Edinburgh Shadow Health and Social Care Partnership
Joint Strategic Needs Assessment
2015
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Appendices

1. List of Topic Papers
1. Introduction - the integration of Health and Social Care

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

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

Scope of the strategic plan for Edinburgh

[Diagram]

Locality 1:
- City of Edinburgh Council
- Functions/services that must be delegated as set out in regulations
- Additional functions/services it has been agreed will be delegated

Locality 2:
- NHS Lothian
- Functions/services that must be delegated as set out in regulations
- Additional functions/services it has been agreed will be delegated

Locality 3:

Locality 4:

National health and wellbeing outcomes

As set out in regulations relating to Public Bodies (Joint Working) (Scotland Act) set 1
Defining the localities

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

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

Services to be delegated to the Edinburgh Integration Authority

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

- Social work services for adults and older people
- Services and support for people with physical and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Assessment and care management inc. OT services
- Health improvement
- Support for carers
- Residential care
- Care at home, reablement and intermediate care
- Rehabilitation
- Day services
- Respite care
- Telecare
- Local Area Coordination
- Aspects of housing support including aids and adaptations
The services that NHS Lothian must delegate to the new Integration Authority for Edinburgh are set out in the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 and include:

**Community Health Services**

- District Nursing
- Services relating to an addiction or dependence on any substance.
- Services provided by AHPs
- Public dental service
- Primary medical services (GP)*
- General dental services*
- Ophthalmic services*

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

**Hospital services**

- Accident and Emergency
- general medicine
- geriatric medicine
- rehabilitation medicine
- respiratory medicine
- psychiatry of learning disability
- palliative care
- hospital services provided by GPs
- mental health services provided in a hospital with exception of forensic mental health services
- Services relating to an addiction or dependence on any substance

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

Also, the function of sexual health has been delegated to the IJBs. There are a number of services that provide sexual health care – e.g. primary care (where most sexual health care occurs), long-acting reversible contraception (LARC) provision in maternity and abortion services, pharmacy and Chalmers Sexual Health Centre.
National Health and Wellbeing Outcomes

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

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

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

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

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

**Outcome 4:** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

**Outcome 5:** Health and social care services contribute to reducing health inequalities

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

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

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

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

2. Joint Strategic Needs Assessment

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

The purpose of the JSNA is to agree a comprehensive local picture of health and wellbeing needs, using intelligence and analysis to determine:

- Current and future needs
- What’s working, what’s not, and what could work better?
- What are the major health inequalities and what can be done about them?
- Unmet needs, including those of seldom-heard populations and vulnerable groups
This will be used to:

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

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

The current needs assessment was done in two phases. The first phase was a desktop analysis of data, and is the focus of this report. The second phase involved engaging a wide range of stakeholders in discussing the findings of phase 1, and more broadly, in using their knowledge and experience as clinicians, practitioners, residents, third sector organisations, service providers etc to form a broader and more complete assessment of needs and priorities. This is summarised in section 6 of this report. Both phases are needed to meet the objectives of the JSNA as outlined above.

The analysis of existing datasets covers four broad themes:

- A profile of Edinburgh and its four localities: its population structure – current and forecast, levels of poverty, the labour market, housing, education, children in need and the health of its population
- An overview of the needs of specific groups including older people, people with disabilities, people with mental health problems, unpaid carers, people with addictions, people in the LGBT community, people with complex needs and people with palliative care needs – current and forecast levels of need are described along with a summary of current priorities for each group
- Profiles of current resource use and activity including spending profiles on NHS and social care services, activity profiles for health and social care, and analyses of specific groups – those people
who are at risk of emergency hospital admission, and people who use relatively high levels of support (“high resource individuals”); profiles of the third and independent sector in Edinburgh are included in this section.

- A summary of known pressures within the health and social care system.

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

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

**JSNA production**

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

**Keeping the JSNA up to date**

As an integral part of the analyse-plan-do-review cycle, the needs assessment will be updated on a regular basis.
2.0 Profile of Edinburgh

2.1 Edinburgh’s Population Structure

Introduction

This analysis summarises population and household data from the 2011 Census, as well as National Records of Scotland (NRS) population projections for local authority areas. Further details will be given in Topic Paper 1, available separately.

The size and age structure of a population are among key determinants of the need for support for universal services such as primary health care and schools, and targeted services such as social care. Other potential indicators of need include single person households. These are of interest because social isolation and loneliness can have significant adverse effects on people’s health and well-being, and age and living alone increase the risk of social isolation and loneliness (evidence from Scottish Parliament’s Inquiry into Age and Isolation, 2015).

Edinburgh’s population – age and gender

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

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

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Edinburgh</th>
<th>Males</th>
<th>Females</th>
<th>North East</th>
<th>North West</th>
<th>S East/ Central</th>
<th>South West</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>74,459</td>
<td>8,037</td>
<td>9,124</td>
<td>7,814</td>
<td>12,062</td>
<td>7,882</td>
<td>8,590</td>
</tr>
<tr>
<td>16-24</td>
<td>69,652</td>
<td>5,544</td>
<td>8,388</td>
<td>6,400</td>
<td>15,241</td>
<td>7,577</td>
<td>9,390</td>
</tr>
<tr>
<td>25-49</td>
<td>188,767</td>
<td>25,481</td>
<td>21,728</td>
<td>25,159</td>
<td>25,920</td>
<td>20,676</td>
<td>21,830</td>
</tr>
<tr>
<td>50-64</td>
<td>82,386</td>
<td>8,714</td>
<td>9,490</td>
<td>8,740</td>
<td>13,538</td>
<td>9,689</td>
<td>10,920</td>
</tr>
<tr>
<td>65+</td>
<td>415,264</td>
<td>47,776</td>
<td>53,717</td>
<td>48,113</td>
<td>58,304</td>
<td>55,523</td>
<td>56,347</td>
</tr>
</tbody>
</table>

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

Table 2. Edinburgh’s Localities – population profile

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

Key points:

- **North West** includes one-third (33.2%) of Edinburgh’s child population aged 0-15 and one-third (33.5%) of the very elderly population aged 85+ (a group which tends to have high levels of need).
- Only 12.8% of **South East/Central**’s population is aged 0-15 compared with the Edinburgh average of 15.3% and a large proportion (22.3%) are aged 16-24 (N = 28,085) - many of these will be further education students. The traditional working age population (16-64) is biggest in **South East/Central** (93,091).
- **East** has the lowest proportion of older people (aged 65+) (13.3%); almost half (45.8%) of its residents are younger adults aged 25-49 compared with the overall Edinburgh proportion of 38.7%.
- **South West** and **East** have relatively low proportions of people aged 85+; the working age population is smallest in the **South West** (77,548).
The following population pyramids illustrate the population structure of Edinburgh and the 4 localities:-
Other characteristics of Edinburgh’s population

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

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

The size of the LGBT community in Edinburgh is not known, but estimated to be at least 5% to 7% of the population.

Edinburgh’s Future Population

Forecasts of the city’s population will help us to estimate future requirements for services, including health and social care services.

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

Approximately 70% of Edinburgh’s future population growth arises from more people coming to live in the city, with remaining 30% resulting from more births than deaths. However, migration is more volatile than births and deaths and therefore difficult to measure accurately. The numbers shown are projections rather than forecasts, estimating what will happen if recent trends continue but taking no account of future economic or policy changes.

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

Work within the Council suggests that official NRS projections are likely to overestimate Edinburgh’s future population growth in the medium term, because population growth within the City is constrained by the limited potential for new housing.
2.2 Poverty and low income

Introduction

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

Definitions and measures

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

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

Summary of key findings

- Research published by the Scottish Government estimates that 18% of all households in Scotland were living on incomes below the poverty threshold (after housing costs) in 2013/14. This represents a total of 940,000 households.

- Poverty rates in Scotland fell gradually in the ten years to 2007, but since that point have remained relatively steady. The year to 2013/14 shows a slight drop in poverty, though this drop is within margins for error for the estimate and should be treated with some caution.

- However, poverty rates have not shown improvements across all household types. Data for families with children, for instance, show poverty after housing costs remaining high, with a trend emerging of increasing material deprivation and deteriorating living standards for families with children on low incomes, for pensioner households, and for households at the lowest end of the income spectrum.

- Edinburgh is an affluent city, with average incomes and most measures of economic success above those of other Scottish local authorities. Despite this success, poverty and low income rates in the city remain similar to the Scottish average.

Alternative measures of poverty and low income in Edinburgh

<table>
<thead>
<tr>
<th>Category</th>
<th>Edinburgh</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>% households on low incomes, 2009</td>
<td>22%</td>
<td>20%</td>
</tr>
<tr>
<td>% children living in low income households, 2013</td>
<td>21%</td>
<td>22%</td>
</tr>
<tr>
<td>% Households in receipt of Housing Benefit, 2015</td>
<td>17%</td>
<td>19%</td>
</tr>
<tr>
<td>% Households who find it very difficult to cope on current income, 2014</td>
<td>9%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: Improvement Service, Child Poverty Action Group, DWP Housing Benefit Caseloads, Experian

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1 Technical note: an equivalised income is used.
In 2009 a major study of income patterns across Scotland estimated that 22% of all households in Edinburgh were living on low incomes. In 2013, research showed that 21% of all children in Edinburgh were living in low income households in 2013.

Within the city wide averages, the data reveal significant variation in poverty rates across the city, with levels of inequality in Edinburgh found to be more marked than other local authorities. Child poverty rates in 2013 ranged from 18% in the North West, to almost 26% in the North West.

At a more local level, these inequalities are even more extreme. Within the South West area, for instance, Sighthill/Gorgie records a child poverty rate more than three times higher that of more affluent areas. Even within wards themselves high levels of inequality can be found. Within Forth, rates of benefits dependency range from a low of 4% of households to a high of 56% between small areas in the ward.

Notably, all localities include areas of high poverty alongside areas of relative affluence. In many cases, data show extreme levels of local income inequality within electoral wards.

The 2010 Marmot Review provided evidence to illustrate the link between income inequalities and inequality across a wide range of health outcomes. In Edinburgh, for instance, data show that the rate of premature mortality due to Coronary Heart Disease in deprived areas of Edinburgh remains at more than twice the average for the city as a whole. Further information on comparative levels of health across the city is provided in section 2.5.

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

**Health inequality in Edinburgh by locality**

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents with a long term health problem which limits day to day activities a lot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td>7.1%</td>
<td>11%</td>
</tr>
<tr>
<td>East</td>
<td>8.3%</td>
<td>14%</td>
</tr>
<tr>
<td>South Central</td>
<td>6.7%</td>
<td>11%</td>
</tr>
<tr>
<td>South West</td>
<td>6.8%</td>
<td>15%</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>7.2%</td>
<td>12%</td>
</tr>
<tr>
<td>Scotland</td>
<td>9.6%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Source: Census 2011
2.3 Labour Market

Introduction

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

Definitions and measures

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

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

Summary of key findings

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

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

Labour supply by locality, 2011

<table>
<thead>
<tr>
<th>Localities</th>
<th>Economic activity</th>
<th>Employment</th>
<th>Economic inactivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West</td>
<td>64.8%</td>
<td>60.9%</td>
<td>35.2%</td>
</tr>
<tr>
<td>East</td>
<td>68.6%</td>
<td>63.5%</td>
<td>31.4%</td>
</tr>
<tr>
<td>South East/Central</td>
<td>57.5%</td>
<td>52.9%</td>
<td>42.5%</td>
</tr>
<tr>
<td>South West</td>
<td>63.6%</td>
<td>58.6%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>63.4%</td>
<td>58.8%</td>
<td>36.6%</td>
</tr>
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Source: Census 2011
This section highlights the key housing issues that relate to health and social care. Further detail and analysis is provided in Topic Paper 4.

Introduction

Housing contributes to all nine national health and wellbeing outcomes. The contribution to outcome 2 (people, including those with disabilities or long term conditions, or who are frail, are able to live, as far reasonable practicable, independently and at home or in a homely setting in their community), is particularly strong, through the provision of good quality housing and support which enables people to live independently.

Housing Demand and Supply

The housing need and demand in Edinburgh is high. Current supply and profile of homes in Edinburgh is neither sufficient nor adequate to meet the needs of an ageing and growing population.

