East Lothian
Integration Joint Board

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 25 AUGUST 2022
VIA DIGITAL MEETINGS SYSTEM

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Voting Members Present:
Councillor S Akhtar (Chair)
Ms E Gordon
Ms F Ireland
Councillor L Jardine
Councillor C McFarlane
Ms V de Souza

Non-voting Members Present:
Ms M Allan
Ms L Cowan
Dr C Mackintosh
Dr P Conaglen
Ms C Flanagan
Ms F Wilson

Officers Present from NHS Lothian/East Lothian Council:
Ms L Berry
Mr P Currie
Ms J Jarvis
Ms L Kerr
Ms G Neil
Ms K Burke
Ms J Irwin
Mr M Kennedy
Ms S O'Kane

Clerk:
Ms F Currie

Apologies:
Councillor L Bruce
Mr P Murray
Mr D Binnie
Mr I Gorman
Dr W Hale
Ms M McNeill
Dr J Turvill
Ms L White

Declarations of Interest:
None

1. MINUTES OF THE EAST LOTHIAN IJB MEETING ON 23 JUNE 2022 (FOR APPROVAL) AND MATTERS ARISING

The minutes of the meeting on 23rd June 2022 were approved and there were no matters arising.

2. ESTABLISHMENT OF A CARE AT HOME CHANGE BOARD

The Chief Officer had presented a SBAR seeking the IJB's agreement to the establishment of a Change Board to oversee the strategic development of Care at Home Services in East Lothian.

Laura Kerr presented the report outlining the proposals, the relevant Directions and the terms of reference for the Change Board. She confirmed that the Change Board would provide regular updates and briefings to the Strategic Planning Group and the IJB.

Ms Kerr responded to questions on the membership of the Change Board and accepted the nomination of Maureen Allan and Lyn Jardine, to represent community groups and the IJB respectively. Further appointments to the Change Board would be made in the coming weeks.

The vote was taken by roll call and the recommendations were approved unanimously.

Decision

The IJB agreed:

i. To the establishment of the Change Board and the Chair and Vice Chair;
ii. The terms of reference and membership;
iii. To request regular updates on progress and project plan development
iv. That the two Directions be adopted by the Change Board

3. EAST LOTHIAN INTEGRATION JOINT BOARD RECORDS MANAGEMENT PLAN

The Chief Officer had presented a SBAR seeking the IJB's approval of a Records Management Plan.

Paul Currie presented the report outlining the legislative background to the Records Management Plan, the types of information and files involved and the agreement with East Lothian Council Information Governance team to manage and store those records covered by the plan. He added that formal approval of the Plan was required from the Keeper of Records by 31st August and he had already been consulted on a draft proposal.

The vote was taken by roll call and the recommendation was approved unanimously.

Decision

The IJB approved the East Lothian Integration Joint Board Records Management Plan and associated Memorandum of Understanding.

4. CHANGE TO THE PROCEDURE FOR APPROVAL OF THE IJB'S ANNUAL ACCOUNTS

Claire Flanagan, the Chief Finance Officer, provided a verbal report to the IJB seeking agreement to a change of procedure for the approval of the IJB's audited annual accounts for 2021/22.

Ms Flanagan reminded members that the audited annual accounts were usually presented to the Audit & Risk Committee for an initial review and then presented to the IJB for final sign-off. This year she was seeking members' agreement to present the accounts to the Audit & Risk Committee on 13th September for review and final sign-off. She confirmed that the IJB's Chair would attend the Audit & Risk Committee meeting, along with the external auditors, and that the accounts would be signed electronically after that meeting.

The vote was taken by roll call and the recommendation was approved unanimously.

Decision

The IJB agreed that, in a change to the usual procedure, the audited annual accounts for 2021/22 would be presented to the Audit & Risk Committee on 13th September for review and final-sign off.

Signed .....

Councillor Shamin Akhtar
Depute Chair of the East Lothian Integration Joint Board

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SBAR - East Lothian IJB Strategic Plan 2022-25

Date: 15th September 2022
Completed by: Paul Currie
Area: Strategic Integration

Situation	East Lothian Integration Joint Board is required by the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) to produce a Strategic Plan every three years. The preceding Plan[1], covering the period 2019-22, applied until end March 2022, but was extended to end September 2022 by the IJB at its meeting of 9th June 2021. This extension was agreed to: • Allow HSCP officers to respond to increased Covid 19 related reporting and other demands. • Provide time to allow the new plan to include any policy/strategy developments arising from the Independent Review of Adult Social Care (IRASC) and the proposals for a National Care Service (NCS). • Ensure the Plan could reflect any changed priorities associated with the review of all IJB Integration Schemes across Lothian. Covid 19 reporting has ended, no IRASC/NCS policy changes have yet been announced, as consultation continues, and the Integration Schemes review did not result in any changes to East Lothian IJB duties.
Background	IJBs were established across Scotland as a requirement of the above-mentioned Act, as a means for health boards and local authorities to integrate adult health and social care services and budgets, through delegation to a locally accountable body. East Lothian IJB was formally established in July 2015. At this point, it took on responsibility for development of integrated planning and delivery of health and social care services and criminal justice social work in the East Lothian Council geographical area, as well as certain acute hospital services managed by NHS Lothian. Each IJB must have a Strategic Plan containing local priority area of action, service modernisation and development, the priorities for partner-delivered services and the principles under which services operate. Under the Act, East Lothian IJB has a duty to issue 'Directions' (binding instructions) to East Lothian Council and NHS Lothian to ensure they deliver the IJB's agreed strategic and operational priorities, contained in the Strategic Plan. In 2016, East Lothian IJB published its first Strategic Plan for the period 2016 to 2019. Its second Strategic Plan was intended to apply from 1st April 2019 to 31st March 2022, but as noted above, was extended to end September 2022. The third Strategic Plan (see appendix 1) will apply from October 2022 until 31st March 2025. Development of a fourth Strategic Plan will commence in September 2024.
Assessment	Consultation for the Strategic Plan was held over January to July 2022 and involved: • IJB and SPG members (including in development sessions). • HSCP Management and teams, across Planning and Performance, Adult Wellbeing, Mental Health, Rehabilitation, Primary Care and Social Care, Substance Misuse. • Change Board reps. • 3rd Sector and Community Groups. • People with lived experience. • Carers and members of the Deaf Community.

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	The themes and issues highlighted through the consultation were considered alongside current local and national policy and strategy drivers, progress to date in delivering integrated health and social care services, and analysis of demographic and other data (the latter contained in a Joint Strategic Needs Assessment[2] carried out by Public Health Scotland) and assessment of delivery of the 2019-22 Strategic Objectives. An IJB Development Session on 25th August agreed a set of proposed Strategic Objectives for the 2022-25 Plan: 1. Develop services that are sustainable and proportionate to need. 2. Deliver new models of community provision, working collaboratively with communities. 3. Focus on prevention and early intervention. 4. Enable people to have more choice and control and provide care closer to home. 5. Further develop/embed integrated approaches and services. 6. Keep people safe from harm. 7. Address health inequalities. The delivery of the Strategic Objectives is supported by: • **Strategic Priorities** - key, high level actions/activities/developments. • **Strategic Enablers** - practical/technical/infrastructure/partnership inputs. • An **Annual Delivery Plan** - providing detail on means of delivery and monitoring. • An **Annual Performance Report** - publicly reporting on yearly progress. The Plan notes that the Strategic Objectives within it and planned accompanying actions, will need to be: *"…flexible enough to make all necessary changes, including reprioritisation, to reflect changes in local and national policy and in local demand and need."* This is to ensure that the Plan can respond over its lifetime to any changes in local or national priorities. The Strategic Plan and its planned local work will align as necessary with the Lothian Strategic Development Framework[3]. This sets out how NHS Lothian will work with partners across the whole health system (comprising primary care, community, and hospital services) to respond to current and future challenges and to deliver strategic change. The Plan was considered by East Lothian Strategic Planning Group at it's meeting of 6th September. The SPG agreed to recommend the Plan, with minor amendments, to the IJB. The Strategic Plan will be subject to an Integrated Impact Assessment (IIA) on 13th September 2022 to assess it for any inadvertent negative impacts on people with protected characteristics or any other groups. The final version of the Plan will be professionally designed and include images.
Recommendation	The IJB is asked to: • Note the consultation and other processes carried out to develop the 2022-25 Strategic Plan and its Strategic Objectives. • Note the intention to develop an Annual Delivery Plan for the Strategic Plan and to report on progress. • Note that the SPG approved the Strategic Plan at its 6th September meeting and agreed to recommend it to East Lothian IJB. • Agree to accept the 2022-25 Strategic Plan.
Further Information	[1] IJB Strategic Plan 2019-22 (https://www.eastlothian.gov.uk/ijbstrategicplan) [2] Joint Strategic Needs Assessment [3] Lothian Strategic Development Framework (https://org.nhslothian.scot/Strategies/LSDF)

DRAFT East Lothian Integration Joint Board Strategic Plan 2022-2025

06-09-2022

Introduction

We are pleased to present this third Strategic Plan for East Lothian Integration Joint Board. The plan arrives at a challenging time in delivering Health and Social Care services across Scotland. As services begin to recover from the disruptions arising from the Covid pandemic, and as services continue to remobilise, we are faced with high demand, increased waits for services and recruitment and retention challenges. We also enter this time as a 'cost of living' crisis is emerging. The significant detrimental impact to health and wellbeing of such a crisis adds to the challenges we face in delivering health and social care in East Lothian

The interruptions to planned service delivery caused by Covid and its restrictions has slowed delivery of some of the priorities set out in the preceding Strategic Plan. Our continuing population growth and its ageing, means many of the priorities remain relevant to meeting the needs of our service users and communities.

Covid impacts on partners, such as NHS Lothian, East Lothian Council and third sector has required actions to stabilise some of their services. We will continue to work in partnership with them in recovering from Covid and in delivering the objectives in this Plan.

Some changes forced by Covid, such as the introduction of remote working for certain groups of staff and the use of telephone access for patients and clients need to remain as they provide efficient means of using scarce staff resources and reducing travel. We know from consultation for this Strategic Plan that telephone access, particularly to GP services, is not universally welcomed. We will always ensure that where in-person access is needed for clinical or equity reasons this will be provided.

As stated in the previous Plan, any Strategic Plan in health and social care needs to be: *"…flexible enough to make all necessary changes, including reprioritisation, to reflect changes in local and national policy and in local demand and need".* This approach will apply to this Plan, which for the reasons noted above, will continue some of the priorities from its predecessor but may need to reprioritise planned work in the next three years, should local or national factors require change.

This plan continues and builds on the work that has established and developed integrated working across all services in East Lothian Health and Social Care Partnership over the last seven years. This progress could not have been made without the staff who work across the Health and Social Care Partnership, the third sector and other partners. We owe particular thanks to those HSCP, NHS and East Lothian Council colleagues,

third sector partners and volunteers who were so critical in responding to the challenges of the Covid pandemic and in delivering our vaccination programme.

In prioritising our work through to end March 2025, we will ensure local need, local priorities and national and local strategies, policies, action plans and targets are responded to appropriately.

This Strategic Plan and the local work it directs in coming years will align with the Lothian Strategic Development Framework which articulates how NHS Lothian will work with partners across the whole health system (comprising primary care, community, and hospital services) to respond to current and future challenges and to deliver strategic change. We will also reflect appropriate elements of the East Lothian Council Plan in our work.

We will continue, through 'co-production' approaches, to include people who access services as well as carers and other stakeholders in the planning, delivery and review of our health and social care services. This will require honest conversations about the budgetary, staffing and other pressures facing all of our services as they continue to recover from Covid and accompanying decisions about service change that may not be universally popular.

Our Strategic Planning Group (SPG) will continue to monitor delivery of strategic priorities. It will assess new policies and strategies and will provide a strategic perspective on these to the IJB.

The IJB will continue to report on its performance through publication of its Annual Performance Report and quarterly performance reporting.

About Us

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

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

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

Functions delegated to IJBs include:

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

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

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

Our Vision and Values

Our Vision describes our aspiration to deliver health and social services in East Lothian to **'support all people in East Lothian to live healthy lives, to achieve their potential to live independently and exercising choice over the services they use.'**

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

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

NHS Lothian:

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

East Lothian Council:

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

You can find out more about East Lothian IJB and ELHSCP here.

Our Strategic Objectives and Delivery Priorities – At a Glance

STRATEGIC OBJECTIVES	1. Develop services that are sustainable and proportionate to need	2. Deliver new models of community provision, working collaboratively with communities	3. Focus on prevention and early intervention	4. Enable people to have more choice and control & provide care closer to home	5. Further develop / embed integrated approaches and services	6. Keep people safe from harm	7. Address Health Inequalities
STRATEGIC DELIVERY PRIORITIES	Planning for an ageing population Developing Intermediate Care Care at Home services Supporting the acute sector Commissioning	Transforming Community Support services Working with communities	East Lothian Rehabilitation Service Falls prevention & management Mental health and wellbeing Support with alcohol Issues	Primary Care services East Lothian Community Hospital Outpatient Services Re-imagining Adult Social Work Dementia support Supporting Carers Palliative and end-of-life care	Integrated teams and approaches Pathway Reviews Meeting housing needs Transitions from Child to Adult services	Public Protection Reducing harm from substance use Justice Social Work Supporting children, young people and families	Understanding health inequalities across our communities Taking action in partnership to address health inequalities

CROSSCUTTING STRATEGIC ENABLERS						
STRATEGIC ENABLERS	**Workforce**	**Financial**	**Partnership, Participation & Engagement**	**Technology**	**Approaches to Improvement & Innovation**	**Information Sharing**
ENABLER DELIVERY PRIORITIES	**Delivery of Workforce Plan**	**Financial planning and delivery of IJB Financial Plans**	**Delivery of Participation and Engagement and Commissioning Strategies** **Involvement in strategic planning partnerships**	**Digital / Technology Workstream**	**Development of Performance and Improvement Framework**	**Development of information sharing approach / protocols and reflection of Scottish Digital Strategy**

→ Our **Strategic Objectives** describe what we want to achieve over the next three years.

→ Our **Strategic Delivery Priorities** are the key, high level actions / activities / developments that we need to prioritise to achieve these objectives.

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

→ Our **Annual Delivery Plan** provides the detail of how we will deliver these priorities**.**

→ Our **Annual Performance Report** publicly reports on progress each year.

Developing the Strategic Plan

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

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

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

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

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

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

Engaging Our Stakeholders

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

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

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

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

Strategic Context and Our Approach

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

Health and Social Care Integration

Central to the context we work in are the requirements of the legislation[1] that established Integration Joint Boards and set the direction for health and social care integration, along with the National Health and Wellbeing Outcomes and Integration Principles set out by the Scottish Government.

Our strategic approach to date has focused on delivery of the National Outcomes, with our approach reflecting the Integration Principles and responding to additional national guidance and direction as it evolved. We plan to use the Framework for Community Health and Social Care Integrated Services[2] to ensure that our strategic direction and service delivery continues to reflect these outcomes / principles. We will make use of the framework to guide the development of our Annual Delivery Plan (see appendix X) and as part of our future performance and improvement activity. The 'Core Components' outlined in the framework are shown in below:

Promoting healthy, independent living by supporting people to:

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

[1] Public Bodies (Joint Working) (Scotland) Act 2014

[2] The Framework for Community Health and Social Care Integrated Services is aligned to the 9 National Health and Wellbeing Outcome and the Integration Principles, as well as reflecting good practice that has emerged since the introduction of Health and Social Care Partnerships.

