East Lothian Integration Joint Board

Annual Performance Report 2018-19

East Lothian
Health & Social Care Partnership

Foreword

Welcome to the East Lothian Integration Joint Board (IJB) Annual Report 2018/19, which offers an insight into the wide range of services that we provide and commission. It shows you the positive impact that integration is having for people who use our services, and their families and carers. Integrated working is stimulating better communication, more effective targeting of resources, and services that are streamlined and better tailored to individual need.

The year from April 2018 to March 2019 has been a very productive one where East Lothian IJB has really come in to its stride. In the first two years, we were finding our feet, setting up the structures we needed to function well and beginning to integrate our staff teams. 2018/19 was the first year when we could really start bringing our vision to life.

It has also been a time of change, in which we bade farewell to David Small, who took up the role of Director of Transformation for Primary Care at NHS Lothian in June 2018. And Children's Services moved to East Lothian Council's Education service, which helps them to better pursue the Getting It Right For Every Child (GIRFEC) agenda and enables us to concentrate on adults from 16 upwards.

As you will see as you read on, it's been a very important year. We engaged extensively on how to transform services for older people and also for adults with complex needs. Those projects are both now at a stage where a new vision is ready to be realised. We also engaged widely around our new IJB Strategic and Primary Care Improvement Plans and again positive developments are now underway.

We won a number of awards, including East Lothian Council Star and NHS Celebrating Success awards, and our Wellwynd Hub has just been nominated for a national COSLA award. We have also been cited for good practice, including by the Coalition of Carers in Scotland for role carers play in our strategic planning.

Our staff are what make us what we are and we would be remiss in not highlighting how their dedication, skill, ideas and passion drives good outcomes for the people we serve. This year, we saw our Workforce Strategy come to fruition, which sets out not only how we will help our existing teams to develop, but also how we will attract and retain more staff to replace those who are nearing retirement.

Continuity is vital to the people who use our services and we are keen to make East Lothian Health and Social Care Partnership a stimulating and rewarding environment for everyone who works for us.

We would also like to thank our staff for their commitment to self-evaluation and continuous improvement. It has played a major role in achieving excellent financial results this year, where we managed to make efficiencies while maintaining the quality of service. That saving will go into our reserve, giving us greater resilience in the years to come.

We hope you find the Annual Report interesting and if you want more information about anything in it please email elhscp@eastlothian.gov.uk or phone 01620 827 755.

Alison Macdonald

Director of Health and Social Care

ELHSCP/Chief Officer East Lothian IJB

Peter Murray

IJB Chair, 2017-19

Contents

About the East Lothian Integration Joint Board (IJB)

Our history

The East Lothian Integration Joint Board is made up of representatives from NHS Lothian, East Lothian Council, the Third and Independent Sectors and those who use health and social care services. It was set up as part of the Public Bodies (Joint Working) (Scotland) Act 2014. This Act focuses on integrating health and social care at a local level. There IJBs are legally separate both from their local health board and local authority. As well as council and NHS Lothian appointed members, the IJB includes health and social care professional and union representation, and carers, service-user, third and independent sector representatives.

What is the East Lothian IJB responsible for?

East Lothian IJB is responsible for the planning, resourcing and governance of health and social care services. It sets the strategic direction of Health and Social Care Delivery in East Lothian.

What is East Lothian Health and Social Care Partnership (ELHSCP)?

ELHSCP delivers services operationally to meet the strategic aims of the IJB. It provides leadership and operational management for services.

What services are we responsible for?

We are responsible for a wide range of services including some hospital services, for example, Accident and Emergency. See the graphic below to get an idea of the range of activities that we cover. You can see more information about all the services delegated to us in Appendix 4.

Our strategic objectives

Getting it right for East Lothian

We developed our Strategic Objectives in consultation with our stakeholders. They show our commitment to adopting approaches that tailor services to the needs of people and communities while, at the same time, developing efficient and future-proofed service arrangements. We will:

- make universal services more accessible and proportionate to need and develop our communities. We want to improve access to our services, but equally to help people and communities to help and support themselves too
- 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
- reduce unscheduled care. We want to reduce unnecessary demand for services including hospital care.
- 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
- deliver services within an integrated care model. We recognise the need to make people's journey through all our services smoother and more efficient
- enable people to have more choice and control. We recognise the importance of person-centred and outcomes focused care planning
- further optimise efficiency and effectiveness. We want to improve the quality of our services whilst recognising and addressing the challenging financial constraints we face
- reduce health inequalities. We want to reduce inequalities, break the cycle and impact of deprivation and support and protect the vulnerable in our communities.
- build and support partnership working. We recognise the importance of developing effective and wide ranging strategic partnerships in delivering our ambition, vision and values.

Golden Threads—themes that underpin all our planning

Our people

Facts and figures about the East Lothian population now and in the future

Our people

Like most public sector organisations, we face some major challenges. Our services are designed to help mitigate this and improve health and wellbeing. We have a rapidly growing population. We also have an increasing number of older people in East Lothian, living longer, with some needing a little extra support. Here is a quick snapshot about living in East Lothian now and in the years to come.

Our growing population

105,000 East Lothian population in 2018

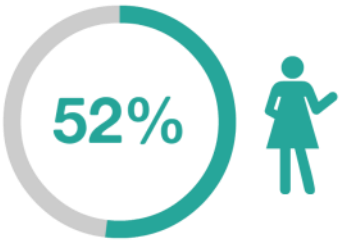
110,695 East Lothian population in 2023

23% population growth by 2037

72% increase in the 65+ age group by 2037

162% increase in the 85+ age group by 2037

About our population



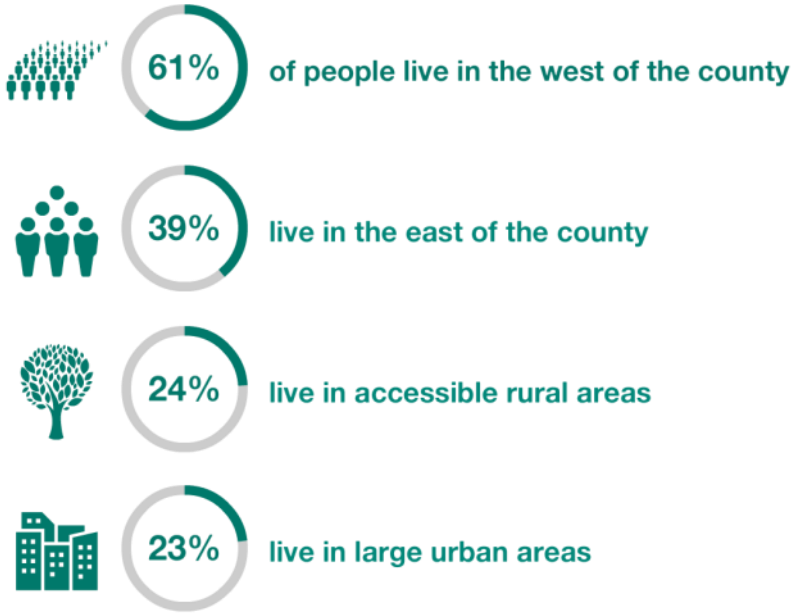
20% of our population is aged 65+

82.7 Average life expectancy for women

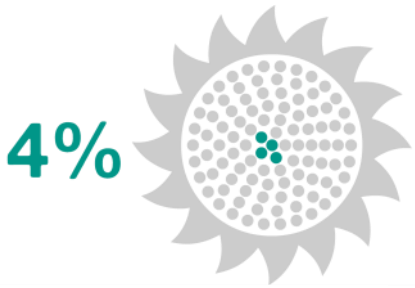
78.3 Average life expectancy for men

Our people

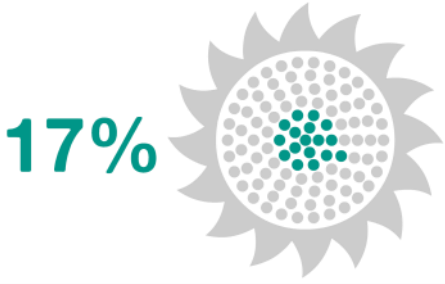
The East/West split



The population is much larger in the west of the county than the east.



of the population live in the most deprived SIMD Quintile



of the population live in the least deprived SIMD Quintile

SIMD (the Scottish Index of Multiple Deprivation) provides a deprivation rank for each of the 6,505 datazones in Scotland. Quintiles split up the dataset into five groups, each containing 20% of the data. For more information, see pages 36-41.

That's why initiatives like the new East Lothian Community Hospital (ELCH) are so important. ELCH will repatriate hospital services back to East Lothian, helping our growing population to access health care closer to home, including ante-natal care. It will also support rehabilitation of older people coming home from hospital in the city, continuing to support our impressive work on reducing delayed discharge.

Keeping people independent and well

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

Supporting independence

East Lothian Health and Social Care Partnership is committed to working with people to help them look after their health and wellbeing. In the course of 2018-19, we have continued to promote healthy living through our Public Health Team and their partners; provided more locally accessible physiotherapy support, and continued with the 1st Response travelling drop-in service, delivered by Penumbra, Changes and Stepping Out. It has been a particularly exciting year for us because we were able to open our new Active and Independent Living Clinic at Wellwynd in Tranent.

Wellwynd Hub

East Lothian Health and Social Care Partnership recently opened Wellwynd Hub as a resource to assess people with functional difficulties to look at solutions to help gain independence and improve activity. The Health and Social Care Partnership, working with East Lothian Council's Housing Service, has converted a sheltered housing warden's flat into a 'dementia friendly' homely setting with smart technology to assist people requiring help with daily tasks such as reminders or turning on lights by voice command. Home to the Active and Independent Living Clinic, it allows people the chance to try adaptations and equipment such as wet rooms, adapted showers, specialist wash/dry toilets, adjustable beds and a wheelchair accessible kitchen.

Occupational Therapist Morven McLelland with Fiona O'Donnell

'We are so excited about Wellwynd Hub because it allows people, and their carers, to experiment with all sorts of mobility aids and technical solutions that can really make a difference to you being independent in your own home. For lots of people, mobility problems make it feel like their much-loved home is now actively working against them. The Hub shows you how you can turn this around.' **Councillor Fiona O'Donnell, IJB Chair**

Breaking News

Wellwynd Hub has been nominated for a COSLA Award in the Service Innovation and improvement category!

Keeping independent and well

Telecare solutions at Wellwynd Hub

People can also find out more about and try out Technology Enabled Care (TEC) and Telecare solutions such as motion sensors, bed sensors and community alarms. Some of the most innovative approaches involve the use of readily available products that people may already have in their homes such as voice activated devices, smart TVs and lighting, and apps that control heating. (For more information about TEC, see Page 20.)

Paul Di Caccia who lives with MS and is a regular user of the Hub has made a video for us about how he uses TEC to help him stay independent and get the most of life.

He says:

'There's something very special about bumble bees. It's not that they've got a stripy coat or that they've got six legs. It's the fact that their wings are too small to carry their body. But, nobody told the bumble bee so it keeps on doing it. That's the way I live my life. I don't worry about the things I can't do. I keep going with the things I can do. And stay a bumble bee and keep flying.'

Paul at Wellwynd Hub

'Just because you have had some trauma in your life, it doesn't mean your life is over. You can change it, keep going forward, embrace change and flourish.'

