East Lothian
Health & Social Care
Partnership

East Lothian Integration Joint Board Strategic Plan 2022 - 2025

Contents

Foreword

We am pleased to present East Lothian Integration Joint Board's third Strategic Plan, setting out our strategic objectives over the next three years.

In this plan, we outline our ongoing commitment to:

- **Developing sustainable health and social care services**
- **Focusing on early intervention and prevention**
- **Increasing access to community-based services**
- **Shifting the balance of care from hospital to homely settings**
- **Keeping people safe**
- **Tackling health inequalities**

Coming immediately after the Covid-19 pandemic, our focus is on recovery, renewal and building resilience for the future.

It is important to start with expressing our gratitude to East Lothian's health and social care workforce and to the people of East Lothian for working with us and rising to the extreme challenges presented by the Covid-19 pandemic. Despite the challenges of responding to the pandemic, we made significant progress in delivering the strategic objectives outlined in our previous Strategic Plan - you can read about some of our achievements in our **Annual Performance Reports**.

Working in partnership is one of the key themes in this Strategic Plan. Much of the progress we have made to date has been the result of strong partnerships with NHS Lothian, East Lothian Council, third sector organisations and local communities. It is this ability to work together, as demonstrated vividly during the pandemic, that will ensure we can achieve what we have set out in this Strategic Plan.

We know from demographic data, that the population of East Lothian will continue to grow, and that older people will make up a greater proportion of our residents. This will have a significant impact on our services, with people living longer and more people living with multiple, long-term conditions. Whilst the demands on health and social care services will continue to grow over time, we are aware that in the current and projected economic climate, it is unlikely that the financial resources available will increase to meet this additional need.

With these pressures in mind, we need to look at how we can deliver services differently, developing new models of provision; working in partnership with communities and the third sector; and intervening at an earlier stage to help slow down or prevent people's needs becoming more significant.

If we are to achieve our policy ambition of caring for people in more homely settings, we need to increase the provision of high-quality community-based services, particularly for people with higher levels of need, and develop more options for keeping people safe and well at home.

Alongside the impact of COVID-19, factors such as climate change and increasing levels of financial hardship and poverty caused by the cost-of-living crisis are also significant in relation to the delivery of health and social care services. Our recognition of the impact of these factors, particularly in relation to health inequalities is reflected in our new strategic objectives.

Engaging people who use our services, carers and other stakeholders is important in ensuring that what we do is shaped by local need. Our ongoing commitment to this is outlined in our forthcoming Participation and Engagement Strategy. We are aware that future engagement will require honest conversations about the significant budgetary, staffing, and other pressures facing all of our services as they continue to recover from Covid.

At the time of writing, developments are underway in relation to the creation of a National Care Service (NCS) for Scotland. The details of what the NCS will look like, including governance arrangements at a local level are yet unclear. Whilst the implications for Integration Joint Boards and Health and Social Care Partnerships are likely to be significant, it is important that this uncertainty does not distract us from our strategic focus. We will, however, remain fully engaged in discussions at a national level regarding the development of the NCS, ensuring that we bring an East Lothian perspective to discussions at every opportunity.

Fiona Wilson – *Chief Officer, East Lothian IJB*
Peter Murray – *Chair, East Lothian IJB*

About Us

East Lothian Integration Joint Board (IJB) governs the East Lothian Health and Social Care Partnership (ELHSCP) which delivers community health and social care services in East Lothian. The arrangements for the IJB and HSCP are set out in the IJB's Integration Scheme.

The key functions of IJBs are set out in legislation, they are to:

- Prepare a Strategic Plan for all delegated functions.
- Allocate the integrated budget to deliver the aims of the Strategic Plan.
- Oversee the delivery of services.

Functions delegated to IJBs include:

- Adult social care services.
- Adult primary and community health care services.
- Some elements of adult hospital care.

The full list of services delegated to East Lothian IJB are shown in **appendix 1**.

Health and Social Care Partnerships bring together NHS Board and Local Authority staff to develop and deliver integrated adult health and social care services, using a budget allocated by the NHS and Local Authority and in line with nationally agreed outcomes and targets.

Our Vision and Values

Our Vision describes our aspiration to deliver health and social services in East Lothian:

Our Vision
"To support all people in East Lothian to live health lives, to achieve their potential to live independently and exercising choice over the services they use."

Our Values
At present, we do not have a distinct set of values for the HSCP, but we follow those values articulated by our partners, NHS Lothian and East Lothian Council (who between them employ all HSCP staff) - these are shown in the diagram below.

We are looking at the potential to develop our own set of core values, which will incorporate the ones below, as part of broader organisational / workforce development activity.

NHS Lothian

- Care and Compassion
- Dignity and Respect
- Quality
- Teamwork
- Openness, Honesty and Reliability.

East Lothian Council

- **Enabling** and encouraging everyone we work with to achieve their full potential
- **Leading** by example and taking responsibility to improve ourselves and others
- **Caring** for each other, or community and the work we do.

Our Strategic Objectives and Delivery Priorities at a Glance

Strategic Objectives

Develop Services that are Sustainable and Proportionate to Need	Deliver New Models of Community Provision, Working Collaboratively with Communities	Focus on Prevention and Early Intervention	Enable People to have More Choice and Control and Provide Care Closer to Home	Further Develop/Embed Integrated Approaches and Devices	Keep People Safe From Harm	Address Health Inequalities

Strategic Delivery Priorities

Planning for an Ageing Population Developing Intermediate Care Care at Home Services Supporting the Acute Sector Commissioning Developing Primary Care	Transforming Community Support Services Working with Communities	East Lothian Rehabilitation Service Falls Prevention and Management Mental Health and Wellbeing Managing Long-Term Conditions	Delivering Primary Care Services East Lothian Community Hospital Outpatient Services Re-imagining Adult Social Work Dementia Support Supporting Carers Palliative and End-of-Life Care	Integrated Teams and Approaches Pathway Reviews Meeting Housing Needs Transitions from Child to Adult services	Public Protection Reducing Harm from Substance Abuse Justice Social Work Supporting Children, Young People and Families	Understanding Health Inequalities Taking Action to Address Health Inequalities

Our Strategic Objectives and Delivery Priorities at a Glance

Crosscutting Strategic Enablers						
Strategic Enablers	**Workforce**	**Financial**	**Partnership, Participation & Engagement**	**Technology**	**Approaches to Improvement & Innovation**	**Information Sharing**
Enablers Delivery Priorities	**Delivery of Workforce Plan**	**Financial Planning and Delivery of IJB Financial Plans**	**Delivery of Participation and Engagement and Commissioning Strategies** **Involvement in Strategic Planning Partnerships**	**Digital / Technology Workstream**	**Development of Performance and Improvement Framework**	**Development of information Sharing Approach / Protocols and Reflection of Scottish Digital Strategy**

- Our **Strategic Objectives** describe what we want to achieve over the next three years
- Our **Strategic Delivery Priorities** are the key, high level actions / activities / developments that we need to prioritise to achieve these objectives
- Our **Strategic Enablers** are the things we need to have in place to support (enable) us to achieve our strategic objectives (for example, we need a dedicated workforce with the right skills to enable delivery of each of our strategic objectives)
- Our **Annual Delivery Plan** provides the detail of how we will deliver these priorities
- Our **Annual Performance Report** publicly reports on progress each year

Developing the Strategic Plan

This Strategic Plan describes East Lothian Integration Joint Board's ambitions for the continued development and improvement of health and social care services in East Lothian over the next three years. This plan was jointly developed by the East Lothian Integration Joint Board and the Strategic Planning Group, bringing together a membership from NHS Lothian non-executives and East Lothian Council elected members, clinicians, people who access services, carers, the third and independent sectors and senior managers in health and social care.

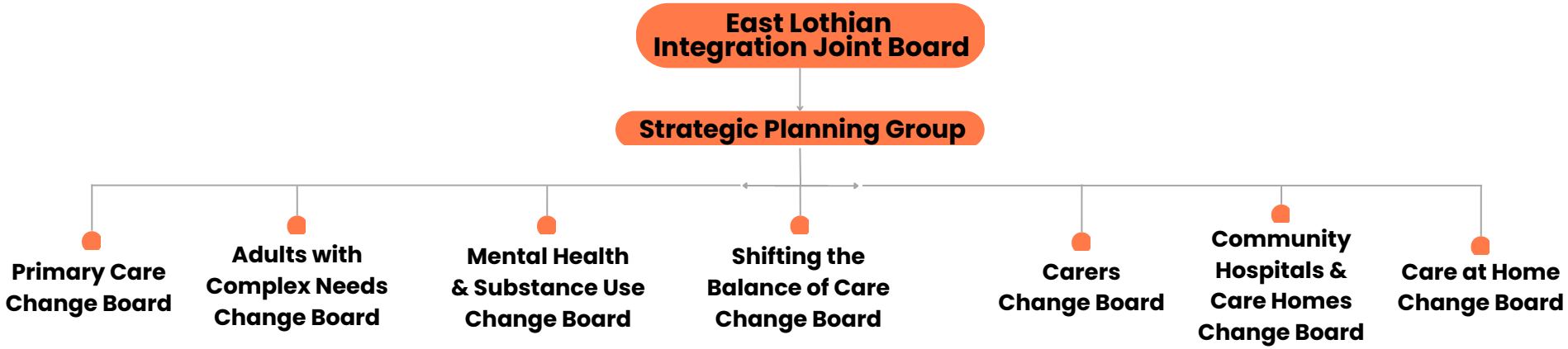
The strategic objectives and delivery priorities in the plan have been identified through the following:

- Discussion involving the East Lothian Integration Joint Board and Strategic Planning Group.
- Engagement with local people, our staff, partner organisations and other stakeholders.
- Consideration of the current local and national context.
- Consideration of progress to date in delivering health and social care in East Lothian, including identification of key learning.
- Analysis of a wide range of demographic and other data.

We will develop an Annual Delivery Plan for each year of the Strategic Plan, providing a detailed outline of how we will deliver our strategic objectives over the year. Annual Delivery Plans will be closely monitored and updated regularly as progress is made and in response to any contextual changes that impact on our activity.

The IJB will regularly review its 'Directions' (binding instructions) to East Lothian Council and NHS Lothian to ensure they deliver the IJB's agreed strategic and operational priorities, contained in the Strategic Plan.

The diagram below shows the structure we have developed to oversee the planning and delivery of our Strategic Plan.



Engaging Our Stakeholders

Stakeholder engagement was a key element of the activity that took place to inform the development of this Strategic Plan. A four-month engagement process involved workshops, group discussions and online approaches to gather the views of local people; third sector and community groups supporting people with a range of needs; and HSCP colleagues involved in planning and delivering services.

Themes emerging from the engagement process helped to shape the strategic objectives and delivery priorities contained in this Strategic Plan. These included:

- Access to services.
- Online/telephone services versus face-to-face.
- Accommodation.
- Carers.
- Communities.
- Co-production and collaborative working.
- Information sharing, reporting and recording.
- Early intervention and prevention.
- Addressing inequalities and supporting people with protected characteristics.
- Money, poverty and the cost of living.
- Covid / National Care Service.
- Older people, outcomes and joined-up working.
- Referrals.
- Social work/social care.
- Transparency and communication.
- Transport.
- Workforce retention, recruitment and training.
- Focus on service resilience and stability.

The full engagement report, which gives a detailed description of the engagement process and feedback received, is available **here**

Strategic Context and Our Approach

This section describes the strategic context that has shaped the development of our Strategic Plan. These strategic drivers (and potentially others) will continue to impact on the Plan's delivery over the next three years.

