East Lothian Integration Joint Board

Annual Performance Report 2020-21

East Lothian
Health & Social Care Partnership

Contents

Foreword

This report covers a year where most of us faced significant changes to how we lived our daily lives. As an organisation at the forefront of delivering essential local health and social care services, these changes presented us with particular challenges. Throughout the year, our services adapted and evolved to work in partnership to continue to provide key services to those in need.

Whilst we were making good progress previously, our collective response to COVID has provided a further catalyst for integration and partnership working.

You will read about the immense effort and commitment of our staff throughout this report. Staff working collaboratively across existing teams, services and organisations has been a crucial factor in our efforts to respond to the pandemic. We owe our staff a huge debt of gratitude.

We must also acknowledge the work of the range of third sector and independent sector organisations who provide vital services to some of our most vulnerable local residents. We recognise that this has been a hugely challenging year for them, and value their flexibility, hard work and commitment in the face of this.

We are grateful for the support of East Lothian Council and its staff in planning and in delivering practical assistance and support to those requiring to shield and in assisting with the administration of our vaccination centre.

Community Resilience Groups also played an invaluable role in supporting members of our communities. Through these groups, local volunteers provided a lifeline to those most in need, offering practical support by delivering food and other essentials, and by helping to make people feel less isolated.

Many of the new ways of working and delivering services developed during 2020-21 have resulted in a real step-change in service development. For example, the need to find alternative ways to deliver adult day services resulted in the development of new, innovative approaches based on building strong community connections and supporting people to participate in their local communities.

Similarly, COVID restrictions meant that many new and existing services relied heavily on telephone and online appointments instead of seeing patients face-to-face. This proved to be a quick, accessible and effective approach to delivery, resulting in excellent outcomes for many patients and helping to overcome some of the impacts of East Lothian's geography and dispersed communities.

Last year's Annual Report, highlighted the opening of East Lothian Community Hospital (ELCH) as an exciting new local development. Since its opening, the number and range of services available at the hospital has expanded, helping to deliver one of our key ambitions of providing health services as close to home as possible for East Lothian

residents. ELCH also played a central role in our COVID response, acting as a hub for PPE and COVID tests supply, before becoming the home of the East Lothian COVID Vaccination Centre.

Even with the challenges presented by a global pandemic, we continued to make good progress during 2020-21 in delivering our strategic objectives. The following report describes our progress and presents key data demonstrating our performance over the year.

Peter Murray	**Alison Macdonald**
IJB Chair	**Chief Officer**

Managing the COVID-19 response in 2020-21

Whilst presenting the HSCP with additional and complex challenges, the impact of COVID in the period this annual report covers has also accelerated some of the developments already planned to deliver the IJB's strategic objectives (which are set out on page 44).

The introduction of new ways of working, including the use of online platforms and other technology to support people and manage services, will help to make services more sustainable in the longer term, as well as giving people more flexibility, choice and control while reducing the need to travel.

Providing services for people with complex needs in their local community rather than as part of building-based service has also been a key feature of our COVID response and has helped to inform the continued development of our Transformation Programme. This proposes new models for the delivery of community provision, involving local communities and with reduced reliance on traditional health and social care services – you can read more about this on page 19.

Managing the response to the complex and rapidly evolving challenges presented by COVID during the year required a high degree of coordination and agility by the HSCP. Systems were put in place in the very early stages of the pandemic to support our response, including:

- A 'daily update' reporting procedure was introduced in March 2020 and continued into 2020-21. This ensured the HSCP management team could maintain a clear overview of the situation; this was particularly important in terms of identifying emergent risks. Daily update reports were required from all services, covering a range of operational matters, including staffing, personal protective equipment (PPE - such as masks, gloves and aprons) supplies, risks and actions.
- Systems were put in place to manage the flow of information and guidance to and from the Partnership. This included setting up a central, online repository for COVID related communication and documentation.
- COVID Management Briefings took place daily, bringing the management team together to monitor the situation and to manage a collective response. These meetings reduced in regularity as the situation became more stable, but with the option to step them up to daily again if needed.
- An Audit Governance Log was developed to record ELHSCP decisions made in response to COVID. The Log included details of the rationale behind each decision; who was consulted; who made the decision; and any expenditure involved.
- Communication with staff was key from the outset, with 'Alison's Blog' updates from the Chief Officer playing an important role in communicating the latest information and advice and allowing a two-way dialogue with staff.

COVID Vaccination Programme

East Lothian Community Hospital (ELCH) became home to the East Lothian COVID Vaccination Centre in February 2021, set up to supplement the work of the Mass Vaccination Centres in Edinburgh. The East Lothian Centre was developed in the existing foyer of ELCH and includes individual vaccination pods and a post-vaccine observation area.

A dedicated clinical and administrative team was established to develop, manage and deliver the East Lothian COVID Vaccination Programme. Since the start of the programme, the team has made excellent progress, keeping pace with national priority targets. The success of the programme has been made possible by the hard work and commitment of HSCP staff, East Lothian Council staff, partner organisations and hospital and Volunteer Centre East Lothian (VCEL) volunteers.

> 'This is the biggest vaccination programme in history and involves a massive and coordinated team effort from our staff and the community to deliver this as quickly and safely as possible'
>
> Krista Clubb, Primary Care Vaccination Service Manager

East Lothian COVID Vaccination Programme facts and figures:

- East Lothian staff vaccinations commenced on 8th December 2020, by 31st December **1,441** staff had received their first vaccine.
- Between 1st January 2021 and 31st March 2021, **1,619** first dose vaccinations and **2,027** second dose vaccinations were delivered to staff.
- **2,249** Care Home staff and residents were vaccinated between 17th December and 31st March.
- GP surgeries vaccinated **14,882** patients aged 75 years and over and patients identified as extremely clinically vulnerable.
- The mass vaccination programme commenced at East Lothian Community Hospital on 1st February 2021, by the end of March, the team had vaccinated **14,888** patients.
- **Equating to over 37,000 COVID vaccinations delivered in East Lothian in less than 4 months.**

Additional Hospital Beds in East Lothian Community Hospital

As part of the COVID response, ELCH was able to offer an additional 44 beds in two unoccupied wards. This additional capacity was used flexibly as part of the remobilisation plan during the first and second waves of COVID. This helped to provide welcome resilience to respond to any surge in demand for acute in-patient beds across the Lothians or local community need.

COVID Assessment Hub at Musselburgh Primary Care Centre

In April 2020, a COVID-19 Assessment Hub opened in Musselburgh as part of NHS Lothian's regional strategy for managing the assessment of people with possible coronavirus infection. Mobile testing units were also set up to help identify positive cases.

Working in partnership

Supplying PPE and Lateral Flow Tests

A PPE (Personal Protective Equipment) Hub was set up at East Lothian Community Hospital (ELCH) in April 2020 to provide PPE for health and social providers, Personal Assistants and unpaid carers / families. The Hub played a vital role in ensuring that individuals and organisations had access to suitable and sufficient PPE, particularly in the early months of the pandemic when resources were scarce and supply lines were being set up.

A dedicated order line and email drop box were set up, as was a PPE delivery service. The Hub was also able to offer supplies out of hours in an emergency.

PPE facts and figures - by the end of 2020-21:

- Approximately 280 local organisations had made use of the Hub to access essential PPE supplies.
- Around 1,000,000 masks; over 4,000,000 pairs of gloves; 95,000 aprons; and just under 300,000 visors had been supplied by the Hub.
- This amounted to nearly 6,000,000 items of PPE in total.

In the later months of 2020-21, ELCH also became the distribution Hub for Lateral Flow Test (LFT) kits. ELCH's experience of managing the PPE Hub meant that it was ideally placed to take on this additional task. Training, guidance and distribution of LFT kits was quickly arranged for 146 staffing groups, involving almost 1,700 staff.

Supporting the Shielding Population

A multi-agency group was set up in the early stages of the COVID pandemic to support people needing to shield. This group included staff from key Council and HSCP services and met daily initially, reducing to weekly and then monthly as progress was made.

An Action Plan was quickly developed and continued to evolve in response to the rapidly changing landscape, reflecting new developments in legislation and guidance. Council and HSCP staff were redeployed to work together to support the delivery of priority actions contained in the Plan.

Local Community Resilience Groups also played a key role in supporting shielding individuals, with local volunteers providing practical support including the delivery of food and other essentials.

Over time, the group's focus shifted to a broader 'Care for People' remit, linking with national 'Care for People' activity to respond to the needs of people at highest risk, rather than just those required to shield.

Commissioned Community Support

ELHSCP commissions a range of Community Support services, including advocacy; support for carers; community link workers; mental health services; older people's day services; dementia services; drug and alcohol services; sensory impairment; and volunteer developments. Housing support services were also commissioned in 2020-21.

Independent Advocacy

ELHSCP has a legislative duty to make independent advocacy available[1]. The Partnership is strongly committed to ensuring that there is sufficient provision of independent advocacy that it is easy to access; and that information on advocacy services is readily available.

In 2020-21, following a needs assessment, we allocated additional funding for independent advocacy for adults with autism, adults with physical disabilities and for people with alcohol and substance use issues. Our existing independent advocacy providers – Partners in Advocacy, EARS and CAPS were commissioned to take this work forward. We contracted on a 2-year basis to help establish continuity in the services and will look to provide an extended contracting period in future years.

Mental Health Services

ELHSCP commissions a number of organisations to provide community services, care at home and rehabilitation services to people needing support with mental health issues. During the pandemic we worked closely with these organisations to help ensure the safety and wellbeing of clients.

In the early stages of the pandemic, risk assessments were carried out for all clients, with each individual assessed for their level of vulnerability and need. This allowed those who were most vulnerable to be identified and additional support quickly provided.

A weekly forum brought colleagues together from provider organisations and statutory services to enable them to provide mutual support and to share information. ELHSCP facilitated access to training on infection prevention and control and use of PPE.

ELHSCP staff maintained frequent contact with providers, offering support, information and advice, and allowing emergent issues to be identified and quickly addressed.

Mental Health Review

Since the pandemic, we have seen increased demand across adult mental health and substance use services. There have also been significant increases in referrals for adults with neurodevelopmental disorders

It has also been reported in some clinical areas that people are not coming forward and seeking help for their mental health until the acuity level is very high or they are in crisis.

[1] Under the Mental Health (Care and Treatment)(Scotland) Act 2003

Those that need more specialist care are generally more unwell, which has put our Intensive Home Treatment Service and inpatient services under considerable pressure.

ELHSCP commissioned a review of Adult Mental Health services in 2020, in partnership with staff and stakeholders to ensure that East Lothian Mental Health Services:

- Reflect national strategic direction and guidance, with a focus *on 'access to care and treatment and integrated accessible services'* to ensure people living in East Lothian get the right help at the right time.
- Are well placed to meet the challenges presented by the COVID-19 pandemic, including responding to the longer term impact of COVID-19 on the population
- Are able to respond to the changing operational context resulting from the Redesign of Urgent Care.

Feedback and themes arising from the review were collated and fed back to staff, and work initiated to explore options and to clarify roles and functions in order to implement improved service delivery.

Support for Adults under 65 with Complex Needs

At the start of the pandemic, services providing support to adults under 65 with complex needs carried out risk assessments for all their service users, to assess their level of vulnerability. This enabled social work colleagues to identify individuals most in need of additional care and support in the community.

Working under COVID restrictions, whilst trying to support service users and their families at a particularly challenging time, placed a huge demand on providers. ELHSCP maintained close contact with providers throughout the year to ensure that they were supported in this role. In the early stages of the pandemic, providers submitted daily situation reports, moving to weekly reports as time progressed. These reports covered issues relating to staffing, PPE and other resources, as well as any concerns in relation to individual service users which were escalated via adult social work if required.

Centres were operating for people with critical needs only, but with outreach support being provided to other service users. Providers quickly developed alternative approaches to more traditional, centre-based support.

Responding to COVID has required flexibility and creativity from all those involved in service delivery. This has brought some valuable learning which is helping to shape plans for service redesign.

Older People's Day Centres

Older People's Day Centres were also forced to close as a result of COVID, and again providers responded flexibly to provide support to people on an outreach basis. As with other services, individuals' risk levels were assessed to help identify those most in need of support.

The Council's Connected Communities service, local resilience groups, and other third sector groups also helped deliver a range of valuable outreach activities for this group of service users.

Once more, the experience of responding to COVID is helping to shape development of the HSCP's Transformation Programme.

Care at Home

Working with our commissioned Care at Home providers was also a priority during 2020-21. Again, we maintained close communication with providers, requiring updated business continuity plans and regular situation reports from them, allowing us to identify and respond to any emergent issues. We also supported providers with PPE through the provision of emergency supplies and by providing advice and training on its use.

We developed a process to make Social Care Provider Sustainability Payments (totalling £1.565m) to all our commissioned social care services, helping to provide a level of financial sustainability for the third sector.