Impact of Wellwynd Hub

- The Occupational Therapy waiting list has reduced from 421 to 322 since January 2019, a reduction of 23%.
- We are able to assess on average an additional 39 people per month.
- The estimated annual saving based on average of 39 clients per month = £57,096.00.
- We have evidence that 87% of people attending clinic have improved personal and/or functional outcomes.

Keeping independent and well

- A rolling programme of Telecare/Smart TEC awareness sessions for all frontline staff in particular care staff, social workers, Allied Health Professions (AHPs), Housing Officers and District Nurses started in April with a maximum of 10 attendees per session. Evaluations indicate 100% would recommend this training to others and as a result had increased in confidence in this area.
- The HUB has been successful in demonstrating Telecare and Smart Technology in a working environment and assisted in reducing anxiety from individuals and their carers during transition into their own properties. The use of technology has allowed greater independence and a reduction in care hours.

HILDA

HILDA, (**H**ealthy **I**ndependent **L**iving with **D**aily **A**ctivities) is our online Healthy Ageing platform which continues to support people with a range of useful information and advice on local services, equipment and help to complete an online self-assessment. People can contact HILDA by mobile phone or tablet.

HILDA promotes healthy ageing for all and offers a range of useful information to help people stay as fit and able as possible. An added feature on HILDA is the Lifecurve ™ an evidenced based tool which can be easily completed to identify needs at an early stage to target the most appropriate intervention and support required.

1,931 people visited the HILDA website since May '18

81% of these were new visitors

Living independently
at home or in your community

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

Living independently at home or in your community

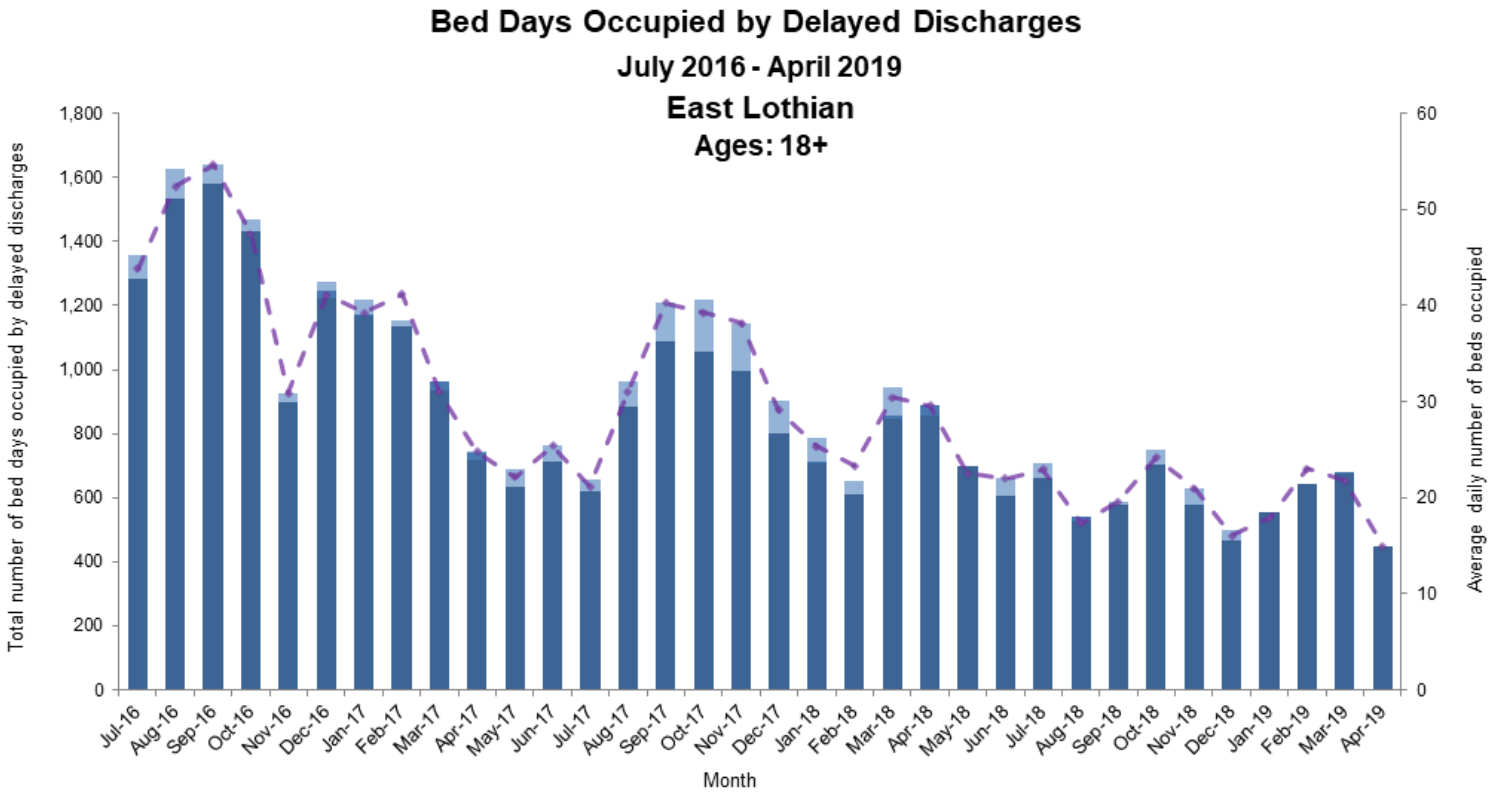
In the section of this report about our Strategic Aims we talked about our intention to:

- reduce unscheduled care
- provide care closer to home.

This section looks at a variety of very effective ways that we are doing this. Their impact can be seen in the tables below.

Driving down delayed discharge

Sustained downward trend in delayed discharge



This downward trend is reflected in our performance against the Scottish Government's National Health and Wellbeing indicators, which show we are outperforming most IJB areas in Scotland. For full information, please see Appendiix 1. The diagrams below show our performance this year.

Living independently at home or in your community

Discharge2Assess team—getting people home from hospital quickly and safely

The Discharge2Assess (D2A) team is an Allied Health Professional (AHP) led service that provides continuing Occupational Therapy (OT) and Physiotherapy (PT) assessment at home on the day or day after someone is discharged from hospital.

Following review and analysis of the established five-day service, we were able to see a clear need for Discharge to Assess to become a seven-day service We made a successful application to NHS Winter Monies fund and were then able to design a model for OT and PT Community Rehabilitation seven-day working that was robust, measureable and equitable, ensuring the best possible care for patients.

OPEN

7 DAYS A WEEK

Evaluation of the service over a 12-week period between January and March 2019 showed that we were able to see five more patients. Sixteen patients were supported to leave hospital over the weekends through D2A/START during this 12-week period, which was 25% of the overall total number of D2A/START patients supported to go home. In 2019, 11% of all interventions carried out over the weekends were new facilitated hospital discharges (this was 12% in 2018). For more about START, see page 19.

904 ♥ patients seen by D2A since May 2015

2,712 ♥ saved bed days

£813,600 ♥ in savings

Much of its success is down to a culture of problem-solving across services to support East Lothian residents. There has been extensive investment in building close relationships with acute AHPs through weekly 'in-reach' contact to Royal Infirmary of Edinburgh (RIE), regular in-service training and proactive use of daily admission lists.

Living independently at home or in your community

START

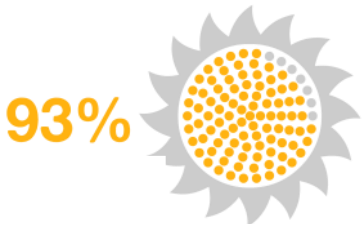
The Short Term Assessment & Rehabilitation Team (START) works with older people in the Tranent, Prestopans and Port Seton area. It was set up in April 2018, and focuses on helping people to become more active and independent after illness. It aims to reduce the delays around hospital discharge, prevent unnecessary admissions and help older people to be more confident and independent in their own homes and communities. It works so well because of its relationships with wider community services including GP practices, District Nurses, Social Work, Hospital at Home, Day Centres and the third sector. Key to its success is the working relationship between the occupational therapists, physiotherapists, community care workers and physiotherapy assistants with STRiVE, East Lothian's third-sector interface organisation. STRiVE has been instrumental in recruiting, training and supporting local people and their families and offering the opportunity to help older people in their local community. The START team members and volunteers help to ensure that once people are discharged from hospital, they have social and practical help. They also encourage families and communities to support each patient's wider rehabilitation and achievement of short and long term goals. People have to be referred to the scheme by the Duty Response and Rehabilitation team, the Discharge to Assess scheme or their GP.

Impact of START

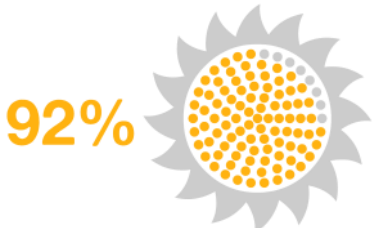
141 ♥ referrals

26 ♥ preventions of admission to hospital

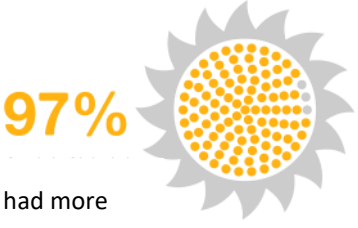
103 ♥ facilitated discharges



% of patients and carers that thought START was beneficial



% of people that felt safe, secure and supported



% of people that felt they had more access to support and advice at home

Living independently at home or in your community

Maureen Allan from STRiVE says:

'Finding volunteers for START didn't just happen overnight. People had to interview for us to show that they had the right skills and outlook; they had to supply us with references, and submit to an enhanced PVG check before they began training with us. We needed to make sure we had the right people. Our volunteers are fantastic and do what they do because they want to give something back to their own community, trying to make their community a better safer place to stay.

'We meet them all regularly and we are always at the end of the phone if they want support or advice. They have built great relationships with all the START staff team and also with the people they support.

'This has been such a good project for people in Tranent, Prestonpans and Port Seton – I can't wait to see how other areas will benefit from it too.'

Technology Enabled Care (TEC)

Technology Enabled Care (TEC) has a key role to play in the modernisation of health and social care. It offers a range of possibilities to help people to live independently for longer. It can also prevent hospital admissions and earlier than necessary moves to residential care. There is now an extensive range of assistive and enabled care technologies available including:

- Telecare
- identifying someone's location to support people with dementia (GPS)
- monitoring blood pressure at home and texting readings to GP practice (see page 21)
- voice activated devices (Amazon Echo)
- tablets and video conferencing/ consultation between professionals to citizens in their own home.

These are just a fraction of the technologies available to us in everyday life and they can either be purchased and set up privately or provided through statutory services following assessment. By ensuring that technology is considered during all stages of our engagement with people, we can support people to make informed choices to find the best possible solutions in line with local and national strategies and outcomes.

East Lothian TEC team currently has over 2,200 clients with analogue connected alarms and 4,301 connected telecare products (as from July 2019).

Living independently at home or in your community

Some telecare figures for 2018/19

To give you an insight into the work of the Telecare Team, here is a breakdown of some of their key activities in 2018/19. CAS stands for Community Alarm Service.

