REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 22 June 2023

BY: Chief Officer

SUBJECT: East Lothian IJB Annual Performance Report 2022-23

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1 PURPOSE

1.1 To present the East Lothian Integration Joint Board Annual Performance Report for 2022-23.

2 RECOMMENDATIONS

The IJB is asked to:

2.1 Review this report, and in doing so, recognise the achievements of East Lothian Health and Social Care Partnership and individual services during 2022-23, and commend the contribution made by staff, volunteers, and partner organisations throughout the year.

2.2 Note that there may be changes to the National Integration Indicators data once the final data set is published by Public Health Scotland at the start of July, and that a final version of the APR, incorporating any changes, will be sent to IJB members for information prior to publication at the end of July.

2.3 Whilst there is no requirement within the statutory guidance for IJBs to formally sign-off APRs, it is requested that IJB members give approval for the publication of the 2022-23 APR as appended, subject to any minor changes as noted in recommendation 2.2 above.

3 BACKGROUND

3.1 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. The Coronavirus Scotland Act 2020 extended the deadline for publication of the APR to the end of November. The extended deadline has now been revoked and IJBs are required to publish an APR by the end of July.

3.2 In line with Scottish Government guidance, the East Lothian IJB Annual Report for 2022-23 describes performance in planning and carrying out integrated functions from 1st April 2022 to 31st March 2023.

3.3 The report includes details of performance in relation to the Core Integration Indicators and additional Ministerial Steering Group indicators. The current, appended version of the report contains data released by Public Health Scotland for management purposes only and may change prior to publication of the final data in early July. The report will be updated once the data is finalised and shared with IJB members as per recommendation 2.2.

3.4 The content of the APR is structured according to the IJB strategic objectives and related strategic delivery priorities as identified in the 2022-25 IJB Strategic Plan. This means that the APR effectively provides a 6 month progress report on delivery of the IJB Strategic Plan since its publication in October 2022.

3.5 The report is written in a style intended to make it as accessible as possible to a non-expert audience. A summary report, including images and infographics, will also be produced and shared with key audiences including HSCP staff, partners, and communities.

4 ENGAGEMENT

4.1 No specific engagement was carried out in relation to the development of the Annual Performance Report.

5 POLICY IMPLICATIONS

5.1 Development and publication of an IJB Annual Performance Report reflects the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

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.

7 DIRECTIONS

7.1 Consideration of directions is not required in relation to the Annual Performance Report.

8 RESOURCE IMPLICATIONS

This paper has no specific resource implications.

9 BACKGROUND PAPERS

9.1 None.

Appendix 1 – East Lothian Integration Joint Board Annual Performance Report 2022-23 (Version 1, June 2023)

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DATE	14th June 2023

Appendix 1

East Lothian Integration Joint Board

Annual Performance Report

2022-23

(Version 1, June 2023)

Contents

Introduction

East Lothian Integration Joint Board (IJB) Strategic Plan

East Lothian Integration Joint Board agreed its new Strategic Plan in October 2022. The new Plan identifies the IJB's 7 strategic objectives for 2022-25, along with a range of strategic delivery priorities linked to each objective. The content of the Plan was based on extensive stakeholder engagement, along with an evaluation of IJB progress to date, and an assessment of current and future local need (based on the content of a Joint Strategic Needs Assessment that was completed).

An Annual Delivery Plan (ADP) has been developed outlining plans for delivery of the IJB's strategic objectives and delivery priorities over the coming year. Responsibility for delivery of activities detailed in the ADP is assigned to either Change Boards or to specific HSCP Officers / Teams. The East Lothian Strategic Planning Group maintains oversight and monitors progress in relation to the ADP.

This Annual Performance Report describes how East Lothian Health and Social Care Partnership (ELHSCP) services have contributed to the delivery of the East Lothian IJB Strategic Objectives during 2022/23. The report's structure is based on the 7 strategic objectives, with a section dedicated to each of these[1].

IJB Strategic Objectives for 2022-25:

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**

You can view the full East Lothian IJB Strategic Plan for 2022-2025 here.

[1] It is recognised that many of the activities described contribute to more than one Strategic Objective. This is reflected in the HSCP's Annual Delivery Plan. However, for practical reasons the Annual Performance Report is structured so that each activity is matched to the Strategic Objective it is most relevant to.

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

1.1 - Planning for an ageing population

Meeting the health and social care needs of a growing and ageing population will continue to be a key challenge for East Lothian IJB over the coming years. East Lothian 'Community Hospitals and Care Homes Change Board' was set up in 2021 to develop a transformation programme to help respond to this challenge.

The Change Board's remit was to review the provision within East Lothian community hospitals and HSCP managed care homes, and to make recommendations in relation to further development and investment in Intermediate Care (see 1.2 below).

As part of this work, an extensive engagement exercise took place during summer 2022 under the title of 'Planning for an Ageing Population'. The purpose of this exercise was to gather public views on what health and social care should look like in later life. A report was produced summarising this feedback and identifying emergent themes for consideration by the Change Board.

The Change Board presented its final report to the IJB in early 2023. This included a number of recommendations which will inform the future development of inpatient community hospital provision, care home beds, and Intermediate Care in East Lothian.

1.2 - Developing Intermediate Care

Developing Intermediate Care services is a high priority for us going forward. As well as delivering better outcomes for our population, Intermediate Care services make better use of resources, ensuring that our services are more sustainable in the longer term.

Intermediate Care services help people to:

- Remain at home when they start to find everyday tasks more difficult
- Avoid going into hospital where possible
- Recover after a fall, an acute illness, or an operation
- Return home quickly after a hospital stay

ELHSCP continued to build on and develop a range of Intermediate Care services during 2022/23, these services include:

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

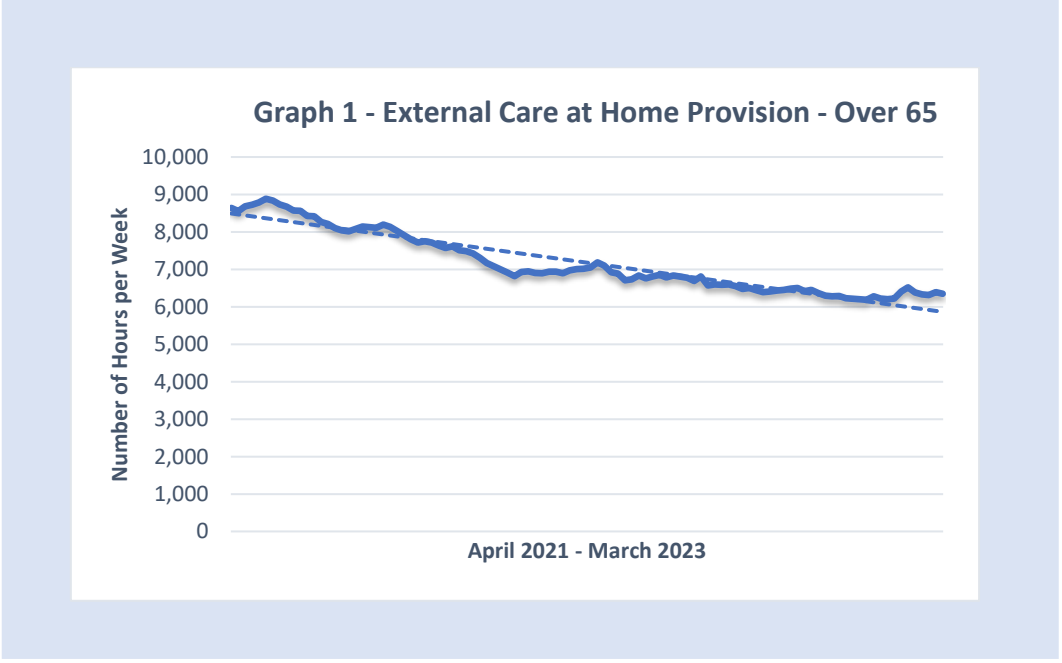
You can read more about developments in relation to some of these Intermediate Care services during 2022/23 below.

1.3 Care at Home services

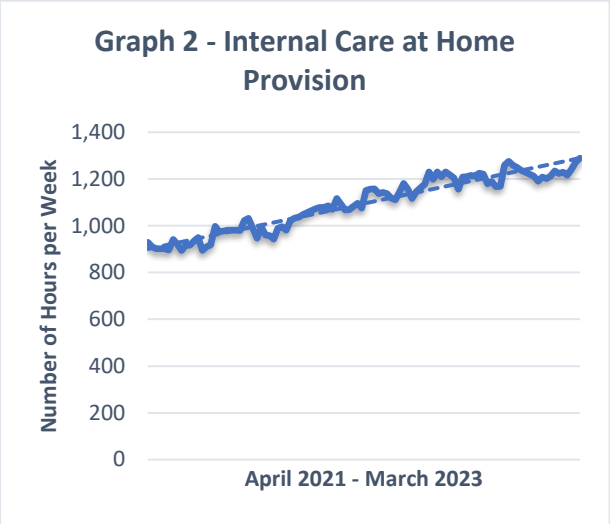
Health and Social Care Partnerships across the country have faced significant challenges in recent years in relation to the delivery of Care at Home (C@H) services. This has been partly due to changes in the type and complexity of care packages required, compounded by difficulties with the recruitment and retention of staff.

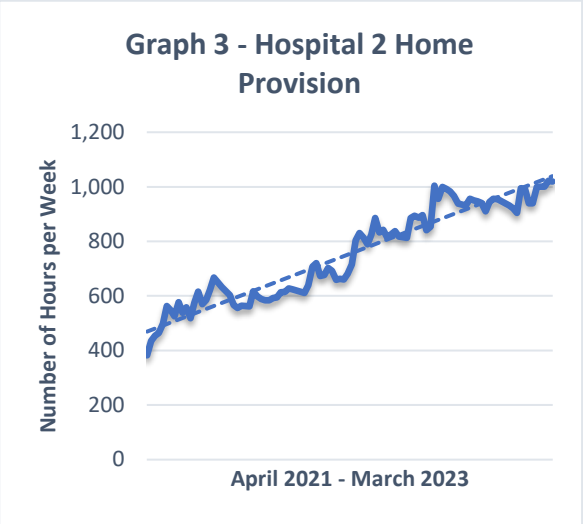
Care at Home services in East Lothian are delivered by a combination of HSCP managed services (Homecare and Hospital 2 Home) and services delivered by external providers (social care companies / organisations).

Graph 1 below shows the impact of the Care at Home crisis in terms of the reduction in the number of C@H hours delivered for adults over 65 by external providers in East Lothian from around 8,500 in April 2021 to under 6,500 in March 2023 – a reduction of around 2,000 hours per week.



In response to the decline in external provision and the ongoing fragility of external providers, East Lothian IJB made a strategic decision during 2021/22 to increase the capacity of HSCP managed Homecare and Hospital 2 Home services. Graphs 2 and 3 show the increase in care hours per week resulting from the expansion of both these services.





- We increased delivery of internal Care at Home from just over 900 hours a week in April 2021 to almost 1,300 in March 2023 – an increase of around 400 hours per week.
- Over the same period, we increased delivery of our Hospital 2 Home service from around 400 hours to over a 1,000 – an increase of 600 hours.

Although significant, this additional capacity has not fully offset the loss of external hours. Whilst internal services have increased the number of hours provided by over 1,000 per week, over 2,000 external hours have been lost – leaving a shortfall of around 1,000 hours per week. A number of other measures have been introduced to help ensure that the available provision is used as effectively as possible. These include:

- Carrying out risk assessments to identify those most at risk so they can be prioritised for service delivery.
- Establishing a dedicated team to manage and respond to situations where providers are unable to deliver contracted hours, including responding to instances when providers have to close or amalgamate.
- Expanding our Support Plan Broker team so that we have more staff to set up packages of care.
- Running a weekly / fortnightly Care at Home Huddle and quarterly Care at Home Oversight Group to monitor the Care at Home situation and respond as needed.

- Developing how we manage referrals so that people do not have to wait to be assessed for support (see page 32 below).