Funding Voluntary and Community Organisations

ELHSCP provides over £1million in funding to voluntary and community organisations through a number of different funding streams. The funding is used support core services and statutory services as well as project-based initiatives related to adult services.

ELHSCP introduced a formal grants process following recommendations from East Lothian Council's Internal Audit and Procurement Board in 2019. A new process was agreed and used to administer grants from April 2020, with the process published on East Lothian Council's website to encourage wider applications. The funding available for allocation was just over £25,000.

We received a total of 8 applications in 2020/21 – two applications from existing providers and six from new applicants.

We recognise that the current budget is relatively small and are looking to increase the amount available in the future to help encourage innovation and increase the number and range of services we can support.

Communication and Engagement

We know that health and social care services are of huge importance to local people and communities. We recognise the importance of communicating effectively with all our stakeholders and of giving people the opportunity to influence the development and delivery of the health and social care services that matter to them.

We continue to build our social media presence. We now have 800 Twitter and around 3,000 Facebook followers – this is one of the largest Facebook followings for any HSCP in Scotland, and larger than Glasgow, Edinburgh and Aberdeen. The use of social media

proved to be particularly valuable throughout 2020-21 as a means of quickly sharing information and advice on keeping safe and well during the pandemic. We also used social media channels to inform people of sources of practical and emotional support.

We continue to make good progress in helping to develop engagement opportunities in local communities:

- There are now Health and Wellbeing Sub-Groups established in each of East Lothian's six Local Area Partnership areas.
- The number of GP practices with Patient Participation Groups rose to over 60%, with our Communications and Engagement Manager continuing to support practices to set up and develop groups.
- Our Change Board structure offers opportunities for local people to be involved in Reference Groups covering a number of priority areas.
- We ran a number of consultation / engagement exercises on a range of issues during 2020-21 – these related to matters including patient experience during COVID; the Public Sector Equalities Duty; Near Me; and the East Lothian Community Hospital Cycle Path.
- We also actively promoted local involvement in national consultation exercises, for example, the Independent Review of Adult Social Care and Alliance's 'Conversation with the People of Scotland'.

Managing Delayed Discharges

We continued through the year to maintain our position as one of the top performing areas in Scotland in relation to delayed discharges.

This level of performance comes from key services working collaboratively to help ensure that East Lothian patients do not remain in hospital longer than is medically necessary. These include the following services / teams, all of which are based in East Lothian Community Hospital:

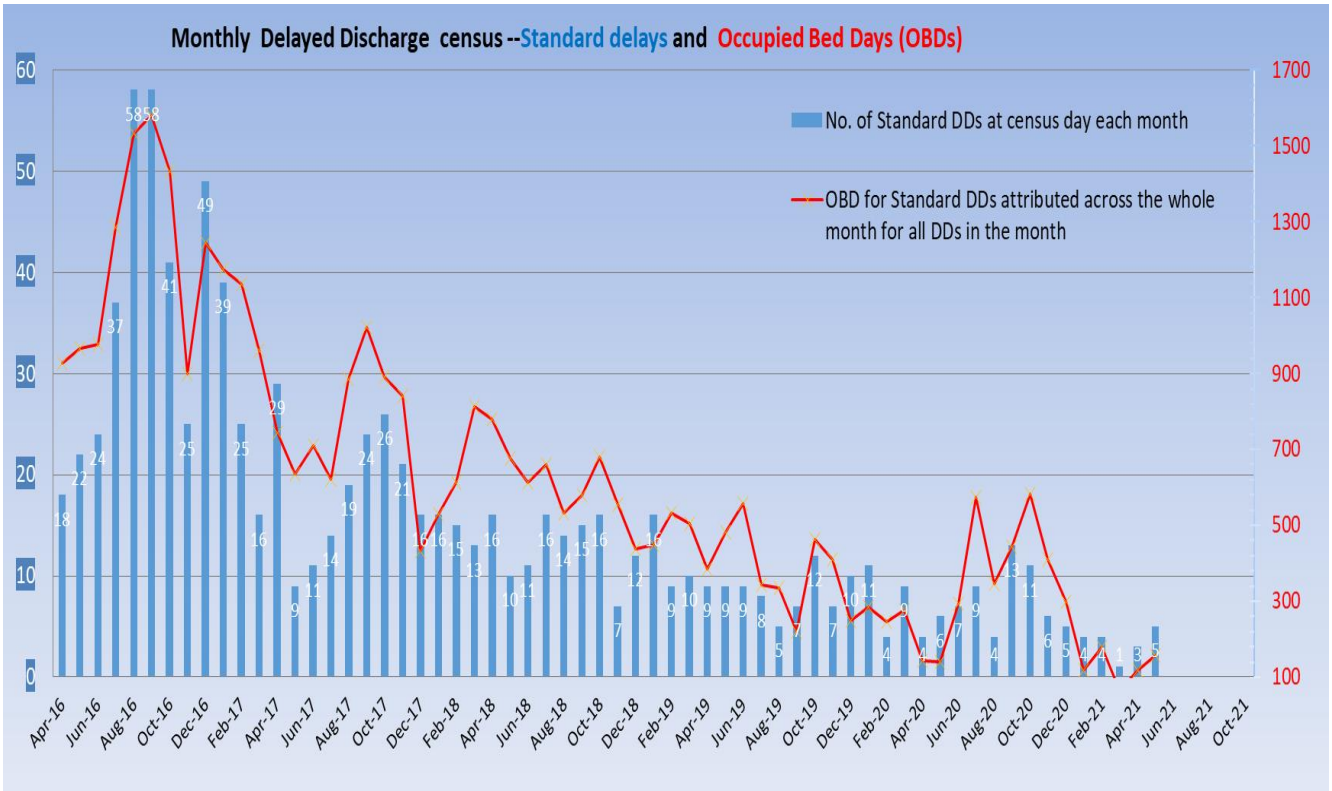
- Hospital to Home Team.
- Hospital at Home Team.
- Capacity and Flow (Discharge) Team.
- Discharge to Assess.
- Home Care Team.
- Emergency Care Team.
- Social Work.
- Care Broker Team.

During 2020-21, the Capacity and Flow (Discharge) Team extended from 5 to 7 days a week, operating for 12 rather than 8 hours a day. The capacity of the Hospital to Home and Home Care teams was also increased over the year.

Staff continue to focus on maintaining and improving the low level of delayed discharges achieved in East Lothian, as well as on avoiding hospital admission where possible. There has been a shift in practice so that coordinated discharge planning is integral to ward rounds. Early and continuous conversations with patients, relatives and carers also helps to promote the 'Home First' philosophy, where supporting individuals to return home where possible is a key objective.

Towards the end of 2020-21, plans were underway to bring teams all under a single overseeing body, the Integrated Care and Assessment Team (ICAT).

The graph below demonstrates ongoing and sustained reductions in the level of East Lothian delayed discharges since 2016.


Monthly Delayed Discharge census --Standard delays and Occupied Bed Days (OBDs)
No. of Standard DDs at census day each month
OBD for Standard DDs attributed across the whole month for all DDs in the month
60
50
40
30
20
10
0
1700
1500
1300
1100
900
700
500
300
100
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17
Jun-17
Aug-17
Oct-17
Dec-17
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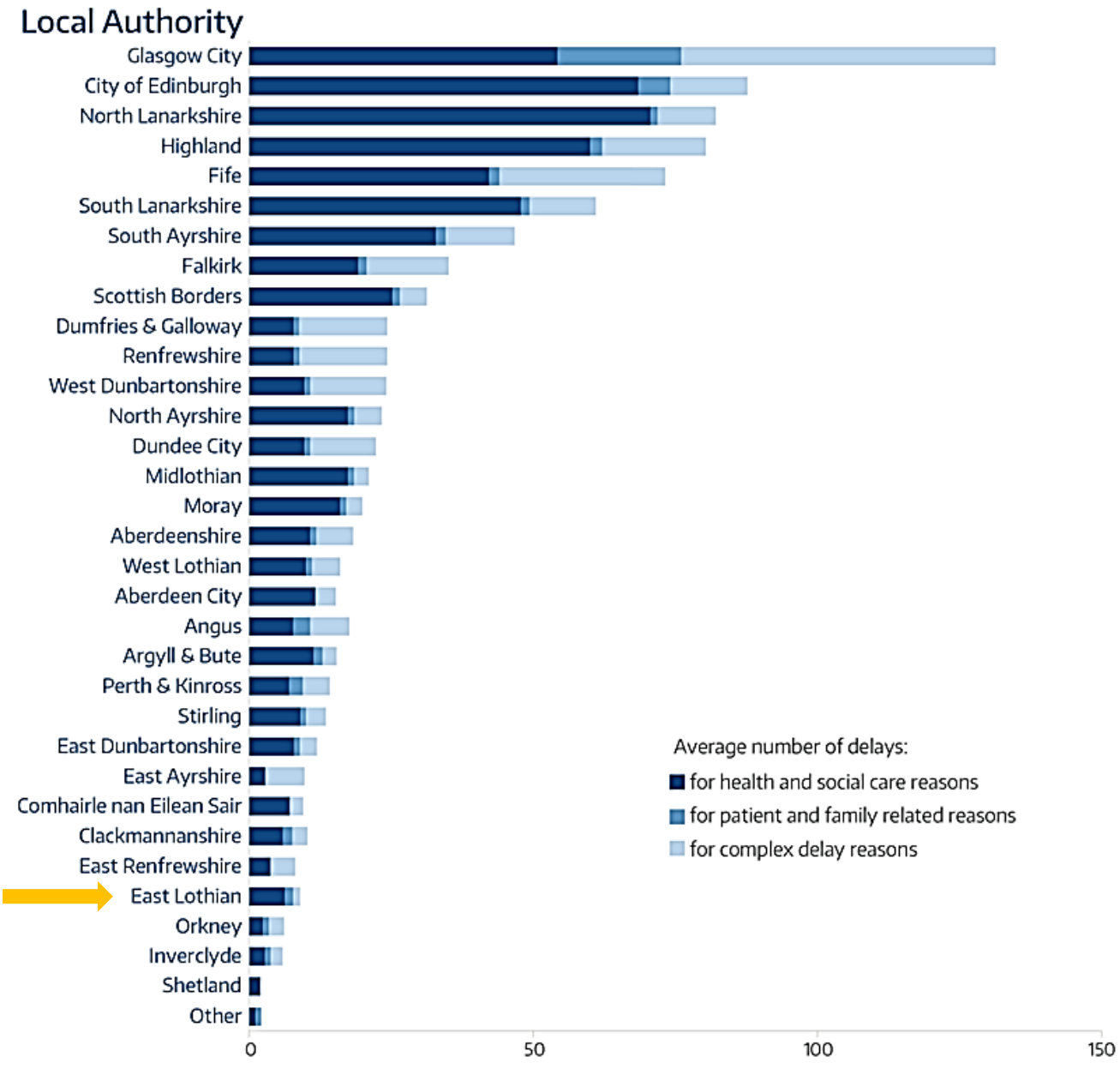
The graph below shows East Lothian performance compared to the national picture (April 2020 – March 2021 – reason and average number)



Discharge to Assess

Our Discharge to Assess (D2A) service is just one of the ways we reduce the length of hospital stay for patients. Embedding D2A as a core East Lothian service has been the focus of a three-year project which featured in the Chartered Society of Physiotherapy's Frontline magazine. It was also included in the 'Innovations in Physiotherapy' database and featured at several conferences including the NHS Scotland conference and annual conferences of the Royal College of Occupational Therapists and the Chartered Society of Physiotherapy.

The D2A model prevents a wait for Occupational Therapy (OT) and/or Physiotherapy (PT) assessment before leaving hospital, for patients who are clinically fit and appropriate to have their therapy assessment completed at home. A joint OT/PT assessment is completed on the day of discharge, reducing length of stay and enabling assessment and rehabilitation to be conducted in the person's own home, bringing better functional outcomes for the service user.

From March 2016 to March 2021, the estimated cost saving by D2A in East Lothian, was estimated to be £1,549,800 from bed days saved (calculated as an average of 3 days per person, costing £300 per day).

Care Homes

Supporting Care Homes through COVID

Colleagues from the Care Home Team, the Care Home Assessment and Review Team (CHART) and the District Nursing Team played a vital role in supporting local care homes as the pandemic developed.

Daily 'huddles' led by the Chief Nurse, were quickly established to help monitor developments in care homes and effective partnership working enabled a quick response to any developing problems and to ensure national guidance was communicated and implemented across East Lothian Care Homes. The submission of daily situation reports allowed care home managers to flag up any issues with PPE supply, staffing levels, COVID cases or deaths and any other risks or concerns. This group reported daily to the Lothian Operational group and weekly to the Lothian Strategic Oversight Group led by the Executive Nurse Director.