466 new CAS alarm referrals

262 new telecare referrals

90 new CAS & telecare referrals

852 technician task visits

59,523 alarms calls into contact centre

Scale-Up BP Project

This project encourages people to use technology to monitor their own blood pressure. Research shows that in the UK blood pressure checks are the second commonest reason for people visiting their GP. However, sometimes surgeries are not the most conducive environment to get representative readings. Reasons for this include 'white coat' syndrome (where people's blood pressure rises because they are worried about having it taken), and, in a few cases, ageing equipment.

The innovative Scale Up BP project is currently funded by the British Heart Foundation and uses text reminders to get patients to monitor their BP regularly at home with state-of-the-art equipment. The readings are shared with the patient's GP, who can then check up on the patient and ask to see them if the readings are abnormal. This is a very useful early intervention technique that can be used to diagnose hypertension and other conditions. It also frees up GP time while providing the patient with a much more robust service. We currently have 872 people registered in East Lothian. The British Heart Foundation funding ends on 31st December 2019. New funding of £126,905 has been granted by the Scottish Government that will enable the project to run through to 31st March 2021.

Living independently at home or in your community

Transforming services for adults with complex needs

The Transformation Programme became 'live' in August 2018 with a range of public and staff engagement events. The ELHSCP Transformation Management Team outlined our ambition to collaborate with all interested stakeholders to review the community based day time needs of people with complex needs, current service provision and, through conversation and debate, reimagine how we can best organise and shape our service provision in East Lothian to best meet the needs of this wide population group.

This process followed an iterative process, where we developed the key messages and emerging model, then went back out to our stakeholder groups to check in, amend and consolidate our thinking at each stage.

We interspersed these conversations with regular newsletters.

Throughout this process we were held to account by the Transformation Programme Reference Group; a group of representatives of carers, users, advocacy groups and service providers, who hold the remit of critical friend and co-producers for this area of work.

By June 2019, we were able to achieve full consensus with our stakeholders on the overarching model framework and our 12 key recommendations.

Currently, in collaboration with the Reference Group, we are working through the options appraisals to detail how we intend the actual delivery model to work, for example, where the various aspects of service might be located.

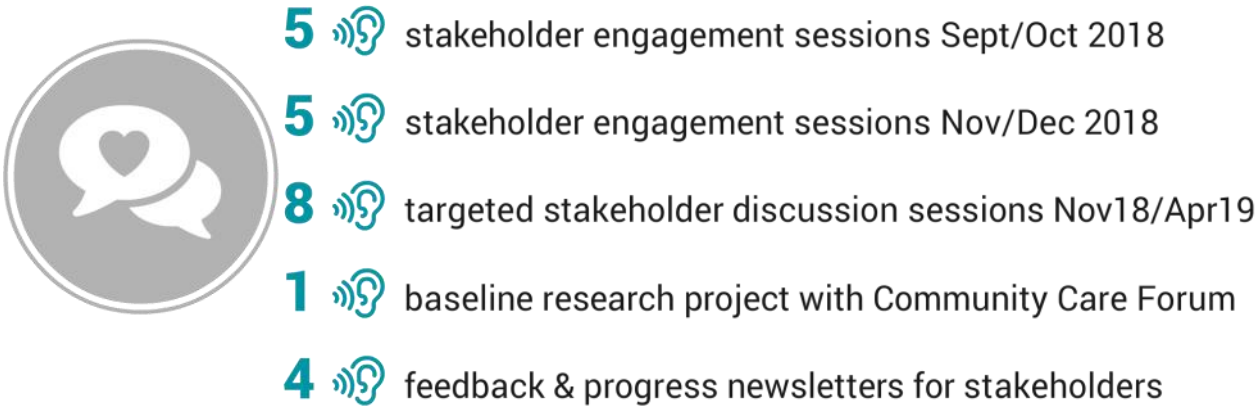
We are also in the process of costing the new model.

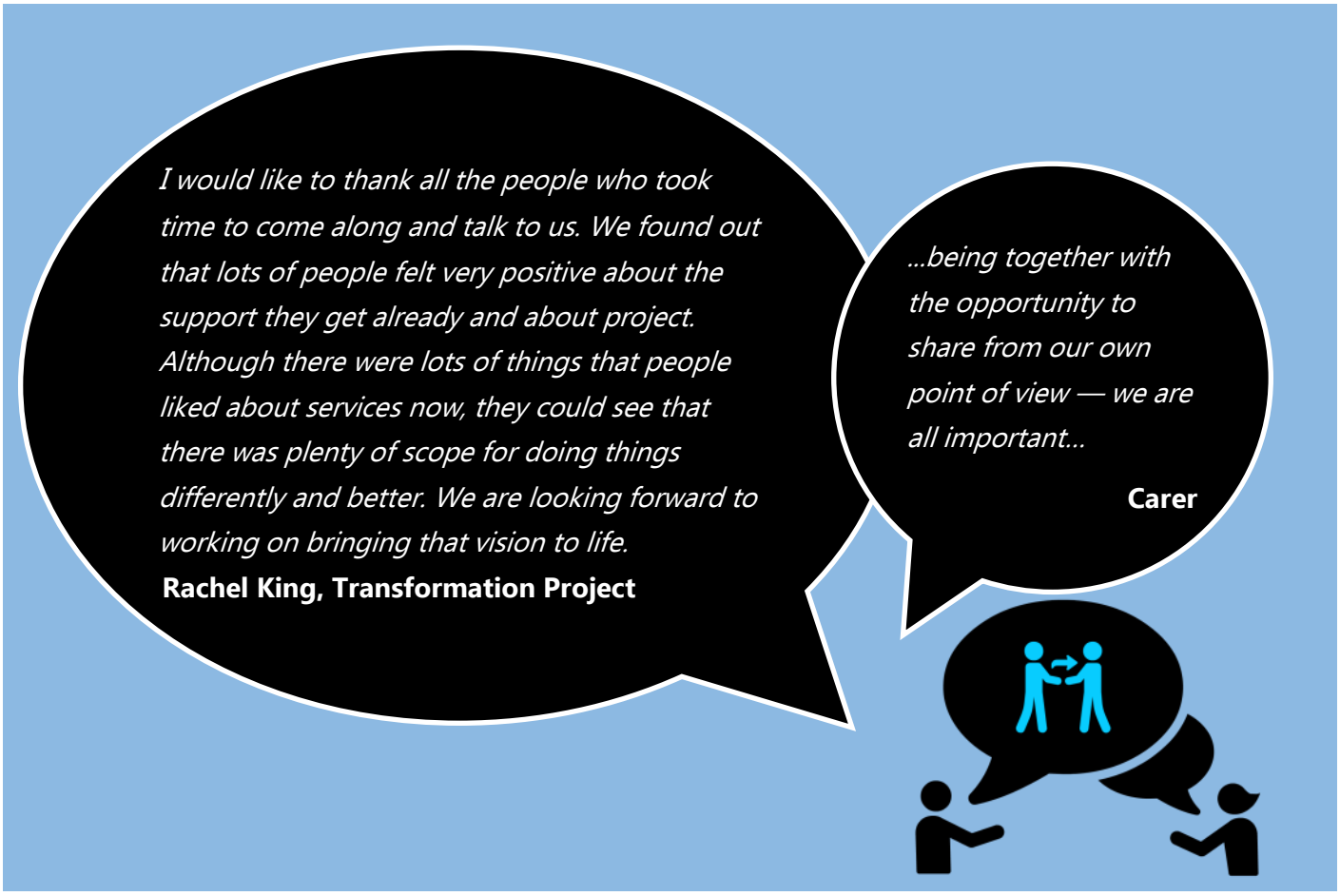
Once these two aspects of work are concluded, we will take the costed model to the Integration Joint Board for endorsement, and permissions to move on to the next stages—developing the commissioning strategy and implementation plan.

Living independently at home or in your community

The engagement process between September 2018 and April 2019

As well as working closely with the reference group, a key part of the project was in-depth engagement with stakeholders, including service-users, carers, staff and providers. Key themes in the feedback included wanting to have more activities locally in mainstream facilities, issues with transport, the need be able to access education, training and employment, and having activities in the evenings and weekend. All the feedback has been used by the team and the reference group to begin work on developing options for the options appraisal. The reference group is part of our strategic planning structure and comprises user, third and independent sector representatives and elhsco officers.





Positive experiences of health and social care

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

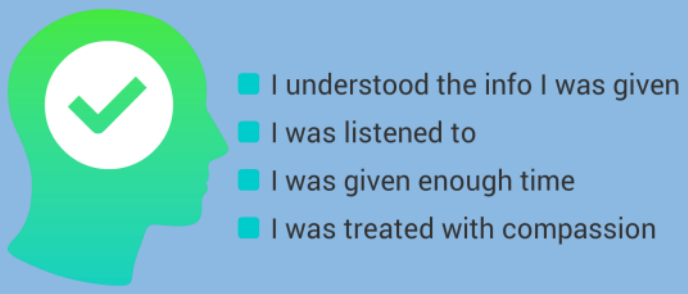
Positive experiences of health and social care

Collaborative Working for Immediate Care (CWIC)

Over the last two years, we have been developing CWIC, an innovative service developed to accommodate 'same day demand' for health care differently. CWIC absorbs this aspect of care from GP colleagues, facilitating their management of more chronic and complex health conditions. Patients who do not require to attend a GP are directed to another, appropriate health care professional. This ensures rapid access to the right care, delivered by the right professional at the right time to receive assessment signposting and/or treatment.

Feedback

Early, locally arranged, evaluation of Patient Experience in CWIC shows that around 80% of patients are very satisfied with the service. Here are key satisfaction themes from that survey.



CWIC in action

Fiona Graham has worked for the NHS for 30 years in a number of roles, all mental-health related. She has been working with CWIC for around 10 months. She says:

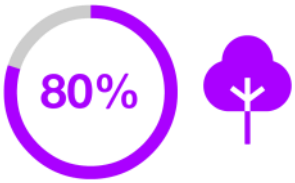
'With CWIC, I work as a Mental Health OT(MHOT). I assess people in a holistic way – looking for both mental and physical health difficulties. OTs are quite distinctive – when registered, we are qualified in physical and mental health and this really helps with the holistic approach. At CWIC, I assess both mental health and the way that impacts on people's lives. I see a very mixed case load, including people who are signed off sick from work. In fact, using the AHP Fitness for Work *report, I can sign people off. Then I can work with them, looking at vocational rehab with goals. I aim to get people well and back to work. Using an MHOT means that people can get counselling and support straight away. It's also good for employers, helping them to support people's return to work and enabling them to make reasonable adjustments and offer ongoing support. We are reducing the reliance on the rest of the primary care team and offering an approach that doesn't rely on prescription medicines.*

'I am also dealing with quite a lot of 18 – 22 year olds who are struggling with transitions from school to uni, self-esteem and confidence issues and social media pressures. I do brief interventions with them to build self-esteem and self-confidence and resilience. Mental health resilience-building is a big factor in mental health these days – supporting people to bounce back.

Positive experiences of health and social care

'I really enjoy it here and I think I am doing some really good clinical work. I feel that I can leave work at the end of the day having done some good preventative work – promoting good self-management. It's more rewarding than I had actually expected because the people I have been seeing could potentially end up with serious mental health problems and I think what we do here is preventing that escalation.'