The most recent data available (November 2022) suggested that 'unmet need' for Care at Home is higher in East Lothian (1.93 per 1,000) than in Scotland as a whole (1.15 people per 1,000). However, our achievements in reducing our assessment waiting list means that there is no 'hidden unmet need' in East Lothian.

Planning the development of Care at Home services to ensure they are able to meet current and future needs is a priority for East Lothian IJB. A Care at Home Transformation Programme was launched in 2022/23, with a Change Board established to lead this work. Initial work undertaken has been to gather and analyse data on current and future Care at Home costs, supply, and demand across East Lothian. Findings from this were reported in April 2023 and will inform the future development of Care at Home service provision, including alternative models for Care at Home support that are more sustainable in the longer term.

1.4 Supporting the acute sector

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

Integrated Care Allocation Team (ICAT)

The Integrated Care Allocation Team (ICAT) was introduced 2021 to support a collaborative approach to assessing people's care and support needs and identifying options for meeting these needs. The work of the team has been vital in preventing unnecessary admissions and supporting timely discharge.

ICAT 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[2], rehabilitation potential and any medical conditions and their management.

[2] '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

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 local services and community resources is also valuable and can allow a more creative approach to meeting needs.

The ICAT 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.

Daily Flow Huddle

A Daily Flow Huddle was introduced in July 2022 to help reduce the number of delays for people leaving hospital. The Huddle brought together staff from a range of HSCP services, along with HSCP managers, and colleagues from acute hospital sites. Meetings were held online and provided a daily opportunity to review East Lothian patients across Lothian hospitals. This helped to support a pro-active, multidisciplinary approach to tracking and monitoring patients and planning their discharge home. This helped contribute to a reduction in delays from a high of 39 delays in July 2022 to an average of 5 by the end of the year[3]. despite a challenging winter, delays were maintained at around 7 for January, February, and March 2023.

Inreach Project

The East Lothian Inreach pilot was developed as a means of helping to reduce pressure on acute hospital beds over Winter 2022/23.

The pilot ran from November 2022 to the end of March 2023 and involved East Lothian Allied Health Professionals (AHPs)[4] working with colleagues at the Royal Infirmary of Edinburgh (RIE) and the Western General Hospital (WGH).

The Inreach model aims to support patient journeys for East Lothian residents presenting at or admitted to acute hospitals. This involves the Inreach team identifying East Lothian patients at the earliest point in their journey, then focusing on optimising that journey by preventing admission or reducing length of stay as appropriate.

The Inreach approach benefits from the East Lothian team's knowledge of and links with local services and other resources (both formal and informal) that can potentially provide support

[3] Based on figures reported at the monthly 'census point'.
[4] Allied Health Professionals are a group of clinicians who provide care to people across a range of care pathways and in a variety of settings – in this instance, the AHPs involved include Occupational Therapists and Physiotherapists.

to patients (this is reflected in the 'onward referral' figures below). Also beneficial is the previous knowledge or involvement that ELRS may have in relation to some of the East Lothian patients presenting.

Despite the Inreach project being a relatively small resource within a much larger system, it was anticipated that it would bring pathway and outcome improvements for patients, as well as having a positive impact on the 'whole system flow'.

An evaluation report produced at the end of March 2023 demonstrated that the pilot had delivered positive results and suggested that an extension of the project over a longer time period would enable fuller evaluation to take place, including providing more data on the impact on 'whole system flow'. Further funding was secured at the end of the pilot to support ongoing delivery of the Inreach project until the end of March 2024.

During the pilot, the Inreach team:

- Case-managed 347 patients and completed 2,300 interventions.
- Worked across 19 different specialities, 35 wards and supported 320 patient discharges.
- Made 296 onward referrals to 31 different East Lothian services for patients in acute wards.
- Caried out over 60 assessments for East Lothian residents presenting at A&E, resulting in 74% of them being discharged home (as well as making 36 referrals to 16 different East Lothian services for people seen at A&E).

In terms of impact:

- The average Length of Stay (LOS) improved from 16 days to 5 days for patients seen by the team.
- Patient admissions reduced from 51.3% to 48.8%.
- 1,320 bed days were saved over the lifetime of the pilot – equating to £518,760 savings (forecast annual saving of 3,168 bed days / £1,245,024 savings)

Mental Health Inpatient Beds

Work took place during 2022/23 to reduce the number of East Lothian mental health inpatient bed days. Again, this focus helped to reduce pressure on acute hospital sites, but importantly, also achieved better outcomes for patients in terms of preventing hospital admission for some and enabling others to return home or to a community setting sooner. It

also meant that the number of inpatients bed days fell to within East Lothian's 'commissioned bed base.'[5]

The approach taken involved:

- HSCP staff attending Hermitage ward Daily Huddles to help monitor and review East Lothian inpatients (the Hermitage ward is the adult acute admission ward for East Lothian and Midlothian patients).
- Setting up a local Community Huddle involving staff from HSCP mental health teams to discuss cases (Intensive Home Treatment Team (IHTT), Community Mental Health Team (CMHT) and CWIC Mental Health service).
- Development and delivery of an Action Plan related to inpatient beds.
- Identification of an East Lothian Clinical Nurse Manager to oversee and coordinate this activity.

This approach resulted in fewer admissions and a reduction in length of stay for East Lothian patients from a high of 20 days in July 2022 to 9 days by the end of 2022. Whilst admissions began to increase at the start of 2023, we have continued to develop this work, and anticipate positive results will continue to be seen over the longer term.

Elder Street support and rehabilitation

April 2022 saw the opening of the Elder Street recovery based supported accommodation / rehabilitation resource in Tranent, replacing existing provision at Cameron Cottage in Musselburgh. Elder Street offers a service for up to 10 people with complex mental health needs. The service is provided on a 24/7 basis by Carrgom, with in-reach support from a number of external providers.

The development of Elder Street responds to an identified need for a community rehabilitation resource for adults with mental health issues. The resource is well used, with a waiting list for placements. Provision at Elder Street is important in terms of helping to prevent hospital admissions and as a stepping stone to recovery and more independent living for people leaving hospital.

1.5 Commissioning

Health and social care services delegated to East Lothian IJB are delivered in a number of ways. Whilst the majority of services are directly provided by the HSCP or via 'hosted' or 'set-

[5] East Lothian IJB commissions NHS Lothian to deliver Mental Health inpatient services (beds).

aside' arrangements[6], a significant proportion are delivered via commissioning arrangements with third and independent sector providers.

The approach we take to commissioning is important in terms of helping to ensure that commissioned services are provided in a way that reflects our vision and values and contribute to the delivery of our strategic objectives.

The IJB agreed the East Lothian HSCP Commissioning Strategy at its meeting in February 2023. The new Strategy includes a number of 'commissioning intentions and key market messages' that will guide activity in this area going forward. These reflect the IJB strategic objectives, as well as committing to an outcome focused approach, and to ethical commissioning that takes into account factors beyond price, including fair work, terms and conditions, trade union recognition, sustainability of services, and environmental impact.

1.6 - Supporting effective & sustainable Primary Care

We continues to witness significant pressure on general practice and other primary care services in East Lothian during 2022/23, reflecting a picture that is common across the UK. Demand on primary care services will continue to grow as the number of people living in East Lothian increases and older people make up a greater proportion of the overall population. This makes the development of effective and sustainable primary care a key delivery priority for the IJB.

The IJB has direct responsibility for the development and delivery of a range of primary care services. The approach to development of these services is detailed in the East Lothian Primary Care Improvement Plan (PCIP) – you can find out more about PCIP primary care services under Objective 4 below. As well as helping to reduce workload for GP practices, these 'PCIP services' have allowed new approaches to service delivery to be developed, with the aim of providing more accessible services for patients.

The HSCP also plays a number of other roles in relation to primary care, including strategic planning, infrastructure development and supporting GP practices in their key role as primary care service providers – some examples are given below.

East Lothian GP Cluster Activity

The East Lothian General Practice Cluster provides a forum for general practices to work collaboratively to improve the quality of clinical services. Each general practice in East Lothian

[6] '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.

is represented on the Cluster Group by a Practice Quality Lead. The Cluster has a workplan in place, identifying priorities for quality improvement activity.

One of the areas of work developed has been in relation to blood pressure monitoring. The HSCP provided funding to GP practices to support delivery of the Cluster's ambition to increase the use of blood pressure home monitoring using a system called 'Scale-Up BP'. The project has been successful, with almost 3,000 people in East Lothian using the blood pressure home monitoring system by the end of 2022/23.

Work is currently underway to develop a quality improvement project in relation to frailty, with several practice teams already developing information to help guide this work.

Primary Care Premises

The IJB's 2020 Primary Care Premises Strategy identifies the communities and primary care buildings regarded as being the highest priority for capital investment. These priorities, along with priorities identified by the other Lothian IJBs, have been ranked by NHS Lothian to help determine future capital investment.

East Lothian has recently benefitted from a £4.1 million investment of capital funding for upgrading of the Cockenzie Health Centre. This has included a new 400m2 extension providing 6 consulting rooms, 2 treatment rooms, 2 community consulting rooms and a health education room. The original practice building has also been refurbished to provide improved accommodation.

Strategic Objective 1 - Our Performance in Numbers

Care at Home hours delivered by external providers fell from 8,500 in April 2021 to 6,500 in March 2023 – a reduction of around 2,000 hours a week.

Internally provided Care at Home were increased by around 1,000 hours a week (leaving a shortfall of around 1,000 Care at Home hours per week).

The emergency admission rate for East Lothian adults fell from 10,428 to 9,358 (per 100,000), the lowest rate in 6 years.

Emergency bed day rates fell from 115,048 in 2021/22 to 114,891 in 2022/23.

Our Inreach Pilot contributed to a reduction in Length of Stay from 16 days to 5 days for patients seen by the team and helped reduce admissions from 51.3% to 48.8%. 1,320 bed days were saved over the lifestime of the Pilot.

The introducuton of a Daily Flow Huddle helped to reduce delayed discharge from a high of 39 days in July 2022 to an average of 5 days by the end of the year.

We were successful in reducing the number of East Lothian mental health inpatient bed days. This led to fewer admissions and a reduction in the Length of Stay from a high of 20 days (July 2022) to 9 days (December 2022).

The proportion of the last 6 months of life spent at home or in a community setting stayed at 88%.

An initaitve led by the East Lothian GP Cluster has contributed to almost 3,000 people in East Lothian using the 'Scale-Up BP' blood pressure home monitoring system.

Strategic Objective 2 – Delivery new models of community provision, working collaboratively with communities

2.1 Transforming Community Services

We continued to make significant progress in delivering our Community Transformation Programme during 2022/23. The Programme focuses on developing community capacity and support for older adults (65+), and adults under 65 with disabilities or mental health support needs.

Key developments during the year included:

- The launch of a new **East Lothian Community First Service** in October 2022.
- The expansion of our **Resource Coordinator Service**.
- The opening of a new **Meeting Centre** in Musselburgh for people with dementia.
- The development of **outreach support for carers** from Older People's Day Centres.
- The introduction of additional **Neighbourhood Networks** – one in Dunbar and one in Musselburgh for young adults who are moving into adult services.
- Supporting the implementation of a new **employability support service** for people with complex mental health needs.
- Supporting the implementation of a **new day service in Musselburgh provided by Teens+** for young people with complex communication needs including autism and learning disabilities.

You can read more about some of these developments below.

Resource Coordinator Service

Our Resource Coordinator team supports people with learning disabilities to access community-based activities where they do not require a Resource Centre based service. There are currently 238 people accessing a range of community based sessions focusing on physical activity and skills development – these include life skills, college outreach, arts and crafts, cooking, mindfulness, yoga, gardening, bowling, swimming, and table tennis.

The service continued to develop and grow during 2022/23, both in the communities already covered, and expanding to cover the Dunbar and North Berwick areas.

Since their introduction, Resource Coordinators have supported the development of a wide range of day opportunities in communities across East Lothian. The team works closely with the third sector and East Lothian Council's Connected Communities team. Feedback from an independent review completed by Outside the Box was very positive, with participants

suggesting that they would like to see further development of the service, including the offer of additional sessions.

