East Lothian
Integration Joint Board

SBAR – IJB Annual Performance Report 2020 – 2021

Date: 15th September 2022
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Area: Planning and Performance

Situation	The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report (APR) covering the period 1st April to 31st March by the end of July each year. The Coronavirus Scotland Act 2020 extended the publication deadline to the end of November in recognition of the pressures faced by HSCPs. This report is presented ahead of the November deadline.
Background	Guidance for Health and Social Care Partnerships identifies the purpose of Annual Performance Reports as being to: '….provide an overview of performance in planning and carrying out integrated functions and is produced for the benefit of Partnerships and their communities'. Partnerships are required to include details of performance against the Core Integration Indicators, developed by the Scottish Government to measure progress in delivering the National Health and Wellbeing Outcomes. Details of financial performance is also required. The Guidance also states that, beyond the minimum requirements, Partnerships should include additional relevant information: '….in order to build as full and accurate assessment as possible as to how the integration of health and social care is delivering for people and communities, and be presented in a way that is clear for non-experts'.
Assessment	In line with Scottish Government guidance, the East Lothian IJB Annual Report for 2021-22 describes performance in planning and carrying out integrated functions from 1st April 2021 to 31st March 2022. The report includes details of performance in relation to the Core Integration Indicators and additional Ministerial Steering Group indicators and financial performance. Beyond these specific requirements, a detailed narrative is also included describing developments across HSCP services and highlighting key achievements throughout the year. This narrative is ordered in accordance with IJB current objectives (which link to the National Health and Wellbeing Outcomes – as mapped in appendix 1 of the report). The report is written in a style intended to make it as accessible as possible to a 'non-expert' audience. In addition, a summary report will be produced that includes images, infographics and case studies (see below for last year's example).
Recommendation	East Lothian IJB is asked to: • Recognise the achievements of East Lothian HSCP and individual services

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	throughout the year. • Commend the contribution made by staff, volunteers, communities and partner organisations.
Further Information	Health and Social Care Integration Partnerships: reporting guidance, Scottish Government, 2016 East Lothian Integration Joint Board Summary Report 2020-21

East Lothian Integration Board

Annual Performance Report 2021-22

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Foreword

This year was another one of change, adaptation and innovation for East Lothian Health and Social Care Partnership. However, there was also an element of settling into what is often aptly described as 'the new normal' – with some things beginning to return to how they were pre-pandemic, but with some changes that had taken place, both positive and negative, looking likely to be more longstanding.

In this Annual Performance Report, you will read about some of the ways our services continued to develop and evolve in response to the challenges presented. The report also describes the progress we made throughout the year in delivering our strategic objectives, and presents key data related to our performance.

In last year's report, we spoke of the debt of gratitude owed to our staff for the immense effort and commitment they showed throughout a particularly difficult year. Once again, we would like to acknowledge our gratitude to staff for their hard work and dedication, particularly given the pressure they have now been under for a sustained period.

We would also like to acknowledge the work of the range of third and independent sector organisations who provide vital services to some of the most vulnerable residents, as well as the valuable contribution made by community organisations and volunteers.

The end of 2021/22 sees us looking ahead to the development of our next Integration Joint Board Strategic Plan. Reflecting on activity from across the Partnership in the course of producing this Annual Performance Report has highlighted just how far we have progressed with delivering our strategic objectives.

Our Performance Report

This Annual Performance Report describes our progress in delivering the Strategic Objectives outlined in the East Lothian Integration Joint Board (IJB) Strategic Plan for 2019 to 2022 – these are:

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

Table 1 at Appendix 1 shows how our East Lothian Strategic Objectives link to delivery of the Scottish Government's National Outcomes for Health and Social Care.

Individual sections of the report relate to each of our Strategic Objectives and give examples of some of the work that has contributed to delivering these during 2021/22 (although note that most of the examples described contribute to a number of different objectives).

The 'Performance in Numbers' section presents data reflecting our delivery of the national health and social care outcomes, which are closely linked to the East Lothian objectives. The 'Our Financial Performance' section describes how we used our financial resources during 2021/22 to deliver our objectives and other priorities.

In Our Communities

Our Strategic Plan 2019-2022 describes our ambition to improve access to services, whilst also ensuring that we are able to continue delivering these services in the longer term with the resources available. This is reflected in our first two Strategic Objectives:

> **Strategic Objective 1 – 'To make health and social care services more sustainable and proportionate to need and to develop our communities'; and**
>
> **Strategic Objective 2 - 'To explore new models of community provision which involve local communities and encourage less reliance on health and social care services'**

To achieve this ambition, we need to reduce reliance on traditional health and social care services. We are doing this by developing approaches that support and empower people to look after their own health and wellbeing. We are also working with communities to build their capacity to deliver services and activities that help meet the needs of local people.

Community Transformation Programme

Our Community Transformation Programme focuses on developing community support for older adults, adults with disabilities and adults with mental health support needs. We continued to make excellent progress in delivering this work during 2021/22 – some areas of development included:

- Piloting of a new Community Outreach and Coordination Service with Volunteer Centre East Lothian (see page 29 below).
- Expansion of the 'Resource Coordinator' Service.
- New outreach support provided from all nine Older People's Day Centres, offering support for individuals and respite for carers, reflecting a blended model of outreach and centre-based support.
- An innovative approach to dementia support by funding the development of a Dementia Meeting Centre in Musselburgh to be run by Dementia Friendly East Lothian (to commence in late summer 2022).
- Investment in additional 'Neighbourhood Networks' – one in Dunbar for people with Learning disabilities and one for people who are moving from young people's services into adult services (a 'transition' network). Networks support individuals to establish a life in which they are safe and more independent in their local community.
- Funding of a new Development Worker for Headway, the brain injury association.
- Working with East Lothian Works to support the development of employability support for adults with complex needs. A pilot service has started, run by Enable Works and funded through the Scottish Government's 'No One Left Behind' fund. This is a specialist employability provision for people who have complex barriers to work including disabilities and long-term health conditions.

Resource Coordinator Service

In last year's IJB Annual Report, we highlighted the successful launch of a pilot Resource Coordinator Service. April 2021 saw the establishment of a new Resource Coordinator Team consisting of a senior day services officer and four day services officers.

The purpose of the Resource Coordinator Service is to develop community-based sessions for people with learning disabilities who do not require a resource centre-based service. The Team has worked closely with service users, families / carers, provider organisations and third sector colleagues to develop the service. This has included significant work on community and asset mapping (to identify what is already available in local communities). Funding has been secured for 2022/23 to recruit additional staff to continue to develop and deliver this model.

In March 2022, an independent evaluation of the Resource Coordinator Service was completed by 'Outside the Box'. This identified that the service was meeting individual service users' needs and had successfully developed a range of alternative community-based options. It also recommended that further sessions should be developed based on feedback from service users.

Another positive development within the Transformation Programme was the commissioning of Teens+ to provide a day service based in East Lothian. Teens+ offer an educational experience to support young adults to develop life skills. This new service will support young people in transition (moving from child to adult services) and will offer a more localised service for the people who are currently travelling to Edinburgh. In year 1 Teens+ will support 15 young people and by year 3 this will increase to 25.

Learning Disability Services

Learning disability services in East Lothian currently include the Learning Disability Social Work Team; Adult Community Resources (Day and Respite Services and Shared Lives) and the Community Learning Disability Team.

The Learning Disability Social Work Team was established in April 2021 and works closely with the Community Learning Disability Team. There are plans to co-locate the teams as part of a wider asset review and to develop an integrated, enhanced Learning Disability Service. This enhanced service will help to ensure that East Lothian residents with a learning disability and their carers / guardians have access to an efficient, specialist and outcomes focused service.

Work is also ongoing to improve the experience of young people as they transition from child to adult services. Colleagues from Children's and Adult Services meet 4 times a year to:

- Co-ordinate, share and update information on all young people due to transition to Adult Services, both prior to and following referrals being made.
- Maintain a transition spreadsheet, which helps with forecasting and planning.
- Confirm school leavers and proposed dates for Adult Social Work allocation.

The Learning Disability Social Work team continues to coordinate and screen initial referrals. This ensures consistency of approach and provides one point of contact.

A draft Transitions Policy was under development in 2021/22, with the aim of delivering best practice in supporting young people's transition to adulthood by promoting their rights, highlighting clear duties, clarifying areas of responsibility and setting timescales. The overall aim of the Policy is to enhance young people's experience of moving to adult services and to support the identification and achievement of their individual outcomes.

Planning for an Ageing Population

Discussions around how to develop health and social care services in response to an ageing population have been ongoing nationally and locally for a considerable time.

At a local level, a year-long engagement process during 2018, culminated in East Lothian IJB approving a paper on the 'Reprovision of Belhaven and Edington Hospitals and Eskgreen and Abbey Care Homes'. This was followed by further activity to determine existing capacity and the wider impacts of the proposed approach.

This work was halted in 2020 due to the Covid pandemic, before restarting in summer 2021. In the intervening time, the landscape for HSCPs had changed significantly, with a number of new issues emerging:

- The short and long term impact of Covid.
- The national consultation on the future design of care homes.
- The proposed National Care Service.
- Increased workforce and recruitment pressures.

The East Lothian Community Hospitals and Care Homes Change Board was formed in June 2021 to continue the work started in 2019, and to consider the impact of subsequent developments. The aims of the Change Board were defined as:

- Delivering high quality care and support to East Lothian's current and future older population, at the right time and in the right place.
- 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.

Three working groups were also set up to support this work, covering Communication and Engagement; Capacity and Planning; and Finance and Capital.

Between June and March 2022, the Change Board and working groups made significant progress in gathering and analysing data and carrying out engagement with HSCP staff and other stakeholders to inform further development of proposals. Preparation also took place for a widescale community engagement exercise planned for spring / summer 2022.

Prevention and Early Intervention

Strategic Objective 3 – 'To improve prevention and early intervention'

We are committed to developing services that focus on prevention and early intervention. By addressing the factors that impact on people's health and wellbeing at an early stage, we can help prevent issues developing in some cases, or stop them getting worse in others. This focus is an important part of our broader effort to maintain independence; to provide rehabilitation support; and to reduce pressure on health and social care services.

Prevention and early intervention have become mainstays of how we do our business, with many of the health and social care services we deliver involving some element of prevention and / or early intervention. Here are some examples of our activity in relation to prevention and early intervention during 2021/22.

Our Performance in Numbers

99% of survey respondents said they were satisfied or very satified with how easy it was to use the CWIC Mental Health Service. 93% said the practitioner who supported them was 'excellent' (80%) or 'very good' (13%) at helping them take control.

Self-referals to CWIC Mental Health grew from 15% (2020/21) to 28% (2021/22). Appointments available increased from 140 per week to 208.

CWIC (Care When it Counts) Mental Health Service

The CWIC Mental Health Service provides quick access to specialist mental health support over the phone for individuals with low to moderate mental health issues. Help is provided on the day where possible or within 72 hours of the patient's initial phone call.

The CWIC MH Service moved from the Primary Care to the Mental Health Directorate during 2021/22. This helped to develop better links between the team and other community mental health services. The Service's clinical leadership and governance was also strengthened by the addition of new Clinical Lead and Team Lead posts. In addition, the team benefitted from completing Level 2 Trauma training and by taking part in monthly supervision groups facilitated by Psychology colleagues.

Individuals can be referred to the service by their GP or other professional, but encouragingly, a growing number contacted the service directly without the need for a referral – 'self-referrals' grew from 15% in 2020/21 to 28% in 2021/22.

Demand for the CWIC MH Service increased significantly over the year, with no unused appointments from July 2021. The team grew by an additional 3.5 full time posts during the year, including the addition of an Occupational Therapy Assistant Practitioner to support community focused work. The additional staffing means that around 208 appointments can now be offered per week, compared to

140 per week the previous year (still allowing time for team meetings, supervision, and staff development).

Feedback from a survey of CWIC MH patients in 2021/22 found:

- 99% were 'very satisfied' or 'satisfied' with how easy it was to use the service.
- 93% said the CWIC MH practitioner was 'excellent' or 'very good' at really listening to them.
- 95% said the practitioner was 'excellent' or 'very good' in terms of showing care and compassion.
- 93% said the practitioner had been 'excellent' or 'very good' at helping them to take control.

Post Diagnostic Dementia Support

Our Dementia Link Workers support individuals with dementia and their families during the first year following diagnosis. Link Workers provide advice and support and can direct people to services they may find helpful. The posts are overseen by a qualified nurse who can provide further advice if required. This initiative is in line with the Dementia Strategy for Scotland and reflects the 5 Pillars Model of Post Diagnostic Support (PDS).

During 2021/22, a decision was made to use additional Scottish Government funding to expand the current Alzheimer Scotland PDS remit to include:

- A Link Worker available with the person at the point of diagnosis.
- A dedicated service and pathway for young onset PDS service East Lothian wide.
- Group work as part of the expanded Link Worker service (which will potentially take place in the Musselburgh Meeting Centre).

Expanding the PDS offer will benefit individuals in terms of them having timely access to support, along with opportunities to participate in peer group work (identified as a valuable source of support for both the person with dementia and their carer). It is also anticipated that this will have a positive impact on the current Community Psychiatric Nursing (CPN) caseload.

Digital Platform

East Lothian Rehabilitation Service (ELRS**)** carried out significant development work during 2021/22 ahead of the launch of a new digital platform **'Access to a Better Life in East Lothian'** in March 2022

This replaces the previous 'Help From H.I.L.D.A' platform and provides a one stop access point for information on the life curve, self-management and support. It also includes an interactive Body Map and Smart House.