CWIC Advanced Nurse Practitioner with a patient



Adults had a positive experience of the care provided by their GP practice across all East Lothian practices

East Lothian Care Home Team: Improving the patient and carer experience

Christine Pizzey, a Nurse Practitioner with the Care Home Team, says: *'Prior to the Care Home Team being in place, the GPs would have to visit the care homes on a regular basis—not just for acute episodes of illness, but also for residents managing long-term conditions—looking at anticipatory and palliative care for patients. These are aspects of what we do now, with the support of the GPs back at the surgery.'* Comprising seven Clinical Nurse Practitioners and two Care Home Liaison Nurses, the Care Home Team:

- Provides medical management to Care Home Residents (Mon-Friday 8-6pm)
- Releases GP time
- Reduces hospital admissions
- Provides training, clinical support and advice to promote local and national standards
- Undertakes polypharmacy reviews
- Undertakes anticipatory care planning and Key Information Summaries
- Undertakes DNA/CPRs
- Has an adult support and protection role
- Makes referrals and liaison with multidisciplinary agencies, for example, social work.

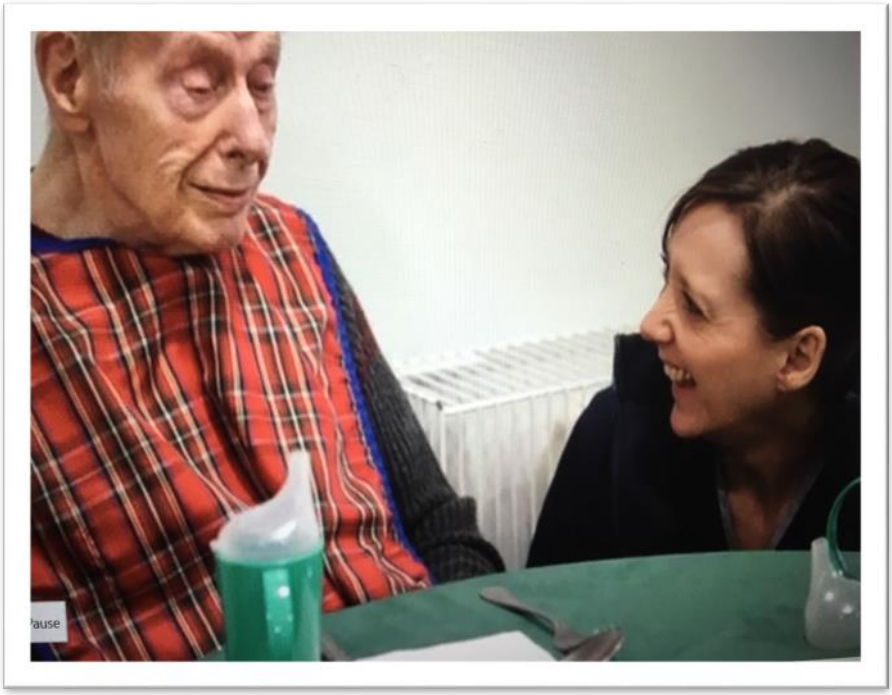
Looking ahead, the team intends to:

- Expand to cover all GP practices in East Lothian
- Improve standards of clinical knowledge and skill through education improving the care provided to care home residents.

Positive experiences of health and social care

Impact of Care Home Team

- ✓ Reduced hospital admission and promote supported discharge, reducing bed pressures and improving patient flow
- ✓ Proactively managed medical conditions
- ✓ Reduced out-of-hours GP call-outs
- ✓ Reduced prescribing through medicine reviews, accurate assessment and multi-agency working.



I don't think GPs have the time to do that holistic care planning. They treat what they see whereas we look to see if there's anything underlying—do we need to look at future anticipatory care planning; do we need to have discussions with families now?'

Suzanne Brown

Nurse Practitioner, East Lothian Care Home Team

Adults receiving any care or support rated it as excellent or good

Practice Administrative Staff Collaborative (PASC)

This collaborative focused on two areas – reducing the amount of time GPs spend on document management, and making the best use of practice appointments and resources so that patients would be able to see the right person, at the right time, in the right place.

As part of this, East Lothian primary care teams have grown their capability in Quality Improvement methodology. We were lucky to have support from the NHS Lothian Quality and Safety Manager for Primary Care to support us during the life of the Collaborative and together we have successfully delivered in both areas.

The Collaborative has helped to forge strong links between practices and enabled them to share learning with other HSCP teams.

Healthcare Improvement Scotland funding supported the delivery of PASC. The majority of this funding was spent on training for administrative staff in areas including Medical Terminology, Docman Workflow (document administration system), Communication Skills and Care Navigation. Staff also attended a number of national learning events and a celebratory event in March 2019.

'This work is crucial to the implementation of the Primary Care Improvement Plans under the new General Medical Services Contract (2018). The new GMS contract supports the expansion of the Primary Care Multidisciplinary team and the evolution of the GP role into that of Expert Medical Generalist. The development of the role of administrative staff in practices is key to enabling this transition.'

Dr Jo Smail, Cluster Quality Lead, West of East Lothian

Maintaining or improving your quality of life

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

Maintaining or improving your quality of life

This is what East Lothian Health and Social Care Partnership is all about so we've picked out some of the key aspects of our work last year that are helping service-users and carers to maintain or improve the quality of their lives.

Self-Directed Support

Self-Directed Support is Scotland's mainstream approach to social care. Self-Directed Support (SDS) puts the person at the centre of the support planning process. It enables people, carers and families to make informed choices about what their social care support is and how it is delivered.

It's not an add-on or a separate way of doing things, since the 2014 Act it is the legal way in which all social care must be delivered. What Self-directed Support does is ensure that people who are eligible for support are given the choice and control over how their individual budget is arranged and delivered to meet their agreed health and social care outcomes.

In East Lothian, we are making good progress in encouraging people to explore all SDS options, as you can see from the table below.

TOTAL UPTAKE FOR EACH OPTION	2017-18	2018-19
All Option 1 (Direct Payment—service user or carer selects and arranges services out of an agreed personal budget)	112	126
All Option 2 (Service-user chooses provider, but ELHSCP or other agency manages budget)	98	196
All Option 3 (ELHSCP selects and arranges support for the service-user)	845	831
All Option 4 (included in Options 1, 2 and 3) (A mixture of options)	129	151
TOTAL UPTAKE FOR WHERE PEOPLE SELECT ONE OPTION ONLY	2017-18	2018-19
Option 1 only	36	72
Option 2 only	45	92
Option 3 only	716	687
Option 4 (mixed)	129	151
TOTAL CLIENTS	926	1002

Maintaining or improving your quality of life

SDS Thematic Review

East Lothian Health and Social Care Partnership (ELHSCP) was one of six Scottish health and social care partnerships to take part in a Care Inspection Thematic Review of the Implementation of Self -Directed Support (SDS) in Scotland. The Care Inspectorate visited East Lothian during September last year and worked with service-users, carers and staff to establish how well SDS was being implemented in the county. They had some very positive insights to share. They thought that the way that we supported people to experience positive personal outcomes through the implementation of self-directed support was good in East Lothian. Here's what the inspectors had to say.

'Good conversations and positive outcomes were clear strengths of our inspection findings in East Lothian. Staff…were confident that they were supporting people to achieve positive outcomes…many supported people and unpaid carers were clear that they were experiencing flexibility, choice and control in their care and support and that this was making a difference to their lives'.

They also noted that staff felt confident, competent and motivated to practice in an outcome-focused and person-led way. They rated us as good, saying:

'The majority of social work staff we met…felt autonomous, confident and supported. There were appropriate arrangements in place to express views, share, discuss and reflect on practice issues at events, workshops and individual support levels with managers.'

Another area that impressed the inspectors was the way we had effectively communicated and engaged with our stakeholders and promoted more flexible commissioning strategies. They also liked the way that we empowered and supported staff to develop and exercise appropriate skills and knowledge, and they felt that leadership was good too.

I've worked with carers for years and have been one for years. I love what I'm seeing now, and I wish this [SDS] *had all been around when I was in the darkest days of being a carer.'*

East Lothian carer

Maintaining or improving your quality of life

They said: *'The self-directed support vision, values and culture were generally well established across the partnership…Overall, the partnership was collaborative, innovative and had designed and embedded numerous new ways of working all based around efficiencies, market stimulation and self-directed support principles'.*

SDS prepayment card

In January 2019, we introduced the SDS prepayment card. We put the amount agreed for the service-user's four-weekly Direct Payment on to it every four weeks. It works like a debit card and has an online user account—just like an online bank account—and each card is PIN-protected.

With more people using Direct Payments, we need to put better, more efficient monitoring in place. The payment card will mean that no one will have to make quarterly submissions any more (and people will be able to check their balance online at any time). There will no longer be any need for people to open special bank accounts for Direct Payments, so it will be much quicker to set Direct Payments up. We think this system will be an added incentive for people thinking about or currently using SDS, as it will make finances much easier for service-users to control.

Martin the Football Barber

Part of maintaining or improving quality of life in care home settings is about making things homely and enjoyable. Here's one small example—meet the Football Barber

Eskgreen Care Home is working with the 'Football Barber' Martin Murphy on a new service. Martin pops into Eskgreen every six weeks to provide a barber's service to residents while talking sports. Martin says:

'I am a football barber! The concept is simple. I aim to deliver a barbering service to gentlemen, while incorporating stimulating conversation through the medium of sport; predominantly the national sport, football!'

Martin's approach is to help people who can't visit their local barber anymore to still be able to enjoy the full barber shop experience. So far, it's been a real winner at Eskgreen.

Maintaining or improving your quality of life

Community Review Team

In 2018, it was agreed that the Community Review Team would be given additional investment to expand the staffing ratio because existing staffing levels were not able to cope with annual reviews of client support plans arranged by staff within the partnership. As a result we now have one senior practitioner, two full-time social workers and five-and-a-half full-time-equivalent Community Care Workers.

Reviews are essential to making sure that people who use services:

- are receiving person centred care
- have plans that reflect what is important to them and assess what is working or not working
- are assured of choice and control around the support they receive (where appropriate)
- have plans that are meeting the outcomes identified in their Support Plans
- are receiving a quality of support that is adequate
- are assured that there no conflicts or complaints.

We have developed a link worker system where reviewing officers meet care at home providers monthly in order to identify and prioritise reviews to hold jointly. This model was developed from the feedback we received from service users who told us that they would prefer multi-agency reviews that have a holistic and person-centred approach. Staff are now 'linked' to agencies on our care at home provider framework and in turn each framework agency will have a single point of contact.

We know from experience that collaborative working with our partners enables a 360° vision of how delivered support assists clients to achieve their outcomes and therefore we will continue to contact partners when undertaking a review.

East Lothian currently provides approximately 22,000 hours of care to roughly 1,600 clients and therefore realistically we would struggle to see every client annually. However, by building and developing the relationship with our providers, we are now in a position to monitor clients who need a review whilst monitoring those clients reviewed by the agency. Establishing positive working relationships enhances good communication and provides a transparent escalation process if issues or complexities are identified. Our goal is prevention and de-escalation through earlier intervention.