Neighbourhood Networks

Neighbourhood Networks provide peer support in people's local communities to help people establish a life in which they are safe and more independent. Members of Neighbourhood Networks are supported to develop skills such as independent travel, cooking, budgeting, employment skills, volunteering, and general life skills. Neighbourhood Networks can help people to feel less isolated and lonely by giving them a sense of belonging and involvement and helping to develop their confidence and self-esteem.

Over 2022/23, we continued to develop Neighbourhood Networks in East Lothian, including introducing a new network in Dunbar, and a network based in Musselburgh for young people moving to adult services. Over 50 people are now benefitting from support provided by Neighbourhood Networks. In addition, a number of people no longer requiring active support have remained involved as 'Associate Members'.

East Lothian Community First Service

The East Lothian Community First Service was launched in October 2022. Community First is delivered by VCEL (Volunteer Centre East Lothian) with funding from East Lothian HSCP. The new service builds on a previous service and a pilot initiative that was delivered in 2021/22.

Community First provides support to people who are struggling with their health and wellbeing, helping them to access community services. It also provides support to people leaving hospital, as well as helping to prevent hospital admission / readmission.

The service is based on 'what matters to you' conversations, helping people to explore the opportunities available to them and carrying out 'goal setting' using a strengths based approach (focusing on what people can do rather than on what they cannot).

People using the service have identified needs related to social isolation, financial hardship, food poverty, benefits issues, carers stress, housing, relationship breakdown, mental health, physical health, hospital appointments, and substance use.

Over 170 people benefited from the Community First service from October 2022 to March 2023. Support is provided by a combination of staff and volunteers - eighteen volunteers were involved in the first 6 months of the service, providing around 360 hours of support.

Meeting Centres

Meeting Centres provide an innovative, peer and carer led, community-based support for people with mild to moderate dementia and their families and friends (you can read more about the Meeting Centre model here).

East Lothian's first Meeting Centre opened in Musselburgh in March 2023. The Centre has been developed through a co-production approach and is delivered by DFEL (Dementia Friendly East Lothian), with grant funding from East Lothian HSCP.

As well as bringing a valuable new resource to Musselburgh, the Meeting Centre provides a strong base on which to develop 'satellite' Centres across East Lothian over the next two years.

This work has been led by people with lived experience and developed as part of a Dementia Friendly Community and via Peer Support Friendship Groups. It reflects a social model of dementia based on citizenship and on rights and opportunities for leadership and control.

Employability Support

A new employability support service was introduced in 2022/23 to support people with complex mental health needs into employment (Individual Placement Support). The service is provided by Triage and is supported by East Lothian Works, the Local Employability Partnership the HSCP's Community Mental Health Team.

2.2 Working with communities

Participation and Engagement

A new IJB Participation and Engagement Strategy was developed during 2022/23 and agreed at the May meeting of the IJB. The Strategy commits to the further development of existing participation and engagement arrangements, as well as strengthening the IJB's focus on engagement with people whose voices tend not to be hear via existing channels and on learning from 'lived experience'[7] wherever possible.

You can view find out more about the East Lothian IJB Participation and Engagement Strategy here.

A range of engagement and participation activities were carried out over the year, examples of two of the larger scale exercises are described below.

[7] The term 'lived experience' refers to first-hand experience of specific issues and / or of using related services.

East Lothian IJB Strategic Plan Engagement – Health, Housing and Place

During 2022, the HSCP worked in partnership with East Lothian Council's Housing and Planning Teams to carry out joint engagement to inform the development of:

- The East Lothian IJB Strategic Plan
- The East Lothian Council Local Housing Strategy
- The East Lothian Development Plan

This shared approach was based on the recognition that health, housing, and place are very much interrelated from participants' points of view / experience. It was also hoped that carrying out joint engagement would help to prevent 'engagement fatigue'.

During the course of the engagement exercise, workshop sessions were held with senior managers, staff, third sector organisations and community groups. Sessions also took place with people with lived experience of the justice system, people in recovery from substance use, people living on a low income, veterans, carers and BSL users. Two online surveys were carried out alongside the group sessions, one in English and one in Polish.

Around 1,000 people participated in the engagement exercise, some as individuals and others as representatives of organisations. Feedback gathered helped to inform the development of the strategic objectives and delivery priorities set out in the IJB Strategic Plan (see page 4 above). You can view a summary of the engagement feedback here.

Planning for an Ageing Population Engagement

The Planning for an Ageing Population[8] engagement programme took place over summer / autumn 2022.

Engagement activities included discussion with service-users, staff and carers at four East Lothian Day centres, as well as online engagement sessions with community representatives, service providers, third sector organisations and carers. An online survey was also set up to gather views from the general public. Feedback received through these various methods helped to inform the development of the East Lothian Carers Strategy and the East Lothian Dementia Strategy (supplementing other engagement carried out by lead officers and 'Outside the Box'). The Planning for an Ageing Population feedback report is available here.

[8] See Strategic Objective 1 for more information on the Planning for an Ageing Population Programme

Strategic Objective 2 - Our Performance in Numbers

Over 50 people currently benefit from the support provided through Neighbourhood Networks. In addition, a number of people no longer requiring active support have remained involved as 'Associate Members'.

Around 1,000 people participated in the Health, Housing and Place engagement which helped to inform the content of the IJB Strategic Plan.

Over 170 people benefitted in the first 6 months of the new Community First service. As well as support provided by Community First staff, 18 volunteers contributed around 360 hours of support during this period.

Strategic Objective 3 – Focus on prevention & early intervention

3.1 East Lothian Rehabilitation Service (ELRS)

East Lothian Rehabilitation Service (ELRS) delivers a wide range of services in East Lothian. More information on these services and their performance during 2022/23 can be found in the ELRS Annual Report (available on the East Lothian IJB web pages). The information below provides a summary of activity related to Strategic Delivery Priorities detailed under Strategic Objective 3 in the HSCP's Annual Delivery Plan. ELRS services also contribute to a number of other IJB Strategic Objectives.

Smart TEC

The Smart TEC (Technology Enabled Care) service makes use of technology to enable people to remain as active, independent and safe as possible in their own homes and in the wider community. The team provides Occupational Therapy (OT) assessments and interventions at the Well Wynd Hub or via home visits or phone calls. A total of 110 interventions took place over the year. Patient comments included:

- 'This session has been so helpful, and we have lots of ideas to take forward.'
- 'I was to use technology to help me to do as much for myself as I can now and to plan for the future.'

The service also plays a key role in supporting colleagues from across HSCP services and the Council's Housing service to consider technology solutions to address people's needs. Over a 9 month period (July 2022 to March 2023), the service delivered 100 'professional support and consultation' interventions. TEC Awareness sessions were also delivered during 2022/23, taking a 'Show & Tell' approach. These were attended by third sector organisations, HSCP inpatient staff, cluster-based therapists, and members of the public.

The Active and Independent Living Clinic, 'Wellwynd Hub', is based within the Loch Square Sheltered Housing complex in Tranent. There are now plans to replicate the Well Wynd Hub in other parts of East Lothian, with the launch of the James Court Hub in Dunbar planned for 2023.

Physical Activity

The new East Lothian Exercise Pathway has been developed to engage people in physical activity, and to maintain this participation over the longer-term. It aims to provide support to people with long-term health conditions, as well as to patients completing rehabilitation.

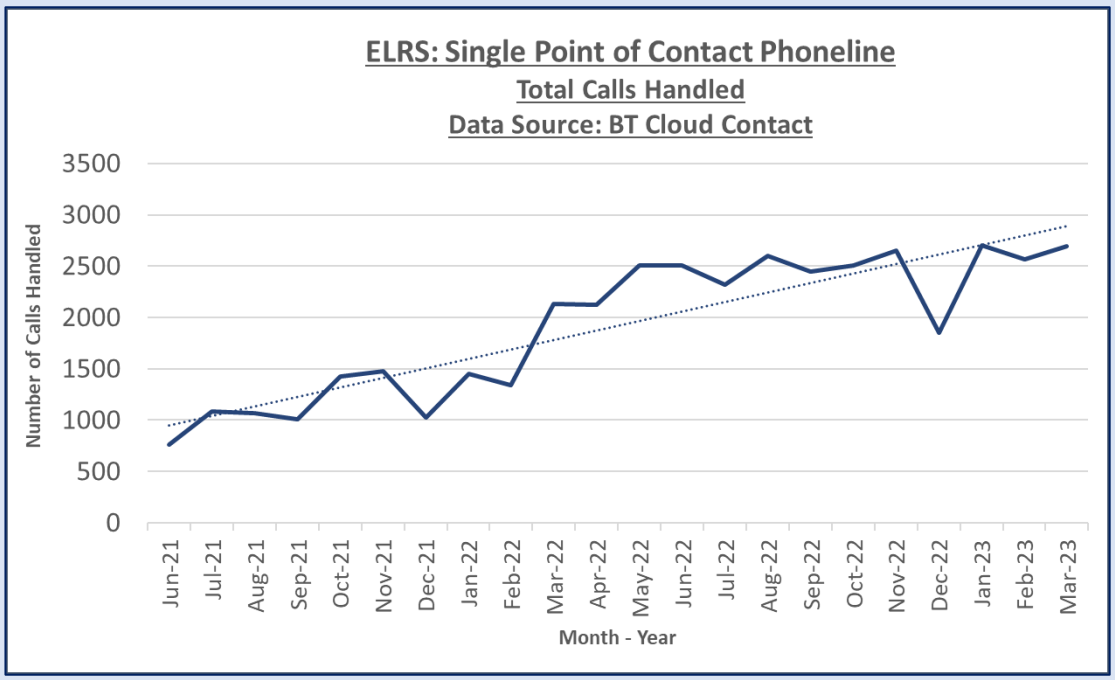
The Exercise Pathway initiative has been developed collaboratively by ELRS and Enjoy Leisure, informed by engagement with a range of community stakeholders. A Steering Group has been established to guide ongoing development, taking a 'Experience-based Co-design' approach. Membership of the Steering Group includes Haddington & Lammermuir Area Partnership, Ageing Well, Live Well, VSEL, and East Lothian Council. Wider consultation is also planned to help ensure the initiative reflects the needs and priorities of the wider community.

ELRS Single Point of Contact

ELRS established a Single Point of Contact (SPOC) phoneline system in June 2021. This allows people to contact the service directly through one central system, and then speak to the professional who is best placed to deal with their enquiry. The SPOC can be used for self-referral, professional referral, or enquiries from existing patients.

Use of the SPOC has increased gradually since its introduction. Almost 41,500 calls have been handled since the phoneline was launched in June 2021, with around 29,500 of them taking place in 2022/23 – this is shown in graph 4 below.

Graph 4 – SPOC Calls handled



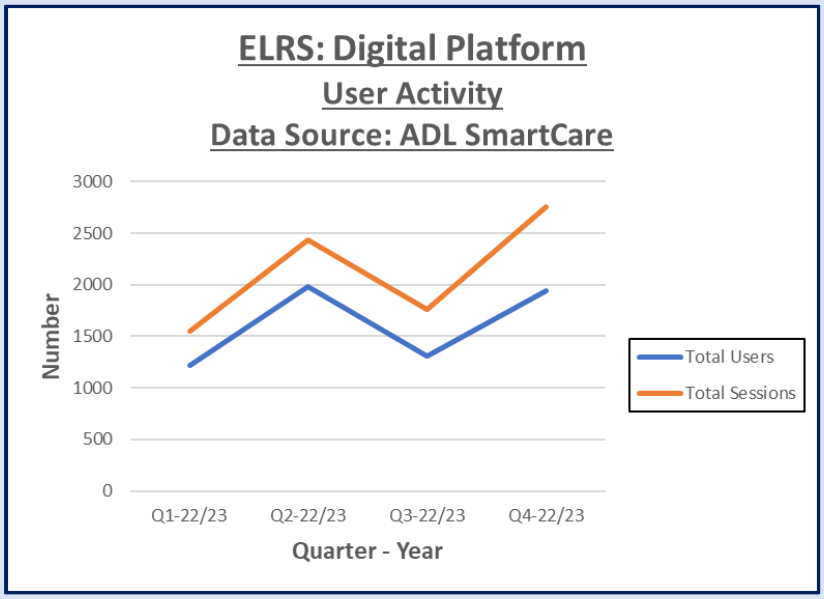
Digital Platform

A new digital platform, 'Access to a Better Life in East Lothian' was launched in March 2022, providing information and tools to support people to manage their own health and wellbeing.

