Tackling inequalities

What we know:

In Edinburgh, 50% of people experiencing ill health do not live in the areas with the highest areas of deprivation

People living in areas experiencing high levels of deprivation are at risk of:

- dying at a younger age
- developing long term conditions 10 years earlier than those in less deprived areas

Many carers experience poor physical and mental health

In Edinburgh, 12% of people aged 16-74 are unable to work due to a limiting long term illness

Communication difficulties can make it harder for many people from minority ethnic groups and people with disabilities to access services

What we plan to do:

Target resources more effectively through working collaboratively with citizens and communities at a local level

Working with our partners to tackle the causes of inequality and health inequality by supporting those at greatest risk and focusing on:

- mitigating the health and social consequences of inequalities
- helping individuals and communities resist the effects of inequality on health and wellbeing

Review the remit, membership and priorities of the Health Inequalities Standing Group and consolidate funding available across health and social care to tackle inequalities

Prioritise actions that increase physical activity, and promote healthy eating, healthier environments and better use of green space

Provide information on keeping healthy in an accessible easy read format for people with communication difficulties

Prevention and early intervention

What we know:

Around 40 – 45% of public expenditure is spent of addressing preventable issues

70% of Edinburgh's population has one or more long-term condition, which increases the risk of emergency admission to hospital if not managed

Loneliness has been shown to be as harmful to health as smoking 15 cigarettes a day

27% of the population of Scotland is obese (predicted to rise to 40% by 2020) leading to increased risk of diabetes, stroke and coronary heart disease

Falls are the leading cause of accident related death in older people - 30% of people over 65 and 50% of those over 80 fall each year

Supporting and encouraging people to achieve their full potential, stay resilient and take more responsibility for their own health and wellbeing; making choices that increase their chances of staying healthy for as long as possible and where they do experience ill health, promoting recovery and self-management approaches.

What we plan to do:

Embed prevention and early intervention in mainstream activity across health and social care

Use the data available within the Joint Strategic Needs Assessment to identify and support people at risk

Develop a shared understanding of the pattern of current resource use in order seek opportunities to invest in preventative activity that will have the most impact

Produce an evidence based prevention and early intervention strategy and action plan for health and social care

Encourage GPs and housing providers to use the JSNA to jointly identify and support people at risk.

Person centred care

What we know:

The relationship between health and social care services and citizens needs to change

The most effective way of meeting people's needs is for them to be active partners in making decisions about and managing their own health and wellbeing

Involving unpaid carers and family members in decisions about the best way to meet needs can lead to better outcomes

There is growing evidence that approaches to person-centred care such as shared decision making and self-management support can improve people's experience, care quality and health outcomes

Placing 'good conversations' at the centre of our engagement with citizens so that they are actively involved in decisions about how their health and social care needs should be addressed.

What we plan to do:

Establish clear mechanisms that embed collaboration with citizens and communities in service planning and delivery

Engage with staff to embed the principles of person centred care in everything we do

Ensure that citizens have access to information, advice and support to make informed decisions about their health and wellbeing and manage their own care where they so choose

Reduce the number of times people have to tell their story by better co-ordination of care

Invest in self management, self-directed support and technology enabled care to allow people to take more control over their lives

Right care, right place, right time

What we know:

Changing models of care and support is a priority to meet current and future care needs

Most people want to live independently for as long as possible, and if they do need support, would prefer to be looked after at home or in a homely setting, and to die there if possible

Remaining in hospital once acute care needs have been addressed is bad for people's overall wellbeing, resulting in loss of confidence and independence

GP and other community health and social care services that help keep people at home, are under severe pressure

Delivering the right care in the right place at the right time for each individual, so that people:

- are assessed, treated and supported at home and within the community wherever possible and admitted to hospital only when clinically necessary
- are discharged from hospital as soon as possible with support to recover and regain their independence at home and in the community
- experience a smooth transition between services
- have their care and support reviewed regularly to ensure these remain appropriate
- are safe and protected

What we plan to do:

Develop an integrated approach to technology enabled care/eHealth

Agree an improved and consistent service model for frail older people and people with dementia

Development of community services for people with learning disabilities with forensic needs, autism and behaviours that challenge

Implementation of a locality partnership model for the delivery of recovery orientated mental health services

Develop a strategy and action plan in relation to long-term conditions

Making best use of capacity across the whole system

What we know:

Unpaid carers are a vital resource and must be supported

Increasing demand, limited resources and workforce challenges make the current system of providing health and social care services unsustainable

The third sector has a vital role to play in strengthening community resilience and supporting people to remain independent

More good quality, affordable and accessible housing is essential to maintain health and wellbeing

The independent sector provides 70% of care at home services to those aged 65+

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

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

to deliver timely and appropriate care and support to people with health and social care needs, including frail older people, those with long-term conditions and people with complex needs

What we plan to do:

Work with communities to identify individuals at risk and help them build personal resilience

Develop ways of working that break down organisational, professional and budgetary silos and actively involve local people, local providers and communities

Develop our understanding of the resources and strengths within the four localities and how all partners can collaborate to meet needs

Work with all partners to ensure that community-based health services, including GP practices can be sustained and developed

Understand how the capacity available under the local Housing Strategy can contribute to the outcomes for Health and Social Care

Managing our resources effectively

What we know:

When faced with increasing demands and limited resources it is essential we make every penny count

Expenditure on NHS services accounted for 71% of total health and social care expenditure in 2012/13

75% of hospital inpatient care is accounted for by emergency/unplanned admissions

2.4% of Edinburgh residents account for 50% of total health care costs and 8.4% of residents account for 50% of social care expenditure

There is avoidable demand currently in our system, which if managed differently, would free up resources to be used to address our priorities

What we plan to do:

Collaborative locality and neighbourhood focused commissioning

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

Take an integrated approach to workforce development, which allows us to work in different and more joined up ways with our partners and reduce unnecessary duplication

Use the ongoing development of the JSNA to embed a joined up approach to data collection, sharing and evaluation

Explore the full potential of technology to both support individuals to live independently and enable integrated and joined up working

Work with our strategic partners to establish the four localities as the basis for service planning and delivery that makes the best use of the resources of all partners, including local communities assets