Making services more accessible and responsive by developing:

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

Improving outcomes by working more effectively to deliver:

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

Shifting the Paradigm of Social Care

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

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

Our approach to social care in East Lothian already reflects many of the themes and principles of the Feeley Report, but there is still more that we need to do. The objectives and delivery priorities identified in this Strategic Plan reflect the key themes from the report, and our Annual

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

Delivery Plans will provide further direction to help us more fully realise the ambitions outlined in the Feeley Report. We have also begun work in relation to early implementation of some of the Feeley recommendations as highlighted in the Scottish Government and COSLA Statement of Intent.

The National Care Service

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

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

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

Health Inequalities

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

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

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

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

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

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

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

Equalities

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

The Promise

The Promise is the vehicle for driving change in response to the findings of the Independent Care Review into children, young people and adults' experience of the care system. Its purpose is to 'support shifts in policy, practice and culture, so Scotland can *#KeepThePromise* it made

to care experienced infants, children, young people, adults and their families – that every child grows up loved, safe and respected, able to realise their full potential'.

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

Equally Safe

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

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

Trauma Informed Services

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

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

The Scottish Government's ambition, shared by COSLA and other partners, is to develop a trauma-informed and trauma-responsive workforce across Scotland[7]. The purpose of this is to ensure that services are delivered in a way that prevents further harm or re-traumatisation for those who have experienced psychological trauma or adversity at any stage in their lives.

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

New Technologies and Data Use

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

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

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

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

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

Lothian Strategic Development Framework

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

Locality Planning

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

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

Climate Change

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

Local Housing Strategy

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

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

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

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

Our Data

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

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

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

<table>
<tr><th colspan="2">Our growing and ageing population</th></tr>
<tr><td>East Lothian's population of 107,900 will grow to 121,743 by 2043. This rate of growth is amongst the highest in Scotland.</td><td rowspan="2">Population growth will continue to place pressures across HSCP services, particularly those serving older people, reflecting the frailty in this age group and the higher care needs of people with dementia.

In supporting people with dementia, we will continue to work with Community Planning, housing and the third sector partners to develop locally relevant community, housing and care responses, taking into account East Lothian's geography, deprivation and community need.

East Lothian continues to perform well in reducing delays for patients who are ready to be discharged from acute hospitals and has delivered a sustained reduction in the number of excess days spent in hospital. This puts it amongst the best performers for delayed discharge in Scotland.

This performance is delivered through integrated working across the Integrated Care Assessment and Allocation Team (ICAAT) the Hospital at Home, Hospital to Home, social care and Discharge to Assess (D2A) teams working together to prevent admissions and to speed up discharge home, or to a homely setting.</td></tr>
<tr><td>The highest growth will be in the 65-74 and 75+ age bands, with the over 75s population increasing markedly. As a result of this, there will be an increase in the number of people affected by dementia and long-term conditions.</td></tr>
<tr><td>East Lothian's current falls rate is 23.4 per 1,000 population aged over 65, making it higher than the Scottish rate.</td><td>Work is underway to develop a robust falls prevention and management service, to respond to current falls and to prepare for increased risk associated with growth in our older population. The development will co-ordinate falls assessments, responses post-fall, community physiotherapy and community occupational therapy support, backed up by equipment, home adaptations and telecare to meet client need.</td></tr>
</table>

<table>
<tr><th colspan="2">Deprivation and inequalities</th></tr>
<tr><td>In East Lothian 8 of its 132 data zones are in the 20% most deprived in Scotland.

People in living in these data zones have a life expectancy 8 years (males) and 4.8 years (females) lower than those in the least deprived areas.</td><td rowspan="2">The East Lothian Public Health Partnership and Place team will work with HSCP colleagues, East Lothian Council, Community Planning, Health and Wellbeing Groups, the third sector and other partners to address inequalities and to identify and respond to community support needs.

Integrated Impact Assessments will continue to be carried out on all service developments and policies to ensure people with protected characteristics are not discriminated against and to assess impacts on service users.</td></tr>
<tr><td>We face challenges in achieving equitable service delivery across our diverse communities, in the more populous and more deprived west of the county and the rural east and south of the county (see map below).</td></tr>
<tr><td>Homelessness increased by 32.4%, from 242 in 2003 to 747 in 2021, a rate of 4.8 per 1,000 population - well above the Scotland rate of 2.9 per 1,000.</td><td>Current and coming increases in the cost of living may increase the risk of homelessness. We will work with East Lothian housing services and other partners to ensure people at risk of homeless are identified and helped to access support. This will assist in achieving new duties in relation to preventing homelessness.

In addition, we will use the opportunities offered through the East Lothian Council Housing Contribution Statement to identify joint working priorities to ensure housing suits the health and social needs of East Lothian residents.</td></tr>
</table>

Social care	
In 2019 there were 7.3 people with a learning disability per 1,000 known to East Lothian services, the fourth highest in Scotland. The national average was 5.2.	To foster independence in clients with learning disability, Neighbourhood Networks are supporting people in the community and a Transition Network is focussed on those moving from young people's services to adult services. Work is also underway with Teens+ to provide educational input to support young adults to develop life skills. Our Resource Coordinator Service is working with service users, families, carers, provider organisations and third sector in developing community-based sessions for people with learning disabilities who do not require a resource centre-based service. Support will be further enhanced through the planned work to establish an integrated and enhanced Learning Disability Service.
Covid restrictions, business pressures on providers and staffing shortfalls resulted in a peak reduction of over 2,000 hours of contracted Care at Home hours per week.	Care at Home is critical to supporting people to remain in their own homes, or for those people in hospital ready to return home. Any shortage in available care delays discharge and interrupts the rehabilitation process, affecting a patient ongoing recovery. The decrease in available hours is being addressed by an increase in Partnership managed service provision, across Care at Home and Hospital 2 Home (H2H) services.
The East Lothian Care Home Team supports care homes within East Lothian, of which 12 are independent and 4 are managed by the Partnership.	The nurse-led team, with Physician Associates input, supports medical practices by significantly reducing the need for GPs to attend care homes, as the majority of clinical care is provided by the team. It also provides training, clinical support, and infection prevention and control advice to care home staff, helping to maintain local and national care standards.

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

<table>
<tr><th colspan="2">Drugs and alcohol</th></tr>
<tr><td>Drug-related hospital admissions are increasing for all of East Lothian, although the rate for the east of the county is below the west and is levelling out.</td><td rowspan="4">The Substance Use Primary Care Outreach Service is operating in 12 of the 14 East Lothian GP Practices. This provides a nurse-led approach to identifying and working with high risk/hard to reach individuals who use substances.

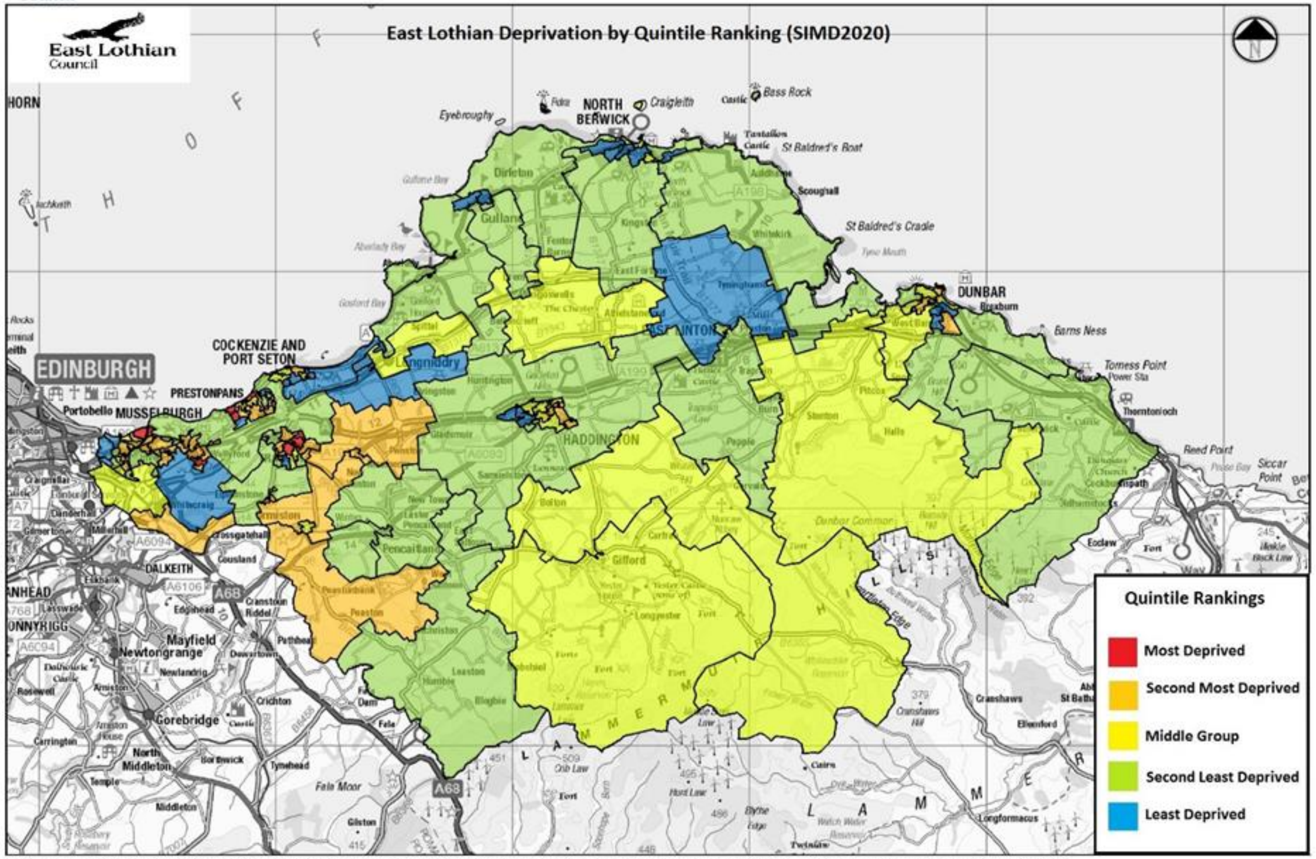
Future work will focus on establishing the Scottish Government MAT (Medication Assisted Treatment) standards, covering service access, treatment retention and trauma informed service delivery.

To improve the provision of information to the public regarding substance use and to improve access to Substance Use Services in Midlothian and East Lothian, MELD (Midlothian and East Lothian Drugs) established a pilot Contact Service during 2021-22.

The service provides a confidential helpline for people seeking support from substance use support services, or information regarding substance use. It uses a trauma-informed, person-centred conversation approach to assist callers in addressing their concerns and needs.</td></tr>
<tr><td>Drug-related deaths increased from 1.8 to 14.0 per 100,000 population from 2006 to 2020.</td></tr>
<tr><td>Alcohol consumption rates have reduced across the population, although the rates for males remain higher than females.</td></tr>
<tr><td>East Lothian has maintained a lower alcohol admission rate than Scotland since 2002/03, with the west higher than the east. However, deaths from alcohol have risen.</td></tr>
</table>

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

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



Our Strategic Delivery Priorities for 2022-25

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

1. Develop services that are sustainable and proportionate to need.
2. Deliver new models of community provision, working collaboratively with local communities.
3. Focus on prevention and early intervention.
4. Enable people to have more choice and control and provide care closer to home.
5. Further develop/embed integrated approaches and services.
6. Keep people safe from harm.
7. Reduce health inequalities.

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

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

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

Strategic Objective 1 - Develop services that are sustainable and proportionate to need

Our Strategic Delivery Priorities for 2022-25

1.1 Planning for an ageing population

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

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

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

This work will focus on reviewing provision at East Lothian's community hospitals (Edington and Belhaven) and HSCP managed Care Homes and on the further development of and investment in Intermediate Care (see 1.2).

1.2 Developing Intermediate Care

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

Intermediate Care[8]: refers to health and social care services that help people:

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

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

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

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

1.3 Care at Home services

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

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

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

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

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

1.4 Supporting the acute sector

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

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

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

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

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

1.5 Commissioning

The functions delegated to East Lothian IJB (appendix 1) are delivered in a number of ways. Whilst the majority of services are directly provided by the HSCP or via 'hosted' or 'set-aside' arrangements[9], some are delivered via commissioning arrangements with third and independent sector providers.

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

Work is underway to produce a new Commissioning Strategy. This will help to further develop and improve our approach to commissioning and will include a number of clearly defined 'commissioning priorities' to guide decision making. Reflecting the recommendations of the Feeley report, these principles will include a commitment to more ethical commissioning in terms of decisions that 'take into account factors beyond price, including fair work, terms and condition and trade union recognition'.[10]

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

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

Strategic Objective 2 - Deliver new models of community provision, working collaboratively with communities

Our Strategic Delivery Priorities for 2022-25

2.1 Transforming Community Support Services

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

- Older people and those with dementia.
- People with mental health problems / illness.
- People with a learning disability.
- People with a physical disability.
- People with Autism.
- People with Sensory Impairment.

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

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

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

2.2 Working with communities

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

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

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

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

Strategic Objective 3 - Focus on prevention and early intervention

Our Strategic Delivery Priorities for 2022-25

3.1 East Lothian Rehabilitation Service

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

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

- Further development of community based multidisciplinary clinics, including Technology Enabled Care (TEC).
- Embedding TEC across all our workstreams within ELRS service development and provision.
- Working with community partners to promote wellbeing a physical activity in the community, such as local leisure provision.
- Following our patients into the acute sector, ensuring that timely assessments are carried out in that setting to promote timely discharge and support in the community (see also Delivery Priority 1.4).
- Continuing to improve and expand the single point of contact for all Rehabilitation Services.
- Promoting the use of the digital platform to support education and patient self-management; expansion of education content specifically around long-term conditions.
- Further development of data analytics to help understand current impact, trends in demand, to make projections, and inform future service development.

3.2 Falls prevention and management

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

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

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

3.3 Mental health and wellbeing

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

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

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

We will continue to develop the service provided by CWIC Mental Health and will also look at other ways to provide early support for people with lower-level mental health issues. This will include introducing a new Distress Brief Intervention[11] programme in East Lothian, as well as looking at ways of further developing services available via third sector partners (including via the use of funding). Third sector organisations play a key role in providing mental health support, particularly as they are able to offer varied and flexible types of provision at a community level.

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

[11] A Distress Brief Intervention is 'a time limited and supportive problem-solving contact with an individual in distress' – read more here.

Strategic Objective 4 - Enable people to have more choice and control and provide care closer to home

Our Strategic Delivery Priorities for 2022-25

4.1 Primary Care Services

Implementation of our Primary Care Improvement Plan led to the development of multi-disciplinary teams providing a range of primary care services alongside those delivered by General Practitioners (GPs). This has included establishing services such as CWIC (Care When it Counts), CWIC Mental Health, CTACS (Community Treatment and Care Service) and the Musculoskeletal Service.

We also delivered the Vaccination Transformation Programme (VTP) to transfer vaccinations responsibility from GP practices to dedicated NHS Board and HSCP teams. These teams were critical in overseeing the Covid vaccination programme across East Lothian in support of the national programme. Covid boosters are now part of the wider delivery of the VTP.