This is an important resource in terms of prevention and early intervention, giving individuals ready access to information that helps support self-management and optimum ageing. The availability of detailed analytics on use of the platform will inform future development and support targeted promotion.

Technology Enabled Care

We recognise the value of using TEC (Technology Enabled Care) to support people to remain as active and independent as possible. When used at the right time, TEC can help prevent hospital admission; facilitate hospital discharge; and enable carers to continue to look after their loved one at home. TEC can also be used as an alternative, or alongside care provision, reducing demand on wider partnership resources. TEC is cost effective and plays a key role as an enabler in modernising health and social care. There is an added advantage in terms of much of the technology used being widely available for individuals to purchase themselves.

The Telecare Team (part of ELRS) provide a range of telecare equipment to support individuals including community alarms and pendants, devices to help detect a fall and environmental sensors to help protect the person in their own home such as fire safety. The team also train colleagues from other HSCP and Housing services to raise awareness and promotes a 'TEC first' approach.

Active Independent Living Clinic (AILC)

The Active and Independent Living Clinic, 'Wellwynd Hub', is based within the Loch Square Sheltered Housing complex in Tranent. This innovative service is a community-based resource to support people at an early stage to prevent a decline in ability and function.

A full assessment is carried out by the Occupational Therapist or Community Care Worker. A wide range of technological solutions are explored as well as support and advice on activity and exercise, access to short or long-term equipment and signposting to other essential community services to support people to maintain and improve their independence and activity levels.

Access to AILC was reduced during the pandemic, but clinics began to be fully operational again in 2021/22.

Reducing Pressure on Acute Services

Our fourth strategic objective focuses on reducing pressure on our acute services:

Strategic Objective 4 – 'To reduce unscheduled care and delayed discharges'

This includes reducing demand for hospital-based care by ensuring that people do not go into hospital when other suitable options can be provided, as well as preventing people remaining in hospital longer than is clinically necessary.

Our Performance in Numbers

Our emergency admission rate for adults (per 100,000 population) was 10,528. This was up slightly from the previous year but still below the Scottish figure of 11,475.

The number of days people over 75 spent in hospital when clinically ready to be discharged was 159 (per 1,000 population). This was significantly below the Scottish rate of 761 days.

The number of bed days lost to delays for all adult age groups (over 18) was 2,672 (per 100,000 population), down from the previous year's figure of 3,935.

Our Discharge to Assess service completed 6,133 interventions during 2021/22 compared to 3,453 the previous year.

Managing Delayed Discharges

East Lothian HSCP faced a challenging year during 2021/22, with higher numbers of people being admitted to hospital and more people needing support to return home once medically ready to be discharged. As a result, our Hospital Delayed Discharge increased slightly in comparison to the previous year. Despite these challenges, we managed to keep to our projected target every month, with the exception of February 2022[1]. Overall, we continued to maintain our position as one of the top performing areas in Scotland during 2021/22

We delivered this level of performance through key services working collaboratively to prevent unnecessary hospital admission and to ensure that patients do not remain in hospital longer than medically necessary. During 2021/22, a new Integrated Care Assessment and Allocation Team (ICAAT) was formed, bringing together the following:

- Capacity and Flow (Discharge) Team
- Hospital to Home Team

[1] Projected monthly delayed discharge target of no more than 10 patients at the monthly census point – management data reported and collated at NHS Lothian level.

- Emergency Care Team
- Care Broker Team
- Allied Health Professionals
- Input from other Social Care Services

You can read more about our ICAAT approach on page 19.

Staff across all teams continue to initiate early and ongoing conversations with patients, relatives and carers in relation to hospital discharge, promoting the 'Home First' philosophy of supporting individuals to return home wherever possible, with relevant support.

Some patients leaving hospital will be moving to a care home placement, so where issues arise in relation to placements this can contribute to delayed discharges. Thanks to infection prevention and control and high vaccination rates, Covid outbreaks in East Lothian care homes remained relatively low during the start of 2021. However, the rise of Omicron towards the end of November 2021 saw infection rates rise again significantly until late March 2022.

This presented challenges in terms of outbreaks in homes leading to suspension of admissions, meaning that some patients who were ready to leave hospital were unable to move to their care home placement. As well as being a potentially frustrating situation for patients and families, this impacted negatively on availability of hospital beds for people requiring admission.

In response to this, the HSCP put in place two 'block contracts' with Haddington Care Home and Harbour House Care Home to guarantee 10 care home beds to be used flexibly to support ongoing discharges through the use of interim placements. A new business support role was established to enable greater tracking of available vacancies across care homes to support hospital discharge. This post also responded to the increased reporting requirements from NHS Lothian's Gold Command emergency planning group, which oversaw work across the four Lothian HSCPs to reduce delayed discharges.

Allied Health Professionals and Unscheduled Care

Our Community Physiotherapy and Occupational Therapy Team supports a number of unscheduled care pathways including:

- Discharge to Assess (D2A)
- Hospital at Home (H@H)
- Prevention of Admission (POA)
- Community Respiratory Pathway – Advanced Physiotherapy Practitioners

The team provides comprehensive assessment and rehabilitation to patients in their own homes to improve independence and reduce requirements for care. In addition, the Community Physiotherapy team provides scheduled care to patients referred into the service either by a health professional or through the self-referral phoneline. This team is based across three local hubs in Belhaven Hospital, Musselburgh Primary Care Centre, and East Lothian Community Hospital.

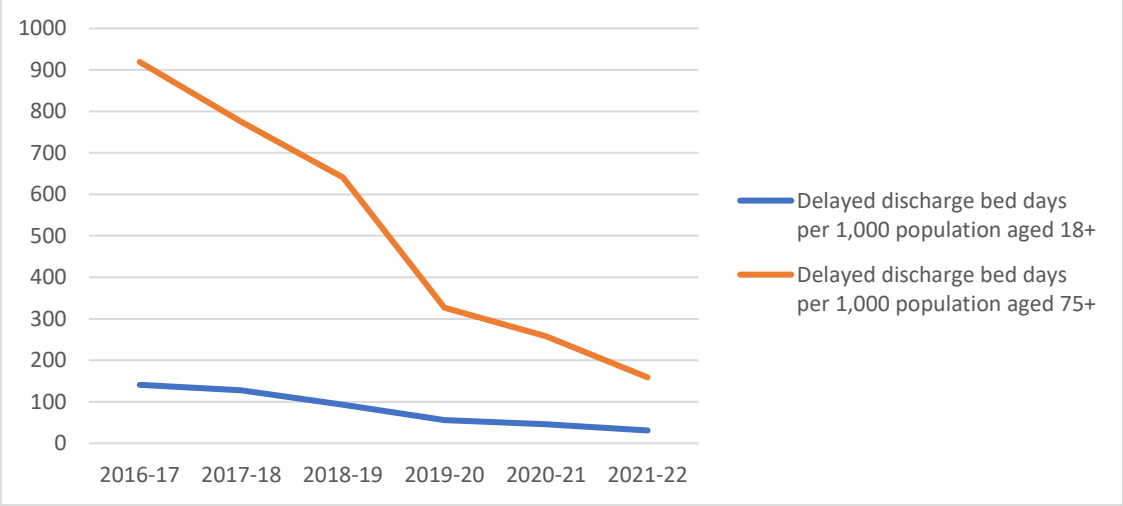
Our Discharge to Assess (D2A) service demonstrates how Allied Health Professional (AHP)[2] delivered services can contribute to reducing the length of hospital stay for patients. The D2A model prevents patients (who are clinically fit and appropriate) from having to wait for Occupational Therapy (OT) and/or Physiotherapy (PT) assessment before leaving hospital. These patients have a joint OT/PT assessment completed in their own home on the day of discharge. This reduces the length of hospital stay and can also make the assessment more effective as a result of it taking place in the patient's home environment. Discharge to Assess completed 6,133 interventions during 2021/22 compared to 3,453 the previous year.

During 2021, the D2A team completed a project enhancing the current model by supporting hospital discharges for patients with short-term care needs, who would otherwise have waited in hospital for a formal package of care. A reablement-focused approach to care visits, enabling practice of goal-orientated activities of daily living led to a reduction in the final need for long-term care support. It was estimated that during the project 249 bed days were saved with a subsequent saving of £74,700. Package of care estimated savings over the project duration (4 months) were £40,114 which would equating to an annual saving of £120,341.

Our Performance in Numbers

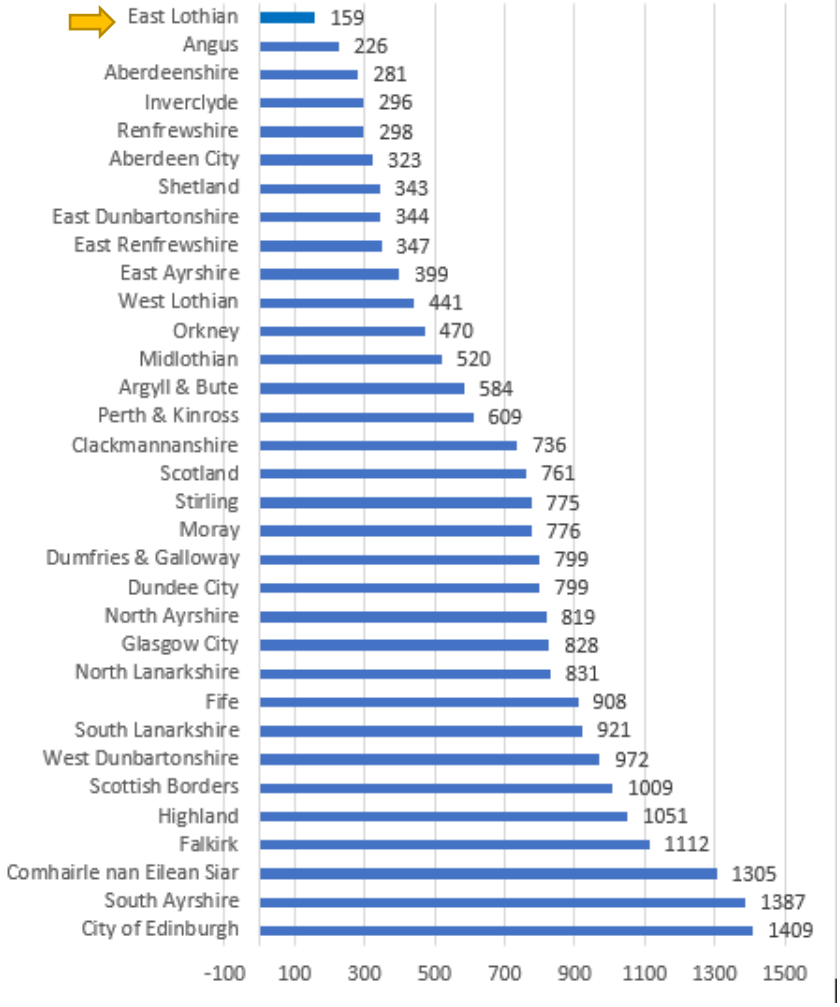
Graph 1 demonstrates an ongoing and sustained reduction in East Lothian delayed discharges since 2016, with Graph 2 showing our performance compared to HSCPs across Scotland during 2021/22.

Graph 1 – Delayed discharge bed days per 1,000 population (by age)



[2] AHPs are a diverse group of Health and Care Professions Council (HCPC) registered practitioners and support staff who support people of all ages to live healthy, active and independent lives. AHPs are a distinct group of practitioners who apply their expertise to diagnose, treat and rehabilitate people of all ages across health, education and social care – Scottish Government 2022.

Graph 2 – Delayed discharge bed days per 1,000 population aged 75+ by Local Authority Area



Care Closer to Home

Strategic Objective 5 – 'To provide care closer to home'

Our aim is to deliver safe and effective care as close to home as possible. This is more convenient for people who use our services and helps to reduce the need for travel to and from appointments.

We are delivering this objective by expanding the range of services available at East Lothian Community Hospital in Haddington and by providing more options for people to access primary care services, for example, over the phone or online.

Our Performance in Numbers

The number of outpatients seen at ELCH has expanded from around 30,000 in the last years of Roodlands Hospital to almost 45,000 in 2021/22.

18,000 appointments were delivered by the HSCP run Community Treatment and Care Service in local community venues during 2021/22.

The Endoscopy and Day Services Unit at East Lothian Community Hospital increased its capacity from 17 to 24 sessions a week, with plans to further increase to 30.

East Lothian Community Hospital

The transfer of Roodlands Outpatient Department to the new East Lothian Community Hospital (ELCH) began in March 2018, with all other services moving across by November 2019. ELCH provides local inpatient care, as well as continuing to develop a growing range of outpatient services, reflecting our objective of providing care closer to home.

Nurse-led outpatient monitoring clinics continue to be developed at ELCH, including clinics for Diabetes, Gastrointestinal, Haematology and Renal specialties. This allows patients to have routine checks without the need for a Consultant appointment (unless test results require further investigation).

ELCH has also played a key role in the pandemic response over the last two years.

The range of Outpatient services has expanded and currently includes:

- Abdominal Aortic Aneurysm (AAA) screening
- Adult Psychiatry
- Antenatal Services
- Audiology
- Cardiology
- Minor Operations
- Monitoring clinics
- Musculoskeletal
- Neurology
- Ophthalmology

- Community Treatment and Care Service (CTACS)
- Dentistry
- Dermatology
- Diabetes
- Dietetics
- Ear, Nose and Throat
- Gastroenterology
- Gynaecology
- Lymphoedema
- Orthopaedics
- Osteoporosis
- Palliative Care
- Phototherapy
- Plastic surgery for hands
- Podiatry
- Rheumatology
- Urology

The number of outpatients seen at ELCH has expanded from around 30,000 in the last years of Roodlands Hospital to almost 45,000 in 2021-22[3].

