ANNUAL REPORT 2017-2018

East Lothian Integration Joint Board

East Lothian
Health & Social Care Partnership

Contents

Foreword

We are pleased to introduce the second annual report of the East Lothian Integration Joint Board (IJB). This report covers the financial year 1 April 2017 to 31 March 2018.

Through 2017-18 the IJB continued to oversee the planning and delivery of integrated adult primary and community health and social care services for East Lothian residents along with some acute hospital services, in line with the vision in our strategic plan.

Considerable progress was made with the East Lothian Community Hospital being built on the grounds of the current Roodlands Hospital. The first phase, the outpatient department, opened towards the end of the financial year. The new building is already providing East Lothian residents with an increased range of locally-delivered services.

Through the year we have explored different service delivery options to improve care and associated patient and client outcomes in health and social care settings. This has allowed us to review and better match client need to service provision.

The review and remodelling of all adult home care services for all adult client groups encouraged new service providers to take on contracts delivering the new framework.

Planning work was completed for consultation and engagement events on reprovision of the Belhaven and Edington community hospitals and of Eskgreen and Abbey Care Homes. In the coming year the feedback on the consultation will be taken into account in planning for changes to services currently delivered at these sights.

Towards the end of the year we started work on a Primary Care Improvement Plan to support introduction of the new Scottish General Medical Services (GMS) contract for GPs. From 2018 this will develop the multidisciplinary primary care team. In support of this we established the CWIC (Collaborative Working for Immediate Care) team, a new and innovative primary care service which, along with our established Care Home Team, will reduce some workload pressure on practices.

Peter Murray, Chair, East Lothian Integration Joint Board

David Small, Chief Officer, East Lothian Joint Board

East Lothian Integration Joint Board

This second annual report describes the work and achievements in 2017-18 of East Lothian Integration Joint Board, which was formally established in July 2015 to cover the East Lothian geographical area. The arrangements for the operation, remit, scope and governance of the IJB to meet its aim of improving the integration of health and social care services are set out in the East Lothian Council and NHS Lothian Integration Scheme[1].

The establishment of IJBs placed a requirement on Health Boards and Local Authorities to integrate adult health and social care budgets, to shift the balance of care from institutional to community based settings and to include clinicians and care professionals from the statutory services, along with those in the third and independent sectors, in the planning and delivery of services.

The IJB has a range of health and social care functions delegated to it and decides how best to deliver these functions (listed below) in line with local, regional and national strategy, policy and performance requirements.

Delegated IJB functions:

- Adult social care
- Primary care services (GP practices, community dentists, community pharmacists and community optometrists)
- Mental health services
- Physical disability and learning disability services
- Community health services
- Community hospital services
- Unscheduled care services (primarily operating out of the Royal Infirmary of Edinburgh and the Western General Hospital).

Directions

The Public Bodies (Joint Working)(Scotland) Act 2014 sets out the process by which an Integration Joint Board delivers its Strategic Plan by issuing 'Directions' to the Local Authority and the Health Board as appropriate. The IJB's policy states that Directions will be issued for each delegated function and for the allocation of the associated financial resource to support delivery of directions. Those Directions operating through 2017-18 are summarised in Appendix 1, with certain Directions continuing through from the previous year and some being 'retired' at year end.

[1] https://www.eastlothian.gov.uk/downloads/file/24356/ijb_integration_scheme_2015

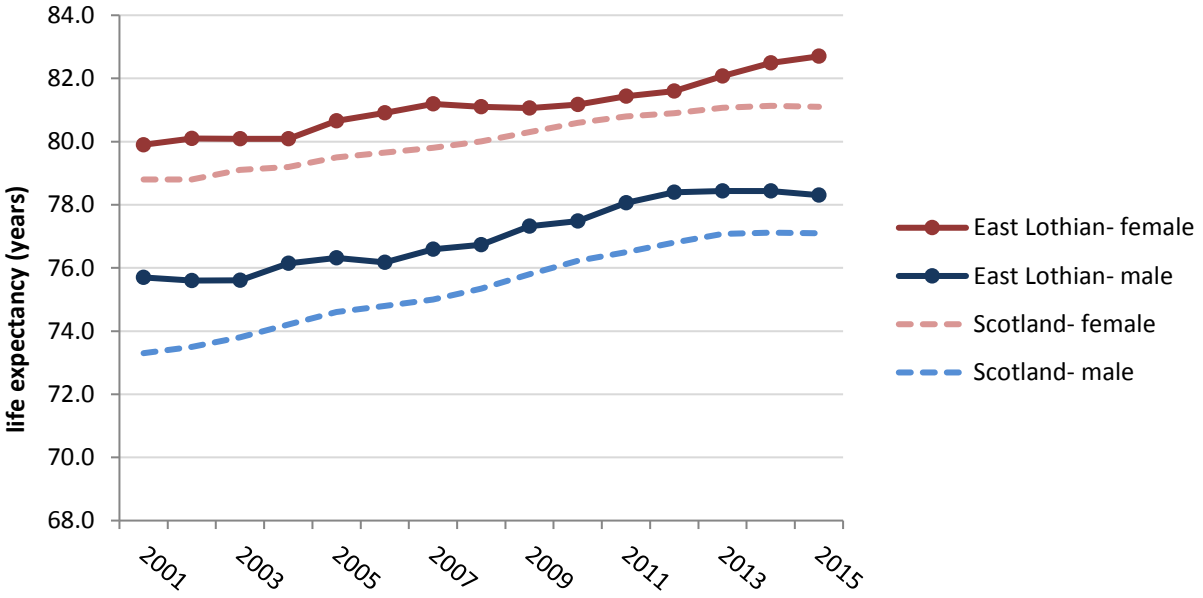
East Lothian Health and Social Care Partnership

East Lothian Council and NHS Lothian set up the East Lothian Health and Social Care Partnership (HSCP) as an integrated joint operational unit managed by the Council and the Health Board to locally plan and deliver services. The Partnership's team manages community health, primary care and adult social care services in East Lothian along with East Lothian children's services.

The HSCP covers a population of 104,070 (estimate for 2017). East Lothian is in a period of population growth with an expected increase of 23.3% from 2012 to 2037. The largest growth over this time will be in the over 65s (at 72.2%). Population growth (of 27.5%) will also be experienced in the 0-15 age group. East Lothian has many demands from the ageing and growing population and in providing services in the populous and more deprived areas in the west of the county and in many rural settings.

Life expectancy varies for males and females (chart 1) and across the county (chart 2) between more and less deprived areas. Female life expectancy in East Lothian has gradually increased between the years 2001 and 2015. Male life expectancy has plateaued since approximately 2012. Life expectancy for males and females in East Lothian has been consistently higher than the national figures.

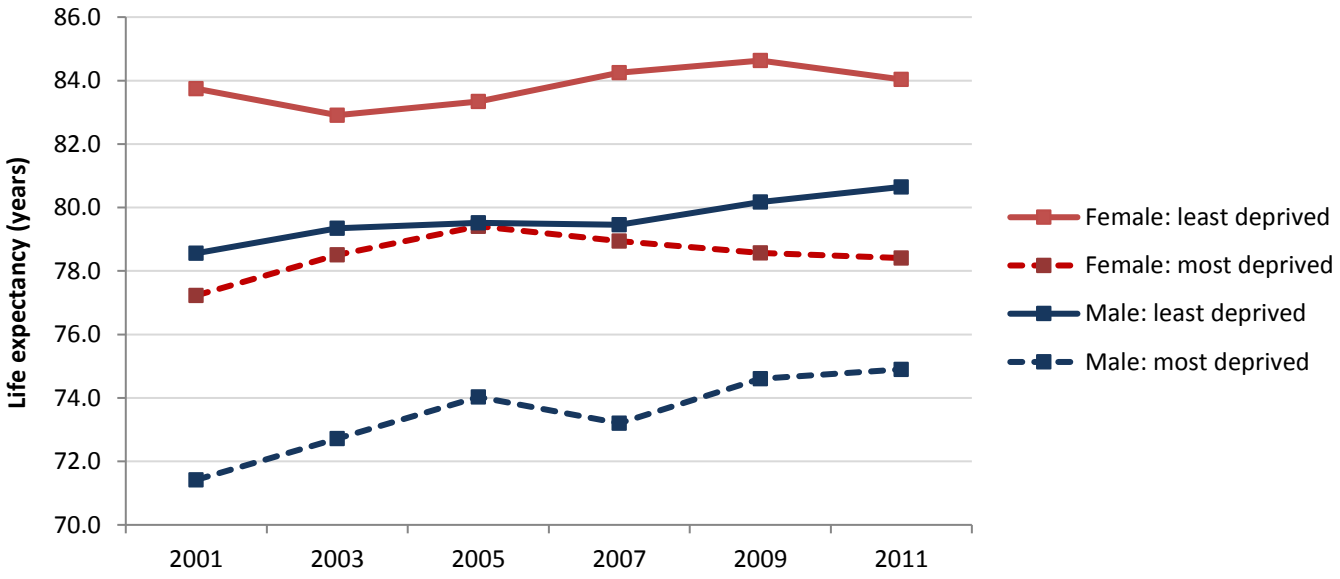
Chart 1 - Male and Female life expectancy in East Lothian and Scotland



Data source: National Records Scotland

A gap continues in life expectancy between the most and least deprived areas of East Lothian for males and females (chart 2).

Chart 2 - Male and Female life expectancy in East Lothian in the most and least deprived areas.



Data source: ScotPHO

In its second year of operation the Partnership has maintained service delivery across integrated adult health and social care services for East Lothian's residents.

Responsibility for governance of the Partnership sits with the Integration Joint Board (IJB), which is guided by the 2016-2019 Strategic Plan[2] and its vision to deliver:

> *'Best Health, Best Care, Best Value for our communities'* while enabling all adults to *'Live the lives they want as well as possible, achieving their potential to live independently and exercising choice over the services they use'.*

The Strategic Plan will be reviewed in 2018-19 with partners, service users and stakeholders, with a view to producing a new plan to deliver actions to meet statutory and other priorities and to address the continuing health inequalities across the county which maintain variations in health experience and outcomes across the county, associated with areas of deprivation.

[2] https://www.eastlothian.gov.uk/downloads/file/27195/ijb_strategic_plan

Public health and health improvement

While many of the wider determinants of health and wellbeing sit beyond the services delivered by the Health and Social Care Partnership the actions of the Partnership have both direct and indirect effects on population health.

NHS Lothian supports the East Lothian HSCP in identifying and addressing population health needs in a number of ways, with input from public health professionals including: a Public Health Consultant and Public Health Policy Officer, a Public Health Practitioner and Health Promotion Specialists. These colleagues link into the HSCP through various routes including representation on operational and strategic groups and also in Community Planning and similar partnerships

The public health team aims to bring health improvement and health intelligence expertise to support partners in taking an evidence-informed, person-centred approach which considers the impact of policy and interventions on health and health inequalities.

The East Lothian Health Improvement Alliance (ELHIA) is where health improvement and health inequalities work is often co-ordinated, although this is not exclusively carried out by this group. ELHIA seeks to bring together organisations from the public, community and third sectors with an interest in improving health and reducing inequalities under the chairmanship of a Health Promotion lead.

Public health practitioners actively lead or contribute, on an ongoing basis, to a number of work-streams in East Lothian. These are set out elsewhere in this report.

Locality planning

Positive planning relationships continued with the six local area partnerships across a range of work areas.

For the purposes of primary care quality improvement initiatives and to secure input to primary care planning the county continued to be organised into two localities (reflecting natural communities and service operating boundaries) in the East and West. This arrangement enabled groups of GP practices and their teams to develop local quality improvement projects, to contribute to service development consultations and to participate in planning for improvements in primary care.

Key challenges for East Lothian Integration Joint Board

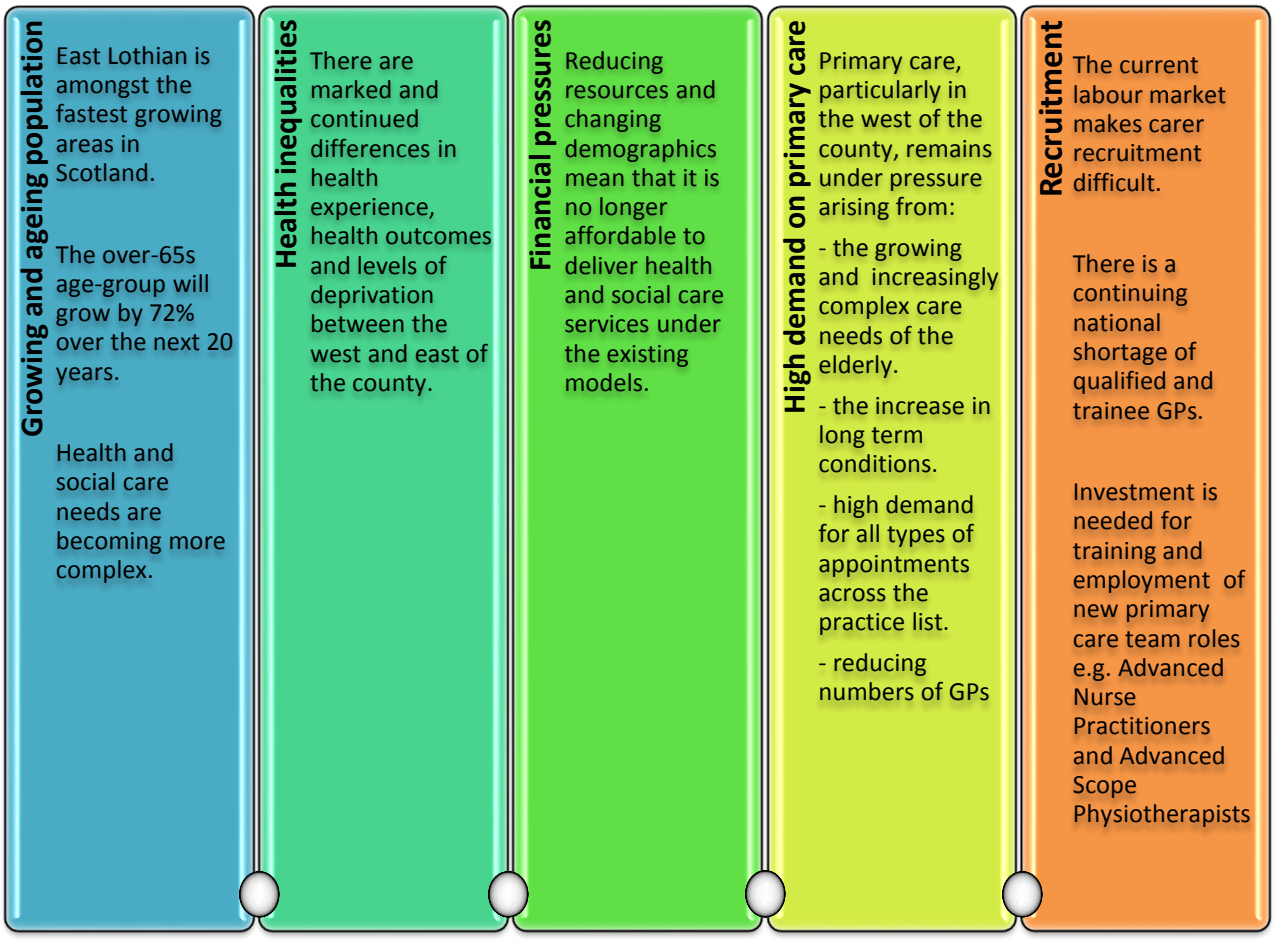
The pressures facing the IJB in 2016-17 continued to apply through 2017-18. We made progress in reducing delayed discharges during the year, with the input of all the HSCP services providing support to people leaving hospital.

Health inequalities continue to present real challenges, driven as they are by the ongoing experience of deprivation in some communities.

Financial pressures remained an issue for the IJB, requiring action to deliver service and financial efficiencies. The outcome at year-end is described in more detail in the finance section.

Actions arising from the new GP contract agreed in 2017 and to be introduced at HSCP and NHS Lothian level over 2018 to 2021 are designed to address the demands on primary care, particularly on GPs and to improve GP recruitment.