Development of these primary care services has also been led by our commitment to ensuring that services are equally accessible to patients, regardless of where they live and which GP practice they are registered with.

We will continue to develop and improve these services and develop others as required, learning from experience to date and working closely with our GP, optometry, dental, community pharmacy and other primary care colleagues.

4.2 East Lothian Community Hospital Outpatient Services

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

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

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

4.3 Re-imagining Adult Social Work

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

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

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

4.4 Dementia Support

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

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

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

4.5 Supporting Carers

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

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

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

4.6 Palliative and End-of-Life Care

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

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

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

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

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

Strategic Objective 5 - Further develop / embed integrated approaches and services

Our Strategic Delivery Priorities for 2022-25

5.1 Integrated Teams and Approaches

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

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

- East Lothian Rehabilitation Service's cluster working approach. This brings together Occupational Therapists from East Lothian Council and NHS Lothian, Physiotherapists, Community Care Workers, Assistant Practitioners, and Business Support to work collaboratively to provide high quality, responsive, person-centred, community-based care. There are three clusters, each of which works closely with Primary Care colleagues.
- The introduction of the Integrated Care Assessment and Allocation Team (ICAAT) which has contributed to the prevention of hospital admissions, reduced delayed discharge rates, and helped to prioritise use of available resources. (see 1.x)
- The establishment of daily activity meetings, involving our own senior managers and staff, along with colleagues from acute hospital sites, with the aim of supporting a coordinated, pro-active approach to hospital discharge. (see 1.x)
- The bringing together of Community Learning Disability and Learning Disability Social Work Teams into a new enhanced Learning Disability Service.

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

5.2 Pathway Reviews

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

Our recent Review of Mental Health Services is one example of work we are doing to improve access and patient pathways[12]. The review has informed a number of improvements that we will introduce to make access to mental health services easier, as well as improving pathways within and between mental health and other services. This will include changes to improve patient experience at the point of entry / first contact with mental health services.

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

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

5.3 Meeting Housing Needs

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

[12] Patient journeys within and between services

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

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

5.4 Transitions

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

The policy will emphasise the importance of starting planning as early as possible in order to enable the young person, their family and carers to work with social work and education teams to develop a real understanding of the young person's ambitions and priorities and to identify what they requires to help them achieve these as they move into adulthood. The policy will reflect the 'Principles of Good Transitions'[13], and will put the young person at the centre of the planning process. It will also outline the process to be followed, define the responsibilities of those involved and set timeframes.

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

Strategic Objective 6 – Keep people safe from harm

Our Strategic Delivery Priorities for 2022-25

6.1 Public Protection

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

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

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

6.2 Reducing Harm from Substance Use

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

We know that making substance use services (including information services) easy to access is important and have identified this as one of our continuing priorities. We have already taken a number of actions in relation to this, most recently through supporting the introduction of a direct Contact Service and new out of hours provision. Offering a range of support options is important and will continue to work with our partners to support the development of different forms of community-based provision.

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

We will also continue to prioritise activity aimed at reducing the number of drug related deaths and the harmful impact of long-term drug use in East Lothian, in line with the Scottish Government's National Mission to reduce Scotland's unacceptable drug deaths rate. As well as the support services described above, we will also continue to develop initiatives targeted on this most at risk – for example, assertive outreach in GP practices and roll out of Naloxone training[14].

6.3 Justice Social Work

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

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

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

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

6.4 Supporting Children, Young People and Families

Our services play an important role in relation to children and young people's health and wellbeing, both through the services we deliver to them directly[15] and through the support we provide to parents and other adults as part of the wider family unit.

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

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

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

Strategic Objective 7 - Address Health Inequalities

Our Strategic Delivery Priorities for 2022-25

7.1 Understanding Health Inequalities

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

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

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

7.2 Taking Action to Address Health Inequalities

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

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

We will also explore the potential for the HSCP to become an 'anchor institution'[16] as further means of addressing the social determinants of health. This will potentially include looking at the impact of our purchasing, our use of buildings, employment of staff, relationships with local partners and the impact we have on the environment.

Work in relation to both 7.1 and 7.2 will be supported by the new Partnership and Place Team (see page xx).

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

Our Strategic Enablers

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

- → Workforce
- → Financial Planning
- → Partnership (including working in partnership with our communities)
- → Approaches to improvement and innovation (including performance management)
- → Technology
- → Information sharing.

This section provides an overview of our Strategic Enablers and our delivery priorities in relation to each of these over the period of the Strategic Plan, with further detail to be included in our Annual Delivery Plans.

Strategic Enabler - Workforce

Our Delivery Priorities for 2022-25

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

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

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

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

Our delivery of the Workforce Plan will also reflect developments as a national level including the commitments in the Scottish Government and COSLA Joint Statement of Intent[17] in relation to the Feeley Report recommendations and the Health and Social Care National Workforce Strategy[18].

[17] Adult social care - independent review: joint statement of intent - gov.scot (www.gov.scot)
[18] Health and social care: national workforce strategy - gov.scot (www.gov.scot)

Strategic Enabler - Partnership, Participation and Engagement

Our Delivery Priorities for 2022-25

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

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

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

This will be delivered through:

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

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

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

Strategic Enabler - Approaches to improvement and innovation

Our Delivery Priorities for 2022-25

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

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

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

Strategic Enabler - Technology

Our Delivery Priorities for 2022-25

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

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

Strategic Enabler - Information Sharing

Our Delivery Priorities for 2022-25

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

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

Strategic Enabler - Financial Planning

Our Delivery Priorities for 2022-25

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

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

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

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

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

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

Shifting Resources

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

The Financial Challenge

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

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

Composition of the IJB Budget

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

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

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

Composition of the East Lothian Integration Joint Board Budget

ADULT WELLBEING	£m	COMMUNITY NHS	£m	HOSTED NHS	£m	SET ASIDE (ACUTE HOSPITALS)	£m
Older People	25.9	Community Hospitals	9.7	Sexual Health	0.8	A&E (outpatients)	2.6
Learning Disability	12.4	Mental Health	5.8	Hosted AHP Services	1.6	Cardiology	0.9
Physical Disability	2.4	District Nursing	3.0	Hosted Mental Health	2.6	Diabetes & Endocrinology	0.5
Performance & Planning	3.0	Health Visiting	2.0	Rehabilitation Medicine	1.1	Gastroenterology	1.6
Access & Rehabilitation	1.7	Community AHPS	4.8	Learning Disabilities	1.7	General Medicine	6.3
Adult Community Resources	2.6	GP (General Medical Services (GMS)	14.7	Substance Misuse	0.5	Geriatric Medicine	3.4
Mental Health	1.8	Prescribing	20.3	Oral Health Services	1.5	Infectious Disease	0.7
Assessment & Review	1.3	Resource Transfer	5.0	Hosted Psychology Service	1.1	Rehabilitation Medicine	0.4
Statutory Protection	0.2	Integration (Social Care Fund)	6.2	Complex Care	0.2	Respiratory Medicine	1.4
Other	10.3	Other Core	7.9	Lothian Unscheduled Care Service	1.4	Therapies/Management	2.2
				Other Hosted	2.5	Other Set Aside	1.6
TOTAL	**£61.6m**	**TOTAL**	**£79.3m**	**TOTAL**	**£14.9m**	**TOTAL**	**£21.7m**

Appendix 1 – Functions Delegated to East Lothian IJB

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

NHS Lothian services delegated to East Lothian IJB:

Accident and Emergency and Combined Assessment *

General Medicine *

Geriatric Medicine *

Rehabilitation Medicine *

Respiratory Medicine *

Palliative Care *

All Community Hospitals (ELCH, Edington and Belhaven)

Mental health inpatient services [3]

Community nursing (inc. children's community health services - district nursing, health visiting and school nursing)

Community mental health services

Community learning disability services

Substance Misuse Services

Allied Health Professionals

Primary Care - General Medical Services, General Dental Services, General Ophthalmic services and Community Pharmacy [1]

Lothian Unscheduled Care Service [1]

Public Dental Service [2]

Palliative care provided outwith a hospital

Psychology services [2]

Community Continence [3]

Kidney dialysis services provided outwith a hospital

Community Complex Care

Sexual Health [4]

East Lothian Council services delegated to East Lothian IJB:

Social work services for adults and older people

Services/supports for adults with physical disabilities

Services/supports for adults with learning disabilities

Day services

Mental health services

Criminal Justice Social Work

Drug and alcohol services

Adult protection and domestic abuse

Carers support services

Community care assessment teams

Care Home Services

Adult Placement Services

Housing support services: aids and adaptations

Local area coordination

Breaks from caring (respite)

Occupational therapy services

Reablement services

Telecare

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* East Lothian HSCP will work with NHS Lothian, Midlothian, West Lothian, and City of Edinburgh HSCPs to progress the Lothian Strategic Development Framework (LSDF).

º Midlothian HSCP hosts (manages) dietetics and art therapy services on behalf of all Lothian HSCPs.

[1] In mid-2018, East Lothian HSCP transferred management of Lothian Unscheduled Care Service to NHS Lothian, which manages it on behalf of the 4 HSCPs.

[2] West Lothian HSCP hosts (manages) clinical psychology, the public dental service, podiatry and orthotics on behalf of all Lothian HSCPs.

[3] Operational management of Mental Health and psychiatric rehabilitation was transferred back to NHS Lothian, with service delivery guided by Directions from IJBs.

[4] Most sexual health services are delivered in primary care. Specialist sexual and reproductive health services in Lothian are hosted by City of Edinburgh HSCP on behalf of the 4 HSCPs.

East Lothian
Integration Joint Board

SBAR – IJB Annual Performance Report 2020 – 2021

4

Date: 15th September 2022
Completed by: Claire Goodwin
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

	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

DRAFT

Contents

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.

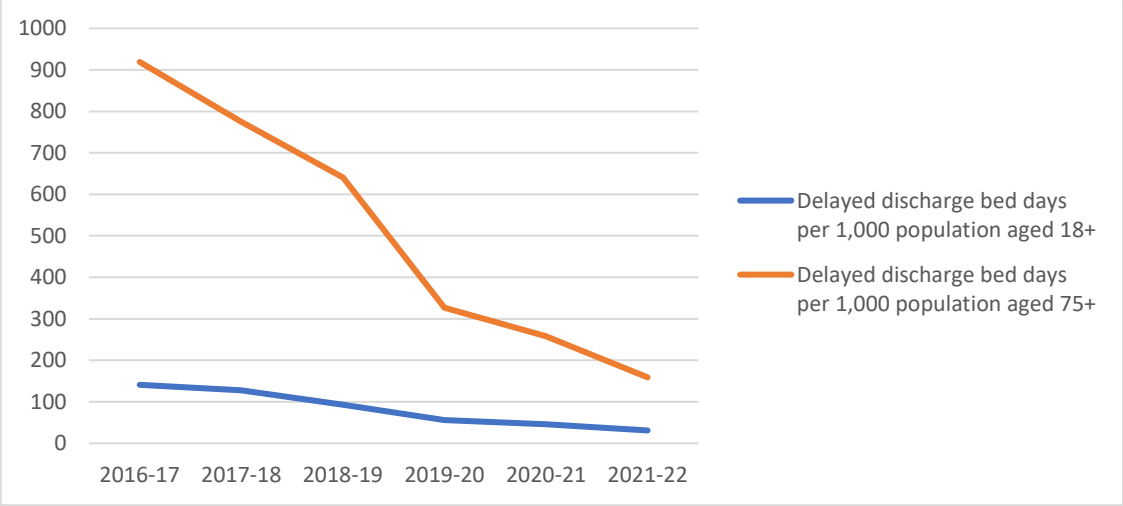
Our Discharge to Assess (D2A) service demonstrates how Allied Health Professional (AHP)[2] delivered services can contribute to reducing the length of hospital stay for patients. The D2A model prevents patients (who are clinically fit and appropriate) from having to wait for Occupational Therapy (OT) 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

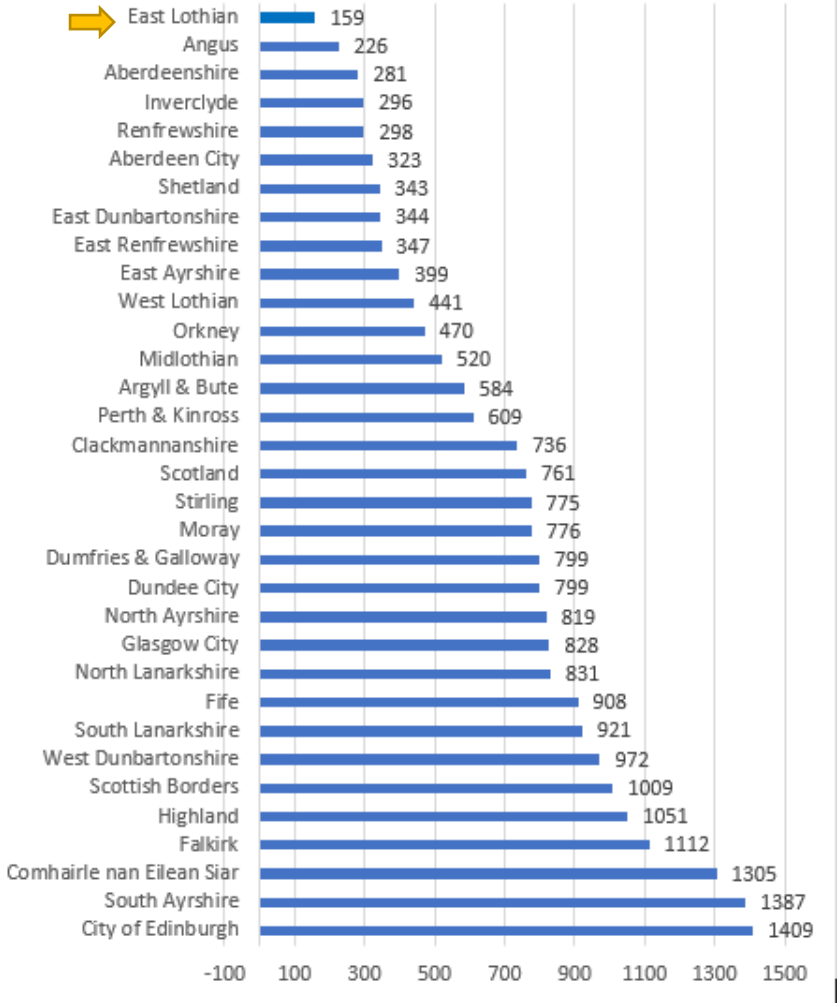
Graph 1 demonstrates an ongoing and sustained reduction in East Lothian delayed discharges since 2016, with Graph 2 showing our performance compared to HSCPs across Scotland during 2021/22.