Maintaining or improving your quality of life

The new model continues to ensure we work closely with the Planning and Performance Team. Contract monitoring is linked to quality assurance and performance and therefore this function needs to work collaboratively with the operational team as the reviewing officer will have the skills to engage with service users and providers to mediate when there is any conflict within the support plan, complaints or poor performance.

Finally, one of the outcomes of our recent Self-Directed Support Thematic Inspection, was that we needed to improve our frequency of reviews whilst ensuring that they were focused on outcomes and person-centred support. The table underneath shows impact on performance

Number of completed reviews	
Jan 2018 to May 2018	Jan 2019 to May 2019
94	234
INCREASE OF 248%	
Efficiencies while delivering the same or better outcomes = £183,335.00	

East Lothian Health and Social Care Partnership runs three care homes and commissions services in nursing homes around East Lothian and further afield. It runs its own Home Care Service and also commissions care at home from a number of providers to deliver this service. In 2018, we completed a major retendering process, which resulted in a new framework of 14 providers in March 2018. The production of the brief for the tender was the product of a long and thorough engagement process with all stakeholders over the period of 18 months.

Here is a snapshot of what we provided every week in 2018/19.

Maintaining or improving your quality of life

Transforming services for older people

In 2017, East Lothian Health and Social Care Partnership was asked to develop a strategy for the reprovision of Belhaven and Edington Community Hospitals and Abbey and Eskgreen Care Homes. These facilities provide a range of services including NHS community beds (step down care, palliative care, NHS Short Care Provision, day treatments), residential care beds, nursing home beds, residential Short Care Provision care and minor injuries (not all the facilities provide all these services). The Edington site also accommodates North Berwick Medical Practice. All the facilities have building challenges and need significant upgrades to meet the expectations for modern care standards. We thought this was a great opportunity to think about how we could do things differently and better and wanted to work with communities to get their thoughts. Therefore we undertook an 12-month initial consultation period to get this work underway. As well as social media and online consultations and media stories, we had more intensive four-month period of engagement between March and June 2018, and a development session with community representatives and the IJB in November 2018.

In December 2018, the East Lothian IJB approved the reprovisioning of Belhaven and Edington Community Hospitals and the Abbey and Eskgreen Care Homes through the development of extra care housing or equivalent alternatives and charged East Lothian Health and Social Care Partnership (ELHSCP) with taking this work forward. Early in 2019, HUB South East agreed to work with ELHSCP on developing a business case and work is about to begin with each of the three communities on provision that is tailored to local need. Peter Murray says:

'Local communities have been instrumental in helping us to get this far and we are looking forward to working together closely with local representatives throughout the next phase. We want to come up with local solutions that meet the individual needs of each of the three communities.'

'I see this as a very exciting time for health and social care in East Lothian and I am delighted that we now have the green light to start taking things forward in terms of preparing business cases.'

IJB Chair (2017-19) Peter Murray

Reducing health inequalities

National Health and Wellbeing Outcome 5

Health and social care services contribute to reducing health inequalities

Reducing health inequalities

Tackling health inequalities is a Golden Thread (see page 9) and is at the forefront of all our planning and delivery. Here are a few projects that we feel will make significant impact in tackling inequalities.

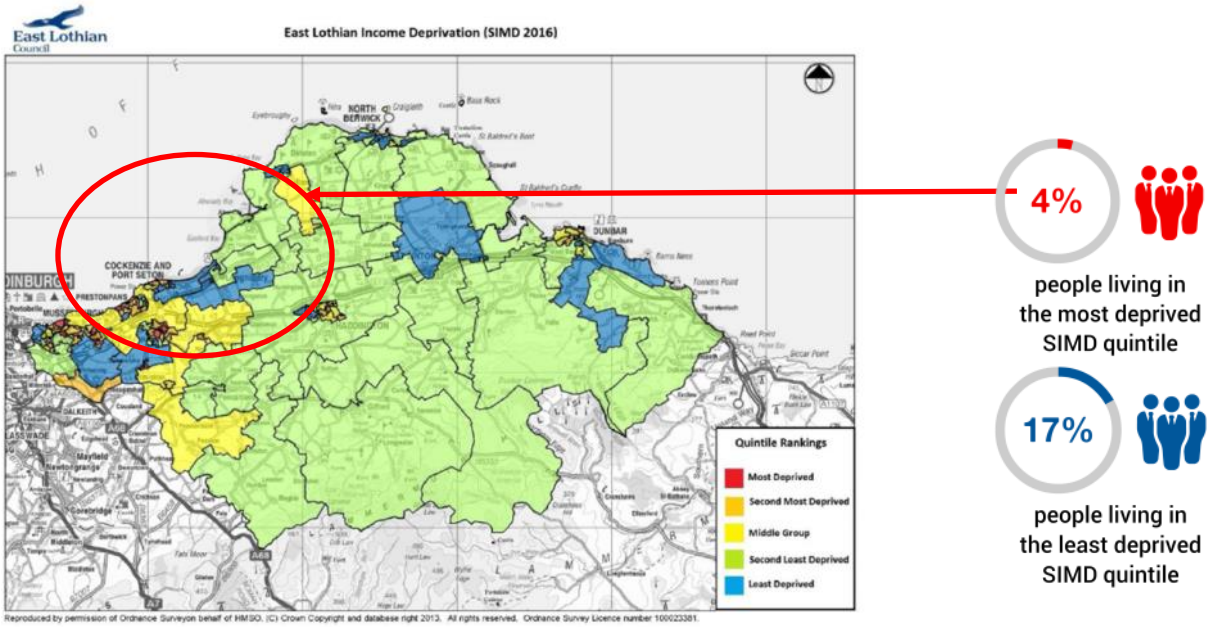
Improving access to primary care for all

In 2018, we produced a Primary Care Improvement Plan (PCIP) to support the new Scottish contract for GPs. The Plan describes how the HSCP will provide new services, including vaccinations; pharmacy support to GPs; community treatment and care services; urgent care; acute musculoskeletal physiotherapy; community mental health and community link workers. The Improvement Plan describes ELHSCP's intentions for development of the primary care multi-disciplinary team to include advanced nurses, advanced physiotherapists, specialist mental health OTs, pharmacists and others who will work with our GP colleagues delivering services which:

- establish new ways of working and new ways to deliver primary care services across the county
- provide improved, accessible information and education
- provide more supported self-care and self-management
- enhance third sector services and community and voluntary support.

As East Lothian's 15 GP practices range in size from 2,700 to over 19,000 patients, with some serving the large towns and others covering more rural areas, care was taken to ensure the timetable for planned service developments matched practice need and focused on inequality (see map below). The Plan also took into account the increasing demand from a growing and ageing population and the pressures this places on individual practices.

Why we need to focus on the West



Reducing health inequalities

New East Lothian Community Hospital open on budget, on time

Three years in the making, and many more in the planning, the new £70 million East Lothian Community Hospital is set to open in September 2019.

Alison Macdonald, Chief Officer East Lothian Integration Joint Board, says:

'This hospital has been long awaited and will bring huge benefits for patients and carers in East Lothian. In particular, it will enable people to have a range of procedures in a brand new, purpose-built hospital for which they previously had to travel to Edinburgh or further afield.

'Services that have already been repatriated from Edinburgh include Urology, Orthopaedics (musculoskeletal), Rheumatology, Gynaecology, Adult ENT and Audiology. We will also be hosting services new to East Lothian, for example, Plastic Surgery for hands, Adult Psychiatry, Ante-natal services, Dietetics and Palliative Care. We are also planning to host Paediatric ENT, Paediatric Audiology and Phototherapy. Being able to receive care closer to home and in a community setting is really important in terms of the positive impact it will have for patients and carers. It will make a big difference to local health care in East Lothian.'

Reducing health inequalities

Roodlands OPD's new home

In March 2018, the Outpatient Department (OPD) of Roodlands Hospital moved into the initial phase of the new East Lothian Community Hospital (ELCH). This provided the same capacity (20 clinic rooms) as the previous configuration. We have been working to attract services to increase their clinic usage within the new hospital.

Working collaboratively with service teams across the Edinburgh-based Outpatients Departments, we have attracted some of these services to East Lothian. This has enabled an increase in outpatient activity of just over nine per cent in the new East Lothian Community Hospital. Services increasing their clinic usage of the new hospital include:

- Urology
- Orthopaedics
- Musculoskeletal
- Rheumatology
- Gynaecology
- Adult ENT
- Audiology.

We have also started some new clinics for:

- Plastic surgery for hands
- Adult Psychiatry
- Ante-natal
- Dietetics
- Palliative Care

Phototherapy treatment will be introduced from October 2019, for certain dermatological conditions, saving patients who currently have to travel into Lauriston twice a week for up to an 12-week treatment cycle, to have that care locally.

Increasing capacity and the range of clinic specialities, reduces the need for East Lothian residents to travel into Edinburgh. In September 2019, phase three will be commissioned providing additional capacity of eight clinic rooms, an interview room and two treatment rooms. We continue to work with services across Lothian to see what additional clinics could be started at ELCH Outpatients Department. Whilst we will require additional staff to enable full utilisation of the extra floor capacity, we will also be ensuring our nursing staff have the opportunity of gaining a wider skill set, to enable us to attract a broader range of clinical services.

Reducing health inequalities

Working with Local Area Partnerships

Our Health Improvement Team works closely with Local Area Partnerships on a wide range of initiatives designed to tackle Health Inequalities. In early 2019, for example, they supported Musselburgh Local Area Partnership's Your Voice, Your Choice 2 initiative. People living in the area were asked to put forward local ideas for projects which would have a positive impact in reducing inequalities. £20,000 of funding was provided by Musselburgh Area Partnership and £45,000 from the Scottish Government's Community Choices Fund.

Fourteen projects were selected, including a local tool library, a big family food garden, a money advice service, a summer play scheme and a Musselburgh community kitchen.

Link worker scheme

We have been running a link worker scheme in East Lothian with STRiVE for the last three years at four practices in areas of greatest need. They work with patients on the day-to-day issues that may impact on general health and wellbeing, for example money and debt issues, social isolation and other personal issues. The link workers are trained to provide first stage advice and link patients with advice and support agencies that can provide expert help. With the advent of the new GMS contract, we are now evaluating this service and looking at how we can roll out link worker provision to support all medical practices and patients in East Lothian.

Reducing health inequalities

Substance misuse is a major contributor to health inequality, impacting on service-users and their families and carers. This new, recovery-based support ts already making a difference.

Primary Care Assertive Outreach Team

Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP), which supports the statutory and third sector integration of substance misuse services in East Lothian, agreed to set up a Primary Care Assertive Outreach service, based in medical practices in key locations across East Lothian. This was with a view to better meeting the Scottish Government strategic objective of delivering a 'recovery orientated approach which reduces harm and prevents deaths'.

Additional Community Psychiatric Nurses (CPN)

This expansion has taken the form of two fulltime substance misuse service community psychiatric nurses, peer support workers and an increase in the Consultant Psychiatrist establishment, to provide learning and support to GP colleagues. This was funded using a proportion of the East Lothian allocation of revenue arising from the Scottish Government strategy, Rights Respect and Recovery, published November 2018.

The service already provides support to medical practices for 223 patients, with a further 258 in transition from secondary to primary care. They support over 300 patients across the following practices—Riverside (Musselburgh), Prestonpans, Tranent, North Berwick and the three in Dunbar.