The HSCP has succeeded in filling key posts during the year. Recruitment to support new multidisciplinary team posts to deliver the new GP contract will be challenging.



Performance monitoring

This second annual report again looks at areas of activity and performance related to the nine National Health and Wellbeing Outcomes:

- Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer.
- Outcome 2 - People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Outcome 5 - Health and social care services contribute to reducing health inequalities.
- Outcome 6 - People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
- Outcome 7 - People using health and social care services are safe from harm.
- Outcome 8 - People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Outcome 9 - Resources are used effectively and efficiently in the provision of health and social care services.

The processing of data relating to IJB performance was carried out by the Local Intelligence Support Team (LIST) colleagues attached to East Lothian HSCP. The LIST team also supported monitoring and reporting of progress in service delivery across East Lothian.

Measuring performance under integration

Monitoring of six new integration measures, developed by the Ministerial Strategic Group for Health and Community Care (MSG) started in 2017-18. These measures concerned:

(1) Unplanned admissions;
(2) Occupied bed days for unscheduled care;
(3) A&E performance;
(4) Delayed discharges;
(5) End of life care; and
(6) The balance of spend across institutional and community services.

When the MSG measures were introduced, each of the four IJBs in Lothian agreed on their local, but broadly equivalent, targets. East Lothian's 2017-18 targets and performance at year end are shown below in table 1.

Table 1 - Attainment (April 2017 to March 2018) against the 2017-18 MSG Indicators - Ages 18+ [3]

1 Unplanned admissions	2 Unplanned bed days	3 A&E performance	4a & 4b Delayed discharges	5 End of life care	6 Balance of care
Target - 5% reduction **Attainment - 7.7% increase** in overall total compared to the same period in 2016-17. **Not met - missed by a large margin, as 2017-18 was an increase compared to the previous year**	**Target - +** 10% reduction **Attainment - 1.8% reduction** in unplanned bed days (acute specialties) compared to the same period in 2016-17. 2.8% reduction in mental health specialties compared to the same period in 2016-17. 79.3% reduction in GLS bed days compared to the same period in 2016-17. **Not met - missed by a medium margin as performance reduced in 2017-18 compared to the previous year**	**Target -** Maintain 95% **Attainment - 2.7% increase** in overall total attendances compared to the same period in 2016-17. Average A&E compliance 82.7% seen within 4 hours compared to 91.1% for the same period in 2016-17. **Not met - missed by a large margin after A&E across Lothian was affected by a 'coding issue' discovered in November 2017**	**Target -** 50% reduction in delayed discharge bed days (4a) and 50% reduction in delayed discharges (4b). **Attainment - 27.7% reduction** in all reason delayed bed days, compared to the same period in 2016-17. **34% reduction** in delayed discharges. 31.1% reduction in HSC+P/C/F reasons compared to the same period in 2016-17. 46.4% increase in Code 9 reasons[4] compared to the same period 2016-17. **Not met - missed by a small margin. Although a large reduction in bed**	**Target -** No more than 10.5% of last 6 months of life spent in large hospital. **Attainment - 11.5% of care** in the last 6 months of life was in a large hospital. Community: 85.9% Palliative: 0.9% Community Hospital: 1.8% Large Hospital: 11.5%. **Not met - missed by a small margin**	**Target -** 98% of over 75s to be supported in non-acute settings. **Attainment -** Acute Setting: 1.5% Community Hospital: 0.3% Hospice: 0.0% Care Home: 5.2% Home: 9.7% (supported) Home: 83.3% (unsupported) In 2016-17 total being supported out of acute settings was 98.5%. **No 2017-18 data available yet. The date of publication has not been given.** **Looking back, this measure was met in 2016-17**

[3] Measures introduced for 2017-18 and reflected in that year's Directions.
[4] Code 9 indicates where timely discharge is outwith the control of the NHS or the local authority.

			days was achieved, it was below target		

MSG indicators for 2018-19

The agreed targets for the MSG indicators in 2018-19 are shown below in table 2.

Table 2 - 2018-19 Targets for the MSG Indicators in East Lothian

1 **Unplanned admissions** [1]	2 **Unplanned bed days** [2]	3 **A&E performance** [3]	4a & 4b **Delayed discharges** [4]	5 **End of life care** [5]	6 **Balance of care** [6]
Target - Reduce unplanned admissions by a further 5% in 2018-19.	**Target -** Reduce by 10% in 2018-19 occupied bed days across all areas of unscheduled care.	**Target -** Reach 4 hour compliance of 95% in Accident and Emergency in 2018-19.	**Target -** 4a. Continue progress towards delivering a 50% reduction in delayed discharge bed days in 2018-19 compared to 2017-18. 4b. Continue work to deliver a 50% reduction in the number of all cause delayed discharges by end of 2018-19 compared to end of 2016-17. *(including those delayed due to Adults With Incapacity)*	**Target -** Achieve and maintain performance of no more than 10% of last 6 months of life spent in a large hospital by end 2018-19.	**Target -** Maintain performance of 98% of over 75s being supported in non-acute settings through 2018-19.
1 - All hospital admissions which are not pre-planned	*2 - The number of days in hospital which result from unplanned admissions*	*3 - % of people being seen within 4 hours in A&E*	*4 - Number of patients delayed in their discharge from hospital*	*5 - Proportion of last 6 months of life spent at home or in a community setting*	*6 - Spend across institutional and community care services*

As in the year being reported on, during 2018-19 progress against the MSG indicators will be reported to the Integration Joint Board at regular intervals.

In 2018-19 all necessary work to deliver against the targets above and other national and local targets will be overseen by 'Change Boards' which are being established as part of a

new strategic planning structure. In addition, performance in 2017-18, in the preceding year and in the first half of 2018-19 and the necessary steps to improve this performance will considered in the review of the 2016-19 Strategic Plan and in the development of the follow-on Strategic Plan which will apply over 2019-22. Also, NHS Lothian, East Lothian Council and East Lothian HSCP will be issued with appropriate Directions by the IJB with the intention of improving partner performance across all measures.

National Health and Wellbeing Outcomes and other measures

The Integration Joint Board received regular performance reports through the year. These were based around the 19 of 23 national indicators (NIs - table 3) for which data was available, Ministerial Steering Group Integration Measures and other measures. It remains the case that 4 of the national indicators (NI-10, NI-21, NI-22 and NI-23) are not yet developed, with their introduction date uncertain).

Table 3 – National Indicators – performance in 2015-16 and in 2016-17

	Indicator	Title	2015/16	2017/18
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	95%	94%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	86%	72%
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	83%	68%
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	82%	66%
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	84%	75%
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	85%	80%
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	92%	75%
	NI - 8	Total combined % carers who feel supported to continue in their caring role	48%	36%
	NI - 9	Percentage of adults supported at home who agreed they felt safe	88%	81%
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA
	Indicator	Title	2016/17	2017/18
Data indicators	NI - 11	Premature mortality rate per 100,000 persons	375	-
	NI - 12	Emergency admission rate (per 100,000 population)	9,581	9,767
	NI - 13	Emergency bed day rate (per 100,000 population)	120,179	108,922
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	100	97
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	86%	87%
	NI - 16	Falls rate per 1,000 population aged 65+	19	18
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	77%	85%
	NI - 18	Percentage of adults with intensive care needs receiving care at home	65%	-
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	1,164	793
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	24%	22%
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA

Data analysis and reporting throughout the year was supported by joint work between the Local Intelligence Support Team (LIST) HSCP officers and Lothian Analytical Services (LAS). This cooperation underpinned performance monitoring across a range of measures and was utilised in the development of the IJB's Directions and the service and policy development, such as the Primary Care Improvement Plan. The data will prove invaluable in the development of the new IJB Strategic Plan in 2018.

Although progress has been made across a number of areas as described below, issues continued regarding access to and satisfaction with primary care services.

The charts in appendix 2 present data on East Lothian HSCP's performance trajectory over the period 2013-14 to 2017-18 for indicators NI-1 to NI-9 and from 2010-11 for NI-11 to NI-20.

Indicators N-1 to N-9 come from the 2017-18 *Health and Care Experience Survey* (which replaced the GP and Local NHS Services Patient Experience Survey) published by the Scottish Government in May 2018. These nine indicators show a falling back in performance for East Lothian across all measures, some more pronounced than others. Recent years have been difficult for primary care due to increasing demand and problems in recruiting and retaining GPs. Local and national action planned to introduce the new GP contract over the next three years should have a beneficial impact on these measures in due course. It should be noted that although the overall response rate has increased since the last survey (from 21% to 29%) the 2017-18 data is based on a sample of 2,522 responses from 8,817 surveys sent out in East Lothian.

Indicators N-11 to N-20 are from the ISD Health and Social Care Team's *'Core Suite of Indicators for Integration'* dataset. Performance for all of these indicators (with the exception of NI-18 for which data is not yet available) has improved (based on currently provisional data) with performance for individual indicators as listed below.

For the N-11 to N-20 indicators East Lothian is:

- **NI-11** - in the first 33% for performance, better than the Scottish average and on an upward trajectory since 2015.
- **NI-12** - in the first 20% of performance, better than the Scottish average and on a fairly flat trajectory.
- **NI-13** - in the first 40% for performance, slightly better than the Scottish average and on an improving trajectory since 2016-17.
- **NI-14** - in the last 45% for performance, on the Scottish average and on an improving trajectory since 2016-17.
- **NI-15** - in the last 10% for performance (across a narrow margin) just below the Scottish average and on an improving trajectory starting in 2015-16.
- **NI-16** - near the first 20% for performance, performing better than the Scottish average and on an improving trajectory since 2015-16.
- **NI-17** - in the first 40% for performance, on the Scottish average and on an improving trajectory since 2016-17.
- **NI-19** - in the lowest 40% for performance, slightly above the Scottish average and on an improving trajectory since 2014-15.
- **NI-20 –** in the first 50% for performance, better than the Scottish average and on an improving trajectory since 2016-17.

Performance for the national health and wellbeing outcomes for East Lothian HSCP in 2016-17 and 2017-18 and compared to Scotland for both years is shown in the two diagrams which follow.

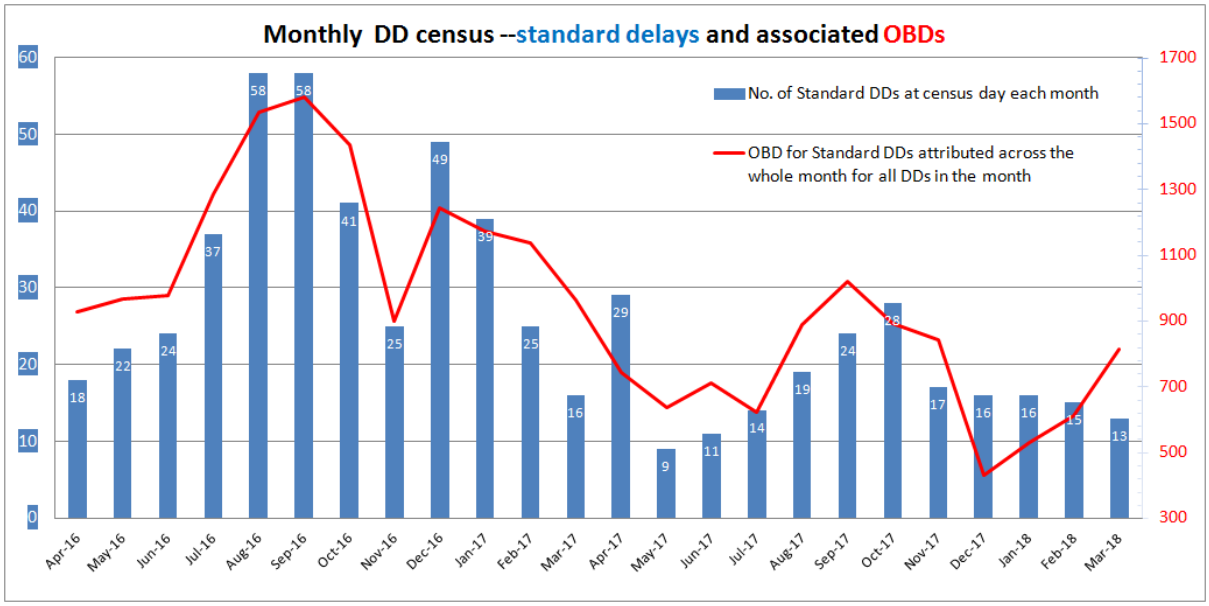
2016-17	2017-18
Premature mortality rate is 320 per 100,000 persons (Scotland 441)	Premature mortality rate is 372 per 100,000 persons (Scotland 425)
Emergency admission rate is 9,398 per 100,000 population (Scotland 12,037)	Emergency admission rate is 9,767 per 100,000 population (Scotland 11,959)
Emergency bed day rate is 114,152 per 100,000 population (Scotland 119,649)	Emergency bed day rate is 108,922 per 100,000 population (Scotland 115,518)
Readmission rate to hospital within 28 days is 95 per 1000 population (Scotland 95)	Readmission rate to hospital within 28 days is 97 per 1000 population (Scotland 97)
85% of the last 6 months of life is spent at home or in a community setting (Scotland 87%)	87% of the last 6 months of life is spent at home or in a community setting (Scotland 88%)
Falls rate is 19 per 1000 population over 65 years (Scotland 21)	Falls rate is 18 per 1000 population over 65 years (Scotland 22)
77% of care services have been graded "good" (4) or better in Care Inspectorate inspections (Scotland 83%)	85% of care services have been graded "good" (4) or better in Care Inspectorate inspections (Scotland 85%)
66% of adults with intensive care needs are receiving care at home (Scotland 62%)	X% of adults with intensive care needs are receiving care at home (Data not available)
The number of days people spend in hospital when they are ready to be discharged is 1,164 per 1000 population (Scotland 842)	The number of days people spend in hospital when they are ready to be discharged is 793 per 1000 population (Scotland 772)
23% of health and care resource is spent on hospital stays where patient was admitted as an emergency (Scotland 23%)	22% of health and care resource is spent on hospital stays where patient was admitted as an emergency (Scotland 23%)

Delayed discharge performance

East Lothian's performance for hospital delayed discharges improved from a peak of 58 in September 2016 to 13 at March 2018, with the usual seasonal fluctuations. Chart 3 below shows the number of inpatients recorded as a delayed discharge (DDs) at the monthly census point (blue column) and the cumulative number of occupied bed days (OBDs - red line). This improvement may be attributed to several actions:

- The East Lothian Community Hospital based Hospital at Home (H@H) service, responding to referrals from GPs, assessed and supported patients at home, thus avoiding unnecessary hospital admissions.
- The Hospital to Home service (H2H) supported patients in leaving hospital by providing appropriate care and rehabilitation at home. On conclusion of Hospital to Home support, a care provider delivers required ongoing care.
- Care packages are retained for up to 7 days for a patient in hospital. This gives patients, carers, family and professionals a discharge goal and provides the client with continuity of care.
- Weekly collaborative meetings across health, social work, care brokers and care providers greatly improved understanding of individual patient needs and established joint working and shared solution focussed approaches. This enabled patients to return home quicker than was possible in a less integrated system.
- Daily health teleconferences managed bed capacity, expected discharges, admissions and H@H and H2H workloads and capacity and with all acute and community sites also reviewed capacity and discharge options.
- Work continues in reviewing care at home hours. These have reduced from 1,500 hrs in March 2017 to 1,000 hrs in March 2018

Chart 3 – Delayed Discharges and Occupied Bed Days



Data source NHS Lothian Trak

Strategic objectives

The East Lothian HSCP strategic objectives were developed in consultation and commit to adopt a range of approaches to tailor service delivery to the needs of individuals and communities while developing efficient and future-proofed service arrangements:

A. Make universal services more accessible and proportionate to need and to develop our communities - We want to improve access to our services, but equally to help people and communities to help and support themselves too.

B. Improve prevention and early intervention - We want to shift and focus services towards the prevention of ill health, to anticipate at an early stage the need for support and to react where possible to prevent crises.