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

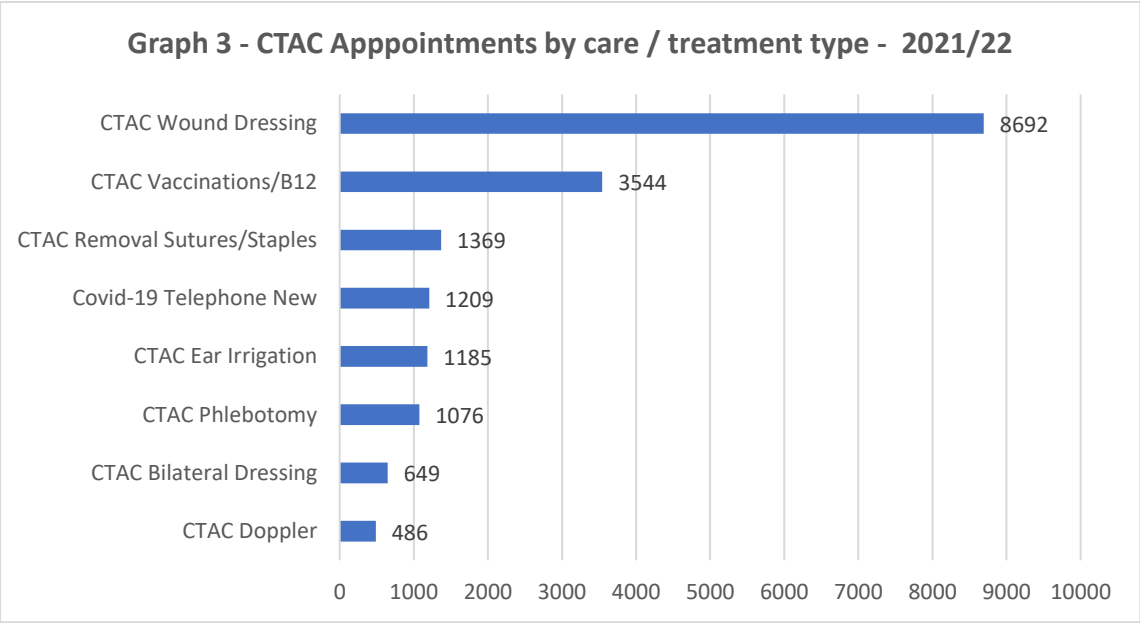
Primary Care has changed significantly in East Lothian as the HSCP has implemented the IJB Primary Care Improvement Plan. This was written in response to the 2018 General Medical services contract which moved responsibility for some services previously delivered by general practice to the HSCP.

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

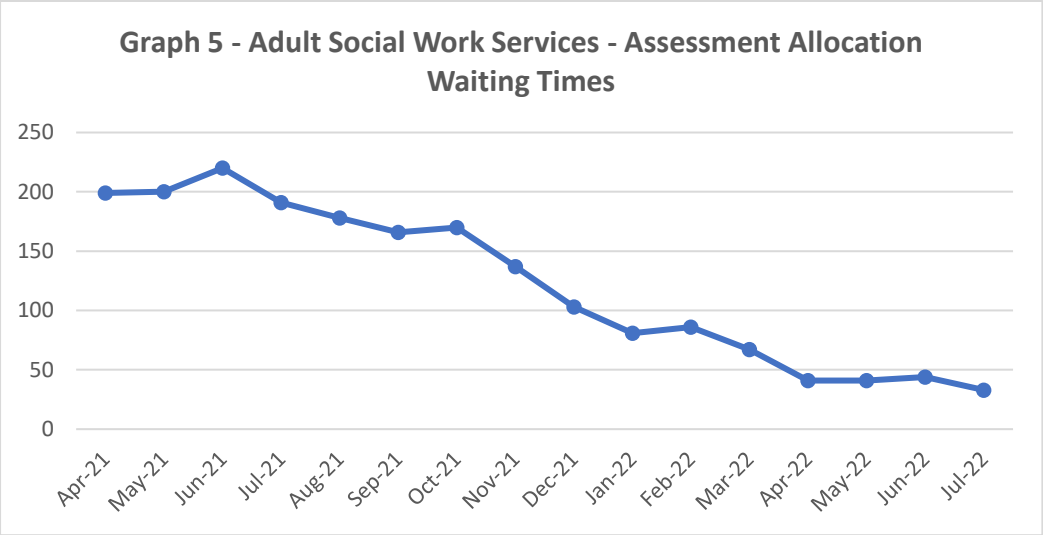
Strategic Objective 10 – 'To support change and improvement across our services'

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)

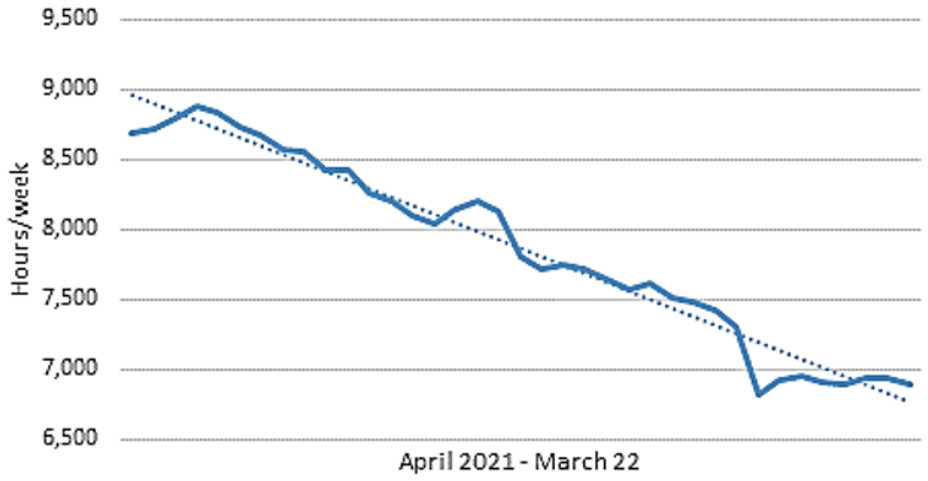
Key Challenges 2021/22 - Care at Home Delivery

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.

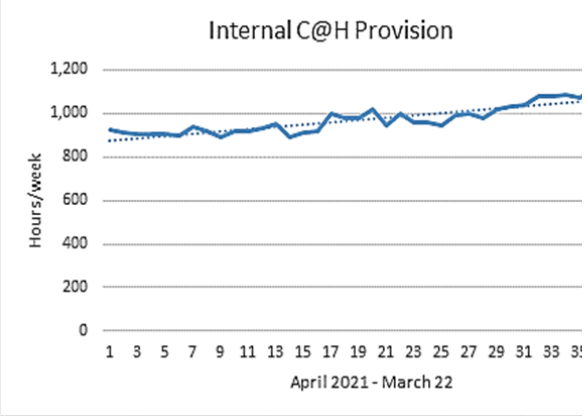
[16] Care at Home services in East Lothian are delivered by a combination of providers – this includes an ELHSCP managed service (accounting for XX% of delivery in 2021/22), along with a number of external Care at Home services delivered by independent providers (delivering the remaining XX%).

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.

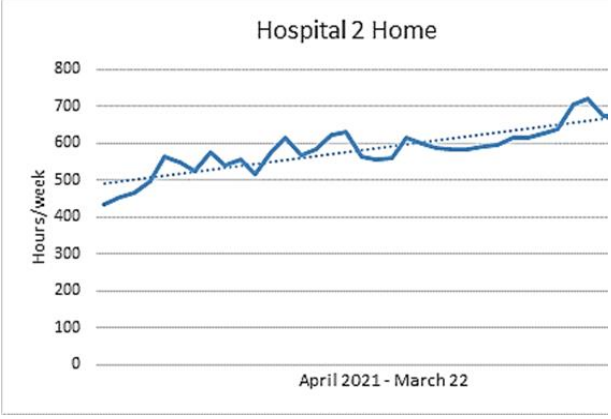
Our Response

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**	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.
East Lothian	19	19	19	23	23	22	✓	✗	
Scotland	21	22	23	23	22	22	– East Lothian performance in line with national level		

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**	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).
East Lothian	77%	85%	84%	85%	85%	77%	✗	–	
Scotland	84%	85%	82%	82%	82%	76%	– East Lothian performance around national level		

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)

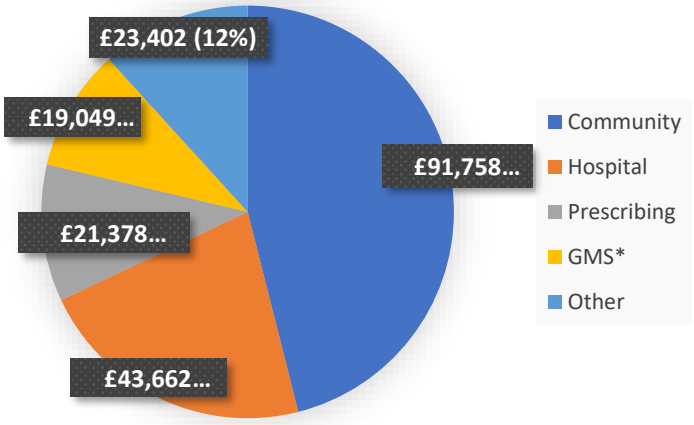


Table 6 – Where the money was spent in 2021/22 (£k)

	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.

East Lothian
Integration Joint Board

East Lothian Integration Joint Board update 15th September 2022

East Lothian Community Hospitals and Care Homes Provision Change Board

5

Date: 15th September 2022
Completed by: Fiona Wilson, Chief Officer.
Area: East Lothian Community Hospitals and Care Homes Provision Change Board SBAR report.

Situation	This SBAR provides members with an update on the progress of the East Lothian Community Hospitals and Care Homes Provision Change Board.
Background	This Change Board was established to consider the Community Hospitals and Care Homes provision throughout East Lothian and re-focus the project taking in to account current circumstances and policies. Progress has been good and we have established 3 working groups, chaired by Health and Social Care Partnership (HSCP) officers; Communication and Engagement, Capacity and Planning and Finance and Capital.
Assessment	We provided an update to the IJB meeting on 13th December 2021 and 24th March 2022. This SBAR provides a further update on the 3 working groups. **Communications and Engagement working group:** A programme of summer events is currently taking place. These have included online surveys, questionnaires, and online zoom/teams sessions. These have predominantly been online sessions with a few more recent face to face sessions being undertaken in Dunbar, North Berwick and Musselburgh. See Appendix 1 for Engagement and Communications Plan update and results from our ongoing social media campaign. The feedback and themes from this work will go to the next Community Hospitals and Care Homes Change Board in October 2022. But some of the initial feedback from the Consultation and Engagement sessions so far has told us: • People do not want to go into care homes or hospital until there is no other alternative. They want to live independently at home, with support when necessary. • Things that keep people independent are activities and social groups, access to transport (in many cases with someone to support them to use it), care packages, families and neighbours who take an interest. • Many groups are keen to develop their services for older (and younger people in an intergenerational approach) but many struggle with funding/short-term funding, the cost of living crisis, and many are finding it difficult to attract volunteers. • Issues with staff recruitment and retention and the impact of the resulting shortfall in staffing on service-users and carers was raised in every session. This is a concern for those providing health and social

	care but is a very real concern to those receiving that care and the impact that this will have on them. • Transport was also raised in almost every session. Lack of transport impacted on people's ability to access services and could lead to functional decline because people could not easily access activities and groups. This impact is being compounded by the cost of living crisis and its impact on taxi fares and fuel for day centre buses. People may also need support to use transport (e.g. getting on and getting off, and accessing the venue they are travelling to). • In a number of sessions, people raised concerns around carer fatigue, particularly in rural areas, where it was harder to get care at home and other support services. • In most sessions people felt that although there were services available, people did not know about them or know how to access services. Solutions included making information about what was available locally easily accessible to a wide range of people and having a Single Point of Contact who would be the go-to person for information about your care or that of someone you were a carer for. • In all sessions people wanted early intervention and prevention, but felt that problems with funding, knowledge about services, access and transport, coupled with concerns about the rising cost of living and affordability of social activities, presented serious problems. • Community Hubs/One-Stop-Shops were seen to be a useful part of tackling the problem with socialisation and information sharing, but it was felt that these could be community-led ventures rather than something imposed on the community. Each community is different, had different needs and requires supports tailored to its needs. • People using health and social care services and the wide range of those providing services understood the wider definition of intermediate care and agreed with the focus/model upon this area of service provision. But they were concerned how this can be developed given the staff and recruitment issues and the long term and continued investment required in this area. **Capacity and Planning working group:** A briefing paper *Capacity and Planning Working Group initial findings* was shared with the IJB on 24th March 2022. This is attached again for ease of reference at Appendix 2. Work on setting out the range of Intermediate Care services currently provided by the HSCP was presented to the Provision Change Board on 3rd August 2022. This is attached at Appendix 3 Intermediate Care Summary. This intermediate care paper highlights the key area of strategic focus and future investment for the HSPC. The paper describes what we mean by the broad term of intermediate care and shows examples of those services provided in East Lothian. There are many which emphasises why they are an important focus of our services already established within the Health and Social Care Partnership.

	Importantly, we are consulting and engaging with people across East Lothian as part of the Communications and Engagement summer engagement programme. This is helping us understand what services people liked, their own experiences of using services and what other intermediate care provision they would like to see in their communities. We are discussing these ideas and thoughts to help better understand what opportunities there are to bring together or co-locate services together (e.g. health, social care, third sector, independent sector, Voluntary). This work will form part of the basis for ongoing co-production and how we can develop these services across East Lothian reflecting the differences across the county and the local communities. The intermediate care paper shows the breadth of provision across East Lothian. We look to build on this as a key part of our IJB Strategic Plan which is currently being revised. **Finance and Capital working group**: The operational budgets for the services under consideration have been identified. The question of the support budgets for the premises used by the services delegated to the IJB has been raised with the partners. Consideration is now being given to the process for the IJB to engage with partners in the procurement of new fixed assets. Our Chief Finance officer has set up a meeting with the senior finance leads in East Lothian Council and NHS Lothian on 7th and 8th September 2022. **Summary to date: the key messages from the work of the Change Board so far is telling us:** In summary, for capacity planning the work to date so far tells us that: • We believe there are sufficient inpatient community hospital beds across East Lothian. We need to do more work as to how we better use these beds and ensure they are in the right place. Maintaining this position will remain challenging. We need to focus upon additional measures and investments in early intervention and prevention through intermediate care. • East Lothian continues to have a higher percentage of people in hospital beds in the last 6 months of life compared to the Scottish average. We need to understand why we are using a greater number of beds days than most parts of Scotland and to ensure people have the choice to die at home. • The data shows us we may need an additional 30 care home beds in East Lothian. However, there will be enough care home places in East Lothian as more are built each year by the private sector. The investment and development (or lack of) of intermediate care will impact positively or negatively on this capacity. • In East Lothian, we wish to continue and further develop our successful rehabilitation and reablement approach to Intermediate Care, with a strong ethos on early intervention and preventative services and the key focus on Home First. This should be a key focus for service

	development and links strongly to the objectives and goals of our IJB strategic plan.
Recommendations	1) To note the actions and work to date undertaken by the Change Board in relation to the 3 working groups and the production of the Intermediate Care Paper and our focus upon Home First. 2) To note the Summary to date of this work and its' key messages. 3) To note the continuing and ongoing pressure on staff as a result of the impact of Covid-19 and service impacts of Covid-19 through high levels of sickness, high vacancies, and staff self-isolating.
Further Information	N/A

East Lothian Community Hospitals & Care Homes Provision Board

Engagement Communications Plan

Audiences

As this piece of engagement is looking at the future of care provision within East Lothian, the communication campaign aims to reach a wide adult audience from age 40+ who may / or may not have previous experience of care services.