Health and Social Care Integration

Central to the context we work in are the requirements of the legislation that established Integration Joint Boards and set the direction for health and social care integration, along with the **National Health and Wellbeing Outcomes** and **Integration Principles** set out by the Scottish Government.

Our strategic approach to date has focused on delivery of the National Outcomes, with our approach reflecting the Integration Principles and responding to additional national guidance and direction as it evolved. We plan to use the Framework for Community Health and Social Care Integrated Services[1] to ensure that our strategic direction and service delivery continues to reflect these outcomes / principles. We will make use of the framework to guide the development of our Annual Delivery Plan **(see appendix 1)** and as part of our future performance and improvement activity. The 'Core Components' outlined in the framework are shown below:

Promoting healthy, independent living by supporting people to:

- Adopt an assets-based approach.
- Manage their own conditions.
- Connect with their communities.
- Live independently at home or in a homely setting.

Making services more accessible and responsive by developing:

- First Point of Contact.
- Anticipatory Care Planning.
- Reablement within all services.
- Short-term, targeted interventions to meet more complex need.

Improving outcomes by working more effectively to deliver:

- Fully integrated community teams.
- Teams aligned to General Practice.
- Seamless working with acute care.
- Enhanced care in care homes and supported accommodation.

[1] Public Bodies (Joint Working) (Scotland) Act 2014:
[2] The Framework for Community Health and Social Care Integrated Services is aligned to the 9 National Health and Wellbeing Outcome and the Integration Principles, as well as reflecting good practice that has emerged since the introduction of Health and Social Care Partnerships.

Shifting the Paradigm of Social Care

The 2021 report of the Independent Review of Adult Care in Scotland[3] (the 'Feeley Report') signalled a shift in the paradigm of social care. The report describes the requirement for a refocus in the delivery of social care, to see it as an investment rather than a burden; to ensure it is consistent and fair; for it to enable individual rights and capabilities and support independent living; for it to be preventative and anticipatory; and developed through collaboration. Also highlighted in the report is the need to have the principles of equality, dignity, and human rights at the heart of all social care provision.

A Scottish Government and COSLA Statement of Intent[4] in relation to the recommendations of the Independent Review was issued in March 2021, supporting early implementation of some of the Review's recommendations, seeing these as not reliant on the introduction of legislation.

Our approach to social care in East Lothian already reflects many of the themes and principles of the Feeley Report, but there is still more that we need to do. The objectives and delivery priorities identified in this Strategic Plan reflect the key themes from the report, and our Annual Delivery Plans will provide further direction to help us more fully realise the ambitions outlined in the Feeley Report. We have also begun work in relation to early implementation of some of the Feeley recommendations as highlighted in the Scottish Government and COSLA Statement of Intent.

The National Care Service

The Independent Review of Adult Social Care also recommended the establishment of a National Care Service (NCS). At the time of writing, activity is underway at a national level in relation to establishing the NCS, including consultation on a draft National Care Service (Scotland) Bill.

The development of a National Care Service will have a significant impact on how community health and social care services are planned and delivered in the future. In particular, the intention to reform Integration Joint Boards into Community Health and Social Care Boards ('Local Care Boards') will impact directly on existing governance arrangements. The duties on Local Care Boards may extend to delivery of Children's Services. Such a change will have impacts in East Lothian that will need to be fully assessed and responded to with partners.

At present, much of the detail regarding the introduction of a National Care Service is unknown. As proposals are firmed up and preparatory work begins, this is likely to begin to impact on activity locally. Our Strategic Planning Group will monitor the situation closely and advise the IJB on developments and any action required.

[3] https://www.gov.scot/groups/independent-review-of-adult-social-care/
[4] Adult social care - independent review: joint statement of intent - gov.scot (www.gov.scot)

Health Inequalities

Health inequalities may be defined as systematic, unfair differences in the health of the population that occur across social classes or population groups.

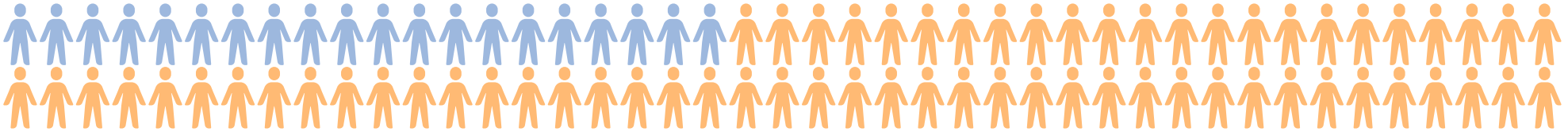
East Lothian IJB is well placed to reduce the health consequences of inequalities[5] by ensuring that services are resourced appropriately for those with higher needs and greatest difficulty accessing health and social care. Services should be universally available and accessible but planned flexibly to deploy proportionately greater resources towards groups or areas with greater need.

The IJB will continue to work to ensure policy development and planning recognises and takes into account people's social circumstances and other needs by ensuring that:

- Services are sensitive to poor health literacy and flexible for people who may find it difficult to navigate traditional pathways.
- Staff are able to identify and address social issues that impact on patients' health and ability to use healthcare.
- An integrated impact assessment is conducted to identify how well the proposal will meet the needs of vulnerable groups.

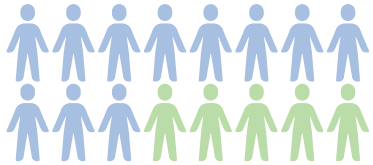
A new Partnership and Place Team, consisting of a Public Health Consultant, a Strategic Programme Manager and two Project Managers will work with East Lothian HSCP and wider partners to tackle health inequalities and improve population health. This will be achieved through strategic and collaborative work focussing on the social determinants of health, especially poverty, housing, employment and education. The team bring health improvement and health intelligence expertise to support East Lothian Health and Social Care Partnership to take an evidence-informed, person-centred approach to improving health and tackling inequalities with a focus on early intervention and prevention.

The Fairer Scotland Duty places a duty on us (along with a range of other public bodies) to actively consider how we can reduce inequalities of outcome caused by socio-economic disadvantage.



[5] A more detailed discussion of health inequalities and their causes can be found at www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes

Equalities



We have developed an East Lothian HSCP Equality Outcomes Plan for 2021-2025 (reflecting the legal requirement all HSCPs now have to publish a set of Equality Outcomes). This describes how we will deliver our aim of making access to services more equitable, respecting and valuing the diversity of our services users and workforce and ensuring that no one using our services or working for us experiences discrimination.

The Promise

The Promise is the vehicle for driving change in response to the findings of the Independent Care Review into children, young people and adults' experience of the care system. Its purpose is to 'support shifts in policy, practice and culture, so Scotland can #KeepThePromise it made to care experienced infants, children, young people, adults and their families – that every child grows up loved, safe and respected, able to realise their full potential'.

The Promise is of importance to the HSCP in terms of both the services it provides directly to children and young people[6], as well as in relation to HSCP services that support adult family members. We will be guided by the principles of 'Whole Family Support' in order to deliver services that consider the needs of the wider family, both adults and children. To help achieve this we will continue to work closely with Children's Services and other agencies involved in supporting families.

Equally Safe

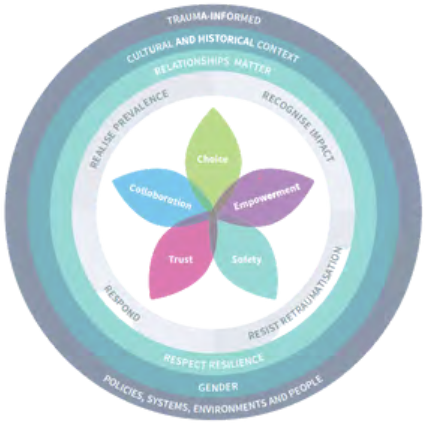
Equally Safe is Scotland's Strategy for preventing and eradicating violence against women and girls. Equally Safe highlights that such violence damages health and wellbeing, limits freedom and potential and is a cause and a consequence of women's inequality.

We are committed to working with East Lothian Council and other partners to support the delivery of Equally Safe priorities locally. This will involve participating in a strategic, whole-system approach to improving outcomes for women, children and young people across East Lothian, through actions to focus on women and girls' equality across all policy and service areas.

[6] A more detailed discussion of health inequalities and their causes can be found at www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes

[7] These include children's community health services (district nursing, health visitors and school nursing) and support for Young Carers

Trauma-Informed Services



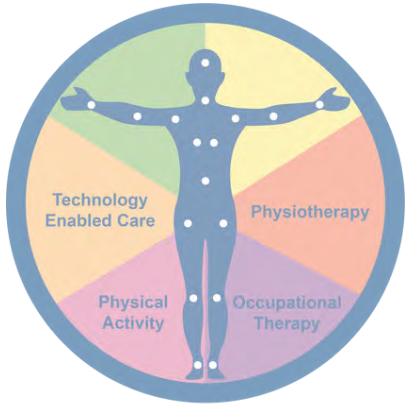
Much activity has taken place at national level regarding responding to adverse childhood and experiences (ACEs) and trauma. This focuses on the adverse and traumatic experiences that people may have in childhood or adulthood and the lasting effect these can have on their lives. It can include experiences such as abuse, neglect, violence, homelessness or growing up in a household where adults are dealing with mental health issues or harmful drug or alcohol use.

The Scottish Government's ambition, shared by COSLA and other partners, is to develop a trauma-informed and trauma-responsive workforce across Scotland[8]. The purpose of this is to ensure that services are delivered in a way that prevents further harm or re-traumatisation for those who have experienced psychological trauma or adversity at any stage in their lives.

We are looking at how best we can develop an approach to ensuring that all health and social care services delivered in East Lothian are trauma-informed and will include specific action in our Annual Delivery Plan to progress this work, including provision for staff training and awareness raising.

New Technologies and Data Use

Scotland's Digital Health and Care Strategy sets out an ambition *'to work together to improve care and wellbeing of people in Scotland by making the best use of digital technologies in the design and delivery of services, in a way that works best for them'*.



East Lothian
Rehabilitation Service

One of the aims of the Digital Health and Care Strategy is to give citizens access to digital information, tools and services that help them to maintain and improve their health and wellbeing. We have already made good progress with respect to this, for example, by launching our **Access to a Better Life in East Lothian** online platform; through the delivery of Technology Enabled Care; and by promoting the use of tech equipment to support self-management. We have identified 'Technology', in all its facets, as one of our Strategic Enablers.

Another aim of the Strategy relates to the recording and sharing of data and use of data to inform service delivery and development. This is an area with have identified as a priority for future development, reflected in our Strategic Enablers 'Information Sharing' and 'Approaches to Improvement and Innovation'.

We are mindful that increasing the use of digital provision risks creating barriers to access for some people. Whilst planning and implementing digital approaches we will consider the risk of digital exclusion and take action to ensure that no individuals or communities are disadvantaged by digital developments.

[8] www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/

Lothian Strategic Development Framework

The disruptions caused by the Covid pandemic means that many acute hospital services are still in the process of recovering from delays in appointments and treatment. We will work with our NHS Lothian colleagues and in line with the new **Lothian Strategic Development Framework for 2022-2027** to support service improvement and service recovery. This work will also focus on recovery of acute services operating in East Lothian Community Hospital.

Locality Planning

Legislation requires the IJB's Strategic Planning Group to take into account the needs of people from different parts of the county and to engage with communities, professionals and partners in planning to meet these needs. The IJB remains committed to working closely with Community Planning Partners in the planning, delivery, and monitoring of services.