The way ahead

We are seeking expansion to cover the rest of the county in 2019/20 financial year and a principal aim of this expansion is to promote health equality by focusing resources on the areas of most need.

Carers

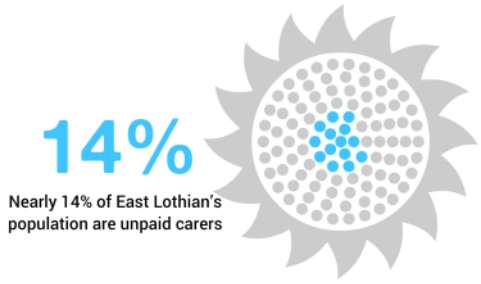
National Health and Wellbeing Outcome 6

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

About the East Lothian Carers Strategy

Our Carers Strategy identifies eight outcomes with key actions under each one that are based on feedback from extensive engagement with carers over a period of 18 months through reference groups, surveys, commissioned research and public events. The outcomes are:



- adult, young adult and young carers are identified and can access support
- carers are well informed and have access to tailored and age appropriate information and advice throughout their caring journey
- carers are supported to maintain their own physical, emotional and mental wellbeing
- breaks from caring are timely and regularly available
- carers can achieve a balance between caring and other aspects of their lives
- young carers are supported to have a life outside their caring role
- carers and young carers are respected by professionals as partners in care and are appropriately included in the planning and delivery of both the care and support for the people they care for and services locally
- local communities are supported to be carer friendly.

Short Breaks

We have developed Short Breaks Services Statement with Carers of East Lothian, written in consultation with carers and other professionals, in line with our duties under the Carers (Scotland) Act 2016. This provides information for unpaid carers, and for others who might support someone, about the different breaks from caring available in East Lothian. It also includes details of local services which may be of help .

Carers can be young carers, young adult carers, parent carers or adult carers.

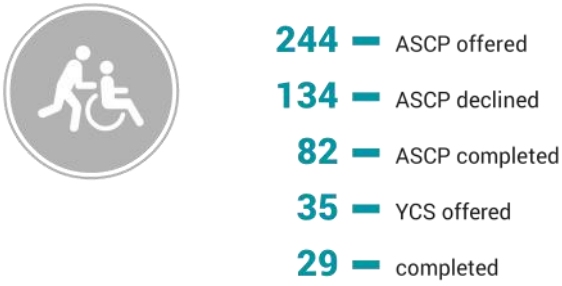
We know that breaks are essential for unpaid carers to help them have the chance to take care of their own health and wellbeing, allow them to have time to themselves, or to spend time with people who are important to them. We have developed a helpful online guide to short breaks that outlines:

Carers

- What a short break means
- How to arrange a short break
- Help from local carer organisations
- Help with costs
- Charges for support
- Planning a break
- What sort of breaks are available.

Adult Care and Support Plans (ASCP) and Young Carer Statements (YCS)

The Carers Act introduced ASCPs and YCSs. They look at how caring affects carers' lives, including for example, physical, mental and emotional needs, and whether they are able or willing to carry on caring. We put a lot of effort into raising awareness of ASCPs and YCSs in partnership with staff, carers and advice organisations and online. We produced a new suite of information leaflets for carers and also used social media and local radio to try to encourage carers to come forward and take up their new entitlements. The graphic below gives the ASCP and YCS activity for 2018/19.



We are continuing to work with partners and awareness campaigns to improve uptake.

Coalition of Carers in Scotland (CCS) Good Practice examples

We received two honourable mentions in the most recent CCS report. They said:

- East Lothian and Aberdeen both provided exit interviews for departing Carer Representatives whose tenures ended. This allows appreciation to be shown and learning to be shared. As noted elsewhere in this report [CCS], planning for succession, recruitment and handover while the representative is still in post are also important.

- [East Lothian] Include carer representation on change boards.

Carers

Thank you to all our carers

In 2018 and 2019, we put a lot of work into National Carers Week. We did this to:

- celebrate the contribution that carers make
- try to encourage more people to identify as carers
- raise awareness of carers' needs amongst the wider community and encourage them to think what they can do to support carers, including businesses and employers.

East Lothian Council Health and Social Care spokesperson Councillor Fiona O'Donnell issued a media release to thank East Lothian's Carers at the beginning of Carers Week. She said:

'There are around 14,500 unpaid carers in East Lothian and unpaid carers across the UK save the economy around £132 billion every year. Carers' Week is an annual "thank you" to our unsung heroes.

'This year I am delighted to say that again East Lothian businesses have come up trumps with lots of discounts and freebies for people who use the East Lothian Carer Card. I want to say a heartfelt thanks for all the very kind offers that we've had, which include cream teas, beauty treatments, therapies, a distillery tour and biking and outdoor adventures. It is wonderful to see businesses big and small getting behind Carers Week.

'East Lothian Integration Joint Board has also been working all out for carers. We have increased funding for carers to over £355,000 this year, which means more for carer support workers, counselling and micro grants for short breaks. It means more Young Carers Club places, support for the Schools' Young Carers worker and transitions support. It also means more for individual carer budgets. There's lots more to do but we have made a good start.'

We did this last year [Carer Card] *and offered the carers a 20% discount off the carer's entry price. We would be happy to do this again during that week when they show their East Lothian Carer card.*

East Links Family Farm Dunbar, one of the many East Lothian businesses to support the Carer Card.

Keeping people safe from harm

National Health and Wellbeing Outcome 7

People using health and social care services are safe from harm

Keeping people safe from harm

Keeping people safe from harm can mean lots of things. It includes public protection, protecting people during mental-health crisis and keeping our communities safe through the work of the Criminal Justice Team.

East and Midlothian Public Protection Office

The East and Midlothian Public Protection Office (EMPPO) has had a busy year across all its areas of activity. It has been active in promoting national campaigns, for example, the White Ribbon Campaign, Financial Harm, Scammers, Coercion and #EyesOpen campaigns. It has also continued to support ELHSCP in Adult Protection matters with providers. One of the highpoints of the year was issuing the EMPPO Position statement on Commercial Sexual Exploitation.

Providing positive alternatives to hospital admission for mental health issues—Intensive Home Treatment Team

The Intensive Home Treatment Team (IHTT) works in partnership with the patient, their family and carers in their treatment and recovery from an acute episode of mental distress requiring intensive interventions. This service is delivered in the patient's own home or other community resource as a direct alternative or prevention of admission to inpatient treatment where safe to do so. It helps in-patients to return to the community by offering the appropriate levels of care, treatment and support to them and their carers. The IHTT team also responds to referrals on the same day, offering patients support by phone and/or an initial face-to-face comprehensive mental health assessment. They take a holistic approach to care planning and treatment. They offer a brief intervention until the crisis has resolved and symptoms have stabilised, and coordinate appropriate onward referral for continued support within the person's community and with appropriate agencies to meet the needs of the person. IHHT has played a major role in reducing psychiatric inpatient admissions for people in East Lothian.

697 Referrals
175 GP referrals
149 Consultant referrals
118 Police referrals
166 Self-referrals

Referrals to IHTT in 2018/19 and the four top referrers

46 inpatient admissions July-Sept 2014
81 IHTT interventions July-Sept 2014
26 inpatient admissions July-Sept 2018
181 IHTT interventions July-Sept 2018

Snapshot of inpatient admissions/IHTT interventions in July-Sept 2014 and July-Sept 2018. Notice both the fall in inpatient admission and the growth in referrals overall

Keeping people safe from harm

1st Response

1st Response is for people who are feeling at crisis point. It's for people who are dealing with long-term, mounting stress and feeling unable to cope. Most of these people will have little contact with the usual agencies like GPs or social work. They may be at crisis point because of:

- money or debt worries
- unemployment or problems at work
- housing issues
- changes in their health
- family or caring concerns.

Whatever the issue, 1st Response can support them to resolve their crisis. It provides face-to-face support throughout East Lothian. Workers provide sensitive and non-judgmental support based on each person's individual circumstances and needs, and helps people to access other services. They support people to plan and manage their next steps and provide information about other organisations which could help (such as health services, social work, benefits advice and other support). A key feature of their work is helping people to develop skills they need to manage their mental health.

1st Response is run by specially trained practitioners and peer workers – people who use their own experience of mental health difficulties to help others achieve recovery. The service is open to anyone aged 18 years old and over who lives in East Lothian and is experiencing distress and reduced mental wellbeing. Appointments are available Monday – Friday at a variety of locations across East Lothian. People are invited to call to make an appointment so that they are guaranteed a face-to-face session.

The scheme enables workers to travel across the county to help people who need help to receive it locally. 1st Response have found that familiar surroundings in a local community are more congenial and also reduce the expense of travel and lack of local transport in some areas. The project is now entering its third year and evaluations have been positive.

Keeping people safe from harm

Criminal Justice Social Work Service

The Criminal Justice Social Work Service in East Lothian is committed to reducing the number of prison sentences handed out by offering a wide range of alternative sentences in the community. These services take into account the needs of the people who offend, the victims of crime and public protection.

In East Lothian the Criminal Justice Team is made up of social workers, unpaid work supervisors, social work assistants and business support staff.

They prepare social enquiry reports to help the client and the courts, and the range of outcomes they work with includes:

- Drug Treatment and Testing Order
- Restriction of Liberty Order
- Monetary Penalty
- Deferred Sentence
- Community Payback Order—unpaid work only
- Community Payback Order—supervision only
- Community Payback Order—supervision and unpaid work.


The Hedges in Tranent

Community Payback Orders (CPO)

CPOs are imposed by the Court to support a person who offends to address their offending behaviour. The Order contains up to nine requirements, each one offering the opportunity to change behaviour, pay back to the local community or protect the public and potential victims of crime.

The East Lothian Community Payback Team supports the work of community and charitable organisations by taking on a variety of jobs that enhance the physical environment for the benefit of the community. This is the result of their labours on behalf of tenants of ELHA's Hedges housing in Tranent. Karen Barry, Housing Manager, East Lothian Housing Association Ltd, says:

'Our community garden project at The Hedges in Tranent looked like it might fall by the wayside. East Lothian Council had drawn up plans for the garden and funds had been set aside for it but there was a real lack of volunteers to do the digging over and planting up. So in stepped ELHSCP's East Lothian Community Payback Team – the plants are now in place and although there are still things to do, the place is looking a lot better!'

Keeping people safe from harm

The road to recovery

Mid and East Lothian Drug and Alcohol Partnership (MELDAP) is a partnership that includes Midlothian and East Lothian Health and Social Care Partnerships, Police and the Voluntary Sector. Together the partners work to raise awareness of the work that is being done to reduce the harm caused to individuals, families and communities by the misuse of alcohol and drugs.

MELDAP has continued to strengthen the development of a Recovery Orientated System of Care (ROSC), a network of community-led and community-based person-centred services designed to promote recovery. For many people wanting to address their problematic alcohol or drug use, the starting point is one of the well-established 'Gateways to Recovery' and they can simply drop into venues such as the Esk Centre or East Lothian Community Hospital Outpatient department. They will be seen immediately and directed to the most appropriate treatment service. The ROSC model also includes self-help groups such as Alcoholics Anonymous, Cocaine Anonymous and SMART available at venues across East Lothian with the SMART group having up to 14 weekly attendees.