	Audience 1	Audience 2	Audience 3	Audience 4
Attributes	Aged 40-60 Little experience of care Working / have own family	Aged 60-75 Little / some experience of care Approaching or recently retired Still active in life, in their 'prime'	Mixed Age Groups Experience of care (either personally or from family member)	Stakeholder groups Care providers / third sector / GPs Community Councils Employee groups
Interest	Looking to the future – retirement years, or having to care for family members – what do they want?	Looking to the next 10-15 years, what services might they require, how find / access them?	Satisfaction levels, experiences to date. What improvements can be made?	Invested interest, looking at direction, strategy, how actions will support community
Key Messages / Hook	Picture yourself in your retirement – how can care services now help you achieve this vision. Digby Brown: "don't need us now, but when you do"	Retirement and beyond … what do you want to enjoy? what care services might you require? what might they look like?	Share your care experiences - we're planning for the future. What can we do to improve care services in the future?	Share your care experiences - we're planning for the future. What can we do to improve care services in the future and in doing so benefit the community as a whole?
Comms Medium	- Social Media Networks & Influencers - Animation / Video - Links to survey - Public places – Supermarkets / Gyms / Schools	- Social Media Networks & Influencers - Animation / Video - Links to survey - Press Release / Courier Feature - Local Radio Stations - Public venues	- Social Media (limited) - Workshops / Events - Focus Groups - Direct contact – in person - Day Centres / Care Homes - Existing users of services - Handing out surveys - Newsletters	- Social Media (limited) - Workshops / Events - Focus Groups - Direct contact – in person - Handing out surveys - Newsletters - Organised meetings - Training sessions

East Lothian Community Hospitals & Care Homes Provision Board

Engagement Communications Plan

Media	- Social Media Video - Social Media Tiles - Posters with link to Survey - Pull Up Banners, to be rotated around ELC Public Places	- Social Media Video - Social Media Tiles - Posters with link to Survey - Pull Up Banners, to be rotated around ELC Public Places	- Events / Focus Groups - Invitations - E-newsletters - Printed Surveys - Workshop Presentation	- Events / Focus Groups - Invitations - E-newsletters - Printed Surveys - Workshop Presentation

Promotional Videos:

- Audience 1 Aged 35-55: https://youtu.be/IyvDlncCSzQ Audience 2 55-75: https://youtu.be/2sjHISRoebg

Social media tiles

Pull Up Banners

Social Media Results to Date

PAID ADVERTISING:

Date Range	Post Details	Reach	Post Engagement	3-sec play	Link Clicks	Link Click v Reach % Return
7th – 31st July		1216	1025	943	78	**6%**
7th – 31st July		2082	1348	1234	112	**5%**
8th – 22nd Aug		4331	98	n/a	70	**2%**
TOTALS		**7629**	**2471**	**2177**	**260**	**3.4%**

Defined target audience: Age | Location | Budget set at £1 spend per day on advertising

East Lothian Community Hospitals & Care Homes Provision Board

Engagement Communications Plan

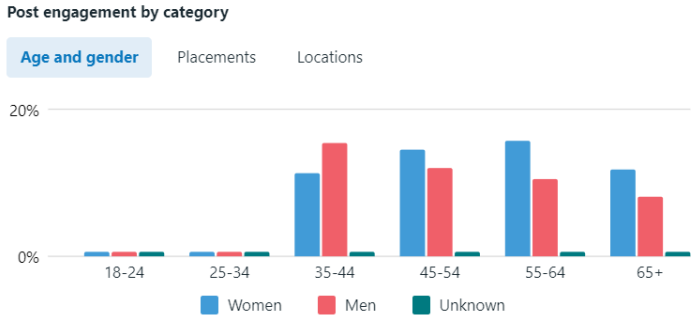
ORGANIC POSTS

Date of Post	Time	Image / Visual	Social Media	Reach	Engagement	Reactions	Comments	Shares
18th July	19:00	Gran, Grandad & Granddaughter	FB	2357	27	3		1
26th July	11:00	Man in chair with son	FB	1885	27	3	1	10
11th July	19:04	Bridge to Nowhere	FB	866	20	4		3
21st July	19:00	Musselburgh High Street	FB	636	25	3		
21st July	19:06	Video Younger Audience	FB	560	61	4	2	2
14th July	19:06	Dunbar Harbour	FB	525	4	1		
28th July	19:04	Dunbar Bridge to Nowhere	FB	443	5			
11th July	19:04	Bridge to Nowhere	Instagram	62		1	1	
14th July	19:06	Dunbar Harbour	Instagram	39		1		
26th July	11:00	Man in chair with son	Instagram	30		1		
28th July	19:04	Dunbar Bridge to Nowhere	Instagram	29		2		
18th July	19:01	Gran, Grandad & Granddaughter	Instagram	27	-	1		
29th Aug	19:00	Gran, Grandad & Granddaughter	FB	597	1			
2nd Sept	19:05	Bridge to Nowhere	FB	583		1		
25th Aug	20:00	Gran, Daughter, Granddaughter	FB	571	1			
2nd Sept	19:05	Bridge to Nowhere	Instagram	34				
25th Aug	19:00	Gran, Daughter, Granddaughter	Instagram	33	2			
29th Aug	19:00	Gran, Grandad & Granddaughter	Instagram	20				
Total				**9297**	**173**	**25**	**4**	**16**

Most popular posts

Demographics

Audience	Women	Men
35-44	29.9%	24.70%
45-54	27.5%	19.4%
55-64	33.6%	21.9%
65+	27.2%	17.3%



East Lothian Community Hospitals & Care Homes Provision Board

Engagement Communications Plan

Engagement Events

Events created on ELHSCP Facebook Page and shared to the following Groups

EVENT POST LISTINGS

3rd Aug	**FB**	**Event Post Eastern Communities Online Event – 11th Aug**		**Reach: 3391**
Post shared to: *Dunbar & East Linton Area Partnership | Dunbar Chatbox | The New Heart of Dunbar | What's on in Dunbar & Surrounding Areas | Dunbar Events | East Linton Online | West Barns. A Village Life | Our Community Kitchen | North Berwick News & Views | Gullane News Group | Haddington Online | West Barns Community Council | Haddington Community Council*				
3rd Aug	**15:50**	**Event Post Western Communities Online Event – 18th Aug**		**Reach: 6017**
Post shared to: *Cockenzie and Port Seton People | Whitecraig Folks | Wallyford, Whitecraig & Wimpey Residents Forums | Pans Folk | Muss Folk | Tranent Folks | Pancakeland People | Macmerry Folks | Ormi Folks*				
8th Aug	**3:59**	**Event Post – Carers Event – 25th Aug**		**Reach: 2587**
Post shared to: Carers of East Lothian				
8th Aug	**3:42**	**Event Post – Dunbar – 5th Sept**		**Reach: 1136**
Post shared to: *Dunbar & East Linton Area Partnership | Dunbar Chatbox | The New Heart of Dunbar | What's on in Dunbar & Surrounding Areas | Dunbar Events | East Linton Online | West Barns. A Village Life*				
8th Aug	**3:46**	**Event Post – Musselburgh – 5th Sept**		**Reach: 963**
Post shared to: *Whitecraig Folks | Wallyford, Whitecraig & Wimpey Residents Forums | Muss Folk |*				
8th Aug	**3:53**	**Event Post – North Berwick – 5th Sep**		**Reach: 243**
Post shared to: *North Berwick News & Views | Gullane News Group*				

East Lothian Community Hospitals & Care Homes Provision Board
Engagement Communications Plan

Pull Up Banners Locations

Friday 5th – Friday 19th August:

					
Musselburgh Primary Care Centre	**Brunton Hall, Musselburgh**	**Fraser Centre, Tranent**	**Loch Centre, Tranent**	**Port Seton Community Centre**	**John Muir House Reception, Haddington**

Friday 19th August -

					
Dunbar Leisure Pool	**Bleachingfield Centre, Dunbar**	**North Berwick Sports Centre**	**Aubigny Sports Centre, Haddington**	**East Lothian Community Hospital**	**John Muir House Reception, Haddington**

Capacity and Planning Working Group initial findings (IJB)

March 2022

Introduction

This paper provides a high level, brief summary of the work and thinking to date from the capacity planning group. It does not provide firm recommendations. The findings will be further developed over the next few months and we will provide a further update to the June 2022 Change Board.

We wish to be able to present and discuss what we have gathered and use this to listen and collect thoughts, views, ideas and other thinking from all our stakeholders on how together with East Lothian residents we can plan ahead for this provision in the future.

We are attempting to highlight the parameters and environment within which we should plan future developments. Set out below is the summary of the position to date. The Change Board Capacity subgroup was originally tasked to review three areas of service provision identified below and set likely parameters to help frame future provisioning discussions. These were:

1. **Inpatient** capacity within ELHSCP – all community hospitals
2. **Care Home** capacity – Private and ELHSCP operated
3. **Intermediate care** capacity

A further update was provided in November 2021 noting:

1. There was unlikely to be any requirement to go beyond current inpatient capacity over the short to medium term.
2. There would likely be no requirement to expand HSCP operated care home capacity beyond what is currently available[1].
3. That further work on capacity modelling will require wider engagement with communities and stakeholders. This was agreed to be progressed after June 2022.

Following the November 2021 Change Board, the Capacity subgroup has concentrated on developing a clearer understanding of:

1. The extent to which existing beds support patient flow within the system.
2. How existing beds levels can contribute to improvements in care quality and patient experience.
3. Whether location of beds impacts the ability to provide more equitable access for East Lothian residents.
4. The impact of third party or external factors on future available capacity including increased referrals from out of area and planned private care homes failing to materialise.
5. What might the capital requirements be for potential future investments in East Lothian Health and Social Care. See below for wider HSCP Property Considerations.

The role housing will play in supporting future health provision is currently unknown but housing colleagues have confirmed the following timescales to update the Joint Strategic Needs Assessment (JSNA) and finalise the Local Housing Strategy (LHS). The development of the JSNA is underway with draft completion by winter 2022/23, followed by consultation and an expected finalised LHS in August 2023.

[1] Available beds refers to current levels of Care Inspectorate Registrations. The current Registration figure is higher than the capacity that can actually be used. The most recent Registration figure does not take account of ten un-commissioned beds within Crookston.

Initial findings from the Capacity sub group were presented and discussed at the Change Board on 3rd March 2022. The summary of these are:

Hospital Beds - initial findings

The review of data indicates that hospital beds are being managed effectively and there is currently sufficient capacity in the system for the foreseeable future. There is unlikely to be a requirement for additional Hospital beds in the medium to long term.

Care Home Beds - initial findings

Scenario testing the 80+ and 83+ demographic supports the initial findings that the potential development of capacity for care home beds in East Lothian may be up to a maximum of 70 replacement beds and potentially 30 new beds. It is important to note that we must consider external provision, intermediate care, capital expenditure options and different models of care and ways to deliver care, together as we work with the public to develop this vision.

Intermediate Care Capacity

Work is taking place with Health Improvement Scotland (HIS) to look at intermediate care models in East Lothian and the rest of the country considering alternative models being developed elsewhere and what we might learn from these. This work will help form part of the consultation and engagement discussions throughout the summer. We wish to gather ideas, input thoughts and views on what intermediate care models people across East Lothian currently like or would wish to see being developed in their local areas and what new or innovative ways we can look to provide health and care services across East Lothian.

Wider HSCP Property Considerations

In undertaking the capacity work we need to consider other potential property and capital developments that may take precedence over recommendations that are ultimately made by the Change Board. Identified future HSCP premises requirements that may need to be prioritised and considered over the medium to long term include:

1. New or replacement Primary Care Premises
2. Additional and Complex Needs accommodation
3. Dementia friendly Housing
4. Replacement Care Home Bed provision

Any proposed funding of these projects would require to go through further capital planning evaluation and process. We must also note that the potential requirements would also be competing with similar requirements from other HSPCs across Lothian and Scotland.

Intermediate Care Report Summary

For The Provision Change Board

East Lothian
Health & Social Care Partnership

Contents

Background

This paper provides a summary position on the intermediate care work stream of the Capacity and Planning working group, chaired by Iain Gorman, Head of Operations. This working group was formed to support the Community Hospitals and Care Homes Provision Change Board.

It explains what intermediate care is and what services we already have in East Lothian. Intermediate care has a wide definition of use. It is not new. Many areas have provided these services for many years including East Lothian.

The intermediate care services in East Lothian have helped contributed towards us having the lowest proportion of delayed discharges compared to other local health and social care partnerships. The investment in these in previous years has been beneficial over longer term. We believe intermediate care is one of the best investment opportunities for the partnership now and in future years.

					Age			
Local authority of residence[1]	Total Population (June 2020)	Delayed discharge bed days 2020/21	Delayed discharge as % of total population	Average daily number of beds occupied 2020/21	Delayed discharge bed days 2020/21: ages 18 to 74	% of total	Delayed discharge bed days 2020/21: age 75+	% of total
City of Edinburgh	527620	32798	6.22%	90	11683	36%	21115	64%
East Lothian	107900	3935	3.65%	11	1346	34%	2589	66%
Midlothian	93150	7150	7.68%	20	2157	30%	4993	70%
Scottish Borders	115240	10217	8.87%	28	2634	26%	7583	74%
West Lothian	183820	7381	4.02%	20	2689	36%	4692	64%

Source: All data sourced from Public Health Scotland (2020/21) Scottish Care Home Census 2021

Strategic Direction

The East Lothian **IJB Strategic plan**[1] commitment is to support people closer to home, in their own home or in a homely setting. This will be achieved through a number of measures resulting from re-modelling services as well as the services we commission. The development of intermediate care services is a key strand of this objective.

Health and Social Care Delivery Plan 2016 Scottish Governments delivery plan[2] sets out the framework and actions needed to ensure that our health and social care services are fit to meet

[1] 2019-2022 East Lothian IJB Strategic Plan (currently being updated)
[2] Scottish Government: Health and Social Care Delivery Plan (Dec 2016)

requirements. The plan links to our focus for intermediate care and Home First approach and to "*ensure people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission*".

More recently the Scottish Governments **Older People's Health and Social Care statement of intent**[3] set out the approach (a new national strategy) to older people's health and social care in Scotland, taking account of Covid on older people and whom were affected worse by the virus. This work has the basis of Building on the **Foundation of the A Fairer Scotland for Older People**[4], which envisions everyone being able to live independently, driving the decisions about their own health and wellbeing.

Living independently, living in their own homes is a theme appearing across many national policies and in the original Shifting the Balance of Care[5] strategy direction by rebalancing the model of care from bed base to community provision.

"We want older people in Scotland to enjoy full and positive lives in homes that meet their needs" is a goal of the ***Age, Home and Community in 2018 (revised from 2011)*[6].**

This will take a person centred approach to achieving the aim of older people enjoying full and positive lives, in a home that meets their needs. This allows individuals to have their say about what they want from their home; the size, location, community, technology, access to transport and the many individual requests that make their home ideal for them.

The ***Older People's Health and Social Care statement of intent*** (2021) focuses upon 4 areas to support its vision.

1. **Prevention**: Staying physically and mentally active can make people more resilient as they age, reducing risks of dementia, widening social circles and helping prevent falls.
2. **Home First**: approach to ensure we deliver care and treatment in peoples own homes and local communities.
3. **Integrated health and social care**: Supporting people to age well and live well requires a multidisciplinary or even multiagency response.
4. **Dignity and respect at end of Life**: When people require end of life care, they must have access to high quality care, focussing on the physical, social, psychological and spiritual dimensions of care.