- The second South East Scotland Housing Needs and Demand Assessment (HNDA2) estimates that the housing need for Edinburgh is likely to be around 38,000 to 46,000 new homes over a 10 year period, or 3,800 to 4,600 a year; but over the last 10 years, an average of only 1,436 new homes (all tenures) were completed each year.
- The population of Edinburgh is projected to grow by almost 30% over the next 25 years. The number of older people over 75 living in the city is expected to grow by over 75% and the number of people requiring intensive levels of support, including those with complex physical and mental health needs, is expected to increase by 61% during the same period.
- Edinburgh has a higher proportion of flats and homes built before 1945 than the Scottish average. This older, flatted profile of homes means that not all homes are suitable for adaptations. In some cases it is possible to adapt the flat but not the stair where the flat is situated.
- The need for social rented homes is high. There are approximately 25,000 applicants registered with EdIndex, Edinburgh’s common housing register for the Council and 20 RSLs (Registered Social Landlords), at any one time. In 2014-15, an average of 144 housing applicants competed for every home available through the Choice based letting system (CHOICE). Around 4,000 households presented as homeless to the Council in the same year. The Council has a statutory duty to provide settled accommodation to the majority of these homeless households. More than half (53%) of the homes available through CHOICE were let to homeless priority households, making it harder for people with no priority to be rehoused in social rented homes.
- Homes built under the new building standards are more accessible, adaptable and energy efficient. Building more new homes will not only help to meet the needs and demand of a growing population, but also improve the accessibility and adaptability of homes available.
- The Council and NHS Lothian have identified the need to invest in specialist housing for people with complex physical and health needs, and more generally, meet the housing and care needs of the city’s growing older population. The partnership to date has helped 80 accessible homes to be built alongside two care homes under the Council’s house build programme, the 21st Century Homes Programme. Work is ongoing to potentially further increase house building alongside integrated health and social care facilities.

Support Services for People with Particular Needs

Adequate care and support, and making better use of modern technology, can help people to remain independent at home or in a homely setting in the community and reduce the need for high cost formal care and unplanned hospital admissions.
• Aids and adaptations are often the most cost effective way to meet peoples’ housing needs. Over £12.3 million of public funding has been invested in more than 3,300 major adaptations in the city in the last 5 years.

• As at the end of September 2015, around one fifth (5,400) of EdIndex applications were from households who considered someone in their household as disabled. Of these 5,400 applicants, only around 400 were awarded with Gold or (Urgent) Gold rehousing priority because their current homes cannot be adapted to meet their needs. The majority of these households are living in a home that already meets their needs if support is put in place, or can be adapted to meet their needs.

• A new joint approach which seeks to match social rented homes available to people with Gold (Urgent) priority for rehousing is helping to address delayed discharge from hospital, where housing is a key factor, and to ensure the best use of limited accessible homes. This is a joint approach between the Council’s Housing Service, Registered Social Landlords, NHS Lothian and Health and Social Care. Between June and October 2015, the pilot matched 10 people to suitable homes, reducing the length of time they had to remain in hospital. The pilot has been rolled out to all 21 EdIndex partners.

• Encouraging people to plan for their future housing needs before crises happen and ensuring housing options information is widely available are service areas that could be developed.

• The number of people presenting as homeless has reduced by nearly 17% between 2009-10 and 2014-15. During the same period, the number of households who presented homeless with one or more support needs has reduced by 35.8%. This is the result of targeted housing support through better linked services, for people who need initial support to establish their tenancy and make contacts with health and care services.

• Although 28% of homeless presentations in 2013-14 had one or more support needs, 59% of those who have been homeless for more than a year had support needs. There is a correlation between support needs, namely mental ill-health and drug/alcohol dependency, and long term homelessness. Integrated approaches are required to tackle some of the problems faced by people with complex needs; Inclusive Edinburgh and Total Place approaches should help.

Health Deprivation and Inequality in Communities

• The quality and design of a place can significantly influence the ability of individuals to lead healthy and sustainable lives. Safe, clean and well managed neighbourhoods can help to improve health and wellbeing. Housing providers, many of whom work within local communities and are key players in area regeneration, have an important role in helping to tackle inequalities.

• Fuel poverty is a major issue which affects the lives and health of some of the poorest and most vulnerable households in the city. Significant investment by social housing providers has meant that social rented homes are more energy efficient that those in the private sector, but the Scottish House Condition Survey 2011-13 estimated that around 26% of social rented tenants were in fuel poverty. This is because household income and energy costs are key factors contributing to fuel poverty and addressing these two factors would help to reduce fuel poverty.

• There is correlation between tenure and health deprivation: 43.3% of the people living in the social rented sector have one or more long term health conditions, compared to the Edinburgh average of 26.4%. This may be, in part, due to legislation requirement for social housing landlords to give reasonable preference to certain vulnerable households when allocating homes. This, however, also presents an opportunity for health and social care service providers to use the expertise of social housing landlords and linking with their wider role services in the localities to address health inequality.
2.5 Edinburgh’s Health

Introduction

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

Summary of key points

• Life expectancy has increased steadily in the last ten years in Edinburgh. However, there are pronounced differences within the city, which reflect social and economic inequalities: boys born in Greendykes and Niddrie Mains between 2005 and 2009 had a life expectancy more than 25 years less than girls born in Barnton and Cammo.

• Health is poorest in the East locality, where the mortality rate is the highest in the city, and higher than both the Lothian and Scotland average. Health profiles across the three other localities are broadly similar.

• The East locality has higher death rates for: coronary heart disease, cardiovascular disease, certain cancers, alcohol-related mortality (adjusted for age and sex structure of the area), and early deaths (i.e. before age 75) and, along with South East/Central, suicide (note that caution is needed as numbers are small for certain categories – see full Topic Report 6a).

• Research shows that people living in areas with higher levels of deprivation also have poorer physical and mental health throughout their lives (see chart below). However, health inequalities are not restricted to areas of multiple deprivation - up to 50% of people experiencing poor health do not live in the most deprived communities.

• There is also very strong evidence of health inequalities associated with social determinants of health. Low income, unemployment and insecure work, homelessness and low educational attainment have particularly strong influences.

• Isolation and loneliness are common health determinants for older people. These are associated with higher all cause mortality for both sexes, as well as lifestyle factors such as poorer dietary intake.

• Race, migration status, disability and gender are among factors associated with poorer health.

• Although overall mortality for people from black and minority ethnic populations is similar or better than the white Scottish population, there are aspects of health – notably cardiovascular and diabetes – where access to services and outcomes are worse, particularly for people from south Asian populations.

• People experiencing physical disability also tend to have poorer health. Limiting long term conditions reduce people’s healthy life expectancy i.e. the period of life lived in good health. There is strong evidence that learning disability is associated with very poor health.
• Within universal services there are often other barriers (including physical, social, environmental, practical and cultural) and lack of capacity where the need is highest. These all contribute to what is termed the ‘inverse care law’ – that quantity and quality of care may be poorest for those with the highest needs. There is evidence in Scotland that resources in our poorest communities are not sufficient for need.

• Edinburgh’s population is increasing. It is estimated that in 2037 the percentage working age population will still be higher than other Scottish local authorities. More GPs, nurses and social care staff will be needed to provide community-based services that serve the population throughout the lifecourse. Filling these key posts will be challenging given the current age profile of these staff groups (see Topic Paper 6.5).

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

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

Physical and Mental Health disorders by socioeconomic status[11], note that socioeconomic status 1 is high
2.6 Summary—Population Characteristics and Needs

1. This section highlights the significant disparities in life expectancy, life chances and health and wellbeing among the population of Edinburgh—these exist between but also within localities. This is directly relevant to two of the national health and wellbeing outcomes:
   - Outcome 1: people are able to look after and improve their own health and wellbeing and live in good health for longer
   - Outcome 5: Health and social care services contribute to reducing health inequalities

2. We know that there are a range of factors which contribute to these disparities in levels of need. These include:
   - **Poverty**: there is a clear link between income inequalities and inequality across a wide range of health outcomes; there are significant pockets within the city; overall, 21% of children were living in low income households in 2013 and Edinburgh has the fifth highest proportion of low income households in Scotland.
   - **Living in an area with high levels of deprivation**: school leavers are less likely to have a positive destination; people are more likely to have poorer physical and mental health throughout their lives; however, 50% of people experiencing poor health do not live in these areas.
   - **Being in a specific group**: there is clear evidence that being a looked after child, being disabled or being a person aged 85 or more increases the need for support. Looked after children, for example, are less likely to sustain a positive destination after school, increasing the likelihood of living in poverty etc.

3. Further details of the current and forecast levels of needs among specific client groups are given in the next section.
   - Edinburgh has a shortfall in supply of accessible and affordable housing with increased investment needed to meet the needs of an ageing population. Investment in affordable housing also provides housing for workers in the health and social care sector. The Council and its partners have tripled the number of new affordable homes approved for development over the past three years. There is a need to sustain this investment and increase private sector housebuilding to meet the needs of a growing city.

4. Other risk factors include social isolation and loneliness which are associated with higher mortality rates among older people—we know that the number of single households in Edinburgh is increasing, and that a substantial proportion (around 38%) of older people live alone.

5. What do we know about the future?
   - Poverty rates are likely to remain high in the next few years
   - There will be an increase in the size of the population—this in itself will lead to an increase in the number of people needing support, even if prevalence rates and economic factors stay the same
   - There will be more older people—again leading to an increase in the numbers of people needing support

5. What are some of the challenges?
   - The “inverse care law”—where the quantity of care may be poorest for those with the highest needs
   - The workforce: the health sector is a major source of labour demand and the sector is expected to grow faster than any other
sector. However, there are skill shortages and unfilled vacancies, even at present.

2.7 Locality Overview

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

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

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

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

The information presented below shows the most notable features of each locality.
**North West**

- **Population**
  - Largest population size: 138,995
  - One-third (33.2%) of Edinburgh’s child population aged 0-15
  - A third of the city’s population aged 85+
  - Highest proportion of single householders over 65 (added 19/8/15)

- **Health**
  - Largest **number** of hospital admissions due to falls
  - Highest spend on health (directly related to the size of the area)
  - Highest **number** of persons with:
    - *One or more health conditions* (N = 36,591)
    - *Deafness/Hearing loss* (N = 8,322)
    - *Blindness/Partial sight loss* (N = 2,989)
    - *Physical Disability* (N = 7,032)
    - *Other Conditions* (N = 22,595).

- **Health and Social Care**
  - Highest **number** of individuals supported by Health and Social Care
  - Lowest rate of new legal orders (mental health, adult protection etc) granted
  - Highest proportion of unpaid carers (15.5%)

- **Other**
  - Diverse, containing the wards with:
    - the highest (27%) and lowest (17%) percentage of households on low income in the City
    - the highest and lowest employment rate
  - Lowest percentage of people living alone (35.7%)
  - Lowest percentage of students (4.9%)
  - Highest percentage of retired people (14.2%)
  - 7.7% of its datazones are in the 15% most deprived areas in

**North East**

- **Population**
  - Total population 110,550 – smallest of the four localities
  - Relatively young: lowest proportion of people aged 65+ (13%)
  - Almost half of population is in the 25 to 49 year old age group
  - Largest number of households from an ethnic minority background
  - Highest concentrations of people with White Polish ethnic origin
  - Contains one of the top 3 wards for largest concentrations of single person householders over 65

- **Health**
  - Poorest health across a wide range of measures
  - Highest percentage of people with long term health problem which limit day to day activity (8%)
  - Highest mortality rate (the only locality with a mortality rate higher than Scottish figure)
  - Largest number of unplanned inpatient admissions

- **Health and Social Care**
  - Highest **number** of individuals supported by Health and Social Care
  - Lowest rate of new legal orders (mental health, adult protection etc) granted
  - Highest proportion of unpaid carers (15.5%)

- **Other**
  - Diverse, containing the wards with:
    - the highest (27%) and lowest (17%) percentage of households on low income in the City
    - the highest and lowest employment rate
  - Lowest percentage of people living alone (35.7%)
  - Lowest percentage of students (4.9%)
  - Highest percentage of retired people (14.2%)
  - 7.7% of its datazones are in the 15% most deprived areas in
**South West**

- **Population**
  - Total population: 111,807
  - 16+ population: 94,093
  - Smallest 16+ population

- **Health**
  - Relatively low proportion of residents with long term health problems which limits day to day activities
  - Highest percentage of residents economically inactive due to limiting long term illness (15%)
  - Relatively high rates of women with dementia, but low concentration among men

- **Health and Social Care**
  - Highest proportion of Health and Social care open cases in under 24 year age group
  - Low take up of direct payments.
  - Lowest concentration of people providing unpaid care (see map series)
  - Highest concentration of people who cycle to work

- **Other**
  - 12.4% of its datazones are in the 15% most deprived areas in Scotland

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**South East/Central**

- **Population**
  - Total population: 126,148 – second largest
  - 16+ population: 109,999 – 13% of the locality total, compared with 15% across Edinburgh
  - Largest proportion of persons aged 16 – 24 (40.3%) (students)
  - Contains one of the top 3 wards for largest concentrations of single person householders over 65
  - Highest concentration of people aged 85+
  - Highest concentrations of black, minority and ethnic groups

- **Health**
  - The only locality showing an increase (albeit small) in stroke-related mortality
  - Sharper decline in under 75 year old mortality rates than other localities

- **Health and Social Care**
  - Highest proportion of individuals in care homes (based on the person’s original home address)
  - Lowest rate of unpaid carers provide 50+ hours per week (19.3%)
  - Highest number of people with Mental Health problems

- **Other**
  - Largest percentage of households on low incomes (23.5%)
  - Low level of economic activity (due to students?) – 57.5%
  - Highest percentage of students (20.9%)
  - Lowest percentage of retired people (9.6%)
  - 4.8% of its datazones are in the 15% most deprived areas in Scotland
3.0 Needs of People in Specific Groups

1. INTRODUCTION

The majority of people in Edinburgh don’t need any particular support from health or social care services other than access to a G.P. and dentist.