Linking people with education

Support to re-engage with education, develop new skills and gain qualifications is provided through the MELDAP Recovery College which, over the last 12 months, has worked with 41 students with 13 gaining SQA qualifications, two moving on to Further Education, five into work and six becoming volunteers. Friday Friends cafe and the Starfish Recovery Cafe help people reconnect with the wider community and reduce isolation seeing some 30 to 40 people weekly. MELD peer support workers, all people with lived experience, provide a range of practical support to clients; helping them engage with services, accompanying them to appointments and acting as an advocate when needed. Support to help clients' mindfulness and support recovery is provided through alternative therapies such as ear acupuncture offered to MELD clients. The Lothian and Edinburgh Abstinence Programme (LEAP) provided a place for 10 people who needed longer-term residential treatment with 70% of clients completing the 12-week programme.

The progress MELDAP made in development a ROSC was noted in the 2017 Care Inspectorate Report. '*There was good evidence that the ADP had laid strong foundations in terms of their community work through the independently commissioned Recovery Orientated System of Care (ROSC) service review and subsequent Recovery Connections Network, mutual aid, whole population approach, new psychoactive substance (NPS) strategy and links to other thematic groups such as community safety.*

Engaging and supporting our staff

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

Engaging and supporting our staff

Working together

We are our staff. Central to our success is ensuring that 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.

Engaging and learning from staff as we change and grow

From the very beginning, we have been committed to keeping our staff informed and have been in a continuous engagement with them on:

- how to develop and improve services
- integrating teams and structures.

At the moment, we have several major engagements that involve both public and staff. We are working with staff, service-users, carers and the full range of stakeholders on:

- transforming community support for adults with complex needs
- better integrating our home care teams
- reproviding our older hospitals and care homes.

Staff input has been invaluable in areas as diverse as bringing into being our Care at Home Framework and the design of the new East Lothian Community Hospital in Haddington. Nursing staff played a key role in ensuring that the new building is patient, carer and clinician friendly.

East Lothian Health and Social Care Workforce Plan

The changing nature of adult health and social care is complex and our aim is to consider what changes will make the greatest difference to outcomes for patients, service users and carers. As a Partnership we will seek to ensure that our workforce is motivated, knowledgeable and skilled and able to respond to the changes we envisage.

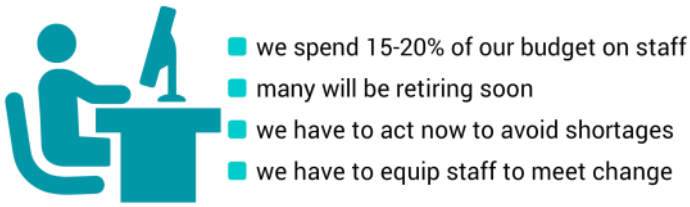
Our workforce has to be equipped to support people to improve their health and reduce health inequalities. We also have to align the skills of our workforce, now and in the future, with the needs of patients and service users. In particular, we need to reskill our workforce to be able to shift the balance of care and move treatment and support away from hospital to community ones.

Integration includes relationships beyond traditional NHS and local authority providers. The majority of social care services, for example, are delivered by the independent sector and integration of services is as relevant and important for them as it is for wider public services such as housing and leisure.

Engaging and supporting our staff

To ensure we meet our statutory and policy requirements, mandatory and statutory training has to be embedded within services to ensure our workforce is meeting legislative and policy requirements. We have to ensure that there are robust arrangements in place in both the Council and NHS to identify and address current and future development needs as well as to deliver and track completion of mandatory and statutory training.

Workforce snaphot



Consequently, learning and development plans for our regulated workforce are clearly linked to continuous professional development.

Central to our workforce plan is the provision of regular supervision. This enables support and guidance for professional practice and practitioner professional development through the assessment of competencies, knowledge, skills and value-based practice.

Working in partnership with independent providers

The independent sector is the largest social services employer in Scotland and employs 45% of care workers in East Lothian

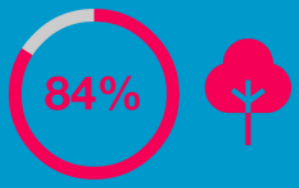
We value the staff who work in our commissioned services and engage with them when appropriate.

'Our workforce is our most valuable asset and one which we need to continue to develop and promote. To help us plan for future needs and demands, we will actively seek to promote health and social care as a career of choice.'

Alison Macdonald
Director of Health and Social Care/ IJB Chief Officer

Partners' workforce

Our partners' commitment to work-force development is reflected in the good inspection results they achieve



Care services graded GOOD (4) or better in Care Inspectorate inspections

Money matters

National Health and Wellbeing Outcome 9

Resources are used effectively and efficiently in the provision of health and social care services

Money matters

2018/19 Financial Performance

Underspend

The IJB was underspent at the end of 2018-19 within both health and social care arms of the budget. That means that the charges from the partners for the IJB's services was less than the income available to the IJB. We have used this surplus to create a reserve.

The main drivers for the underspend in social care related to one-off benefits and may not continue into 2019-20. You can find the full financial commentary in Appendix 2 on page 61.

Increased demand for care services

The areas where we saw most pressures were increased demand for care services, particularly external care for older people and people with learning and physical disabilities, as well as increased transport costs.

'We have had a successful year in terms of coming in on budget. We are in this fortunate position because of the way that everyone has worked together to use our resources efficiently and well. There has been no reduction in service.

'This achievement is down to our staff and I would like thank them for their hard work and dedication to the people who use our services.

'We will continue to face challenges in the coming year due to increased demands with a growing population. However, if we continue in this focused manner, we will be able to ensure we are able to continue to support the most vulnerable in our communities'.

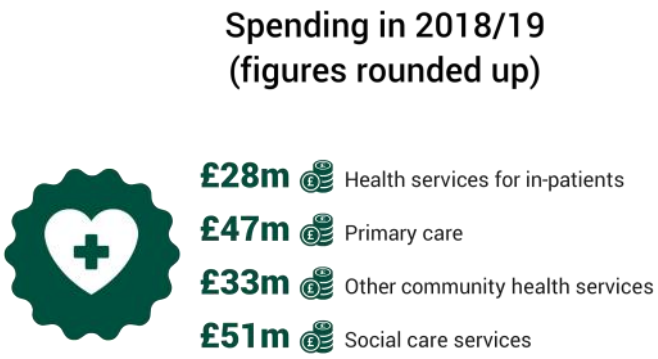
Alison Macdonald , East Lothian Director of Health and Social Care/IJB Chief Officer

East Lothian Integration Joint Board Income (IJB) and Expenditure 2018/19

	Income	Expenditure	Surplus
	£000's	£000's	£000's
Health	116,531	115,060	1,471
Social Care	45,058	44,747	311
Total	161,589	159,807	1,782

Money matters

Change Boards oversee all transformational change. This transformational change will, in turn, lead us to services that deliver more efficiently and effectively and contribute to an improved financial position, not just in 2018/19 but also as we progress in the years to come.



Alison Macdonald adds:

'We have been careful with our resources this year and have managed to set aside a reserve against future years without reducing services to our service-users and patients. We have to be careful though not to be too jubilant. The impact of the growing population is, and will continue to, place a huge demand for services.

'What is heartening is that we have been able to show that integrating teams and a move towards working together in local groups in local settings and new ways of working to make a better use of resources are popular with people who use our services and our staff.

'There will be lots of changes ahead but underlying everything that we do is to do our best for the people we are here for. That means shifting the balance of care, getting involved earlier to prevent complications later, linking people to good information and advice, and being able to keep people at home or closer to home in a homely setting. Our work in primary care in particular is about trying to help people to be seen quicker by the right clinical professional at the right time. As you will have seen in the article about CWIC, this is having a very positive impact on patients.

''We cannot keep on doing what we have always done. We have to be clever, careful and compassionate in designing services and support that meet the needs of people now. We have lots of exciting developments underway now and I look forward on being able to report back to you this time next year.'

Thank you for taking the time to read our Annual Report. If you need more information or make a comment, please email us at elhscp@eastlothian.gov.uk or phone 01620 827 755.

Appendices

Performance against National Health and Wellbeing Outcomes

Finances

Strategic Planning Structure

1. Performance against National Health & Wellbeing Outcome

94% — **1. Adults are able to look after their health very well or quite well**

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	96	n/a	94	n/a
Scotland	n/a	95	n/a	93	n/a

72% — **2. Adults supported at home agreed that they are supported to live as independently as possible**

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	84	n/a	72	n/a
Scotland	n/a	83	n/a	81	n/a

68% — **3. Adults supported at home agreed they had a say in how their help care or support was provided**

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	79	n/a	68	n/a
Scotland	n/a	79	n/a	76	n/a

66% — **4. Adults supported at home agreed that their health and social care services seemed to be well coordinated**

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	76	n/a	66	n/a
Scotland	n/a	75	n/a	74	n/a

75% — **5. Adults receiving any care or support rated it as excellent or good**

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	85	n/a	75	n/a
Scotland	n/a	81	n/a	80	n/a

80% — **6. Adults had a positive experience of the care provided by their GP practice**

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	85	n/a	80	n/a
Scotland	n/a	85	n/a	83	n/a

75% — **7. Adults supported at home agreed their services and support had an impact on improving or maintaining their quality of life**

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	91	n/a	75	n/a
Scotland	n/a	83	n/a	80	n/a

36% — **8. Carers feel supported to continue in their caring role**

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	45	n/a	36	n/a
Scotland	n/a	40	n/a	37	n/a

1. Performance against National Health & Wellbeing Outcome

81%

9. Adults supported at home agreed they felt safe

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	86	n/a	81	n/a
Scotland	n/a	83	n/a	83	n/a

333 per 100,000

11. Premature mortality rate

	2014	2015	2016	2017	2018p
East Lothian	n/a	n/a	375	372	333
Scotland	n/a	n/a	440	425	432

10.035 per 100,000

12. Emergency admission rate

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	n/a	9,622	10,338	10,035
Scotland	n/a	n/a	12,215	12,192	11,492

94,445 per 100,000

13. Emergency bed day rate

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	n/a	121,931	120,782	94,445
Scotland	n/a	n/a	126,988	123,035	107,921

94 per 1,000

14. Readmission rate to hospital within 28 days

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	n/a	100	106	94
Scotland	n/a	n/a	100	103	98

89%

15. Of the last 6 months of life is spent at home or in a community setting

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	n/a	86	86	89
Scotland	n/a	n/a	87	88	89

19.6 per 1,000

16. Falls rate (65+)

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	n/a	18.9	18.8	19.6
Scotland	n/a	n/a	20.8	22.7	21.6

84%

17. Care services graded GOOD (4) or better in Care Inspectorate inspections

	14/15	15/16	16/17	17/18	18/19p
East Lothian	n/a	n/a	77	85	84
Scotland	n/a	n/a	84	85	82

1. Performance against National Health & Wellbeing Outcome

??%	18. Adults with intensive care needs are receiving care at home		2014	2015	2016	2017	2018p
		East Lothian	n/a	n/a	65	64	
		Scotland	n/a	n/a	62	61	

648 per 1,000	19. The number of days people spend in hospital when they are ready to be discharged		14/15	15/16	16/17	17/18	18/19p
		East Lothian	n/a	n/a	1,158	775	648
		Scotland	n/a	n/a	841	762	805

21%	20. Health and care resource spent on hospital stays where patient was admitted as an emergency		14/15	15/16	16/17	17/18	18/19p
		East Lothian	n/a	n/a	23	25	21
		Scotland	n/a	n/a	24	25	22

Please note that some of these figures stem from a bi-annual survey, meaning that the last figure we have is for the year 2017/18 and does not demonstrate progress that we made in 2018/19.