The Act also requires HSCPs to have a minimum of two localities. In East Lothian there is a West Locality (with a population of around 64,000) and East Locality (with a population of 44,000). Due to East Lothian's small size, it is not always feasible to plan for service delivery at a local level across all services. Data is available at locality level where needed for planning and is reported annually through the IJB Annual Report.

Climate Change

We will support NHS Lothian's **Sustainable Development Action Plan** and **East Lothian Council Climate Change Strategy 2020-25** as part of the Scottish Government commitment for public bodies to show leadership on the global climate emergency. We will also, for the first time, issue our own Net Zero Emissions Target Statement by end November 2022, as required by Scotland's mandatory annual reporting by public bodies on their statutory climate change duties. This statement will reflect the commitments of our partners whose buildings and facilities we occupy and their policies and procedures regarding buildings, transport and energy.

Local Housing Strategy

Housing Contribution Statements were introduced by the Scottish Government in 2013, to strengthen formal links between housing, planning and health and social care joint strategic commissioning. Involving housing in the integration of health and social care is critical to support the achievement of national health and wellbeing outcomes and potential investment in housing-related preventative expenditure. The Statement recognises that housing services are essential to meeting the health and social care needs of individuals through a joined-up, trauma-informed approach to the provision of quality affordable housing and housing support.

The Housing Contribution Statement provides a bridge between the Local Housing Strategy and the IJB Strategic Plan. The Scottish Government expects that a seamless strategic process will develop, focused on shared outcomes, priorities and investment decisions that positively contribute to health and well-being. With the establishment of Integration Authorities, Housing Contribution Statements became an integral part of the Strategic Plan and required to be expanded and strengthened to achieve the following:

- Describe the role of the local housing sector in the governance arrangements for the integration of health and social care.
- Set out the shared outcomes and service priorities linking the Strategic Plan and Local Housing Strategy.
- Provide an overview of the shared evidence base and key issues identified in relation to housing need and the link to health and social care.
- Provide an overview of housing-related challenges and improvements required.
- Set out the resources and investment required to meet shared outcomes and priorities and identify where these will be funded from the integrated budget and from other (housing) resources.
- Cover key areas such as adaptations, housing support and homelessness and describe the housing contribution across a wide range of groups.

At the time of writing, East Lothian's Local Housing Strategy (LHS) was under review, with research, engagement and consultation underway in anticipation of a revised LHS for the period 2023-28. As such, the decision was taken to delay a formal Housing Contribution Statement until the final IJB Strategic Plan was agreed and a Draft LHS signed off (expected Summer 2023). This will ensure that the Housing Contribution Statement is a true reflection of the shared ambitions and visions, allowing the statement to be a meaningful vehicle to drive joint working over the period of the forthcoming documents.

Our Data

The Joint Strategic Needs Assessment (JSNA) accompanies and informs this Strategic Plan and will be updated regularly as new data becomes available. It will also inform ongoing service planning and progress monitoring across our work programmes. Some of the key findings from the JSNA are described below. Other JSNA derived information appears in other parts of this Plan.

Comprehensive information on East Lothian and its communities is available in a **Joint Strategic Needs Assesment** document produced by colleagues from the Local Intelligence Support Team (LIST) of Public Health Scotland.

The JSNA describes the rates of various long-term health conditions as well as mental health issues, dementia, physical disability, sensory impairments and weight across the East Lothian population and compares these with Scotland and/or Lothian.Where relevant, information is provided on associated admissions to acute hospitals. Information is also provided on lifestyle issues, covering smoking, drug and alcohol use and physical activity. As we continue to develop the JSNA, we will look at identifying more social care and social work related data for inclusion.

Our Growing and Ageing Population	
East Lothian's population of 107,900 will grow to 121,743 by 2043. This rate of growth is amongst the highest in Scotland.	Population growth will continue to place pressures across HSCP services, particularly those serving older people, reflecting the frailty in this age group and the higher care needs of people with dementia. In supporting people with dementia, we will continue to work with Community Planning, housing and the third sector partners to develop locally relevant community, housing and care responses, taking into account East Lothian's geography, deprivation and community need.
The highest growth will be in the 65-74 and 75+ age bands, with the over 75s population increasing markedly. As a result of this, there will be an increase in the number of people affected by dementia and long-term conditions.	East Lothian continues to perform well in reducing delays for patients who are ready to be discharged from acute hospitals and has delivered a sustained reduction in the number of excess days spent in hospital. This puts it amongst the best performers for delayed discharge in Scotland. This performance is delivered through integrated working across the Integrated Care Assessment and Allocation Team (ICAAT) the Hospital at Home, Hospital to Home, social care and Discharge to Assess (D2A) teams working together to prevent admissions and to speed up discharge home, or to a homely setting.
East Lothian's current falls rate is 23.4 per 1,000 population aged over 65, making it higher than the Scottish rate.	Work is underway to develop a robust falls prevention and management service, to respond to current falls and to prepare for increased risk associated with growth in our older population. The development will co-ordinate falls assessments, responses post-fall, community physiotherapy and community occupational therapy support, backed up by equipment, home adaptations and telecare to meet client need.

Deprivation and Inequalities	
In East Lothian 8 of its 132 data zones are in the 20% most deprived in Scotland. **People in living in these data zones have a life expectancy 8 years (males) and 4.8 years (females) lower than those in the least deprived areas.**	The East Lothian Public Health Partnership and Place team will work with HSCP colleagues, East Lothian Council, Community Planning, Health and Wellbeing Groups, the third sector and other partners to address inequalities and to identify and respond to community support needs. Integrated Impact Assessments will continue to be carried out on all service developments and policies to ensure people with protected characteristics are not discriminated against and to assess impacts on service users.
We face challenges in achieving equitable service delivery across our diverse communities, in the more populous and more deprived west of the county and the rural east and south of the county (see map below).	
Homelessness increased by 32.4%, from 242 in 2003 to 747 in 2021, a rate of 4.8 per 1,000 population - well above the Scotland rate of 2.9 per 1,000.	Current and coming increases in the cost of living may increase the risk of homelessness. We will work with East Lothian housing services and other partners to ensure people at risk of homeless are identified and helped to access support. This will assist in achieving new duties in relation to preventing homelessness. In addition, we will use the opportunities offered through the East Lothian Council Housing Contribution Statement to identify joint working priorities to ensure housing suits the health and social needs of East Lothian residents.

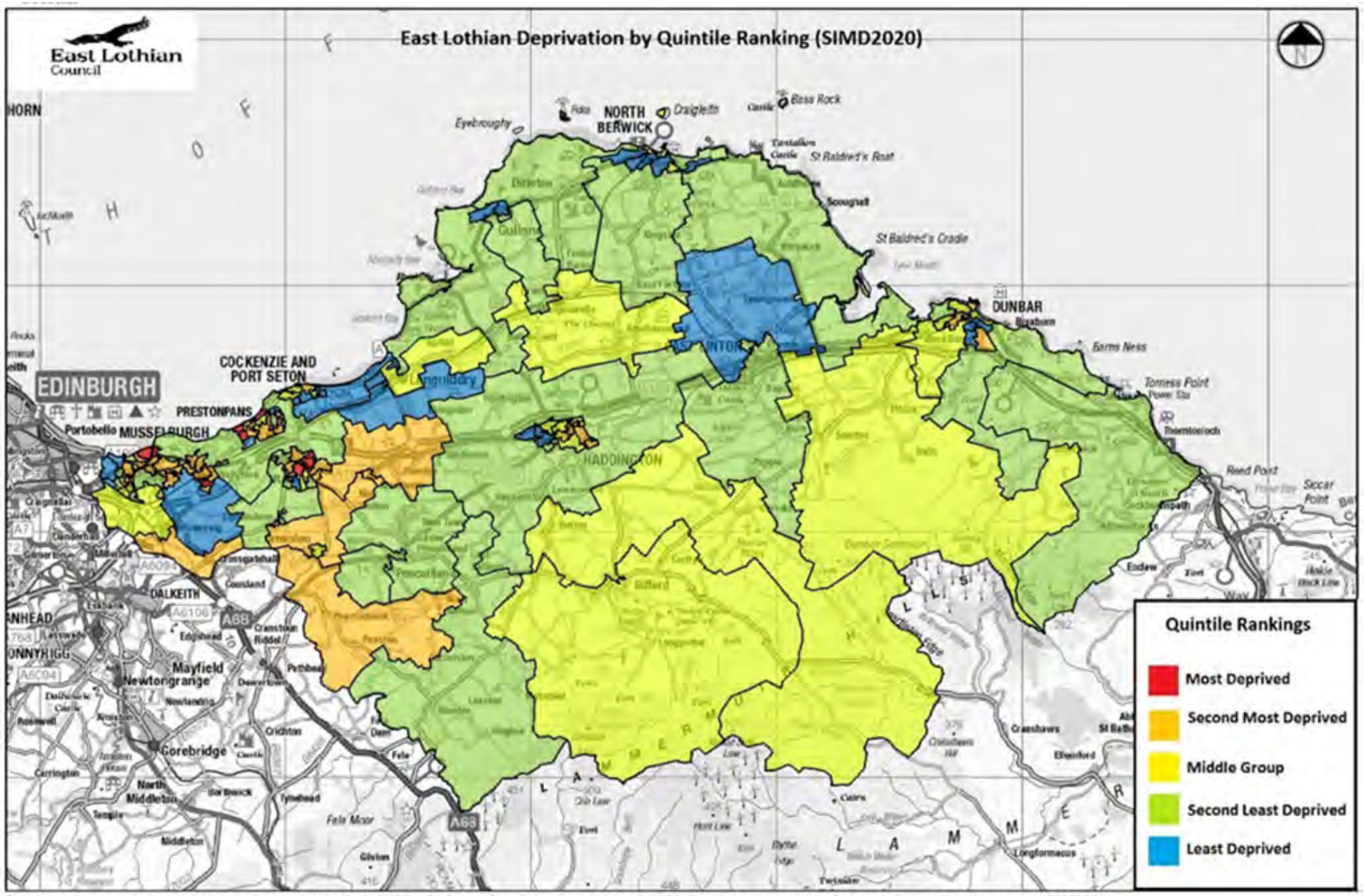
Social Care	
In 2019 there were 7.3 people with a learning disability per 1,000 known to East Lothian services, the fourth highest in Scotland. The national average was 5.2.	To foster independence in clients with learning disability, Neighbourhood Networks are supporting people in the community and a Transition Network is focussed on those moving from young people's services to adult services. Work is also underway with Teens+ to provide educational input to support young adults to develop life skills. Our Resource Coordinator Service is working with service users, families, carers, provider organisations and third sector in developing community-based sessions for people with learning disabilities who do not require a resource centre-based service. Support will be further enhanced through the planned work to establish an integrated and enhanced Learning Disability Service.
Covid restrictions, business pressures on providers and staffing shortfalls resulted in a peak reduction of over 2,000 hours of contracted Care at Home hours per week.	Care at Home is critical to supporting people to remain in their own homes, or for those people in hospital ready to return home. Any shortage in available care delays discharge and interrupts the rehabilitation process, affecting a patient ongoing recovery. The decrease in available hours is being addressed by an increase in Partnership managed service provision, across Care at Home and Hospital 2 Home (H2H) services.
The East Lothian Care Home Team supports care homes within East Lothian, of which 12 are independent and 4 are managed by the Partnership.	Work is underway to develop a robust falls prevention and management service, to respond to current falls and to prepare for increased risk associated with growth in our older population. The development will co-ordinate falls assessments, responses post-fall, community physiotherapy and community occupational therapy support, backed up by equipment, home adaptations and telecare to meet client need.