Enabling this is the way we develop and deliver our integrated health and social care services to support people to live well and independently in their own communities. The Independent Review of Adult Social Care[7] and the development of the National Care Service will influence the way in which services can be developed.

[3] 2021 Scottish Government Older People's Health and Social Care statement of intent
[4] 2019 Scottish Government
[5] 2009 Improving outcomes by Shifting the Balance of care Shifting the Balance of care delivery group
[6] 2018 Age, Home and Community: next phase
[7] 2021 Independent Review of Adult Social Care in Scotland (*sometimes short hand as The Feeley Report*)

The work we are doing within the Provision Change Board and in our future actions and objectives around intermediate care supports the direction of the Scottish Governments Older Peoples statement of intent.

This paper is not providing specific recommendations. It is produced to help support the communication and engagement sessions and wider discussions over the summer period to have discussions with the public and to gather their thoughts, views, challenges, ideas or proposals on how we can develop further the intermediate care provision across East Lothian. And in the next stage of this work with local areas, residents, local groups to develop these models and provision across the County.

What is Intermediate Care?

What is Intermediate Care.

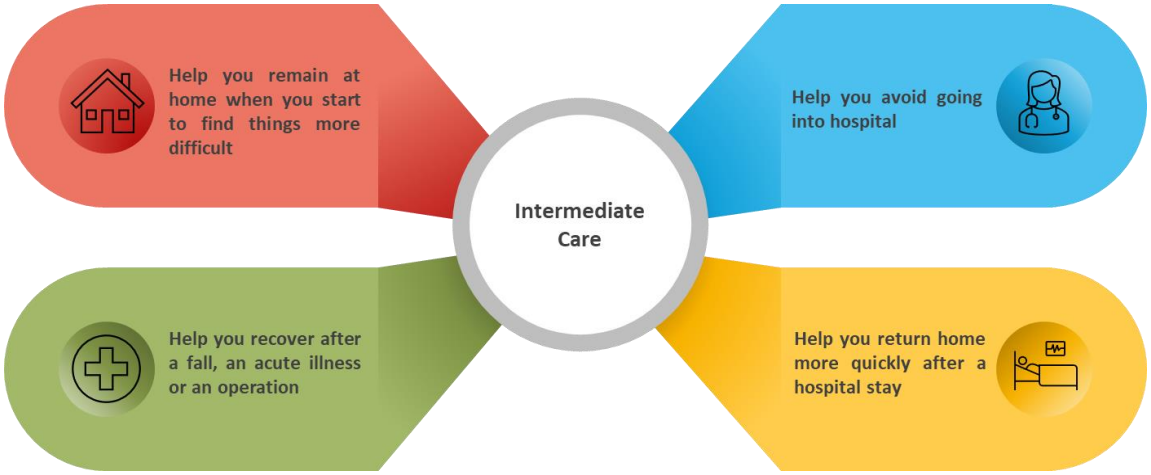
There are many definitions used. At its simplest, intermediate care services are those health and social care services that prevent people needing to go in to hospital or getting them home from hospital more quickly. Home First, reablement, rehabilitation and intermediate care are terms we also use and they all represent different aspects of intermediate care.

The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system – community services, hospitals, GP's, and social care.

The Scottish Governments *National Intermediate Care Framework* document (2012)[8] describes it as "maximising recovery and promoting independence".

The National Institute for Health and Care Excellence suggest "Intermediate care services help people recover, regain independence and remain at home." (NICE[9]) and show in diagram 1.

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



This definition links clearly to our Home First approach and the goals of, people being cared for at home (or as close to home as possible). Secondly, preventing avoidable admissions to hospital and thirdly, where hospital admission is necessary, Home First seeks to support timely discharge.

[8] 2012 Scottish Government Maximising Recovery, Promoting Independence: an intermediate care framework for Scotland.
[9] 2018 National Institute for Health and Care Excellence

What type of services are intermediate care.
Intermediate Care encompasses a range of functions which focus on **prevention**, **rehabilitation**, **reablement** and **recovery**, depending on the needs of the individual. These may be provided through Bed based services (in our community hospitals and care homes), Community based services (providing assessment and intervention in peoples own homes, Crisis response (such as Emergency Care and Falls services), and reablement and rehabilitation (e.g. Hospital to Home and East Lothian Rehabilitation service).

How is intermediate care delivered.
A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care will depend on a person's needs at that time.

What are the aims of intermediate care.
There are three main aims of intermediate care and they are to: -

1. Help people avoid going into hospital unnecessarily.
2. Help people be as independent as possible after a stay in hospital; and
3. Prevent people from having to move into a care home until they really need to.

We need it to prevent unnecessary acute hospital admission, help support quick and appropriate discharge. It promotes faster recovery from illness and support anticipatory care planning and helping people to self-manage their long term conditions.

It is clear the key demographic changes taking place in Scotland and East Lothian.

- Over 65yrs population - increases by 63% by 2035
- Over 75yrs population - increases by 82% by 2035
- Over 85yrs population - increases by 147% by 2035

In East Lothian[10]:

Age Group	2020-2030	% change	2020-2043	% change
0 to 14	-693	-3.8%	-474	-2.6%
15 to 24	1,156	10.5%	432	3.9%
25 to 44	1,954	7.9%	1,458	5.9%
45 to 64	-1,338	-4.3%	2,204	7.1%
65 to 74	3,118	25.8%	2,303	19.0%
75 to 84	2,397	32.7%	5,846	79.8%
85+	741	28.2%	2,540	96.8%
Total	7,335	6.8%	14,309	13.3%

[10] Source: NRS 2018 based principal population projections for Council areas

The health and social care system faces major challenges, ever tighter budgets, rising demand, increasing and inflationary costs. Levels of hospital activity have also continued to rise over recent years. The impact of Covid-19 continues and will do for a considerable period. These pressures will be intensified by demography shown above.

The work to date indicates that we do not require additional community hospital bed capacity in the short to medium term in East Lothian but we will need to continue to monitor this. Care Home beds require replacement due to the fabric and condition of some of the HSCP-owned stock. Developing intermediate care will be a key focus.

Key variations between different parts of the country showed[11] :

- Emergency hospital admissions of people aged 75 and over varies
- Hospital admission of people aged 75 and over from residential care/ nursing homes varies 604-fold
- Admissions to residential care and nursing home of people funded by councils varies six-fold
- The number of people still at home 91 days after being discharged from hospital to a reablement/rehabilitation service varies nine-fold.

The National Audit of Intermediate care (2015) highlighted that Reablement capacity was actually falling – despite increasing evidence of its effectiveness – and waiting times for intermediate care are rising. We know this locally with the need to identify capacity, staffing and resource to provide additional packages of care and reablement care, occupational and physiotherapy in the community.

Evidence shows that well-designed intermediate care can[12]:

- improve people's outcomes and levels of satisfaction
- reduce admissions to hospital and long term social care services
- reduce delayed discharges.

The national audit of intermediate care also **noted positive outcomes** from the use of intermediate care provision:

92% of people who used home-based or reablement services maintained or improved their dependency score (a measure of the help they need with activities of daily living).

93% of people who used bed based services maintained or improved their dependency score.

70% of people who received intermediate care following a hospital stay, were able to return to their own home.

[11] 2015 National Audit of Intermediate Care Summary Report (England)
[12] 2015 National Audit of Intermediate Care Summary Report

72% of people did not move to a more dependent care setting.

88% of people using health based intermediate care services meet their goals (wholly or partially).

90% of people said they were treated with dignity and respect.

These are positive patient outcomes from the use of intermediate care provision.

Intermediate Care services in East Lothian

Intermediate Care services in East Lothian

Set out below are a list of some of the Intermediate care services that we have in East Lothian, with a description of what they do and what their goal is.

East Lothian Rehabilitation services (ELRS)

Intermediate Care provides intensive short-term interventions that are goal and outcome focused. The professionals have a strong rehabilitation ethos, are positive risk takers and work collaboratively with patients and citizens to agree person-centered goals.
The East Lothian Rehabilitation Service (ELRS) already provide many services which fit within this model of care and are well suited to develop to further provide Intermediate Care within the East Lothian Health and Social Care Partnership (ELHSCP).

Community Advanced Physiotherapy Practitioner

The role of the Community Advanced Physiotherapy Practitioner (APP) was established within ELRS in March 2020 with the remit of developing a pathway for the management of patients with Long Term conditions in East Lothian.

Shortly after this, the emergence of COVID shifted the primary focus of the team to the establishment of a Respiratory Pathway within East Lothian, supporting the pan-Lothian response to COVID and the management of high-risk chronic respiratory patients.

Within the 3 geographical clusters (based in Dunbar, Haddington, and Musselburgh) the APPs provide highly specialist assessment and intervention, including nebuliser trials and oxygen weans and liaise closely with both Primary and Secondary care to optimise the patient pathway and clinical care. In contrast to traditional Community Respiratory Teams, input from the APP's is open to patients with all long-term respiratory conditions. Referrals are received from the acute for supported discharges' and optimisation of current care/self-management. Additionally, referrals are accepted from GP's for Prevention of Admissions (POA) Admission's, self-management support and long COVID input. Individuals seen by APPs are able to directly self-refer into the service at any time in the future should their condition change or deteriorate.

The APPs are an essential role within an Intermediate Care model to provide specialist community input and support this patient group to avoid unnecessary hospital admissions and maintain optimum physical and mental wellbeing

Community Advanced Practice Occupational Therapist (APOT)
The role of the Community Advanced Practice Occupational Therapist (APOT) was established within ELRS as a test of change in July 2021 for 1 year, to develop a pathway of early intervention for those with long term conditions. Given the rising ageing population in East Lothian, the decision was made to focus on those considered 'frail' displaying multiple co-morbidities. Reflecting the interface with primary care, the pathway was developed in collaboration with a GP in Dunbar Medical Practice, tested and rolled out across our east cluster. This includes 6 GP practices: 3 in Dunbar, East Linton, Gullane and North Berwick.

With the backdrop of wider service pressures on capacity, this post holder has also been utilised to respond to core cluster work of Discharge to Assess (D2A), Hospital@Home (H@H) and Prevention of Admission (POA) referrals, significantly reducing time available to work with the GP practices on the new pathway. There has also been an urgent need to address the increasing number of referrals taken from the SafeHome OT pathway from A&E. With the broader Occupational Therapy and Physiotherapy community clusters struggling to respond jointly, the decision was taken to utilise the advanced clinical reasoning and decision-making skills of the APOT. This has had the positive impact of saving clinical hours within the cluster.

Alongside establishing this pathway with the frail population, the need to address post-COVID referrals within ELRS became evident. The APOT resource has therefore also been utilised to triage, assess, and provide intervention to post-COVID referrals.

The development of the APOTs is important within an Intermediate Care model to provide specialist community input and support to this patient group to avoid unnecessary hospital admissions, support early discharge including from A&E and to maintain optimum physical and mental wellbeing of this patient group.

Community Physiotherapy and Occupational Therapy team
The Community Physiotherapy and Occupational Therapy team support several unscheduled care pathways including Discharge to Assess (D2A), Hospital@Home (H@H) and Prevention of Admission (POA).

- Discharge to assess: Appropriate for patients with ongoing therapy assessment and rehabilitation needs to facilitate timely discharge from hospital. Assessment takes place on day of discharge or following day as agreed between referrer and accepting clinician.
- Prevention of admission: Suitable for patients in the community with an acute decline in mobility and function, requiring urgent assessment of transfers and mobility, where equipment provision and support in accessing emergency care (as required) could prevent a hospital admission. These patients should have had a medical review within 24hrs of referral to rule out new medical issues that require attention

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

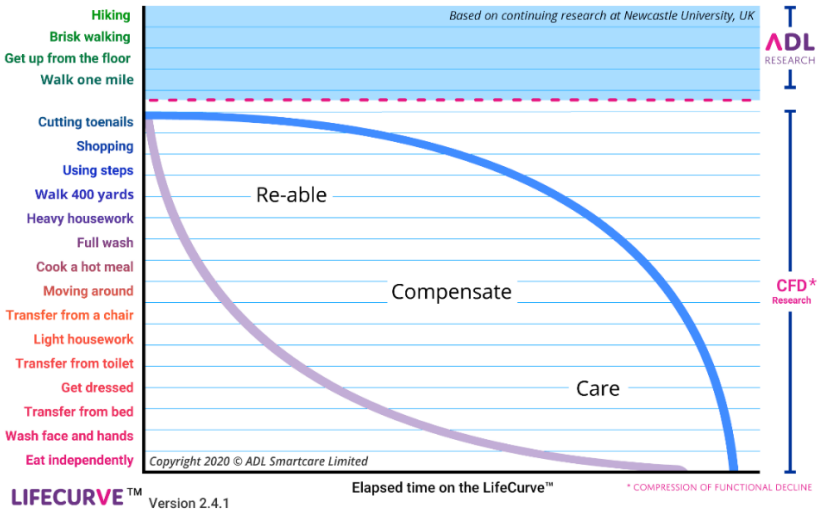
This team already provides the key elements of Intermediate Care and furthermore completed a successful Test of Change in 2021 looking at enhanced D2A model to provide rehabilitation focused short term care. The project was able to evidence a saving of an average of 11 days per patient with subsequent cost saving of £3,300. In addition, 68% of patients during the Test of Change had a reduction in their care package on completion on their rehabilitation.

East Lothian Rehabilitation service Digital platform

In March 2022 ELRS launched a new digital platform ***Access to a Better Life in East Lothian*** https://abetterlife.eastlothian.gov.uk. It provides information and tools to support people to manage their own health and wellbeing, and to be a resource if they care for others. The new platform provides a one stop access point for information on the LifeCurve, support on self-management and how to contact and refer into the ELRS. The platform is interactive with an interactive Body Map and Smart House.

The **LifeCurve model** below shows the paths that may happen for an individual and how with reablement, rehabilitation or other support this trajectory could be changed more positively**.** Research shows that if people can act early, they can have the greatest impact on their ageing journey. Most people will start to lose the ability to carry out some daily tasks and if people are able to keep their abilities for the longest possible time at the early stages in this decline, they will have the best ageing journey.

The most recent ADL INSIGHTS report shows encouraging progress on the development of the digital platform and a report is attached for reference. It covers the period February 2021 – to February 2022 with the latest platform being launched in March 2022.



ELRS has identified the following LifeCurve Insight Projects:

1. Enhanced Discharge to Assess – Completed
2. Pain Management
3. Frailty – APOT
4. Leisure Services in collaboration with Enjoy Leisure
5. Falls Pathway
6. Online Rehabilitation Platform
7. Volunteer Centre of East Lothian
8. Community Care Worker led early intervention and supported self-management clinics
9. Digital platform development

The digital platform is an important element of an Intermediate Care model to ensure individuals access the right support at the right time to promote early intervention and self-management and subsequently optimum aging. It also helps East Lothian HSCP receive direct feedback on what is important to people who have accessed the platform.

East Lothian Community Occupational therapy

The Community Occupational Therapy team in East Lothian provide a wide range of interventions. There is a *Single Point of Contact Telephone Service* where professionals, clients or carers can telephone to seek advice on solutions or discuss requesting Occupational Therapy intervention. An *assets-based approach* is utilised at this first point of contact to determine whether some people can self-manage and look at opportunities to improve function through exercise programmes, signpost to the *Access to a Better Life in East Lothian* website or self-purchase equipment which may meet their needs. Once these options have been explored if a person needs an assessment, the person

will be prioritised and either allocate immediately to an Occupational Therapist or placed on the waiting list for assessment.