The platform includes information on the LifeCurve9, support on self-management, and details of how to contact and self-refer to ELRS services. Also included is an interactive Body Map and Smart House.

Use of the Digital Platform has grown steadily over the year (see graph 5 below) as the content has been developed and social media activity has increased. It is anticipated that use will rise significantly following the public launch in April 2023.

Graph 5 – Digital Platform User Activity



East Lothian Carers Pathway

ELRS was allocated funding from the Carers Change Board in 2022 to create a new Occupational Therapy led Pathway for unpaid carers. The purpose of the Carers Pathway is to help to ensure that carers gain access to the support they need to maintain their physical, emotional, and mental wellbeing, and to help them achieve a balance between their caring role and other aspects of their lives.

As this was a new Pathway, there was a requirement to develop criteria, triage and target response times, referral routes and documentation, processes, and outcome measures. Referrals can be made by Adult Social Work teams, Carers of East Lothian or from other ELRS services. Referrals grew steadily from mid-December (when the team was in place), and 68

[9] Find out about LifeCurve here.

interventions had been completed by the end of March 2023. Carer feedback has been extremely positive, comments include:

- 'it was really good to feel understood'
- 'this has been very beneficial, and I believe has reduced my stress levels'
- 'she helped me to realise why I was having panic attacks'

3.2 Falls Prevention & Management

Falls can have a significant impact on people's health and wellbeing, making early intervention and prevention a priority for HSCP services. Falls are the most common cause of emergency hospital admission for adults in Scotland, resulting in significant financial costs and putting pressure on hospital beds, care packages and rehabilitation services.

Further development of the approach to the prevention and management of falls was identified as a strategic delivery priority for the IJB. A review of falls and falls services in East Lothian took place during 2021/22 and resulted in the creation of an East Lothian Falls Service and a Falls Project Manager post to lead on the development of a new, integrated Falls Pathway.

This work has also been supported by the introduction of an 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.

There have been over 1,000 referrals to the new Falls Service since the existing pathway was transferred from Duty Social Work in October 2022.

3.3 Mental Health & Wellbeing – Prevention & Early Intervention

Many people will experience issues with their mental health at some stage in their lives. For some, mental health issues will be more complex and require a higher level of treatment and support from mental health services. 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. This section describes a number of developments that took place during 2022/23 in relation to services providing a preventative / early intervention approach.

CWIC Mental Health

Our CWIC (Care When it Counts) Mental Health service was redesigned in 2020 to provide easily accessible support for people with a range of 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.

Individuals can be referred to CWIC MH by their GP or other professional and people are also actively encouraged to access the service directly to get support when they need it. A growing number of people now 'self-refer' – with the proportion rising from 15% in 2021/22 to around 28% in 2023/24.

CWIC MH delivered over 6,000 appointments during 2022/23, averaging at around 512 appointments per month. Waiting times for an initial appointment with the service increased to around 4 weeks during 2022/23, suggesting that demand for the service was increasingly outstripping capacity. It is anticipated that a number of developments during 2023/24 will help to address this, including the introduction of a new DBI service (see below) and the delivery of group sessions through collaboration with third sector partners such as Changes.

Distress Brief Intervention (DBI)

Development work around the introduction of a new Distress Brief Intervention (DBI)[10] service took place during 2022/23. DBI offers quick and accessible support to people in distress. People referred to the DBI service are seen quickly and provided with 'compassionate, problem solving support, wellness, and distress management planning, supported connections and signposting – reducing both immediate distress and empowering ability to manage future distress.'[11]

The HSCP is commissioning a third sector partner to deliver the DBI service in East Lothian. It is anticipated that the service will be operational from June 2023, initially taking referrals from our IHTT (Intensive Home Treatment Team) and CWIC MH services.

MELD Contact Service

The MELD (Midlothian and East Lothian Drugs) Contact Service provides information and advice regarding substance use, and support with accessing Substance Use Services. The service was developed as a pilot in 2021/22 and continued into 2022/23 following positive evaluation.

The Contact Service helpline offers callers the opportunity to benefit from a confidential, trauma-informed, person-centred conversation, focused on addressing their concerns and needs. They are then directed to the most appropriate support service (or services). If

[10] Distress in this context is defined as 'An emotional pain which led the person to seek help, and which does not require further emergency service involvement' (www.dbi.scot/aim/)
[11] Aim - Distress Brief Intervention Scotland (dbi.scot)

engagement with MELD or with the Substance Use Service is required, a triage appointment is arranged.

During 2022/23:

- There were 1,053 enquiries to the Contact Service from East Lothian residents.
- 108 people were directed to East Lothian Substance Use Service following a triage assessment.
- 207 people were directed to MELD following a triage assessment.

Other MELD activity during 2022/23 included:

- The continued running of the long established Starfish Recovery Café in Musselburgh and the introduction of two new Low Threshold Cafés[12] in Prestonpans and Tranent.
- An increase in the number of SMART Recovery Meetings (with a total of 4 a week now held).
- The launch of a Music Group at the Starfish Café.

3.4 Improving the management of long-term conditions

An increasing proportion of our population is now living with long-term conditions, and this is set to continue to increase over time as more people live longer. Promoting and supporting people with self-care of long-term conditions results in better outcomes and quality of life for them, as well as helping to reduce pressure on health and social care services.

This has led to the IJB identifying the development of a proactive approach to the management of long-term conditions as a strategic delivery priority. Examples of activity taking place in 2022/23 in relation to this priority include:

- The East Lothian Rehabilitation Service's development of 'A Better Life in East Lothian' digital platform to support education and patient self-management (see page 21 above). The content specifically related to the management of long-term conditions will be developed further during 2023/24.

- The expansion of outpatient services and clinics at East Lothian Community Hospital, including those related to the management of long-term conditions (see page 31).

- Activity to raise awareness of and improve public information on the range of primary care services that people can access directly to support their health needs (see page 30).

[12] Whilst Recovery Cafés require someone to be in recovery / not under the influence of alcohol / other substances, Low Threshold Cafés are open to people whether they are under the influence or not.

- Delivery of an initiative led by the East Lothian GP Cluster and funded by the HSCP to increase the number of people using a blood pressure home monitoring system (see page 12).

Strategic Objective 3 - Our Performance in Numbers

The Smart TEC service delivered 110 interventions over the year that involved providing information, advice and support to individuals. The service delivered 100 'professional support and consultation' interventions.

The 'Access to a Better Life in East Lothian' digital platform was visited almost 2,000 times in the last quarter of 2022/23.

The new East Lothian Carers Pathway delivered 68 interventions to support carers in its first 3 months.

The falls rate for people aged 65+ fell slightly to 21 people per 1,000 population – this is the lowest rate recorded since 2019/20.

There have been over 1,000 referrals to the Falls Service since the pathway was transferred from Duty Social Work in October 2022.

The CWIC Mental Health service delivered over 6,000 appointments during 2022/23, averaging at around 512 appointments per month.

There were over 1,000 enquiries to the MELD Contact Service from East Lothian residents during 2022/23.

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

4.1 Primary Care Services

The vast majority of patient contacts in the NHS occur in primary care. The 2018 General Medical Services Contract moved responsibility for some services previously provided by GP practices to Integration Joint Boards. Details of how these services are to be developed and delivered in East Lothian are contained in the East Lothian Primary Care Improvement Plan (PCIP). Primary care services covered in the PCIP currently include:

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

Some of the developments taking place during 2022/23 in relation to these services are described below.

Care When It Counts (CWIC)

The CWIC service supports GP practices by offering same-day appointments with a team of medical professionals. The CWIC service can currently be accessed by patients registered at Riverside Medical Practice (Musselburgh), Inveresk Medical Practice (Musselburgh), Tranent Medical Practice, and the Harbours Medical Practice (Cockenzie and Port Seton).

The CWIC multidisciplinary team has a strong improvement culture and a clear focus on providing high quality care through a great training environment. This approach has been recognised nationally with the team shortlisted for the final of the Royal College of Nursing Learning in Practice Award.

The External Review into Access and Capacity of Riverside Medical Practice LLP & Associated Services was published in 2022. The Review report included a recommendation that the HSCP increase the level of provision by CWIC to Riverside Medical Practice. Through a combination of recruitment, training, and adjustment of processes within the CWIC service, the HSCP increased the CWIC provision available to patients registered with Riverside, whilst also improving the reliability of the service available to patients registered with one of the other three practices covered by CWIC.

During 2022/23:

- The number of weekly appointments provided by CWIC increased during 2022/23 from an average of 325 per week (May 2022 to January 2023) to 457 (January 2023 – June 2023)
- The goal of offering 300 appointments per week to Riverside Practice patients was achieved by April 20223.
- Since January 2023, three GP practices (Tranent, Inveresk and Harbours) have received between them a minimum of 40 appointments per day / 200 per week

Pharmacotherapy Team

The East Lothian HSCP pharmacotherapy team consists of pharmacists and pharmacy technicians who work across all 15 East Lothian general practice. By March 2023 there was the equivalent of 8.2 pharmacists and 7 pharmacy technicians in the team.

The role of pharmacy technicians may be less familiar to people than the role of a pharmacist, but they now play a crucial role in providing primary care services. Pharmacy technicians are registered healthcare professionals who carry out specialised tasks in relation to the management of prescriptions.

The Pharmacotherapy Team have supported the transfer of some of the prescription related workload from GPs and have also contributed to improving patient outcomes and experience.

During 2022/23, the team:

- Carried out 16% more medicines reconciliation after discharge from hospital compared with the previous year.
- Responded to 84% more medicines related queries, mainly related to resolving issues where a medicine was unavailable / had gone out of stock.
- Increased the number of patients receiving serial prescriptions - it is now estimated that around 14% of patients across East Lothian who have a repeat prescriptions have serial prescriptions (see below).
- Delivered the Prescribing Plan which, achieving £648k of cost savings.

A serial prescription (SRx) allows for the supply of up to 56 weeks of medication. The use of serial prescriptions helps to reduce GP practice workload as staff are only required to issue and authorise SRx once or twice a year, as well as contributing to a reduction in the volume of calls related to repeat prescriptions. SRx are also easier and more convenient for patients.

Primary Care Vaccination Programme

Responsibility for the planning and delivery of all vaccination programmes was fully transferred to the HSCP in May 2022 (elements of vaccination programmes were previously undertaken by or shared with GP practices). The Primary Care Vaccination Team manages all community based vaccinations outwith school settings from age five upwards, this includes:

- COVID vaccinations and boosters
- Flu inoculations
- Shingles and pneumococcal vaccines
- Vaccinations recommended by GPs or Consultants due to specific health needs.

The Team has operated across a number of community venues (Haddington Corn Exchange, Musselburgh Primary Care Centre, and Edington Hospital) during 2022/23, as well as in Care Homes and on an outreach basis using the Vaccination Bus and by visiting people at home when they have been unable to attend vaccination centres. This approach has contributed to the HSCP having the highest uptake of COVID and Flu Vaccinations across all Lothian HSCPs. During the Autumn / Winter of 2022/23:

- 112,000 COVID and Flu vaccinations were provided to East Lothian residents
- 72% of all eligible adults received a COVID vaccination (compared with an average of 67% across Lothian)
- 89% of East Lothian residents over 65 received a COVID vaccination (Lothian average – 87%)
- 88% of residents over 65 received a Flu vaccination (Lothian average – 85%)

Right Care, Right Place

As described above, primary care services have changed significantly in recent years, with more services now being delivered outwith GP practices, and people being encouraged to access different primary care options without having to go via their GP.

As well as the HSCP delivered PCIP services listed above, individuals can go directly to NHS Inform, NHS 24, or their local pharmacy for support. Other primary care services include local dentists and opticians.