C. Reduce unscheduled care - We want to reduce unnecessary demand for services including hospital care.

D. Provide care closer to home - We want to deliver safe and effective care as close to home as possible, allowing people to remain in their homes and communities for as long as they can.

E. Deliver services within an integrated care model - We recognise the need to make people's journey through all our services smoother and more efficient.

F. Enable people to have more choice and control - We recognise the importance of person-centred and outcomes focused care planning.

G. Further optimise efficiency and effectiveness - We want to improve the quality of our services whilst recognising and addressing the challenging financial constraints we face.

H. Reduce health inequalities - We want to reduce inequalities, break the cycle and impact of deprivation and support and protect the vulnerable in our communities.

I. Build and support partnership working - We recognise the importance of developing effective and wide ranging strategic partnerships in delivering our ambition, vision and values.

National Health and Wellbeing Outcome 1

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

94% of adults are able to look after their health very well or quite well

(Scotland 93%)

75% of adults receiving any care or support rated it as excellent or good

(Scotland 80%)

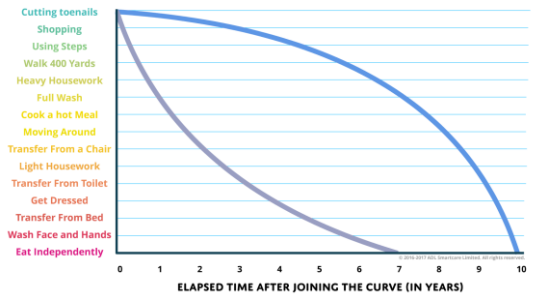
80% of people had a positive experience of the care provided by their GP practice

(Scotland 83%)

Healthy ageing

East Lothian Community Rehabilitation Services used the AILP LifeCurve[5] to promote independence and self management in patients they support, promoting activity and independence, to prevent loss of function and to increase well-being and engagement in local community activities.

All projects being developed in the Access and Rehabilitation Service are underpinned by the AILP model. The introduction of Help from Hilda[6] (which provides clients with access to equipment) also uses the AILP LifeCurve to underpin service provision. To



Remember: Life Curves can go up as well as down!

[5] http://www.knowledge.scot.nhs.uk/ahpcommunity/lifecurve-survey-2017.aspx
[6] https://helpfromhilda.eastlothian.gov.uk

date 138 LifeCurve Assessments have been started. This supports people in exploring how to live better for longer and to improve their healthy ageing journey.

Future work

There are plans to develop an Early Intervention Clinic to deliver telecare and telehealth innovation in dementia. This will provide carers, families and members of the public with specialist advice and support. The opportunity will also be explored to deliver specialist multi-disciplinary clinics locally, including 'virtual' consultations using Skype and other communication platforms, reducing the need for people to travel to hospitals or other health facilities.

Physical activity

Public Health colleagues were active participants in driving the physical activity strategic group and physical activity implementation group.

Future work

A project is planned to work alongside East Lothian Council, Queen Margaret University and other partners to start the development of the new physical activity plan for 2019 onwards

Supporting people at home and to return home from Hospital

ELSIE (East Lothian Service for Integrated care of Elderly people) is a multi-disciplinary and multi-agency team which assesses and delivers against the support needs of patients and carers to avoid unnecessary admissions. It has four elements: Hospital at Home; Hospital to Home; a Care Home Team and a Response and Rehabilitation team. Over the year, the component parts of ELSIE delivered the following interventions:

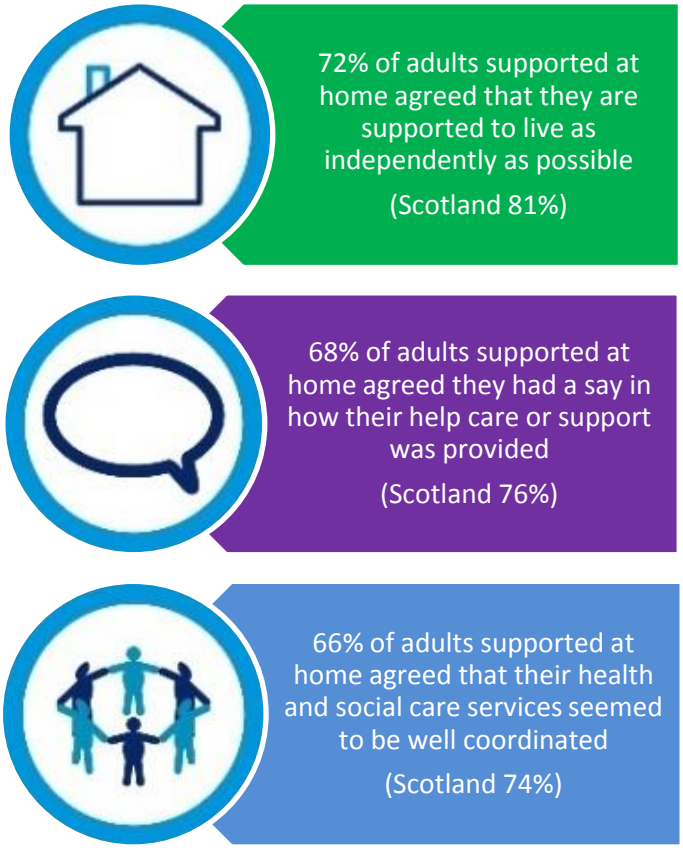
- Hospital at Home - 423 interventions
- Hospital to Home - 228 interventions
- Care Home Team - circa 500 interventions
- Duty Response and Rehabilitation Team - 150 discharge referrals monthly.

Over 2017-18 East Lothian patients had 3,123 episodes, totalling 20,720 occupied bed days in the Western General Hospital. Of these, 225 episodes were recorded as delayed discharges, resulting in 2,052 occupied bed days

In the Royal Infirmary of Edinburgh, there were 9,500 episodes for East Lothian patients, totalling 47,000 occupied bed days, with 680 delayed discharges resulting in 3,200 occupied bed days.

National Health and Wellbeing Outcome 2

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



Care homes

Our social worker and community care worker team continued to provide timely high quality, person-centred and compassionate care home placements to individuals requiring such intensive support. As well as winning an East Lothian Council Star Award, during the year the team:

- Maintained the quality of service provided in care homes through routine reviews and by responding to adult protection concerns, incidents and complaints.
- Monitored service provider compliance with National Care Home Contract and National Care Standards, taking action as necessary.

- Ensured minimal disruption to residents following the closure of Levenhall private care home.
- Provided individual care homes with 'linked' Social Workers to enhance communication and partnership working with providers.
- Supported service planning to support a new 60 bed care home in Haddington and the extension of Muirfield to increase its bed capacity from 28 to 60 beds.
- Contributed to planning for a reduction in the bed numbers in Belhaven hospital and alternative provision.

Telecare and Technology Enabled Care (TEC)

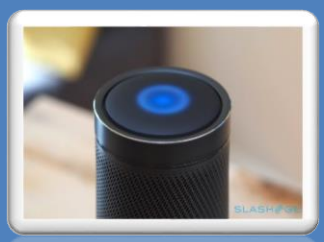
East Lothian Health and Social Care Partnership is committed to promoting technology enabled person-centred care as a way of enabling people to live more independently for longer in their own homes or in a homely setting.

Telelecare equipment includes items such as sensors and alarm systems that are programmed into the Community Alarm Service to make an automatic call alert if the sensor detects a problem in the service-user's home. Technology Enabled Care equipment includes sensors that can detect smoke, floods and gas and alarms that can remind service users when to take their pills and to call for help. The HSCP Adult Social Care services work closely with colleagues in the Contact Centre, who provide the alarm monitoring service and the Emergency Responder Service, which deals with alarm calls.

The HSCP also works closely with East Lothian Council's housing team to improve the quality of service and reduce duplication of support, particularly in amenity housing so that we use council resources more effectively.

Other work in the year included:

- The HOWZ project, which aims to enable earlier discharge from hospital and rehabilitation at home with help from colleagues in the Discharge 2 Assess team
- Supporting service redesign to ensure TEC is embedded at all key points in the integrated care pathway.



'I have had quite an exceptional life and I don't believe in letting anything get in my way.'

Paul has MS which now severely limits his mobility. He has remodelled his home (with help from the Environmental Control Team, Telecare Team, Social Work, carers and family) so he can live independently on his own) with some care at home support to help him. He sources his TEC on eBay, from mainstream and specialist providers. He makes full use of SDS personal budgeting to support his way of life.

We also revised charges for the Community Alarm Services so that all service-users pay towards the service in an equitable and fair way.

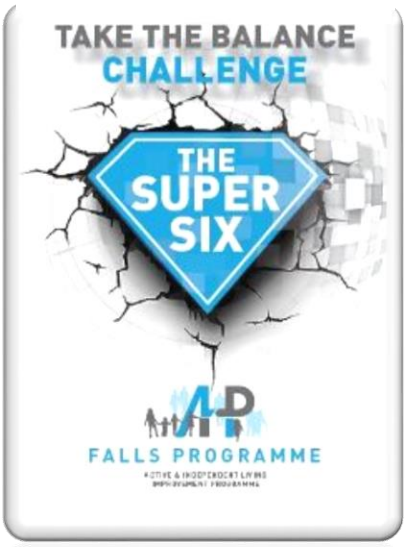
Physio on the Go

This physiotherapy-led community-based, proactive falls prevention initiative is currently being reviewed and improved. The initiative provides falls prevention awareness sessions in sheltered housing complexes, lunch clubs and day centres as well as providing walking aid checks and repairs in care homes. The Steady-On Falls Prevention Service was recently introduced in the Prestonpans/ Musselburgh area, extending the reach of the service beyond East Lothian Community Hospital.

The D2A team have extended the in-reach component of the service to include Medicine of the Elderly and stroke. As a result, we have seen increased referrals and have facilitated the timely discharge of patients from these clinical areas.

START (short-term assessment and rehab team) is an Allied Health Professional (AHP) led service which supports, promotes and enables active independent living through rehabilitation. The team works to facilitate early discharge, to prevent unnecessary hospital admission and to promote independence and self management.

We have also been actively promoting the Super Six – Take the Balance Challenge



Community-provided support

Shared Lives East Lothian recruits and supports Shared Lives carers who, working on a self-employed basis, open up their home and family life to welcome an adult with support needs. This enables the client to be part of family, household and community life. The service accepts referrals for people aged between 16 and 65 who have support needs that may be associated with a learning disability, physical disability, sensory impairment and/or mental health issue. Support is provided in homely settings and community involvement and skills development is at the heart of the approach. The service enables users to make choices and decisions about their life and encourages them to be as independent as possible.

In 2017-18 Shared Lives recruited additional hours to enable the service to expand and improve in line with best practice guidance and relevant standards.

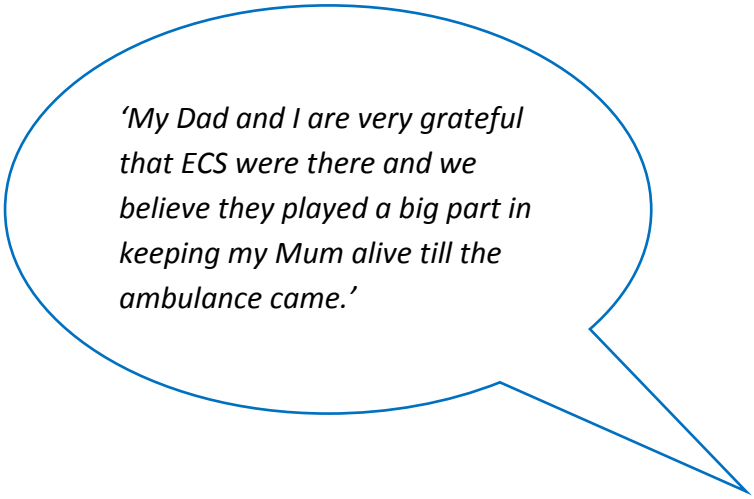
Both locally and nationally the Shared Lives model results in excellent outcomes for service users and reduced costs compared to 'traditional' services.

The Shared Lives carers provide a range of support including:

- **Day support** – This can involve having one or two people going to a carer's home to share activities and interests, it often involves going out and participating in community activities.
- **Short breaks** – This involves carers sharing their home with someone for a few days to a few weeks. It may be to give the person's main carer a break and/or it may be to provide a holiday/break to a person who needs support.
- **Long-term care** – This can be a direct alternative to residential care or can be a stepping-stone to more independent living. The service offers an opportunity for the individual being cared for to live in a family home and share their social and community networks. Through the work of the Shared Lives Carers and support from Shared Lives Coordinators many service users have become involved in community projects. The increased use of universal services has resulted in people with care needs becoming more integrated into their local communities and less reliant on traditional social work resources.

Care in an emergency

The Emergency Care Service (ECS) provides short term, emergency care and support to clients to prevent hospital admission, to enable hospital discharge and to support clients who are in a crisis situation. The team works closely with all agencies to prevent hospital admissions, monitoring health and domestic concerns and responding early to prevent health issues becoming a crisis.



ECS also provide emergency care to clients whose main carers are admitted to hospital (usually a spouse or family members). In the year, the service provided care to 52 clients who had experienced crisis or breakdown of normal care due to illness of a carer

ECS referrals come from social work, occupational therapists, hospital discharge teams, GP's and other agencies.

ECS responds to call outs for assistance from personal alarms (mostly in response to client falls) with clients safely lifted using specialised lifting equipment. They also provide emergency personal care, re-programme alarm pendants and react to various requests for help.

The call outs number around 130 per month, totalling 1,534 calls for assistance in 2017-18.

Around 100 clients per month require emergency care, a total of 1,186 in 2017-18.

National Health and Wellbeing Outcome 3

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

75% of adults supported at home agreed that their services and support had an impact on improving or maintaining their quality of life

(Scotland 80%)

Physiotherapy and musculoskeletal services

East Lothian's physiotherapists continued to provide a range of musculoskeletal and rehabilitation services for a wide range of conditions in all age groups in a variety of out-patient, domiciliary and hospital settings across the county. With the introduction of the CWIC service in Musselburgh Primary Care Centre they also started to respond to same day demand for practice patients.

Access to the out-patient and domiciliary services is through a referral management system. Adults with musculoskeletal (MSK) health issues can self refer to the NHS24 MSK Advice & Triage Service in normal office hours.

Patient feedback about our MSK support was good during the year, with patients reporting:

- *"I feel very confident in her ability."*
- *"All positive and helpful."*
- *"Felt less worried."*
- *"Great service."*
- *"Caring person."*
- *"First class, made to feel at ease."*

Self Directed Support

East Lothian HSCP's vision for Self-Directed Support (SDS) is:

> *'...we want people who receive social care support to choose how that support is provided. We want them to have as much ongoing control as they want over the individual budget spent on their support. We will empower and build people's capacity to take responsibility for their choices and support them to explore innovative and flexible solutions that meet their agreed outcomes.'*

The partnership's approach aims to ensure that SDS in the county does more than simply deliver the four options. It also aims to promote personalisation, choice, control and autonomy.

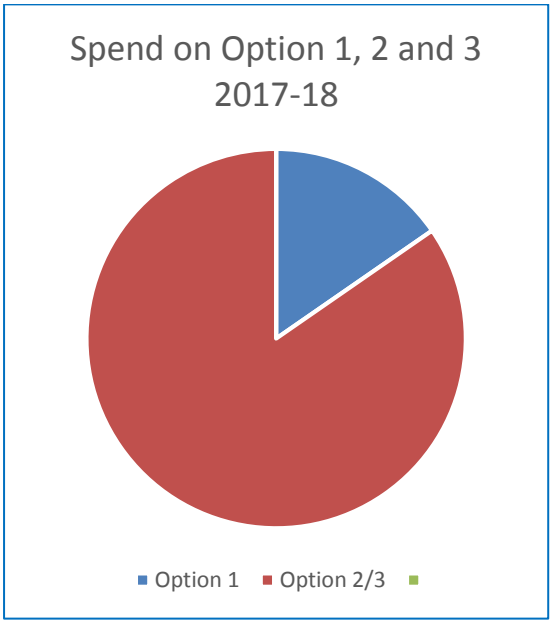
SDS brings with it significant investment. In 2017-18 SDS spend was £13.6m, 46% of the total budget for all clients (table 4).

