ANNUAL REPORT 2016-2017

East Lothian Integration Joint Board

Achieving best care, best health and best value for our communities

East Lothian
Integration Joint Board

Contents

Foreword

'Welcome to the first annual report of the East Lothian Integration Joint Board (IJB). This was formed on 1 July 2016, taking on responsibility for the planning and delivery of a wide range of adult primary and community health and social care services in East Lothian, as well as some acute hospital services.

'This report looks at the period between April 2016 and March 2017. During this time we focused on integrating our health and social care management and service teams and we reshaped the commissioning and delivery of services in line with our strategic vision.

'We also laid the groundwork for the way that we want to work with our stakeholders. We spent all of 2016 engaging with providers, service-users and advocacy groups on a wide range of projects. Stakeholder feedback was instrumental in shaping the procurement process for our new care at home framework, our day centre strategy and our primary care strategy.

'This annual report shows what we achieved in 2016-17. Much of it is very positive but there are also areas where we want to do better. Therefore, we have included information about what we want to do next. Planning and delivery doesn't stop and start with each new financial year, but is a continuous process.

'Integrated working has huge potential benefits, for example, sharing knowledge and skills and making better use of resources to secure better outcomes for people in East Lothian. One of the great strengths of health and social care integration in Scotland is that it also provides the opportunity to engage in longer-term, sustainable planning, which, in East Lothian, will help us to achieve our vision of best health, best care, best value for our communities.'

'We look forward to working with our partners in coming years to deliver this vision.

Peter Murray, East Lothian Integration Joint Board Chair

David Small, Chief Officer, East Lothian Integration Joint Board

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About East Lothian Health and Social Care Partnership

East Lothian Integration Joint Board (IJB) was formed on 1 July 2015, with a responsibility to plan for the delivery of the functions delegated to the IJB by East Lothian Council and NHS Lothian. These functions are:-

- Adult social care
- Primary care services (GP practices, community dentists, community pharmacists and community optometrists)
- Mental health services
- Physical disability and learning disability services
- Community health services
- Community hospital services
- Unscheduled care services (services that are generally delivered from the Royal Infirmary of Edinburgh and the Western General Hospital)
- Community Justice.

The IJB assumed formal responsibility and associated budget for these functions on April 2016. The IJB published its 2016 to-19 Strategic Plan for these functions in March 2016, in line with the processes set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

This report looks at our performance during the first full year of operation and how we have delivered the vision in the IJB's Strategic Plan of best health, best care and best value.

Our vision - Best health, best care, best value for our communities

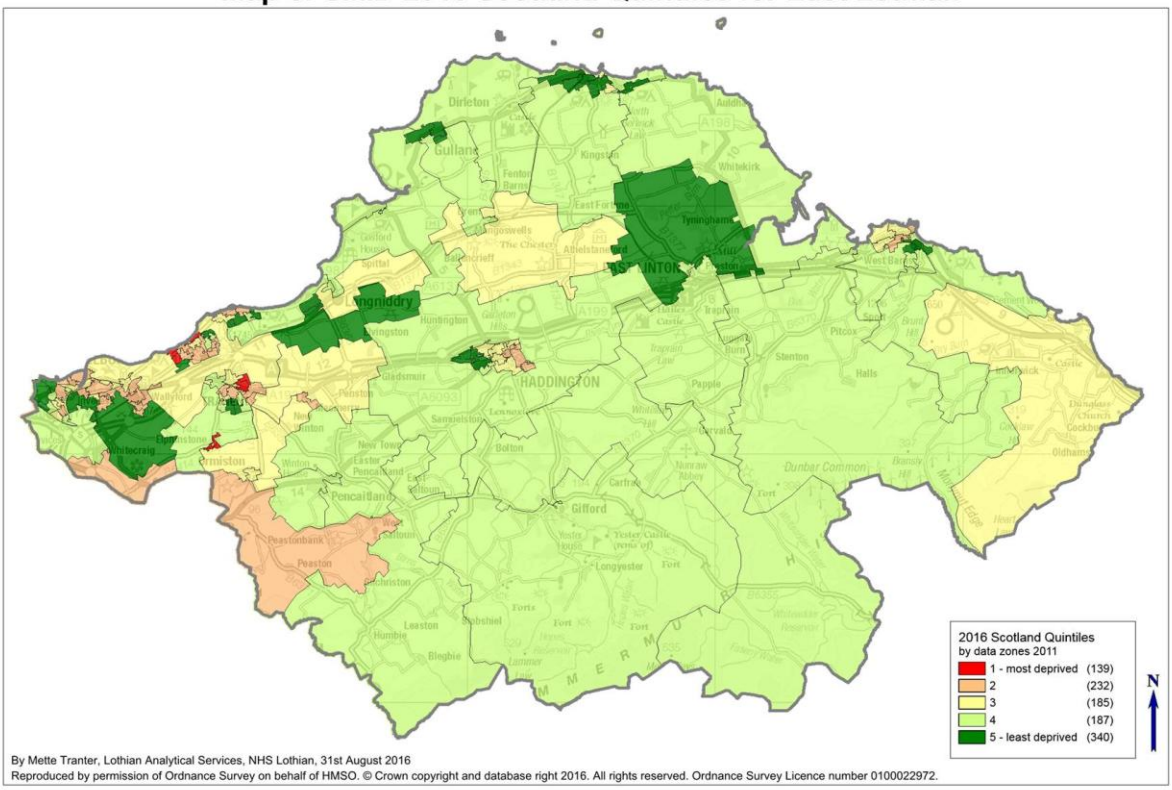
We want to make sure our services:

- are joined-up for service-users
- take account of the particular needs of individual service-users and their circumstances in different parts of the county
- respect our service-users' rights and take account of their dignity
- take account of the way that our service-users participate in their communities
- protect and improve our service-users' safety
- improve the quality of our services and ensure that they are planned and delivered locally in a way that is engaged with our communities
- anticipate needs and prevent them from happening
- make the best use of the available facilities, people and other resources.

You can find out more about our vision for health and social care in East Lothian over the next few years in our strategic plan on www.eastlothian.gov.uk/elhscp.

The strategic plan underpins all our decision making, focuses on delivery of the nine National Health and Wellbeing outcomes set out in the 2014 Act and seeks to address health inequalities across the county (see following map). As the strategic plan notes, across East Lothian people living in the poorest neighbourhoods, can on average, expect to die four years earlier than people living in the richest neighbourhoods and spend more of their lives with ill health.

Map of SIMD 2016 Scotland Quintiles for East Lothian



Locality planning

The HSCP has established good relationships with East Lothian's six local area partnerships. As set out in the Strategic Plan, it was decided to have two localities – East and West – as this model best reflects the county's demography. Initial locality work on primary care is already underway and this approach will be further developed within the Strategic Groups.

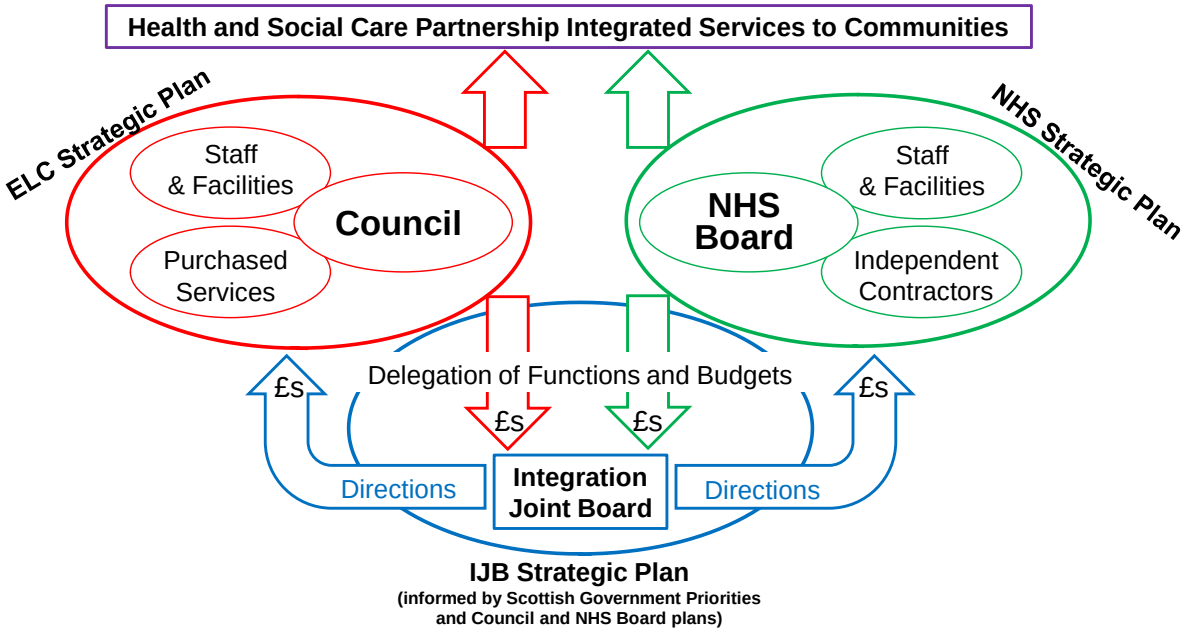
What is a 'locality''?