However an important minority do need support. There are just over 400,000 adults aged over 18 in Edinburgh. Of these, the numbers who are supported by the Health and Social Care Department³ are:

- 14,056 older people
- 1,380 people with learning disabilities
- 1,991 people with physical disabilities
- 1,300 people with mental health issues
- 816 people with addictions
- 1,153 other vulnerable people

This section of the JSNA summarises the needs of people in the specific groups listed above. Although each section concentrates on a particular group, such as older people or people with disabilities, it is important to recognise that the integration delivery principles include support being integrated from the point of view of the people being supported and that it takes account of the particular characteristics and circumstances of different service-users. Integration and the move to locality working both offer an opportunity to better organise services around the complexity of people’s lives, and to deliver personalised care and support.

This initial section outlines the information that we currently have about how people’s needs can span the categories of need listed above, and outlines where services work to common goals across types of needs. The key points are that:

- People can have multiple needs which may require both specialist and standard types of support, such as a package of care.
- People with different challenges, such as physical frailty, learning disabilities or mental health problems may have similar goals, for example to become less socially isolated and more connected within their communities.

2. PEOPLE WITH MULTIPLE NEEDS

Information from Health and Social Care records at City of Edinburgh Council illustrates how an individual can have more than one type of need. The key findings from an analysis of this information are:

**Adults under age 65**

- For those whose main client category is **addiction**, around one in five also are involved with criminal justice services, around one in six also have a mental health problem, and around one in ten also have a physical disability.
- For those with **learning disability** as their main client category, around one in five also have a physical disability and around one in ten also have a mental health problem.

³ Source: Topic Paper 12 – Adult Social Care Activity Profile, figures are based on main client category
• For those with a physical disability as their main client category, around one in 20 also have a mental health problem
• For those with mental health as their main client category, almost one in ten also have a physical disability, almost one in ten are involved with criminal justice and almost one in 20 have an addiction.

**Adults aged 65 and over**

- For those whose main category was an older person with support needs, around one in ten have a physical disability, almost one in 20 have a mental health problem, around one in 50 have dementia.
- 202 people had dementia as their main client category.
- For older adults it is worth noting that problems that they have had in younger life are likely to persist into older age including addictions, mental health problems, physical disabilities and learning disabilities. People may also acquire addictions, mental health problems and physical disabilities in old age.

There are some limitations to the information that we have on people’s needs:

- Sometimes, only the main category of need is recorded for an individual, even though they have other types
- Dementia is known to be under-recorded

Examples of current improvements to services so that people’s multiple needs can be addressed include⁴:

- Addictions – improving working between adult services and children and family services and improving links with mental health services to improve arrangements for care co-ordination
- Better integration of sexual health, substance misuse, gender based violence, mental health, housing, welfare and other service areas
- Alcohol related brain injury (ARBD) – incorporating the ARBD pathway into work around Inclusive Edinburgh and complex needs
- Improving workforce skills around ageing in people with learning disabilities, including those with Alzheimers; and heightening awareness of mental health needs among people with learning disabilities
- Development of a plan for people who have both learning and physical disabilities.

**3. DIFFERENT CHALLENGES: SAME GOAL**

Individuals may have different challenges but need support to move towards the same goal. This presents an opportunity for staff teams to share joint learning or to work together.

*3a Reduce social isolation*

People who receive social care services are likely to be at higher risk of social isolation that the rest of the population. Work is ongoing across client groups to help reduce social isolation and increase social connectivity. In written evidence to the Scottish Parliament ‘Age and Social Isolation’ Inquiry, the Third Sector in Edinburgh stated that the current focus of befriending is on people with specific needs, such as learning disabilities or for LGBT people. While these are beneficial, "it has

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⁴ Taken from the client group chapters of the JSNA
become clear that there is a crucial need for generic befriending activity, tackling social isolation and loneliness, available across the city.

3b Short breaks and respite
People with a wide range of needs require short breaks and respite.

3c Information and Advice
All people who need social care and health services need to be able to access good quality information and advice appropriate to their needs.

3d Rehabilitation
Rehabilitation is a vital service for people with physical disabilities, some older people and some people with long term conditions.

3e Care Pathways
The need for improved care pathways is outlined in the JSNA chapters on autism, physical disabilities and alcohol related brain injury.

3f Helping people into work or training
People with a range of needs such as young adult carers, people with learning disabilities and people with autism, and people with mental health problems require support to be able to access work, training or volunteering.

3g Workforce Training/ Awareness
The JSNA client group chapters outline a range of training and awareness raising required within the health and social care workforce and which reflects people’s multiple needs. This includes: awareness of disability issues in older people’s services and of ageing issues amongst learning disability services; awareness raising of mental health issues amongst people with learning disabilities; autism champions to raise awareness of autism issues in the teams; awareness raising of sensory disabilities; increase knowledge of skills of care providers around healthy living for people with learning disabilities; workforce training of carers’ needs and issues.

3h Workforce planning
Workforce planning as a key challenge, and particularly in Edinburgh due to high levels of employment. This is an issue for service providers across client groups, particularly those relying on care workers where pay is relatively low.

4. CONCLUSION

There is work going on to improve our focus on people’s individual and complex needs. This will continue as we integrate and move to locality working.

This following chapters provide an overview for each main group of people with specific needs including:

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

Further details (including references) are provided in the set of topic reports which are available separately.
3.1 Older people

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

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

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

There are also challenges. With increasing age there is also an increase in the number of people living with long-term conditions, disabilities and complex needs. Whilst healthy life expectancy (i.e. the length of time people live in reasonable health) has been increasing, overall life expectancy has been increasing faster. This means people are living longer but are less healthy for longer and are likely to require complex health and social care packages for longer periods than in the past.

The number of people aged over 85 is expected to double by 2032 to 19,294. The number of older people requiring intensive levels of support is expected to increase by 61% over the next 20 years due to demography alone. Within 20 years the number of people living with dementia could rise by 61.7% to 11,548 people.

Dementia is one of several conditions which are more likely with age. It is estimated that there are around 7,560 people in Edinburgh with dementia, around a third of whom are thought to be undiagnosed and so will not be receiving treatment and support. The average cost of supporting a person with dementia is estimated to be almost £28 thousand per year. A skilled workforce and good joint working arrangements are needed to provide good quality care.

Loneliness and isolation are increasingly recognised as having a significant impact on health and wellbeing; research suggests that loneliness can have a greater impact than obesity and smoking. Whilst loneliness can affect people of all age groups, it is often linked to ageing as people are more likely to face the loss of friends, family and connections as they get older.

As more older people are supported to live at home, this puts additional demands on unpaid carers who are a key part of the health and social care workforce. Many people do not have carers that live close by and are able to provide support as they get older. Edinburgh has 26,320 single person households aged 65+.5

Needs of older people with protected characteristics

It is estimated that between 5–7% of the population are lesbian, gay or bisexual, which would be between 24,000 – 34,000 people in Edinburgh, of whom between 3,000 – 5,000 are aged over 65. Lesbian, gay, bisexual and transgender (LGBT) older people are likely to face many of the same issues as other older people, but research suggests that they are also:

- 2½ times more likely to live alone

5 Census 2011
• twice as likely to be single as they age
• 4½ times more likely to have no children to call upon in times of need
• 10 times more likely to indicate that they have no-one to call on in times of crisis or difficulty
• Cautious about seeking support for fear of invasion of their privacy and being “outed”.

Edinburgh hosts a multicultural society. There are around 1,100 older people from ethnic minorities in Edinburgh\(^6\). Older people from ethnic minorities can face barriers related to language and culture which make it difficult to access mainstream services.

2. CURRENT PRIORITIES

Preventative services – investment in preventative services was a key focus for the national Reshaping Care for Older People strategy, informed by the Christie Commission report on the future delivery of public services. Preventative priorities include reducing social isolation, falls prevention, supported self-management of long term conditions, technology enabled care, promoting healthy lifestyles and support for unpaid carers.

Developing sustainable community services for frail older people - supporting higher numbers of older people with complex conditions in the community requires robust, integrated services to be in place. The current capacity and formation of services in the community and in hospitals is under severe pressure and is unlikely to be able to meet future demands.

Re-ablement, rehabilitation, recovery and supported self-management - approaches which maximise the independence of people and focusing on what is important to the individual, have been shown to deliver better outcomes for individuals whilst also providing efficient service models.

Supporting people with dementia – as noted above, with more people being supported in the community, there is a need for integrated health and social care services to provide the support needed at the right time, and to increase awareness and understanding in local communities.

Accommodation strategy – to ensure that there is a suitable care home or community setting for people if they are unable to manage at home, and a range of long and short term accommodation options to prevent people being admitted to hospital and enabling them to be discharged when they no longer require hospital care.

Preventing hospital admission and reducing delays in discharge from hospital - a range of workstreams are underway which aim to support the increasing numbers of frail older people with increasing health care needs in the community, preventing avoidable hospital admissions.

3. FUTURE USE OF RESOURCES

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

In line with the national Reshaping Care strategy, ‘Live Well in Later Life’ is predicated on a shift in the balance of investment to support the shift in the balance of care. With a limited financial envelope, this will require

\(^6\) 2011 census
disinvestment in services in order to shift the resource to new models of care and agreed priorities.

Workforce planning and development is another key challenge for delivering health and social care services. The recruitment and retention of staff is a challenge for all service providers and is a particular issue in Edinburgh due to relatively high levels of employment.

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

4. EXISTING STRATEGIC PLANS

A Sense of Belonging, a joint strategy to improve the mental health and well-being of the population of Lothian (2011 - 2016)
Commissioning Plan for Social Care Day Services for Older People 2012-17
NHS Lothian Strategic Plan: Our Health, Our Care, Our Future

5. FURTHER DETAILS
The Topic Paper (7.1) provides further details on:

- The policy direction
- Profiles of activity across the spectrum from preventative to hospital and end-of-life care
- Maps showing the distribution of older people across Edinburgh
- The balance of resources
- Existing planning groups

Topic Paper 7.10 provides further details on issues for the older LGBT community.
3.2 Mental Health

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS:
At any one time, around one in four people (over 120,000 people) in Edinburgh experience a mental health problem. Anxiety and depression are the most common mental health problems, but others include schizophrenia, personality disorders, eating disorders and dementia.

Mental ill health is not evenly distributed across society and is more common in socio-economically deprived areas. Being old is also a risk factor for poor mental health with depression affecting one in five older people living in the community and two in five living in care homes. Dementia is far more prevalent in people over 60 with the incidence increasing further with age.

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

Needs of people with protected characteristics

Despite improving social attitudes, LGBT people experience very significantly higher rates of mental ill health than the general population, as a result of stigma and discrimination (see Topic Paper 7.10). Evidence shows that:

- Suicidal behaviour is 3 times more prevalent among lesbian, gay and bisexual (LGB) people when compared to the general population; this rises to 8 times among transgender people.
- Self-harm is 8 times more prevalent among LGB people; this rises to 20 times among transgender people.