The HSCP has developed a Primary Care Communication Plan aimed at raising awareness of the range of services available, providing information on how to access them, and encouraging people to contact these services directly rather than going to their GP first.

The first part of this Communication Plan was delivered in early 2023, with the launch of a new Primary Care Health Services web page.

4.2 East Lothian Community Hospital Outpatient and Day Services

East Lothian Community Hospital (ELCH) provides local inpatient care, as well as an ever growing number of outpatient services and clinics, reflecting our Strategic Objective to provide care closer to home where possible. The number of outpatients seen at ELCH has grown from around 30,000 in the last years of Roodlands Hospital[13] to just over 55,000 in 2022/23 (a 60% increase).

During 2022/23, we added to the range of nurse-led patient monitoring clinics available at ELCH. This allows patients to have routine checks without the need for a Consultant appointment in a hospital out with East Lothian (unless test results require). We also changed our approach so that clinics became generic rather than speciality specific. This led to a more efficient use of appointment slots and reduced DNA (Did Not Attend) rates from 25% DNA in 2021/22 to 15% in 2022/23. We recognise that this is still a relatively high DNA rate and will continue to work on reducing it.

Key developments during the year included:

- Introducing nurse-led minor operations clinics at ELCH from autumn 2022.

- Doubling capacity for Dermatology Ultraviolet Phototherapy treatment at ELCH, reducing further the number of East Lothian residents having to travel into Edinburgh for twice weekly sessions (over 10-12 weeks). This will be in place by June 2023.

- Increasing the capacity and use of the Endoscopy and Day Services Unit at ELCH so that it now offers up to 30 sessions a week (from 17 sessions a week in 2021/22).

- The ongoing development of teaching / training by the Endoscopy and Day Service Unit at the hospital's state-of-the-art facilities and lecture theatre. This has included the Unit working towards JAG Accreditation[14], which would make it the first NHS facility in Scotland to achieve this status.

- Increasing the length of Ultrasound clinics by 2 hours each day (from 8am to 6pm) and offering Endoscopy sessions on Saturdays throughout January, February, and March to address appointment backlogs and offer more patient choice.

- Working with the Haematology Unit at the Edinburgh Cancer Centre to provide Intravenous (IV) therapy at ELCH as an alternative to travelling to the Western General.

[13] The transfer of Roodlands Outpatient Department to the new East Lothian Community Hospital began in March 2018, with all other services moving to ELCH by the end of 2019.
[14] This accreditation is awarded by the Royal College of Physicians Joint Advisory Group (JAG) on Gastrointestinal Endoscopy.

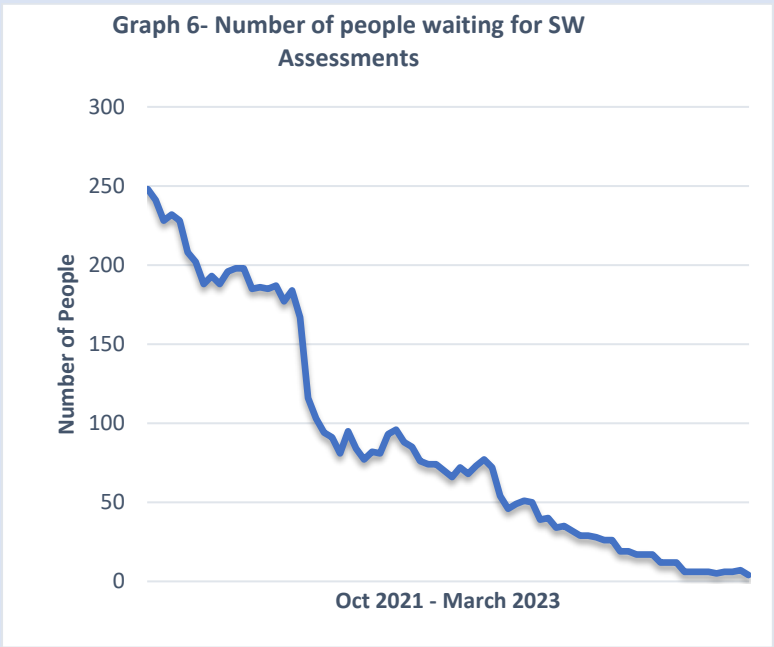
4.3 Re-imagining Adult Social Work

In last year's Annual Report, we described how our Adult Social Work Service was working with IRISS (Institute for Research and Innovation in Social Services) on a programme to re-imagine the approach to Social Work services for adults in East Lothian. This work has been developed in response to the need to ensure that social work services are effective, responsive, and fit for the future. Priorities have included:

- Reducing the time people are on our waiting lists for social work assessment
- Moving towards a more preventative and early intervention approach
- Taking a more 'outcome focussed' approach to meeting people's needs (by looking at what is important to them and considering how they can be supported to achieve this)

As part of this work, we introduced a new operating model and supporting structures in 2021. The new model is designed to ensure that as many cases as possible were dealt with by our Duty system at the 'first point of contact', rather than people being added to a waiting list. Importantly, this was underpinned by a shift in culture and approach within the service, with the ambition to eradicate waiting lists a key focus.

By the end of 2022/23, this approach had reduced the waiting list for assessment to zero, with assessments being carried out at the first point of contact or passed on for allocation if required in most instances (for both Adult Social Work and Learning Disability teams).



Graph 6 shows the reduction in the number of people waiting for a social work assessment from around 250 in October 2021 to zero from the start of 2023.

The strength of our performance is evident when compared to previous years, but also when seen in comparison to other HSCPs across Scotland. Although full year figures are not available as yet for 2022/23, the most recent comparative data demonstrates the following:

	Number of people waiting for assessment for social care (per 10,000 population)	
	November 2022	**March 2023**
East Lothian	3.2	0.4
Scotland (estimated)	17.5	Not available currently

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. Keeping waiting lists to a minimum also helps reduce 'hidden risk' in terms of people with a high, but unknown, level of need / risk waiting to be assessed.

Significant improvements have also been made in relation to the Mental Health Officer (MHO) waiting list. During 2022/23, the waiting list for Adult Guardianship Orders was reduced to a point where there are no longer any outstanding MHO reports – previously, a waiting time of 18 months was not uncommon as shown in table x below.

	Number of people waiting assessment for Adult Guardianship Orders	**% waiting 18 months or more**
May 2021	34	41%
March 2023	0	n/a

4.4 Dementia

Post Diagnostic Support

Post Diagnostic Support is currently provided for one year following a diagnosis using the Alzheimer Scotland 5 Pillar Model of Post Diagnostic Support (PDS). This is in line with the Dementia Strategy for Scotland. The service offers advice and support to help people understand the condition and to signpost them to services they may find helpful. Post Diagnostic Support can also assist with the development of a person-centred plan, as well as providing support for carers.

The PDS service went out to tender during 2022, based on a longer term contract to help aid recruitment and reduce the waiting list for support. A three year contract was awarded to Alzheimer Scotland (with an option to extend by 2 further 2 year periods).

Going forward, the PDS service will develop a more asset-based approach to post diagnostic support and will also place greater emphasis on building community supports. This will include linking in with the new Musselburgh Meeting Centre model and its roll out across East Lothian. It is expected that once staff recruitment has been completed, the waiting list for the service will reduce significantly. It is also anticipated that this will have a positive impact on the current Community Psychiatric Nursing (CPN) caseload.

Dementia Strategy

Work took place throughout 2022/23 to develop an East Lothian Dementia Strategy. Feedback gathered through the IJB Strategic Plan, and the Planning for an Ageing Population engagement exercises helped to inform the Strategy's development. Separate community engagement with people with lived experience was also completed by Outside the Box. In addition, 1:1 consultation was completed with East Lothian Care Home managers who support residents with more complex levels of dementia.

A Technical Report was also developed to inform the content of the Strategy. This contains a range of data, including data on the number of people with a formal diagnosis of dementia, the geographical spread of those with a diagnosis, and projections of future need.

Key elements of the Strategy include taking a more community focused approach and expanding the current offer of Post Diagnostic Support from 1 year to cover the lifetime that a person has dementia.

Consultation on the draft Strategy will take place from June 2023 and a final version is expected by the end of summer.

4.5 Supporting Carers

Work took place throughout 2022/23 to develop a new East Lothian Carers Strategy. Once complete, this will guide activity in this area over the next three years. Engagement with carers, carer organisations and carer representatives has helped to inform the content of the Strategy. It is anticipated that the new Strategy will be agreed in June 2023 and that it will be accompanied by an implementation plan that will be monitored and reviewed annually.

Other developments during 2022/23 included:

- Allocation of Carers Act funding to support a wide range of carer support services. These included information and advice services from Carers of East Lothian; East Lothian Young Carers Service; Older People's Day Service Outreach Work; carer identification and support via Community First (VCEL); Leuchie@home; Meeting Centre development; Alzheimer's Scotland D' cafes; PASDA engagement; and the introduction of Teens+ to East Lothian.

- Allocation of Carers Act funding to support Carers of East Lothian 'Time for me' fund, giving support and funding to carers enable them to arrange short breaks.

- The appointment of a Carers Strategy Officer to develop the new Carers Strategy and to take forward the carers' agenda across the HSCP.

- The short term appointment of a Mental Health Officer to help clear the backlog of private guardianship applications.

- The appointment of a Community Care Worker to provide support to carers.

- Allocation of personal budgets to 20 carers to help meet their personal outcomes.

- The appointment of an Occupational Therapist within East Lothian Rehabilitation Service (ELRS) to support an innovative Carers Pathway (focused on health and wellbeing outcomes for carers)

- Development work to secure a number of respite beds in local Care Homes to provide planned, bookable respite (with the first bed being available from March 2023).

- HSCP staff and CoEL forming a working group to review East Lothian's Adult Carer Support Plans and pilot a revised form with a small number of carers. Implementation of the new ACSP is due to take place during 2023/24.

- Development of a new Carers Pathway to improve carers access to support services (see p x).

- Ongoing development of the Hardgate Short Breaks Service (see below)

Hardgate Short Breaks Service

Hardgate short breaks service offers regular flexible breaks for individuals with learning disabilities and complex health needs in the heart of Haddington. In addition, it can provide emergency accommodation and support. The service has grown over the last year to offer a service to 9 service users. Ongoing work will allow for new referrals to be accepted later in 2023.

The service provides parents and carers in East Lothian with frequent reliable respite from their caring duties, whilst their loved ones enjoy a break in a familiar setting with staff who have the specialist skills required to provide a safe and nurturing environment throughout their stay.

The Hardgate team works in partnership with the Community Learning Disability Team (CLDT) to ensure that each individual's needs are fully assessed prior to, and completely met during their stays. Staff working in the service have completed training and attended information sessions to enable them to support a range of health and social care needs safely and effectively (for example, training in epilepsy and emergency medication administration; oxygen administration; British Sign Language; and positive behavioural support).

Staff training and development has meant that the service is able to offer short breaks for people with clinical intervention requirements that have previously been supported by nursing staffed respite services rather than in social care settings.

4.6 Palliative and End-of-Life Care

Our Strategic Plan highlights our commitment 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 carers.

During 2022/23:

- Our Hospital to Home and Care at Home services worked closely with Hospice at Home to provide care packages in the community. 117 people were supported in this way, with over 2,500 visits taking place.

- Following a successful pilot, we continued to offer palliative care beds at the Abbey Care Home, with around 4 people a month being admitted.

- District Nursing and East Lothian Palliative Care Team worked closely to support end of life care in people's homes where this was their wish.

- We continued to roll out a palliative care and end-of-life care education and training programme for staff.

Strategic Objective 4 - Our Performance in Numbers

The number of outpatients seen at ELCH has grown from around 30,000 in 2019 to just over 55,000 in 2022/23 (a 60% increase).

DNA (Did Not Attend) rates for East Lothian Community Hospital Outpatient appointments fell from 25% DNA in 2021/22 to 15% in 2022/23

Capacity at East Lothian Community Hospital for Phototherapy and for the Endoscopy and Day Services Unit doubled from the previous year

The number of weekly appointments provided by CWIC increased during 2022/23 from an average of 325 per week to 457 per week.