Support provided to homes by the Care Home Team included:

- Clinical support for care home residents.
- Supported connection with lead General Practices for each care home.
- Practical and emotional support to care home staff and managers.
- Escalated support to homes with positive COVID cases.
- Support with the application of Health Protection Scotland (HPS) guidance.
- Training and advice on the use of personal protective equipment (PPE) and other infection prevention and control (IPC) measures. This was provided via video link, but with training visits to homes where requested – e.g., to demonstrate how to put on and take off PPE safely.
- Support with care home resident and staff COVID testing
- Help to ensure homes had adequate PPE, and in arranging urgent supplies if needed
- Administering winter flu and COVID vaccinations to care home residents and staff

The Partnership also offered supplementary staffing support to homes through the NHS Staff Bank Service. This helped to ensure that homes had appropriate staffing levels as increased staff testing began to result in more staff absences.

As part of our contingency planning, Leuchie House was changed from a respite service to a temporary care home, with the potential to offer up to 12 care home beds if needed. Haddington Care Home also earmarked an additional 5 beds to be used in the event that an individual's usual support within the community broke down as a result of COVID.

Overall, the range of support provided by the HSCP helped care home managers respond to the challenges the pandemic presented, including supporting them to comply with Health Protection Scotland guidance – this made a significant contribution to reducing the number of COVID positive residents in East Lothian care homes.

About the Care Home Team

The East Lothian Care Home Team was established in 2015 and now delivers medical management, education and support to 19 Care Homes across the county.

The Team provides Nurse Practitioner support in relation to anticipatory care, long-term conditions and acute illness presentations in HSCP managed and independent care homes. Staff from the Team work closely with GP colleagues for advice regarding medical conditions. This greatly reduces the need for GPs to attend care homes and has helped to reduce hospital admissions for care home residents.

The Care Home Team also plays an important role by providing training, information and clinical support and advice to care home staff, which helps to support the delivery of local and national care standards in homes.

During 2020-21, the Team worked with the Living Well in Communities (LWiC) team from the Improvement Hub to develop an approach to measuring the Team's impact. Some of the findings included:

- Care Home Team Nurse Practitioners are now the first point of clinical contact for Care Homes in East Lothian.
- A close working relationship has developed between the Care Home Team and Care Home staff – this has allowed any training or educational needs to be addressed and has promoted multidisciplinary working.
- In one study area (Tranent) an average of 8.25 hours of GP time was being saved each week.
- There had been a downward trend in the number of 999 calls from Care Homes.
- Anticipatory Care Planning had improved.

As described above, the Care Home Team provided vital support to care homes during the pandemic, helping to reduce pressure on primary care. As one GP said:

> *"The Care Home Team has been a huge asset to us in primary care during the pandemic. They have provided a joined-up approach across the county. At the outset of the pandemic in 2020, the Team worked very hard to help update anticipatory care plans, arrange medication where required and to provide a pragmatic approach to care. The Team has also been involved in delivering vaccinations to Care Home residents which was organised in a timely manner."*
>
> East Lothian GP

In your community

Care at Home

Care at Home services responded to increased demand throughout 2020-21. This was generated by COVID-driven restrictions on day support and carers needing additional support to cope with the additional pressure placed on them. Staffing pressures also contributed to the challenges facing Care at Home providers.

The HSCP was able to step up the number of hours delivered by the internal homecare service in response to this demand. Use of Hospital to Home funding and block contract awards to external providers also helped.

The Partnership also provided ongoing practical support to Care at Home providers as described above.

Transforming Community Support

The Community Transformation Programme focuses on two areas of service provision:

- Community based day services for adults **under 65** with complex needs.
- Community based day services for adults **over 65** with complex needs.

Specific activities since the start of the Community Transformation Programme in 2018 have included:

- Comprehensive needs assessment / data analysis.
- An extensive programme of community and stakeholder engagement.
- Capacity building with provider organisations.
- Collaboration with the Reference & Engagement Group and Change Board for Adults with Complex Needs to agree recommendations and proposed service models.
- Exploration with iHub (improvement Hub of Healthcare Improvement Scotland) of options for service design and new commissioning models.

The proposed service model developed as a result of these activities for adults under 65 is based on enabling people to be as independent of services as possible, whilst ensuring community based supports are available as option for those who need them, as well as specialist centre(s) for people with multiple complex needs.

Proposed Service Model for Adults Under 65

A similar service model is proposed for adults over 65, which reflects the fact that capacity in centres is reduced due to COVID infection control measures. Those needing most support being able to attend Day Centres (or the proposed new Meeting Centre in Musselburgh), with outreach support also being provided from Centres and the planned expansion of Shared Lives.

Proposed Service Model for Adults Over 65

The onset of the pandemic accelerated the move to more community based and outreach services, reflecting the direction of travel envisaged by the Transformation Programme. A further needs analysis was carried out by HSCP staff to identify service users most in need of building-based services. Where service users did not require a building-based service, providers offered alterative community-based provision (see below).

Day Services for Adults with a Learning Disability

There are three Resource Centres for Adults with a Learning Disability in East Lothian which are managed by Health and Social Care staff – Fisherrow, Port Seton and Tynebank. The centres operated at reduced capacity during 2020-21 in line with infection prevention and control guidance. Due to reduced capacity people with assessed critical needs were prioritised.

In line with the Transformation Programme, and in response to the pandemic, we developed a range of different approaches to provide support to people who previously attended day services, including outreach support to enable people to take part in activities in their local communities.

Resource Coordinators

A pilot Resource Coordinator Service for people under 65 with a Learning Disability was launched in 2020-21 based on a recommendation of the Transformation Programme. The Resource Coordinators' role is to support people with Learning Disabilities who can no longer access building based services to reconnect with friendships; build connections with their communities; and maintain skills and interests or develop new ones.

To date, resource coordinators have developed various community activities across the county. Community based activities such as football, lunch groups and gardening have been developed for people who do not require a centre-based service. The aim of these activities is to meet individual outcomes, whilst supporting people in their local communities.

The Health and Social Care Partnership continues to work closely with other support agencies to map what community resources are already available and to develop additional support opportunities. We are looking at using local venues to provide small group activities as we know that people have felt isolated and want to reconnect with their friends.

Older People's Day Centres

East Lothian's nine Older People's Day Centres were also forced to significantly reduce building-based provision as a result of the pandemic, moving instead to provide outreach support where possible. The number of building-based hours of support was reduced by 65% over 2020-21. Prior to the pandemic, around 15-20 people could attend each of the Centres for approximately 6 hours a day; this reduced to a maximum of 2-3 people attending for approximately 1-2 hours a day.

Despite some individuals' needs being met, securing care to replace that previously provided at a Day Centre grew to account for 60% of social work referrals for older people. A significant proportion of these referrals were for people affected by dementia.

Shared Lives

Shared Lives is a model of community/family-based care that provides long-term, short breaks and day support within Shared Lives Carer's homes. It is based on relationships, sharing family, social networks and community life and delivers safe and highly personalised care and support. In 2020-21, we agreed a new payment structure for our self-employed Shared Lives carers which builds a platform for expanding the scheme.

Hardgate Court

In October 2020 Hardgate Court in Haddington opened as a short-break service for adults with complex learning disabilities and specific health needs. This bespoke service offers support from nursing and social care staff and its integrated approach delivers a person centred service. In addition, external support agencies can access the accommodation to provide respite to carers of people they support. There is opportunity to support up to three

people within the service, however, since opening it has operated at reduced capacity in line with COVID guidance.

Hardgate Court has proved to be a very valuable and much needed resource, providing critical short-breaks for those with complex health needs and in once particular case, this resource has reduced the number of A&E presentations due to the specialist care provided.

The Hardgate staff team have been shortlisted for a national Nursing Times Award 2021, which describes the journey they have been on to deliver this specialist Learning Disability service within a local and community setting.

Learning Disability Service

Planning in 2020, delivered the transfer in April 2021of a number of social work, community care workers and the learning disability commissioned budgets and workstreams from Adult Social Work to align with the Community Learning Disability Team to create and develop a specialist learning disability service across health and social care.

Meeting Centres

In February 2020, we started conversations about developing a dementia Meeting Centre in Musselburgh, with a view to this starting in 2020-21. Unfortunately, this work had to be paused temporarily due to COVID-19. We are still committed to this work and plan to develop discussions further during 2021-22.

A Meeting Centre is a local resource, operating out of ordinary community building, and offering friendly, expert support to people with mild to moderate dementia and their families. At the heart of the Meeting Centre is a social club where people meet to have fun, talk to others and get help in relation to what they feel they need. Meeting Centres are based on research evidence on what helps people cope well when adjusting to living with dementia

Healthcare when and where you need it

East Lothian Community Hospital

In last year's Annual Report, we highlighted the opening of the new East Lothian Community Hospital (ELCH) as a one of our key achievements of that year. A year on, the hospital is providing East Lothian residents with local access to an ever growing range of services. It also played a key role in our pandemic response.

Health services delivered at ELCH now include:

- In-patient care.
- Urology.
- Orthopaedics.
- Rheumatology.
- Gynaecology.
- Adult Ear, Nose and Throat and Audiology.
- Plastic surgery for hands.
- Adult Psychiatry.
- Antenatal Services.
- Dietetics.
- Palliative Care.
- Phototherapy.
- Osteoporosis.
- Lymphoedema.

Although clinical departments at the hospital had to pause or significantly restrict delivery at the height of the pandemic, every effort was made to recommence appropriate levels of provision as soon as safe and practical.

Clinical services were still operating at Amber level at the end of 2020-21 but continued to increase the number of initial face-to-face outpatient appointments offered. Throughout the year, clinics also made effective use of 'Near Me' video appointments.

Collaborative work with Western General Hospital resulted in delivery of intravenous therapies and venesection for some patient groups within the Endoscopy Suite as part of their treatment, rather than requiring trips into the Edinburgh Cancer Centre. This has been a welcome service development for patients.

Nurse-led monitoring clinics were established within outpatients, covering; Diabetes, Gastrointestinal, Haematology and Renal specialties, and have run successfully for the last year. This has allowed patients to be routinely checked without the need for a Consultant appointment, unless test results warrant further investigation. More specialties will be added in the coming months, such as Rheumatology

ELCH also played a key role in the COVID response by offering additional beds and as the base for the East Lothian COVID Vaccination Centre and the PPE hub.

Developments in Primary Care Services

Our Primary Care Improvement Plan (PCIP) sets out to deliver the 2018 General Medical Services (GMS) contract aim of:

'Developing collaborative multi-disciplinary teams working alongside GPs in their role as Expert Medical Generalists to manage patients in their own community'

In East Lothian, we have also been guided by our priority of ensuring that primary care services are equally accessible to patients, regardless of where they live in the county and which GP practice they are registered with.

Progress during 2020-21 included:

- The establishment of a **Community Link Worker Service** for all GP practices.
- HSCP delivery of a **Flu Vaccination Programme** (with plans for the team to deliver all flu vaccinations for 2021-22, including those previously administered by GP practices).
- The provision of **Pharmacotherapy Services** to all GP practices, with plans to increase provision further.
- The establishment of **Community Treatment and Care Service** (CTACS) bases around the county.
- The expansion of the **Care When It Counts (CWIC)** service from one GP practice to four, resulting in the service now being available to 47% of the East Lothian population.
- The provision of direct access to a **Musculoskeletal (MSK) Service**, making access quicker and easier for patients.
- The establishment of a **CWIC Mental Health Service**, providing people from across East Lothian with access to support for mild to moderate mental health issues.

You can read more about some of these primary care services below.

Community Link Worker Service

Work to establish a new, East Lothian wide, Community Link Worker (CLW) service took place during 2020, with the new service being launched in February 2021. Community Link Worker services are embedded in local community areas and delivered across the county by three third sector providers: We Are With You, Penumbra, and the Royal Voluntary Service (RVS). Each organisation brings their own expertise and skills in service delivery and works collaboratively with the East Lothian HSCP to ensure a high quality service across East Lothian.

The East Lothian Community Link Worker service provides targeted support to individuals (aged 18 and over) who are experiencing difficulties due to social-economic factors, social isolation, relationship breakdown, or other factors related to health inequalities.

The aim of the CLW service is to support clients in achieving their identified health and well-being goals through offering social prescribing and support for clients to benefit from wider community support and resources.

Community Link Workers work closely with all 15 GP Practices in East Lothian, and work in partnership with wider third sector and community organisations to ensure appropriate support in relation to non-clinical needs is available, or to identify any gaps.