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

In relation to the redesign of the Council’s in-house care and support service, we will be shifting to a reablement model to provide early

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7 Foley, T (2013), Bridging the Gap: The financial case for a rebalancing of health and care resources, Royal College of Psychiatrists.
8 SPICe briefing, Mental Health in Scotland, May 2014
9 SPICe briefing, Mental Health in Scotland, May 2014
10 Scotland’s Mental Health, October 2012, NHS Health Scotland
11 Adults In Later Life with Mental Health Problems, Mental Health Foundation quoting Psychiatry in the Elderly, 3rd edition, Oxford University Press, 2002
intervention, prevent hospital admission and to support and facilitate timely discharge from hospital.

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

**Delayed Discharge** within acute mental health wards is a major priority. In the adult under 65 service, currently 25% of inpatients are either waiting for supported accommodation or waiting for an alternative NHS resource. There are, for example, ten to twelve people waiting for a place in the inpatient rehabilitation service. In the last 12 months the overall occupancy has ranged from 104% to 82%. It normally rises in summer (particularly August).

### 3. FUTURE USE OF RESOURCES

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

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

- There is capacity for much greater joint working across third sector organisations. This is partially a result of the way that services are currently commissioned.
- Although all services are moving toward a more personalised method of service delivery, some services are more developed than others.
- There is capacity for much greater use of peer support and peer working.
- The accommodation situation for mental health and wellbeing services may not be sustainable.
- There is a significant barrier to these services offering a fully personalised service as they do not have the capacity to manage an individual budget for a service user.
- Use of these lower level services prevents the need to use more intensive and expensive services.

### 4. EXISTING STRATEGIC PLANS:

The current joint strategic plan is **A Sense of Belonging** which runs until 2016.

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

### 5. FURTHER DETAILS

See Topic Papers 7.2 for further details on needs among people with mental health problems; and 7.10 for mental health among the LGBT community.
### 3.3 Disabilities

#### 1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

**Learning Disabilities**

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

**Sensory Impairment**

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

**Physical Disability**

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

**Estimates of Future Demand**

**Learning Disabilities**

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

**Physical Disabilities**

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

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

**Autism**

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

#### 2. CURRENT PRIORITIES

**Learning disabilities**

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

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12 ‘Same as you? A review of services for people with learning disabilities’ 2000 Scottish Government

13 ‘Our Lives Our Way’ 2007 NHS Lothian
December 2015, there were 122 people aged under 65 years who were placed out of Edinburgh, at an annual cost of around £6.8 million a year.

The three key messages in the Edinburgh Learning Disability Plan are ‘choice and control’, ‘better local services for people with complex needs’ and ‘making the money go further’. There are a wide range of current workstreams which seek to achieve these three key aims.

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

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

**Sensory Impairment**
‘See Hear’ is the national sensory impairment strategy. The City of Edinburgh Council has been awarded £87,000 to implement the strategy through local partnership networks in 2013/14 and 2014/15. Our local plans focus on developing awareness and improving access to services.

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

3. FUTURE USE OF RESOURCES

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

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

4) Integrated support with GP practices. There is a need to increase the relationship between learning disability teams and GP practices.

5) There is a need to develop a plan for people with learning and physical disabilities who are not currently supported by NHS Lothian.

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

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

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

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

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

### Move to Locality working

*Learning Disabilities*
Community Learning Disability Teams (CLDTs) are well placed to take on the locality agenda as they are currently geographically based in the four social work sectors. Work has started to integrate the CLDTs with the existing social work teams. The developing plans for remodelling care at home services for people with disabilities include consideration of organisation on a locality/neighbourhood basis.

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

*Physical Disability*
As we move to a greater focus on rehabilitation in social care services, discussions on shifting the balance of rehabilitation to the community will be done within the context of the locality model. The developing plans for remodelling care at home services for people with disabilities include considering how to organise on a locality/neighbourhood basis. Many of the voluntary organisations are condition specific, for example Huntington’s Association/Arthritis Care, with a citywide remit. We will need to find a way for the localities to engage with them. There are two Council day services for people with disabilities, including a rehabilitation service for stroke. These are already aligned to the north and south of the city.

### 4. EXISTING STRATEGIC PLANS

- Edinburgh Learning Disability Plan 2011
- Edinburgh Autism Plan 2013
- Our Lives Our Way
- Scottish Sensory Impairment Strategy 2014 – See Hear
5. FURTHER DETAILS
See Topic Papers 7.3 for further details on needs among people with disabilities; and 7.10 for needs among the LGBT community

3.4 Addictions

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

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

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

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

Needs of people with protected characteristics
Research shows that LGBT people are 2 to 3 times more likely than the general population to suffer from alcohol addiction. Reasons include:

- the problems of dealing with societal oppression
- using alcohol to cope with depression
- the role of bars and clubs in gay social networks, where LGBT people feel safer and more at ease.

In spite of this high level of need, research shows that LGBT people are less likely to access mainstream alcohol services for advice or treatment.

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

The development of a recovery community has started already in Edinburgh, creating a social focal point for people who have achieved abstinence.

The peer support service within treatment and support services is being developed to encompass all areas of delivery. Peer support workers will be well trained and supervised to ensure they sustain their own recovery whilst supporting others.

As a part of the development of a recovery community, consideration is being given to how people who continue to use methadone (and are therefore in treatment) can be seen as a part of the recovery community.

The high number of drug related pregnancies remains a challenge. Edinburgh Drug and Alcohol Partnership (EDAP) commissions a specialist service (Prepare) that brings together maternity services, health visiting and alcohol and drug treatment services to support pregnant women who do not effectively engage in mainstream services. Alongside this, services need to develop to meet the needs of family members (both children and adults) and to bring focus to family recovery.

Treatment responses to new psychoactive substances are being developed.

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

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

3. FUTURE USE OF RESOURCES

This section identifies those developments needed to address the gaps in the current system:

- A coherent approach to preventing problem substance misuse. We need to develop a framework for investing in prevention.
- Trauma-informed services and a focus on relationships to maximise effective engagement and minimise relapse.
- For counselling services to prevent relapse, as opposed to focussing on being a first point of access.
- Investment in a broader range of aftercare services that focus on preventing relapse.
- A “stepped care” approach to prescribing opiate replacement therapy (methadone and other opiate replacements) in primary and secondary care to ensure people receive an intervention which meets their recovery needs.
- Redesign of services to increase the availability of detox in the community.
• Clarify and shift roles and responsibility between practitioner groups to create greater efficiency.
• A need to integrate with Mental Health and other services with a shared client group.

4. EXISTING STRATEGIC PLANS
Treatment and Recovery Group Action Plan

5. FURTHER DETAILS
See Topic Papers 7.4 for further details on needs among people with addictions; and 7.10 for needs among the LGBT community.
3.5 People with complex needs

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

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

Different services have different estimates of who ‘this group’ are, ranging from 150-1,000 individuals. While the actual number is uncertain, what is clear is the need to make sure than no-one is excluded from receiving appropriate care. The focus of ‘Inclusive Edinburgh’ is people who struggle to navigate and make effective use of services, and services that struggle to provide effective support to people with complex needs. An estimate from the Access Point produced a list numbering approximately 300 homeless people with whom services have struggled to engage in a way that noticeably alleviated poor outcomes. The coping workstream will need to complete its work before a more accurate figure can be produced.

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

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

2. CURRENT PRIORITIES

There are four workstreams outlined below

Scoping workstream: this workstream has two main components:
- Data: services, budgets, human and other resources, and volume of need (stakeholders, both known and potential)
- Effectiveness in achieving positive outcomes.

The scoping exercise will analyse the information gathered in order to respond to the following questions:
- What is being done well to deliver positive outcomes for people?
- What needs to be done differently to promote better outcomes?

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

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

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

**Workforce planning and development workstream**: learning opportunities, including training and education will be developed for all staff levels and agencies to promote understanding of the changes required to practice in individual service settings.

### 3. FUTURE USE OF RESOURCES

The ‘Inclusive Edinburgh’ review is currently in process.

**Moving to locality working**

The development of homeless pathways may result in a clear locality perspective. This is still being developed. While ‘A Sense of Belonging’ stresses the importance of asset building and ‘Inclusive Edinburgh’ has a city wide scope and will consider the benefit of the locality approach, none of these strategies yet has a clear locality perspective.

### 4. EXISTING STRATEGIC PLANS

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


There is a significant overlap between the groups considered ‘high risk’ for suicide and those in scope for ‘Inclusive Edinburgh’.

For the ‘Inclusive Edinburgh Summary’; ‘Inclusive Edinburgh Committee Report’ and ‘Inclusive Edinburgh Update Report’ go to: [http://www.edinburgh.gov.uk/info/20029/have_your_say/948/inclusive_edinburgh](http://www.edinburgh.gov.uk/info/20029/have_your_say/948/inclusive_edinburgh)
3.6 Carers

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

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

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

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

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

2. CURRENT PRIORITIES

There are six priority areas identified within the strategy for Edinburgh’s carers:

- identifying carers
- information and advice
- carer health and wellbeing
- short breaks/respite
- young adult carers
- personalising support for carers

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

3. FUTURE USE OF RESOURCES

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

- more and better financial and benefits advice for carers
- more locally accessible advice, counselling, advocacy and emotional support
- more flexible short breaks, tailored to individual needs and more breaks for carers from their caring role
- more accessible information on short breaks and respite
- more dedicated young adult carer support (aged 16 to 25)

14 ‘Caring Together- the Carer’s Strategy for Scotland 2010-2015’ (July 2010) Scottish Government and CoSLA

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

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

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

4. EXISTING STRATEGIC PLANS
Edinburgh Joint Carers’ Strategy for children, young people and adults who provide care to others.
Edinburgh Joint Strategic Commissioning Plan for Carer Support

5. FURTHER DETAILS
See Topic Papers 7.6 for further details on needs among carers; and 7.10 for needs among the LGBT community.

Moving to locality working
The recent procurement exercise for carer support will reflect the move to locality working as many of the new services are geographically specific to one or more of the localities in the city. There is a co-production process underway for carer support grants. Within this we are exploring with grant funded providers how to move to better locality planning.
3.7 Palliative care

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

Lothian’s Palliative Care strategy ‘Living & Dying Well in Lothian’ sets out strategic priorities aimed at improving care in all settings. It includes a full review of needs assessments undertaken in Lothian and the literature on Palliative Care needs. This can be found here: Review of Palliative Care needs. Note that the data for this topic are only available at Lothian level.

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

Chart 1

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

2. PROFILE OF ACTIVITY

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

3. CURRENT PRIORITIES

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

4. FUTURE USE OF RESOURCES

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

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

5. EXISTING STRATEGIC PLANS

• Lothian’s Palliative Care strategy ‘Living & Dying Well in Lothian’ can be accessed via this link.
• Emerging national Strategic Framework for Action in Scotland

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

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

Health Protection Scotland publish blood borne virus data by Health Board but not by Local Authority. During calendar year 2013, 235 cases were newly identified as hepatitis C antibody positive in Lothian. The majority of these are likely to have been infected some years ago. This compares with an average of 203 in the years 2002-2009. Since testing became available in the late 1980s there have been 4,876 persons reported as hepatitis C antibody positive in Lothian (to 31st Dec 2013) of whom 3,960 are still alive.

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

Further planning work is required to estimate the numbers of people with HIV or hepatitis C now and in the next five to ten years living in Edinburgh who are likely to require Health and Social Care services.

Under sixteens pregnancy rate in Lothian showed a 22% reduction in 2011 and a further small decrease in 2012. Gonorrhoea: in 2012 Lothian males had the second highest rate of infection in Scotland, mostly among men who have sex with men (MSM). Syphilis: there is again a slight rise in cases in 2011 and 2012, with 205 cases in Lothian - the majority of cases are in men who have sex with men whose needs are being addressed through the implementation of the findings from the Men who have Sex with Men Needs Assessment. Chlamydia: in Lothian, chlamydia testing rates remain high. Prevalence is highest in the under twenties and under twenty-five year old age groups. Work continues with primary care and specialist services to ensure that chlamydia testing is provided to those who need it and that unnecessary testing is stopped.