The Pharmacy Team carried out 16% more medicines reconciliation after discharge from hospital and responded to 84% more medicine related enquiries (compared with the previous year).

112,000 COVID and Flu vaccinations were provided to East Lothian residents. 72% of all eligible adults received a COVID vaccination (compared with an average of 67% across Lothian).

89% of East Lothian residents over 65 received a COVID vaccination (Lothian average – 87%) and 88% received a Flu vaccination (Lothian average – 85%).

The number of people waiting for a social work assessment in East Lothian was reduced from around 250 in October 2021 to zero from the start of 2023.

The number of people waiting assessment for Adult Guardianship Orders was reduced from 34 in March 2021 to zero by March 2023.

Personal budgets were allocated to 20 carers to help meet their personal outcomes.

Our Hospital to Home and Care at Home services worked with Hospice at Home to provide support to 117 people in the community, with 2,500 visits taking place.

Strategic Objective 5 – Develop and embed integrated approaches and services

5.1 Integrated Teams and Approaches

Enhanced Learning Disability Service

The development of an enhanced Learning Disability (LD) Service in East Lothian is proving to be successful in delivering better outcomes for local people. Learning Disability Social Work and other HSCP teams have been brought together to take a integrated, multidisciplinary approach to support more complex and high risk learning disability patients, especially those with significant health needs or mental health issues.

The enhanced service offers 24 hour support, providing continuity and delivering positive experiences and better outcomes in a safe environment. The service also contributes to the prevention of hospital admissions, timely discharge, and a reduction in carer stress. The approach also makes best use of resources which is particularly important given the workforce and social care provision issues currently faced by services.

Many of the cases seen by the enhanced LD service have been subject to Adult Protection measures and / or are frequent attenders at Accident and Emergency (A&E). We have been working collaboratively with A&E colleagues to help reduce presentations.

The enhanced LD Service's delivery is based on a care-coordination model, which ensures that the right people are involved with the individual at the right time, the first time.

5.2 Pathways

We identified reviewing patient pathways as one of our delivery priorities under Strategic Objective 5. The term 'patient pathways' refers to the journey from a person's initial contact with a service, through to their subsequent interaction with the service and related services, through to discharge if / when appropriate.

One example of patient pathway development activity that took place during 2022/23 was in relation to the 'Complex Care Assessment Pathway'. This pathway relates to the patients likely to need Hospital Based Complex Clinical Care (HBCCC) or a Care Home placement. Development of the pathway aims to ensure that the patient's journey is managed smoothly and efficiently; that actions and decisions are clearly recorded; and that patients, their carers, and families are provided with the information they need to make decisions at key points in the journey.

Other examples include the development of the ELRS Carers Pathway (see page 35), and work focused on promoting direct patient access to HSCP delivered primary care services (page 30).

Review of access to Mental Health Services

The review of access to Mental Health services is another example of work being carried out to improve access to services and patient pathways. The review is ongoing but has already resulted in a number of service developments including:

- 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 has helped to facilitate closer working with the Community Mental Health Team (CMHT) and Intensive Home Treatment Team (IHTT).

- Commissioning a new DBI (Distress Brief Intervention) service for East Lothian, providing timely, accessible, short term support for people experiencing distress (see page 24 above).

- Development work around the introduction of a new 'first point of contact' for mental health services. Once implemented, this will make initial access easier / clearer. It will also ensure that people's needs are assessed and that a plan is agreed for meeting these needs at this first point of contact.

- Introduction of a senior clinical decision maker role across the CWIC Mental Health and Intensive Home Treatment Team.

- Development of a dedicated multidisciplinary Neurodevelopmental Pathway and clinics (responding to the increase in waiting lists and waiting times for neurodevelopmental assessment).

- 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.

- Commissioning 'Autism Initiatives' to carry out neurodevelopment assessments over a fixed term period to help address the backlog with assessments.

Work in relation to each of these developments will continue throughout 2023/24. In addition, a programme will be agreed in relation to the review of Older Adult Mental Health (OAMH) services.

5.3 Meeting housing needs

The HSCP's Adult Social Work and East Lothian Council Housing Services have developed a Service Level Agreement to deliver 8 units per annum for priority housing groups. Adult Social Work assessors complete housing needs assessments for all service users and this is used to inform future housing demand by housing model and area. A total of 33 units have been delivered since 2019.

This process is managed through collaborative 8 weekly meetings with the Council's Housing Managers and Social Work Managers. Children's Services are also represented as this gives the opportunity to explore future housing options for young people with complex support needs who are transitioning to Adult Services.

Since 2019 Adult Social Work has been working towards providing tenancies in a Core and Cluster Model which allows care to be delivered by one provider on one site and ensures that there is individual support during the day to deliver outcomes and a robust overnight response which is shared by all individuals.

The close link between health, social care, housing, and place was reflected in the carrying out of a joint consultation exercise to inform the new IJB Strategic Plan, Local Housing Strategy and East Lothian Development Plan (you can read about this in page xx above). Housing colleagues also ran specialist works to enable HSCP to have a direct input into the Local Housing Strategy development.

The commencement of the Housing and HSCP Strategic Group in May 2023, will ensure continued joint working, including in relation to the development of a Housing Contribution Statement and supporting further HSCP input to the draft Local Housing Strategy.

5.4 Transitions

Planning for young people's transition from child to adult services is already well established in East Lothian, with transition referrals made at an early stage and contact and multidisciplinary meetings taking place on a regular basis. The young person is allocated an Adult Services Social Worker well in advance of them moving to Adult Services, and the young person and their family are involved and supported throughout.

Work continued during 2022/23 on the further development of this collaborative approach to transitions, including the development of a draft East Lothian Transitions framework. The framework reflects the 'Principles of Good Transitions'[15], and places further emphasis on the young person being at the centre of the planning process. The final framework will further formalise the process to be followed, defining the responsibilities of those involved, and

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

expected milestones and timescales. It is anticipated that the implementation of the new framework will begin in summer 2023.

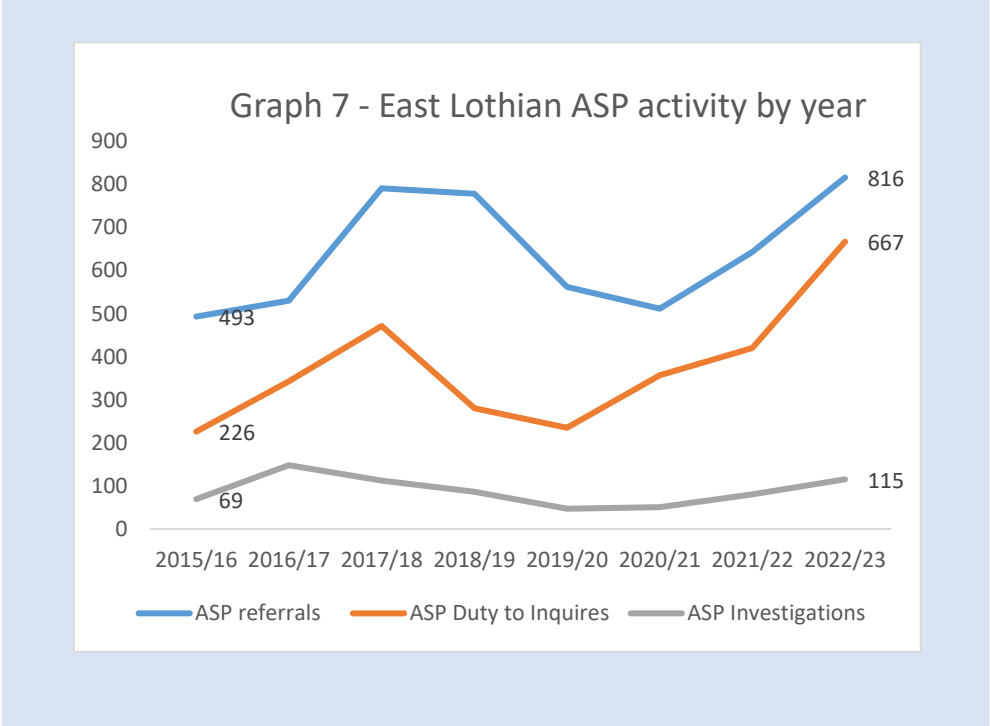
Strategic Objective 6 – Keep people safe from harm

6.1 Adult Support and Protection

Detailed data in relation to the East Lothian Adult Support and Protection service performance is reported in the EMPPC[16] Annual Report. This will be available on the EMPPC website in the autumn once completed. Quarterly newsletters describing Public Protection activities and including articles on a range of related topics are also available on the website. This section highlights some elements of performance during 2022/23 and gives examples of service development activity during 2022/23.

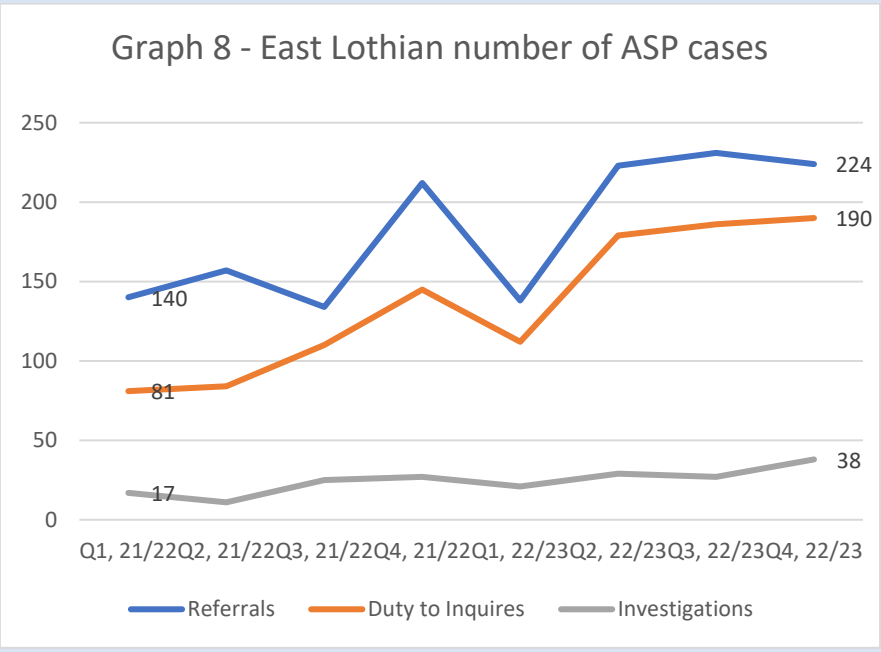
In terms of level of activity:

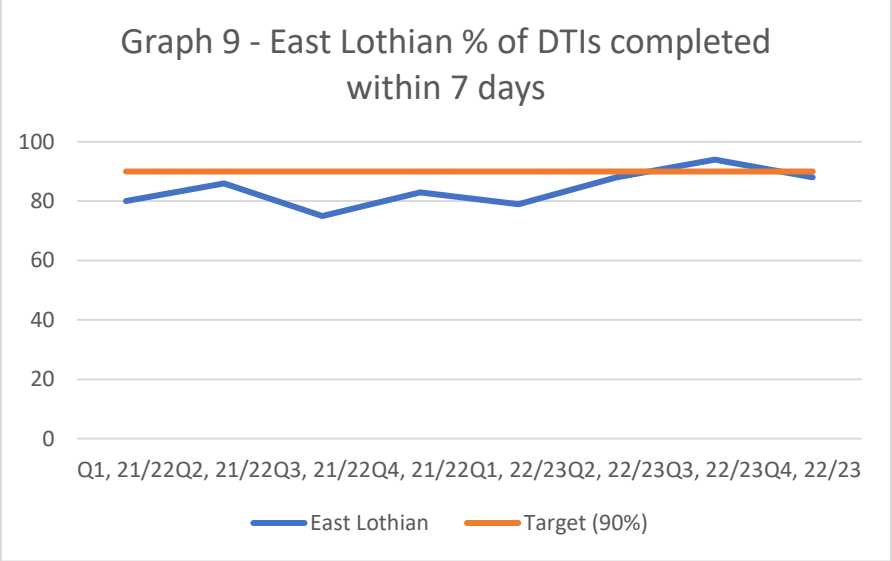
- There were 816 referrals categorised as Adult Protection in East Lothian during 2022/23 – an increase of 173 (27%) from the previous year and a 60% increase since 2020/21.
- There were 667 Duty to Inquires (DTIs) – a 59% increase from the previous year.
- The number of Adult Support Protection Investigations increased by 44% from 80 the previous year to 116 in 2022/23.
- Graph 7 below shows the upward trend in ASP activity from 2015/16.