Dermatology ultraviolet (UV) phototherapy treatment is one of services which has been successfully introduced at ELCH. The treatment requires patients to attend twice a week for between 10 and 12 weeks. In the past, patients had to travel to the Lauriston Building in Edinburgh for treatment, so being able to access this locally has been hugely beneficial. Discussion begun to take place towards the end of 2021/22 around the potential to double capacity from 15 to 30 patients at any one time.

The Endoscopy and Day Services Unit at ELCH now comprises of three procedure rooms (compared to two rooms at Roodlands Hospital previously) and has increased capacity from 17 sessions to 24 sessions per week, with plans to increase capacity to the maximum of 30 session per week during 2021/22. The Unit involves service specialities based at the Royal Infirmary, Western General and St John's hospitals – the three main specialities are Gastroenterology, Gynaecology and Urology.

The Endoscopy and Day Services Unit also provides teaching / training within the hospital's state-of the-art facilities and lecture theatre. The Unit has begun the process of applying for JAG Accreditation[4]. Should this be successful, this will be the first NHS facility in Scotland to have this accreditation.

Collaboration with the Edinburgh Cancer Centre Haematology Unit over the last two years has enabled the Intravenous Therapy Suite within Endoscopy to delivers intravenous therapies and venesection as part of patient's treatment. This allows people to be treated in Haddington as opposed to having to travel to the Western General Hospital in Edinburgh.

Although clinical departments at the hospital had to pause or significantly restrict delivery at the height of the Covid-19 pandemic, every effort was made to recommence appropriate levels of provision as soon as safe and practical.

Clinical departments were still operating at Amber level at the end of 2020/21 and into 2021/22 but were gradually increasing the number of initial face-to-face outpatient appointments offered. The use of 'Near Me' video appointments had resulted in some real benefits for staff and patients, for example, in terms of making appointments more accessible, time-effective and convenient. Effective use continued to be

[3] TRAK

[4] This Accreditation is awarded by the Royal College of Physicians Joint Advisory Group (JAG) on Gastrointestinal Endoscopy.

made of 'Near Me' appointments where appropriate even as 'in-person' attendance become increasingly possible.

Developments in Primary Care Services

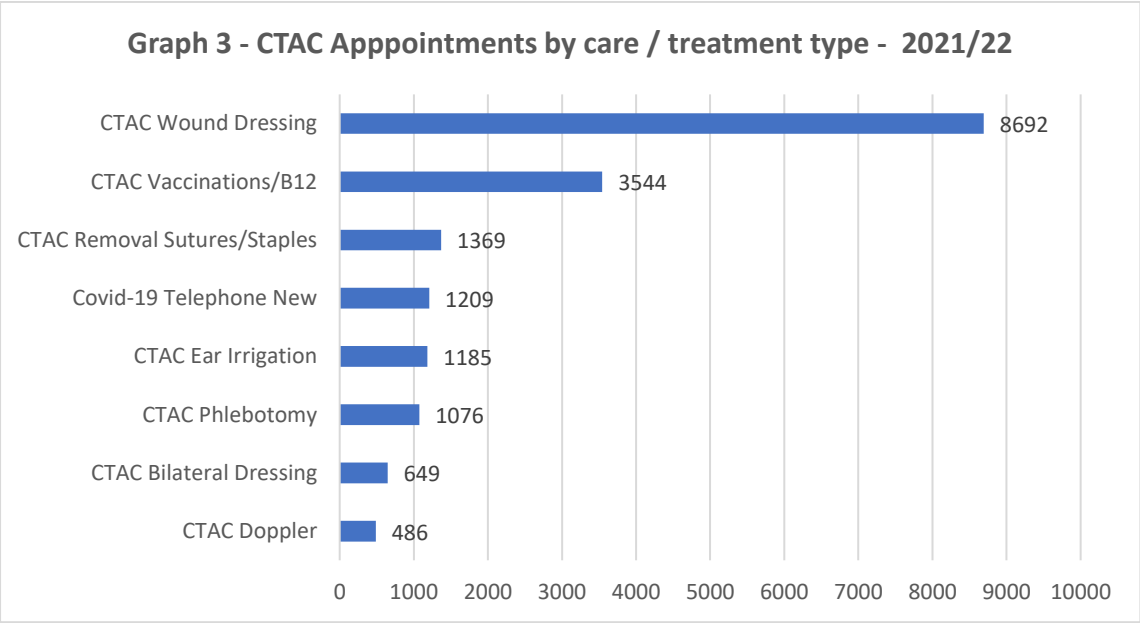
Primary Care has changed significantly in East Lothian as the HSCP has implemented the IJB Primary Care Improvement Plan. This was written in response to the 2018 General Medical services contract which moved responsibility for some services previously delivered by general practice to the HSCP.

Using new funding from the Scottish Government, the HSCP has implemented the Primary Care Improvement Plan, leading to more choice for people living in East Lothian and increasing the capacity in our services. A further 75 whole time equivalent of staff have joined the HSCP to support delivery of one of the following services:

- Primary Care Vaccination Team
- Community Treatment and Care (CTAC) service
- Pharmacotherapy Service
- Care When It Counts (CWIC) service
- Musculoskeletal (MKS) direct access service
- Care When It Counts (CWIC) Mental Health service
- Link Worker Service

Community Treatment and Care (CTAC) Service

The CTAC service is available in most large communities in East Lothian and provides a range of services including wound management, ear care, Doppler assessments, removal of sutures / staples, B12 injections, phlebotomy and some vaccinations. During 2021-2022 the service provided over 18,000 appointments to people in East Lothian. Graph 3 below shows the breakdown of types of care / treatment provided.



Physician Associates

We first recruited Physician Associates[5] (PAs) in 2020 as part of the CWIC service, when they quickly became an important part of the multi-disciplinary team. Following on from this success, PAs have undergone further training to become integral to the delivery of care within East Lothian Community Hospital, H@H (Hospital at Home) and the Care Home Team, as well as assisting during peak demand for Covid vaccinations. On occasion, PAs have also been successfully deployed within GP practices.

There are now 5 full-time Physician Associates in post, with a sixth post to be recruited to in 2022. There are likely to be further teams and services that would benefit from this addition to their staffing and further development of the role is being explored.

East Lothian GP Cluster Activity

There are 15 General Practices in East Lothian, each working as independent contractors. East Lothian GP Cluster provides a mechanism for practices to work collaboratively and to collectively engage with the HSCP as well as NHS Lothian initiatives. The GP Cluster plays a key role in advising on the development and delivery of the East Lothian Primary Care Improvement Plan, as well as supporting wider quality improvement activity in partnership with HSCP colleagues. In addition, the Cluster has provided a supportive network for communication between practices during the Covid pandemic.

The Cluster is supported by 2 Cluster Quality GP Leads who link in with representatives from practices and lead on Cluster-led quality improvement projects.

One example of Cluster activity during 2021/22 has been work carried out collectively to improve the management of hypertension through the promotion of Blood Pressure (BP) home monitoring systems, enabling patients to share BP readings with their practice when convenient to them and reducing the need for visits to the practice.

Another example was a Quality Improvement (QI) project aimed at simplifying and clarifying the processes for GPs referring young people to mental health services. In the initial stages of this project, engagement with GPs and other stakeholders identified that there was not a clear, standardised process for referral from primary care. This led the QI project team to work with CAMHS (Child and Adolescent Mental Health Service) to produce a flow chart as a guide for GP practices.

Discussion is currently underway regarding a future Cluster project to standardise and promote frailty coding across the region, with the aim of increasing awareness and improving management of frailty. It is hoped that this will lead to a number of QI projects, with practices working alongside secondary care colleagues to develop new ways of improving quality of care and outcomes for patients with frailty.

Supporting Medical Practices

2021/22 saw the completion of a £3.4m extension at Harbours Medical Practice following 10 months of construction. The new 400m^2 extension provides 6 consulting rooms; 2 treatment rooms; 2 community

[5] Physician Associates support doctors in the diagnosis and management of patients and can be based in medical practices, community teams or hospitals.

consulting rooms and a health education room. Construction phases 2 and 3 will involve refurbishment of the original building to provide further improved accommodation.

Smaller property improvements also took place throughout the year, including refurbished reception areas in Gullane and East Linton surgeries and reconfiguring of space to provide additional consulting rooms in Prestonpans, North Berwick and Dunbar.

Other support to practices came in the form of funding to support staff wellbeing and resources to support training for practice administrative staff.

Integrated Services

Strategic Objective 6 – 'To deliver services within an integrated care model'

We want to make people's journey through all our services smoother and more efficient. We are doing this through the ongoing development of integrated working between health and social care services. In some cases, this may involve bringing teams together under one banner; in others, it will involve developing integrated approaches to service delivery.

There are examples of how we are delivering this objective throughout this report. We have included a more detailed description of our Integrated Care Assessment and Allocation Team (ICAAT) below as an illustration of what integrated working can achieve.

The Integrated Care Assessment and Allocation Team (ICAAT)

A new Integrated Care Assessment and Allocation Team was formed in 2021/22 to support an integrated approach to assessing individual care needs and identifying appropriate care and support services to meet these needs. The work of the team has been vital in helping to avoid unnecessary hospital admission and support timely hospital discharge during 2021/22 (see page 10 above), as well as helping to manage the prioritisation of available care services for people requiring care and support at home (see page 44 below).

Daily meetings, involving a range of health and social care colleagues, are central to the ICAAT approach. These meetings bring together disciplines including Social Work, Nursing, Occupational Therapy and Care Brokers. Information is shared based on previous knowledge of the person requiring care, along with professional perspectives on the person's support needs, level of risk, functional assessment[6], rehabilitation potential and any medical conditions and their management.

Multi-disciplinary discussion enables a more comprehensive consideration of what an individual needs. This can often result in the care / support developed for the individual being more appropriate than what was originally requested.

The team's collective knowledge of services is also valuable and can allow a more creative approach to meeting needs. There are examples where the use of Day Centre outreach and other community resources has been facilitated as an alternative to paid care. In one case, temporary assistance with meal provision was needed, there was no care availability, so arrangements were made for a hot meal to be collected from a local nursing home and delivered to the person by a volunteer.

The ICAAT is also able to maintain a clear overview of care availability and care demand. This means that when care packages are closing, the care that becomes available can be quickly reallocated to where it is most needed.

Another benefit of the ICAAT approach is the opportunity it brings to target the use of in-house services (managed by the HSCP). One example of this is where in-house services have been developed to cover

[6] 'Functional assessment measures an individual's level of function and ability to perform specific tasks on a safer and dependable basis over a defined period' – PM&R knowledge now

specific areas in order to release private providers to focus on a more concentrated geographic 'patch', thus allowing them to consolidate care runs and maximise the care time available.

The following case study[7] is an example of how the ICAAT works in practice:

> Margaret is in her 80s and was admitted to hospital after a fall. The hospital has advised that she is now well enough to return home but has suggested that she will need a carer coming in the morning and evening to allow this to happen. Unfortunately, the availability of morning / evening care provision has been impacted by staffing shortages and it looks like Margaret's discharge will be delayed.
>
> After discussion at the ICAAT daily meeting, an Occupational Therapist (OT) from the team liaises with the hospital team who referred Margaret. After further investigation, the ICAAT OT establishes that Margaret would be able to manage getting up and going to bed independently but would benefit from other assistance from a carer during the day. The team identify a care provider who has availability during the day, and Margaret is able to return home without any delay.

[7] These examples are not related to real-life people but are typical of the sort of cases the ICAAT deals with.

Choice and Control

Strategic Objective 7 – 'To enable people to have more choice and control'

We are committed to delivering services that are person-centred, reflecting what individuals want and need, and helping them to achieve their personal outcomes. An important part of this is ensuring that people are involved in planning their care and support, as well as providing a range of services that they can access to support their own health and wellbeing.

We know that the majority of people want to be able to live in their own homes and communities for as long as they can. We continue to develop health and social care services that enable them to do this.

You can read about some of the ways we support people to have choice and control below.

Our Performance in Numbers – 92.6% of adults in East Lothian said they were able to look after their own health 'very well' or 'quite well' (compared to 90.9% across Scotland).

The Musculoskeletal (MSK) core team delivered a total of 25,223 appointments during 2021/22, not including MSK Advice Line contacts.

A total of 12,762 calls were received by our new East Lothian Rehabilitation Service single point of contact phoneline between June 2021 and March 2022.

East Lothian Rehabilitation Service (ELRS)

Rehabilitation services are key to maintaining and improving people's quality of life, as well as 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, helping to reduce pressures and costs on all parts of the health and social care system (see also page 10 above).

East Lothian Rehabilitation Service (ELRS) continues to grow and develop the services it offers. Service developments and performance highlights during 2021/22 are described below.

Community Occupational Therapy

Our East Lothian Council (ELC) Community Occupational Therapy (OT) team provides a wide range of interventions. The team runs a Single Point of Contact Telephone Service through which professionals, clients or carers can get advice or discuss requesting OT support. An assets-based approach is taken to support people to self-manage where possible, which can include, for example, signposting them to the 'Access to a Better Life in East Lothian' website (see below) or looking at opportunities such as

exercise programmes to improve their functional ability. Where these options are ruled out, individuals will either be allocated to an OT or added to a waiting list for assessment.

The Specialist Community Occupational Therapy Team was established as part of the East Lothian Council Community Occupational Therapy (OT) Service in June 2021. The team covers: major adaptations to owner occupied properties; complex cases and equipment; children's equipment and adaptations; Access Officer (Education); statutory reviews and assessments in care homes, and care assessment and reviews.