2. CURRENT PRIORITIES

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

3. MOVING TO LOCALITY WORKING

The integration of health and social care and the emphasis on locality working is in line with the strategic direction of the Sexual Health and HIV Strategy Board. Work will continue to have sexual health services delivered in primary care where appropriate: specialist sexual health services will be delivered in localities, particularly in areas of deprivation, in locality based clinics; specialist services for gay and bisexual men will be expanded into locality based clinics; clinical sexual health services for young people, Healthy Respect Plus will be established in additional areas of deprivation over the next two years; Healthy Respect will continue to review and increase drop-in provision across the city, along with partner agencies, and will adjust and expand where applicable and feasible; the network and education services delivered by Healthy Respect will be planned and delivered according to local area priorities; the strategic direction of the Board will be influenced by local area evidence and reporting and the work of voluntary sector partners and others will be commissioned according to available evidence, including evidence regarding particular communities.

Locality working should also maximise the opportunities to integrate services across disciplines and health areas. Healthy Respect has already implemented this by taking a holistic approach to health and wellbeing at drop-ins. There are opportunities to improve the local integration of services to improve person centred support, such as better integration of sexual health, substance misuse, gender based violence, mental health, housing, welfare and other service areas. Work has progressed on this but significantly more effort is required.

4. EXISTING STRATEGIC PLANS

Lothian Sexual Health and HIV strategy 2011-2016

5. FURTHER DETAILS

See Topic Papers 7.8 for further details on needs among people who have blood borne viruses; and 7.10 for needs among the LGBT community.
3.9 Alcohol Related Brain Damage

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

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

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

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

2. ESTIMATES OF FUTURE DEMAND

ARBD often remains undiagnosed making prevalence difficult to ascertain. Typically, those who are expected to develop ARBD are men aged 50+ but, with the increased rates of alcohol consumption and a binge drinking culture, younger people, including women, are now developing this condition. This currently puts pressure on public services, including the NHS and Health and Social Care, in terms of managing a group of people who have cognitive difficulties and other complex needs, for example, by providing healthcare, community supports and accommodation. If rates of alcohol consumption continue to rise, there will be an ongoing demand from this group of service users.

3. CURRENT PRIORITIES

Current priorities relate to capacity across the care pathway.

The Department of Health and Social Care and NHS Lothian examined the care pathway for people who have ARBD. In order to reduce the number of alcohol-related bed nights, in 2014, a step-down unit was developed at Milestone House of 10 beds, for admissions from the Royal Infirmary of Edinburgh, the Western General Hospital and St John’s Hospital.

The unit feeds into community residential service provision which consists of 2 care and support services and one care home. However, the total number of beds available across these services is only 42 and these beds are also required by people in the community. Therefore, it has been necessary to place people with ARBD in services outwith Edinburgh which is costly to the Council.

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

NHS Lothian and the Edinburgh Alcohol and Drug Partnership fund CARDS, a service from Rowan Alba which provides visiting support service for people with ARBD, and plays a key role in preventing hospital admissions and keeps people in their own homes and away from alcohol use by providing diversionary activities and support for the service user.

4. EXISTING PLANNING GROUPS

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

5. EXISTING STRATEGIC PLANS

National Plans:

- Care and treatment of Mr H - Mental Welfare Commission (2006)

6. FUTURE USE OF RESOURCES

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

- Additional supported accommodation for people who have ARBD
- In terms of streamlining care pathways, the ARBD pathway will be incorporated into the work pertaining to Inclusive Edinburgh and complex needs.

7. FURTHER DETAILS

See Topic Papers 7.9 for further details on needs among people who have alcohol related brain damage; and 7.10 for needs among the LGBT community.
3.10 People with Long Term Conditions

1. OVERVIEW OF CURRENT AND FORECASTED NEEDS
The Quality and Outcomes Framework (QOF)\textsuperscript{16} disease registers, which are recorded in GP practices within primary care, provide information on the number of people who have one or more long term condition. Examples of long term conditions include asthma, cancer, dementia, diabetes, epilepsy, learning disability and rheumatoid arthritis.

Multiple morbidity

Multiple morbidity is defined as the presence of two or more long term conditions. The Integrated Resource Framework (IRF) is being developed to enable Health Boards and Local Authorities to determine the cost and quality implications of health and social care. Lothian’s IRF contains long term condition data from 16 QOF disease registers from the majority of GP practices in Lothian at patient level. This data is used to establish the needs of the population of Edinburgh with multiple morbidity.

Key findings

- 23\% of the total population of Edinburgh (i.e. around 113,000 people) have one or more long term condition.
- 38\% of people with a long term condition have two or more long term conditions (Figure 1).
- The proportion of people with multiple morbidity increases with age - 63\% of people aged 75+ with a long term condition will have multiple morbidity.

- The proportion of people with multiple morbidity is greater in the most deprived quintile across all age bands.
- Multiple morbidity occurs around 10 years earlier in most deprived areas compared to least deprived.
- However, the number of people with multiple morbidity is higher in the least deprived quintiles compared to the most deprived quintile for Edinburgh, particularly for older people.
- The number of different items prescribed increases with the number of long term conditions: average 5 different items prescribed for people with 1 long term condition, average of 16 items prescribed for people with 5+ long term conditions.
- There are many different combinations of multiple morbidity, identified using IRF data (Figure 2).

\textsuperscript{16} Care must be taken with the definition of some of these registers as they may not be reporting what they appear at face value (topic paper for details of caveats in LTC data).
Implications for services

- Deprived areas will have a higher proportion of people with multiple morbidity (MM) at a younger age, with implications for delivery of care and support.
- More people of working age in deprived areas will have multiple morbidity and will need access to services that may be predominately accessed by older people in less deprived areas.
- Despite the prevalence of multiple morbidity, the current health service model is to focus on single long term conditions. For people with several conditions, this can result in multiple primary and secondary care appointments, increased prescribing costs and risks of medication interactions. People with multiple long term conditions often experience disjointed services and have a high ‘burden of treatment’ from the various professionals they interact with to manage their conditions.
- Many people with multiple long term conditions will require support from beyond health services including from the voluntary sector and local authority housing, social care and employability services.

Figure 2: MM groups based on the most common combinations of MM. The size of the bubble represents the relative number of patients for Edinburgh CHP. Data source: Lothian IRF 2012/13.

Summary

As the population of Edinburgh ages, the number of people with long term conditions and multiple morbidity will increase leading to increasing demand on primary and secondary care services, with significant cost implications.

For health services to be holistic and person-centred, multiple morbidity must be prioritised. The current health model of dealing with each single health problem separately is unrealistic and unfeasible since some health conditions are more likely to occur together. It is inefficient both in patient and professional time as well as with cost, thus ultimately unsustainable. Topic Paper 7.12 provides more details.
3.11 Children and Families

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

We have an increasing number of children in Edinburgh.

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

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

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

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

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

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

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

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

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

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

The table below, taken from the Scottish Government Publication ‘Educational Outcomes of Looked After Children’ published in 2014, shows the average tariff score (attainment measure) and positive destination six months after leaving

<table>
<thead>
<tr>
<th>Measures for 2012/13</th>
<th>Average tariff score</th>
<th>% in a positive destination</th>
</tr>
</thead>
<tbody>
<tr>
<td>All (Scotland) school leavers</td>
<td>407</td>
<td>90%</td>
</tr>
<tr>
<td>All (Scotland) school leavers that were Looked After</td>
<td>116</td>
<td>74%</td>
</tr>
<tr>
<td>All school leavers that were Looked After by Edinburgh</td>
<td>87</td>
<td>65%</td>
</tr>
</tbody>
</table>

**Children living in deprivation**

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

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

<table>
<thead>
<tr>
<th>% of pupils in most deprived areas gaining 5+ awards at SCQF Level 6 by the end of S6</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh</td>
<td>7.4%</td>
<td>7.8%</td>
<td>8.1%</td>
<td>8.7%</td>
</tr>
<tr>
<td>National</td>
<td>8.0%</td>
<td>9.0%</td>
<td>10.1%</td>
<td>12.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gap between most deprived areas and the whole population (S6)</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh</td>
<td>20.6</td>
<td>21.2</td>
<td>21.6</td>
<td>21.7</td>
</tr>
<tr>
<td>National</td>
<td>15</td>
<td>16</td>
<td>15.6</td>
<td>19.4</td>
</tr>
</tbody>
</table>

**Young people with disabilities leaving school**

The number of young people with disabilities, and profiles of their needs, is also relevant to service planning. The overall prevalence of people with learning disabilities is expected to rise, due in part to improved neonatal care, meaning that more premature babies are surviving with very high likelihood of severe and multiple disabilities. In recent years, the average number of people with disabilities who leave school and need funding to live their lives safely was 36. However, in 2015-16, the number had increased to 45. The complexity of needs is also increasing, including challenging behaviour.
1. OVERVIEW OF CURRENT AND FORECASTED NEEDS

The size of Edinburgh’s lesbian, gay, bisexual and transgender (LGBT) population is not known:
- None of the Scotland-wide surveys (e.g. the 2011 Census or the Scottish Household Survey) ask people for information about their sexual orientation
- Many people, particularly older people, can be reluctant to disclose their LGBT status, having faced discrimination or having had poor experiences of services and support because of their status

It is estimated that a significant minority (between 5% and 7%) of the adult population is in the LGBT group, and this tends to be higher in urban/city areas.

Estimating the size of the LGBT population at locality level is challenging, but there is anecdotal evidence of relatively high numbers in some localities, for example Leith and Portobello.

This is a population group which experiences a high level of health inequalities, with for example high levels of poor mental health experienced across this population group. However, needs among the LGBT population also vary widely.

2. SPECIFIC GROUPS

Within the LGBT population, there are groups of people with specific types of need. These are summarised below. Further details are available in Topic Paper 7.10.

People aged over 50
Research consistently indicates that older LGBT people have both a greater need of support services and a reluctance to seek support. For example, a study by the Brookdale Center on Aging in New York found that older LGBT people have significantly diminished support networks when compared to the general older population and were:
- 2½ times more likely to live alone
- twice as likely to be single as they age
- 4½ times more likely to have no children to call upon in times of need.

Transgender people
Transgender people constitute a severely disadvantaged minority facing complex and little understood challenges:
- 3 in 5 have been the victim of hate crime
- 3 in 5 report feeling isolated and marginalised
- 9 in 10 have experienced mental health difficulties (3-4 times level found in general population)
- 1 in 3 have attempted suicide and 1 in 2 have self-harmed and (respectively 8 and 20 times level found in general population).

The transsexual population is relatively small; currently around 20,000 individuals in the UK have presented for gender reassignment. This number is growing rapidly and the number of those who have undergone gender reassignment is now set to double every 5 years.
**People with dementia**

There is minimal literature specifically around transgender people and dementia. However widespread discrimination and poor experiences of healthcare means that societal and healthcare attitudes are a very significant barrier to help-seeking for dementia.

A number of issues might be of particular concern to this population. Namely, seeking assistance with activities of daily living, including personal care, presents particular challenges. Also long term hormone therapy (testosterone or oestrogen) may be used as part of their transition to maintain physical changes and support emotional and psychological wellbeing. Cessation of hormones, which can happen due to the onset of dementia, admission to hospital or care home, can have a significant negative mental and physical impact.

**Mental health**

LGBT people experience very significantly higher rates of mental ill health than the general population, as a result of stigma and discrimination. Evidence shows that:

- Suicidal behaviour is 3 times more prevalent among lesbian, gay and bisexual (LGB) people when compared to the general population; this rises to 8 times among transgender people.
- Self-harm is 8 times more prevalent among LGB people; this rises to 20 times among transgender people.

**Learning disabilities**

There is to date limited research on the needs and experiences of LGBT people with learning disabilities. However the research which exists strongly indicates that there is a lack of understanding and acceptance of same-sex relationships and transgender identities of people with learning disabilities. LGBT people with learning difficulties may have additional needs or face particular barriers in developing relationships, including prejudice and discrimination in the wider society, as well as from staff, services, family and friends, which often results in depression, loneliness and even self harm and attempted suicide.

**Drug and alcohol use**

Research shows that LGBT people are 2 to 3 times more likely than the general population to suffer from alcohol addiction. Reasons include the problems of dealing with societal oppression, using alcohol to cope with depression and the role of bars and clubs in gay social networks, where LGBT people feel safer and more at ease.