What our partners say:

> *'Our link worker Sam has quickly become an integral part of our team. He is able to engage really well with our patients who have non-medical problems that are impacting their physical or mental health and support them to make changes. This can be anything from starting a new hobby, enrolling on a course, joining a social group, increasing their exercise or help addressing financial or housing.'*
>
> Dr Anna Beedel, Prestonpans Group Practice

Flu Vaccination Programme

ELHSCP worked with partners to ensure that all those eligible could access flu vaccinations over the winter period. Flu vaccinations for adults were delivered by a combination of GP practices, community pharmacies, CTACS and ELHSCP run clinics. This was the first year that the HSCP had directly delivered flu vaccination clinics, held at a range of community venues, including local high schools. HSCP clinics targeted eligible adults between 18 and 64 years of age, allowing GP surgeries to focus on delivery for the over 65s.

Between them, partners vaccinated:

- 8,594 'at risk' adults between 18 and 64 – 58% of those eligible (up from 40% the previous year).
- 10,161 adults aged 65 to 75 – 81% of those eligible (up from 70%).
- 8,979 adults aged 75 and over – 85% of those eligible (up from 80%).
- An overall total of 27,734 adults – 73% of the target eligible population and an increase of 12% from 2019/20.
- 1,976 pre-school and 5,771 primary school pupils were also vaccinated, 66% of the target population (up from 50% in 2019/20).

As well as reducing the pressure on GP surgeries over the winter period, our role in delivering flu vaccinations allowed the team to gain experience and develop capacity for the role they were to play in delivering COVID-19 vaccinations (see page 40 above). The HSCP is well placed to assume full responsibility for the 2021-22 adult flu vaccination programme.

Pharmacotherapy Services

Since the introduction of the new GMS (General Medical Services) contract in 2018, ELHSCP has expanded the number of pharmacy support posts (both pharmacists and pharmacy technicians) to all GP practices in East Lothian. This support helps to reduce GP workload and improves efficiency in relation to medicine-related issues.

Community Treatment and Care Services (CTACS)

Although launch of the Community Treatment and Care Service (CTACS) was delayed as a result of COVID, the new service commenced delivery in June 2020. Initially covering patients at the Haddington GP practices, the service was extended to practices across the whole of East Lothian from August 2020.

CTACS offers a range of 'treatment room' activities including phlebotomy; management of minor injuries and dressings, ear syringing; suture removal; and chronic disease monitoring. Delivery of these activities by an HSCP employed team helps to reduce workload pressures for GP surgeries and enables the delivery of centrally managed, standardised treatment by skilled practitioners, whilst meeting the needs of local communities.

Patient feedback has demonstrated extremely high levels of satisfaction, with 94% of patients saying the service they had received was 'very good' or 'excellent'.

What our colleagues say:

> *"We have a fantastic team of experienced NHS nurses in our team. CTACS can offer patients longer appointments when needed, allowing the team to take time to fully assess and plan individualised care to patients.*
>
> *This is a new way of receiving care – one which helps us to ensure people are able to see the right person, at the right place, at the right time, which I know people are coming to value."*
>
> Deirdre Quigley, CTACS Lead

Collation and analysis of CTACS service data has enabled the deployment of staffing resources where they can have the most impact. This analysis has also informed proposals to employ new Health Care Support Workers in 2021-22 to help boost the service's capacity to carry out more routine health care tasks.

CWIC (Care When it Counts)

Launched in 2018, the CWIC service offers a 'seen on the day' service, delivering person-centred, safe and timely care.

Although the service was suspended for around 4 months as a result of COVID, it resumed delivery for Musselburgh patients in July 2020 and had extended its service to Harbours, Inveresk and Tranent practices by the end of the year. At the end of 2020, around 75% of CWIC consultations were taking place over the phone, with the remainder face-to-face.

The expansion of CWIC to cover 4 GP practices means that the service is now available to 47% of the East Lothian population. Working collaboratively with GP practices has been key to shaping the CWIC service. CWIC staff have worked with GP colleagues on Quality Improvement activities throughout 2021-22.

CWIC is based on a multidisciplinary model of care, involving skilled and experienced practitioners working collaboratively alongside GPs in their role as expert medical

generalists. The CWIC team currently consists of nurse practitioners, advanced nurse practitioners, physician associates and GPs.

A sample of GP practice data (February 2021) showed that 89% of patients had their needs resolved by a CWIC practitioner on the day they contacted the service.

Feedback from a survey of CWIC patients identified that:

- 98% were either 'very satisfied' or 'satisfied' with how quickly they were contacted by a CWIC practitioner
- 98% said the practitioner they saw was 'very good' in terms of really listening, and 90% reported the practitioner was 'very good' at understanding what mattered to them
- 93% said the practitioner made them feel at ease, and 93% also said they were 'very good' at explaining things clearly

Patients described the service as:

> 'Professional, attentive, reassuring and friendly'
>
> 'Prompt and efficient…the Practitioner was fab and very thorough'
>
> 'Fast, efficient and patient centred'
>
> 'The best experience I've had in a doctor's surgery'

CWIC (Care When it Counts) Mental Health Service

The CWIC Mental Health multi-disciplinary team was established in April 2020 as a direct response to COVID-19, in order to maximise existing resources, ensure workforce resilience across the county, and establish easy-to-access mental health support.

The CWIC MH service is available to residents aged over 18 across the whole of East Lothian. The service is based in East Lothian Community Hospital and Musselburgh Primary Care Centre and works in partnership with all East Lothian GP practices.

CWIC MH provides access to a mental health practitioner via a dedicated phone line. Patients can be referred to the service by their GP or other health practitioner, or they can contact the service directly without the need for a referral. By March 2021, 33% of all appointments were being made directly by individuals.

Mental Health Occupational Therapists (OTs) in the CWIC MH Team help patients to better self-manage and to be less reliant on health and social care services. Patients benefit from meaningful intervention, leading to avoidance of crisis and reducing the need for referral on to secondary mental health services.

Throughout most of 2020-21, the CWIC MH service had been delivered via telephone or by using Near Me, however the option of face-to-face consultations was introduced in spring 2021.

The main benefits of CWIC MH can be summarised as:

- CWIC MH provides a brief treatment model for common mental health issues.
- Individuals with low to moderate mental health concerns can quickly access specialist mental health support over the phone.
- CWIC MH provides a clear, easy to understand pathway for patients.
- Help is provided where possible the same day or within 72 hours of a patient's initial phone call.
- The service helps to reduce pressures on GPs (data suggests that up to 40% of visits to GPs are now in relation to mental health needs).
- GPs and other health practitioners benefit from an accessible mental health support service to refer patients to, with the assurance that they will receive a quick response.
- It is contributing to a shift in patient expectations, whereby patients no longer automatically see their GP as their first port of call for all health concerns.
- Patient feedback has suggested that the service offers a caring and compassionate approach, a timely response and easy access to support.

CWIC MH facts and figures:

- Around 66% of people using the service were female, 33% were male.
- The age groups making most use of the service were aged18-25 and 50-65.

Feedback from a survey of CWIC MH patients:

- 98% were 'very satisfied' or 'satisfied' with how easy it was to use the service.
- 87% said the CWIC MH practitioner was 'excellent' or 'very good' at really listening to them.
- 93% said the practitioner was 'excellent' or 'very good' in terms of showing care and compassion.
- 91% said the practitioner had been 'excellent' or 'very good' at helping them to take control.

What people using the service have said:

'Wonderful that I was seen on the day I needed help.'

'Really approachable and caring staff.'

'*Really helped me stay working despite feeling anxious and stressed*.'

'I can't begin to thank you enough; I feel like I know what to do now.'

A recent survey of GP practices found that:

- 78% agreed that CWIC MH is a useful resource to signpost patients to during a consultation.
- 86% felt confident in the service that CWIC MH provides to patients.

Comments from GPs suggested that CWIC MH offers:

> *'Equitable access across the country. Fast response times. Reduced pressure on practices.'*
>
> *'Better access for patients to obtain help for their mental health. Helps patients take initiative for their mental health.'*

Maintaining and improving your quality of life

East Lothian Rehabilitation Service

Rehabilitation services are key to maintaining and improving people's quality of life, as well as to helping them to retain their independence after illness. Rehabilitation services also play an important role in keeping people out of hospital, or allowing them to be discharged sooner, and, as such, help to reduce pressures and costs on all parts of the health and social care system.

East Lothian Rehabilitation Service (ELRS) has expanded its capacity over recent years to meet growing and increasingly complex patient needs. The service developments during this year are described below.

Post-COVID Rehabilitation

As more people started to experience challenges in recovering from COVID, the HSCP began to look at ways of delivering effective and efficient post-COVID rehab. This resulted in development of a multidisciplinary post-COVID pathway, resource pack and education strategy.

The development of a single point of contact for GPs, secondary care and other professionals is also planned as part of this approach. This will ensure ease of access (and re-access) to the service, enabling patients to get the right help, delivered by the right person at the right time.

Our response to post-COVID rehabilitation is to manage referrals through the long-term condition pathways. This means that Advanced Practitioners within Occupational Therapy and Physiotherapy will assess and treat service users, using a blend of telephone, Near Me and face-to-face contact. 'Test of Change' funding has been secured for a year for an Advanced Practice Occupational Therapy post for long-term conditions in one of our geographical clusters.

Technology Enabled Care (TEC)

Our TEC team continued to provide patient consultations remotely throughout the year. Provision included the introduction of a 'self-install service' of supportive technology, which was well received.

The team worked with clusters and inpatient teams to trial, and later embed into practice, the Alcuris lifestyle monitoring tool. In some cases, Alcuris reduced or removed the need for a care package, in others, it facilitated discharge home or helped to prevent hospital admission.

Plans for 2021-22 include replicating the successful Wellwynd SMART TEC Hub in the east of the county. The TEC team is also working on further development of self-management information available on the East Lothian digital platform – ensuring that information on TEC

and how it can help support effective self-management, is readily available to East Lothian citizens.

Request for Assistance (R4A)

Request for Assistance is a new model of practice where 'Good Conversations' and an assets-based approach is used in determining what matters to the person requesting support. Senior Practitioner Occupational Therapists take all the calls. After talking with the caller using the 'good conversation' approach they either signpost the person to appropriate support, allocate them directly for an assessment, or place them on the waiting list if the request is for routine intervention.

Community Clusters

In May 2020, we reorganised our community teams into three integrated geographical clusters, covering the whole of East Lothian. These clusters bought together Occupational Therapists from both East Lothian Council and the NHS, alongside Physiotherapists. The clusters deliver several workstreams including facilitating discharge from hospital and prevention of admission, as well as community rehabilitation and the assessment and provision of adaptations and equipment. Processes are constantly evolving and developing but this integrated model has improved communication, reduced duplication and increased efficiency for service users.

Collaborating with our colleagues in Volunteer Centre East Lothian (VCEL) has led to volunteer support being accessible for those discharged from hospital with Discharge to Assess (D2A) pathway, increasing the scope of support people are able to receive. This can include wellbeing checks both virtually and in person, support to apply for appropriate benefits and support to engage in aspects of their rehabilitation programme. Volunteers have made a significant impact to increasing people's confidence and decreasing social isolation.

Physical Activity and Community Education (PACE) Service

The Physical Activity and Community Education (PACE) service had to adjust its approach significantly during 2020-21 due to COVID restrictions. PACE staff created 'Exercise Fundamentals' allowing patients to continue with tailored activity, at their own pace, remotely, with telephone contact also provided at set times. Content was made available online via YouTube as well also in paper format for those who needed it.

Pain Management

The East Lothian Pain Management Service was launched in September 2020, accepting referrals from GPs, Allied Health Professionals and Consultants. The service aims to reduce the impact pain is having on an individual's quality of life through teaching ways of self-management and coping with persistent pain.

After an initial assessment, a number of treatment options are offered. These include online resources, pain management groups (virtual or face-to-face where restrictions allow) individual treatment, or onward referral to other services within ELRS, for example PACE or the Lothian Chronic Pain Service at Astley Ainslie Hospital.

The East Lothian Chronic Pain Service was the first to deliver digital online pain management groups in Lothian. This approach improved the patient experience by enabling direct access to pain management services from their own home during COVID restrictions.

To date 129 patients have accessed the service receiving support in response to individual need. Eight online and face-to-face pain management groups have been delivered, providing pain management support and education for individuals experiencing a range of long-term conditions. Services are delivered locally at ELCH and more recently at the Edington hospital, facilitating easier access and minimising travel for this patient group.

A recent patient experience evaluation has demonstrated high levels of satisfaction with the service provided:

> *"This is a long awaited helpful period for long0-term health condition from genuinely understanding professionals."*
>
> *"Well paced and good level of teaching, empathy from evidence based professionals."*

Anticipated future service developments include the support from Pharmacy and Mental Health Services on a sessional basis.

Musculoskeletal (MSK) Service

East Lothian Physiotherapy Musculoskeletal (MSK) Service underwent significant service redevelopment during 2020-21. This included the launch of a new MSK Advice Line in May 2020, significantly improving patient access routes to physiotherapy.