This development recognised that some more complex, less frequent and specialised tasks completed by Community OTs could be more efficiently carried out and / or supported by a dedicated team.

A number of the Community OT team are trained to provide moving and handling to informal carers where appropriate. This can be particularly helpful when there are gaps in formal care that can be bridged by family members. The teams will also look at how care is assessed and managed and consider whether it can be provided single handed safely by one carer using equipment such as tracking hoists.

Community Advanced Practice Occupational Therapist

The role of Community Advanced Practice Occupational Therapist (APOT) was established in June 2021 as a one-year project, with the purpose of developing a pathway for early intervention for people with long-term conditions. Given the growing ageing population in East Lothian, the decision was made to focus on those with multiple co-morbidities and frailty. The pathway was developed in collaboration with a GP in Dunbar Medical Practice and expanded across the East cluster, covering 6 GP practices in Dunbar, East Linton, Gullane and North Berwick.

In total 62 patients were seen by the Community Advanced Practice Occupational Therapist from June 2021 to March 2022. Due to service pressures, the APOT post was also used to support other mainstream work across ELRS.

Community Advanced Physiotherapy Practitioners

The Community Advanced Physiotherapy Practitioner (APP) team has been established for two years. The remit of the Community APP's is to support the management of patients with Long Term conditions. With the emergence of Covid, the primary focus shifted to establishing a Respiratory Pathway, supporting the wider Lothian response to Covid and the management of high-risk chronic respiratory patients.

There are now three APPs in post, one based in each geographical cluster. APPs provide highly specialised assessment and intervention in the community, helping to avoid unnecessary hospital admission and maintain optimum physical and mental wellbeing for patients they work with. During 2021/22, 213 patients were seen by the Community APPs through the ELRS Respiratory Pathway between, compared to 87 the previous year.

Falls

East Lothian's falls rate has increased over the last 4 years and sat at 23.4 per 1,000 population aged over 65 during 2021/22 – this takes our level to above the average. Having carried out a review of falls and related activity during 2021/22, it was agreed that work should be carried out to develop an integrated 'Falls Pathway'. A Falls Project Manager was recruited to carry out an extensive mapping exercise of current falls services, followed by the development of detailed proposals for a new falls framework and pathway – this is expected to be completed by May 2022.

Musculoskeletal (MSK)

The Musculoskeletal (MSK) Physiotherapy Service delivers several workstreams including the MSK Advice Line. The MSK Advice Line is staffed by a team of Advanced Physiotherapy Practitioners (APPs) and provides quick and easy access to physiotherapy assessment and intervention. Individuals receive a call back within two working days from contacting the service to allow for early identification of any signs of serious pathology and are offered a brief assessment and advice. The APP can then organise any follow up required in a timescale appropriate for the complaint and individual.

The core MSK team delivers specialist rehabilitation to those complaining of MSK conditions. They provide education, rehabilitation, self-management strategies and are actively involved in screening to determine any opportunities for prevention or early intervention. The core team delivered a total of 25,223 appointments during 2021/22 (not including MSK Advice Line contacts). Exercise Specialists are a vital part of the team, helping to support individuals into longer term management plans and to self-manage in community settings (for example, in local gyms).

Pain Management

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

During 2021/22, we received Scottish Government winter funding for a period of six months to increase capacity which included a dedicated Exercise Specialist.

From December 2021 to 31st March 2022, the number of participants visiting their GP regarding their pain reduced by 23%. The increased funding resulted in the Pain Management waiting list reducing from 14 weeks to 0.

Mental Health Physiotherapy Team

The Mental Health Physiotherapy team provides Physiotherapy input to patients who require ongoing input from other Mental Health Professionals. This input is provided in a variety of settings across East Lothian including Inpatient, Outpatient, Domiciliary and Exercise Therapy Groups. The team uses a person-centred approach to promote, maintain and restore physical, psychological and social wellbeing. The aim is to promote physical health to enable improvement in mental health and wellbeing.

Treatment options provided by the team include rehabilitation, exercise provision and support, promotion of functional movement and health promotion. Currently there is no waitlist for Inpatient, Outpatient or Domiciliary input. During Covid-19 lockdowns, there were restrictions on capacity for the Exercise Therapy Groups and the waiting time increased to 6 months, however, capacity has now increased, and the waiting time has been reduced to 6 weeks.

Contacting East Lothian Rehabilitation Service

ELRS implemented a new single point of contact phoneline in June 2021. A total of 12,762 calls were received between June 2021 and March 2022. Graph 4 shows the rise in level of calls from June 2021 until the end of the reporting year. Calls to the phoneline relate to the following services:

- Patient focused booking.
- MSK Advice Line.
- Request for Assistance Occupational Therapy.
- Community Physiotherapy.

The phoneline supports patients and professionals to speak to the right person at the right time in order to access the right care.

Graph 4 – Total calls handled on Single Point of Contact phoneline

Data Driven Improvement

In 2021/22, ELRS launched a project focusing on 'Digital and Informatic' development, led by a specialist clinician. The purpose of this is the development of robust, high-quality analytics to ensure that operational delivery, service re-design and innovation is data driven.

Case Study – Community Occupational Therapy

Bill[8] is 79 and lives with his wife in one of East Lothian's seaside towns. Bill has a number of significant health issues and has become very frail over the last year or so. His mobility has become extremely limited, and he now spends most of his time in bed. Bill's wife has her own health issues and struggles to care for him, although formal carers come to help in the morning and evening, his care needs have increased. Family members pop round to support Bill and his wife when they can.

Bill's family are concerned that it is becoming more and more difficult to get Bill in and out of bed safely and to reposition him in bed in between visits from his formal carers.

Jackie and Louise from the Community Occupational Therapy Team visit Bill at home to look at ways to support his family with his care. They carry out a moving and handling assessment and order a number of pieces of equipment that will help. Once the equipment arrives, they return to the house to demonstrate how to use it safely and support the family to try it for themselves as they will be providing care while Bill awaits an increase to his package of care. Bill's formal carers will also be able to make use of the equipment.

The Team will continue to monitor how things are going at home for Bill, but in the meantime, the new equipment has helped make the situation more manageable and has addressed some of the family's concerns.

[8] The case studies included in this report are not related to real life people but do reflect some of the experiences of staff and of people who use our services.

Health Inequalities

Strategic Objective 8 – 'To reduce health inequalities'

Health inequalities result from the uneven distribution of income, power and wealth which can lead to individuals and groups experiencing poverty and exclusion. As a result, such groups and individuals are less likely to be able to access good quality housing, employment, education and learning, green space and social opportunities[9] – all of which can have a significant negative impact on their mental and physical health. Health inequalities contribute to thousands of premature deaths every year in Scotland, illustrated vividly in the difference in life expectancy (and 'healthy life expectancy') between the least and most deprived areas.

Our Strategic Plan identifies our commitment to addressing the health inequalities that impact on people's quality of life and health expectancy. During 2021/22, we identified the need to further develop our approach to health inequalities, with IJB members taking part in a Development Session to initiate fresh discussion on this topic. Our new IJB Strategic Plan which will cover the period 2022-2025 will outline our ongoing commitment to tackling health inequalities, and further development work is anticipated to strengthen our approach, ensuring that this commitment is reflected in future development and service delivery.

Tackling Poverty

The East Lothian Poverty Plan (2021-23) was developed by a working group involving East Lothian Council, NHS Lothian, Volunteer Centre East Lothian, the two local Citizens Advice Bureaux and ELHSCP. The new plan combines the previous Poverty and Child Poverty Action Plans and identifies actions required from partners to support this work. The Plan includes a number of specific actions for the HSCP.

The HSCP allocated Scottish Government funding during 2021/22 to help address fuel and food poverty through a number of initiatives. This included providing £10,000 to Carers of East Lothian (CoEL) to support carers experiencing food and / or fuel poverty – in the previous year, CoEL had established a system to effectively manage the distribution of funding to over 40

Link Workers

The East Lothian Community Link Worker Service offers support with a range of non-medical issues, which can include issues that contribute to financial hardship such as employment, debt and household costs. Community Link Workers can signpost service users to financial inclusion and other advice services.

The Macmillan Improving the Cancer Journey project was launched in 2021, with a range of partners, including the HSCP, involved in the steering group for this initiative. The service provides person-

[9] These and other factors are described as 'social determinants of health'

centred support via a Link Worker to help people affected by cancer in relation to non-clinical issues – this can include employment, housing and financial matters (for example, access to benefits).

Our Inclusive Vaccinations Approach

An important element of our Covid / Flu vaccination delivery has been making clinics and drop-ins as easy to access as possible across the county, as well as being proactive in reaching out to those who may be less likely to take up the opportunity for vaccination. Elements of our 'inclusivity' approach included:

- Delivering clinics in local venues – including community centres, sports centres, third sector buildings.
- Working with other services and organisations to reach individuals – for example, Housing, Connected Communities, Substance Use Service, VCEL (Volunteer Centre East Lothian), Community Learning Disability Team, Young Carers, Throughcare / Aftercare Team.
- Training staff in Community Learning Disability Team so they can deliver vaccinations.
- Delivering a 'house bound' programme to vaccinate people at home where they were unable to attend a clinic.
- Delivery of vaccinations by the Care Home Team (supported by the PCVT) to staff and residents in East Lothian Care Homes.
- Support with transport from Dial-a-Ride and the Royal Voluntary Service (RVS).

You can read more about our performance in delivering vaccinations on page 47.

Partnership Working

Strategic Objective 9 – 'To build and support partnership working'

Partnership working is one of our key strategic objectives and is key to delivering many of our other objectives.

Working in partnership enables us to achieve more with the resources available and has also supported the development of new and innovative approaches – all of which delivers better outcomes for the people who use our services.

There are numerous examples of partnership working throughout this report. This includes collaboration between different teams and organisations, as well as with third and independent sector organisations. We are also working more and more with local communities (see 'In Our Communities' above). Here are some further examples from 2021/22.

Supplying Personal Protective Equipment (PPE) and Lateral Flow Tests

Organisations and individuals working together was key to responding to the challenges brought by the Covid pandemic. A good example of this is the role the HSCP played in the supply of PPE and Lateral Flow Tests. A Hub was set up in East Lothian Community Hospital in April 2020 and continued to provide PPE and Lateral Flow Tests to health and social care providers, Personal Assistants and unpaid carers during 2021/22.

Supporting Care Homes

Partnership working across HSCP services and care homes has been even more important over the last two years in the face of the Covid pandemic.

Throughout the year, twice weekly huddle meetings, chaired by the HSCP Chief Nurse, took place to monitor the situation across care homes, including compliance with national guidance, identifying where intervention or assistance was needed.

Care home managers have continued to implement national guidance requiring a greater emphasis on infection prevention and control. They have received ongoing support, advice and guidance with this from the Care Home Team, Care Home Assessment and Review Team (CHART) and the NHS Quality Improvement Manager. A rolling programme of supportive visits to homes also continued throughout the year (feeding into the huddle meetings described above).

The continued rollout of the vaccination booster programme, including mop-up vaccination sessions for new residents and staff, has meant East Lothian care homes have achieved a high degree of vaccination coverage. This assisted greatly in reducing the impact of Covid on staff and residents.

About the Care Home Team

The East Lothian Care Home Team supports 20 Care Homes across the county – three of these are managed by ELHSCP and the remaining 17 are run by independent providers.

The Team provides Nurse Practitioner support in relation to anticipatory care, long-term conditions and acute illness presentations in care homes. In 2021/22, Physician Associate posts were added to the Team, further increasing its capacity.

The Team works closely with GP colleagues for advice regarding medical conditions. The work of the Care Home Team supports medical practices by significantly reducing the need for GPs to attend care homes. Previous evaluation has also suggested that the service helps to reduce hospital admission for care home residents.

The Care Home Team also plays an important role by providing training, information and clinical support and advice to care home staff, helping to support the delivery of local and national care standards in homes. This has included working with NHS Lothian Corporate Education Team to deliver training in homes.

During 2021/22, the Team administered the second Covid vaccination and two sets of booster vaccinations to all Care Home residents and some staff.

ELCHASE

East Lothian Care Home Assessment Service and Education (ELCHASE) delivers 3 weekly clinics in East Lothian Care Homes. These clinics focus on issues with residents experiencing stress and distress, also taking into consideration any physical causes that may be contributing to this (working closely with the Care Home Team to do this).

Through its work, ELCHASE helps to reduce the need for hospital admission and can enable patients to remain in the familiar surroundings of their Care Home. ELCHASE also responds to immediate 'crisis' situations by either providing advice or by attending the Care Home (within a maximum of 48 hours).

Care Homes also benefit from training and guidance provided by ELCHASE. This includes training around stress and distress in residents and how to respond.

VCEL

Volunteer Centre East Lothian (VCEL) leads the Third Sector Interface (TSI) in East Lothian and is one of our key community partners, with whom we work closely on a range of initiatives. The examples below give a flavour of the role played by VCEL in supporting people living in East Lothian.

VCEL's hospital discharge support project was set up as a 'test of change' in 2017 to work jointly with East Lothian Community Integration Rehabilitation Team (CRIT) to help prevent hospital admission and enable early supported hospital discharge. More recently, the service has been increasingly working with social work colleagues to support early intervention for people living at home.

A further 'test of change' community support initiative began in December 2021 to pilot the signposting of individuals to VCEL to help relieve pressure on Social Work and Care at Home services.

Over the festive period in 20201/22, VCEL volunteers supported people with tasks such as delivering shopping and by making contact by phone with people who were potentially socially isolated. Volunteers also assisted with delivery of Carers support funding in the run up to Christmas.