In spite of this high level of need, research shows that LGBT people are less likely to access mainstream alcohol services for advice or treatment.

**Carers**

The information on the needs of carers tends to be anecdotal rather than research based at present. LGBT Health and Wellbeing carried out a focus groups and interviews with LGBT carers in Edinburgh in 2009, exploring issues, needs and challenges they face. Key points include:

- Many had experienced direct discrimination, including one being told not to kiss or hug his partner in hospital. “If we kiss and cuddle in the public visiting area, we’re told to stop. I was told not to sit on his bed.”
- Perhaps the single biggest issue for LGBT carers was the various ways in which they felt they were invisible to services and the wider world. Many had never been asked if they were “the partner” or “the
daughter-in-law” because the presumption is that two same-sex people are not a couple.

- They also felt that services did not represent LGBT identities in the visual images they chose for newsletters, service leaflets and posters. “I got the newsletter, it put me off. There were photos of men and women, grannies and daughters.”

3. KEY CHALLENGES

- Knowing the size of the LGBT population – as yet, there are no robust sources of information, and as a result, LGBT needs are not adequately addressed within planning cycles and policy development due to lack of robust data
- The needs of the LGBT population - there are significant research and evidence gaps
- Lack of equality monitoring in relation to sexual orientation or gender identity means service providers are unable to benchmark the levels of engagement and experiences of LGBT people
- The low level of understanding of the access barriers faced by LGBT people, including past experience of discrimination, stigma and invisibility
- Providers need to ensure that it is safe for people to be themselves i.e. to disclose their LGBT status, and that staff are able to give appropriate responses and ongoing support
- Generic service providers for older people need to make specific efforts to ensure older LGBT people feel included, able to access services on their own terms, without fear of discrimination, and that the information and services they receive are relevant and responsive to their circumstances and needs.

- Poor experiences of engagement from health and other services (see Experiences of hospital care, in Topic Paper 7.10) can lead to people being reluctant to seek support at an early stage and so the opportunity for prevention or low-level intervention is lost.
- Long waiting times to access a Gender Identity Clinic in Lothian for hormone treatment and surgery are problematic: 3 in 5 individuals report their mental health worsened during this time; 2 in 3 harmed themselves more.
- The UK Drug Policy Commission (Drugs and Diversity: LGBT communities - Learning from the evidence, UK Drug Policy Commission, July 2010) found awareness and uptake of drug services, given the high drug use in this population, was low.

4. FURTHER DETAILS
See Topic Papers 7.10 and 7.11.
3.13 Summary: Care Group Profiles – estimates of future need

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

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

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

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

3. Disabilities

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

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

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

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

4. Addictions
As with mental health, there is some evidence for an increase in addictions during periods of economic recession, low growth or insecurity; and the epidemiology is being reviewed. In the meanwhile conservative planning assumptions are that numbers will increase by an average of 1.4% in line with the annual increase in the adult population.
5. People with complex needs
It is more challenging to estimate future levels of demand for this group, because there are different definitions of the group, reflected in the range of estimates of the size of the current group being from 150-5,000 individuals. The level of demand may increase through national-level factors such as welfare reform and public sector cuts.

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

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

8. Blood borne viruses
The number of people with blood borne viruses will be influenced by a range of social and intervention-related factors. The clear objective is to reduce the number.

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

10. People with long term conditions
Long term conditions become more prevalent with age, and so the number of people with long term conditions is likely to increase as the older population grows. Preventative activities, early intervention and changes in the way care is delivered are intended to reduce the level of demand on hospital-based care.

11. Young people with disabilities leaving school
The number of people leaving school and needing support has been increasing gradually over recent years, and is expected to continue to increase, again, through population growth and also as a result of improved neonatal care, leading to increases in survival rates.

12. LGBT community
As yet, there are no robust sources of information on the size of the LGBT population. However, making the assumption that the proportion of the population who are in these groups will remain the same, the size of this community will increase in line with population growth.

13. In summary
Population growth alone will increase the need for support. A number of wide ranging factors could increase demand further, and these include:
- The economy, levels of poverty and changes in benefits
- Improved medical interventions
- Increases in diagnosis rates

Our conservative estimate of a 1.4% increase in demand each year presents a significant challenge for planners and providers of support.
4.1 Resource Use - Spend on NHS and Social Care Services

Introduction

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

Summary of key findings

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

<table>
<thead>
<tr>
<th>TABLE 1: 2012-13 EXPENDITURE PROFILE [%]</th>
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<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Inpatients</td>
</tr>
<tr>
<td>Day Care</td>
</tr>
<tr>
<td>Other Hospital</td>
</tr>
<tr>
<td>Community Based</td>
</tr>
<tr>
<td>GP Prescribing</td>
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<tr>
<td>Other Family Health Services</td>
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<tr>
<td>TOTAL NHS</td>
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<td>Care Homes</td>
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<tr>
<td>Other accommodation based care</td>
</tr>
<tr>
<td>Home Care</td>
</tr>
<tr>
<td>Other community based care</td>
</tr>
<tr>
<td>TOTAL SOCIAL CARE</td>
</tr>
</tbody>
</table>

Chart 2: Proportion of Total Spend (2012-13) on social care services by Age Group – Edinburgh and Scotland
Chart 3: Total NHS and Social Care Spend per Head (2012-13) by Age Group – Edinburgh, Lothian and Scotland

Chart 4: Expenditure per Weighted Capita on NHS and Social Care Services by Age Group - Edinburgh, Lothian and Scotland
4.2 Hospital Inpatient and Hospital Day Case Activity

Introduction

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

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

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

Summary of key findings

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

Introduction

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

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

- These cohorts are defined by risk of emergency admission in the following year; emergency admission risk is the highest contributor to total health cost for all three SPARRA cohorts.

- Across the three groups, health costs per head increases with the SPARRA risk score.

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

- The SPARRA LTC cohort (16-74 years):
  - is the largest of the three (195,440 patients) - 70% of the Edinburgh SPARRA population aged 16-74 years are in the LTC cohort, and 55% are aged under 50 years; 57% are female
  - 79% of people in areas with the highest level of deprivation (Q1) are in this cohort compared to 67% of people in areas with the lowest deprivation scores (Q5)
  - Almost one third of people in this group that have a record of at least one LTC in primary care have two or more LTCs; 1% have five or more LTCs recorded
  - is responsible for the highest total health cost but the lowest health cost per head

- The SPARRA frail elderly cohort (75+):
  - Includes 77% (33,157 patients) of the Edinburgh SPARRA population aged 75 years and over; 29% are aged 85 years or more; 63% are female
  - 81% of people in the least deprived quintile (Q5) are in this cohort compared to 67% of people in Q1
  - 66% that have a record of at least one LTC in primary care have two or more LTCs and 6% have five or more LTC recorded
  - has the highest total health cost per head

- The SPARRA younger emergency department (ED) cohort:
Includes 14% (38,476 patients) of the Edinburgh SPARRA population aged 16-55 years; 56% are aged 35 years or less; 49% are female.

Is the smallest cohort, with the lowest total costs but the second highest health cost per head.
Across all three groups:
- acute inpatients account for the largest proportion of total healthcare costs (see first chart)
- non-elective admissions account for a greater proportion of total cost than elective admissions (second chart)
- long stay inpatients account for the highest cost per head, although as a proportion of the total cost, long stay inpatient activity is a relatively small proportion for both the LTC and the younger ED groups
- increased risk is associated with an increase in the number of different items prescribed

A large proportion of the Edinburgh population is in the lowest risk score category (1-20% risk of admission) of the SPARRA LTC cohort and accounts for a large total cost, because the group is large. Reducing the cost of delivering care to this low-risk group could have a significant impact on resources. Early interventions for LTC to prevent people’s conditions progressing, and their risk of admission increasing, would be one option for doing this.

Having multimorbidities (two or more conditions) is accompanied by increased number of return outpatient appointments, number of different items prescribed, A&E attendance and emergency admissions.

Resource use by SPARRA cohorts
4.4a High Resource Individuals

Introduction

This section presents the key findings from an analysis of another dataset provided by ISD Scotland on “high resource individuals” (HRI). A more detailed report is provided in Topic Papers 9 and 11. The purpose of this analysis is to gain a better understanding of resource use i.e. NHS spend for the Edinburgh Partnership. *High Resource Individuals* were identified by ranking all individuals within a local council area, and then selecting those individuals who fell into the top 50% of the total health expenditure for that area. A separate group is calculated for the whole of Scotland. As the pattern of expenditure varies between areas, an individual identified as ‘high resource’ in a local area may not be a high resource individual at the national level.

Summary of key findings

- “High Resource Individuals” (HRI) increases considerably with age. Among females, this increased from 3.7 per 1,000 population 0-17 to 80.2 per 1,000 population 75+. Among males, the increase was from 3.9 per 1,000 population 0-17 to 75.9 per 1,000 population 75+.
- Among those aged 75+, there is a greater rate of HRI who are female (84.9 per 1,000) than male (62.1 per 1,000) in East Edinburgh, compared to all other localities.
- Coronary Heart Disease (CHD) appears to be the most prevalent long term condition for HRI across all localities. Heart failure, dementia and Cardio Vascular Disease (CVD) were also quite high.
- It is important to remember that HRI are only a small proportion of people receiving health care in the Edinburgh partnership area, which can vary from year to year. The analysis would benefit from a longer time series. Caution should be taken with planning and decision making using small numbers.
Graph 12: Total health cost of HRI split by locality, gender, and age group

Graph 13: Total health cost per head of HRI split by gender, locality and age group
4.4b Resource Use – High Resource Individuals (Lothian IRF)

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

Summary of key findings
Resource use (cost) is heavily skewed, with a small proportion of people accounting for a high proportion of costs:\n- 2.4% of CEC residents account for 50% of total health care costs
- 8.4% of CEC residents account for 50% of all social care costs

Four groups have been identified among Edinburgh’s population, based on their health and social care resource use – the first three account for 50% of total health and/or social care costs, while the 4th accounts for the remainder:
1. Those with high health care costs and high social care costs – “HRI health and HRI SC”
2. High healthcare costs only (not high social care costs) - “HRI health”
3. High social care costs only (not high health care costs) – “HRI SC”
4. People who have low costs for both – “Non-HRI”

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

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

<table>
<thead>
<tr>
<th>Resource Group</th>
<th>Headcount</th>
<th>Cost Per Head</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRI health and HRI SC</td>
<td>188</td>
<td>£68,619</td>
<td>£12,900,295</td>
</tr>
<tr>
<td>HRI health</td>
<td>7,181</td>
<td>£29,764</td>
<td>£213,736,667</td>
</tr>
<tr>
<td>HRI SC</td>
<td>1,702</td>
<td>£48,731</td>
<td>£82,940,828</td>
</tr>
<tr>
<td>Non HRI</td>
<td>300,704</td>
<td>£882</td>
<td>£265,092,228</td>
</tr>
</tbody>
</table>

17 These are the costs which are included in Lothian’s IRF dataset, which does not include complete costs for primary care. The Topic Report gives more details.
Characteristics of the resource groups

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

Gender
- Higher proportion of females than males in all groups

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

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

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

Figure 2: Proportion of patients in each resource group with 1, 2, 3, 4, or 5 or more LTCs for CEC residents in 2010/11.
4.5 Adult Social Care - Activity Profile

Introduction

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

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

- Over the 12 month period (Dec 2013 – Nov 14), almost 23,000 individuals were in contact with Health and Social Care to have their needs assessed or were being supported, a rate of 55 per 1,000 population (16+). The East locality had a higher rate than the other three localities, while North West had the highest number of individuals.
- The East locality shows the highest rate of assessment requests, while South East/Central had the lowest.
- Across localities, there is a clear pattern of increasing numbers with age, up until around 80 years. The average age of people receiving support from Health and Social care was 70, with all four localities supporting people over the age of 100.
- Older people formed the largest group of people being supported (60% of the total in the East rising to 73% in the North West).

- The main client group of the open cases for the under 65 population in the four localities varied, with East locality having the highest number of people with learning disabilities, physical disabilities and addictions and South East/Central having the highest number of people with mental health problems.