Table 4 - Self Directed Support Budget in 2017-18

2017-18 Option 1/2/3	Total Budget	SDS Spend	%
ALL Clients	29,657,632	13,629,962	46%

The balance of spend on SDS Options 1, 2 and 3 is shown below in chart 4.

Chart 4



What are SDS Options 1 to 4?

1 – The client receives a direct payment to purchase support directly. There is access to advice and support from the council and others.

2 – The client chooses their own support while the council holds the money and arranges the chosen support on the client's behalf.

3 – The client chooses to have the council select and arrange the appropriate support.

4 - A mix of options 1, 2 and 3 for specific aspects of a client's support.

Since 2016 there has been a steady increase in the number of clients receiving Option 2. The numbers of hours of care have increased at a faster rate than the number of clients as shown in chart 5. Chart 6 shows the choice of Option selected by different client groups in 2017-18.

Chart 5 – SDS Option 2 Uptake April 2016 to April 2018

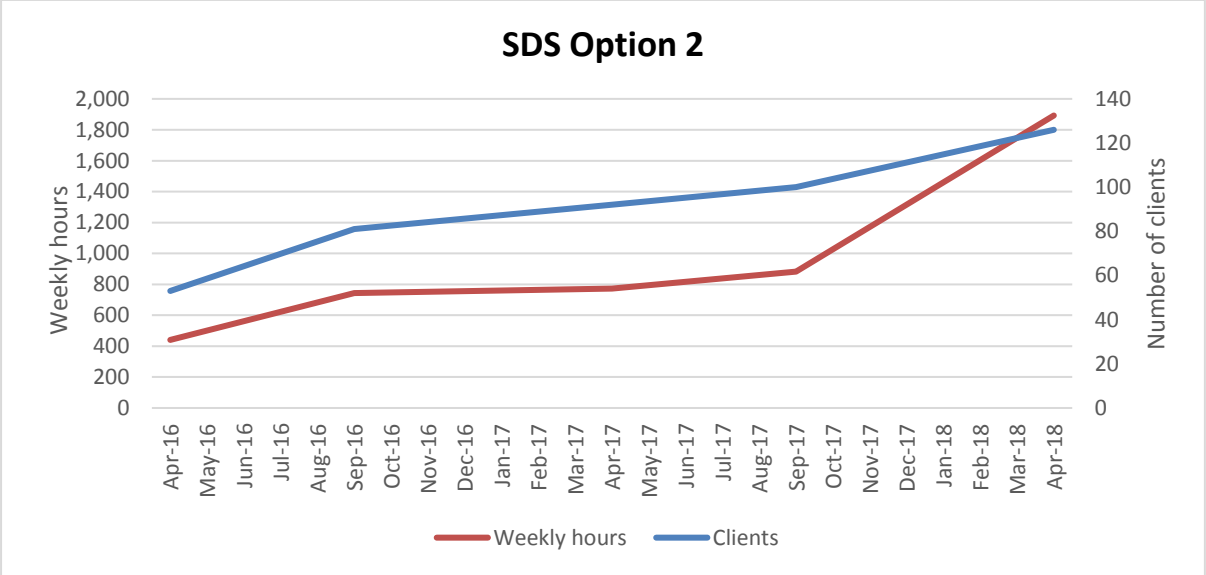
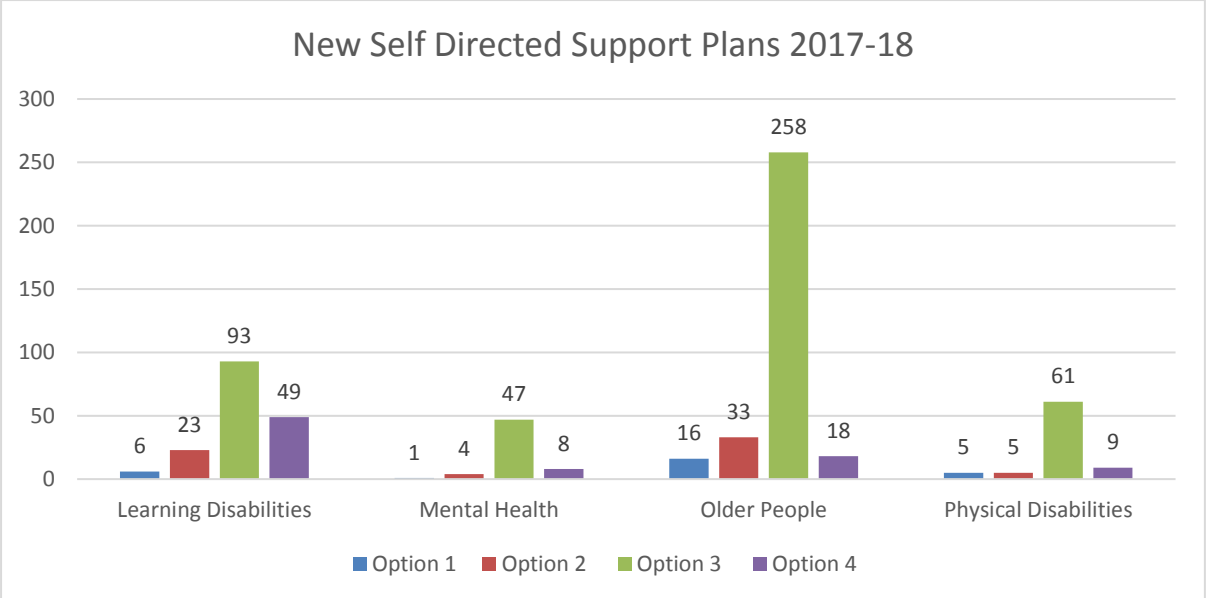


Chart 6 – Selection of SDS Option by Client Groups - 2017-18



Housing and transport

Two key areas for strategic development link to housing needs and transport review. A comprehensive housing needs assessment of older people was conducted by HSCP officers, the outcomes of this exercise are forming the basis of a range of change projects and developments to better meet the housing needs of older people. In time other clients groups will be similarly assessed.

A project approach to reviewing transport in East Lothian was started to look at use of transport by social care, education and other services and the potential for efficiencies through the development of strategies and polices to support improved networks and overall provision.

Primary care

With its amalgamation of another practice Riverside Medical Practice in Musselburgh became the second largest practice in the Lothians with around 19,000 patients.

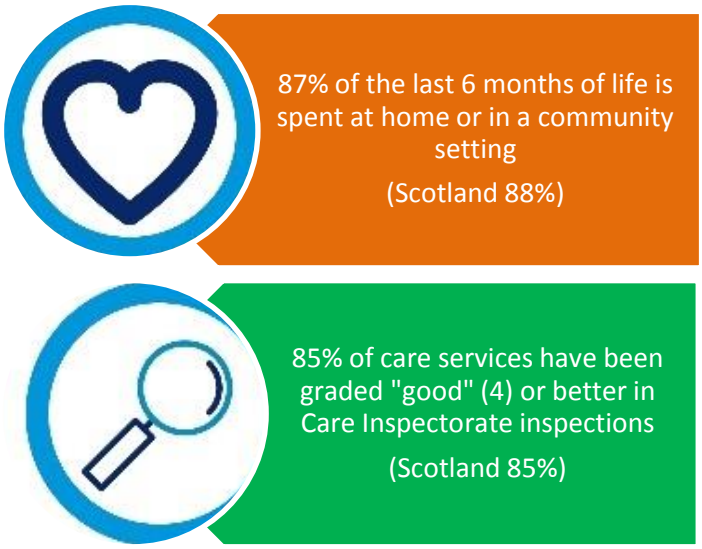
In a partnership with the Health and Social Care Partnership and NHS 24 the new CWIC (Collaborative Working for Immediate Care) team commenced a pilot service to develop new approaches to respond to same day demand in primary care. The team, comprising Advanced Nurse Practitioners, advanced Physiotherapy practitioners, mental health and others provided support to help Riverside patients who did not need to consult a GP to access the right non-medical health professional at the right time.

The development of advanced nurse and physiotherapy-led services provides a model of approach to primary care service provision that will be tested in other practices in East Lothian in the coming year. As part of this, protocols are being developed. For example CWIC's Advanced Physiotherapists contributed to the development of standard operating procedures to guide staff in dealing with any clinical issues needing escalated after consideration in virtual clinics.

Recent feedback from people using the CWIC service showed that 74% rated their experience as 'excellent', 19% as 'great' and 7% as 'good'.

National Health and Wellbeing Outcome 4

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



Care at Home Review Project

The Health and Social Care Partnership commissions services with the independent and third sector to meet individual client's outcomes and also works with East Lothian Council to plan services that make effective use of their combined resources and that will meet future demand.

The HSCP purchases approximately 20,000 hours per week to support 1,400 service users in their own homes. Regular reviews ensure allocation of resources which prevents clients in the community reaching crisis point due to delays between the assessment, planning and delivery of support. In the case of clients admitted to hospital, the availability of care at home speeds up discharge, so avoiding delays.

The HSCP has a statutory duty to keep each supported person's plan under review and to ensure that their eligible needs continue to be met. In carrying out reviews and in agreeing any necessary changes we involve the service user.

Each review identifies if the person's needs have changed and may lead to a reassessment and revision of the support plan, including the personal budget. Like care and support planning the review process is person centred, outcome focused, accessible and proportionate. Part of the plan will be about maintaining support and ensuring that needs are met as well as reviewing progress, support problem solving and planning next steps.

The plan should reflect what is important to the service user and what is important for the service user.

We undertook a comprehensive review of home delivered care that posed the following questions:

- How do we ensure that the service-user's voice is heard?
- How can we make our processes are more efficient and effective?
- How can we ensure that our resources are meeting client outcomes?
- Are we confident that our resources are allocated to those with the greatest need considering current capacity issues?

We considered options for further improvements in the quality of service to clients, to maintain dignity, to respect client opinion, to deliver client outcomes and to make processes more efficient and effective, while ensuring that resources are targeted to those with eligible needs.

Person centred support planning puts people at the heart of their care and offers them an opportunity to have choice and to take control over their care and support. Each person with eligible care and support needs has a care and support plan, describing what needs the person has and how eligible needs will be met. Some people will have a personal budget as part of their plan that identifies the cost of their care and support and the amount that the HSCP will contribute towards it.

Our multidisciplinary team of social workers and community care workers are responsible for approximately 2,000 service users who are not allocated to any assessment teams but are receiving a paid service funded by the HSCP.

Regular reviews allow the HSCP to continually and actively benchmark eligible needs against delivery of services, ensuring need is appropriately responded to and where present any unused commitment is returned back into the budget.

We know that there are many service users who have their care purchased directly by the HSCP but continually underuse the resources we procure on their behalf evidencing that the HSCP is meeting their outcomes.

National Health and Wellbeing Outcome 5

Health and social care services contribute to reducing health inequalities

Premature mortality rate is 372 per 100,000 persons (Scotland 425)

East Lothian Community Hospital

After many years of planning and after building work commencing in October 2016, the keys to the Out-Patient Department in the new East Lothian Community Hospital were handed over on 23rd February 2018, with the department opening on Monday 19th March 2018.

At the time, David Small, Chief Officer, East Lothian Health and Social Care Partnership, said: "This is an exciting time for the communities of East Lothian and it marks a significant development in delivering a joined-up health and social care service through the East Lothian Health and Social Care Partnership".

The new facilities will support an increase in delivery of gastroenterology, orthopedics, urology, ear, nose and throat services to patients in East Lothian and the introduction for the first time of locally available plastic surgery and phototherapy services.

The new Out-Patient Department is the first stage of a £70 million building programme to replace Roodlands hospital in Haddington with a modern, purpose-built hospital. The new hospital is anticipated to be completed by early 2020.

Tobacco prevention

Work started on creating smoke-free outdoor areas where children congregate, reflecting this priority in the Scottish Government tobacco control strategy.

Continuation of the smoke-free homes project we offer to primary schools, with an emphasis this year on targeting P7 classes as a way of preparing children who are about to move to high school to remain smoke-free. To date 17 East Lothian primary schools have taken part in the project over the past few years, although unfortunately none took part in the 2017-18 school session.

Decipher-Assist, a peer led approach to tobacco prevention, piloted by NHS Lothian on behalf of the Scottish Government was delivered in partnership with East Lothian Council community learning and development staff. This involved all secondary schools in the county.

Future work

From September 2018 health promotion and public health colleagues plan to work with 4 primary schools (one from each local authority area in Lothian) to pilot an approach which aims to make areas around school gates smoke-free.

These colleagues will liaise with East Lothian Council education services in order to encourage greater involvement of schools in 2018-19.

Plans are established to complete a fourth (and final) year of delivering Decipher-Assist in 2018-19.

Health Improvement Fund

Through the link officer role, the health promotion service supported various projects in East Lothian to ensure they adopted a health inequality focus.

Future work

The 2018 year of funding will include Ageing Well and Start Well to focus on physical activity at different life stages. In addition, Positive Realities will focus on children and young people's mental wellbeing and the Pennypit Nutrition project in Prestonpans will focus on early years nutrition.

Alcohol licensing

A Senior Health Promotion Specialist and Public Health Consultant sit on the East Lothian Alcohol Licensing Forum to ensure licensing policy and decisions consider the health and wellbeing of the population.

Future work

The public health team will actively contribute to the consultation survey on the new Statement of Licensing Policy for 2018-2022.

Food and health

Links with projects and practitioners were made and maintained through East Lothian Food and Health Practitioners Network.

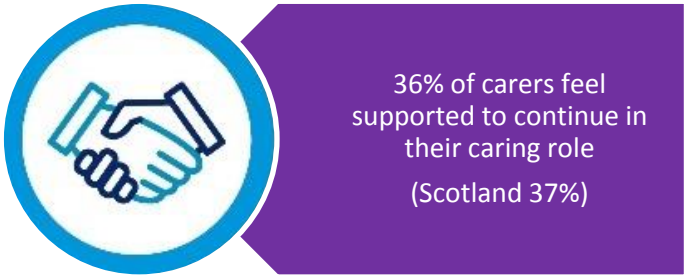
The team contributed to the local Food Poverty Action Plan and to the development of the local growing strategy.

Future work in child food poverty and child poverty

In partnership with the HSCP and strategic partnerships public health will participate in discussions to formulate recommendations, reporting mechanisms and planning for development of local action plans and the strategic implementation of these plans at an authority wide level as part of the Child Poverty (Scotland) Bill 2017. This work will include reviewing opportunities to embed more sustainable models that address child and food poverty for all East Lothian children e.g. cost of the school day and holiday hunger.

National Health and Wellbeing Outcome 6

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



Carers

The draft Carers Strategy, an important part of our plans to develop support for carers and to begin to deliver on the requirements of the Carers (Scotland) Act, was completed by the 1st April.

The process of developing the strategy Included consultation with carers, carer organisations and other third sector organisations to obtain feedback on what people wanted the strategy and the carers eligibility criteria to cover and how they should be involved in the planning and delivery of services.

The Carers Strategy aims to provide clearer and better access to information services to improve carer health and wellbeing through a range of outcomes such as ensuring carers can achieve a balance in their lives, through the provision of support, advice and regular breaks so improving their own health and wellbeing.

The strategy also aims to support carers to continue to care for longer in the community. In doing so, this will have a positive impact on the cared-for person and provide support to remain at home for longer.

Future work

Training for staff will be developed using the Equal Partners in Care (EPIC) framework and sessions rolled-out across all relevant departments and third sector organisations to support continued learning and awareness-raising on behalf of unpaid carers. Training on applying the new carers eligibility criteria will also be delivered.