Cancer and Long-term Conditions	
Cancer remains the commonest cause of death in East Lothian, followed by coronary heart disease and stroke, although rates are reducing. **The early cancer deaths rate (those under 75) for East Lothian is significantly lower than in the Scottish population.**	HSCP teams will engage with primary care colleagues, including optometrists, dentists and community pharmacists and all screening, health promotion and early intervention programmes to maintain progress in identifying cancer early and to refer to specialist services. People living with cancer will be supported by specialist and HSCP services, and through third sector partners and the Macmillan 'Improving the Cancer Journey' Link Worker delivered service to access a range of practical and emotional support.
COPD rates and COPD hospitalisations are reducing. **Type two Diabetes rates remain high.** **Although smoking rates have decreased for several years, these increased from 14.3% to 20.2% between 2018 and 2019. Smoking in pregnancy continues to decrease, although the west of the county has higher rates.** **Smoking remains the main cause of lung cancer deaths, although registrations and deaths have decreased from 2010-2020**	The continuing growth in long-term conditions and in people living with several health problems, will require our teams to respond to increasingly complex care needs, through the delivery of co-ordinated support, tailored to individual need and linkage with relevant Managed Clinical Networks. We will continue to work through primary care, rehabilitation, and respiratory and other specialist services to maintain support to people living with COPD and to reduce the incidence of exacerbations resulting in hospital admission. We will ensure that clients who smoke, including pregnant women, are supported to access smoking cessation support.
In recent years, physical activity levels have reduced across the population.	We will link with Enjoy Leisure's Move More programme and other schemes across the county to support people to increase their physical activity levels.

Drugs and Alcohol	
Drug-related hospital admissions are increasing for all of East Lothian, although the rate for the east of the county is below the west and is levelling out.	The Substance Use Primary Care Outreach Service is operating in 12 of the 14 East Lothian GP Practices. This provides a nurse-led approach to identifying and working with high risk/hard to reach individuals who use substances. Future work will focus on establishing the Scottish Government MAT (Medication Assisted Treatment) standards, covering service access, treatment retention and trauma informed service delivery. To improve the provision of information to the public regarding substance use and to improve access to Substance Use Services in Midlothian and East Lothian, MELD (Midlothian and East Lothian Drugs) established a pilot Contact Service during 2021-22. The service provides a confidential helpline for people seeking support from substance use support services, or information regarding substance use. It uses a trauma-informed, person-centred conversation approach to assist callers in addressing their concerns and needs.
Drug-related deaths increased from 1.8 to 14.0 per 100,000 population from 2006 to 2020.	
Alcohol consumption rates have reduced across the population, although the rates for males remain higher than females.	
East Lothian has maintained a lower alcohol admission rate than Scotland since 2002/03, with the west higher than the east. However, deaths from alcohol have risen.	

Hospital Services	
The numbers of people admitted to psychiatric hospitals has decreased over recent years. More admissions come from the west than the east.	Support to people with mild to moderate mental health issues, which do not require specialist services, will continue to be delivered by the CWIC (Care When it Counts) Mental Health service located in primary care, linking with community-based support options. Our Community Mental Health Team will continue to work with third sector partners and Royal Edinburgh Hospital mental health services to provide ongoing, acute and specialist support
The decrease in outpatient activity is reversing as local and Lothian services recover from Covid restrictions and take action to reduce waits for patients.	East Lothian Community hospital continues to step up outpatient clinic provision to address delays arising from service disruptions caused by the Covid pandemic The HSCP will work with NHS Lothian and other partnerships to deliver local and Lothian-wide service improvements, as set out in the 'Lothian Strategic Development Framework'.
The proportion of the last 6 months of life spent at home or in a community setting has remained fairly static in recent years reaching 88% for East Lothian compared with 90% for Scotland.	Our planning for hospital facilities and care home beds is including consideration with palliative care partners of future palliative and end of life care needs and required support provision across the county.

Deprivation in East Lothian by SIMD (Scottish Index of Multiple Deprivation) Quintile



Our Strategic Delivery Priorities for 2022 – 25

We have identified seven strategic objectives based on feedback from stakeholder engagement, consideration of the current strategic context, review of our achievements to date, and analysis of data related to our local population. These strategic objectives are:

Strategic Objective 1

Develop services that are sustainable and proportionate to need

1.1 Planning for an Aging Population

Discussion on how to develop health and social care services in response to an ageing population has been ongoing locally and nationally for a considerable time. In East Lothian, this has included a year-long engagement process in 2018, leading to the development of a proposal on reprovisioning of community hospitals and care homes. Work was halted in 2020 due to the pandemic and restarted in 2021 with the formation of an 'East Lothian Community Hospitals and Care Homes Change Board'.

This Change Board will continue to deliver a transformation programme with the following aims:

- Delivering high quality care and support to East Lothian's current and future older population, at the right time and in the right place by the right people.
- Ensuring services for older people are sustainable and able to adapt to the current financial climate, the impact of the Covid-19 pandemic and national policy.
- Engaging with communities within East Lothian to ensure services are delivered equitably across our diverse population.

Our strategic delivery priorities are the key, high level actions / activities / developments that we need to prioritise to achieve our strategic objectives. The following section provides a short overview of each of our strategic delivery priorities, with further details on delivery contained in our Annual Delivery Plan.

To recap, this is how our strategic objectives and other elements of our Strategic Plan link together:

Strategic Objectives

describe what we want to achieve over the next three years.

Strategic Delivery Priorities

are the key, high level actions / activities / developments that we need to prioritise to achieve these objectives.

Strategic Enablers

are the things we need to have in place to support (enable) us to achieve our strategic objectives (for example, we need a dedicated workforce with the right skills to enable delivery of each of our strategic objectives).

Annual Delivery Plan

provides the detail of how we will deliver these priorities.

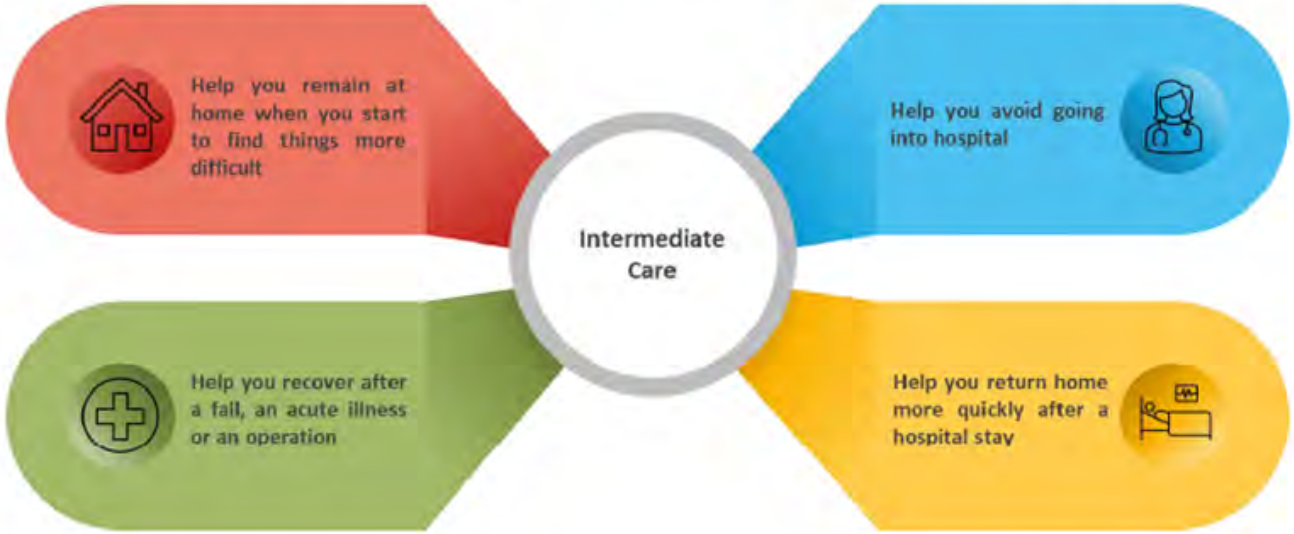
1.2 Developing Intermediate Care

Further developing and increasing the capacity of Intermediate Care services in East Lothian is one of our key priorities going forward. Intermediate Care services play a central role in achieving a number of our strategic objectives. As well as delivering better outcomes for our population, Intermediate Care services represent an efficient use of our resources and will help to ensure that our services are sustainable in the longer term.

Intermediate Care[9]: refers to health and social care services that help people:

- To remain at home when they start to find things more difficult.
- To avoid going into hospital.
- To recover after a fall, an acute illness or an operation.
- To return home more quickly after a hospital stay.

Diagram 1. The Four Key Principles of Intermediate Care from the NICE Guidelines, 2018

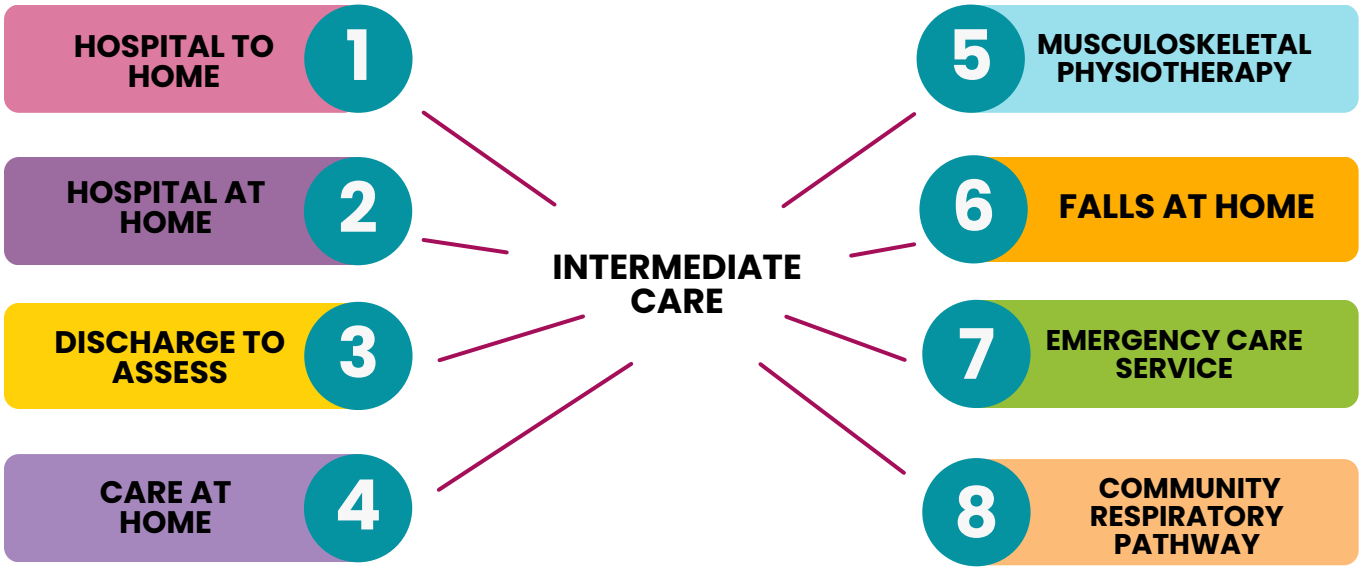


[9] Based on diagram developed by the National Institute of Health and Care Excellence (NICE)

We have a number of established services that fall into the category of Intermediate Care, these include (but are not limited to) the following:

- Hospital to Home.
- Hospital at Home.
- Discharge to Assess.
- Care at Home.
- Musculoskeletal Physiotherapy.
- Falls Service.
- Emergency Care Service.
- Community Respiratory Pathway.