![Chart HSC5: Count of people aged under 65 years who supported, by main client category](chart)

Table 1: Domiciliary service provision (30 November 2014)
<table>
<thead>
<tr>
<th></th>
<th>People receiving service</th>
<th>Hours provided per week</th>
<th>Average Package of Care (hours per week)</th>
<th>Weekly hours - rate per 1,000 population (16+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East</td>
<td>1,082</td>
<td>25,796</td>
<td>23.8</td>
<td>272.4</td>
</tr>
<tr>
<td>North West</td>
<td>1,264</td>
<td>23,257</td>
<td>18.4</td>
<td>203.6</td>
</tr>
<tr>
<td>South East/Central</td>
<td>1,056</td>
<td>19,416</td>
<td>18.4</td>
<td>176.5</td>
</tr>
<tr>
<td>South West</td>
<td>987</td>
<td>18,431</td>
<td>18.7</td>
<td>195.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,389</strong></td>
<td><strong>86,900</strong></td>
<td><strong>19.8</strong></td>
<td><strong>210.4</strong></td>
</tr>
</tbody>
</table>
• Table 1 above shows that the average size of a package of care to support someone at home was largest in the East (24 hours per week compared with the City-wide average of 20).

• Profiles of support vary between localities. For example the rate of people receiving direct payments is lower in South West than the other localities, and the number of people in care homes in South East/Central is higher.

• The large increases in direct payments over the last few years suggests that people are willing to take more choice and control over the supports they receive to support their social care needs. This shift in Health and Social care support is developed further by the implementation of Self-Directed Support legislation. This shift in control of arranging support and the types of support available in the community needs to be monitored and the impact on future commissioning of services considered.

• The use of legal orders for individuals who have mental health issues, capacity issues and those at risk of abuse varies between localities, with North West having a relatively low rate of new orders granted compared to the other three localities, which are fairly similar as shown in Table 2 below.

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

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

• Increases in the overall size of the population and in the number of older people (see Topic Paper 1), shifting the balance of care and reducing delays for people ready for discharge from hospital (see delayed discharge paper) suggest that the pressures on Health and Social Care will increase in the future.

• Section 5 provides a summary of pressures and unmet need across health and social care.
Introduction

‘Primary Care’ is a wide grouping of health professions and support staff providing universal first line healthcare advice, diagnosis and treatment in the community and referring to secondary (usually hospital based) health services when needed. In this first needs assessment the most detailed analysis has been concentrated on GPs due to their significance in the policy guidance which established health and social care partnerships, and due to the significant GP workforce challenges.

1. DEMAND AND FORECASTED NEEDS

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

1a. Population Growth and Change

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

The older population is increasing. People are living longer, but are also less healthy for longer and are likely to require complex health and social care packages for longer than in the past. Older people with complex needs require more and lengthier consultations. In terms of the need for GP support, there are no longer significant differences in morbidity and hence healthcare needs between three groups of frail elderly - those in nursing homes, those in care homes and those who housebound. In the past, the highest levels of need were found in nursing and residential homes. Now, people in all three settings could be considered as having equivalent levels of need in planning terms.

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

1b. Shifting the Balance of Care

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

1c. Deprivation levels and inequality

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

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18 Population Growth and Primary Care Premises in Edinburgh 2014-2019 (April 2014) NHS Lothian
19 John Appleby, ‘Spend on health and social care in the next 50 years’ King’s Fund 2013
20 Care of the Frail Elderly and 2020 Vision: Lothian GP sub-committee 2015
21 Care of the Frail Elderly and 2020 Vision: Lothian GP Sub-committee 2015
22 John Appleby, ‘Spend on health and social care in the next 50 years’, King’s Fund 2013
23 Our Health, Our Care, Our Future 2014-2024, Appendix 3: NHS Lothian Primary Care Strategy, Demand, Capacity and Access an overview
1.d. Health Predictions
Currently 27% of the adult Scottish population is obese\textsuperscript{24} and this is anticipated to increase to 40% by 2020. Diabetes currently affects more than 5% of the population. If obesity prevalence does increase, type 2 diabetes prevalence will also increase. The ill health effects of both of these conditions has significant health and social care resource implications.

2. CAPACITY

2a Spend on Primary Care services
Against the above mentioned pressures, nationally there have been real term decreases in spend in two key areas of primary care: GP practices (reduced by 2.5% between 2009/10 and 2013/14) and district nursing (reduced by 13%).

2b. Primary care Workforce in Edinburgh
2bi - GPs
The actual, not whole time equivalent (WTE) number of GPs in Edinburgh has increased by 10% to 508 from 2006 to 2014\textsuperscript{25}. However, numbers of actual GPs per 1,000 population in Edinburgh increased between 2006 to 2008, before falling sharply to below 2006 levels by 2013. The situation improved slightly in 2014. There is no robust data on changes to numbers of WTE GPs, although there is a widespread perception that the well evidenced increase in female GPs (up by 24% since 2006) in Edinburgh has led to an increase in part-time working. A BMA UK survey\textsuperscript{26} (UK wide) found that almost one in five (17%) of GPs intend to move to part-time working within five years and that a third of GP trainees want to work part-time within five years.

In 2014, of GPs whose age is recorded (10% are not recorded), 65% of GPs are aged under 50, 18% aged 50-54 and 12% aged 55-59. 5% are aged 60 and over. These percentages are almost identical to those in 2006. It should be noted that all GP trainee positions have been filled in South East Region each year since 2010\textsuperscript{27} and there has been an overall increase in numbers of performer registrars/specialist trainees between 2006 and 2014 (from 42 to 58).

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

In terms of the effect of GP pressures on patient access to GPs, Edinburgh is not meeting the national targets, but performs as well as Lothian and Scotland\textsuperscript{28}. Edinburgh patients' reported ability to be able to access a GP or Nurse within 48 hours stood at 85% in 2013/14. This is the same as the Lothian and the Scottish figure of 85% although lower than the Scottish Standard of 90%.

GP Employment type
There have been striking changes in the balance of GP employment types in recent years, with a substantial increase in salaried GPs (as opposed to those who are partners in a practice) from 11% in 2006 to 21% in 2014. There has also been

\textsuperscript{24} Scottish Health Survey 2013
\textsuperscript{25} ISD
\textsuperscript{26} British Medical Association survey of GPs ;The Future of General Practice 2015\textsuperscript{7}: a report by ICM for the BMA
\textsuperscript{27} NHS Education for Scotland
\textsuperscript{28} Health and Social Care Experience Survey
an increase in trainee GPs. All trainee positions have been filled in South East region each year since 2010\textsuperscript{29}.

**Lothian Unscheduled Care Services**

There is an ongoing national challenge in GP staffing within out of hours services. This is related to the pressures that GPs are experiencing within their day time practices as well as changes to working patterns, pension changes and increasing complexity and workload during the out of hours period.

**Effect on GP Practices**

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

**Meeting the Challenge**

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

**A Note on GP Workforce Data**

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

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\textsuperscript{29} NHS Education for Scotland

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**2bii – CAPACITY WITHIN OTHER PRIMARY CARE PROFESSIONALS**

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

**District Nursing**

The picture for the GP workforce is similarly replicated with regard to the community nursing profession, which has not kept pace with population growth. The district nurse workforce is ageing, with many staff approaching retirement age. This is a particular issue for band six nurses.

The reduced capacity in the service has led to a reduction in the range of services delivered by these staff. This reduction is particularly noted in the care of patients who are frail, have multiple morbidity or palliative care needs where spare capacity is required to manage unexpected clinical events. This will have a domino effect upon Out-of-Hours services and, inevitably, on A&E services and unscheduled admissions. Preparedness for 2020 Vision would indicate a need for more, rather than fewer community nurses, particularly to meet community palliative care needs\textsuperscript{30}.

**Physiotherapists**

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

\textsuperscript{30} Our Health Our Care Our Future 2014-2024– appendix 1 Demand, Capacity and Access’ NHS Lothian
Dietetics
The staffing level in Edinburgh has been maintained through skill mix to absorb the impact of budget cuts. The main reasons for referrals are being malnourished, obese or diabetic, with the latter two being conditions projected to increase in prevalence. The increase in the elderly population with multimorbidity will also significantly impact on this service.
Podiatry
NHS Lothian podiatry service has the smallest share of podiatry staff relative to population (0.66%) compared to other Scottish regions. The workforce is declining due to posts being released in 2014/15 to meet savings targets. The age profile of staff may present a challenge over the next 10-15 years as staff retire. Increasing numbers of older people will impact on podiatry which sees large numbers of older people with long term conditions. The main workforce implications relate to an increase in demand for diabetes related foot services.

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

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

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

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33 Our Health Our Care Our Future 2014-2024– appendix 1 Demand, Capacity and Access’ NHS Lothian.
4.7 Resource Use Profile – Edinburgh’s Voluntary Sector

Introduction (see also Topic Paper 15)

This section has been produced by Edinburgh Voluntary Organisations’ Council (EVOC) – Edinburgh’s Council for Voluntary Services (CVS) – which, with Volunteer Edinburgh and Edinburgh Social Enterprise Network (ESEN), comprises The Edinburgh Third Sector Interface (TSI).

Edinburgh’s Third Sector is diverse, consisting of charities, social enterprises and voluntary organisations/community groups. These organisations can be comprised of paid staff and volunteers or run entirely by volunteers.

What is the size of the Sector?

There are upwards of 4,000 voluntary organisations based within Edinburgh. These are comprised of 2,801 organisations formally registered with The Office of the Scottish Charity Regulator (OSCR) as charitable, as well as an estimated 1,200 community groups.

- 71% of these organisations work solely or largely within Edinburgh,
- 29% working across Scotland, the UK or internationally.

The combined income of these organisations, at £2.2 billions (which rises to £2.45 billions when Further and Higher education and private schools are included), makes a major contribution to the city’s economy, with the Sector also one of Edinburgh’s largest employers.

What does the sector do?

Statistics from the Scottish Charity Register show that there are 655 charities whose purpose is the improvement of people’s health. Set alongside other purposes, such as working with disadvantaged people (691) and the relief of poverty (537), this gives an indication of the scope of the sector in delivering both health and social care services.

As noted above, there are more than 4000 different organisations within the city – 71% of whom work exclusively within Edinburgh. This diversity within the Sector allows a level of freedom which is, in many ways, in direct contrast to the Statutory Sector with its ‘Command and Control’ management structures.

34 OSCR June 2015, includes charitable trusts and foundations and newly formed organisations which meet the charity test and excludes Further Education establishments, Higher Education establishments and private schools.

35 EVOC 2015
At the time of the Compact Voice survey (2014), 54% of organisations indicated that they are engaging more volunteers than the previous year and 74% reported that volunteers were also giving more hours than the previous year. Despite this, 56% indicated that they do not currently have enough volunteers.

Full descriptions of categories can be found at [www.oscr.org.uk](http://www.oscr.org.uk)

*Source: OSCR June 2015, excludes Further Education establishments, Higher Education establishments and private schools in Edinburgh*
Within Edinburgh, Volunteer Scotland reports that 29% of all adults within the City, an estimated 120,000 people, volunteer formally through an organisation or group. This is marginally above the national average of 28%. Quoting 2012 figures, this often undervalued resource delivered 17 million hours of support, advice, training and other skills into the Third Sector at a value of approximately £308Millions. 

Since 2014, a comprehensive mapping exercise of activities delivered by the Third Sector within Edinburgh has been initiated by EVOC.

4.8 Resource Use Profile – Independent Sector

Introduction (see also Topic Paper 16)
This section provides an overview of support provided by the independent sector, which includes voluntary and private sector providers. It summarises current provision of care in people’s own homes and care homes, including changes in the dependency levels of residents.

Care in People’s Homes
There are 28 independent care at home service providers delivering care packages for Edinburgh citizens. Ten of these are contracted by the City of Edinburgh Council while a further seven are subject to spot contracting. These 17 providers deliver 27,578 hours of care for 1,901 clients. Twelve independent providers support people on a private basis i.e. not via the local authority.

As of October 2015, there are over 15,000 mapped activities offered by the various voluntary organisations across all themes (e.g. children and families, environmental as well as health and social care) and are categorised by geography and within Edinburgh’s new Locality structures. For example: The Red Book mapping exercise has revealed that there are over 400 organisations delivering over 2500 activities and services for Edinburgh’s older people each week. Of these activities the majority are delivered by small community based organisations run by volunteers or by a very small staff complement. These include the range of providers from tiny groups for just a few people within a single small community to large Scotland-wide providers of registered care services.

The configuration of support in people’s homes, provided directly or arranged by City of Edinburgh Council (as at 2 August 2015) is summarised below.