By the end of March 2021, the MSK Advice Line had generated over 6,000 referrals directly into the MSK Service, with 40% of these managed with a one-off telephone consultation. The remainder were passed on to the core Physiotherapy team to continue the rehabilitation in a timeframe guided by individual clinical need, rather than by patients being added to a waiting list.

This direct access approach has improved patient experience, by removing the need to go via their GP. It also led to a significant reduction in waiting times for core MSK services (to 1 week). The approach also benefits GP practices by decreasing MSK related demands on their time.

The Advanced Practice Physiotherapy team are currently undergoing training to allow them to generate their own X-Ray requests, helping to further decrease GP workload.

Patient experience evaluation carried out in 2020-21 demonstrated high levels of satisfaction with the service provided – all respondents rated the service as 'excellent' or 'good/ great', with no respondents suggesting it was 'fair' or 'poor'. Comments about the service included:

> *"Got through to service quickly. Very professional, helpful and empathetic support. I feel reassured about my recovery."*
>
> *"Clear, concise, easy exchange of information, no need to leave home for the assessment."*
>
> *"Wouldn't change anything, I was happy after speaking to the physio and knowing I could contact them again."*

Anticipated future service developments include an electronic self-referral option and 'webchat' function for those unable or choosing not to engage with Physiotherapy services via the MSK Advice line.

What our colleagues say:

> *"With joint or muscle pain, the earlier you get advice and support the better. Putting up with pain may be brave, but it's not good for you. We wanted to make sure that people could access physio and occupational therapy and support as soon as they needed it,"*
>
> Lesley Berry, General Manager for Access and Rehabilitation

Mental-Wellbeing Playlist

The East Lothian Psychological Therapies Service developed a resource during 2020-21 which can be accessed by anyone looking for support with their mental wellbeing. There are nine video playlists in total, each one focusing on different aspects of mental wellbeing. The team designed the videos so that they can be watched in sequence or dipped into according to individual preference. This initiative received generous support from the Edinburgh and Lothians Health Foundation.

> *"I know that we have all been through the mill with COVID-19 and many people have been feeling anxious or low. These are normal feelings and, even without a pandemic to contend with, ones that most of us will experience at some time in our lives. These videos are really useful in helping us to understand why we might be feeling low and suggests simple things that we can do to start feeling better."*
>
> Peter Murray, Chair of East Lothian IJB

Reducing health inequalities

Tackling Poverty

The East Lothian Poverty Plan (2021-23) was developed by a working group involving East Lothian Council, NHS Lothian, Volunteer Centre East Lothian, the two local Citizens Advice Bureaux and ELHSCP. The new plan combines the previous Poverty and Child Poverty Action Plans. Monitoring of the previous plans demonstrated that progress had been made against most of the actions in the plans. The new plan identifies ongoing action required by all partners to tackle inequality and poverty and to deal with the consequences of the pandemic.

Financial Inclusion

Two services new to East Lothian in 20200-21are set to play a role in promoting financial inclusion.

The East Lothian Community Link Worker service (see page 42) was launched in early 2021 to support people across East Lothian. The service, available in all GP practices, offers support with a range of non-medical issues, which can include issues that contribute to financial hardship such as employment, debt and household costs. Community Link Workers can signpost service users to financial inclusion and other advice services.

Work to establish the Macmillan Improving the Cancer Journey service in East Lothian began in East Lothian in 2020-21, with a range of partners, including the HSCP, involved in the steering group for this initiative. The service will provide person-centred support to help people affected by cancer in relation to non-clinical issues including employment, housing and financial inclusion.

Health Improvement Fund

NHS Health Improvement Fund is administered by the East Lothian Health Improvement Alliance. Projects funded in 2020-21 included:

- Ageing Well – an initiative promoting physical activity and providing groups, classes and other activities for older adults.
- Pennypit Community Nutritionist – a project providing information, advice and training to local people on nutrition – for example, through family cooking groups.
- People Know How – an initiative providing mental health support to vulnerable young people.
- Start Well – a project promoting physical activity for the under 5s.
- Carefree Kids – a service lending equipment to vulnerable families and offering a uniform / winter clothes bank.

Community Justice

The East Lothian Community Justice Partnership published its new Community Justice Local Outcome Improvement Plan 2021-2024 in June 2021.

The Partnership includes a range of organisations including East Lothian Council, Police Scotland, the Scottish Prison Service, Skills Development Scotland, Queen Margaret University, NHS Lothian, ELHSCP and third sector representatives.

Throughout 2020-21 the Partnership continued delivery of its three main workstreams:

- Early Intervention and Prevention.
- Community Engagement.
- Reducing Reoffending.

Integrated Impact Assessments

ELHSCP, like all public sector organisations, is required to assess the impact of decisions and policies on equalities groups. We do this through a process called Integrated Impact Assessment (IIA).

Representatives for people affected by our decisions (including staff, service-users, the third and independent sectors) work through an IIA framework together. They look at the potential and actual positive, neutral and negative impacts of decisions on the groups they represent. This allows for appropriate adjustments to be taken into account in planning and delivery of services and policies.

Supporting carers

Caring for someone can be a rewarding experience, but coping day to day with meeting the needs of a loved one can be challenging for carers. We continue to work closely with young carers, adult carers and with carer organisations to try to ensure carers have the information and support they need.

We made further progress with implementing the East Lothian Carers Strategy in 2020-21, but also responded proactively to help support carers and organisations with the additional challenges posed by COVID.

As the pandemic developed, ELHSCP worked with carer organisations to provide support to carers during this particularly challenging time. Our shared priority was to make sure that carers continued to access existing services as much as possible. Care organisations acted swiftly, moving to online or telephone support and reduced or stopped face-to-face contact in line with government guidance.

Carer organisations responded flexibly and creatively to maintain support over the year – examples of different approaches include:

- The Bridges Project reported high levels of young carer engagement via online platforms (around 90% engaging with online support).
- East Lothian Young Carers (ELYC) moved their activity clubs online, delivered activity packs to young people's homes and offered tutoring and 1:1 support when required.
- Alzheimer Scotland kept in touch with carers using Near Me and GoTo platforms.
- Dementia Friendly East Lothian (DFEL) ran online weekly friendship groups.
- Carers of East Lothian (COEL) and DFEL worked with local community resilience groups, with COEL developing a directory of local resilience resources that carers could access.
- COEL reported contacting a significantly higher number of carers than usual over the year, including carers who were on their database but who had not been in contact for a long time.
- As restrictions eased, organisations moved to implement their recovery plans, again showing creativity with service delivery options – for example, COEL began to offer garden visits, making use of 'pop up pods' to allow support workers to sit outside to chat to carers regardless of the weather.

Prior to COVID, micro grant funding was available to carers to help provide respite breaks. As respite could not be accessed due to lockdown, we agreed with COEL that this money could be used to provide grants to families on low incomes with children under 21 living at home. Grants could be used to purchase items such as toys, games and subscriptions to help alleviate the pressure of keeping children and young people occupied at home during lockdown.

Connected Community Hubs across East Lothian supported families with food deliveries and other practice support. Carers' feedback suggested that the Hubs were well organised and responsive, providing much appreciated additional support during the pandemic.

Carers' organisations reported that lockdown was having a significant impact on carers' mental health. COEL continued to provide counselling sessions via Zoom and ELYC reported an increased need to provide emotional support to parents of young carers as well as young carers themselves. We also worked with organisations to promote uptake of the new CWIC Mental Health service by carers (see page 45).

ELHSCP made PPE supplies available to carers via the PPE Hub at East Lothian Community Hospital. We received positive feedback from carers saying that they were able to access PPE quickly and easily from the Hub.

Looking Ahead

A workshop was held with carer organisations and other third sector partners in October 2020 to begin work on reviewing the outcomes in the current East Lothian Carers Strategy. The workshop included discussion of how COVID may have impacted on some of these outcomes. Feedback from the workshop will help to shape a redraft of the Carers Strategy.

Safe from harm

Public Protection

The East Lothian and Midlothian Public Protection Committee (EMPPC) is committed to working in partnership to improve services to support and protect all people at risk of harm within our communities. EMPPC covers all aspects of Public Protection across East and Midlothian, including Adult Support and Protection; Child Protection; Violence Against Women and Girls; and Multiagency Public Protection Arrangements (MAPPA). One of its key strengths is the involvement of a wide range of multiagency senior representatives from across services and key agencies.

EMPPC and partner agencies continued to deliver robust public protection arrangements throughout the pandemic, adapting service provision where required – its Annual Report for 2020-21 describes its main activities and performance in more detail - some of the key figures for 2020-21 included in the report are outlined below.

Adult Support and Protection

In response to lockdown, the HSCP produced *'Managing Risk During the COVID-19 Epidemic'* guidance, which was quickly followed by EMPCC *'COVID-19 Practice Guidance for Adult Support and Protection 2020-21'*. The guidance included the interim measure of carrying out Inter-agency Referral Discussions in place of Adult Protection Case Conferences. Provision was also made for maintaining contact with individuals through the safe and appropriate use of PPE and electronic methods such at MS Teams and Skype were used to carry out meetings remotely.

Figures for Adult Support and Protection activity during 2020-21 include:

- 511 Adult Support and Protection (ASP) referrals were received over the year, a 9.1% reduction from the previous year.
- Police, followed by Health were the largest single referrers.
- 69.9% of referrals progressed to a Duty to Inquire (DTI), and 14.3% of DTIs progressed to Adult Support and Protection (ASP) Investigations.
- The rate for referrals being converted to DTIs increased by 28% in 2020-21, although the conversion from DTIs to Adult Support and Protection Investigations decreased by 5.7%.
- The most common type of harm investigated under ASP was financial harm. Over the last 5 years this has been the most common type of harm in all but one year.
- The most common category of client group with an ASP Investigation was 'infirmity due to age, accounting for 39% of the total.
- 82% of DTIs were completed within the standard of 7 days.
- 88% of ASP Case Conferences were held within the standard of 28 days.
- Where ASP Case Conferences were delayed this was in order to ensure good multi-agency representation – performance measured indicate a very good level of multi-agency attendance, including Police and Health colleagues.

Violence Against Women and Girls (VAWG)

The impact of the COVID pandemic on domestic abuse saw increased opportunities for perpetrators to exert coercive control, and concerns for the increased invisibility of victims and perpetrators during lockdown. Being able to access help during lockdown was an issue for victims, and those who were able to access support often needed more frequent contact, longer sessions and longer term support.

We put in place a number of measures to ensure that victims and services were able to access information about available support. This included working with Children's Services to enhance their support for survivors of domestic abuse and for children through the local Hubs where there was capacity.

We developed East Lothian Council *'COVID-19 and Domestic Abuse Community Housing and Homelessness'* staff briefings to raise awareness and give guidance on how to support survivors and set up four single points of contact.

Justice Services, the Police and the VAWG Co-ordinator collaborated to provide a SNAPfax-style leaflet with advice and supports for help with stress which police gave to perpetrators when attending an incident.

The figures below describe the context we delivered services in during 2020-21:

- 1,163 incidents of domestic abuse were recorded by the Police during 2020-21 – this was a reduction of 8% from the previous year
- 16 Multi Agency Risk Assessment Conferences (MARAC) were held for 111 victims – this was an increase of 20% on the number of MARACs held the previous year, a reflection of the increased need for this type of intervention.
- 344 referrals were made to the Domestic Abuse Referral Pathway, up 20.5% on the previous year
- Children were involved in 64.9% of cases referred to MARACs
- 235 sexual crimes were reported to Police in 2020-21, an increase of 19.3% from the previous year
- There was an increase in non-recent sexual crimes being reported, as well as an increase in non-contact online sexual offences
- There was a 20% increase in survivors requesting support from domestic abuse services after reporting an incident to the Police, with individuals needing more intense and longer term support.

Drug and Alcohol Use

There was a heightened risk of harm during 2020-21 due to the increase in availability of Etizolam (also known as 'street Valium'), Xanax and other forms of illicit benzodiazepine in East Lothian. Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP) and partner organisations responded by working together to share intelligence on drug availability and to issue advice and information to those at risk. People who use a number of drugs at the same time (poly drug use) are at particular risk, and work was focused on

this group, including providing them with harm reduction information and discussing with them strategies to help minimise risk.

The Substance Misuse Service also continued to deliver assertive outreach in primary care. This consists of providing direct access to a specialist consultant, nurses and Peer Support Workers in GP practices across East Lothian. Specialist nursing staff also provide support, information and advice to primary care colleagues to help improve prescribing practices.

During the year, our Substance Misuse Service consistently met and exceeded the Waiting Times Local Delivery Plan Standard.

Justice Social Work

Justice Social Work, in line with other aspects of Public Protection activity, was identified as an 'essential' service and adapted its approach throughout the year to ensure continuity of service delivery.