East Lothian Community First service, delivered by Volunteer Centre East Lothian (see 2.2) will also play an increasing role in the provision of Intermediate Care as it develops.



1.3 Care at Home Services

Recent experience has demonstrated the vulnerability of care at home services throughout the country. The situation in East Lothian has been no different, with provision of care at home services being heavily impacted by staff shortages and a reduction in the capacity of services delivered by external providers.

This has led to the establishment of a 'Care at Home Change Board' to take forward a programme to review and redesign the delivery of care at home services in East Lothian. The Change Board's programme will focus on:

- Developing a new approach to the commissioning of care at home services from external providers.
- Redesigning the internal care at home services we provide – these include Hospital to Home; the Emergency Care Service; and
  Homecare.

The Change Board will ensure that the development of both internal and external care at home services reflects the IJB's broader strategic approach and objectives - for example, focusing on earlier intervention and prevention and addressing health inequalities. Development will also take into account any future changes to the strategic context (for example, the development of the National Care Service).

1.4 Supporting the Acute Sector

Due to many factors, it is anticipated that pressures on the acute hospital sector will continue to be a cause for concern for the foreseeable future, particularly, but not limited to, the winter period when hospital admissions are generally higher.

East Lothian HSCP has a strong performance record in preventing hospital admissions and in maintaining low delayed discharge rates. This has been achieved through key services working collaboratively to prevent unnecessary hospital admission and to ensure that patients do not remain in hospital longer than is medically necessary. Services contributing to this include the Intermediate Care services listed above (Delivery Priority 1.1), as well as the Capacity and Flow (Discharge) and Care Broker teams.

The introduction of our Integrated Care Assessment and Allocation Team (ICAAT) in 2021 has made a significant contribution to this area of work, by bringing together the services and disciplines described.

We have also introduced a daily activity meeting that brings together representatives of a range of HSCP services, along with our managers and senior leaders, and colleagues from acute hospital sites. These meetings, which are held online to minimise travel, provide an oversight into residents who are currently in hospital and enables us to take a proactive approach to planning their discharge home, so that we can provide the right care and support in the right place.

We will continue to deliver services and approaches that contribute to reducing admissions and supporting hospital flow over the lifetime of the Strategic Plan.

"East Lothian HSCP has a strong performance record in preventing hospital admissions and in maintaining low delayed discharge rates"

1.5 Commissioning

The functions delegated to East Lothian IJB (appendix 1) are delivered in a number of ways. Whilst the majority of services are directly provided by the HSCP or via 'hosted' or 'set-aside' arrangements [10], some are delivered via commissioning arrangements with third and independent sector providers.

Our approach to commissioning is important in terms of being able to ensure that commissioned services are provided in a way that reflects our strategic approach and values and contribute to the delivery of our strategic objectives.

Work is underway to produce a new Commissioning Strategy. This will help to further develop and improve our approach to commissioning and will include a number of clearly defined 'commissioning priorities' to guide decision making. Reflecting the recommendations of the Feeley report, these principles will include a commitment to more ethical commissioning in terms of decisions that 'take into account factors beyond price, including fair work, terms and condition and trade union recognition'. [11]

1.6 Developing Primary Care

The level of demand on General Practice and other primary care services currently outstrips capacity. It is likely that demand will continue to grow over time as the number of people living in East Lothian increases and older people make up a greater proportion of the overall population.

Our ambition is to work collaboratively, with General Practice and others, to ensure that primary care services are strong, resilient, and accessible, and that they make effective use of the staffing and funding resources available.

"Work is underway to produce a new Commissioning Strategy"

[10] 'Hosted' services are operationally managed by a HSCP or business unit within NHS Lothian on behalf of two or more of the Lothian IJBs. 'Set aside' services are acute, hospital based services operationally managed by NHS Lothian on behalf of all 4 IJBs.

[11] Chapter 9 Commissioning for public good - Adult social care: independent review - gov.scot (www.gov.scot)

Strategic Objective 2

Deliver new models of community provision, working collaboratively with communities

2.1 Transforming Community Support Services

We began to develop our Community Transformation Programme in 2018, and since then, have made considerable progress in redesigning day services and day opportunities for the following groups:

- Older People and those with dementia.
- People with mental health problems/illness.
- People with learning disability.
- People with a physical disability.
- People with autism.
- People with sensory impairment.

Work so far has included the development of a new service model which focuses on encouraging people to be as independent of centre-based services (e.g. resource centres) as possible, by supporting them to become involved in groups and activities in their local communities and to build a social support network. For those who need more support, the model still includes centre-based provision. Development of this approach has been informed by extensive community engagement.

Ongoing implementation of the Community Transformation Programme will be a delivery priority over the life of this Strategic Plan. Future plans include the continued development of our Resource Coordinator service; investment in additional Neighbourhood Networks; and the introduction of new employability support for adults with complex needs (in partnership with East Lothian Works). In response to feedback, we will consider how we can develop provision to include evenings and weekends, as well as how to increase provision of short breaks. We will also be looking at the potential of our **Shared Lives** service to offer daytime support.

Another area of work that will feature in our Delivery Plan is the development of a Community Hub model for people who do not require specialist building based services. Community Hubs will provide an opportunity for people to take part in 1:1 work; attend group sessions; and get involved in community-based activities. This model will be piloted within the new Wallyford Learning Campus.

2.2 Working with Communities

Community groups and volunteers (both formal and informal) play a significant role in supporting local people. This was demonstrated during the pandemic when Community Resilience Groups played an invaluable role, providing practical and emotional support to some of the most vulnerable members of our communities.

Many of the activities needed to deliver our Strategic Plan will involve us working in partnership with community groups. This is why continuing to build and develop relationships is one of our key priorities over the next three years.

One important activity will be working with Volunteer Centre East Lothian (VCEL) to deliver a new Community Outreach and Coordination Service. The service will build on previous 'test of change' initiatives delivered by VCEL, taking a person-centred approach to improving people's health and wellbeing by supporting them to benefit from sources of support within their local community, including support from community volunteers.

We will also be looking to develop our approach to collaboration and coproduction with community partners more generally. This will include continuing to work with Dementia Friendly East Lothian to establish a Meeting Centre in Musselburgh for people with dementia and their families and carers. The learning from this, and other initiatives, will inform our future approach to collaboration / coproduction.

"Continuing to build and develop relationships is one of our key priorities over the next three years"

Strategic Objective 3

Focus on Prevention and Early Intervention

3.1 East Lothian Rehabilitation Service

Rehabilitation services are key to maintaining and improving people's quality of life, as well as to helping them to retain their independence after illness. Rehabilitation services also play an important role in keeping people out of hospital or allowing them to be discharged sooner. This helps to reduce pressures and costs on all parts of the health and social care system. Our rehabilitation services are a key component of our Intermediate Care provision (see 1.1 for a definition of Intermediate Care).

East Lothian Rehabilitation Service (ELRS) has expanded its capacity over recent years to meet growing and increasingly complex patient needs. It is anticipated that further development over the next three years will include:

- Further development of community based multidisciplinary clinics, including Technology Enabled Care (TEC).
- Embedding TEC across all our workstreams within ELRS service development and provision.
- Working with community partners to promote wellbeing a physical activity in the community, such as local leisure provision.
- Following our patients into the acute sector, ensuring that timely assessments are carried out in that setting to promote timely discharge and support in the community.
- Continuing to improve and expand the single point of contact for all Rehabilitation Services.
- Promoting the use of the digital platform to support education and patient self-management; expansion of education content specifically around long-term conditions.
- Further development of data analytics to help understand current impact, trends in demand, to make projections, and inform future service development.

3.2 Falls Prevention and Management

We know that falls are the most common cause of emergency hospital admission for adults in Scotland, with those over 65 being 7 times more likely to have a falls related admission. Falls can result in reduced confidence and increased frailty for older people, negatively impacting on their quality of life. Falls are one of the biggest financial costs for the NHS and HSCPs, put pressure on hospital beds and lead to increased demand for care packages and rehabilitation services. The current falls rate in East Lothian is ahead of the Scottish average.

We already have a range of excellent services in place to prevent and manage falls. However, we have identified a number of actions needed to make these services more integrated and to improve each client's journey. This work will be progressed through the development and implementation of a new integrated falls prevention and management pathway.

This work will be supported by the emergent ELHSCP Community of Practice for Falls Prevention, which includes representation from a broad range of services and organisations from across health, social care and the third sector.

3.3 Mental Health and Wellbeing

Many people will experience issues with their mental health at some stage in their lives. Furthermore, there is growing concern that factors such as the pandemic and cost of living crisis will lead to an increase in the numbers experiencing poor mental health.

For some people, mental health issues will be more complex and will require a higher level of treatment and support from mental health services, including services providing by the HSCP. For others, the issues experienced will be less complex, and will benefit from early, lower-level interventions to support individuals to cope and to improve their own mental wellbeing.

Our CWIC (Care When it Counts) Mental Health service was introduced in 2020 as an easily accessible service for people experiencing mild to moderate mental health issues. Since its introduction, the service has demonstrated the effectiveness of this early intervention approach and has been positively received by patients and medical staff.

We will continue to develop the service provided by CWIC Mental Health and will also look at other ways to provide early support for people with lower-level mental health issues. This will include introducing a new Distress Brief Intervention[12] programme in East Lothian, as well as looking at ways of further developing services available via third sector partners (including via the use of funding). Third sector organisations play a key role in providing mental health support, particularly as they are able to offer varied and flexible types of provision at a community level.

Our ambition across all our mental health services, regardless of the level of need, is that people are able to access the right help, at the right time, first time. This guiding principle will lead the development of all our mental health services.

[12] A Distress Brief Intervention is 'a time limited and supportive problem-solving contact with an individual in distress'

3.4 Improving the Management of Long-Term Conditions

An increasing proportion of our population is now living with long-term conditions, and this is likely to continue to increase as the result of demographic change, with more people living longer.

We are committed to developing a proactive approach to the management of long-term conditions. Promoting and supporting people with self-care of long-term conditions results in better outcomes and quality of life for them, as well as helping to reduce pressure on health and social care services.

This will include making use of data to monitor the effectiveness of approaches to long-term conditions and to identify priorities for improvement.

Strategic Objective 4

Enable people to have more choice and control and provide care closer to home

4.1 Delivering Primary Care Services

The vast majority of patient contacts in the NHS occur in primary care. The HSCP now has responsibility for the direct delivery of a number of primary care services. These include vaccinations; community treatment and care services; CWIC (Care When it Counts); the Musculoskeletal Advice Line and CWIC Mental Health. Our Primary Care Improvement Plan sets out our priorities in relation to the ongoing development of HSCP managed primary care services.

This range of primary care services offers more choice to people in terms of how, when and where they can access health care, and in some cases, offers care closer to home.

Now that these services are well established, we aim to work with General Practice to improve pathways between services and to help make it clearer with regards to how and where people can access care. This will include looking at how digital pathways can help people get to the right service, as well as improving direct access to HSCP run services instead of patients having to go via their GP.

4.2 East Lothian Community Hospital Outpatient Services

The new East Lothian Community Hospital (ELCH) was opened in 2019, to deliver inpatient and outpatient care. As well as having played a key role in the pandemic response, the hospital has continued to expand the number of outpatient services offered. Outpatient provision now includes a wide range of outpatient clinics and an Endoscopy and Day Services Unit.

Many of the outpatient services now available at ELCH would have previously required patients to travel into the Western General or the Royal Infirmary in Edinburgh or St John's in Livingston, in some instances weekly or more over a sustained period of time.