Both of these VCEL services take a person-centred approach to improving people's health and wellbeing by supporting them to benefit from local sources of support within their own communities, including support provided by community volunteers. They are based around a 'good conversation', whereby people are encouraged to identify what matters most to them and to think about how their personal outcomes and priorities can be met within their local community.

VCEL also plays a key role in supporting community partners and developing relationships between statutory, third sector and community organisations.

At the end of 2021/22, proposals were being developed in relation to a new, expanded, 'East Lothian Community First' service, funded by the IJB and delivered by VCEL, combining the services described above and further developing this approach to community support.

Change and Improvement

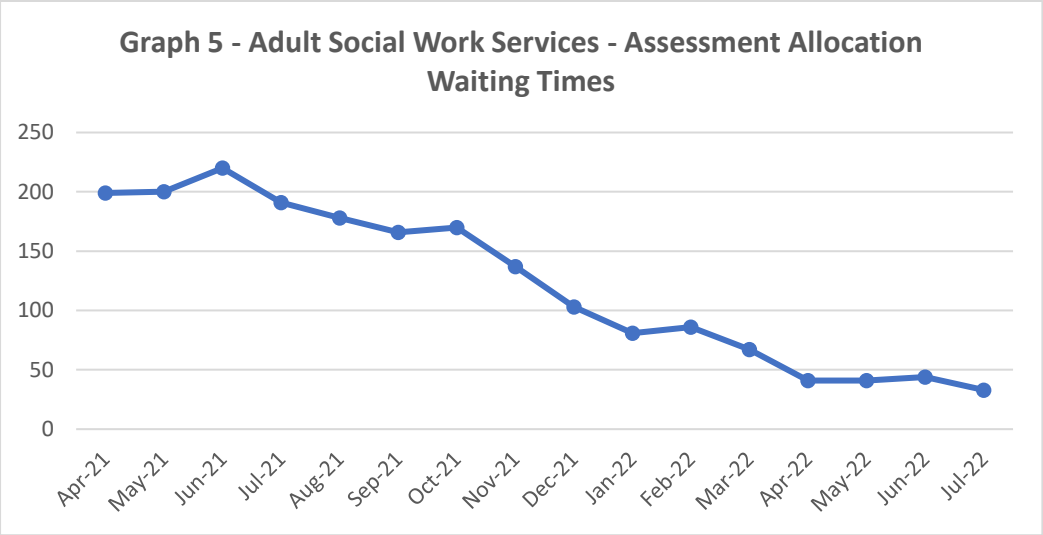
Strategic Objective 10 – 'To support change and improvement across our services'

East Lothian IJB has overseen a journey of significant change and improvement since its inception in 2015, a journey that will continue through the delivery of our new Strategic Plan (from 2022 to 2025).

Adult Social Work Services

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 coherent framework for multiple changes and developments to ensure that our social work service is effective, responsive and fit for the future. This has included work to reduce the time people are on our waiting lists for assessments and move towards a more preventative and early intervention approach. Our ambition is to take a more outcome focussed approach to supporting individuals in a range of different ways most suitable to their needs at that time. This work will continue in 2022 as tangible changes to systems and processes are introduced.

A new operating model and supporting structures were developed in Adult Social Work Services (ASWS) during 2021/22, with the aim of improving outcomes for individuals, families and carers. The new model is designed to ensure that as many cases as possible are dealt with by the Duty Social Worker (the first point of contact) rather than being progressed to a waiting list unnecessarily. This has contributed to a significant reduction in waiting times for assessment as shown in graph 5 below.



A reduction in waiting time means that individuals are seen at an earlier stage, enabling the team to take a more preventative / early intervention approach. This results in better outcomes for the

individual and can help prevent care needs becoming more significant or a crisis arising. The ambition is for the service to reach a point where individuals are allocated at the point of referral following triaging and screening through the duty system.

Changes were also made to the delivery of the adult social work duty system during 2021/22. Previously, the duty system was managed by a dedicated team. However, the impact of the pandemic was felt particularly acutely within this team, with the intense nature of the work affecting organisational and personal resilience. A decision was made to integrate the Duty Team and the Long-Term Team, resulting in a larger pool of social work staff sharing responsibility for the duty system, along with assessment and care management tasks. As well as reducing pressure on individuals, this has improved performance as practitioners now practice across all areas of activity from crisis intervention to long term work.

A new caseload management system and enhanced supervision policy were introduced during the year. This involves case managers using a 'self-assessment evaluation tool' to assess their cases in relation to key performance criteria prior to supervision. Changes also involved the introduction of a new caseload weighting system. This system manages the allocation of cases to help ensure work is distributed fairly and to protect practitioners welfare by ensuring that they have a manageable caseload.

Support Plan Brokers

Support Plan Brokers process all requests for care / support plans and source the services needed in response to these requests. Once a care package has been identified, Brokers purchase the service and set up the contract with the care provider. If care cannot be sourced, the case is added to a waiting list.

Support Plan Brokers also liaise with the ICAAT (see page 19) and hospital team to manage packages of care for existing clients going into or being discharged from hospital.

Support Plan Brokers help facilitate the setting up of Self Directed Support[10] arrangements. This includes providing advice and guidance to those involved, setting up the provision and liaising with finance to ensure the smooth introduction of prepaid cards or financially managed services.

The Team increased the number of referrals purchased from 2,090 in 2020/21 to 2,490 in 2021/22 (an increase from 26% to 31%).

Corporate Appointeeship Service

Work continued throughout 2021/22 on the development of our new, in-house, Corporate Appointeeship Service (taking over from an external provider). This service supports service users who are unable to or do not have the capacity to manage their welfare benefits.

[10] Explainer re SDS

Clients were transferred from the outgoing service at the start of 2021, and the new service began to accept referrals around that time. By March 2021, the team were managing over £900K in client funds.

Developing the service has been complex and required coordination with a number of East Lothian Council departments, including Corporate Banking, IT, Legal, Data Protection, Internal Audit, the Welfare Rights Team and the Financial Assessment Team.

New workflow processes have been set up on Mosaic[11] including a new review document that will help support clients to identify individual outcomes which can be met using their personal funds. Covid has had a significant negative impact on opportunities for some service users to undertake activities of their choice. It is a goal of the team to work with clients to support them to reintroduce these.

The new service underwent a full internal audit, and a positive final report was published and presented to the Audit and Governance Committee in November 2021.

Mental Health Review

In last year's Annual Report, we described work underway to review access to mental health services in East Lothian. Work on the Review continued throughout 2021/22, with a view to ensure:

- That our mental health services are delivered in a way that means people in East Lothian get the 'right help at the right time';
- That they are able to meet the challenges presented by the Covid pandemic, including being able to respond to the longer-term impact of Covid; and
- Services are able to respond to the changing operational context resulting from the Redesign of Urgent Care.

Despite broader operational challenges, we continued to make good progress with the Review during 2021/22. This included working with staff to define roles and remits and to produce process maps of patient journeys in order to identify points where improvements could be made. An Away Day gave further opportunity for staff to develop ideas around improvements and benefitted from input from Midlothian and West Lothian HSCPs.

We also began to introduce changes to reflect some of the emerging Review recommendations. These included:

- Bringing the CWIC Mental Health Service under the same directorate as other East Lothian mental health services (CWIC MH previously sat within the Primary Care directorate). This move helped to facilitate closer working with community mental health teams and other services, helping to improve pathways between services.
- Securing funding and starting work to commission a new DBI (Distress Brief Intervention) service for East Lothian. DBI provides quick and easy access to support for people in distress. Frontline health, police, primary care and other staff will be able to refer individuals to this service which

[11] Mosaic is an IT system for social work case management and associated finance services.

will be delivered by a third sector provider who will contact them within 24 hours to start 1-1 support.

- Development work around the introduction of a new 'first point of contact' for mental health services in East Lothian. Once implemented, this will mean that there is a clear access route for mental health services, and that people will have their needs assessed and a plan agreed for responding to those needs at this 'first point of contact'.
- Development of proposals to establish a separate multidisciplinary neurodevelopmental pathway out with the wider Community Mental Health Team (responding to the increase in waiting lists and waiting times for neurodevelopmental assessment due to an increase in demand for mental health services in general and a growth in neurodevelopmental referrals).
- Introduction of a specific ADHD (Attention Deficit Hyperactivity Disorder) patient pathway as the first phase of the broader neurodevelopmental pathway work, and recruitment of a dedicated Consultant to support this.

Mental Health Officer Team

The East Lothian Mental Health Officer Team delivers statutory functions. Developments during 2021/22 included:

- The team halved the waiting list for Adults with Incapacity (Guardianship Orders) by the end of the year, with no service user waiting more than six months to have their application progressed.
- There was an increase of 80% in the number of Local Authority Guardianship Orders during 2021/22 – with the team allocating these in a timely manner.
- The development of an Adults with Incapacity Lead Officer supports the further development of dedicated provision in response to projected demographic change in East Lothian.
- Work to develop capacity within the team and reduce reliance on temporary and agency staff – this included a training programme for suitably experienced social workers (and planning for a recruitment drive in summer 2022).
- Development of a suite of performance indicators and baseline data to evidence demand and delivery of outcomes for service users. This will support ongoing planning and improvement activity.

Community Mental Health Services

The East Lothian Community Mental Health Recovery Service provides supported accommodation, with associated outreach, for people with complex mental health needs. The service helps to prevent hospital admission, as well as supporting people upon discharge from hospital. The person-centred approach taken by the service focuses on:

- Supporting individuals to return to a meaningful life within the least restrictive environment possible.
- Ensuring that people supported by the service and transitioning from the service create and maintain community connections.

In last year's Annual Report, we described work underway to develop new residential provision for the Community Mental Health Recovery Service (in place of the existing provision at Cameron Cottage in Musselburgh). This work was completed in 2021/22 and the move to the new accommodation took place during April 2022.

The new accommodation at Elder Street in Tranent provides a residential recovery service for up to 14 people, with a range of organisations / services involved in providing support. Car Gomm provides 24/7 support and care; whilst in-reach support, assessment and review are provided by Psychiatry, Community Mental Health Team, Social Work, Housing and other relevant services (according to individual needs). The ground floor of Elder Street also provides permanent tenancies with support for individuals with learning disabilities.

Penumbra is another of our main providers of support for people with a mental health diagnosis or concern. Up until now, Penumbra have been providing two of our community mental health services – the Nova Day Service and a separate Care at Home Service. Both services are based on a recovery model aimed at supporting people to lead a meaningful and fulfilling life in the presence or absence of mental health problems.

During 2021/22, a 'test of change' project was introduced to combine Penumbra's Care at Home and Nova Day Service and to introduce a single budget and single referral route for both services. Introduction of these changes helped to streamline access to these services, resulting in a quicker, more flexible response. This was particularly welcome as demand for mental health support services grew as a result of the Covid-19 pandemic.

East Lothian Rehabilitation Service (ELRS) Remobilisation Clinics

The Covid-19 pandemic resulted in significant restrictions to the delivery of ELRS services, resulting in an increase in waiting times for 'routine' assessments for both Community Occupational Therapy (COT) and Domiciliary Physiotherapy (PT).

ELRS ran Remobilisation Clinics during October and September 2021 to enable clinical assessments and interventions to be carried out in a timely and efficient way, with the aim of reducing waiting times for both COT and PT services. The model used allowed for holistic and comprehensive assessments to be carried out, including looking at the potential use of technology. This clinic environment allowed options to be explored aimed at maximising individuals' independence.

The Remobilisation Clinics had a significant impact in terms of reducing the number of people on waiting lists for assessment and lowering the average waiting time to within 6 weeks. A positive impact on client outcomes was also noted.

Workforce Development

In common with health and social care employers across the UK, we faced growing challenges in relation to staff recruitment and retention throughout the year. The challenges and our planned approach to meeting these are described in detail in the new East Lothian Health and Social Care Partnership Workforce Plan. Due for publication in summer 2022, the new plan will focus on the next

three years as well as setting the foundations to respond to workforce requirements beyond that period. (link to be added once available)

Our workforce planning priorities 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.

We took a number of actions during 2021/22 to help address workforce challenges, including:

- Our Adult Social Work Team initiating a pilot sponsorship scheme for one Community Care Worker (CCW) to obtain a Social Work degree and a second CCW to be supported to obtain modules towards obtaining a degree). If successful, this will be continued on an annual basis.
- Making use of the Scottish apprenticeship levy available through Skills Development Scotland to create a qualification pathway for health and social care staff to attract more people into the roles.
- Removing the requirement for a Social Work qualification for non-Social Work roles – previously specialist posts such as the Workforce Development Manager required a Social Work qualification.
- Agreeing that certain roles requiring a health or social care qualification would be advertised as 'integrated posts' in the future, giving the successful candidate the opportunity to choose where to work under NHS or Council terms and conditions.

Communication and Engagement

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

We continue to build our social media presence. We now have 900 Twitter and around 4,000 Facebook followers – this is one of the largest Facebook followings for any HSCP in Scotland, and larger than Glasgow, Edinburgh and Aberdeen. The use of social media proved to be particularly valuable throughout 2021/22 as a means of quickly sharing information about our vaccination programme, and to share public safety messages, jobs and engagement opportunities.

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

- There are now Health and Wellbeing Sub-Groups established in each of East Lothian's six Local Area Partnership areas. These are attended by ELHSCP Strategy Officers to act as a link between the groups and the Partnership
- The number of GP practices with Patient Participation Groups rose to over 60%, with our Communications and Engagement Manager continuing to support practices to set up and develop groups.

- Our Change Board structure offers opportunities for local people to be involved in Reference Groups covering a number of priority areas.
- We ran a number of consultation / engagement exercises on a range of issues during 2021/22 – including Planning for an Ageing Population and the IJB Strategic Plan.