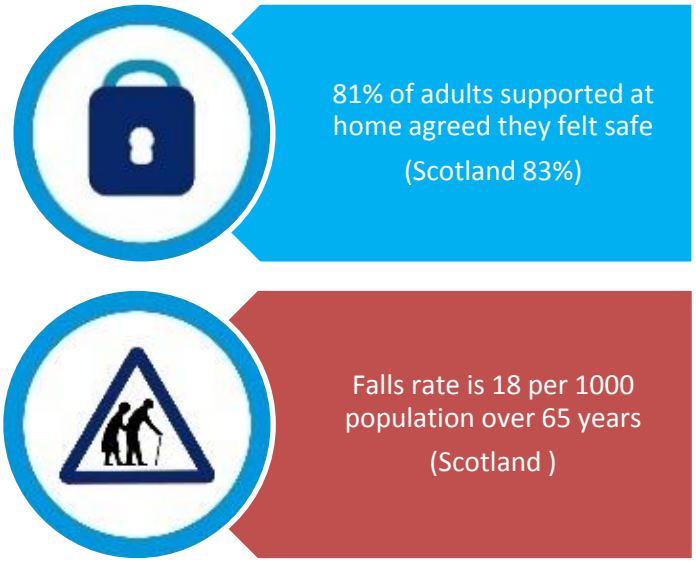
We will look at how we can work with lunch clubs, day centres, education, housing and other settings and with employers across East Lothian to raise awareness of carers. This will include promoting Carer Positive status amongst employers in the county.

The Equal Expert and Valued report[7] by the Coalition of Carers in Scotland included East Lothian in a 'Spotlight on local practice, noting that the HSCP had established a Carers Strategic Group to lead the development of the Carers Strategy and workplan as part of the delivery of the Carers Act requirements. It also noted that the Carers Strategy Team had worked with Carers of East Lothian as part of Adult Carer Support Plan developments.

[7] http://www.wrenandgreyhound.co.uk/wp-content/uploads/2018/05/60597-Coalition-of-Carers-in-Scotland-SUMMARY-Report-DIGITAL-VERSION.pdf

National Health and Wellbeing Outcome 7

People using health and social care services are safe from harm



Adult support and protection

The Adult Support and Protection Act makes provision to protect those adults who are unable to safeguard their own interests and are at risk of harm because they are affected by disability, mental disorder, illness or physical or mental infirmity. The definition of harm covers all harm including self-harm and neglect.

The principles emphasise the importance of striking a balance between an individual's right to freedom of choice and the risk of harm to that individual. Any intervention must be reasonable and proportionate. It is recognised that, at times, there will be a need to carefully weigh and consider the various principles, particularly where the adult at risk does not wish support or they themselves are the source of the risk.

The Act provides measures to identify and to provide support and protection for those individuals who are vulnerable to being harmed whether as a result of their own or someone else's conduct. In 2017-18 the team received 820 Adult protection referrals and carried out 115 investigations.

One priority of the IJB workforce plan aims to ensure that our workforce are knowledgeable, skilled and able to deliver the relevant sections within the East Lothian Strategic plan which specifically promote the protection of service users.

Current 'live' Adult Protection cases are discussed monthly in supervision in order to ensure staff are supported and that practice adheres to agreed standards whilst keeping the service user safe.

Prevention of violence against women and girls

Public health colleagues:

- worked with the Violence Against Women and Girls Partnership to produce a briefing paper and position statement on commercial sexual exploitation
- delivered training courses: Level 1 'Understanding and Responding to Domestic Abuse' and 'Routine Enquiry of Domestic Abuse' to HV teams
- joined a pool of chairs for a Multi-Agency Risk Assessment Conference (MARAC).

Children and young people's mental health

Partnership working with HSCP, Education and third sector colleagues allowed public health to scope and map data and services across East Lothian, to share examples of good practice, review existing and emerging resources and to provide input to the development and implementation of a local children and young people's mental health strategy. This all aims to provide a prevention and early intervention approach to increase timely access to appropriate mental health support for all children and young people in East Lothian.

Care Home inspections

A number of services were inspected through the year in announced and unannounced visits by the Care Inspectorate to care homes and adult services.

There were 19 inspections carried out in East Lothian care homes, most in the private sector. Although most were graded highly for quality and care, 5 private homes received low grades and follow up action plans for improvement. Of these 5 homes, the low grades in 2 homes required follow-up large scale investigations. The other 3 homes were kept under close monitoring. This supervision of and support to private care homes in difficulty places extra demands on HSCP colleagues.

East Lothian's performance in 2017-18 against national indicator NI-17 – *'Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections'* was 85%, an improvement of 8% since the previous year, putting it in first 40% for performance across all IJBs and equalling the Scottish average.

National Health and Wellbeing Outcome 8

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

East Lothian Clinical and Care Governance Framework

Work began in December 2017 to develop an accountability framework to empower professionals on the front line to work together effectively in the delivery of services.

The approach was designed to also allow service representatives to meet with Lothian Clinical and Care Governance Group to describe their work – what's going well, what could be better and what might be keeping them awake at night. Having teams present in this way on a regular basis is part of making the HSCP a place where colleagues can:

- practice in line with professional standards, codes of conduct and organisational values
- be responsible for upholding professional and ethical standards in practice and support continuous learning and development
- provide the best possible care and treatment experience for service-users and their families
- provide accurate information on the quality of care and highlight areas of risk and concern
- work in partnership with management, service-users and carers and staff in designing, monitoring and improving the quality of care and services
- speak up, in line with local whistle-blowing policy and regulatory requirements, when practice is seen that endangers the safety of patients, service-users or staff
- engage with colleagues, service-users, communities and partners to ensure that local needs and expectations for safe and high quality health and care services, improved wellbeing and wider outcomes are responded to.

Perinatal and Infant Mental Health Group (PIMH)

Public Health partnered with PIMH to develop, host and present examples of locally produced resources/good practice through an 'ACES; how to respond?' conference. This was one of a series of continuing professional development events run over the past few years for local practitioners to; increase knowledge, awareness and confidence of various early years issues that inform practice in supporting local families with perinatal-infant mental health and early attachment/relationships.

NHS Lothian achieved the next level of the Carer Positive award scheme, becoming an 'established' carer positive employer. This award recognises the efforts to identify carers in the workforce and to use supportive policies in the workplace to allow colleagues to balance work and caring commitments

Neurological strategy

An education strategy for Neurological Conditions was established for all Occupational Therapists and Physiotherapists across the partnership. This provided an initial full day training session in conjunction with Chest, Heart and Stroke Scotland, to develop a range of competencies, joint education sessions and collaborative working groups. The aim is to achieve long term, sustainable, education of all allied health professional (AHP) staff in a range of neurological conditions, thus placing East Lothian in an optimum position to meet the rehabilitation needs of all neurological patients in the community.

Continuous professional development and in-service training

A timetable of joint in-service training was established across Occupational Therapy and Physiotherapy services. This includes in-house training from peers and external speakers and a programme of clinical education courses. Bringing teams together to share skills, knowledge and clinical experience, supports all colleagues in their learning and development journey. Combined with the promotion of action learning sets for staff in CPD sessions this promotes reflection and supports a personalised outcomes approach.

East Lothian Allied Health Professional Conference

In September 2017 East Lothian AHPs held a successful first conference to promote their services across the HSCP. This provided an opportunity to share the vision for the future delivery of AHP services and the ambition to improve outcomes, in line with the Scottish Government strategic drivers. The Conference, which created a platform for staff to share ideas and current developments to deliver integrated services, was attended by all East Lothian AHP staff. Another conference is planned in 2019.

National Health and Wellbeing Outcome 9

Reprovision of Belhaven and Edington Community Hospitals and Eskgreen and Abbey Care Homes

The East Lothian Strategic Plan (2016–2019) identified a key aim of shifting resources from institutional and acute care to community based and focused care, to enable delivery of improved outcomes for the people of East Lothian. This reflected the Scottish Government's 2020 vision for everyone to live longer healthier lives at home or in a homely setting. It also supported the Single Outcome agreement (SOA) in further shifting the balance of care in East Lothian.

In 2017-18, East Lothian IJB issued a Direction to initiate the process of reprovision of Belhaven and Edington Community Hospitals and of Eskgreen and Abbey care homes. Review work started in the summer of 2017.

The work was prioritised due to a number of pressing strategic and local issues:

- A growth in the number of older people in East Lothian and associated increase in care requirements
- A focus on shifting the balance of care from bed based to community based care while delivering care closer to home
- A move to support more independent, community-based living
- A drive to raise standards of service, through, among other actions the provision of facilities fit for modern care.

In February 2018 the IJB endorsed an initial report identifying a potential new model of provision based around 'extra care' housing. This housing model offers a modern, homely, flexible, future focused solution to both the reprovision of existing facilities and a contribution to meeting the needs of the growing population. This approach supports the IJB Strategic Plan and the Local Housing Strategy.

A further, updated report was produced for the IJB following a March to June 2018 consultation and engagement period.

Future work

The IJB will be asked to approve the establishment of a Project Board supported by three project teams to reprovide services for Dunbar, North Berwick, and Musselburgh. This work will be undertaken in line with the IJB engagement policy of co-production to engage the local communities to develop this model further and to take into account different local needs across the three areas. It is expected that delivery of new, alternative provision across the areas will take between 3-5 years.

Charging policy

A review of the current social care charging policy was completed, with the development of an updated policy scheduled for summer 2018. The review aimed to produce a policy making it clear what is charged for and why and which complied with the latest COSLA guidance on charging for non-residential care services. In addition, the review also improved financial assessment and billing and introduced a right to appeal which was previously missing.

Provider movement

A number of providers elected not to participate in the tender to be part of the new service framework. This resulted in a lot of potential change for clients and carers and required the transfer of a large numbers of care hours to another provider. This work concluded in October 2017.

IJB Finances – Budget 2017-18

The financial year 2017-18 was the second in which East Lothian IJB received a financial allocation from its partners (East Lothian Council and NHS Lothian) for the functions delegated to it. The IJB built on the experience of its budgetary management in 2016-17 and undertook a detailed financial assurance process examining the budget offers from its partners for 2017-18. This process allowed the IJB to consider two broad issues:

1. Was the allocation proposed by the partner 'fair' – that is, was the allocation a fair share for East Lothian of the total resources available to the partner?

2. Was the allocation adequate?

In terms of fairness, the IJB accepted that the budgets offered were a fair share of the overall resources available to the partners. In terms of adequacy, the IJB had to consider the financial pressures in the system which the partners had provided to the IJB to allow the financial assurance process. The IJB agreed to accept the partners' offers on the basis that actions would be taken in-year to resolve the financial pressures identified.

2017-18 Out-turn – Financial Performance

The IJB broke even at the end of 2017-18, that is the charges from the partners for the IJB's services was equal to the income available to the IJB. However, this was after considerable non-recurrent support from the IJB's partners, especially East Lothian Council.

In summary, before any further adjustments, the initial year end out-turn for East Lothian IJB was as follows:

	£000's	£000's
Initial position	250	(1,101)
Move underspend	(250)	250
Additional support from partners	75	796
Move support	(75)	75
Year end position	**0**	**0**

The initial financial position for 2017-18 (before any adjustments) was an underspend within the health arm of the budget and an overspend within the social care arm of the budget. The IJB directed NHS Lothian to make these under spent funds available to East Lothian Council to support the social care position. That adjustment did not allow the IJB to break-even. Both partners made further funds available to the IJB to reach a break-even position, with the largest element of the non-recurrent support coming from the Council.

Although the health element of the IJB's budget was underspent, there were some underlying pressures within 'acute set aside' (the budgets for the delegated functions managed in the acute hospitals, described in more detail below) and GP prescribing. These pressures were managed in year on a non-recurrent basis, that is from underspends in other operational services.

The main drivers in the social care position are the significant overspends in those services supporting older people especially in care homes and care at home and in services for adults with learning and physical disabilities. Along with these operational pressures the achievement of the efficiencies built into the opening budgets has proven to be a challenge and an element of the overspend was driven by unachieved efficiencies.

Overall, the break-even position has been achieved by non-recurrent support and slippage (underspends) in elements of the health services. The IJB is building the management of these pressures into its financial plans for 2018-19.

The total overall position was as follows:

East Lothian IJB - Budget Performance in 2017-18

	Budget £000's	Actual £000's	Variance £000's
Health Services for In-Patients	30,414	30,490	(76)
Primary Care	46,054	46,363	(309)
Other Community Health Services	32,255	31,641	614
Social Care Services	49,729	50,829	(1,100)
Non-Recurrent Support	871		871
Total	**159,323**	**159,323**	**0**

Note - variances are underspend/(overspend)
Social care services include the social care fund

Primary Care expenditure includes:

- GMS – the costs of running the GP service in East Lothian
- GOS – support to the delivery of community ophthalmic (optician) services
- GPS – support to the delivery of community pharmacy services
- GDS – support to the delivery of community dental services
- GP Prescribing – the costs of prescriptions for the 15 East Lothian GP practices.

Part of the budget above includes the £21.6m of acute set aside budget. Acute set aside is the expenditure on functions that are delegated to the IJB but managed by the NHS Lothian acute management team, these budgets being 'set aside' on behalf of the IJB. This concerns mostly inpatient bed costs but there is also a small element of outpatient services depending on how the delegated function is delivered. This includes the Accident and Emergency service at the RIE.

Included in the social care services above is:

- Expenditure on social care services on care homes or adult placement - £6.4m
- Expenditure on social care services to support carers - £0.3m

It should be noted that support to carers is a thread that runs through all services, there is not a specific carers budget, nor expenditure identified. The value above is the total of specific providers and workers who provide direct support to carers.

In 2017-18, the Scottish Government made a second tranche of the Social Care Funds available in addition to the first allocation in 2016-17. The Social Care Fund now stands at £6.2m for East Lothian. This fund has been used to underpin the additional costs resulting from ensuring that all staff who provide social care received the Scottish living wage. It has also supported the creation of additional capacity within social care. The Social Care Fund is now recurrent and incorporated into the IJB's baseline budget.

The financial year ahead

The IJB has agreed budgets for 2018-19, having used the same methodology as last year. There remains a significant financial challenge both in terms of additional pressures from demographic growth and other increases in demand and from the underlying financial pressures which were, as described above, supported non-recurrently in 2017-18.

The Scottish Government has made available a further £66m nationally (East Lothian's share being £1.2m) to the Councils to support social care - all of these funds have been passed by the Council to the IJB.

The Scottish Government has also committed to further investments in primary care, mental health and substance misuse services. These funds have been made available to the IJB in 2018-19.

The IJB continues to develop its financial plan and will use the additional resources discussed above to allow it to further the transformation of its services which will provide fully integrated, locally delivered and community based services for East Lothian that are financially sustainable.

Appendix 1 – All Directions Applying in 2017-18

New Directions for 2017-18

10 - Directions to NHS Lothian on Primary Care

D10a - Preparations for the New GMS Arrangements (supersedes D01e and D01f, aligned with D01g, Do4a, D04b)
D10b - Support to Primary Care Quality Clusters (New Direction)
D10c - Primary Care Strategy (New Direction)

11 - Directions to NHS Lothian and ELC on reducing use of acute services and increasing community provision

D11a - Emergency Assessment Services and Emergency Admissions (New Direction)
D11b - Occupied Bed Days (new Direction)
D11c - Delayed Discharges (supersedes D07)
D11d - End of Life Care (new Direction)
D11e - Transfer of AHP resource from Secondary Care (new Direction)
D11f - Contracts for Care at Home (new Direction)

12 - Directions to NHS Lothian and ELC on shifting the balance of care for care groups

D12a - ELC delivered care at home services (supersedes D02a and D02b)
D12b - Extra care housing (new Direction)
D12c - Day services for older people (supersedes D02e)
D12d - Reprovision of Eskgreen and Abbey care homes and Edington and Belhaven hospitals (supersedes D01c and D02c)

D12e - Integrated Care Fund Review (supersedes D06)
D12f - Transfer of patients of Ward 2 Belhaven Hospital to Ward 3 Belhaven Hospital (issued January 2018)

13 - Direction to NHS Lothian to support delivery of Modern Outpatients recommendations

D13a - Redesign of diabetes services and further development of care of Type 2 diabetes in primary care (new Direction)

14 - Direction to NHS Lothian and ELC on support to carers

D14a - Finalisation and implementation of the East Lothian Carers' Strategy and preparation for the Carers' Act (aligned with D02d)

15 - Directions to NHS Lothian on drug and alcohol services and mental health

D15a - Allocation to ELHSCP of the full 12% of Drug and Alcohol funding (new Direction)
D15b - Redesign of MELDAP (new Direction)
D15c - Provision of adult mental health services (new Direction)
D15d - Provision of older adult mental health services (new Direction)

16 - Direction to NHS Lothian and ELC on Community Justice

D16a - Work with the Reducing Reoffending Board (new Direction)

Continuing Directions from 2016-17

D01a - Continue to support an Outline Business Case, Final Business Case and Financial Close for a new integrated East Lothian Community Hospital.