We will look at how we can continue to develop the outpatient offer at ELCH as a key way of delivering on our strategic objective to provide care closer to home. We will work with colleagues from across NHS Lothian hospitals to achieve this. We are also keen to further build on the role that ELCH plays in relation to teaching, training and staff development.

4.3 Re-imagining Adult Social Work

Our Adult Social Work Service has been working closely with IRISS (Institute for Research and Innovation in Social Services) on a project to re-imagine the approach to Social Work services for adults in East Lothian. This has included engaging with staff, prioritising areas for improvement and creating a framework to support the delivery of multiple changes and developments. This has helped to articulate our ambitions for a social work service that:

- Is effective, responsive, and fit for the future.
- Supports an increasingly preventative and early intervention approach.
- Takes a more outcome focussed approach to supporting people in a range of different ways that best reflect their needs at the time.

We have already made a number of changes that have taken us closer to achieving these ambitions and will continue this work. This will include the introduction of changes to some of our key social work systems and processes.

4.4 Dementia Support

Data analysed as part of our Joint Strategic Needs Assessment indicates that the number of people affected by dementia in East Lothian will continue to increase as our population ages. We need to ensure that we are able to make provision to respond to the needs of the growing number of people who will be affected by dementia (both individuals and their families / carers).

Our forthcoming Dementia Strategy will set out our plans for future development of services aimed at improving outcomes for people affected by dementia. The strategy will include plans related to inpatient and residential care, care pathways, older adult community mental health services, an early diagnostic clinic and post-diagnostic support.

An important strand of the Dementia Strategy is provision for those living with mild to moderate dementia. We will continue to develop this in line with our community transformation approach, working collaboratively with community partners to provide support in people's local communities. This approach is reflected in the support we have given to the establishment of a 'Meeting Centre' in Musselburgh for people affected by dementia, which, in time, we hope will offer a 'hub and satellite' service across East Lothian.

4.5 Supporting Carers

Caring for someone can be rewarding, however coping day-to-day with meeting the needs of a loved one is often challenging and exhausting. We are committed to continuing to work closely with young carers, adult carers and carer organisations to try to ensure carers can access the support they need.

At the time of writing, work is underway to develop a revised Carers Strategy. Once complete, this will guide our activity in this area over the next three years. We anticipate that the main priorities in the Strategy will be providing breaks from caring; reviewing the approach to Adult Carer Support Plans and increasing carer involvement in hospital discharge.

As well as delivering actions to develop the support available to carers, we will continue to ensure that wider strategic and service development reflects carers voices and takes into account the specific needs of carers.

4.6 Palliative and End-of-Life Care

We are committed to delivering high-quality palliative and end-of-life care through a number of multidisciplinary teams in home, community and hospital settings. Our aim is to provide patients with choice whilst reducing the reliance on acute hospital beds in favour of community-based care that takes care to the patient whilst also supporting families and carer.

The palliative care community nursing team currently works collaboratively with the district nursing team, care home team and St Columba's hospice to ensure that patients are cared for as close to home as possible or within their own home, through integrated multidisciplinary team work, ensuring that patient receive patient-centred holistic care.

Part of our focus will be the continued expansion of 'Hospice at Home' service. This is delivered by St Columba's Hospice, supported by the HSCP's Hospital to Home team. This approach is proving to be extremely beneficial for patients and families alike, enabling people to stay in their own homes, whilst also ensuring that patient choice is at the centre of any decision making, building on this blended approach will be one of our key priorities.

Although a growing number of patients choose to remain at home, there are some who prefer to spend their last days in hospital. A current pilot to provide beds within local nursing homes is being explored, enabling patients to access local facilities rather than travelling to East Lothian Community Hospital in Haddington. If successful, this will be rolled out across all council care homes to ensure that local access is available.

One of the ways in which we will support the further development of our approach to end-of-life and palliative care and to improving patient journeys will be through the delivery on a comprehensive education programme for staff involved.

Strategic Objective 5

Further develop/embed integrated approaches and services

5.1 Integrated Teams and Approaches

We have made good progress to date on delivering integrated health and social care services in East Lothian. In some cases, this has been achieved through bringing teams together under one banner; in others, it has involved developing integrated approaches across a number of teams.

Examples of existing integrated working / approaches that we will continue to develop include:

- East Lothian Rehabilitation Service's cluster working approach. This brings together Occupational Therapists from East Lothian Council and NHS Lothian, Physiotherapists, Community Care Workers, Assistant Practitioners and Business Support to work collaboratively to provide high quality, responsive, person-centred, community-based care. There are three clusters, each of which works closely with Primary Care colleagues.

- The introduction of the Integrated Care Assessment and Allocation Team (ICAAT) which has contributed to thie prevention of hospital admissions, reduced delayed discharge rates, and helped to prioritise use of available resources.

- The establishment of daily activity meetings, involving our own senior managers and staff, along with colleagues from acute hospital sites, with the aim of supporting a coordinated, pro-active approach to hospital discharge.

- The bringing together of Community Learning Disability and Learning Disability Social Work Teams into a new enhanced Learning Disability Service.

We will continue to look at opportunities to further develop integrated services, teams, and approaches, learning from the success of examples like the ones described above.

5.2 Pathway Reviews

We know that people getting the 'right care at the right place at the right time' requires services to be as accessible as possible. For people who need care or support from more than one service, it is also important that these services are coordinated and that there are effective links between them.

Our recent Review of Mental Health Services is one example of work we are doing to improve access and patient pathways[13]. The review has informed a number of improvements that we will introduce to make access to mental health services easier, as well as improving pathways within and between mental health and other services. This will include changes to improve patient experience at the point of entry / first contact with mental health services.

One development already underway is the introduction of a new neurodevelopmental pathway outwith the wider Community Mental Health Team, this is in response to the rise in neurodevelopment referrals which had resulted in an increase in the waiting list size and waiting times for assessment.

Over the period of the Strategic Plan, we will look to carry out pathway reviews for other services to help ensure that they are as accessible and joined up as possible. This will include, for example, dementia and falls patient pathways (see also delivery priorities 3.2 and 4.3).

5.3 Meeting Housing Needs

The availability of appropriate housing can be a key factor in providing the right type of care and support to enable individuals to achieve their personal outcomes. We will continue to work closely with our East Lothian Council Housing colleagues to develop housing that supports people's wider needs. This will include ongoing development of housing models such as 'core and cluster' housing to provide options in local communities for people with complex needs. Delivery of such models has already been successful in enabling people to move back to East Lothian from 'out of area' placements and have also facilitated hospital discharges where specialist provision was needed.

At the time of writing, we are working with housing colleagues on an updated strategic needs assessment that will help to inform the new East Lothian Local Housing Strategy (due for publication in spring / summer 2023). Once complete, the Local Housing Strategy will help to inform the ongoing development of alternative housing models to support the delivery of our Learning Disability, Mental Health and Substance Use services.

We will also be developing work in response to our new duties in relation to preventing homelessness. Again, we will be working closely with housing colleagues in relation to this. Activity will include looking at existing practice and potentially carrying out staff and service development in response to gaps identified.

[13] Patient journeys within and between services

5.4 Transitions from Child to Adult Services

We know that the transition from children's to adult services can be daunting, particularly for young people with additional support needs. At the time of writing, work is underway to develop a Transitions Policy aimed at ensuring young people have a positive experience of moving to adult services.

The policy will emphasise the importance of starting planning as early as possible in order to enable the young person, their family and carers to work with social work and education teams to develop a real understanding of the young person's ambitions and priorities and to identify what they requires to help them achieve these as they move into adulthood. The policy will reflect the 'Principles of Good Transitions'[14], and will put the young person at the centre of the planning process. It will also outline the process to be followed, define the responsibilities of those involved and set timeframes.

"At the time of writing, work is underway to develop a Transitions Policy aimed at ensuring young people have a positive experience of moving to adult services. "

[14] 'Principles of Good Transitions 3' - Scottish Transitions Forum

Strategic Objective 6
Keep people safe from harm

6.1 Public Protection

The East and Midlothian Public Protection Committee (EMPPC) is the local partnership for policy and practice in relation to Adult Protection, Child Protection, Offender Management and Violence Against Women and Girls. EMPPC provides leadership and strategic oversight for these public protection functions. It also has a number of sub-groups that take forward specific activity on specific areas of work. Senior managers from East Lothian HSCP are directing involved in these structures.

Our continued involved in EMPPC and related activities will contribute to the delivery of our strategic objective to 'keep people safe from harm'.

The operational delivery of Adult Support and Protection is the responsibility of the HSCP and we ensure that there are robust systems and procedures in place to ensure the safety of service users identified as being at risk of harm. Along with Police Scotland, HSCP staff play a key role in ensuring that concerns that an adult may be at risk of harm are identified and appropriate action is taken. The Adult Social Work Service has particular obligations upon it in this regard which it prioritises. With the support of the EMPPC, we will implement changes in national policy including the revised Codes of Practice. There is also a prevention aspect to our work, and we will support our staff and the wider public through training and public awareness.

6.2 Reducing Harm from Substance Use

We continue to work with partner organisations to provide services for people experiencing issues with substance use in East Lothian. The term 'substance use' is used here to cover the use of substances including illegal drugs, alcohol, and prescription medicines. Support provided ranges from person-centred treatment and support with recovery, to family support and help with addressing wider needs such as housing, income maximisation, education, training, and employment.

Embedding the Scottish Government MAT (Medication Assisted Treatment) Standards will also be a key focus over the period of the Strategic Plan, leading further improvements to access to services and helping to ensure our services are trauma-informed.

We will also continue to prioritise activity aimed at reducing the number of drug related deaths and the harmful impact of long-term drug use in East Lothian, in line with the Scottish Government's National Mission to reduce Scotland's unacceptable drug deaths rate. As well as the support services described above, we will also continue to develop initiatives targeted on this most at risk – for example, assertive outreach in GP practices and roll out of Naloxone training[15].

6.3 Justice Social Work

Our approach to delivering Justice Social Work will continue to be based on a number of key principles. These are a reflection of what we know works in terms of reducing offending and reoffending. We will support the use of interventions that are proportionate in terms of reflecting the level of risk and the servicer user's needs whilst aiming to be as least restrictive as possible. Similarly, we will support the use of non-custodial interventions on the basis that evidence indicates that they are more likely to reducing reoffending. We also recognise the effectiveness of early intervention and prevention and will continue to reflect this in our service development and delivery.

Community Payback Orders that include a requirement of 'unpaid work / other activity' offer an opportunity for individuals to be involved in community activities. We will look at ways of further developing the use of Community Payback Orders to ensure that they are of benefit to local communities, whilst having a positive impact for the person who is the subject of the Order.

Our approach will continue to be guided by the aim of supporting individual service users to make lifestyle changes and choices that enable them to engage more meaningfully with family, friend, neighbours, and local communities. We are also planning to look at how we can ensure the voices of people with lived experience of the justice system are heard and that they help to inform future service provision.

6.4 Supporting Children, Young People and Families

Our services play an important role in relation to children and young people's health and wellbeing, both through the services we deliver to them directly[16] and through the support we provide to parents and other adults as part of the wider family unit.

Where families are vulnerable and children's wellbeing is at risk, this is often linked to the needs of adults in the household – for example, in relation to the adult's mental health, issues with addiction or problematic substance use or the incidence of domestic violence. In many cases, these needs have their roots in past trauma or adverse childhood experiences.