In recognition of the importance of communications, we have appointed a Senior Communications Officer and a Content Officer who will be producing a Communications Strategy for internal and external communications. We also created a new role of Equalities and Engagement Officer to deliver a new engagement strategy, with a greater emphasis on engaging with harder to reach and underrepresented groups and individuals.

Inspections

The Care Inspectorate inspects our care homes and care at home services to assess the quality of care. The Care Inspectorate amended the way they performed scrutiny and inspection over the course of the pandemic. In order to reduce the risk of transmission of COVID through on-site inspections, visits were initially performed virtually and then through targeted inspections for services that required increased levels of monitoring. This meant that services were not graded as normal, and an increased focus was placed on assessing providers' ability to implement infection, prevention and control measures through the introduction of Key Question 7 – How Good is our Care and Support During COVID.

The table below shows grades reported for our internal care homes in 2021/22.

Care Inspectorate Grades:

6	Excellent	3	Adequate
5	Very Good	2	Weak
4	Good	1	Poor

Name	Service Type	Date inspected	Care Inspectorate Framework – Areas of Evaluation					
			People's Wellbeing	Leadership	Staff Team	Setting	Care and Support planning	Care and Support during COVID
Belhaven	Care Home	12/12/2019	3 - Adequate	4 - Good	3 - Adequate	4 - Good	3 - Adequate	-
Crookston	Care Home	02/12/2021	5 – Very Good	-	-	-	-	4 - Good
Eskgreen	Care Home	17/02/2021	-	-	-	-	-	3 - Adequate
The Abbey	Care Home	05/12/2019	5 – Very Good	-	-	-	5 – Very Good	-

Supporting Carers

Responding to 'Carers needs' is one of the key principles or 'Golden Threads' that cuts across all our strategic objectives. This means that Change Boards must take into account carers needs when considering any strategic or service developments. Some of our specific activity to support carers during 2021/22 is described below.

Funding Support for Carers

Carers have felt the effects of the Covid-19 pandemic disproportionately and been placed under huge pressure, carer numbers are estimated to have increased, and many existing carers have taken on more intensive caring roles, while also losing access to breaks from their caring role. Throughout 2021/22, we have been acutely aware of the challenges felt by carers and have continued to develop the support available in partnership with third sector colleagues.

Through our Carers Change Board, we allocated additional Carers Act funding to support the following:

- Day Centre Transformation Project.
- East Lothian Rehabilitation Service.
- Block booking for respite care.
- Appointment of a new Community Care Worker.

Due to Covid constraints, it was not possible to progress these areas of work as anticipated. For example, the block booking of respite care could not go ahead as hoped due to the impact of the Omicron variant on Care Homes. However, an alternative way of using the funding was developed so that carers would still benefit.

One use of the funding was allocation to local Carer organisations to distribute as 'microgrants' to individual carers. This enabled individual carers to apply for money to pay for things to help to promote their own health and wellbeing, thus supporting them in their caring role. Microgrants were used in a wide variety of ways by carers, including breaks away from home; leisure or fitness (e.g., golf membership); fitness equipment; cookery lessons; and holistic therapies (e.g., massage). Grants are available to both adult and young carers and assessment is kept to a minimum to help encourage applications.

Carers of East Lothian

We have a contract with Carers of East Lothian (CoEL) to provide support to adult carers. The contract is for an initial two years, with a potential extension for a further two years, offering stability for both CoEL and the HSCP.

Carers of East Lothian continues to make excellent progress in identifying and supporting carers. This includes through the offer of Adult Carer Support Plans to newly registered carers. The number of new carers taking up this opportunity remains low, but this has been identified as an improvement area for the coming year.

During 2021/22. CoEL met its internal target of 90% of referrals being acknowledged within 5 days and initial engagement taking place within 3 weeks. Feedback suggested that 85% of carers had felt an improvement in their confidence and ability to cope and a better caring / life balance as a result of the service received.

Young Carers

The decision was taken in 2021 to develop an in-house service for Young Carers, closely aligned with the Inclusion and Wellbeing Service (part of East Lothian Council Children's Services). The new co-ordinator was in post by Oct 2021 and began work to engage with schools to increase the number of Young Carers accessing support.

Early work included awareness raising among staff and pupils in schools and the recruitment of two full time youth workers (with recruitment for a third worker underway).

The service reported an increase in the number of young carers requesting a 'Young Carer Statement'. Within 6 months of the service starting, the number of Young Carer Statements had surpassed the number in any previous year. The service also implemented use of the Viewpoint screening tool which allows the Young Carer Statements to be completed online and links outcomes to the SHANARRI[12] indicators.

Other Developments

A dedicated Carers Strategy Officer was appointed in 2022 to support the delivery of our commitment to 'Valuing, Recognising and Supporting Carers' (reflecting the national strategy).

We also created a new Community Care Worker role within Adult Wellbeing dedicated to support the development of individual Carers Support Plans. In addition, we appointed a Mental Health Officer to support private guardianship applications.

East Lothian Council received Carer Positive 'engaged' status in June 2021 and has an action plan in place to progress through the Carer Positive accreditation scheme.

[12] Wellbeing (SHANARRI) - Getting it right for every child (GIRFEC) - gov.scot (www.gov.scot)

Protecting People from Harm

Public Protection

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

EMPPC and partner agencies continued to deliver robust public protection arrangements throughout the pandemic, adapting service provision where required.

Adult Support and Protection

As described above, Adult Support and Protection is one element of the Public Protection remit. Under the Adult Support and Protection (Scotland) Act 2007 we have a requirement to make inquiries into an adult's wellbeing and financial affairs if it is believed they might be at risk and require measures of protection. In East Lothian, a specially trained social worker called a Council Officer undertakes referral screening and the Duty to Inquire (DTI). Following this, a decision may be made to carry out an Investigation, potentially including a range of agencies

In 2021/22:

- There were 643 referrals categorised as Adult Protection – an increase of 26% from the previous year
- There was an increase of 18% (63) in the number of DTIs completed.
- The number of Adult Support Protection Investigations increased by 57% (29)

Justice Social Work

East Lothian Justice Social Work Service's vision is to 'reduce the risk of harm caused by crime within our community' by contributing to the following outcomes:

- Promoting greater equality of opportunity, enabling our service users to lead more fulfilling lives.
- Making our communities safer places to be by addressing offending behaviour.
- Our interventions are proportionate and based on individual risk, need and responsivity.
- We reduce reoffending through fostering a sense of belonging and involvement in our community.

Throughout 2021-22, the impact of the pandemic has lessened with staff and service users more able to engage in meaningful interventions. Justice Social Work (JSW) published its first Business Plan (2021-24) and went on to publish an Annual Report in September 2021 which included a

comprehensive Improvement Plan. The service also produced an Evaluation Timetable (2021-23), with the first report related to this due in August 2022.

Key achievements during 2021/22 included:

- Development of 'An Opportunity to Think' programme for individuals diverted from prosecution but who still require support to reflect on their behaviour.
- An increase in delivery of in-house modules and groups to meet the needs of people required to do 'unpaid work' in the community and a Blended Learning Pack to supplement 'other activity' requirements.
- Continuing to work with third sector partners at Heavy Sounds, Volunteer Centre East Lothian, Dadswork and Access to Industry to identify opportunities and improve access to services. Street Cones delivered an online production that was live streamed with both local residents and Elected Members engaging in the post-production discussion.
- Working in partnership with SACRO to undertake an 'Early Intervention and Prevention Strategic Needs and Strengths Assessment', alongside delivery models for Arrest Referral, Diversion from Prosecution, Bail Supervision and Structured Deferred Sentences, with a roll-out plan for 2022-23.
- Increasing the Social Work Assistant capacity to allow for a more nuanced provision to service users. The staff mix in the team means that paraprofessional and professional staff can be matched to tasks required based on service user risk and need.

Substance Use Service

In East Lothian we continue to tackle substance use by working with our Partner agencies and the third sector. Addressing housing needs, family support and providing person-centred treatment are considered alongside education, training and employment opportunities. We have a number of initiatives to help reduce substance use in East Lothian and reduce the number of drug related deaths including:

- A direct Contact Service
- Assertive outreach into GP practices for those most at risk
- Advocacy services
- Increased support to families and loved ones.
- Embedding and implementing the MAT (Medication Assisted Treatment) Standards including increasing choice of treatment
- Council and Community roll out of Naloxone[13]
- Developing a new out of hours provision
- Recovery Cafes – currently in Musselburgh and Dunbar, with plans for Prestonpans and Tranent
- Recovery College
- SMART Recovery Groups
- Youth and community initiatives
- New innovation fund

[13] Naloxone is a medication used to block or reverse the effects of opioid drugs.

- Linking in with third sector organisations (Alcohol Education Trust, Re-Solv, 6VT)
- Continue to provide phones, top-ups and tablets to help people get or stay connected

These initiatives assist individuals to reduce the harmful impact of long-term drug use. Further detail of some of the work we have progressed during 2021/22 is detailed below.

Over the last year, there has been additional investment in the Substance Use Primary Care Outreach Service. As a result, 12 of the 14 county GP Practices now receive support from Community Psychiatric Nurses (CPNs) to manage patients using the Opioid Risk Tool (ORT)[14]. The level of service depends on how many patients require this type of support within the practice, and ranges from 1 day a fortnight to 3-4 days a week. Each CPN has their own allocated GP Practices to promote continuity of care.

The team continues to develop Assertive Outreach to proactively identify high risk / hard to reach individuals. There is a specific Outreach Nurse who leads on this. This role has also developed to incorporate the delivery of Naloxone training to other health and social care professionals and plans are underway to establish pop-up outreach clinics.

Around 20% of the current caseload is prescribed Buvidal[15]. This medication has been beneficial in supporting treatment retention in poly-substance using individuals and has also benefitted those who are in employment as they are no longer tied to regular pharmacy attendance.

The main focus of the coming year will be around embedding the Scottish Government MAT (Medication Assisted Treatment) Standards. These standards focus on service access, treatment retention and trauma informed service delivery. As part of these standards there is an expectation that services offer a same day prescribing service to those for whom it is appropriate. Funding has been secured for a Clinical Nurse Specialist to take this forward.

The Midlothian and East Lothian Drugs Contact Service

The MELD (Midlothian and East Lothian Drugs) Contact Service was delivered as a pilot initiative during 2021/22 with funding from CORRA and MELDAP. The service provides information to the public regarding substance use and easy access to Substance Use Services in Midlothian and East Lothian.

People looking for support from substance use support services, or for information regarding substance use, can call the Contact Service helpline to have a confidential, trauma-informed, person-centred conversation focused on addressing their concerns and needs. They are then directed to the most appropriate service or combinations of services as below:

- MELD
- East Lothian Substance Use Service
- ELCA (East Lothian Council on Alcohol)
- Peer Support Service
- Family Support Services

[14] ORT is a self-report screening tool for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for chronic pain.
[15] Buvidal is a prolonged-release, long-acting buprenorphine injection used for treating opioid dependence – it can be administered by a health professional weekly or monthly.

- SMART Groups
- AA, NA, CA Fellowships (Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous)

If engagement with MELD or the Substance Use Service is required, a triage appointment is used to assess what support the individual needs and to refer them directly to the most appropriate service / services.

In the first three months of 2022, the Contact Service received 243 enquires from East Lothian residents and arranged 112 appointments. Of the total enquiries, 56% were in relation to alcohol, 27% in relation to drugs; and 4% in relation to alcohol and drugs.

> "Having a single point of contact for referrals has simplified the process for both service users and professionals. The ability to offer telephone or face to face triages has improved flexibility and had a positive impact upon referral rates" (Caroline Downie, Substance Use Team Manager)

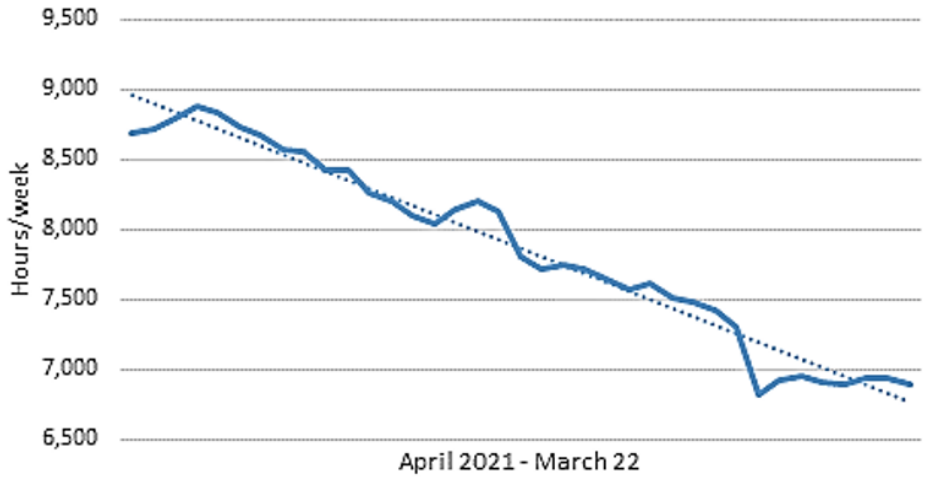
Key Challenges 2021/22 - Care at Home Delivery

The Challenge

Although pressure on Care at Home (C@H) services had been growing over many years, this reached a peak in the second half of 2021/22. This resulted from ongoing changes to the nature and complexity of care packages needed, compounded by significant recruitment and retention challenges faced by Care at Home providers.[16] HSCPs across Scotland faced a similar situation during the year.

Graph 6 below shows the impact of the growing crisis on the number of externally provided Care at Home hours available for over 65s between April 2021 and March 2022. A reduction of over 2,000 hours of care per week can be seen from the start to the end of the year.