D01b - Continue to support, develop and agree a "decant programme" from Liberton and Midlothian Hospitals

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D01d - Deliver business cases for Prestonpans and Harbours Medical Practices.

D01g - Develop and implement a prescribing budget calculation which more accurately reflects demographic change and need across Lothian.

D02d - Develop and implement a new Carers Strategy for East Lothian.

D02f - Establish a housing and health and social care planning interface group.

D02g - Complete a scoping exercise for a redesigned model of re-ablement

D02h - Complete a review of all current Section 10 grants against an agreed prioritisation framework to ensure strategic fit and best value and bring forward proposals for investment and disinvestment.

D03a - Ensure the repatriation of East Lothian residents from Liberton Hospital in Edinburgh with the associated shift in aligned financial resources to the IJB.

D03b - Ensure the repatriation of East Lothian residents from Midlothian Community Hospital with the associated shift in aligned financial resources to the IJB, based on agreed activity data to match this.

D04a - Continue to work collaboratively to support and accelerate local delivery of the key recommendations of the national review of primary care out of hours services.

D04b - Continue to work collaboratively to support and accelerate local delivery of the key actions of the Transitional Quality Arrangements for the GMS contract in Scotland.

D05a - East Lothian Integration Joint Board direct NHS Lothian to make payments to East Lothian Council in line with the payment schedule outlined in Section 10 of this Direction

D05b - East Lothian Integration Joint Board direct East Lothian Council to provide services as outlined and within and in accordance with the budgets outlined in Section 10 of this Direction.

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D08 - NHS Lothian to delegate the agreed budget for the Integration (Social Care) Fund to the IJB in line with the proposal from East Lothian Council.

_____

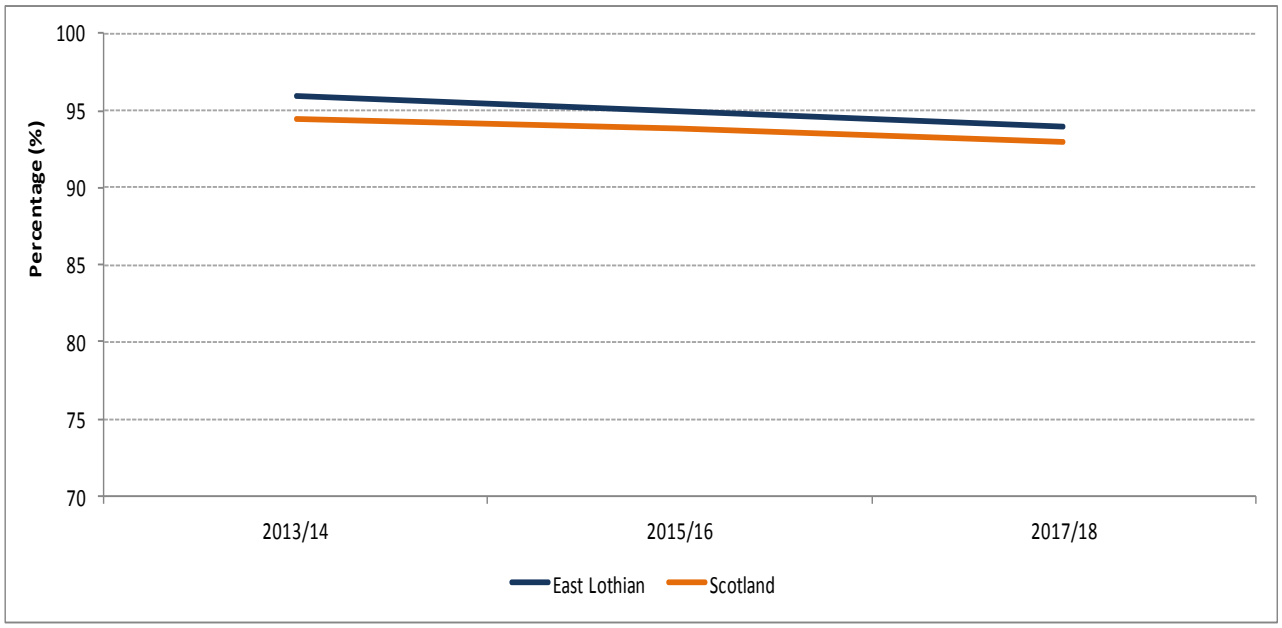
D09 - Provide a full analysis on the detail of human and financial resources identified within NHS Lothian's Strategic Programmes budget within the financial year 2015/16, including an analysis of resource and activity as it relates to all delegated functions.

_____

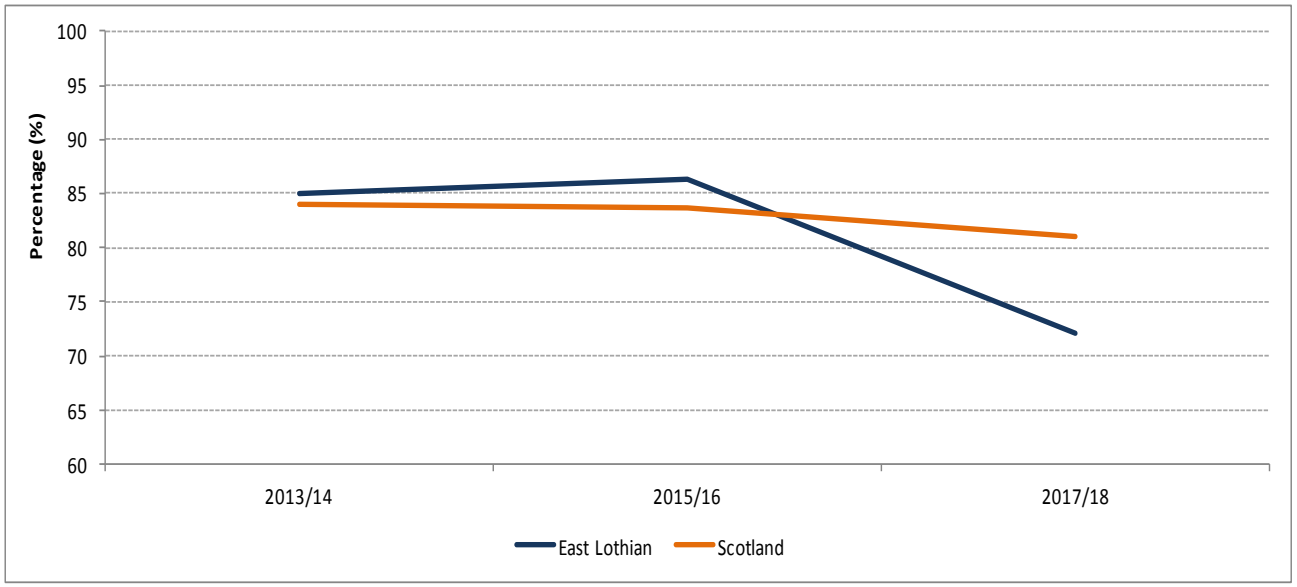
Each of these directions will remain in place until varied, revoked or superseded by a later direction in respect of the same function.

Appendix 2 - Trend Graphs for the National Indicators

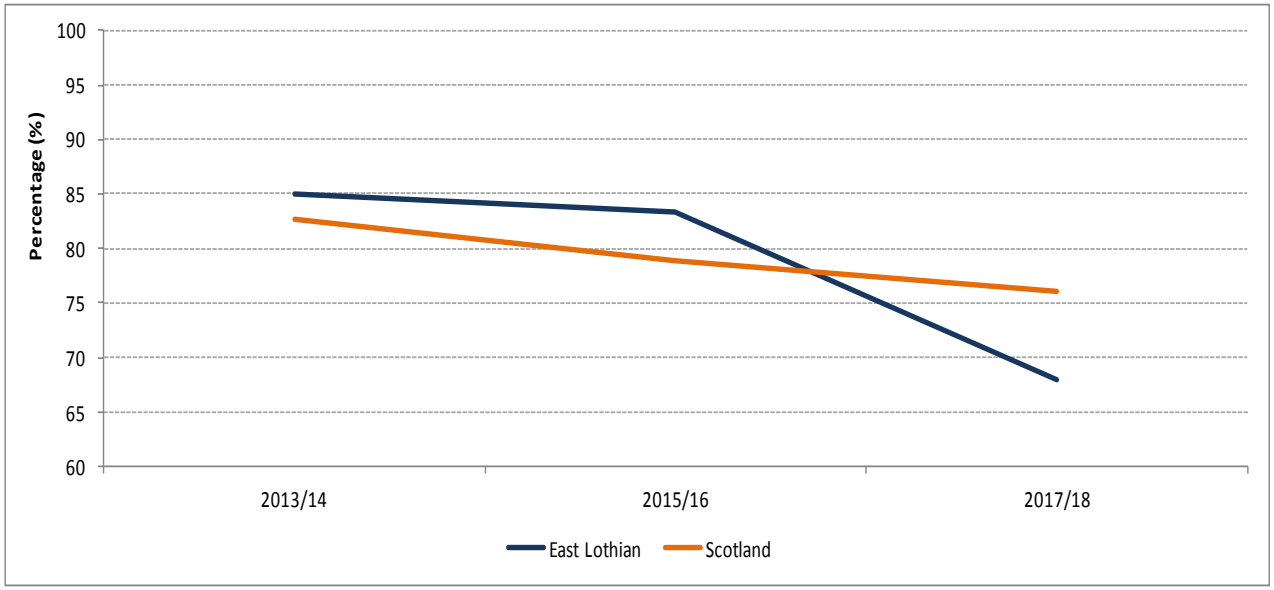
NI-1 - Total combined percentage of adults able to look after their health very well or quite well. (Trend for East Lothian and trend for Scotland).



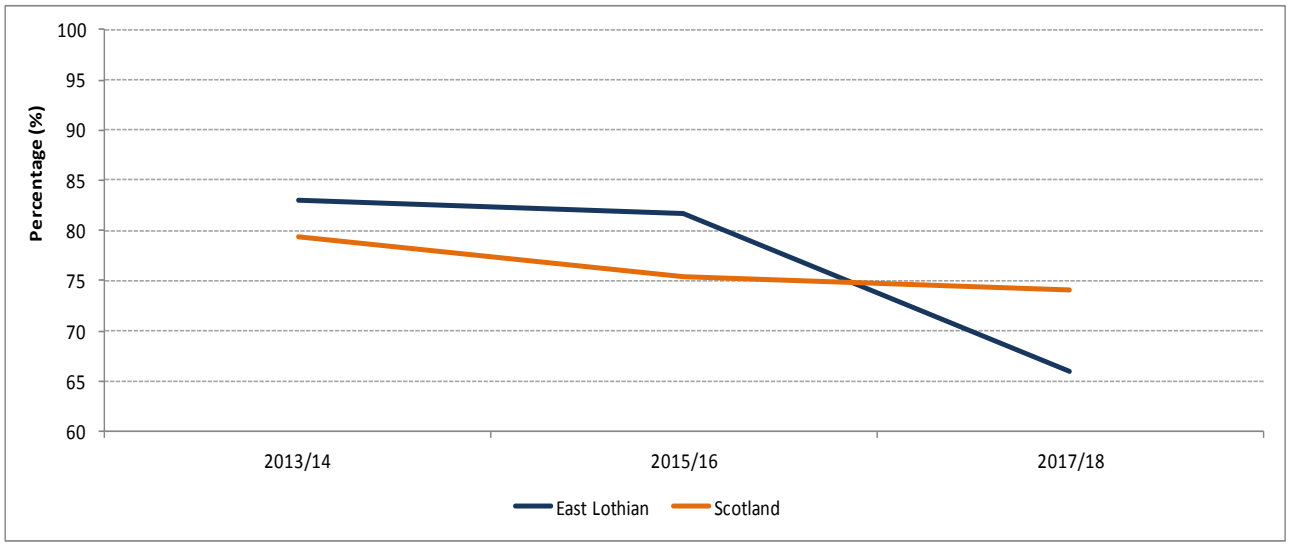
NI-2 - Percentage of adults who responded that they either strongly agreed or agreed that they are supported to live as independently as possible (trend for East Lothian and trend for Scotland).



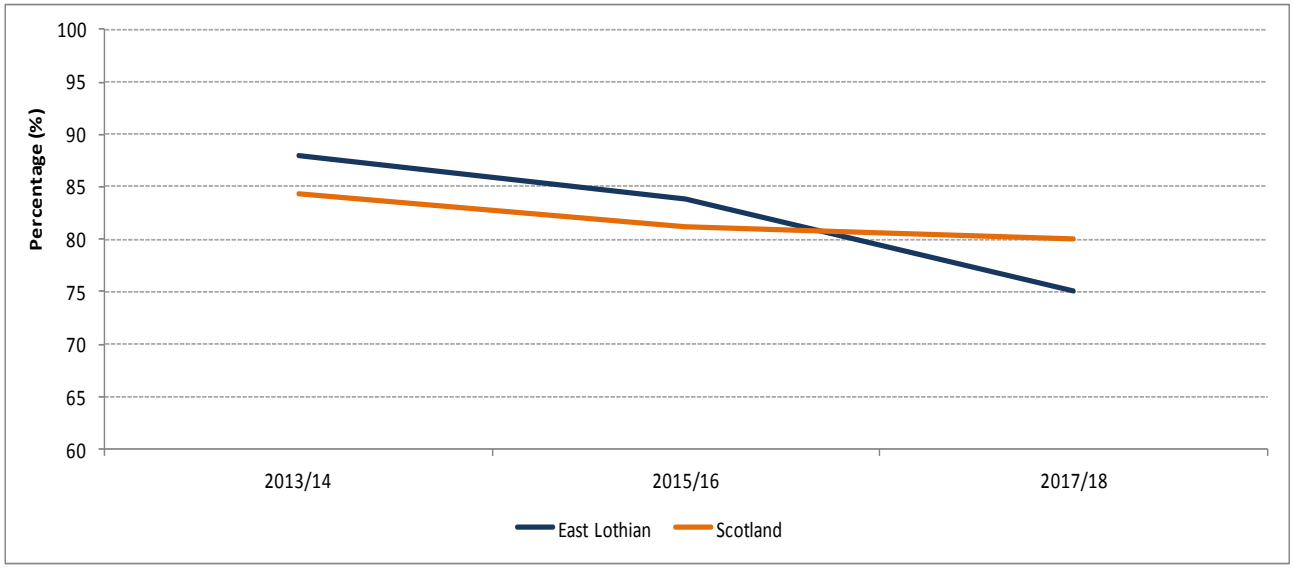
NI-3 - Percentage of adults who responded that they either strongly agreed or agreed that they had a say in how their help, care or support was provided (trend for East Lothian and trend for Scotland).