A system to assess all service users was quickly established as lockdown began. This was based on assessment of risk of harm to self or others, alongside consideration of issues such as severe and enduring poverty / deprivation, mental ill-health or substance use which, if left unchecked or unsupported, could have resulted in serious harm or self-neglect. Where such risks were identified, individuals were provided with in-person support in appropriate office spaces and / or on their doorsteps, if necessary. To continue delivering our essential services we redeployed staff and utilised PPE in all client-related activities.

Justice Social Workers continued to provide services based on risk and need. All those subject to oversight relating to domestic abuse offences were reviewed and the team made specific efforts to increase contact and support where there was a victim / survivor in the home and / or the perpetrator was in contact with an intimate partner. Staff undertook additional training to deliver a behaviour intervention programme to men convicted of domestic abuse offences, with the aim of reducing the risk of re-offending on an individual basis.

In relation to the Early Prisoner Release programme, we developed multi-agency pre-release planning groups to address the risk and needs of individuals prior to release (including housing, mental health, substance use, finances, etc.).

Workforce

Rising to the Challenge

We recognise that our single most valuable resource is our workforce. The role played by staff in responding to the challenges brought by COVID demonstrates just how exceptional our workforce is. Without the staff commitment, creativity, flexibility and enthusiasm shown, we would have been unable to continue the delivery of key health and social care services to the people of East Lothian.

To successfully deliver transformational change, our workforce will be required to do things differently to support new models of care. We will rely on having an experienced, skilled, innovative and adaptable workforce doing new and different things. The flexibility required from our workforce to respond to COVID-19 demonstrate that they have the enthusiasm, skills, and commitment to rise to the challenge.

Engaging and Supporting Our Staff

Throughout the year, our staff had to work in very different ways to previously. A significant proportion moved to home working, adapting to carrying out their roles using telephone and online platforms. Others were faced with working in workplaces that had changed dramatically due to social distancing and infection prevention and control measures. All the while, they continued to respond to new and changing service demands and changing COVID guidance.

ELHSCP, along with East Lothian Council and NHS Lothian took a range of actions to engage and support staff throughout the pandemic. These included:

- Communication with staff was key from the outset, with the Chief Officer's Blog updates playing an important role in communicating the latest information and allowing two way dialogue with staff.
- NHS Lothian's COVID 'Speedreads' also provided staff with up to the minute information, advice and guidance.
- Many teams set up 'daily huddles', either face-to-face or online, allowing sharing of information and providing support to staff.
- Focus on Wellbeing Programmes delivered throughout the year to empower and encourage staff to focus on personal resilience and self-care – including topics such as sleep, stress and anxiety, mindfulness and balancing work and home life.
- Wellbeing Wednesdays – run by East Lothian Council.

Workforce Development

Our ELHSCP Workforce Plan (2021-22) reflects our commitment to ensuring that we have the right level of skilled and experienced staff, working together in the right settings and with the right support, to deliver high quality, integrated and sustainable health and social care services.

Our Workforce Plan outlines how we intend to deliver on this commitment. The Plan identities how we will work with East Lothian Council and NHS Lothian to deliver integrated workforce planning which will include:

- Profiling the workforce.
- Re-designing jobs and services.
- Undertaking a 'skills gap analysis' to identify skills development requirements.
- Integrating workforce policies and practices as far as possible.
- Supporting proactive recruitment campaigns.

East Lothian IJB Strategic Plan

East Lothian Integration Joint Board approved its current Strategic Plan in April 2019, covering the period from 2019 to 2022. The Plan outlines ten strategic objectives:

1. To make health and social care services more sustainable and proportionate to need and to develop our communities.
2. To explore new models of community provision which involve local communities and encourage less reliance on health and social care services.
3. To improve prevention and early intervention.
4. To reduce unscheduled care and delayed discharges.
5. To provide care closer to home.
6. To deliver services within an integrated care model.
7. To enable people to have more choice and control.
8. To reduce health inequalities.
9. To build and support partnership working.
10. To support change and improvement across our services.

Two years into our current Strategic Plan, we continue to make good progress in relation to each of these objectives. Every one of the East Lothian Health and Social Care (HSCP) delivered service developments or activities described in this Annual Report can be seen to contribute to one or more of these objectives, with many contributing to multiple objectives.

Change Board Review

Change Boards were established to deliver the strategic priorities identified in our Strategic Plan – there is a Change Board for each of the following areas:

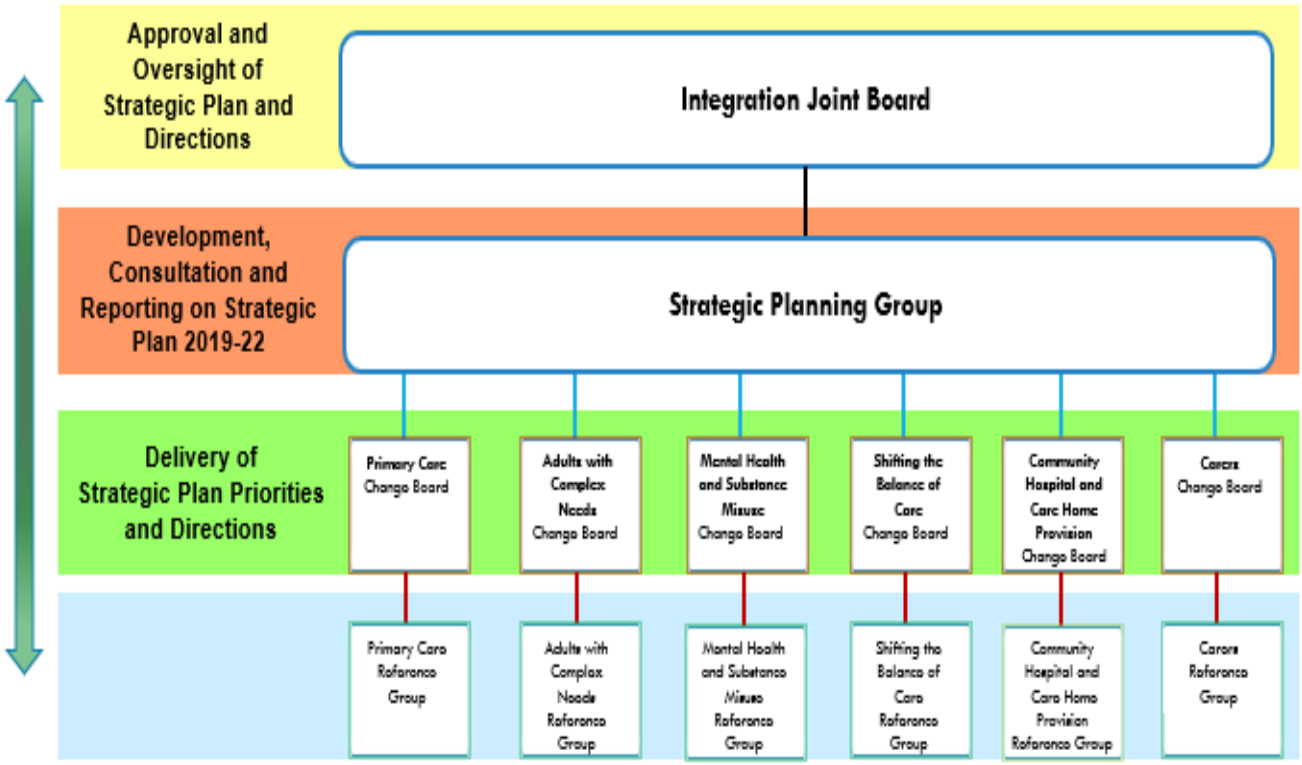
- Primary Care.
- Adults with Complex Needs.
- Mental Health and Substance Misuse.
- Shifting the Balance of Care.
- Community Hospital and Care Home Provision.
- Carers.

Each of these Change Board has an associated Reference Group. The membership of Reference Groups is made up of service-users, carers and professional, operational, management and planning colleagues. Reference Groups provide a 'sounding board' to help inform the work of each Change Board.

The relationship between Reference Groups, Change Boards, the Strategic Planning Group and the Integration Joint Board are shown in diagram 1 below.

An Internal Audit of Changes Boards in 2020 suggested that Change Boards operated well, but that there were some improvement opportunities in terms of enhancing governance arrangements. The HSCP went on to carry out a review of Change Boards during 2020-21 which included consulting the range of stakeholders currently involved in these groups. Review recommendations will be actioned during 2021-22.

Diagram 1 - East Lothian IJB Strategic Groups



How we performed

National Integration Indicators

The Scottish Government published a Core Suite of 23 National Integration Indicators in 2015. The Ministerial Strategic Group for Health and Social Care later developed a number of additional indicators. Between them, these indicators provide a means for Health and Social Care Partnerships to measure progress in delivering the National Health and Wellbeing Outcomes.

The tables below provide the more recent available data for each of these indicators, along with the figure for Scotland and trend information where available / appropriate.

Data for the Core Suite of Indicators is published on the Public Health Scotland website, the most recent publication can be found here.

Core Suite of National Indicators

(i) Scottish Health and Care Experience Survey (2019/20)

Nine of the national integration indicators are based on data from the biennial Scottish Health and Care Experience (HACE) survey (table 1). The most recent survey was in 2019/20, so reflects data from the year before this annual report covers.

Public Health Scotland (PHS) notes that the HACE survey is carried out with a sample of patients aged 17+ registered with GP practices in Scotland and is therefore affected by sampling error. The effect of sampling error is identified by PHS as being *'relatively small for national estimates'* but is more significant when looking a smaller sub-sections of the population due to the results being based on a relatively small sample size.

Sampling error may be the case in relation to East Lothian where the sample size for the 2019/20 survey was 7,579, with only 2,633 surveys completed (a 35% response rate). The number of responses was lower still for the questions that were only relevant to a subset of respondents (for example, carers). As a result, care should be taken in making any comparison between the Scottish and East Lothian figures.

In Table 1, the column 'Statistically Significant?' relates to the degree of uncertainty around the survey results due to sample size, and whether differences between the East Lothian and Scotland result should be seen as significant or not. This was determined using the 95% confidence intervals included in the survey results. More detail on this can be found in Appendix 2.

Table 1: National Integration Indicators based on Health and Social Care Experience Survey (2019/20)		East Lothian	Scotland	Statistically Significant?
1.	Percentage of adults able to look after their health very well or quite well	94%	93%	No
2.	Percentage of adults supported at home who agree that they are supported to live as independently as possible	72%	81%	No
3.	Percentage of adults supported at home who agree they had a say in how their help, care or support was provided	75%	75%	No
4.	Percentage of adults supported at home who agree that their health and social care services seemed to be well coordinated	61%	74%	Yes
5.	Percentage of adults receiving any care or support who rate it as 'excellent' or 'good'	76%	80%	No
6.	Percentage of people with positive experience of care at their GP practice	72%	79%	Yes
7.	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	70%	80%	No
8.	Percentage of carers who feel supported to continue in their caring role	33%	34%	No
9.	Percentage of adults supported at home who agree they felt safe	70%	83%	Yes

Due to changes to data methodology, only indicators 1, 6 and 8 are comparable with previous years.

- Indicator 1 remained unchanged from the previous survey (carried out in 2017/18).
- Indicator 6 had fallen from 80% to 72%.
- Indicator 8 had fallen from 36% to 33%.

(ii) Operational Performance Indicators

The Core Suite of indicators includes a number of indicators based on hospital and other health and social care service activity, along with data from National Records of Scotland's death records. Performance against each of these indicators is shown below.

It should be noted that, where indicated, the figures given are for calendar year 2020. Calendar year 2020 is used as a proxy for 2020-21 due to the national data for 2020-21 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and other Health and Social Care Partnerships.