[16] East Lothian and Midlothian Public Protection Committee (EMPPC) is the local strategic partnership responsible for the overview of local policy and practice in relation to Adult Protection, Child Protection, MAPPA and Violence Against Women and Girls.

Despite the ongoing increase in level of demand, compliance in relation to completing DTIs within 7 days of referral increased, demonstrating improved performance (see graphs 8 & 9 below).





We continued to develop our approach to performance management and improvement in relation to Adult Support and Protection (ASP) services during 2022/23. This included:

- Updating our Adult Support and Protection Procedures to ensure they align with the Scottish Government's revised Code of Practice (with revised procedures due to be implemented during 2023).

- Introduction of a new analytical risk assessment framework and guidance for professionals involved in ASP.

- Revision of recording templates to ensure that the right information is captured to support evidence-based risk assessment.

- Implementation of an Escalating Concerns Procedure (from autumn 2022). This Procedure is used to support a multi-agency approach where there concerns about an adult's safety, but they do not fit the criteria to allow them to be managed under ASP legislation.

- Preparation for and involvement in a Joint Inspection of East Lothian Adult Support and Protection in East Lothian.[17] The final inspection report is due to be published in June 2023. An Improvement Plan will then be developed in response to any recommendations made in the report.

- Hosting an online learning event on self-neglect and hoarding for over 300 staff from across the Lothians (in response to the growing number of ASP referrals related to self-neglect across the country).

6.2 Reducing harm from substance use

The introduction of Medication Assisted Treatment (MAT Standards) is a key element of the Scottish Government's strategy to tackle the rise in drug related harm and deaths and to promote recovery. MAT Standards are described as 'evidence based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland'.

Responsibility for implementation of MAT Standards lies with health and social care service providers, including HSCPs. The MAT Standards framework has a number of elements, aimed at ensuring that MAT is accessible, safe, effective, and based on a person-centred approach to care.

[17] The Joint Inspection was carried out by the Care Inspectorate, Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland.

The Scottish Government set a target for the full implementation of MAT Standards 1 to 5 by April 2023 (there are 10 Standards in total). East Lothian HSCP worked closely with Alcohol and Drug Partnership (ADP) to achieve this in advance of the target date. This involved a considerable collective effort by all partners, some of the key activities delivered included:

- Full implementation of same day access for assessment and treatment, 5 days a week, with people either coming via the MELD contact service (see page 24), triage, external referral, or self-presentation. In the first 4 months, 25 people had accessed the same day service and the median time between first contact and starting a prescription was 2 days.

- Supporting people to make an informed choice about medication options and dosage in both primary and secondary care settings. This resulted in a steady update of Buvidal. Buvidal is prolonged release medication that can be administered weekly or monthly, making it easier for people to stick to their planned medication and also offering a more convenient option for people in work or education.

- Midlothian and East Lothian Drugs (MELD) developing a low threshold café model in targeted areas. Cafés began to operate in the Tranent and Prestonpans areas in early 2023.

- Carrying out engagement with People with Lived Experience to help inform the delivery of treatment and support options related to the implementation of MAT Standards. This is being led by MELD and involves peer support staff engaging with stakeholders.

6.3 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.

The service has a Business Plan in place (for 2021-24) and publishing an Annual Report each autumn, which includes a comprehensive Improvement Plan. The service also produced an Evaluation Timetable (2021-23) and reported on this in August 2022.

Activities during 2022/23 included:

- Increasing the use of the Caledonian System[18], resulting in a threefold increase in Caledonian orders since September 2020. A dedicated member of staff has been identified to support uptake of Caledonian. We have also adjusted our screening process to encourage greater use (this approach has been adopted by neighbouring local authorities as best practice). Our success was reflected in the service being a finalist in the Scottish Social Services Awards.

- Building on our approach to early intervention and prevention through the development of Structured Deferred Sentences (with roll out beginning in March 2023). Structured Deferred Sentence is a way to 'provide social work support to individuals who may need a short term intervention to address needs by who do not require the level of supervision of a Community Payback Order'[19]. Where successful, SDS helps to reduce the frequency and seriousness of offending behaviour and lessen the need for intensive supervision in the community.

- The Community Payback Work Team developing new options for unpaid work for service users. This included getting authorisation to set up 'classroom' to enable the delivery of an extended range of options, including group work, learning opportunities and modules delivered by partner organisations (e.g., the Scottish Fire and Rescue Service and CHANGES).

- Involvement in work at a national level to pilot a new Justice Social Work Report (JSWR) template. The new template gives the service an opportunity to provide the Court with more information about an individual prior to them being sentenced.

In terms of level of activity over 2022/23:

- 162 Community Payback Orders (CPOs) were issued for East Lothian residents – this was an increase of 28% from the previous year (from 127 CPOs).
- 115 of the CPOs issued had a Supervision Requirement (61 included unpaid work) – this was an increase of 77% from the previous year (and a 74% increase in unpaid work requirements).

[18] The Caledonian System is national programme described as 'an integrated approach to addressing domestic abuse. It combines a court-ordered programme for men, aimed at changing their behaviour, with support services for women and children' – more information is available here.
[19] Structured Deferred Sentence - Community Justice Scotland

- 244 Justice Social Work Reports were requested – 93% were completed within the timescale of two working days prior to the return to court date.

More detailed information and data on the performance of the Justice Social Work Service will be reported in the annual Community Payback Order Report (due in October 2023) and the East Lothian Chief Social Worker Annual Report (available around the same time). Both reports will be published on the East Lothian IJB webpages (link to be added).

6.4 Supporting children, young people, and families

HSCP 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[20] and through the support we provide to parents and other adults as part of the wider family unit.

As articulated in The Promise[21], we need to ensure that our services are guided by the principles of 'Whole Family Support'. This includes our staff working closely with other services involved in supporting families to identify and respond the needs of the whole family. Although we already work closely with colleagues from Children's Services and other organisations, we are committed to further development of collaborative working.

Examples of how we will do this include:

- Training and awareness raising for HSCP staff in relation to 'whole family approach'.
- HSCP representation in the East Lothian Trauma Informed Working Group and identification of an HSCP Trauma Informed Champion.
- Participation of HSCP staff in 'Safer and Together' training and in the East Lothian 'Equally Safe' group.
- Providing support to young carers as outlined in the East Lothian Carers Strategy (see page 35).
- Working with Children's Services colleagues to ensure a positive transition for young people moving to adult services (see page 41).

6.5 Suicide prevention

The HSCP will work with a range of partner organisations during 2023/24 to develop and deliver an updated East Lothian Suicide Prevention Action Plan based on the national strategy - 'Creating Hope Together – Scotland's Suicide Prevention Strategy 2022-23'. This will build on the previous work of the East Lothian Suicide Prevention Steering Group.

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

[21] Home - The Promise

Strategic Objective 6 - Our Performance in Numbers

There were 816 referrals categorised as Adult Protection in East Lothian during 2022/23 – an increase of 173 (27%) from the previous year and a 60% increase since 2020/21.

There were 667 Duty to Inquires (DTIs) during 2022/23 – a 59% increase from the previous year.

The number of Adult Support Protection Investigations increased by 44% from 80 the previous year to 116 in 2022/23.

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Strategic Objective 7 – Reducing health inequalities

7.1 / 7.2 Understanding health inequalities / Taking action to address health inequalities

The inclusion of Strategic Objective 7 in the IJB Strategic Plan reflects the IJB's recognition of the key role it plays in relation to reducing health inequalities[22] in East Lothian.

Many of the activities described in this report contribute to reducing health inequalities. However, a number of specific activities also took place during 2022/23 to further develop our approach to reducing health inequalities, some of these are described below.

Developing an understanding of health inequalities

We completed a Joint Strategic Needs Assessment[23] (JSNA) during 2022-23 - you can view our JSNA here . As well as helping to inform the development of our IJB Strategic Plan, this added to our knowledge of East Lothian communities in terms of demography, as well as in relation to health and other outcomes. We will continue to develop the JSNA during 2023/24, particularly in terms of content that contributes to our understanding of health inequalities.

Work will also take place over coming year to look at how we can further develop our understanding of local health inequalities by gathering data and other information through the services we deliver.

Our approach to health inequalities

Integrated Impact Assessments (IIAs) are carried out by public bodies to consider the available evidence in order to determine whether proposals are likely to have an unfair or negative impact on particular groups of people within the community or on the environment.

Our use of IIAs was identified as an area for improvement during 2022/23, leading to the development of an IIA Improvement Plan. Actions from the Plan delivered during the year included:

- Making all current IIAs available on the East Lothian Council website and introducing a consistent approach to ensure that any new IIAs are also published there.

- IJB members attending a development session which highlighted their duty to ensure that IIAs have been considered and carried out where necessary in relation to proposals

[22] Health inequalities can be defined as systematic, unfair differences in the health of the population that occur across social classes or population groups. Find out more about health inequalities here
[23] You can learn more about the Joint Strategic Needs Assessment process here.

requiring an IJB decision. Ongoing information and training for IJB members to ensure continuing awareness of equalities issues.

- Encouraging HSCP staff to take part in Lothian IIA group training (delivered regularly throughout the year). Uptake of this was positive, and this will continue to be monitored.

- Preparation for the introduction Equalities Champions in HSCP teams / services to promote awareness and understanding of inequalities. Champions will also lead on screening activities in their service area, carrying out IIAs when needed (Equalities Champions will be identified during 2023/24).

Our Financial Performance

Spend in 2022/23

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 £204m and ended the year with a deficit of £10.1m – this means that the charges from partners for services delivered on behalf of the IJB were more than the income available to the IJB. However, this deficit is due to the IJB receiving income last year 2021/22 from Scottish Government for use in this financial year 2022/23 with the 'operational' underspend being c. £0.2m.

A significant element of the funds received last year for use during 2022/23 relates to Covid-19 funding. The IJB started the year with £9.1m to meet the additional costs of the pandemic and spent £5.5m. The remaining balance of Covid-19 funding of £3.6m has been reclaimed by Scottish Government, therefore the IJB has a Covid-19 reserve balance of nil.

The operational underspend will be taken to the IJBs general reserve which was £5m at 31 March 2023.

Further details of our total reserves balance are shown below. The financial position of the IJB at the end of 2022/23 is explained in more detail in the annual accounts.