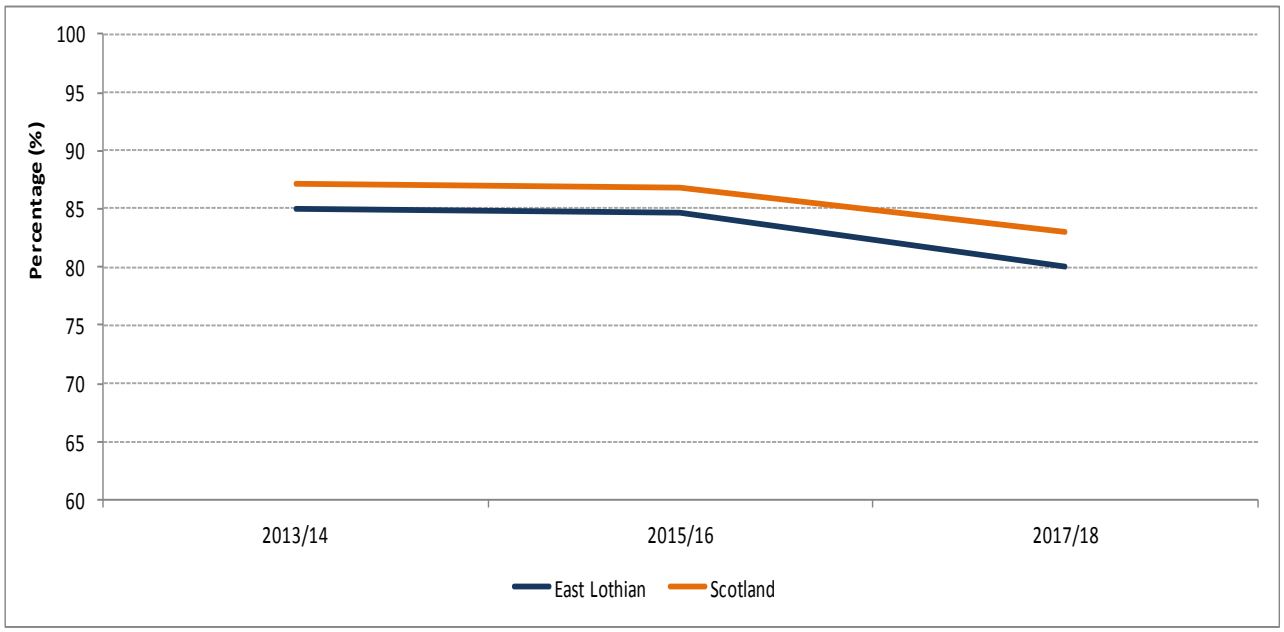
NI-4 - Percentage of adults who responded that they either strongly agreed or agreed that their health and social care services seemed to be well co-ordinated (trend for East Lothian and trend for Scotland).



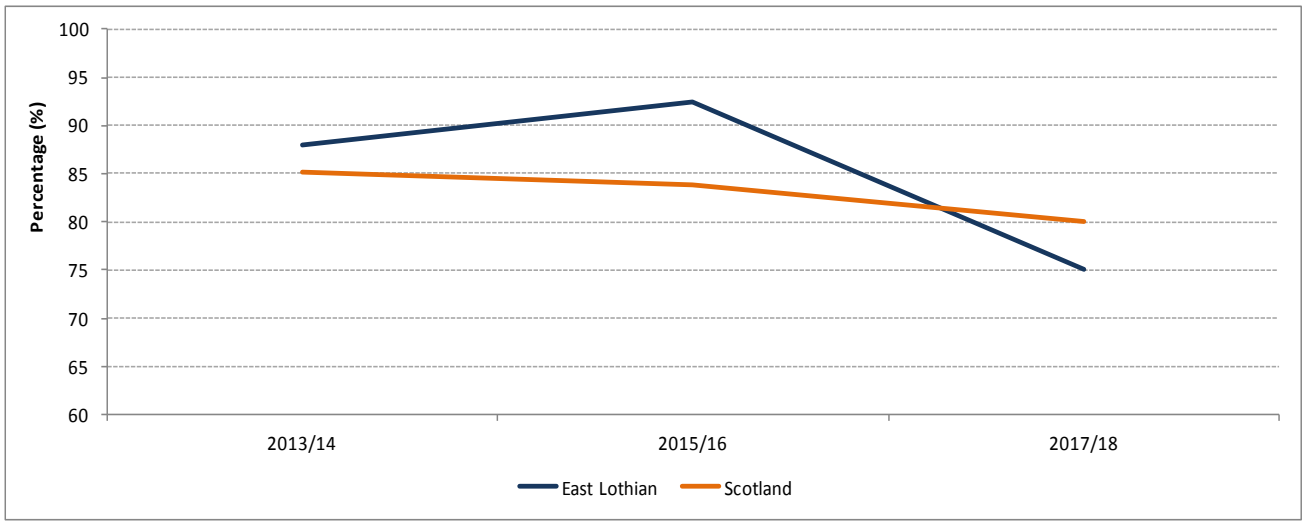
NI-5 - Percentage of adults who rated their care or support as excellent or good **(t**rend for East Lothian and trend for Scotland).



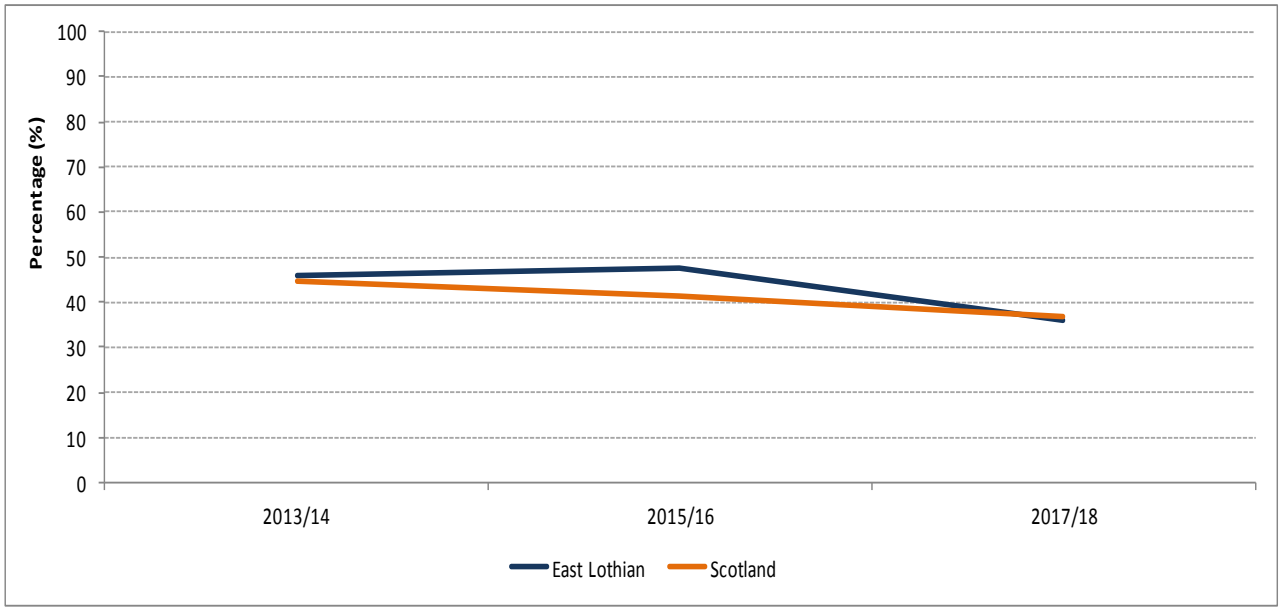
NI-6 - Percentage of adults who rated the care provided by their GP practice as excellent or good (trend for East Lothian and trend for Scotland).



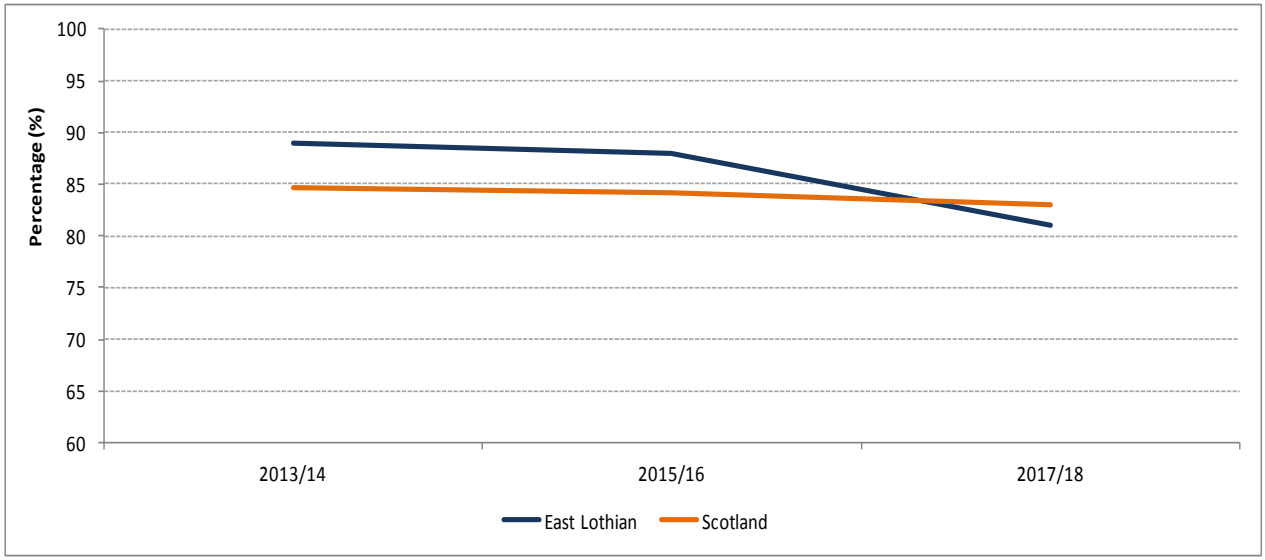
NI-7 - Percentage of adults who either strongly agreed or agreed that their services and support had an impact on improving or maintaining their quality of life (trend for East Lothian and trend for Scotland).



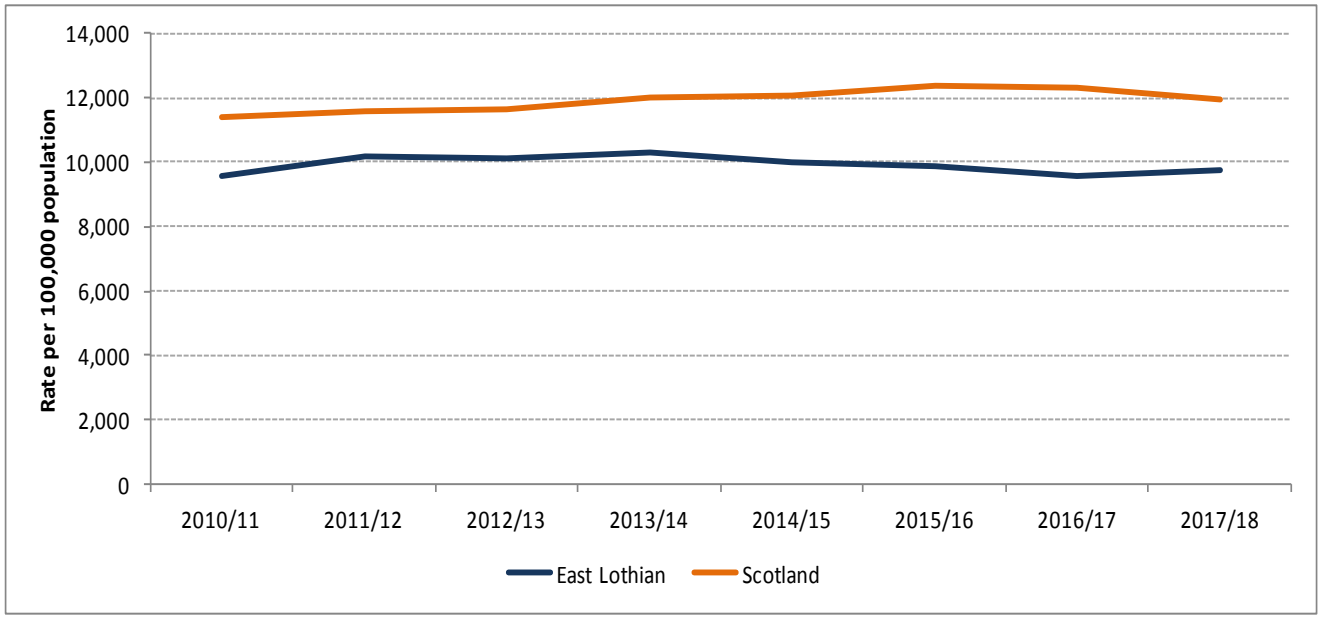
NI-8 - Percentage of carers who either strongly agreed or agreed that they felt supported to continue in their caring role (trend for East Lothian and trend for Scotland).



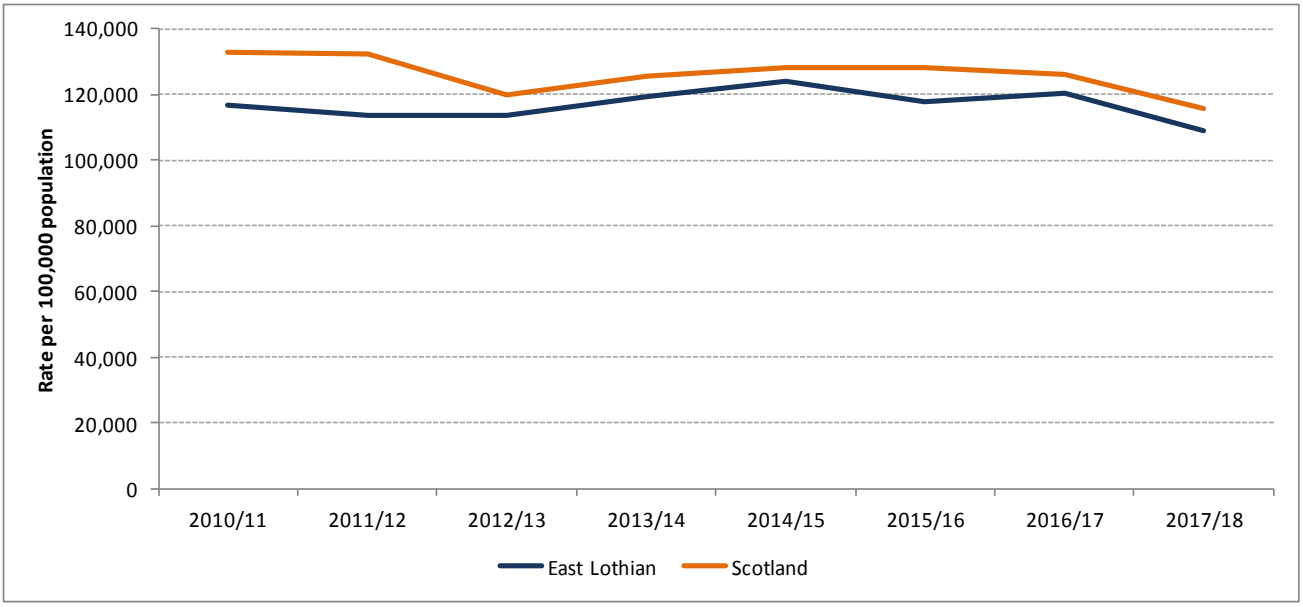
NI-9 - Percentage of adults supported at home who either strongly agreed or agreed that they felt safe (trend for East Lothian and trend for Scotland).



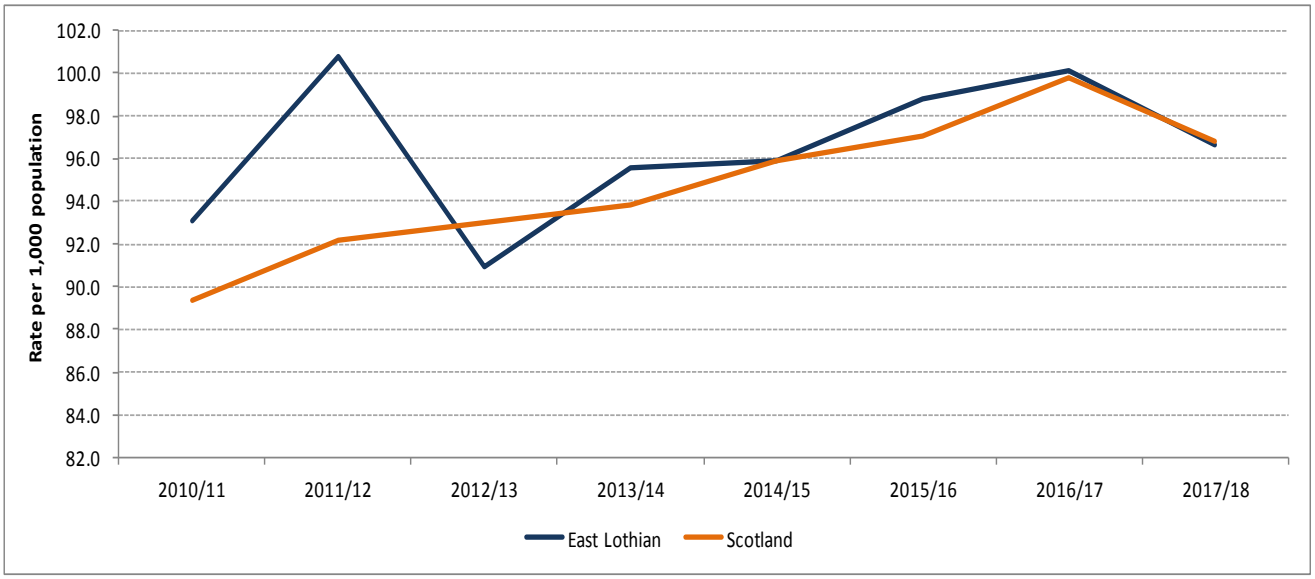
NI-12 - Rate of emergency admissions per 100,000 population for adults (trend for East Lothian and trend for Scotland).