The Person Environment Occupation Performance Model (PEOP) is utilised during assessment which allows assessment of how a person's Occupational Performance is shaped by interactions between the person, environment, and occupation. Following this assessment, the team discuss solutions and opportunities to the areas of need identified. These will initially be in the form of rehabilitation and equipment to stabilise a situation if this is needed. Should a person still be unable to manage their Occupational performance tasks longer term equipment and adaptations to keep them as independent as possible will be pursued.

At this point the team will transfer a persons' Occupational Therapy needs onto the Occupational Therapy specialist services to look at design aspects of their environment, identify higher spec equipment needs e.g. postural management and enhanced Moving and handling tasks for those further down the LifeCurve with no rehabilitation potential.

The East Lothian Council Community Occupational Therapy team provide essential interventions within an Intermediate Care model to provide specialist assessment and interventions to support people to live independently at home for longer

East Lothian Council Community Occupational Therapy Complex Cases and Adaptations
The Complex Cases and Adaptations part of the Community Occupational Therapy service was established in June 2021. The service areas comprise: major adaptations to owner occupied properties; complex cases and equipment; children's equipment and adaptations; Access Officer (Occupational Therapist in Education); statutory reviews and assessments in care homes, and care assessment and reviews.

Although most of these roles were previously met by Community Occupational Therapists, it was recognised that some areas of assessment and provision are specialist and complex and if these tasks are not carried out regularly within case working, that the time taken to complete tasks is considerably greater. Therefore, to have a team with specialist knowledge for those accessing assistance and colleagues who may need support in any of the areas highlighted would be beneficial.

Most recently, the team has been able to support the assessment of moving and handling in response to the care crisis. Three Occupational Therapists are now in post to complete functional assessments, particularly in relation to whether rehab can achieve improvement and if not, to provide an observed assessment of functional ability to make accurate recommendations for care.

Several of the team have recently completed moving and handling **train the trainer** training which means staff can train informal carers in moving and handling tasks when appropriate. This is of particular benefit if there are gaps in care that can be bridged by family members.

The service is also developing links with the tissue viability service and the care home teams to complete joint training and assessment to improve the outcomes of some of the most vulnerable in our community.

By enabling properties to be adapted and providing specialist advice and intervention in terms of moving and handling and postural management, this enables people to remain at home for longer in line with the Intermediate Care model.

Falls

Pre COVID, East Lothian Rehabilitation Service ran a falls prevention programme entitled 'Steady On.' This mainly took the form of a 12-week programme of Otago Strength and Balance classes, with an additional education component. Patients who had had a fall, were identified as at risk of falling or had a fear of falling were eligible for referral into the service. Unfortunately, due to the COVID pandemic in March 2020, all 'Steady On' programmes were discontinued. Initially any patients who were in the middle of a programme were supported remotely where possible, via telephone consultations and posted resources/signposted to online resources.

With regards to falls in general, there has been significant work into the area of Falls Prevention and Management in Scotland[13], with well published National Guidelines and Frameworks, and the requirement that falls are now a National indicator that every Health and Social Care Partnership must report on annually. Following a review of falls East Lothian wide, it was acknowledged that an integrated Falls Pathway was absent. As a result, a Falls Project Manager post was created, with the remit of completing an extensive mapping of all falls services currently provided across East Lothian and producing a detailed recommendation report on the development of a falls framework and pathway for East Lothian Health & Social Care Partnership. This was completed in May 2022. The paper was ratified and approved by ELHSCP Transformation Board: TEC, and is due to be taken to ELHSCP Strategic Planning Group in October 2022.and Social Care Partnership.

Inpatient Occupational (OT) and Physiotherapy (PT)

The Occupational Therapy and Physiotherapy service provides assessment and intervention to 88 inpatient beds over 4 wards at ELCH; wards 3 and 4 which are predominately assessment and rehabilitation wards and wards 5 and 6 have a step-down remit. Wards 5 and 6 were established on an interim basis due to covid-19 and in due course this additional capacity will retract back to wards 1-4 being available.

Therapy intervention is predominately one to one, with additional therapeutic groups provided as required including a Breakfast Group, Exercise Group and Destination Home Group. Group provision has been limited due to COVID restrictions and limited staff capacity. The patient cohort covered is over 65's and includes Medicine of the Elderly, stroke, orthopaedics and general medical patients. Therapy staff provide a rehab focused approach to all interventions and are a key part of successful discharge planning, including provision of equipment, Technology Enabled Care (TEC), assess for care and onward referral for ongoing input in the community.

Current patient cohorts have changed in profile over the last 3 years and have become more complex with higher clinical/care needs and multifaceted causes. Our developing pathways have

[13] 2019 Falls and Fracture Prevention Strategy for Scotland, 2019-2024, 2014 The Prevention and Management of Falls in the Community

enabled more straight-forward patients to be discharged directly from the acute into community care, without a requirement for hospital-based rehab.

Mental Health provision

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 Lothian including Inpatient, Outpatient, Domiciliary and Exercise Therapy Groups. The team uses physical approaches 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. A person centred approach is used, with the best available scientific and clinical evidence followed. Treatment options provided include rehabilitation, exercise provision and support, promotion of functional movement and health promotion.

Musculoskeletal (MSK) Physiotherapy including Advanced Practice Physiotherapy and Exercises Specialists

The Musculoskeletal Physiotherapy Service provide several work streams including the MSK Advice Line, which allows timely access to physiotherapy assessment and intervention. Staffed by a team of Advanced Physiotherapy Practitioners (APPs) an individual will receive a call within two working days of contacting the service to allow for early identification of any sign's serious pathology, offer brief assessment, and advice. The APP can then organise any follow up required in a timescale appropriate for the complaint the individual is presenting with.

The core MSK team deliver 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 e.g. early fall presentations being seen in MSK services with an injury as a result of a fall.

Exercise Specialists are a vital part of this team helping support individuals into longer term management plans and to self-manage within community settings such as local gyms.

The MSK service is an important part of an Intermediate Care model, to optimise early and effective rehabilitation and support self-management of conditions.

This service was established as an interim at Edington Hospital whilst the bed capacity transferred to East Lothian Community Hospital. It has been well received with over 770 attendances at the clinics.

Neurology Outpatient Physiotherapy

East Lothian Rehabilitation Service provides an unfunded neurology outpatient physiotherapy service which includes exercises specialists. This service provides essential early intervention and rehabilitation to patients with neurological conditions. Enhancing patients understanding of their conditions, importance of appropriate self-management strategies and a knowledge of when and where to request further assistance. This input supports citizens to maintain the right path on the LifeCurve.

Multi-disciplinary team (MDT) neurology pathway funding bids in 2021 and 2022 have both been unsuccessful. A neurology outpatient service is an important element of an Intermediate Care model to support early intervention, prevention, and self-management.

Pain Management

The East Lothian Physiotherapy Led Pain Management Service (ELPMS) was established within East Lothian Rehabilitation Service in September 2020, to provide specialist pain management support for individuals living with persistent pain across East Lothian. The service is the first and only service in Lothian to utilise the expertise of Exercise Specialists in supporting patients living with persistent pain. Referrals are received from all health professionals including allied health professionals (AHPs), GPs and Pain Consultants.

The aims of the service are to:

- Reduce the effect pain is having on an individual's quality of life through teaching ways of self-managing and coping with persistent pain
- Improve the individual's ability and confidence to self-manage pain associated disability
- Reduce reliance on health care resources.
- Reduce presentation with pain related issues to primary care.
- Promote sustainable behaviour change /change unhelpful beliefs and ways of thinking which contribute to disability.
- Improve participation in daily activities.
- Improve quality of life through changes in physical fitness, strength, endurance, and flexibility.

To achieve these aims, ELPMS delivers group and one to one pain management sessions in response to individual need. During the pandemic, the ELPMS was the first in Lothian to utilise technology to deliver live, online pain management group services through the NHS Scotland CISCO Video Conferencing System, with over 120 digital appointments offered.

Group sessions continue to be delivered both face to face and digitally in response to patient need, optimising access to pain services across a wide geographical area. The service promotes long term sustainable behavioural change through onward referral to the East Lothian Fundamental Rehabilitation and PACE exercise programs.

To optimise quality of life and meet the often complex needs of the individual, ELPMS collaborate with the multidisciplinary services within the Health and Social Care Partnership, with onward referral to Community Mental Health services, Pain Psychology (Lothian Chronic Pain Service, AAH), Pain Clinic and Domiciliary therapy services.

The team actively support the wider clinical teams through the delivery of Level II Pain Training, In-reach to GP practices and providing peer support in the management of complex persistent pain presentations.

Over the past year since the service began in October 2020, demand for East Lothian Pain Management services has increased and it is an important part of an Intermediate Care model to support appropriate intervention for this patient group.

Single Point of Contact Phoneline

ELRS established a single point of contact phoneline system utilising the BT Cloud Contact platform in June 2021. This has enabled citizens to contact the service through one central system and speak to the right professional at the right time. This allows for self-referral and supports self-management. To date there are five services that are within this system already, with plans to further increase this. Current services included are:

- Patient focused booking (PFB)
- Musculoskeletal (MSK)
- Request for Assistance Occupational Therapy (R4A)
- Community Physiotherapy and Occupational Therapy (APP)
- Enquiry line (Enquiry)

The individual contacting the phone line will speak to a member of the administrative team if calling the PFB / MSK / Enquiry line. A message will be passed to the appropriate clinical team and a senior clinician will contact the patient directly within two working days hours to complete a telephone assessment if required. The individual will speak directly to a senior clinician on the R4A and APP line who are able to provide relevant information or complete a referral.

This service already has good analytics, to report volume of work and several subsequent variables. For example, the volume of calls per GP Practice and the outcome of calls.

This phone line is an important element of an Intermediate Care model to ensure the population of East Lothian have one phone line to contact all services, promoting self-management and reduced GP appointment.

Technology Enabled Care (TEC)

ELRS recognise the value of using TEC (Technology Enabled Care) to help people remain as active, independent, enabled and as safe as possible key principles within an Intermediate Care model. TEC has been identified as the Golden Thread running through all services within ELHSCP due to the improved outcomes it creates for patients, carers and staff. When used at the right time it can aid prevention of admission, facilitate hospital discharge, and enable carers to continue to look after their loved one. TEC can also be used as an alternative to, or alongside care provision, reducing demand on this scarce resource. TEC is cost effective and plays a key role as an enabler in modernising health and social care. The TEC team meets the key principles of an Intermediate Care model.

The TEC (telecare) team, compromises of 4 TEC officers, 1 manager and admin support. In addition, there is 1 Occupational Therapist (0.6WTE) and TEC Officer (0.6WTE) to provide Smart TEC

intervention. The telecare team 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 TEC team provide essential training in TEC awareness to ELHSCP and Housing staff to inform and upskill the workforce to ensure a TEC first approach is considered. The Smart TEC team also provided outcome focused Occupational Therapy interventions at either Wellwynd hub, via phone call or home visit.

ELRS in May 2020 purchased three Alcuris Memohubs which are lifestyle monitoring kits including smart plugs. The team have positive case studies where including Alcuris Memohubs in an individual's home resulted in a reduction in care required. In one case this resulted in a saving of 14 hours care.

Hospital to home team

Provides packages of care in the community. The service is led by the Senior Charge Nurse with full time band 3 carers and registered nursing staff.

A re-ablement model is used which leads to a reduction in the need for care through time, at times stopping the package of care altogether. By using this approach it maximises, maintains and can improve a person's independence by empowering them to return to the activities of daily living and maintaining their independence. Some key benefits of this service is set out below:

- Review of patients, no less than weekly, which prevented re-admission and influenced a change to some of care packages.
- For some patients their care package were increased by one visit which allowed the patient to remain in their own home, where as several other care packages were reduced, due to an improvement of the patients' abilities.
- Patient care is managed efficiently and effectively through integrated team work and enhanced improved communication between both Health and Social care.
- Maintain and deliver high standards of quality holistic care by implementing a flexible person centred approach, based on patient needs.
- Applying the enablement model to maximise, and maintain, the patients' independence thus empowering the patients.
- Support patient flow from acute Secondary Care beds by facilitating a swift and timely discharge.
- Cost effective by reducing acute bed days within acute and community hospitals.
- Lessens institutionalisation, the risk of contracting Hospital Acquired Infection, delirium and confusion.

To date the hospital to home team have supported 50 people to no longer need a care package, increased an individual's independence and therefore reduced the amount of support 28 people required and have supported 7 palliative patients who were cared for and died at home. The service has scored 97% satisfaction rates by patients and their families, 429 patients over the last 2 years have received the services of the team (data from the past year).

Hospital at home

This service is led by a Lead clinician and seeks to support the twin goals of avoiding unnecessary Hospital admissions, and where an admission is necessary, to support the patient's prompt Discharge from hospital back to their own home in the community. The service brings together the multidisciplinary team (MDT) and integrates this around the needs of the patient, setting goals and implementing a care plan to reach these goals through continuous review and monitoring that takes place at the daily huddle where all members of the team meet to discuss progress.

The service provides an urgent assessment that is responsive and able to provide monitoring and intervention for patient with an acute episode of illness that would otherwise require to an acute hospital admission, working with all members of the multidisciplinary team to get the patient seen in the right place at the right time by the right person who reviews the patient on a regular basis. The service works with teams who already exist within the community, such as the district nurses and general practitioners to achieve the best outcome for the patient within their own home setting.

The team have a half time lead clinician , a GP who provides two sessions per week and a full time Staff Grade doctor, to support the service which has provided care for over 800 patients to date. Updated figure. The service have recently seen the addition of three band 3 care support workers who have been introduced to the team , the purpose of this additional resource is to support patients in the community with personnel care until the acute phase of their illness has subsided.

Care Home team

Provide support and guidance to the 17 care homes in East Lothian. They identify training needs and provide education, facilitate access to specialist services when required. They work closely with East Lothian Council when concerns are raised or investigated.

The aim of the service is to help maintain quality care, improve standards of care, aide staff to access the skills and knowledge needed to care for their residents, prevent unnecessary hospital admissions, facilitate hospital discharge for complex cases and to improve links and access to secondary care services.

They work in conjunction with other teams to ensure that residents within the care home setting are supported to remain within their home.

Care at Home

Care at Home services can help to provide support to allow people to continue to live independently in their own homes. This may need support on an ongoing basis, or for a short period of time, such as following a stay in hospital while individuals recover or adapt to new circumstances. Care at Home staff can help with personal care tasks, such as:

- washing and dressing
- taking and managing medication
- going to the toilet
- help with preparing and eating meals

Care at home services are offered seven days a week (including public holidays) and can be provided by in-house or by private providers. The Health and Social Care Partnership contract with around 20 care at home providers to provide high-quality care and support. Managing the different

geographies and rural/town landscape provides huge challenges for all the providers across the county

Daily Huddle review of East Lothian discharges
To ensure that effective and efficient use of all intermediate care resources and to get patients to the right place at the right time a daily huddle has been introduced, which is multi-professional and looks at getting patients who have been admitted to the right place, this may be discharged with a package of care with or without discharge to assess. Alternatively patients may be discharged home without any care or be supported to residential or care home setting.