Budget Summary

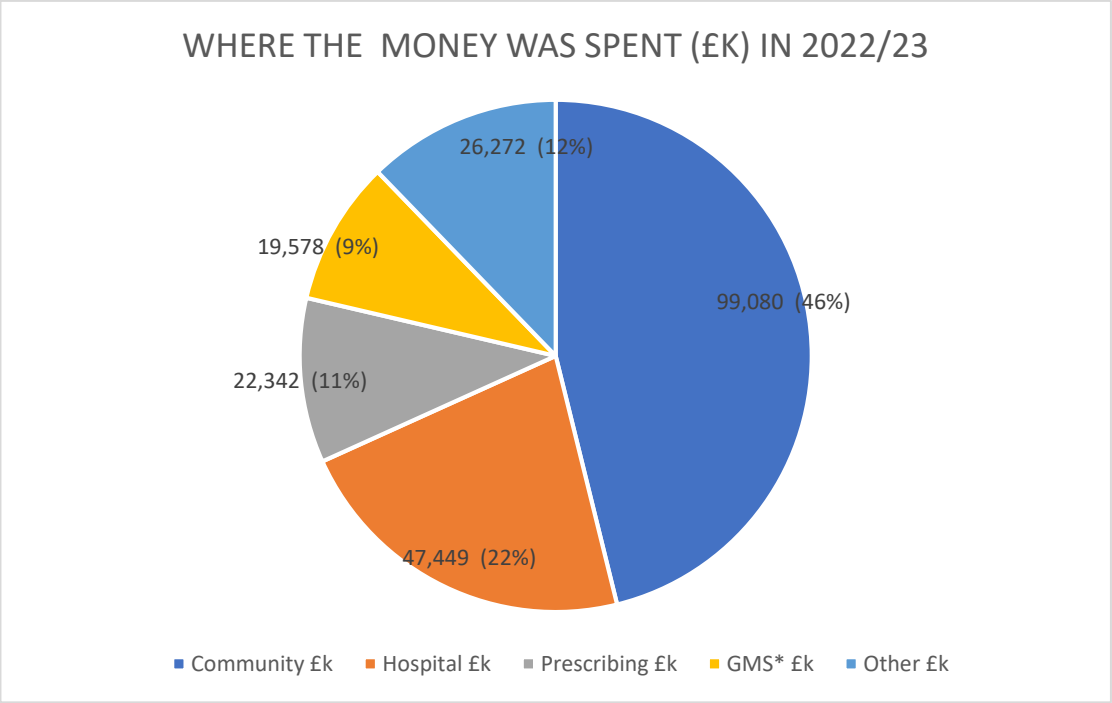
	2022/23 Budget	**2022/23 Expenditure**	**2022/23 Variance**
	£k	**£k**	**£k**
Health	£142,908	£153,357	-£10,449
Social Care	£61,644	£61,362	£282
Total	£204,552	£214,719	-£10,167

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

Where the money was spent in 2022/23

	Community £k	Hospital £k	Prescribing £k	GMS* £k	Other £k	Total £k
Expenditure	99,080	47,449	22,342	19,578	26,272	214,720
% of total	46%	22%	10%	9%	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 2022/23 is shown in the table below:

Budget and expenditure by service in 2022/23

	Budget £k	Expenditure £k	Variance £k
Direct East Lothian Services			
Community AHPS	6,176	5,868	308
Community Hospitals	14,560	14,038	521
District Nursing	3,127	2,964	163
General Medical Services	19,229	19,578	-349
Health Visiting	2,207	2,106	101

Mental Health	6,160	6,302	-142
Other	7,630	16,733	-9,103
Prescribing	21,279	22,342	-1,062
Resource Transfer	4,969	4,969	1
Older People	34,008	33,693	315
Mental Health	2,226	2,550	-324
Physical Disabilities	2,755	2,894	-139
Learning Disabilities	17,923	18,756	-833
Statutory	215	180	35
Planning and Performance	3,159	3,140	19
Other	1,358	150	1,208
Pan Lothian Services			
Set Aside	24,764	25,960	-1,196
Mental Health	2,871	3,122	-251
Learning Disabilities	1,606	1,624	-18
GP Out of Hours	1,593	1,676	-83
Rehabilitation	1,137	940	198
Sexual Health	911	928	-18
Psychology	1,580	1,584	-4
Substance Misuse	592	567	25
Allied Health Professions	1,888	1,765	123
Oral Health	1,626	1,565	61
Other	4,697	4,420	277
Dental	7,617	7,617	0
Ophthalmology	2,093	2,093	0
Pharmacy	4,596	4,596	0
Totals	**204,552**	**214,720**	**-10,167**

Reserves

The IJB does hold reserves and more detail on these reserves can be found in the IJB annual accounts for 2022/23.

Future financial pressures

Key financial challenges in 2023/24 for the IJB will be NHS Lothians forecasts significant financial pressure in the health part of the IJB, particularly within our prescribing, GMS and set aside budgets. Within the social care budget, inflation, and demand increases (through population growth) will continue to create financial pressures. This will be examined further in the IJB's multi-year financial plan.

National Integration Indicators - How We Performed

*** MANAGEMENT INFORMATION ONLY *** - This information has been released for management information purposes only and is not for onward distribution. An updated version of this report will be completed following the publication of the latest MSG and Core Suite Indicator figures in July.

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 a set of 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.

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. You can view the 2021/22 data in last year's annual report.

(ii) Operational Performance Indicators

The Core Suite of indicators includes a number of 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 (indicators 12, 13, 14, 15, 16, and 20), the figures given are for calendar year 2022. Calendar year 2022 is used as a proxy for 2022-23 due to the national data for 2022-23 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.

All proxy data shown in the tables below should be considered management information. An updated version of this section will be completed when the latest MSG figures are released on the 4th July. Due to this, the latest Scottish data has only been included for indicators 17, 18, 19, and 20.

Performance Symbols Key					
Improvement trend	✔	Performance similar to previous years / only slight change	—	Downward trend	↓
Performance above the Scottish level	✔	Performance around the same as Scottish level	—	Performance below the Scottish level	✕

11. Premature mortality rate for people aged under 75 per 100,000 persons (by calendar year)									
	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**Trend**	**6-year Trend**	The premature mortality rate for people aged under 75 has increased since 2019. The rate also increased at a national level. East Lothian's premature mortality rate is still significantly lower than the Scottish rate.
East Lothian	375	372	333	313	342	375	↓	—	
Scotland	440	425	432	426	457	466	-	-	

12. Emergency admission rate for adults (per 100,000 population)									
	2017/18	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022**	**Trend**	**6-year Trend**	Performance improved, with the lowest emergency admissions rate in 6 years.
East Lothian	10,095	10,071	10,964	10,073	10,428	**9,358**	✓	✓	
Scotland	11,942	12,283	12,529	10,957	11,629	-	-	-	

13. Emergency bed day rate for adults (per 100,000 population)									
	2017/18	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022**	**Trend**	**6-year Trend**	Performance improved, with the East Lothian rate of emergency bed days decreasing slightly from the previous year.
East Lothian	122,688	103,451	100,497	105,628	115,048	**114,891**	✓	✓	
Scotland	124,118	121,126	119,667	101,837	112,637	-	-	-	

14. Readmission to hospital within 28 days of discharge (rate per 1,000 discharges)									
	2017/18	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022**	**Trend**	**6-year Trend**	East Lothian performance improved, with 2022 having the lowest readmission rate recorded since 2017/18.
East Lothian	106	99	102	117	104	**89**	✔	✔	
Scotland	103	103	105	120	107	**-**	-	-	

15. Proportion of last 6 months of life spent at home or in a community setting									
	2017/18	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022**	**Trend**	**6-year Trend**	East Lothian performance did not change from the previous year. A 2% improvement can be seen in the East Lothian figure over the last 6 years.
East Lothian	86%	88%	87%	89%	88%	**88%**	—	✔	
Scotland	88%	88%	88%	90%	90%	**-**	-	-	

16. Falls rates per 1,000 population aged 65+									
	2017/18	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022**	**Trend**	**6-year Trend**	East Lothian performance improved, with the falls rate at the lowest recorded since 2019/20.
East Lothian	19	19	23	23	22	**21**	✓	↓	
Scotland	22	23	23	22	23	-	-	-	

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. A similar decrease was seen at a Scottish level.
East Lothian	77%	85%	84%	85%	85%	77%	↓	—	
Scotland	84%	85%	82%	82%	83%	76%	-	-	

18. Percentage of adults with intensive care needs receiving care at home									
	2017	**2018**	**2019**	**2020**	**2021**	**2022**	**Trend**	**6-year Trend**	The percentage fell to the lowest recorded since 2019. There was also a reduction at national level.
East Lothian	64.9%	61.0%	63.3%	62.7%	64.3%	61.6%	↓	↓	
Scotland	61.1%	62.1%	63.0%	63.0%	64.6%	63.5%	-	-	

19. Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)									
	2017/18	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**Trend**	**6-year Trend**	2022/23 shows the first increase in rate since 2017/18. An increase can also be seen nationally. East Lothian continued to perform well in relation to delayed discharge rates relative to other HSCPs.
East Lothian	775	641	327	258	153	206	↓	✓	
Scotland	762	793	774	484	784	919	-	-	

20. Percentage of health and care resources spent on hospital stays where the patient was admitted in an emergency								
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**Trend**	**6-year Trend**	East Lothian performance improved. The percentage of resources spent on emergency hospital stays is the lowest recorded since 2017/18.
East Lothian	21.8%	22.0%	24.5%	23.1%	22.8%	✔	↓	
Scotland	23.2%	23.3%	24.1%	24.1%	24.0%	-	-	

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 for the indicator as yet. 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.

Ministerial Strategic Group (MSG) Indicators

The indicators shown below were developed by the Ministerial Strategic Group for Health and Social Care. Health and Social Care Partnerships have been required to set their own targets for each of these indicators – East Lothian's are shown in the table below. These figures are based on reports released for management information only. Due to different configuration of services, figures for the hospital / hospice categories may not be comparable across partnership areas.

Performance Symbols Key					
Improvement trend	✔	Performance similar to previous years / only slight change	—	Downward trend	↓

East Lothian Health and Social Care Partnership

Indicator	2017/18	2018/19	2019/20	2020/19	2021/22	2022	Trend	6-year Trend
1. Number of Emergency Admissions (18+)	8,285	8,194	9,008	8,252	8,510	**7,677**	✔	✔
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	80,826	66,269	66,144	66,399	70,887	**71,914**	↓	✔
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay[24] (18+)	446	455	2,637	6,725	6,514	**5,911**	**Issue with data**	-

[24] Issue with data completeness for 2020

2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay[25] (65+)	446	281	2,230	6,577	6,294	**5,672**	**Issue with data**	-
2iii. Number of Unscheduled Hospital Bed Days – Mental Health[6] (18+)	16,232	15,075	14,179	12,964	13,433	**13,823**	**Issue with data[26]**	-
3. New Accident and Emergency attendances (18+)	20,125	21,176	21,305	17,923	21,218	**21,369**	↓	↓
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	10,668	7,839	4,781	3,935	2,672	**3,637**	↓	✓
5. Percentage of last six months of life spent in community setting	85.6%	87.8%	87.4%	88.8%	88.0%	-	—	↓
6. Percentage of the population at home – supported and unsupported (aged 65+)	96.3%	96.4%	96.6%	96.8%	96.6%	-	↓	✓

[25] Issue with data completeness for 2020

[26] Issues with this data are like to be related to changes in coding so meaningful comparisons with previous years are not valid [6] Issue with data completeness for 2020

East Lothian Localities

Indicator	Locality	2017/18	2018/19	2019/20	2020/21	2021/22	2022
1. Number of Emergency Admissions (18+)	**East**	2,870	3,001	3,247	2,925	3,157	**2,815**
1. Number of Emergency Admissions (18+)	**West**	5,414	5,190	5,765	5,328	5,317	**4,862**
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	**East**	30,468	26,436	26,129	24,746	29,562	**27,173**
2i. Number of Unscheduled Hospital Bed Days – Acute (18+)	**West**	50,382	40,948	40,564	42,023	42,537	**44,741**
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)	**East**	258	-	534	2,153	2,880	**2,834**
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)	**West**	188	455	2,204	4,572	4,016	**3,527**
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (65+)	**East**	258	-	481	2,131	2,819	**2,384**
2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (65+)	**West**	188	281	1,850	4,446	3,857	**3,288**
2iii. Number of Unscheduled Hospital Bed Days – Mental Health6 (18+)	**East**	9,239	8,318	7,861	5,373	6,191	**5,668**
2iii. Number of Unscheduled Hospital Bed Days – Mental Health6 (18+)	**West**	7,338	7,167	5,766	7,019	7,109	**8,155**
3. New Accident and Emergency attendances (18+)	**East**	6,055	6,640	6,763	5,849	7,405	**7,287**
3. New Accident and Emergency attendances (18+)	**West**	14,070	14,536	14,542	12,074	13,821	**14,082**
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	**East**	5,388	3,293	2,469	1,615	1,040	**1,519**
4. Total number of Bed Days lost to delays (all delays and all reasons 18+)	**West**	4,642	4,259	2,241	2,294	1,601	**2,049**