Please note that the figures presented will not take into account the full impact of COVID-19 during 2020-21.[2]

[2] Text as advised in 'Public Health Scotland guidance regarding the reporting of National Integration Indicators in 2020/21 Annual Performance Reports' (June 2021)

Performance Symbols Key					
Improvement trend	✔	Performance similar to previous years / only slight change	—	Downward trend	↓
Performance above the Scottish level	✔	Performance around the same as Scottish level	—	Performance below the Scottish level	✕

11. Premature mortality rate for people aged under 75 per 100,000 persons (by calendar year)									
	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**Trend**	**6-year Trend**	The premature mortality rate for people aged under 75 rose slightly in 2020, showing a similar level of increase as with the Scottish rate. East Lothian's rate **remains significantly below** the national figure, with the **fourth lowest premature morality in Scotland**.
East Lothian	320	375	372	333	313	342	↓	↓	
Scotland	441	440	425	432	426	457	✔	-	

12. Emergency admission rate for adults (per 100,000 population)									
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020**	**Trend**	**6-year Trend**	Performance improved, with a lower rate of emergency admissions than the previous year. East Lothian's emergency admission rate remains lower than the Scottish rate.
East Lothian	10,053	9,634	10,337	10,069	10,959	10,157	✔	↓	
Scotland	12,295	12,230	12,211	12,279	12,524	11,111	✔	-	

13. Emergency bed day rate for adults (per 100,000 population)									
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020**	**Trend**	**6-year Trend**	There were a higher number of emergency bed days for East Lothian residents (per 100,000 population) during 2020. Although the number of bed days had risen from the previous year, the level was still lower than the Scottish rate and showed an overall positive trend.
East Lothian	119,053	120,373	120,661	99,549	96,617	101,588	↓	✔	
Scotland	127,659	126,077	122,868	120,276	118,607	102,961	✖	-	

14. Readmission to hospital within 28 days of discharge (rate per 1,000 discharges)									
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020**	**Trend**	**6-year Trend**	Performance was down from previous years, with slightly more readmissions (although the numbers involved were small –equating to an additional 11 readmissions per 100,000 population). East Lothian's readmission rate was similar to the Scottish rate (which shows a similar trend over the 6 year period).
East Lothian	99	100	106	99	102	113	↓	↓	
Scotland	98	101	103	103	105	115	✓	-	

15. Proportion of last 6 months of life spent at home or in a community setting									
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020**	**Trend**	**6-year Trend**	Performance improved from the previous year and continued to be in line with the Scottish rate. A 5% improvement can be seen in the East Lothian figure over the last 6 years.
East Lothian	84.7%	85.6%	85.6%	87.8%	87.5%	89.7%	✓	✓	
Scotland	87.0%	87.3%	88.0%	88.0%	88.4%	90.0%	—	-	

16. Falls rates per 1,000 population aged 65+									
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020**	**Trend**	**6-year Trend**	The falls rate per 1,000 population for aged 65+ stayed at the same level as the previous year.
East Lothian	19.4	18.9	18.8	19.0	22.9	23.4	—	↓	
Scotland	21.1	21.4	22.2	22.5	22.8	21.7	—	-	

17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections									
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**Trend**	**6-year Trend**	84% of care services were graded 'good' or better in Care Inspectorate inspections – around the same level as the previous year. A strong upward trend can be noted for East Lothian since 2015/16.
East Lothian	76.6%	76.6%	85.0%	84.2%	84.7%	83.5%	—	✓	
Scotland	82.9%	83.8%	85.4%	82.2%	81.8%	82.5%	—	-	

18. Percentage of adults with intensive care needs receiving care at home									
	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**Trend**	**6-year Trend**	Performance remained consistent with the previous year and in line with the Scottish rate.
East Lothian	65.6%	65.1%	64.9%	61.0%	63.3%	62.7%	—	↓	
Scotland	61.2%	61.6%	60.7%	62.1%	63.0%	62.9%	—	-	

19. Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)									
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**Trend**	**6-year Trend**	Performance improved significantly in relation to the number of delayed discharge bed days for the 75+ age group. This improvement trend has continued over a number of years, with the East Lothian rate now sitting significantly below the Scottish rate.
East Lothian	1,314	1,158	775	641	327	262	✓	✓	
Scotland	915	841	762	793	774	488	✓	-	

20. Percentage of health and care resources spent on hospital stays where the patient was admitted in an emergency									
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020**	**Trend**	**6-year Trend**	Performance improved from the previous year, with 2% less spent on hospital stays where a patient was admitted in an emergency. This performance is in line with the Scottish average
East Lothian	21.8%	22.0%	24.3%	22.5%	22.5%	21.4%	✓	✓	
Scotland	23.2%	23.4%	24.1%	24.2%	24.1%	21.2%	—	-	

There are a further four National Indicators which cannot be reported on currently as national data is not yet available or there is no nationally agreed definition for the indicator as yet. These indicators are:

- Indicator 10 - % of staff who say they would recommend their workplace as a good place to work.
- Indicator 21 - % of people admitted to hospital from home during the year, who are discharged to a care home.
- Indicator 22 - % of people who are discharged from hospital within 72 hours of being ready.
- Indicator 23 - Expenditure on end of life care costs in last 6 months per death.

Ministerial Strategic Group (MSG) Indicators

The indicators shown below were developed by the Ministerial Strategic Group for Health and Social Care. Health and Social Care Partnerships have been required to set their own targets for each of these indicators – East Lothian's are shown in the table below. These figures are based on reports released for management information only. Due to different configuration of services, figures for the hospital / hospice categories may not be comparable across partnership areas.

Performance Symbols Key					
Improvement trend	✔	Performance similar to previous years / only slight change	—	Downward trend	↓

Indicator	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Trend	6-year Trend
1. Number of Emergency Admissions (18+)	7,935	7,659	8,259	8,194	9,003	**8,261**	✔	↓
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	77,549	80,150	80,627	66,269	65,769	**64,946**	✔	✔
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay[3] (18+)	3,365	2,154	446	455	2,637	**6,669**	**Issue with data**	**-**

[3] Issue with data completeness for 2020

2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay[4] (65+)	3,226	2,154	446	281	2,230	**6,577**	**Issue with data[5]**	**-**
2iii. Number of Unscheduled Hospital Bed Days – Mental Health[6]	15,633	16,659	16,858	15,440	13,345	**12,134**	✔	✔
3. New Accident and Emergency attendances (18+)	19,004	19,532	20,063	21,176	21,304	**17,902**	✔	✔
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	15,829	14,762	10,668	7,839	4,781	**3,935**	✔	✔
5. Percentage of last six months of life spent in community setting	84.7%	85.6%	85.6%	87.8%	87.6%	**88.9%**	✔	✔
6. Percentage of the population at home – supported and unsupported (aged 65+)	96.2%	96.3%	96.4%	96.7%	96.8%	**96.8%**	—	✔

[4] Issue with data completeness for 2020
[5] Issues with this data are like to be related to changes in coding so meaningful comparisons with previous years are not valid
[6] Issue with data completeness for 2020

Our financial performance

Budget spend in 2020-21

As in previous years, East Lothian Integration Joint Board (IJB) received a financial allocation from its partners – East Lothian Council and NHS Lothian – for the functions delegated to it.

East Lothian IJB had a budget of just under £193m and ended the year with an underspend of £7.2m – this means that the charges from partners for services delivered on behalf of the IJB were less than the income available to the IJB. However, this underspend is largely made up of committed funds that have been carried forward into 2021-22 with the 'operational' underspend being c. £1.3m.

A significant element of the committed funds carried forward relates to COVID-19 funding. The IJB received funding of £10.7m to meet the net additional costs of the pandemic and spent £7.1m. COVID-19 related costs will span across financial years, therefore funding allocations which have not been fully used in 2020-21 have been carried forward to 2021-22.

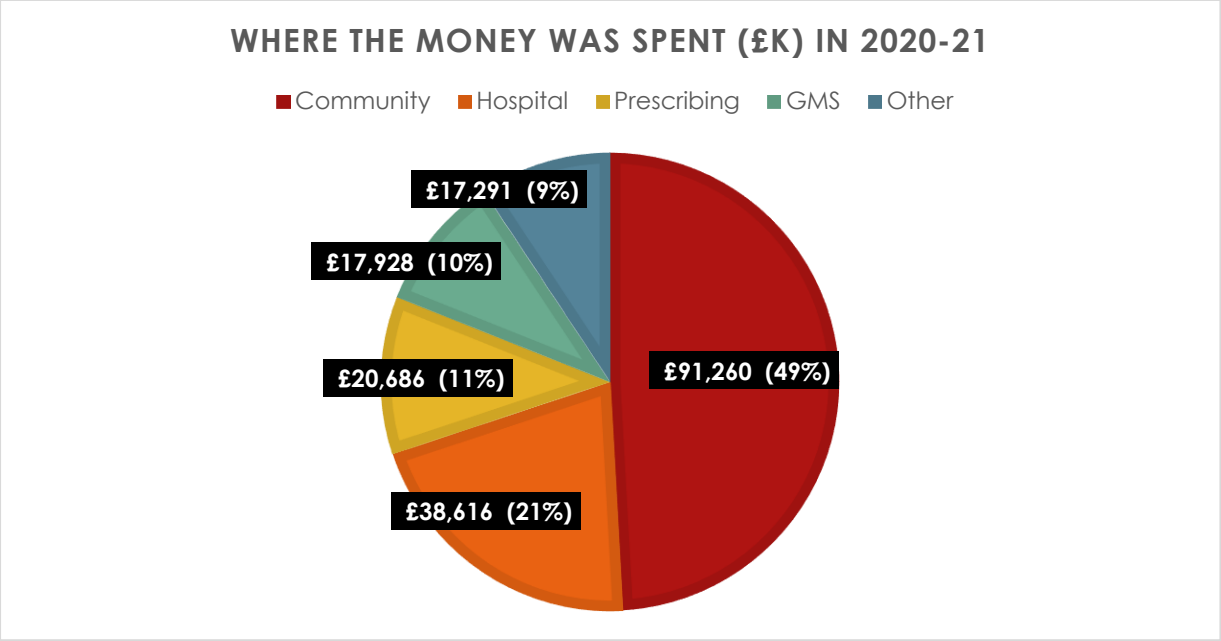
The operational underspend will be taken to the general reserve which was £3.1m at March 2021.

Further details of our total reserves balance are shown below.

	2020-21 Budget **£k**	**2020-21 Expenditure** **£k**	**Variance** **£k**
Health	£143,606	£136,829	£6,777
Social Care	£49,385	£48,952	£433
Total	£192,991	£185,781	£7,210

The financial position of the IJB at the end of 2020-21 is explained in more detail in the annual accounts.

The graph below shows our budget spend according to category of activity.



	Community £000	Hospital £000	Prescribing £000	GMS* £000	Other £000	Total £000
Expenditure	91,260	38,616	20,686	17,928	17,291	185,781
% of total	49%	21%	11%	10%	9%	100%

* GMS (General Medical Services) expenditure is the cost of running the GP service in East Lothian. Prescribing expenditure is the costs of prescriptions for the 15 East Lothian GP practices.

Breakdown of the budget and expenditure by service for 2020-21 is shown below:

	Budget £000	**Expenditure £000**	**Variance £000**
Direct East Lothian Services			
Community Allied Health Professionals	4,037	3,993	44
Community Hospitals	11,613	11,608	5
District Nursing	2,600	2,488	112
General Medical Services	17,746	17,928	(182)
Health Visiting	1,900	1,740	160
Mental Health	8,165	7,887	277
Other	21,568	13,546	8,022
Prescribing	20,599	20,686	(87)
Resource Transfer	4,733	4,738	(4)
Older People	26,466	28,126	(1,660)
Physical Disabilities	3,378	3,073	305
Learning Disabilities	16,103	16,325	(222)
Planning & Performance	2,871	2,543	328
East Lothian share of pan-Lothian Services			
Set Aside	21,921	21,957	(36)
Mental Health	2,411	2,492	(81)
Learning Disabilities	1,816	1,786	30
GP Out of Hours	1,392	1,517	(125)
Rehabilitation	875	773	103
Sexual Health	801	748	53
Psychology	908	990	(82)
Substance Misuse	411	407	4
Allied Health Professionals	1,500	1,391	109
Oral Health	2,098	2,060	38
Other	3,846	3,746	100
Dental	6,824	6,824	0
Ophthalmology	2,046	2,046	0
Pharmacy	4,363	4,363	0
Total	**192,991**	**185,781**	**7,210**

Reserves

As discussed above, the IJB's underspend is largely made up of committed funds that have been carried forward into 2021-22 with the 'operational' underspend being around £1.2m. This is laid out in detail in the analysis of reserves below. This operational underspend will take the general reserve to £3.1m at March 2021. The IJB's reserve strategy proposed a reserve of around 2% of the IJB's turnover which would equate to around £3.8m.

The IJB has set aside future amounts of reserves for future policy purposes; funds that are set aside for specific purposes; and funds which are not earmarked for specific purposes but are set aside to deal with unexpected events or emergencies (general).

In 2020-21 investment was given by the Scottish Government for COVID-19, programmes in Primary Care, Mental Health and Alcohol and Drug Partnerships. The reserve is broken down as follows into specific purposes and general reserves:

Earmarked Reserves	**£000**
COVID-19	3,623
Primary Care Improvement Fund	226
Action 15 – Scottish Government Mental Health Strategy	53
Alcohol and Drugs Scottish Government Allocation	766
Community Living Change Fund	346
Locally Committed Programmes	1,512
Committed Project Funds	**6,526**
General Reserves	**3,082**
Total Reserves	**9,608**

Financial pressures

Existing recurring financial pressures in some service areas continued in 20200-21. In other areas, financial pressures have been minimal due to reduced levels of activity.

During the course of the year the Scottish Government provided £10.7 m of funding to meet all additional costs and unachieved savings associated with the pandemic. This reflected the funding requested through the IJB's Local Mobilisation Plan submissions and further funding confirmed by the Scottish Government in February 2021 in respect of ongoing COVID related cost pressures. Expenditure of £7.1 m was incurred during the year, leaving a balance of £3.6m to be transferred to reserves to meet ongoing costs during 2021-22.