Graph 6 – Care at Home hours available from external providers (over 65s)



The issues faced by Care at Home providers impacted on the broader health and social care system in East Lothian as some people needing packages of care were unable to leave hospital if a Care at Home service was not available (adding to delayed discharge rates). The situation also created an unprecedented degree of risk to both individuals and the Health and Social Care Partnership as it became a daily effort to stem the reduction in delivery and, most importantly, ensure that those most in need were prioritised for service delivery.

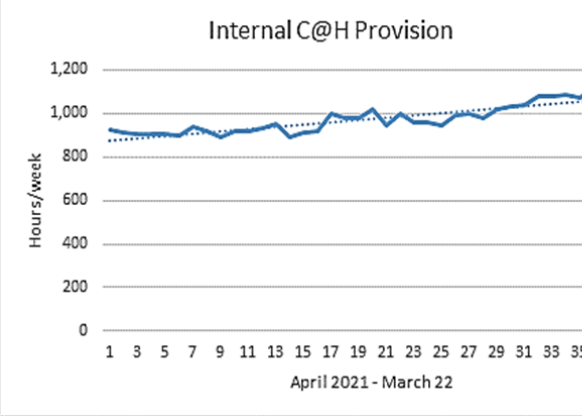
[16] Care at Home services in East Lothian are delivered by a combination of providers – this includes an ELHSCP managed service (accounting for XX% of delivery in 2021/22), along with a number of external Care at Home services delivered by independent providers (delivering the remaining XX%).

The rapid decrease in external Care at Home hours slowed as it reached just below 7,000 hours in January 2022 and has remained at around the same level since. This provided some welcome stability, but the number of care at home hours available remains very limited.

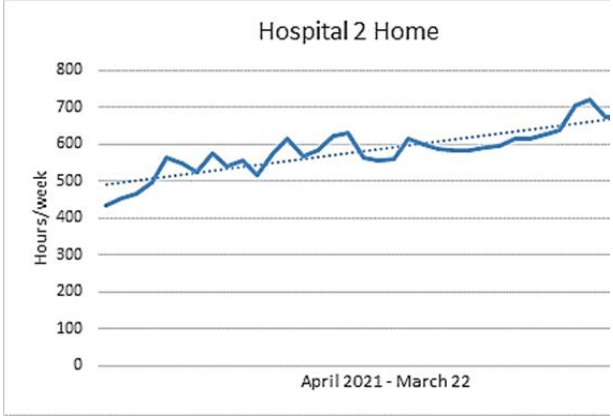
Our Response

In response to the emerging situation, a strategic decision was made to increase ELHSCP's internal service provision, including in both Care at Home and Hospital 2 Home (H2H) services. Graphs 7 and 8 below show the increase in care hours per week provided by the expansion of both these services. However, this additional capacity did not offset the loss of hours from external providers, with internal services increasing by 500 hours but an overall loss to the market of around 2,000 hours.

Graph 7



Graph 8



An increase in our internal services means that we have more control and flexibility in directing available resources where they are most needed – for example, to respond to staff shortages or to provide a service in areas where recruitment can be difficult, particularly rural and isolated areas.

Besides increasing internal service provision, a number of other HSCP actions have helped to reduce the impact of the Care at Home crisis:

May 2020 (ongoing) - Risk assessment of service users in the community to identify those at highest risk and ensure that they are prioritised for service provision.

May 2021 (ongoing) - Development of Integrated Care Assessment and Allocation Team (ICAAT) to provide a central point for service prioritisation.

June – October 2021 – Dedicated team established to manage and respond to situations where providers were unable to deliver contracted hours. This included the provision of care by HSCP staff during the initial crisis and involvement of agency care staff between September and October.

August 2021 – Increase in Support Plan Broker capacity from 3 to 4 full time equivalent posts and introduction of Senior Support Plan Brokers and business support.

September 2021 – Introduction of daily Care at Home Huddle and weekly Care at Home Oversight Group to monitor the situation and to respond to provider challenges.

March 2022 – Recruitment of Senior Social Worker and Social Worker to the ICAAT to support management of unmet need on a permanent basis.

Key Challenges 2021/22 - Vaccination Delivery

Our Performance in Numbers

89,843 people living in East Lothian had received at least one Covid-19 vaccination by the end of March 2022.

88% of adults over the age of 70 received their flu vaccination in 2021/22.

The Challenge

A Vaccination Transformation Programme (VTP) was developed in 2017 as part of planned changes to the delivery of primary care[17]. In essence, the VTP outlined steps in the move away from a model based on GP delivery of vaccinations to one based on NHS Board / Health and Social Care Partnership delivery via dedicated teams. Delivery of the Programme began in 2018, with the expectation that it would be fully implemented by the end of April 2022. The outbreak of the Covid pandemic and the subsequent need for an intensive whole-population Covid vaccination programme brought significant additional challenges to the delivery of the VTP.

Our Response

Last year's Annual Performance Report described our success in rolling out the first 4 months of Covid vaccinations by the Primary Care Vaccination Team (PCVT) – delivering some 37,000 vaccinations between December 2020 and March 2021 and opening a vaccination centre at East Lothian Community Hospital. Further progress in 2021/22 included:

June 2021 - Increase in capacity at East Lothian Community Hospital (in response to the mass vaccination centre at QMU closing) with the ELCH centre open 7 days a week.

September 2021 – Additional vaccination clinic opened in Musselburgh Primary Care Centre (MPCC) to improve access for people living in the west of East Lothian. After a 'soft launch' this also moved to 7 day a week coverage.

September 2021 – Scottish Government announced Covid vaccinations were to be offered to 12-15 year older – letters were sent out to all East Lothian 12-15 year olds inviting them to attend evening clinics at ELCH.

September 2021 – The PCVT began a 'co-administration programme' so that people could receive Flu and Covid vaccinations on a single visit. Joint Flu / Covid vaccination clinics were delivered at ELCH and MPCC, and additional smaller satellite clinics were run in other venues across East Lothian to broaden access (including at Edington Hospital and 'pop-up' venues).

[17] Part of the General Medical Services (GMS) Contract - https://www.gov.scot/publications/gms-contract-scotland/

December 2021 – Scottish Government issued a directive to further increase delivery across the whole of Scotland and to encourage people to get 'Boosted by the Bells'. As ELCH was becoming busier, the Vaccination Team managed to secure a new base for the main vaccination centre at Haddington Corn Exchange. A lease was secured for us of the Corn Exchange up to December 2022. The vaccination clinic at ELCH closed on the 31st December.

March 2022 – Vaccination for 5-11 year olds commenced, with child friendly clinics delivered at Haddington Corn Exchange. Our local childhood immunisation and children's vaccination teams supported the Vaccination Team to develop confidence in vaccinating this younger cohort.

March 2022 – Spring Booster roll out started, initially focusing on the housebound programme, Care Homes, over 75s and people who were immunosuppressed.

The success of the programme has been made possible by the hard work and commitment of HSCP staff, East Lothian Council staff, partner organisations and hospital and Volunteer Centre East Lothian (VCEL) volunteers.

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

How We Performed

National Integration Indicators

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

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

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

Core Suite of National Indicators

(i) Scottish Health and Care Experience Survey (2021/22)

Nine of the national integration indicators are based on data from the biennial Scottish Health and Care Experience (HACE) survey (table 1). The most recent survey was in 2021/22, so reflects data from the year before this annual report covers.

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

Sampling error may be the case in relation to East Lothian where the sample size for the 2021/22 survey was 6,866, with only 2,156 surveys completed (a 31% response rate). The number of responses was lower still for the questions that were only relevant to a subset of respondents (for example, carers). As a result, care should be taken in making any comparison between the Scottish and East Lothian figures.

In Table x, the column 'Statistically Significant?' relates to the degree of uncertainty around the survey results due to sample size, and whether differences between the East Lothian and Scotland result should be seen as significant or not. This was determined using the 95% confidence intervals included in the survey results. **As shown in the table, the difference between the East Lothian and Scottish figure is only statistically significant is in relation to indicator one, where East Lothian's performance is slightly ahead of the Scottish average.**

Further detail on determining the statistical significance of data can be found in Appendix 2.

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

- Indicator 1 had fallen from 94% to 93%
- Indicator 6 had fallen from 72% to 65%

- Indicator 8 had fallen from 33% to 31%.

However, it should also be noted that the difference between East Lothian and Scottish performance was only statistically significant for one of these indicators – in that case, East Lothian's performance was above the national figure.

Table 2: National Integration Indicators based on Health and Social Care Experience Survey (2020/21)	East Lothian	Scotland	Statistically significant?
1. Percentage of adults able to look after their health very well or quite well	92.6%	90.9%	Yes
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible	72.1%	78.8%	No
3. Percentage of adults supported at home who agree they had a say in how their help, care or support was provided	60.6%	70.6%	No
4. Percentage of adults supported at home who agree that their health and social care services seemed to be well coordinated	54.1%	66.4%	No
5. Percentage of adults receiving any care or support who rate it as 'excellent' or 'good'	70.3%	75.3%	No
6. Percentage of people with positive experience of care at their GP practice	64.8%	66.5%	No
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	63.1%	78.1%	No
8. Percentage of carers who feel supported to continue in their caring role	30.8%	29.7%	No
9. Percentage of adults supported at home who agree they felt safe	69.5%	79.7%	No

(ii) Operational Performance Indicators

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

It should be noted that, where indicated, the figures given are for calendar year 2021. Calendar year 2021 is used as a proxy for 2021-22 due to the national data for 2021-22 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and other Health and Social Care Partnerships. Please note that the figures presented will not take into account the full impact of Covid-19 during 2021-22.[18]

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

Performance Symbols Key					
Improved performance	✓	Performance similar to previous years / only slight change	—	Decline in performance	✗
Performance better than Scottish level	✓	Performance around the same as Scottish level	—	Performance below Scottish level	✗

11. Premature mortality rate for people aged under 75 per 100,000 persons (by calendar year)[19]									
	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**Trend**	**6-year Trend**	The premature mortality rate for people aged under 75 rose slightly in 2020, showing a similar level of increase as with the Scottish rate. East Lothian's rate remains significantly below the national figure, with the fourth lowest premature morality in Scotland.
East Lothian	320	375	372	333	313	342	✗	✗	
Scotland	441	440	425	432	426	457	✓ East Lothian performance ahead of national figure		

[19] No new data available since 2020

12. Emergency admission rate for adults (per 100,000 population)									
	2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**Trend**	**6-year Trend**	The rate of emergency admissions increased from the previous year but is lower than in 2019/20. It is difficult to comment on reasons given the atypical circumstances resulting from Covid pandemic. East Lothian's emergency admission rate remains lower than the Scottish rate.
East Lothian	9,634	10,337	10,070	10,963	10,074	10,528	✗	✗	
Scotland	12,229	12,211	12,280	12,525	10,952	11,475	✓ East Lothian performance ahead of national figure		

13. Emergency bed day rate for adults (per 100,000 population)									
	2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**Trend**	**6-year Trend**	There were a higher number of emergency bed days for East Lothian residents (per 100,000 population) in 2021/22. This increase is partly explained by the inclusion of East Lothian Community Hospital in the figures. Although the number of bed days had risen from the previous year, the level was still lower than the Scottish rate and showed an overall positive trend.
East Lothian	120,373	120,690	100,125	97,800	103,489	109,653	✗	✓	
Scotland	126,007	122,571	120,007	118,574	101,115	105,957	✗ East Lothian performance below national level		

14. Readmission to hospital within 28 days of discharge (rate per 1,000 discharges)									
	2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**Trend**	**6-year Trend**	Performance improved from previous two years and ahead of Scottish level.
East Lothian	100	106	99	102	117	100	✓	—	
Scotland	101	103	103	105	120	103	✓ East Lothian performance ahead of national figure		

15. Proportion of last 6 months of life spent at home or in a community setting									
	2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**Trend**	**6-year Trend**	Performance level similar to the previous year but slightly behind the Scottish level. Hospital and care home bed provision planning will include consideration of future palliative and end of life provision enabling people to remain at home or in a community setting.
East Lothian	86%	86%	88%	87%	89%	88%	✗	✓	
Scotland	87%	88%	88%	88%	90%	90%	✗ East Lothian performance below national level		

16. Falls rates per 1,000 population aged 65+

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Trend	6-year Trend
East Lothian	19	19	19	23	23	22	✓	✗
Scotland	21	22	23	23	22	22	– East Lothian performance in line with national level	

The falls rate per 1,000 population for aged 65+ has been around the same level at the Scottish rate for a number of years.

The longer-term trend may reflect a growth at the older end of the 65+ age group.

17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Trend	6-year Trend
East Lothian	77%	85%	84%	85%	85%	77%	✗	–
Scotland	84%	85%	82%	82%	82%	76%	– East Lothian performance around national level	

77% of care services were graded 'good' or better in Care Inspectorate inspections – a decrease of 8 percentage points from the previous year. However, the national figure also showed a decline.

Due to the relatively small number of care services in East Lothian (compared to larger HSCPs) this percentage is prone to fluctuation (i.e., an improvement / decline for 1 or 2 services results in a larger percentage change).