As articulated in **The Promise** , we need to ensure that the services we provide are guided by the principles of 'Whole Family Support'. This includes our staff work closely with other services involved in supporting families to take a coordinated approach to identifying and responding to the needs of the whole family. Although we already work closely with colleagues from Children's Services and other organisations, we are committed to the ongoing development of collaborative working.

[15] Naloxone is a medication used to block or reverse the effects of opioid drugs.
[16] These include children's community health services (district nursing, health visitors and school nursing) and support for Young Carers

Strategic Objective 7
Address Health Inequalities

7.1 Understanding Health Inequalities

There are opportunities to take action to address health inequalities across all areas of our work. To do this effectively, we need to develop our understanding of inequalities, including how our activities impact on inequalities.

We will do this by introducing a programme of training and awareness raising as part of our organisational and workforce development. This will cover staff across all levels and roles and will also include development sessions for individuals involved in our strategic planning structure.

We will continue to build our local knowledge of health inequalities through the ongoing development of our Joint Strategic Needs Assessment. This will include the gathering and use of data related to population needs, service access and delivery, and outcomes.

7.2 Taking Action to Address Health Inequalities

This increased knowledge and understanding will help to inform decision making that makes a positive contribution to reducing health inequalities. Importantly, this will include taking health inequalities into account when making decisions about resource allocation and service development and delivery.

At an operational level, training will help to ensure that staff consider factors (such as income, education and employment) that may present barriers to people accessing and engaging with services. Work to support trauma-informed service delivery will also contribute to this.

We will also explore the potential for the HSCP to become an 'anchor institution'[17] as further means of addressing the social determinants of health. This will potentially include looking at the impact of our purchasing, our use of buildings, employment of staff, relationships with local partners and the impact we have on the environment.

Work in relation to both 7.1 and 7.2 will be supported by the new Partnership and Place Team.

[17] https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution#:~:text=First%20developed%20in%20the%20US,of%20the%20populations%20they%20serve.

Our Strategic Enablers

We have identified six Strategic Enablers that we need to have in place to support/enable the delivery of our strategic objectives, they are:

Strategic Enabler 1
Workforce

Our staff are our greatest asset and key to the delivery of each and every one of the strategic objectives defined in this Strategic Plan. Our experience during the Covid pandemic highlighted the extraordinary level of commitment of staff across all our services. Valuing, supporting and investing in our workforce has to be one of our most important priorities over the coming years.

One of the issues most commonly raised in our stakeholder engagement was the 'workforce challenge' of ensuring that we have the right level of staff, with the right skills, to deliver the services that will be needed in East Lothian, particularly as demand will continue to increase as a result of the demographic changes ahead.

Our **Workforce Plan** sets out how we plan to respond to this challenge. Workforce priorities identified in the Plan include:

- Profiling the current workforce.
- Redefining career pathways.
- Undertaking a skills gap analysis and identifying developmental requirements.
- Integrating East Lothian Council and NHS Lothian workforce policies and practices as far as possible.
- Supporting proactive recruitment campaigns.

Our delivery of the Workforce Plan will also reflect developments as a national level including the commitments in the Scottish Government and COSLA Joint Statement of Intent[16] in relation to the Feeley Report recommendations and the Health and Social Care National Workforce Strategy[17].

[16] Adult social care - independent review: joint statement of intent - gov.scot (www.gov.scot)
[17] These include children's community health services (district nursing, health visitors and school nursing) and support for Young Carers

Strategic Enabler 2
Financial Planning

An aligned financial framework is needed to achieve the ambitions of this Strategic Plan and all planned work has to be provided within the resource available. This means on occasions some developments may have to progress at a slower rate than is desirable or may require the delivery of financial and other efficiencies through innovation, redesign or cost savings.

As our partners NHS Lothian and East Lothian Council in the main produce annual budgets this means the three-year financial plan in this Strategic Plan will need to adapt in the event that partners' planning changes.

In this section we set out the funding that the IJB will receive and how it is allocated to meet our priorities. We also describe the challenge that the IJB has to meet to ensure it can plan and commission all necessary and appropriate activity within the resources available over the next few years.

Legislation requires that the Integration Joint Board, as a 'stand-alone' legal body, must deliver financial balance in every year and must financially plan to deliver recurrent balance.

The IJB's financial plans are designed to be robust and to ensure maintenance of financial stability, so providing the bedrock on which to build sustainable and financially efficient services to deliver change, to support reform within East Lothian's health and social care system and to improve health outcomes.

The IJB is gaining considerable ground in moving support provision from hospital-based settings into community settings. Many more people are now receiving care closer to home where this is clinically appropriate for their individual needs.

Shifting Resources

The IJB recognises that there was a historical over-reliance on centralised and hospital care at the expense of local and community focussed developments. Therefore, the previous Strategic Plan reflected on the need for the four Lothian IJBs to work together to avoid any destabilisation of centrally provided services when seeking to transfer resources. This remains an important consideration but still allows for centralised resources to follow any sustained transfer of patient activity to East Lothian HSCP provided services.

The Financial Challenge

The medium-term financial outlook for the wider public sector remains challenging. This will continue to have a direct impact on the overall grant settlement for NHS and Council budgets.

There remains the need to continue to develop ongoing future sustainable budgets within a reduced cost base. There needs to be a focus on investment in community-based models to support the strategic direction whilst responding to new and emerging cost and demand pressures.

Composition of the IJB Budget

The IJB receives a recurrent allocation from both partners for each financial year and a further indicative allocation for the following 2 years (see charts on pages 57 and 58 below).

The IJB's budget is agreed in line with legislation. Aligned services and resources are identified across four broad categories:

- The social care budget determined and agreed by East Lothian Council.
- The core health budget, including community nursing, Allied Health Professionals, community hospitals, General Medical Services (GP services) and prescribing.
- Delegated hosted services, managed on a pan-Lothian basis by certain HSCPs or NHS Lothian business units.
- Acute services (also called 'set aside') held by NHS Lothian on the IJB's behalf which are required to respond to IJB directions.

Strategic Enabler 3
Partnership, Participation and Engagement

Our relationships with our partners, communities, staff and the people who use our services are central to the delivery of our strategic objectives. We will focus on building and strengthening these relationships. This activity will be led by the implementation of our Participation and Engagement Strategy, which is under development.

Our draft Participation and Engagement Strategy describes our Vision for delivering this priority:

> *'East Lothian Health and Social Care Partnership wants to work in partnership with service-users, carers, staff, partners and communities in East Lothian to improve the health and wellbeing of everyone in East Lothian. This can only be achieved by ongoing, meaningful engagement that gives people an equal say in plans for them and their communities. We commit to having honest and open conversations and to planning together for health and social care in East Lothian.'*

This will be delivered through:

- The participation of partner organisations and representatives of service-user and carer representatives in our strategic planning structures (SPG, IJB and Change Boards).
- Our involvement in Area Partnership Health and Wellbeing Subgroups.
- The ongoing engagement with and participation of service-users, carers, our staff, partners and the public in our Transformation
  Programmes.
- Our engagement with third sector partners and providers - directly and through Volunteer Centre East Lothian.
- Wider public engagement on a range of issues to ensure we hear as broad a range of views as possible.
- At an individual service-user level, working with service-users, families and carers to identify what matters to them and how our services can support then to achieve personal outcomes.

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- At an individual service-user level, working with service-users, families and carers to identify what matters to them and how our services can support then to achieve personal outcomes.

Our new Commissioning Strategy, described in Delivery Priority 1.3 above, will also be significant with respect to the further development of our relationship with the provider organisations that we engage to deliver some of our services.

We are also involved in partnerships and groups that support collaboration at a strategic level, including East Lothian Community Planning Partnership, East Lothian and Midlothian Public Protection Committee, East Lothian Community Justice Partnership, as well as topic-based partnership groups, such as the East Lothian Poverty Working Group and Climate Change Group.

Strategic Enabler 4

Approaches to improvement and innovation

We have a strong track record of developing new and innovative approaches to delivering services. As we continue to develop new ways to improve our services and achieve better outcomes for patients and service users, we want to ensure that learning is shared across the organisation, informing and inspiring further improvement and innovation.

We also know that we need to improve our collection and use of performance data. This is important in terms of allowing us to identify how well we are performing across our services and identifying where action is needed to improve performance. Performance data is also important in terms of allowing us to judge the impact of any changes that we introduce. From a governance perspective, robust data is needed to support review and scrutiny of our service delivery (both locally and in our reporting to Scottish Government).

With this in mind, one of our priorities over the period of this Strategic Plan will be to develop a new Performance and Improvement Framework. This will be based on our strategic and other objectives and will identify the data we will gather to measure our performance in relation to these. It will also provide details of how this performance data will be used in terms of performance management; and will outline our approach to using data to drive improvement and innovation.

"develop a new Performance and Improvement Framework"

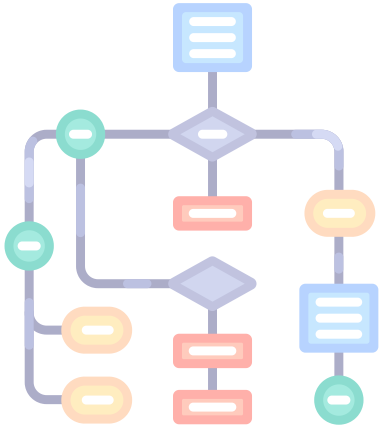
" robust data is needed to support review and scrutiny of our service delivery"

Strategic Enabler 5
Technology

One of the impacts of the Covid pandemic has been to speed up the adoption of digital technology and use of telecare and telehealth across health and social care services. Although born out of necessity, some of the new and accelerated uses of technology has brought real benefits to patients, service users and staff. For example, the reliance on telephone or online appointments in place of face-to-face ones has proven to be a quick, accessible and effective approach to delivery, resulting in excellent outcomes for many patients and helping to overcome some of the impacts of East Lothian's geography and dispersed communities. The increased use of Technology Enabled Care (TEC) and promotion of the use of smart technology at home, along with the introduction of the new ABEL digital platform to support self-management have all been significant developments.

We are committed to further developing our existing use of technology / digital options, and to explore new opportunities to use technology to make our services more efficient and sustainable, whilst also improving outcomes for patients and services users. With this commitment in mind, our Annual Delivery Plan will include a technology / digital workstream. We anticipate that teams already making good use of technology, for example the TEC service, will play a key role in leading this area of work.