A decision is made at that meeting is also made to pull patients to ELCH if admitted to RIE or the WGH so that they are closer to home so that local services can be involved in discharge planning but also improve and enhance communication with relatives and carers.

Integrated Care Assessment and Allocation Team ICAAT
The main function of the team is to review and process referrals for package of care requests enabling individuals who have been assessed as needing CAH support to receive the appropriate care they require in the right way at the right time. This is achieved through the multidisciplinary team meeting on a regular basis to agree priorities cases.

Nursing: The nursing staff within the team will screen the referrals that are received daily from the hospital, they will manage the most urgent referrals addressing each individual resident or patients' personnel needs at that time to support them to continue to live in the community.

Social Work: The social workers main role is work with their colleagues to escalate and address key issues that need progress to support individuals to be discharged from hospital, supported more effectively in the community, receive respite, or admitted into nursing/residential long term care.

Social Work staff also meet with the providers to work with them to help recruit staff to provide care in the community. The Social Work Staff also work with Community Care Brokers to ensure that all Providers are working as efficiently as possible, clustering providers into small areas to reduce travel time.

Occupational therapy: Occupational therapy team will screen the admissions received overnight highlighting those that could or should be supported back into the community back to their own home. They will assess a referral for care if there has been a change in an individual's condition or circumstances that needs a mobility or environmental assessment.

Emergency Care Service (ECS)
The ECS team delivers a 24-hour support service for all adults anywhere in East Lothian, responding to calls made through personal alarms pendants, wristbands and telecare systems, for example, door sensors, fall detectors as well as self-referrals from people who do not have an alarm system installed in their home.
The ECS service has two teams. ECS 1 who provides short-term support service to clients to prevent their admission to hospital. This includes early intervention to prevent escalation of situations as well as one off visits that only require a single carer.

The second team, ECS 2 works in pairs, answering emergency calls to people who have fallen. They also provide some short term support to clients to prevent hospital admissions.
The role of this team is increasingly supporting people who are at the end of their life and wish to die at home allowing the wishes of individuals to be carried out, keeping them as comfortable as possible and also supporting their families. ECS adopts a holistic and collaborative approach when supporting a client, working with several agencies to look for ways to increase the safety of a person in their home and checking on their wellbeing to prevent further falls and prevent admission to hospital.
Recently, ECS 1 provided over 2400 visits to 302 clients. ECS 2 responded to over 7600 calls of which over 1700 were from people who had fallen and could not get up themselves

Primary Care
General practitioners and their teams treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.

Care When it Counts (CWIC)
The Care When It Counts service is a nurse-led service, supported at times by GPs or Physician's Associates. It offers same-day appointments to patients at a number of GP Practices across East Lothian, who have new symptoms or flare-ups of existing conditions. Patients are referred to CWIC via calling their Practice.
If an individual calls about a new health concern (or a flare-up of an existing condition) which they think needs attention that day, the care may be provided by the CWIC service.

CWIC (Mental Health) is a primary care service for people in East Lothian aged over 17 years and 9 months. They work closely with GP practices, Adult Mental Health services and local third sector services to help access the right support for an individual's needs.

General practice has an important role in looking after patients in their homes and within the communities where they live. They are part of a much wider team whose role includes promoting, preventing and initiating treatment. They look after patients with chronic illness, with the aim to keep people in their own homes and ensuring they are as well as they possibly can be.
General Practice is often the first point of contact for anyone with a physical or mental health problem and patients can be at their most anxious. Looking after the whole person - the physical, emotional, social, spiritual, cultural and economic aspects through patient-centred approaches is a vital part of any GP's role. This is becoming more important with terminally ill patients often choosing to stay at home.

Additional support to Intermediate care

Additional support to Intermediate care

Additional support to intermediate care services (listed above) are highlighted below. They are an integral support and also play an important role in keeping someone at home for as long as possible as well as helping to keep individuals well and safe and hopefully prevent or reduce hospital admission.

East Lothian Community First (ELCF)

The aim of this service is to improve the health and wellbeing of local people through better connections to appropriate sources of support within their local communities, including the use of volunteers. The service was initially set up as a test of change in collaboration with ihub (the Improvement Hub of Healthcare Improvement Scotland) in 2017 to support hospital discharge of people who did not require ongoing care services. The service has since expanded in 2021 to provide support to people at home.

The support provided by ELCF will include an extended range of activities: meeting with the person in the hospital/home to talk about what they would like to achieve (talking through short and long term goals and gathering the information of the 'nominated contact' or community champion); practical support such as ensuring utilities are in place; support to engage with meaningful daily activities; assistance and support to go for prescriptions or shopping (either volunteer or nominated person); support to access and contribute to their local community and support to reduce social isolation. Support is tailored to each person and agreed personal outcomes are set; if further support is required then signposting to relevant agencies will be provided. Support is reviewed after 8 weeks.

Alzheimer Scotland PDS Link workers

Improved post-diagnostic information and support was recognised as an area in which immediate change was required in the National Dementia Strategy 2013 – 2016. It focused on providing good quality of life at home for longer, supporting the development of dementia-friendly local communities, timely, accurate diagnosis, and better post-diagnostic support

Alzheimer Scotland have been commissioned to provide Post Diagnostic Support Link Worker support in East Lothian since 2015. Funding now supports 2 x 35hr Post Diagnostic Support workers, initially funding had supported 1 support worker. Demand and subsequent increasing waiting lists supported additional investment.

The Post Diagnostic Support Link Workers are based within the Community Mental Health Team (CMHT). Supervision is provided through the CMHT once a month to support with team issues or any concerns with the people they are supporting. Each worker carries a maximum of 50 active cases. Each person supported receives a person-centred support plan based on their individual needs, desires and aspirations including the '5 Pillar of PDS' and the Link Workers are trained to the enhanced level of the national 'Promoting Excellence Framework'

A key aim is to deliver sustainable, continuous post diagnostic services across East Lothian. This can best be achieved by giving the current service provider flexibility in developing the service over three years, rather than being tied to a year on year funding system which has caused difficulties with regards to recruitment and retention over the last 3-4 years. There is an established evidence base for PDS provided by Alzheimer Scotland currently.

A recent successful funding proposal (following a 12 month extension as of April 2022) was to award funding to Alzheimer Scotland specifically for post diagnostic funding for a minimum 3 year contract.

Older People Day Centres

The existing funding for older peoples centres is continued until 31 March 2023. This will allow time to undertake further work, taking note of the issues outlined below and with the aim of developing a longer term integrated framework model for both centre and outreach from April 2023.
The IJB has agreed the underpinning principles for Day Centres:

- Commissioned to deliver local services that reflect the varying needs of the local communities
- Flexibility of provision allowing for both centre and community based services which address fluctuating COVID-19 restrictions ('blended model')
- Reduction in carer stress
- Preventative in nature reducing social isolation and loneliness
- Innovation in dementia care and support
- Effective governance arrangements based on genuine partnership and collaboration with providers and communities

Carers funding and support

Carers funding and support

As Carers are significant and integral part to supporting individuals to remain at home for as long as possible recent, short term funding extensions have been supported. These will require assessment and review of longer term funding options. A few of these are set out below for information.

It is worth highlighting that Carers are providing a huge contribution to Intermediate care services, not necessarily in relation to the more formal health and social care definitions but their essential role and future support must be recognised.

Extend Older People's Day Centres Outreach.

Building on the success of the day centre outreach it supports carers needs for additional respite through outreach support. This can involve centre staff visiting people at their homes or delivering meals, when someone is house bound. *Increase in Funding to Voluntary Centre East Lothian* ***VCEL*** to develop their Community Outreach service which will be integrated with Community Support Service(s) – Hospital Discharge and the Community Taskforce. Based within the local community setting, the service addresses concerns, difficulties and issues that an individual presents with to reduce isolation, carer stress and issues escalating.

Dementia Cafes

Alzheimer Scotland. Two dementia cafes in Musselburgh and Dunbar. Providing peer support and professional advice for people who are living with a diagnosis of dementia and their carers.

Meeting Centres

The development of the Meeting Centre in Musselburgh to support people living with dementia is now in place in Musselburgh with work being undertaken to look at a centre to the east of the county.

Summary

Summary

This paper describes what we mean by the broad term of intermediate care and show examples of those services provided in East Lothian. Also emphasising why they are an important focus of our services already established within the Health and Social Care Partnership. There are other models out-with East Lothian that we would like to learn from too and we are working with Health Improvement Scotland to look at these.

Importantly, we want to listen and hear from people across East Lothian as part of the Communications and Engagement work as to what services people liked, their own experiences using them and what other intermediate care provision they would like to see in their communities.

We would like to discuss their ideas and thoughts on these services in their local areas and what opportunities there are to bring together/co-locate services together e.g. health, social care, third sector, independent sector, Voluntary. We want this work to form part of the basis for ongoing co-production of how we can develop these services across East Lothian reflecting the differences across the county and the local communities to try and develop local services.

We know there are unrelenting pressures on beds and we have set out in other papers our thoughts on these. There needs to be further debate, focus and resources on developing more Intermediate care provision. There is so much more being done and much more we would like to do to keep people at home, for as long as possible enjoying a high quality, healthy life surrounded by their family and friends.

East Lothian
Integration Joint Board

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 15 September 2022

BY: Chief Finance Officer

SUBJECT: 2022/23 Q1 Financial Update

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1 PURPOSE

1.1 This report lays out the results of the partner's (East Lothian Council and NHS Lothian) quarter one financial reviews and considers how these impact on the projected financial position of the IJB for 2022/23. Plus reports on the work to support sustainable financial solutions as part of the COVID exit planning.

2 RECOMMENDATIONS

2.1 The IJB is asked to:

i. Note the quarter one financial review undertaken by partners.
ii. Note the COVID exit planning.

3 BACKGROUND

3.1 At the IJB meetings during March 2022, the IJB accepted the budget offers from Partners NHS Lothian and East Lothian Council.

3.2 The Budget Offers made by Partners at the start of the financial year is shown below

IJB Opening Budget 2022/23	**£k**	**£k**
East Lothian Council		67,788
Baseline Budget	59,159	
New Scottish Government Monies	8,629	
NHS Lothian		111,225
Core	62,137	
Hosted	14,337	
Set Aside	19,332	
GMS	12,831	
Uplift & Other	2,588	
Total		**179,013**

(Fig 1: IJB Opening Budget 2022/23)

3.3 Both partner organisations have now completed their quarter one financial review which provides an updated forecast financial outturn for 2022/23. The East Lothian Council and NHS Lothian quarter one financial reviews are based on information to the end of June 2022.

3.4 The quarter one financial review position for the IJB is a projected overspend of £1,106k at the end of the financial year and a breakdown is shown below

	Annual Budget as at end of June 2022 **£k**	**Forecast Expenditure** **£k**	**Q1 Forecast Under/(Over) Spend** **£k**
Core	79,294	79,112	183
Hosted	14,909	14,950	-41
Set Aside	21,656	22,837	-1,181
Health	**115,859**	**116,898**	**-1,040**
Social Care	67,788	67,854	-66
Total	**183,647**	**184,752**	**-1,106**

(Fig 2 : IJB Quarter 1 review forecast)

3.5 The budget movements from the partners budgets offers at the start of the financial year to the IJBs budget position at Q1 are a combination of additional funding allocations from Scottish Government and COVID funding being drawn down from the reserve to support the remaining COVID costs in 2022/23.

3.6 The forecast position reflects the projections for both partners. NHS Lothian have presented their overall Q1 position to their Finance & Resources Committee on the 17th August 2022. East Lothian Council will be looking to present their Q1 financial projections to their Cabinet meeting on the 13th September 2022.

3.7 The forecast highlights an almost break even forecast for the majority of the IJBs delegated budgets with our set aside budgets being the main area projecting an overspend. This is made up of Gastroenterology drugs, the drugs pressure across acute is significant and has been growing due mainly to new medicines. Within Medicine of the Elderly there are overspends in medical pays predominantly at the RIE. Similarly General Medicine facing increased costs in medical staffing. Further work is required by these set aside services to identify and develop mitigating actions.

3.8 The Core services within Health although reporting a very small underspend do have some areas projecting small overspends for example within General Medical Services (GMS) across East Lothian.

3.9 The Social Care overall forecast is very close to break even, with only a small projected overspend of £66k. It should be noted that there are underlying pressures that need to be addressed to ensure this position can be achieved, specifically there are financial challenges within commissioned services and in particular Learning Disabilities.

3.10 There has been work undertaken nationally to assess the level of anticipated COVID expenditure in the 2022/23 financial year. The outcome of the review was that there is a national shortfall of funding and as such HSCPs were advised to align their winter funding allocations, where possible, to support COVID exit.

	2022/23 **£k**
Care at Home Capacity	2,376
MDT	766
Additional investment in social care of £200 million nationally*	3,841

* please note first priority for this funding is to ensure paying the real living wage.

(Fig 3 : Funding allocations - recurring)

3.11 Within East Lothian HSCP, we have looked to undertake a prioritisation exercise whereby assessing the priorities of all current COVID expenditure and winter spend plans against the funding for winter. This allowed the HSCP to realign funding and spend plans to fund on a recurring basis critical services set up or enhanced during COVID. This exercise has supported COVID exit but overall, there remain COVID costs unable to be funded by alternative sources. These will be reported as our COVID costs during this financial year to Scottish Government. The areas are shown below:

- **NHS** - costs relating to the additional wards open within East Lothian Community Hospital, and additional costs in Primary Care (GMS and Prescribing).
- **Social Care –** costs relating to the ongoing sustainability payments to our external providers and the loss of income from core services.

	2021/22 £k	Q1 2022/23 Return via NHS Lothian £k
COVID Reserve as at March 2022		9,182
COVID cost projections	8,141	4,499

(Fig 4 : COVID Cost Projections)

The COVID Earmarked reserve will be utilised to offset the expenditure for the current financial year, but a recurring solution has not been identified. Therefore, exit plans will be required for the 2023/24 financial year.

3.12 The outturn projections will continue to be refined throughout the year, and regular updates will be brought back to the IJB. The main outstanding risk not included in the above projection is the settlement of the pay awards. We await clarity to assess the impact of this with our Partners both in terms of cost projections and any additional funding.

3.13 Currently under development is the IJBs longer-term financial outlook this longer-term financial outlook had been paused due to the uncertainty of COVID however given we have undertaken COVID exit planning then this work has recommenced and will be reported back to the IJB in due course.

4 ENGAGEMENT

4.1 The IJB makes its papers and reports available on the internet.

4.2 The issues in this report have been discussed with the IJB's partners but do not require wider engagement

5 POLICY IMPLICATIONS

5.1 There are no new policies arising from this paper.

5.2 The recommendations in this report implement national legislation and regulations on the establishment of IJBs.

6 INTEGRATED IMPACT ASSESSMENT

6.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy

6.2 The issues in this report do not require an integrated impact assessment.

7 DIRECTIONS

7.1 The IJB may wish to issue directions regarding the use of the reserves (especially these funds carry forward to support the Covid pandemic).

8 RESOURCE IMPLICATIONS

8.1 There are no immediate resource implications from this report. Any resource implications from the outcome of the process will be highlighted in a future report if required.

9 RISK

9.1 None

10 BACKGROUND PAPERS

10.1 None

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