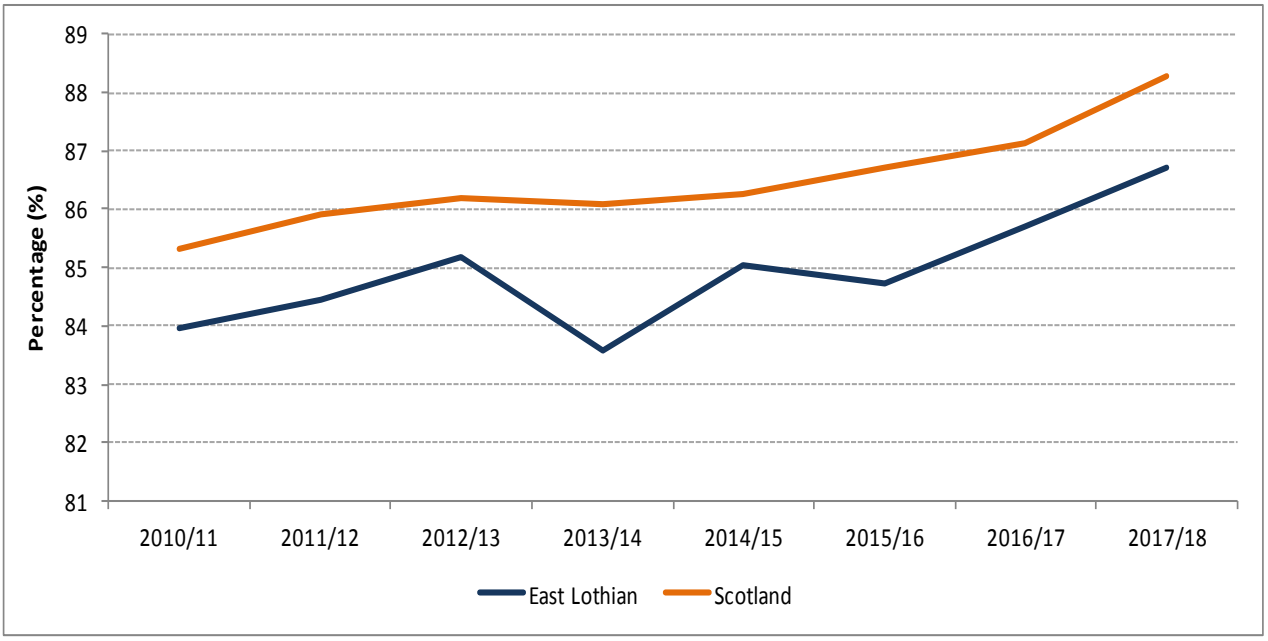
NI-13 - Rate of emergency bed day per 100,000 population for adults (trend for East Lothian and trend for Scotland).



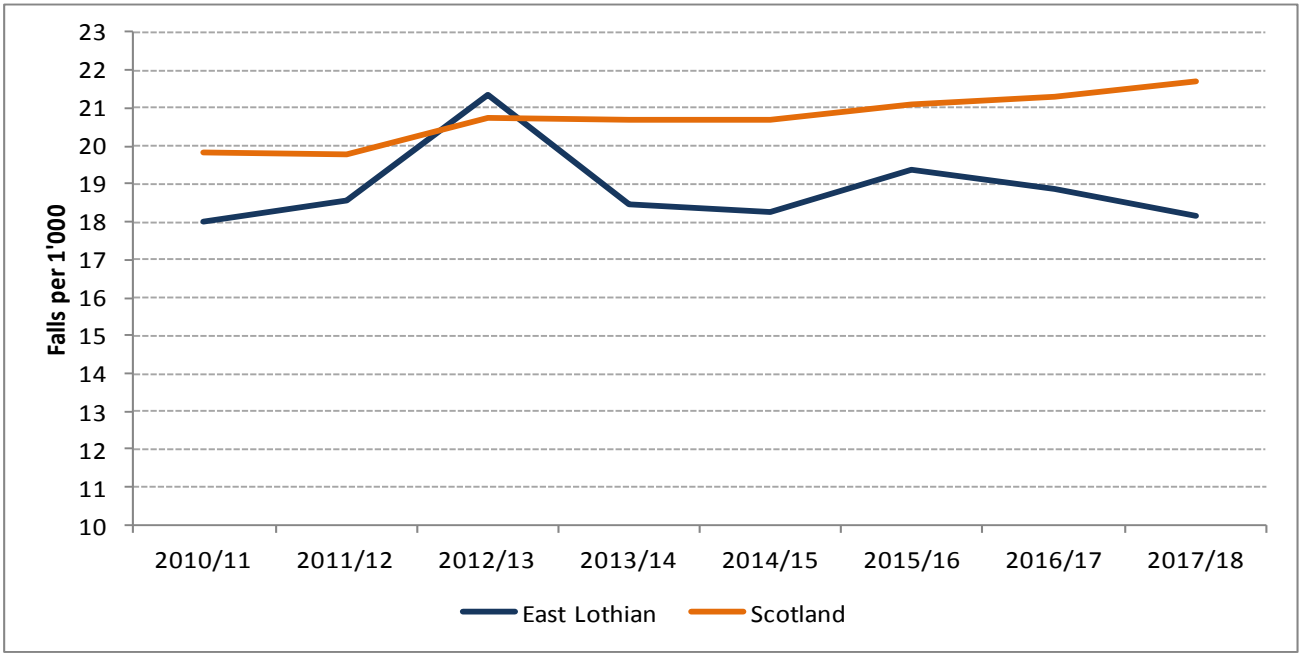
NI-14 - Readmission to hospital within 28 days of discharge per 1,000 admissions (trend for East Lothian and trend for Scotland).



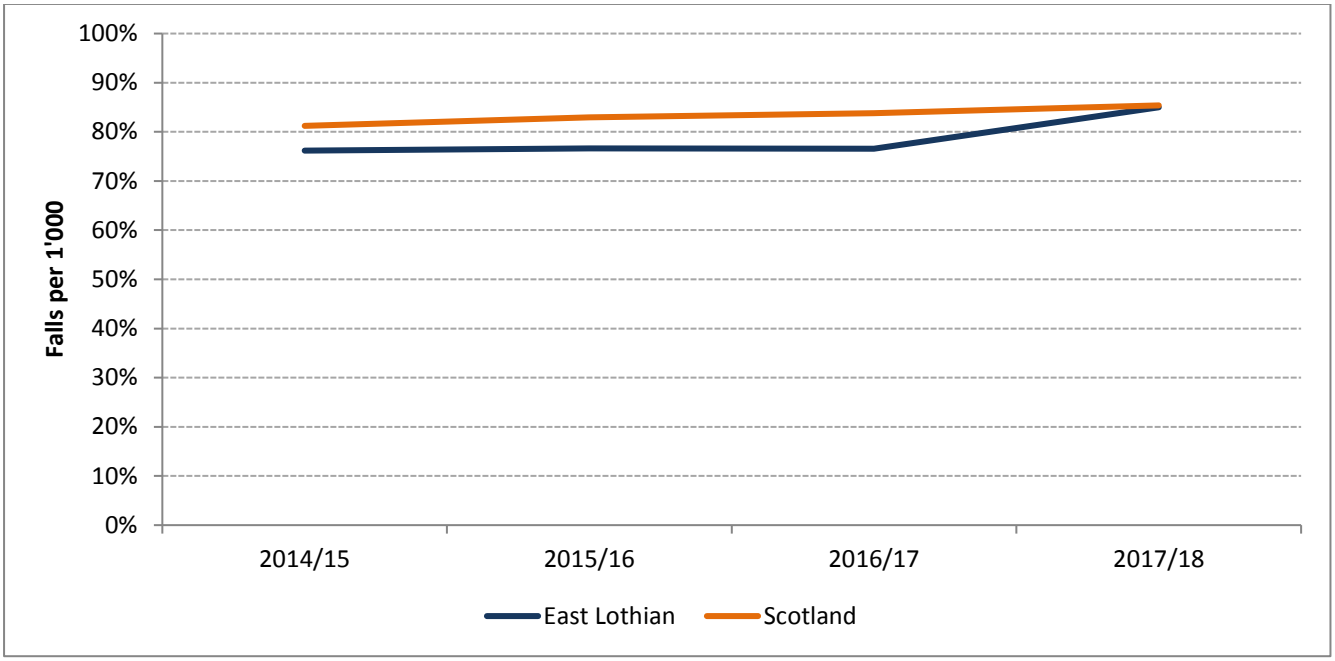
NI-15 - Percentage of time spent by people in the last 6 months of life at home or in a community setting (trend for East Lothian and trend for Scotland).



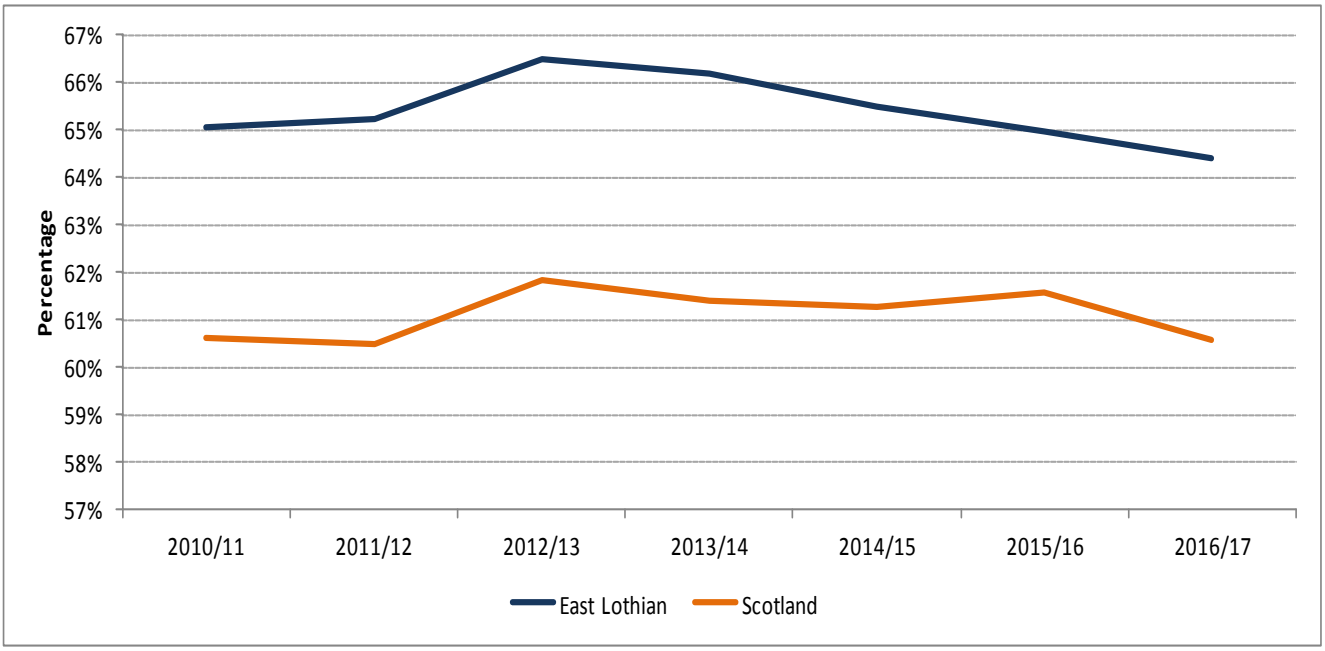
NI-16 - Falls Rate per 1,000 population aged 65+ (trend for East Lothian and trend for Scotland).



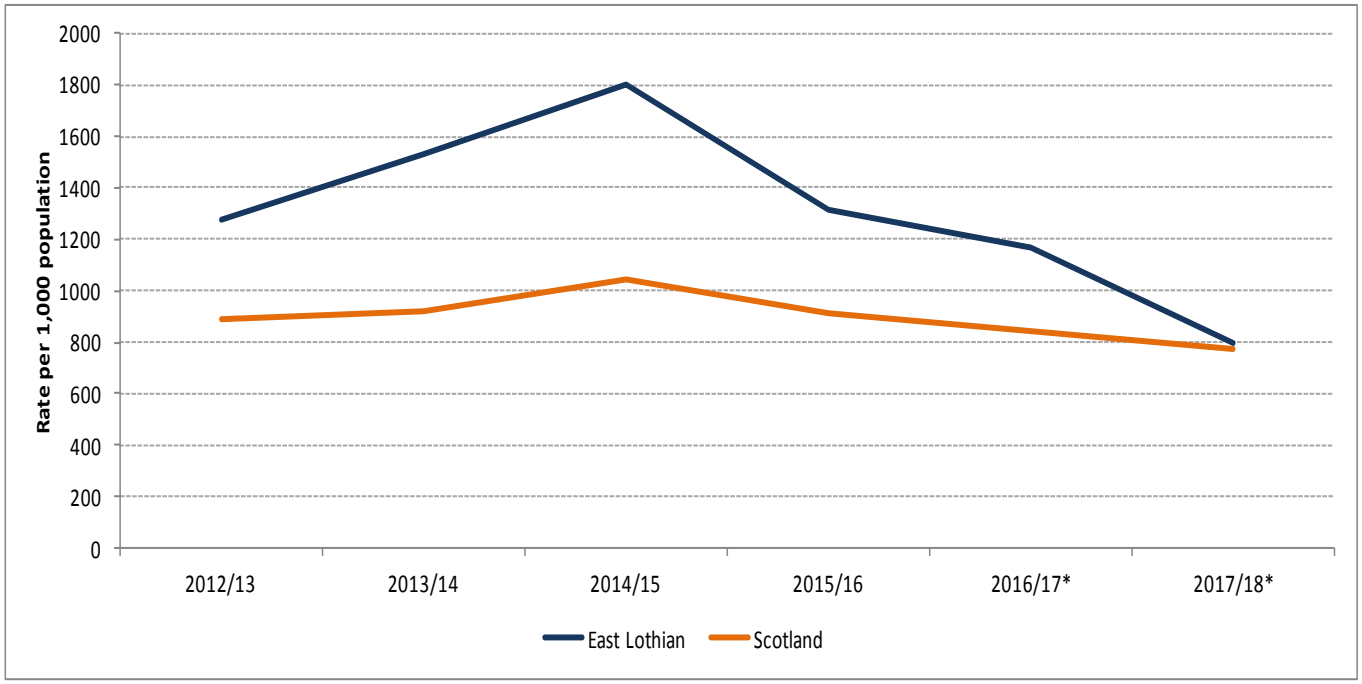
NI-17 - Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections (trend for East Lothian and trend for Scotland).



NI-18 - Percentage of adults with intensive care needs receiving care at home (trend for East Lothian and trend for Scotland) data only available up to 2016-17.



NI-19 - Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population (trend for East Lothian and trend for Scotland).



NI-20 - Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency (trend for East Lothian and trend for Scotland).