The main additional COVID related costs during 2020-21 included those related to:

- Sustainability payments to local social care providers to enable them to continue to deliver a sustainable service.
- Opening up an additional 44 hospital beds at East Lothian Community Hospital.
- Delivering a COVID Assessment Hun in Musselburgh.
- Delivering the East Lothian COVID Vaccination Programme.
- Supporting the health and social care staff bonus payments.
- Developing a long-COVID and post-COVID rehabilitation provision.
- Supporting Care Homes with challenges relating to outbreaks through Infection Prevention and Control training and advice.

Future financial pressures

As noted above COVID-19 allocations not fully used in 2020-21 were carried forward by IJBs to support remobilisation in 2021-22. The Remobilisation Plan submitted by NHS Lothian to the Scottish Government identified that Health and Social Care Partnerships are unlikely to be able to continue to redeploy resources to meet COVID pressures, suggesting that increased additional resources will be necessary. At the time of writing, the level of COVID related funding for 2021-22 has still to be confirmed but it is the expected that additional costs incurred will be fully funded.

Aside from the immediate cost impact of COVID-19, there are other, longer term, financial challenges likely to result from the pandemic. These include uncertainty regarding long-term prescribing issues, the impact of COVID on our independent sector providers and the implications for future service reconfiguration. These issues are common across Scotland and continue to be a regular feature of discussions between IJBs and the Scottish Government.

East Lothian HSCP will continue to face increasing demands on services brought by an ageing and growing population. The challenge of meeting the needs of a range of different communities, both urban and rural also places additional financial pressures on the Partnership.

Efficient and effective use of resources

As noted in last year's report, the duty of 'Best Value' applies to all public bodies in Scotland and underpins East Lothian IJB's strategic planning, procurement and service evaluation processes.

Audit Scotland is committed to ensuring that Best Value auditing across the public sector:

- Adds value to existing arrangements.
- Is risk-based and builds on our knowledge of individual public bodies.
- Reports on the delivery of outcomes for people who use services.
- Protects taxpayers' interests by examining the use of resources.
- Puts an increasing emphasis on self-assessment by public bodies with audit support and validation.
- Works collaboratively with NHS Quality Improvement Scotland to ensure our work is aligned and to prevent duplication.

East Lothian IJB works within NHS Lothian and East Lothian Council internal audit programme. All areas of work are audited, including planning, performance and engagement. The East Lothian IJB's Audit and Risk Committee and ELHSCP Clinical Governance Group also play key roles in ensuring Best Value.

In terms of procurement, commissioning and delivery of services:

- We have a clear procurement timetable to ensure services operate under clear contractual terms.
- Our contracts include performance measures and service specifications that service outcomes can be measured against.
- We have a Commissioning Board in place to oversee the commissioning and decommissioning of services.
- Our scorecard system ensures that services are reviewed annually, and evidence is provided of year-on-year service improvement.

Examples of the impact of Best Value on ELHSCP's commissioning and procurement include:

- Delivery of an in-house Financial Management Service to mitigate external provider risks.
- Implementation of a Carers Support Providers Framework (covering contracts with providers).
- Implementation of a Community Support Framework.

The HSCP Commissioning Team monitors and evaluates the delivery of outcomes with service users and ELHSCP staff. We also have specialist teams such as the Community Review Team and Care Home Assessment and Review Team who work closely with providers to monitor and evaluate outcomes.

Challenges and opportunities ahead in 2021-22

Remobilisation

Ongoing work to remobilise all HSCP services safely and appropriately will continue throughout 20210-22. Whilst providing the best possible services in the 'new normal' presents challenges, the Partnership has proven to be adept at developing new and innovative responses to service delivery. We will continue to fully engage with NHS Lothian Remobilisation planning and activity throughout the year.

Long-term impact of COVID

The longer term impact of COVID in terms of additional demand health and social care services has been widely discussed.

Particular attention has been given to the potential impact on the number of mental health related presentations, although estimates vary. The introduction of the CWIC Mental Health service during 2020-21 reflects our commitment to improve access to mental health support. Work to look at patient pathways in mental health services began in 2020-21 and will result in improvements to these pathways being introduced in the coming year.

The need for post-COVID rehabilitation has also emerged as a longer term impact of COVID, although, again, it is hard to predict the level of service demand this will generate. We have made good progress in developing a service response and will continue to develop our multidisciplinary approach to deliver effective post-COVID rehabilitation.

Adult Social Care

The February 2021 report on the Independent Review of Adult Social Care (IRASC) commonly called the Feeley Report, generated bold and far-reaching recommendations that are set to have a significant impact on the duties and powers of IJBs and the environment HSCPs work within over the coming years.

The principles set out in the Feeley Report, such as empowering people and embedding a human rights approach to social care, already guide our service development and delivery, and will continue to do so. However, the implications of the proposed development of a National Care Service and resulting changes to governance and accountability for delivery of health and social care at a local level and the timetable for change cannot be predicted with any certainty.

Although some aspects of the change ahead of us may not be introduced for several years, the development of the new IJB Strategic Plan and its priorities will be informed by the initial outcomes of the consultation on the National Care Service,

Service Providers

This Annual Report has described how we worked with external providers throughout the year to support their continued delivery of services across the county. The challenging operational environment during 2020-21 looks set to continue into the new financial year. This causes particular concern in terms of providers' resilience and their ability to operate in a pressurised context over a sustained period of time. The workforce challenges faced by the HSCP, in terms of staff recruitment and retention, are also a significant issue for providers.

Transformation Programme

We made significant progress during 2020-21 in developing our Community Transformation Programmes for adults under and over 65 with complex needs. Work will continue to further develop our proposed new service models over the coming year.

Engagement with communities, provider organisations and other stakeholders to date has helped to establish a strong foundation for continued collaboration on the development of innovative and flexible approaches to service delivery.

Vaccination Programme

We are proud of the role played by staff and volunteers in the delivery of the COVID vaccination programme during 2020-21, the largest and most ambitious vaccination programme in history. This built on the success of the HSCP's new role in delivering the 2020-21 winter Flu Vaccination Programme. However, the ongoing need for COVID vaccinations and boosters, along with increased responsibility for delivering the 2021-22 Flu Vaccination Programme, places a significant additional responsibility on the HSCP, with implications for already stretched resources.

Workforce

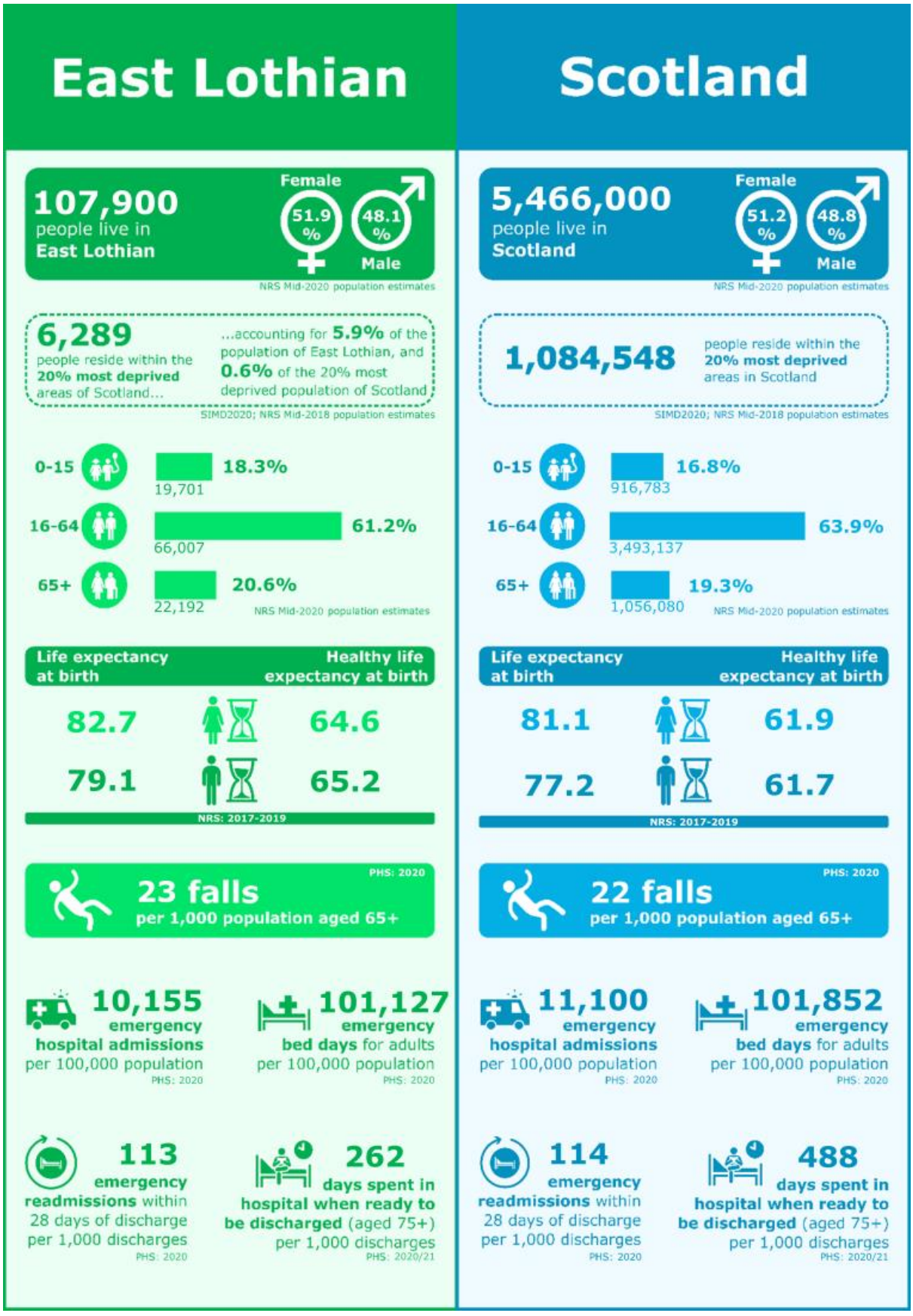
Our workforce demonstrated an extraordinary level of professionalism and commitment during the year to ensure services were delivered to those most in need. We will continue to support and invest in our workforce over the coming year. However, we share concerns expressed regarding the impact on health and social care staff of continuing to work under this level of pressure over a sustained period of time.

Recruitment and retention of staff will continue to present a challenge. The ongoing shortage of health and social care staff at a national level is well documented. This is reflected in our local experience of difficulties in recruiting and retaining staff to deliver key services.

Primary Care

Work will continue on delivering the commitments within the Memorandum of Understanding for Primary Care Improvement, as agreed between Scottish Government, British Medical Association, Integration Authorities (IJBs) and NHS Boards. This will further develop services in East Lothian to support the transfer of activity from GP practices to the HSCP as part of the continuing delivery of the next stage of the GP contract. In support of this, we will, within the limitations of available capital funding, progress GP premises developments as set out in the East Lothian Primary Care Premises Strategy.

Appendix 1 – East Lothian by numbers



Appendix 2 – Confidence Intervals

Alongside the results for the Health and Care Experience Survey from the Core Suite of Integration Indicators, 95% confidence intervals have been produced to allow further interpretation of the East Lothian results when compared to Scotland.

95% confidence intervals indicates the 95% probability that the survey result lies within the range between the upper and lower confidence limits. If these ranges do not overlap (e.g. the upper confidence limit for East Lothian is lower than the lower confidence limit for Scotland) we have labelled the results as 'statistically significant'.

Confidence intervals tend to be smaller for results where the sample size was larger e.g. Scotland, and larger for smaller sample sizes, such as in East Lothian.

National Integration Indicators based on Health and Social Care Experience Survey (2019/20)

Indicator	Area	Result	Lower Confidence Limit	Upper Confidence Limit
Percentage of adults able to look after their health very well or quite well	East Lothian	94	93	95
	Scotland	93	93	93
Percentage of adults supported at home who agree that they are supported to live as independently as possible	East Lothian	72	61	82
	Scotland	81	80	82
Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	East Lothian	75	65	86
	Scotland	75	74	77
Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	East Lothian	61	50	72
	Scotland	74	72	75
Percentage of adults receiving any care or support who rate it as excellent or good	East Lothian	76	66	86
	Scotland	80	79	81
Percentage of people with positive experience of care at the ir GP practice	East Lothian	72	70	74
	Scotland	79	78	79
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintain	East Lothian	70	59	81
	Scotland	80	79	81
Percentage of carers who feel supported to continue in their caring role	East Lothian	33	28	38
	Scotland	34	34	35
Percentage of adults supported at home who agree they felt safe	East Lothian	70	59	81
	Scotland	83	82	84