reality of the IJB's situation.

We did this because we believe that co-production can help us find better solutions. It will enable us to leverage the breadth of knowledge, experience and ideas from the city's diverse communities and make better use of the resources we have.

For solutions to be viable, they need to either directly support our compliance with our statutory responsibilities or save money.

Importantly, until the IJB reaches financial viability, savings produced also need to be realised within the IJB's own areas of responsibility and will need to materialise as 'real cash'.

In practice, this means that the IJB cannot afford to spend more money in one area unless doing so will directly translate into the IJB being able to spend less money elsewhere. We will also need to prioritise savings that provide a return on investment within the near term over savings that may occur in many years to come.

With this shared understanding, we look forwards to co-producing the services the IJB will provide in the future.

Primary aim: To develop a competency framework and associated training plan for leading and learning through co-production

Co-production		
We will…	**Which will…**	**Measures…**
• Work with citizens to produce accessible information about how people can help shape decisions about health and social care in their communities • Share information in various formats to suit different people's preferences and involve them in deciding how best to do this • Work in partnership with the people of Edinburgh to decide what we need to do and how to do it • Be clear about what we are trying to achieve • Be clear about the financial constraints we are working with • Be clear about what 'red lines' exist about what must be done or cannot be done • Be a reliable partner to work with • Provide training and support for people on how to do co-production effectively • Involve people in important decisions from the start • Enable people to have the time needed to work more collaboratively • Work to a multi-year Strategic Plan and financial plan • Ensure that everybody involved has the information they need • Use the Scottish approach to service design when planning change • Develop a competency framework and associated training plan for leading and learning through co-production • Involve people with lived experience in decisions about services that affect them • Ensure people from all sections of society can participate in co-production • Regularly evaluate how well we work with others • Regularly engage with communities on the best way to engage them in co-production • Consistently give feedback to people about what has happened as a result of their involvement	• Help more people to get involved in decision-making • Provide a shared sense of purpose • Enable resources to be concentrated where they are needed most • Allow us to build on what works well already and provide opportunities to change what does not • Make sure our plans are realistic • Help build and maintain trusting relationships • Ensure we have the capability needed for co-production • Ensure people are given the chance to shape their communities and the services provided • Enable better long-term decision-making • Provide a systematic way of solving problems • Increase the pool of ideas • Help reduce health inequalities • Help us to continuously improve • Encourage greater participation in future co-production	• Number of people assessed as competent to lead co-production activities • The range of people from different communities being represented in decision-making • Capacity and capability for co-production • Experience of engaging with EIJB on service design and change

Climate Change

The earth's climate is changing. This is largely due to the way humans have used the planet's resources in an unsustainable way and polluted the atmosphere. As a result, the polar ice caps are melting which is causing sea levels to rise. This is threatening to coastal communities and entire island nations. Also, weather is becoming increasingly extreme with more heatwaves, droughts, storms and floods.

Climate change poses a profound risk to human health.

In response, the Scottish Government has produced the NHS Scotland climate emergency and sustainability strategy: 2022-26 and the green growth accelerator programme to support public bodies to take the action required. The public bodies climate change duties report is produced each year to track what progress is being made.

The most visible impacts on health faced by the population of Edinburgh are likely to come from an increase in extreme weather events such as heatwaves and floods. Whilst the link to climate change is less intuitive. Other significant risks to the health of our population caused by climate change include an increase in food and water insecurity and rising prices for essentials causing increasing poverty.

The legal duties to reduce carbon emissions and adapt the city to better withstand the consequences of climate change rest with NHS Lothian and the City of Edinburgh Council. As the commissioner for many of the services they provide, the IJB has an important role in helping them to fulfil their duties by commissioning services in an environmentally responsible way. This moral responsibility extends to how the IJB commissions all our services.

As well as helping to reduce the damage caused, responding to the climate emergency provides opportunities to improve health. For example, people using more active travel methods by walking and cycling rather than driving. This has many benefits for both their physical and mental health as well as helping to improve the city's air quality from having fewer vehicles on the streets burning fossil fuels.

We are, however, conscious that the IJB does not currently have a system in place to help us understand our carbon footprint and to inform our improvement planning.

Our first area of focus throughout this Strategic Plan will be to work with our partners, NHS Lothian and the City of Edinburgh Council, to develop a robust method for mapping the IJB's carbon footprint.

Our second area of focus will be to minimise the necessity for travel within the services we commission, to promote active travel where possible, and increase use of electric vehicles, when required, as an alternative to fossil fuel consumption.

Primary aim: To develop a method to quantify the IJB's carbon footprint and to track how it changes over time as a basis for improvement planning.

Climate change		
We will…	**Which will…**	**Measures…**
• Implement a new care at home framework which concentrates activity for providers within sections of the city to reduce travel between visits • Use TotalMobile to plan and track journeys of our community teams • Provide opportunities for hybrid working wherever it is appropriate to job roles • Provide opportunities for combined appointments or 'one stop shops' for people with multiple conditions that need to see more than one member of the team • Work with NHS Lothian and City of Edinburgh Council to help make active travel a convenient option when accessing health and social care sites • Provide options for online and telephone appointments whenever appropriate • Work to reduce unnecessary prescriptions of medications • Work to reduce unnecessary equipment provision • Work to increase returns and recycling of equipment no longer needed • Promote climate change mitigations wherever possible when commissioning therapeutic greenspace activities • Consistently record the therapeutic use of community greenspaces and share with this information with the Council • Ensure plans are in place to maintain all essential service provision throughout extreme weather events • Work with NHS Lothian and City of Edinburgh Council to quantify the carbon footprint of the services they provide on behalf of the IJB	• Help to reduce travel • Reduce carbon emissions • Reduce waste consumption • Help mitigate the impact of climate change on health and social care services • Help strengthen the case for maintaining current and developing new community greenspaces • Enable us to take data-informed decisions about how to further reduce our impact on the environment	• Number of miles travelled by care agencies for each person under their care • Number of miles travelled by community teams per service user under their care • Number of miles travelled to appointments per service user per year • Number of miles travelled to commute for each person employed • Number of items of equipment recycled • Carbon footprint for EIJB commissioned services

More information

This Strategic Plan has outlined the challenges and opportunities currently facing the IJB and how these are expected to develop over the next three years.

We have been clear about what we consider to be the IJB's strategic priorities and how we intend to approach each of them.

This Strategic Plan should be read alongside these linked documents:

Document	What's inside
Implementation plan	A detailed breakdown of the specific actions we will take to deliver the Strategic Plan and the timescales for doing so.
Medium term financial strategy (MTFS)	Our most up-to-date assessment of the IJB's financial position and how we intend to pay for the actions in our implementation plan.
Measurement framework	A comprehensive set of measures which show how our health and social care system is performing and how well our Strategic Plan and implementation plan is working.

It is not possible to foresee all eventualities. We will inevitably need to adapt our plans as we go in response to changing circumstances. The principles laid out in this Strategic Plan will continue to guide our approach.

Any significant change of direction to the approach laid out in this Strategic Plan would need to be agreed by the IJB's strategic planning group (SPG), if not by the IJB itself.

We will regularly monitor the progress we make against the implementation plan, the impact on the performance of our system and our financial plan. We will report these regularly to the IJB's performance and delivery (P&D) Committee. The P&D committee will also provide a summary report to the IJB at least once a year.