18. Percentage of adults with intensive care needs receiving care at home

	2016	2017	2018	2019	2020	2021	Trend	6-year Trend	
East Lothian	65.1%	64.9%	61.0%	63.3%	62.7%	63.4%	—	✗	Performance remained similar to previous years, although slightly behind the Scottish rate.
Scotland	61.6%	60.7%	62.1%	63.0%	63.0%	64.9%	✗ East Lothian performance slightly below national level		

19. Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Trend	6-year Trend	
East Lothian	1,158	775	641	327	258	159	✓	✓	Performance improved significantly in relation to the number of delayed discharge bed days for the 75+ age group. This improvement trend has continued over a number of years, with the East Lothian rate now sitting significantly below the Scottish rate.
Scotland	841	762	793	774	484	761	✓ East Lothian performance ahead of national figure		

20. Percentage of health and care resources spent on hospital stays where the patient was admitted in an emergency[20]								
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**Trend**	**6-year Trend**	Performance slightly decreased from the previous year, with 0.4% more spent on hospital stays where a patient was admitted in an emergency.
East Lothian	21.8%	22.0%	24.3%	22.6%	23.0%	—	—	
Scotland	23.2%	23.3%	24.1%	24.1%	24.2%	✕ East Lothian performance slightly below national level		

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

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

[20] Most recent data 2019/20

Ministerial Strategic Group (MSG) Indicators

The indicators shown below were developed by the Ministerial Strategic Group for Health and Social Care. These figures are based on reports released for management information only. Table X shows data for the whole of the ELHSCP area, whilst Table Y displays data for the East and West localities.

Due to different configuration of services, figures for the hospital / hospice categories may not be comparable across different HSCP areas.

Performance Symbols Key					
Improved performance	✔	Performance similar to previous years / only slight change	—	Decline in performance	✘

Table 3 - MSG Indicators - East Lothian Partnership Level

Indicator	2016/17	2017/18	2018/19	2019/20	2020/19	2021/22	Trend	6-year Trend
1. Number of Emergency Admissions (18+)	7,659	8,285	8,194	9,008	8,252	**8,510**	✘	✘
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	80,150	80,826	66,269	66,144	66,399	**70,887**	✘	✔
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)[21]	2,154	446	455	2,637	6,725	**6,514**[22]	**Issue with data**	-
2ii. Number of Unscheduled Hospital Bed Days – Geriatric	1,154	446	281	2,230	6,577	**6,294**[24]	**Issue with data**	-

[21] Issue with data completeness for 2020
[22] The increase in hospital bed days can be partly explained by the inclusion of East Lothian Community Hospital bed days in the figures.
[24] Again, increase in hospital bed days is partly explained by the inclusion of East Lothian Community Hospital in the figures.

Long Stay (65+)[23]								
2iii. Number of Unscheduled Hospital Bed Days – Mental Health (18+)	16,659	16,232	15,075	14,179	12,964	**13,433**	**Issue with data[25]**	-
3. New Accident and Emergency attendances (18+)	19,532	20,125	21,176	21,305	17,923	**21,218**	✗	✗
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	14,762	10,668	7,839	4,781	3,935	**2,672**	✓	✓
5. Percentage of last six months of life spent in community setting	85.6%	85.6%	87.8%	87.4%	88.8%	**88.0%**	—	✓
6. Percentage of the population at home – supported and unsupported (aged 65+)	96.2%	96.3%	96.4%	96.6%	96.8%	**96.6%**	—	✓

[23] Issue with data completeness for 2020

[25] Issues with this data are likely to be related to changes in coding so meaningful comparisons with previous years are not valid

Table 4 – MSG Indicators - East Lothian Localities Level

The Public Bodies (Joint Working) (Scotland) Act requires HSCPs to have a minimum of two localities. We are also required to include indicator data for localities as part of our Annual Performance Report. In East Lothian there is a West Locality (with a population of around 60,000) and an East Locality (with a population of circa 39,000). The table below shows MSG indicator data for each of our localities.

Indicator	Locality	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
1. Number of Emergency Admissions (18+)	East Lothian **East**	*NA*	*2,870*	*3,003*	*3,247*	*2,924*	*3,172*
1. Number of Emergency Admissions (18+)	East Lothian **West**	*NA*	5,414	5,191	5,761	5,328	5,338
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	East Lothian **East**	*NA*	30,468	25,944	25,672	24,376	28,309
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	East Lothian **West**	*NA*	50,382	40,690	40,472	42,023	42,578
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)	East Lothian **East**	*NA*	258	-	534	2,153	2,667
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)	East Lothian **West**	*NA*	188	455	2,103	4,572	3,847
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (65+)	East Lothian **East**	*NA*	258	-	481	2,131	2,606
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (65+)	East Lothian **West**	*NA*	188	281	1,749	4,446	3,688
2iii. Number of Unscheduled Hospital Bed Days – Mental Health6 (18+)	East Lothian **East**	*NA*	9,239	8,318	7,847	5,356	6,233

2iii. Number of Unscheduled Hospital Bed Days – Mental Health6 (18+)	East Lothian **West**	*NA*	7,338	7,167	5,864	7,086	6,853
3. New Accident and Emergency attendances (18+)	East Lothian **East**	*NA*	6,055	6,640	6,763	5,849	7,400
3. New Accident and Emergency attendances (18+)	East Lothian **West**	*NA*	14,070	14,536	14,542	12,074	13,818
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	East Lothian **East**	5,331	5,388	3,293	2,469	1,615	1,040
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	East Lothian **West**	5,996	4,642	4,259	2,241	2,294	1,601

Our Financial Performance

Spend in 2021/22

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

East Lothian IJB had a budget of just over £209m and ended the year with an underspend of £10.6m – this means that the charges from partners for services delivered on behalf of the IJB were less than the income available to the IJB. However, this underspend is largely made up of unspent committed funds for specific programmes of work that have been carried forward into 2022/23 with the 'operational' underspend being c. £1.7m.

A significant element of the committed funds carried forward relates to Covid-19 funding. The IJB received further funding of £13.7m to meet the additional costs of the pandemic and spent £8.1m. Covid-19 related costs will span across financial years, therefore funding allocations which have not been fully used in 2021/22 have been carried forward to 2022/23, therefore the IJB has a Covid-19 reserve balance of £9.1m.

The operational underspend will be taken to the IJBs general reserve which was £4.8m at 31 March 2022.

Further details of our total reserves balance are shown below. The financial position of the IJB at the end of 2021/22 is explained in more detail in the annual accounts.

Table 5 – Budget Summary

	2021/22 Budget £k	**2021/22 Expenditure £k**	**2021/22 Variance £k**
Health	£156,160	£146,427	£9,733
Social Care	£53,771	£52,824	£947
Total	**£209,931**	**£199,251**	**£10,680**

The graph and table below show our budget spend according to category of activity

Graph 9 - Where the money was spent in 2021/22 (£k)

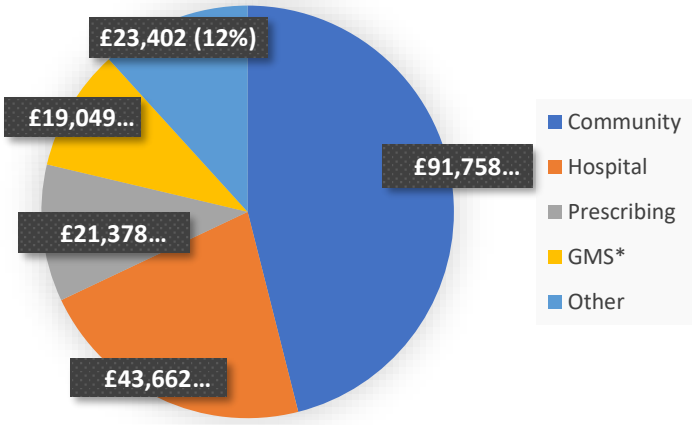


Table 6 – Where the money was spent in 2021/22 (£k)

	Community £k	Hospital £k	Prescribing £k	GMS* £k	Other £k	Total £k
Expenditure	£91,758	£43,662	£21,378	£19,049	£23,402	£199,249
% of total	46%	22%	11%	10%	12%	100%

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

Breakdown of the budget and expenditure by service for 2021/22 is shown in Table 7 below:

Table 7 – Budget and expenditure by service in 2021/22 (£k)			
	Budget £k	**Expenditure £k**	**Variance £k**
Direct East Lothian Services			
Community AHPS	£6,027	£5,927	£100
Community Hospitals	£13,307	£12,800	£507
District Nursing	£2,795	£2,671	£124
General Medical Services	£18,835	£19,049	-£215
Health Visiting	£2,030	£1,923	£107

Mental Health	£6,116	£6,049	£67
Other	£20,163	£10,757	£9,407
Prescribing	£20,894	£21,378	-£485
Resource Transfer	£4,961	£4,964	-£2
Older People	£29,394	£30,012	-£618
Mental Health	£1,867	£2,011	-£144
Physical Disabilities	£2,496	£2,699	-£203
Learning Disabilities	£14,943	£17,827	-£2,884
Planning and Performance	£2,984	£2,877	£107
Other	£8,303	£3,614	£4,689
East Lothian share of pan-Lothian Services			
Set Aside	£23,652	£23,825	-£174
Mental Health	£2,721	£2,778	-£58
Learning Disabilities	£1,699	£1,713	-£15
GP Out of Hours	£1,580	£1,572	£7
Rehabilitation	£1,055	£949	£106
Sexual Health	£836	£811	£25
Psychology	£1,046	£1,113	-£67
Substance Misuse	£419	£407	£12
Allied Health Professions	£1,716	£1,597	£119
Oral Health	£2,225	£2,187	£38
Other	£4,197	£4,067	£130
Dental	£7,026	£7,026	£0
Ophthalmology	£2,091	£2,091	£0
Pharmacy	£4,555	£4,555	£0
Total	**£209,933**	**£199,249**	**£10,680**

Reserves

As discussed above, the IJB's underspend is largely made up of committed funds that have been carried forward into 2022/23 with the 'operational' underspend being around £1.7m. This is laid out in detail in the analysis of reserves below. This operational underspend will take the general reserve to £4.8m at March 2022. The IJB's reserve strategy proposed a reserve of around 2% of the IJB's turnover which would equate to around £3.9m.

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

In 2021/22 investment was given by the Scottish Government for Covid-19, programmes in Primary Care, Mental Health and Alcohol and Drug Partnerships. The reserve is broken down as follows into specific purposes and general reserves:

Table 8 - Earmarked Reserves	**£k**
Covid-19	£9,182
Primary Care Improvement Fund	£354
Mental Health Strategy	£488
Alcohol and Drugs Strategy	£1,038
Community Living Change Fund	£346
Care at Home Capacity	£419
Interim Care	£420
Multi-disciplinary Teams	£158
Carers Strategy	£79
Locally committed programmes	£2,996
Committed Project Funds	**£15,480**
General Reserves	**£4,809**
Total Reserves	**£20,289**

Financial pressures

Existing recurring financial pressures in some service areas continued in 2021/22. In other areas, financial pressures have been minimal due to reduced levels of activity.

During the year, the Scottish Government provided a further £13.7 m of funding to meet all additional costs and loss of income associated with the pandemic. This funding allocation was supported through the HSCP's Local Mobilisation Plan submissions. Expenditure of £8.1 m was incurred during the year, leaving a balance of £9.1m to be transferred to reserves to meet ongoing costs during 2022/23.

The main additional Covid related costs during 2021/22 included those related to:

- Sustainability payments to local social care providers to enable them to continue to deliver a sustainable service.
- Opening up of additional hospital beds at East Lothian Community Hospital.
- Delivering a Covid Assessment Hub in Musselburgh.

- Delivering the East Lothian Covid Vaccination Programme.
- Developing a long-Covid and post-Covid rehabilitation provision.
- Supporting Care Homes with challenges relating to outbreaks through Infection Prevention and Control training and advice.

Future financial pressures

A key financial challenge in 2023/24 will be the non-availability of any additional funds to support the additional costs of the Covid pandemic. The Scottish Government's is currently indicating that no new funds will be available in 2022/23 (or beyond) to support further costs generated by the Covid pandemic. In recognition of this, the Scottish Government is working with the partners to develop an exit strategy.

In addition, NHS Lothians forecasts a significant financial pressure in the health part of the IJB, although this is an early indication and requires further analysis and development. This will be examined further in the IJB's multi-year financial plan. Within the social care budget, inflation, and demand increases (through population growth) will continue to create financial pressures.

Appendix 1 – National Outcomes / East Lothian Strategic Objectives Mapping

Table 1

National Outcomes	East Lothian IB Strategic Objectives
Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer	Objective 1: Make services more sustainable and proportionate to need and use them to develop our communities Objective 2: Explore new models of community provision which involve local communities and encourage less reliance on health and social care services Objective 3: Improve prevention and early intervention
Outcome 2: People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	Objective 2: Explore new models of community provision Objective 3: Improve prevention and early intervention Objective 7: Enable people to have more choice and control
Outcome 3: People who use health & social care services have positive experiences of those services, and have their dignity respected	Objective 6: Deliver services within an integrated care model Objective 7: Enable people to have more choice and control
Outcome 4: Health & social care services are centred on helping to maintain or improve the quality of life of people who use those services	Objective 2: Explore new models of community provision Objective 3: Improve prevention and early intervention Objective 4: Reduce unscheduled care and delayed discharges Objective 6: Deliver services within an integrated care model

Outcome 5: Health & social care services contribute to reducing health inequalities	Objective 8: Reduce health inequalities
Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	Objective 7: Enable people to have more choice and control Objective 8: Reduce health inequalities
Outcome 7: People who use health and social care services are safe from harm	Objective 7: Enable people to have more choice and control
Outcome 8: People who work in health & social care services feel engaged with the work they do and are supported to continuously improve information, support, care and treatment they provide	Objective 10: Support change and improvement across our services
Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services	Objective 10: Support change and improvement across our services Objective 2: Explore new models of community provision Objective I: Improve partnership working Objective 9: Deliver services within an integrated care model

Appendix 2 – Confidence Intervals

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

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

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