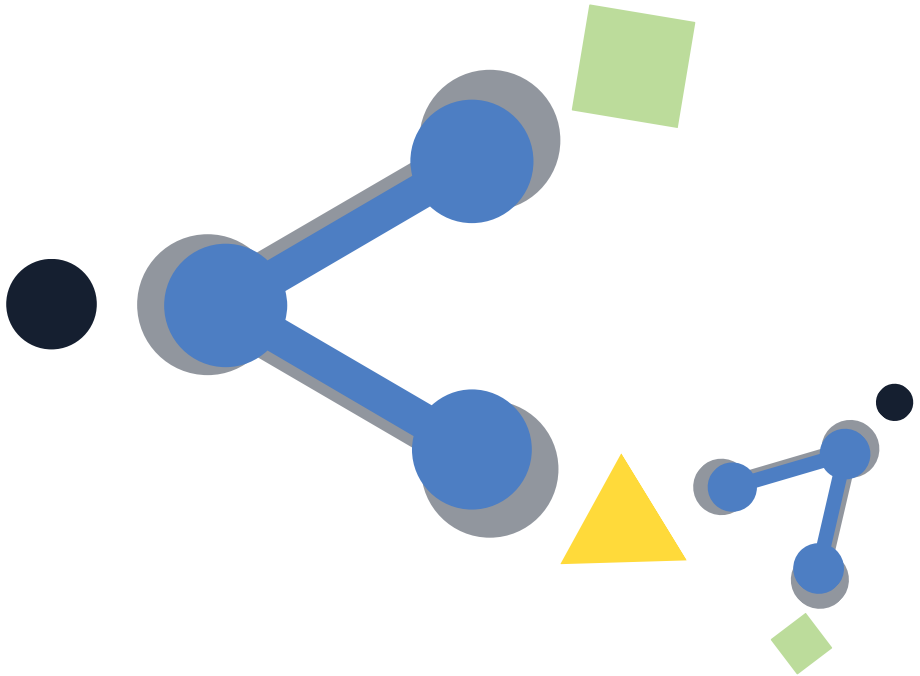
"Facilitating information sharing will also be a key consideration in our development of new IT and other (data management) systems"



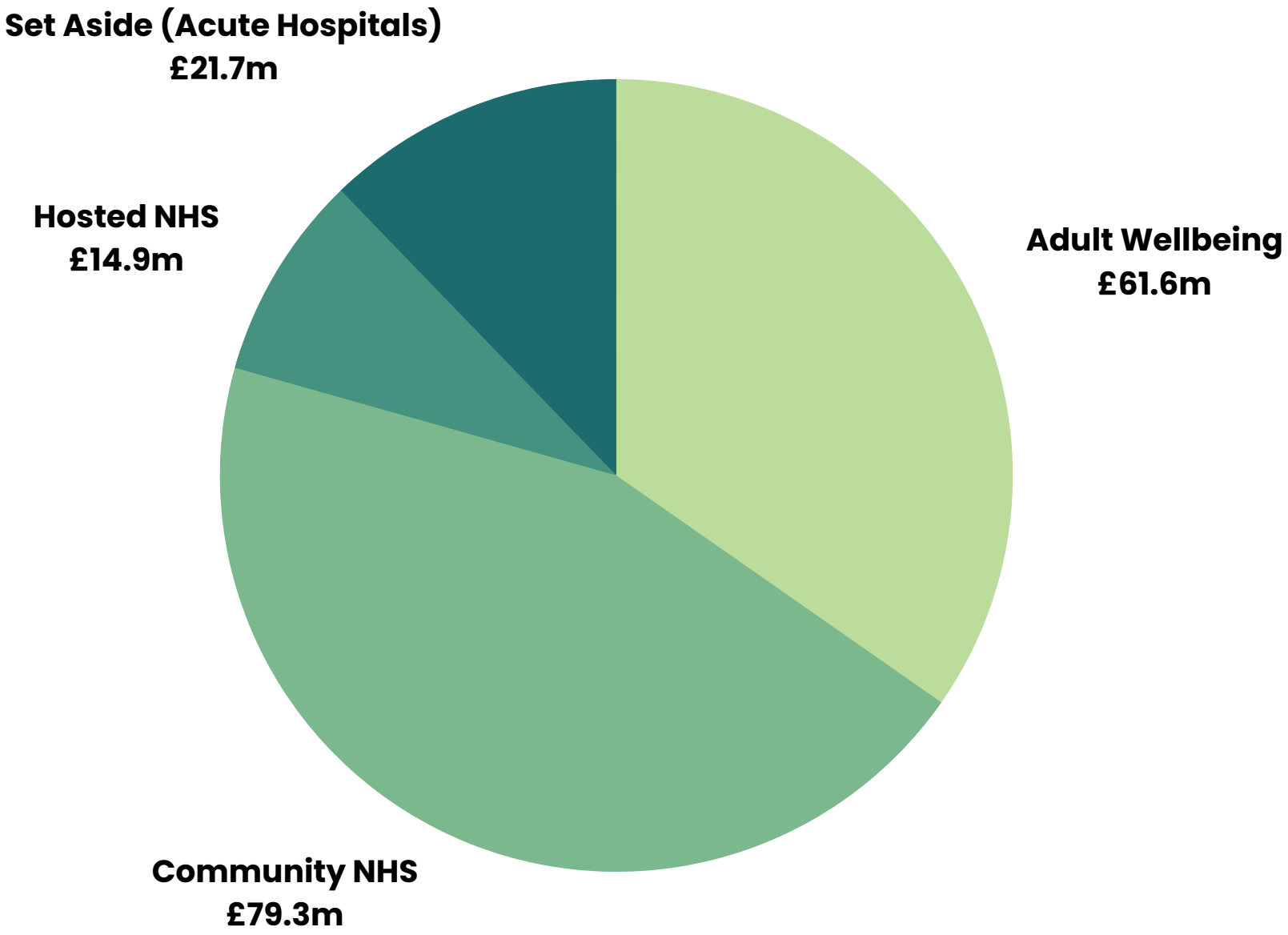
Strategic Enabler 6
Information Sharing

Sharing of information is one of the most commonly raised issues when the integration of health and social care is under discussion. Perhaps unsurprisingly, this was one of the challenges frequently highlighted by people who took part in the Strategic Plan engagement.

We will continue to look at ways to address issues related to information sharing. In some instances, this will require work between partners to develop or revise information sharing protocols. Facilitating information sharing will also be a key consideration in our development of new IT and other (data management) systems. Information sharing will also be considered at an early planning stage in relation to the development of new service approaches and transformation programmes. This work will be progressed in line with GDPR requirements and East Lothian Council and NHS Lothian's Data Protection policies.



Composition of the East Lothian Integration Joint Board Budget



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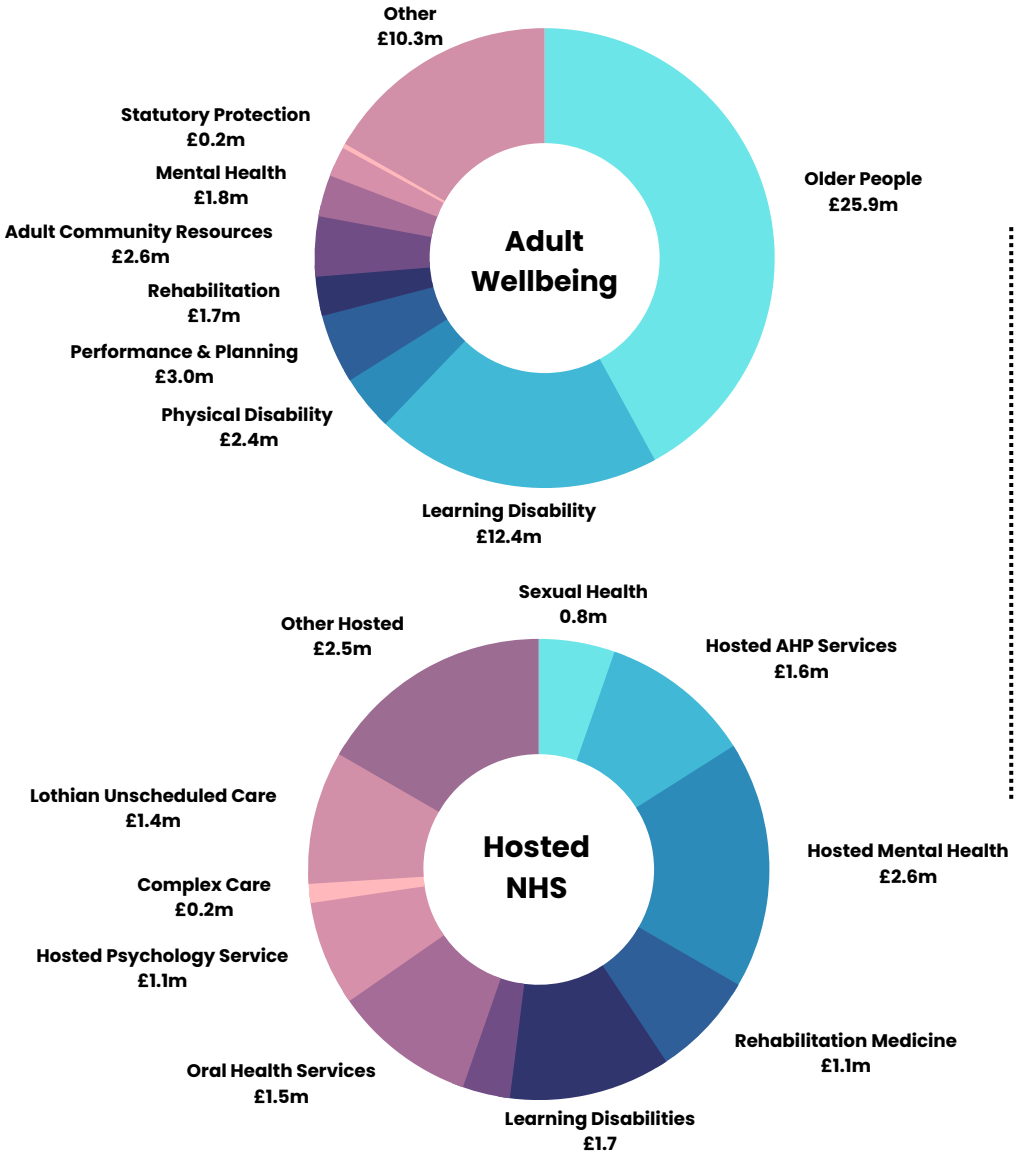

Appendix 1 – Functions Delegated to East Lothian IJB

This Strategic Plan does not cover children's services, following a decision in January 2019 to remove children's wellbeing services from the East Lothian IJB responsibilities.

NHS Lothian services delegated to East Lothian IJB:

Accident and Emergency and Combined Assessment *
General Medicine *
Geriatric Medicine *
Rehabilitation Medicine *
Respiratory Medicine *
Palliative Care *
All Community Hospitals (ELCH, Edington and Belhaven)
Mental health inpatient services [3]
Community mental health services
Community learning disability services
Community nursing (inc. children's community health services - district nursing, health visiting and school nursing)
Substance Misuse Services
Allied Health Professionals
Primary Care - General Medical Services, General Dental Services, General Ophthalmic services and Community Pharmacy [1]
Lothian Unscheduled Care Service [1]
Public Dental Service [2]
Palliative care provided outwith a hospital
Psychology services [3]
Community Continence [4]
Kidney dialysis services provided outwith a hospital
Community Complex Care
Sexual Health [4]

* East Lothian HSCP will work with NHS Lothian, Midlothian, West Lothian, and City of Edinburgh HSCPs to progress the Lothian Strategic Development Framework (LSDF).
° Midlothian HSCP hosts (manages) dietetics and art therapy services on behalf of all Lothian HSCPs.
[1] In mid-2018, East Lothian HSCP transferred management of Lothian Unscheduled Care Service to NHS Lothian, which manages it on behalf of the 4 HSCPs.
[2] West Lothian HSCP hosts (manages) clinical psychology, the public dental service, podiatry and orthotics on behalf of all Lothian HSCPs.
[3] Operational management of Mental Health and psychiatric rehabilitation was transferred back to NHS Lothian, with service delivery guided by Directions from IJBs.
[4] Most sexual health services are delivered in primary care. Specialist sexual and reproductive health services in Lothian are hosted by City of Edinburgh HSCP on behalf of the 4 HSCPs.

East Lothian Council services delegated to East Lothian IJB:

Social work services for adults and older people
Services/supports for adults with physical disabilities
Services/supports for adults with learning disabilities
Day services
Mental health services
Criminal Justice Social Work
Drug and alcohol services
Adult protection and domestic abuse
Carers support services
Community care assessment teams
Care Home Services
Adult Placement Services
Housing support services: aids and adaptations
Local area coordination
Breaks from caring (respite)
Occupational therapy services
Reablement services
Telecare