- 51,245 hours of care per week split approximately 25% /75% in-house/external:
  - 1,813 people per week receive an in-house service (mainstream 1,400, Reablement 413)
  - 2,154 people per week receive a Care at Home Service.

Key Challenges
- Ensuring that all older people with intensive care and support needs, irrespective of where they live, have these needs met in their locality.


38 ibid
- Having adequate resources and flexibility of support to meet the needs of those with intensive care and support needs, and those with lower level needs simultaneously.
- Responding to growing demand by recruiting and retaining new staff, given current terms, conditions and pay rates, coupled with the increasingly complex work loads.

**Key Opportunities**
- Embedding a reablement approach
- Promotion of health and social care as a career
- Promote common learning & development and shared work activity across sectors and settings.

**Hours of care per week by provider**

- In House: 38,170 (74%)
- External: 13,075 (26%)

- Lack of parity for the third and independent sectors in terms of pay and other terms and conditions with NHS or local authority jobs.
Care homes
There are 2,803 care home beds within Edinburgh excluding respite. Of these 594 are run by the City of Edinburgh, 647 by the voluntary sector and 1562 are owned by private providers (November 2015).

Of the 63 care homes, 37 are nursing homes and 26 are residential homes (do not employ nursing staff).

Support for care homes will be increasingly important as frailty levels continue to increase. The criteria for NHS IPCC beds is likely to change next year and so larger numbers of frail older people are likely to be managed in care homes rather than in hospital settings.

Successive studies and censuses demonstrate that residents in care home settings are becoming increasingly frail with complex and multiple conditions, and often high levels of cognitive impairment. Surveys of the dependency level of care homes residents in Edinburgh undertaken by ISD between 2000-2011 demonstrated the increasing needs of residents. For example, the proportion in the highest needs category increased from 8% to 13%. A further survey is underway.

The median length of stay in Edinburgh care homes has reduced in recent years, from to 2.1 to 1.7 years\textsuperscript{39}. Many residents admitted to care homes with nursing will die within a year of admission from advanced progressive incurable diseases such as dementia, stroke etc.\textsuperscript{40} so care home staff are seeing a much larger turnover of residents.

Demographic change, increased levels of frailty and reduced levels of public sector finance present significant challenges for the whole system of health and social care services. Care homes are an important part of the health and social care system and are facing particular challenges, including:

- Increased numbers of residents with dementia
- Increased complexity of health needs of residents
- Ensuring sufficient support from primary and secondary health services
- Workforce recruitment, retention and skill levels
- Maintaining quality standards

The implications for care homes are that staff need to be skilled and confident in caring for people with much higher levels of need, including medications management, nutrition and hydration, palliative and end of life care.

Opportunities
- A partnership approach with care homes and social care professionals. This means shared information, assessments, policies, training and learning to support quality improvement and clinical governance to tackle challenges that affect the quality of life of residents.
- Creation at both national and local partnership level, of cross sector collaboration on workforce modelling, planning and development
- Development of common core skills across health and social care
- Expansion of care homes to deliver flexible services and improved outcomes in a sustainable environment e.g. use of intermediate beds, step up, step down

\textsuperscript{39} Median complete length of stay, ISD Scotland 2014

\textsuperscript{40} Kinley J et al (2013), Anticipatory end-of-life care medication for the symptoms of terminal restlessness, pain and excessive secretions in frail older people in care homes , End of Life Journal, 2013, Vol 3, No 3
4.9 Summary of Resource Use

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

Summary

- The highest proportion of NHS and social care expenditure is on inpatient care, which accounted for a quarter of the total in 2012-13 (4.1)
- Three quarters of the acute inpatient care is on non elective (unplanned) admissions (4.2)
- Spend per head across localities is similar (4.2)
- Among adults, spend per head increases with age – spend for people aged 85+ was on average 6 times the average for the total population (4.1, 4.4)
- Risk of emergency admission to hospital increases with the level of deprivation (4.3)
- A large proportion of the Edinburgh population is in the lowest risk category for long term conditions group, but, because of the size of the group, it accounts for a large proportion of the total cost. There is scope, through early interventions for people with long term conditions, to reduce this total cost (4.3)
- Resource use (cost) is heavily skewed, with a small proportion the Edinburgh population accounting for a high proportion of costs (4.4b):
  - 2.4% of the population account for 50% of total health care costs
  - 8.4% of the population account for 50% of all social care costs
- The group of people who make intensive use of both health and social care services have an average annual cost of around £68,600 (although there were only 188 people in this category) (4.4b)
- Those people who make intensive use of social care services only (N=1,702), cost on average around £49,000 per person each year (4.4b)
- As noted elsewhere in this report, population size, old age and deprivation are key drivers of the need for social care: the East locality had a higher rate of people supported than the other three localities, while in volume terms, the North West (the biggest locality) had the largest number (4.5).
- Similarly, older people formed the largest group of people being supported by social care services (60% of the total in the East rising to 74% in the North West) (4.5).
- The main client group of the people being supported by Health and Social Care for the under 65 population in the four localities varied, with East locality having the highest number of people with learning disabilities, physical disabilities and addictions and South East/Central having the highest number of people with mental health problems.
- The voluntary sector in Edinburgh has 400 organisations delivering over 2500 activities and services for older people
- Research from 2012 showed that volunteers delivered around 17 million hours of support, advice, training and other skills in the year
- However, 55% of organisations said that the level of volunteering was not sufficient
- The independent sector provides around 75% of support to people who are supported by the City of Edinburgh Council in their own homes
- It also provides...
5.1 Pressures and Unmet Need

Introduction

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

5.2 Delayed Discharge

Summary of key points (see also Topic Paper 13)

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

- Edinburgh’s rate of bed days occupied by delayed discharges per 100,000 population was the highest of the 32 local authorities in Scotland - 13,065 bed days occupied per 100,000 population in 2012/13 (all ages) (see the first chart opposite).
- The rate of delayed discharge was highest among the 75+ age group
- The total cost of delayed discharge in Edinburgh (as a rate per 100,000 population) ranked second highest with a total cost of £7.4 million per 100,000 population in 2012/13 (see the second chart).
- The total cost arising from delayed discharges in Edinburgh increased by 13% over 2012/13, lower that the Scottish increase of 23%. Over two thirds of this cost in Edinburgh is associated with the 75+ age group.
- The number over 6 weeks was 31 and the number over the national standard of 4 weeks was 47 – the target for both is zero. The number waiting for over 2 weeks, the standard from April 2015, was 64.
**Current position:** the total number of delays for Edinburgh recorded on the ISD census in October 2015 was 126 against a local target of 78. However, the number over 6 weeks was 41, the number over 4 weeks was 64 and the number of the new national standard of two weeks was 101.

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

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

Graph 4 shows that Edinburgh’s rate of bed days lost in the three months from August – October 2015. The number of bed days lost was 23,849, 16.1% of the Scottish total. As a rate per 1,000 population aged 75+, Edinburgh ranked 3rd, behind Aberdeen and the Comhairle nan Eilean Siar.

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

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

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

Summary of key points (see also Topic Paper 12)

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

Table 1: Average size of package (hours needed) on waiting list by locality

<table>
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<tr>
<th>Locality</th>
<th>31/03/2014</th>
<th>30/06/2014</th>
<th>30/09/2014</th>
<th>15/12/2014</th>
<th>23/03/2015</th>
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<td>12.9</td>
<td>12.6</td>
<td>12.9</td>
<td>16.4</td>
<td>11.7</td>
<td>10.5</td>
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<td>NW</td>
<td>10.9</td>
<td>12.5</td>
<td>9.6</td>
<td>10.9</td>
<td>7.5</td>
<td>11.8</td>
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<tr>
<td>SC</td>
<td>10.4</td>
<td>11.6</td>
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<td>13.2</td>
<td>11.0</td>
<td>12.4</td>
<td>9.7</td>
<td>14.7</td>
<td>11.1</td>
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<td>Grand Total</td>
<td>11.3</td>
<td>12.0</td>
<td>10.2</td>
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<td>10.6</td>
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5.4 Staffing

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

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

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

- Skills shortages were highlighted in health sector as vacancies become harder to fill. In 2013, 24% of vacancies in the health and social care sector (nationally) were hard to fill, up from 13% in 2011.

- Given that future demand is expected to be concentrated in health and social care professionals, challenges in recruitment for non graduate roles, attracting new applicants, and addressing the ageing profile of the sector workforce will persist and increase in the future.

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

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

As at 31 December 2014, 3,819 people were employed in Health and Social Care within the City of Edinburgh Council

Each year, an average of 7.9% of Health and Social Care staff leave the employment of the Council

The highest area of turnover is care workers employed with the Home Care service and Residential Care for Older People

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

Figure 22: GP headcount rates for Lothian

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

A recent profile of the Health and Social Care workforce showed the following.
**6.0 Phase Two of the JSNA and plans for further development**

**Introduction**

This section summarises the feedback which was obtained through a range of events to discuss the findings of the first phase of the JSNA. However, rather than identify additional or different needs from those which had been described in the draft JSNA, the feedback related more to gaps, the presentation of the findings and issues and concerns. Identified gaps in coverage included the needs of the LGBT population, which has now been addressed. The sections below outline the remaining gaps and issues.

**Gaps**

- The specific needs of different ethnic groups
- Levels of physical activity, environment, green space, diet
- More detailed locality profiles:
  - built environment
  - housing
  - density of population
  - concentrations of older people
  - health inequalities
  - economic activity such as low pay/zero hour contracts/diversity in wealth and food banks as indicators of poverty.
- Digital inclusion
- Limited information on health promotion and inequalities
- Detailed data on the workforce, including GPs
- More detailed information on the third sector

**Issues emerging**

There is a discrepancy in boundaries created by the clusters of neighbourhoods into localities and those formed by the addresses of patients who are registered at a GP practice within a locality. This is common across Scotland. Agreement needs to be reached about which boundaries should be used for which purpose.

**Ongoing development of the JSNA**

Work will begin in early 2016 to:

- develop more detailed locality profiles, recognising that there is as much variation within localities as there is between them
- enable the identification, monitoring and assessment of emerging issues, for example, the use of legal highs and the health and support needs of people who are obese
- support the identification of trends and shifts in resource use and unmet needs
- understand the needs of people from ethnic minorities who have mental health problems, disabilities, frailty etc
- further investigate methods of forecasting needs among specific groups – at present, forecasts are based largely on population growth
• consider alternative indicators in areas such as inequalities and identify indicators for mental health

References


Appendix 1 – List of Topic Papers

<table>
<thead>
<tr>
<th>Topic Paper</th>
<th>Authors</th>
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</table>
| 1 Edinburgh’s Population | Russell Morris, Senior Research and Information Officer, Health and Social Care, City of Edinburgh Council  
                         | Steven Di Ponio, DA to the Convener of Health, Wellbeing & Housing, City of Edinburgh Council |
| 2 Poverty and Low Income | Chris Adams, Senior Business Intelligence Officer, Corporate Governance, City of Edinburgh Council  
                           | Louise Wright, Social Inclusion Team, Health and Social Care, City of Edinburgh Council |
| 3 Labour Market      | Chris Adams, Senior Business Intelligence Officer, Corporate Governance, City of Edinburgh Council  
                         | Gareth Dixon, Business Intelligence Officer, Corporate Governance, City of Edinburgh Council |
| 4 Housing            | Gillian Campbell, Senior Project Manager, Housing and Regeneration, Services for Communities, City of Edinburgh Council  
                         | Ada Yiu, Project Manager, Housing and Regeneration, Services for Communities, City of Edinburgh Council |
| 5 Children and Families | Karen Brannen, Performance Manager, Children and Families, City of Edinburgh Council |
| 6 Health Profiles    | Dr Dermot Gorman, Martin Higgins, Public Health and Health Policy, NHS Lothian  
                         | Duncan Sage, Lothian Analytical Services, NHS Lothian |
| 7.1 Older People     | Caroline Clark, Planning and Commissioning Manager (Older People)  
<pre><code>                     | Jamie Megaw, Strategic Programme Manager for Older People, NHS Lothian. |
</code></pre>
<p>| 7.2 Mental Health    | John Armstrong, Pathway Manager Mental Health, City of Edinburgh Council |</p>
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<td>Colin Beck, Senior Manager Mental Health, Criminal Justice &amp; Substance Misuse</td>
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