2. IJB Finance report for 2018/19

Managing our resources well

The financial year 2018-19 was the third 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 the last two years and undertook a detailed financial assurance process examining the budget offers from its partners for 2018-19. This process allowed the IJB to consider two broad issues:

- 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?
- 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.

2018-19 Out-turn – Financial Performance

The IJB were underspent at the end of 2018-19, that is the charges from the partners for the IJB's services was less than the income available to the IJB. The year end out-turn for East Lothian IJB was as follows:

	Income	Expenditure	Surplus
	£000's	£000's	£000's
Health	116,531	115,060	1,471
Social Care	45,058	44,757	301
Total	161,589	159,807	1,772

This surplus has been used to create a reserve which is described further below.

The financial position for 2018-19 was underspent within both health and social care arms of the budget. The main drivers for the underspend in social care related to one off benefits and is unlikely to continue into 2019-20.

Within the health budgets although there were operational overspends within Mental Health Services and GMS these were offset by underspends in Health Visiting and Prescribing and slippage (that is some programmes starting later in the year than planned and thus generating an underspend) within the system.

2. Finance report for 2018/19

Within the social care budgets the pressures lay within increased demand for care services, particularly elderly external care and clients with learning and physical disabilities as well as increased transport costs. These pressures were managed in year on a non-recurrent basis, that is from underspends in other operational services.

All services in health and social care are being reviewed through a formal Change Board structure. This is to ensure they deliver the best quality care within the resources available. Some initial benefits of this redesign have contributed to the improved financial position for the IJB within this financial period. Many historic operational pressures remain a challenge and further efficiencies are required in the coming year to ensure financial balance remains.

Overall, the break-even position has been achieved by non-recurrent benefits and slippage (underspends) in elements of the health and social care services. Although an in year surplus, the IJB continues building the management of pressure areas into its financial plans for 2019-20. The total overall position was as follows:

East Lothian IJB - Budget Performance in 2018-19

	Budget	Actual	Variance	
	£000's	£000's	£000's	
Health Services for In-Patients	28,437	28,942	(505)	
Primary Care	46,926	47,295	(369)	
Other Community Health Services	34,953	32,608	2,345	
Social Care Services	51,274	50,973	301	
Total	161,589	159,807	1,772	

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 £19.9m 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 of £6.2m.

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 recurrent and incorporated into the IJB's baseline budget.

Reserves

The IJB now has a reserve which the IJB can use in later years to support service provision. As noted above, the IJB has £1,772k reserves at 31 March 2019.

The IJB has set aside future amounts of reserves for future policy purposes. These reserves normally comprise; 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.

In 2018-19 investment was given by the Scottish Government for specific programmes in Primary Care, Mental Health and Alcohol and Drug Partnerships. As slippage in expenditure occured in the initial set up of these programmes, this sits within the reserves until needed.

The reserve is broken down as follows into specific purposes and general :-

	£000's
Primary Care Investments	219
Mental Health	164
Alcohol and Drug	312
General Reserves	1,077
Total	1,772

The financial year ahead

The IJB has agreed budgets for 2019-20, 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, benefited from non-recurrently in 2018-19.

The Scottish Government has made available £30m nationally (East Lothian's share being £546k) to the Councils to support Free Personal Care for under 65's (Franks Law) and £10m (East Lothian's share £188k) for the Carers Act. - all of these funds have been passed by the Council to

the IJB.

As in 2017-18 the Scottish Government continues to invest in primary care, mental health and substance misuse services. These additional funds along with the carry forward reserves have been made available to the IJB in 2019-20.

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.

3. IJB Change Board Structure

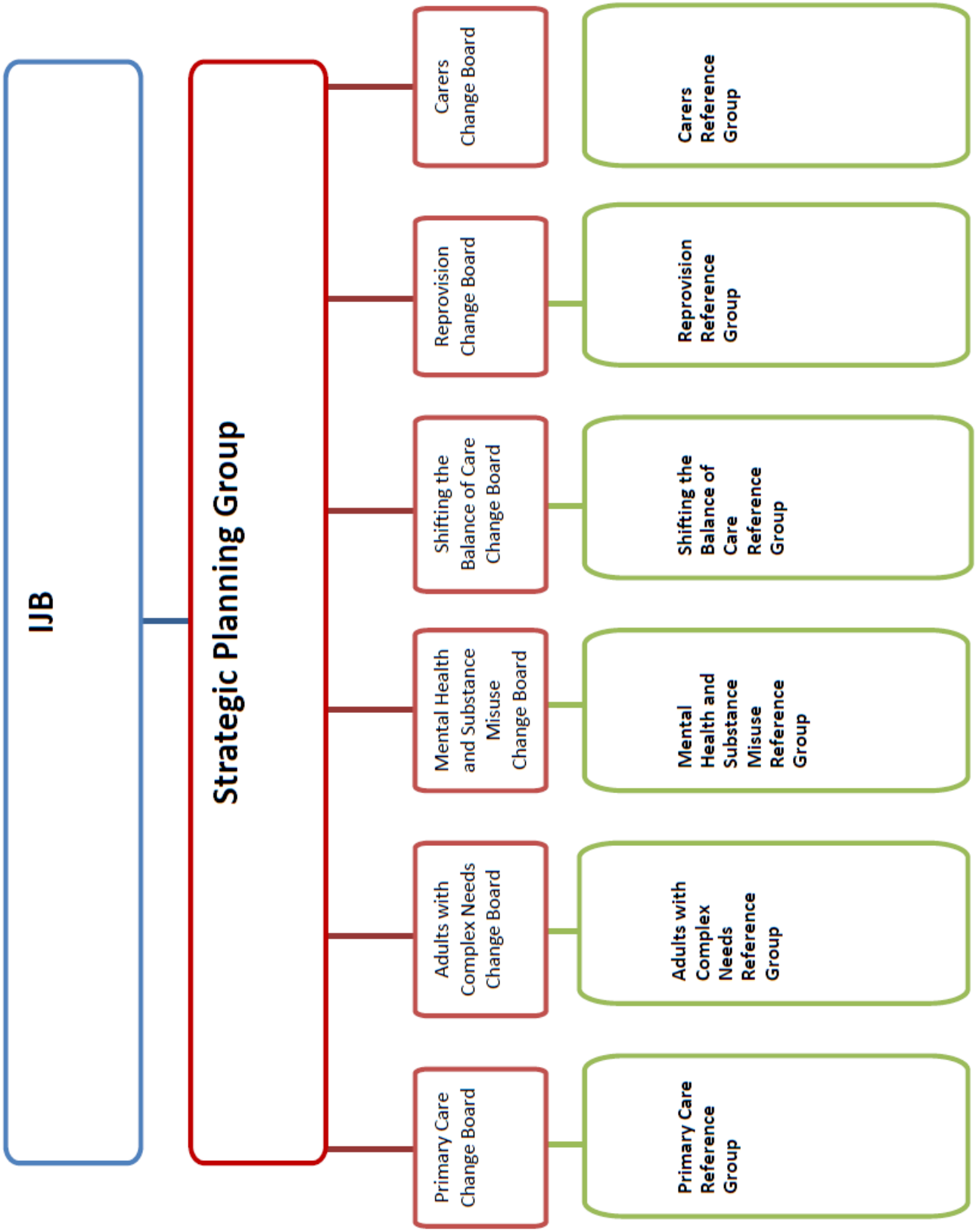


Figure 1 – strategic planning structure

4. Services delegated to the IJB

Services currently provided by NHS Lothian which are to be delegated

(Source: East Lothian Integration Scheme)

Interpretation of this Part 2 of Annex 1

In this part—

"Allied Health Professional" means a person registered as an allied health professional with the Health Professions Council;

"general medical practitioner" means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"general medical services contract" means a contract under section 17J of the National Health Service (Scotland) Act 1978;

"hospital" has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

"inpatient hospital services" means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

"out of hours period" has the same meaning as in regulation 2 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004(); and

"the public dental service" means services provided by dentists and dental staff employed by a health board under the public dental service contract.

The functions listed in Part 1 of Annex 1 are delegated to the extent that they are exercisable in the provision of the following services:

Part 2A

Provision for people over the age of 18

The functions listed in Part 1 of Annex 1 are delegated to the extent that:

a) the function is exercisable in relation to the persons of at least 18 years of age;

b) the function is exercisable in relation to care or treatment provided by health professionals for the purpose of health care services listed at numbers 1 to 6 below; and

c) the function is exercisable in relation to the following health services:

Accident and Emergency services provided in a hospital.

Inpatient hospital services relating to the following branches of medicine—

general medicine;

geriatric medicine;

rehabilitation medicine;

respiratory medicine; and

psychiatry of learning disability.

Palliative care services provided in a hospital.

Inpatient hospital services provided by General Medical Practitioners.

Services provided in a hospital in relation to an addiction or dependence on any substance.

Mental health services provided in a hospital, except secure forensic mental health services.

District nursing services.

Services provided outwith a hospital in relation to an addiction or dependence on any substance.

Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

The public dental service.

Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978().

General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978().

Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978().

Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978().

Services providing primary medical services to patients during the out-of-hours period.

Services provided outwith a hospital in relation to geriatric medicine.

Palliative care services provided outwith a hospital.

Community learning disability services.

Mental health services provided outwith a hospital.

Continence services provided outwith a hospital.

Kidney dialysis services provided outwith a hospital.

Services provided by health professionals that aim to promote public health.

Part 2B

NHS Lothian has also chosen to delegate the functions listed in Part 1 of Annex 1 in relation to the following services:

Provision for people under the age of 18

The functions listed in Part 1 of Annex 1 are also delegated to the extent that:

a) the function is exercisable in relation to persons of less than 18 years of age; and

b) the function is exercisable in relation to the following health services:

Primary Medical Services and General Medical Services (including GP Pharmaceutical services)

General Dental Services, Public Dental Services and the Edinburgh Dental Institute

General Ophthalmic Services

General Pharmaceutical Services

Out of Hours Primary Medical Services

Learning Disabilities

Health Visiting

School Nursing

4. Services delegated to the IJB

Services currently associated with the functions delegated by the Council to the IJB

Set out below is an illustrative description of the services associated with the functions delegated by the Council to the Integration Joint Board as specified in Part 1A and 1B of Annex 2.

Social work services for adults and older people

Services and support for adults with physical disabilities and learning disabilities

Mental health services

Drug and alcohol services

Adult protection and domestic abuse

Carers support services

Community care assessment teams

Support services

Care home services

Adult placement services

Health improvement services

Aspects of housing support, including aids and adaptions

Day services

Local area co-ordination

Respite provision

Occupational therapy services

Re-ablement services, equipment and telecare

Criminal Justice Social Work services including youth justice