Localities should, as far as possible, reflect natural communities, boundaries and established service operating boundaries, focussing on populations and service design to meet their needs.

Planning and delivery structures

The Public Bodies (Joint Working)(Scotland) Act 2014 sets out the process by which an Integration Joint Board delivers its Strategic Plan by issuing 'Directions' to the Local Authority and the Health Board as appropriate. Directions are issued for each delegated function and for the allocation of the associated financial resource to support delivery of

directions. The graphic below shows the relationship between the IJB, Council, NHS Board and Health and Social Care Partnership and the table highlights the key challenges facing the HSCP.



Key challenges for East Lothian Health and Social Care Partnership

Growing and ageing population	Health inequalities	Financial pressures	High demand on primary care	Recruitment
East Lothian is amongst the fastest growing areas in Scotland. The over-65s age-group will grow by 72% over the next 20 years. Health and social care needs are becoming more complex.	There are marked and continued differences in health experience, health outcomes and levels of deprivation between the west and east of the county.	Reducing resources and change demographics mean that it is no longer affordable to deliver health and social care services under the existing models.	Primary care, particularly in the west of the county, remains under pressure arising from: - the growing and complex care needs of the elderly. -the increase in long term conditions. -high demand for appointments across the practice list. -reducing numbers of GPs	The current labour market makes carer recruitment difficult. There is a national shortage of qualified and trainee GPs. Investment is needed for training and employment of new primary care team roles (e.g. Advanced Nurse Practitioners and Advanced Scope Physiotherapists.

Performance against Directions

At its meeting of 31st March 2016 East Lothian IJB agreed its 2016-17 directions, aligned to the Strategic Plan and reflecting the nine National Health and Wellbeing Outcomes and the 23 performance indicators and covering all the functions delegated to the IJB. These were issued to East Lothian Council and NHS Lothian in March 2016 for the financial year 2016/17.

At its last meeting of 2016/17 the IJB agreed its 2017/18 Directions and which of the previous year's Directions would end, be replaced by alternatives, or continue into the following year. This was intended to ensure the 2017-18 Directions focused on a smaller number of areas compared to the preceding year.

During the year, progress against Directions was monitored and reported to the IJB.

National Health and Wellbeing Outcomes

How we monitor our performance

The Scottish Government established a suite of 23 performance indicators to enable health and social care partnerships across Scotland to demonstrate how well they are achieving a variety of measures related to the nine National Health and Wellbeing outcomes. East Lothian's performance against the 19 measures for which data are available is shown below.

In looking at performance between different IJB areas across the country it is important to remember that:

- Priorities are locally set by IJBs, reflecting national and local strategic issues and local needs assessments
- IJBs face differing challenges, demands and availability of resources
- Other areas of activity that also help to deliver National Health and Wellbeing outcomes are not represented in these performance indicators.

National health and wellbeing outcomes for East Lothian HSCP

95% of adults are able to look after their health very well or quite well (Scotland 94%)

86% of adults supported at home agreed that they are supported to live as independently as possible

(Scotland 84%)

83% of adults supported at home agreed they had a say in how their help care or support was provided

(Scotland 79%)

82% of adults supprted at home agreed that their health and socialcare services seemed to be well coordinated (Scotland 75%)

84% of adults receiving any care or support rated it as excellent or good

(Scotland 81%)

85% of people had a positive experience of the care provided by their GP practice

(Scotland 87%)

92% of adults supported at home agreed that their services and support had an impact on improving or maintaining their quality of life (Scotland 84%)

48% of carers feel supported to continue in their caring role

(Scotland 41%)

88% of adults supported at home agreed they felt safe

(Scotland 84%)

Premature mortality rate is 320 per 100,000 persons

(Scotland 441)

Emergency admission rate is 9,398 per 100,000 population

(Scotland 12,037)

Emergency bed day rate is 114,152 per 100,000 population

(Scotland 119,649)

Readmission rate to hospital within 28 days is 95 per 1000 population (Scotland 95)

85% of the last 6 months of life is spent at home or in a community setting (Scotland 87%)

Falls rate is 19 per 1000 population over 65 years

(Scotland 21)

77% of care services have been graded "good" (4) or better in Care Inspectorate inspections

(Scotland 83%)

66% of adults with intensive care needs are receiving care at home

(Scotland 62%)

The number of days people spend in hospital when they are ready to be discharged is 1,164 per 1000 population (Scotland 842)

23% of health and care resource is spent on hospital stays where patient was admitted as an emergency

(Scotland 23%)

How we performed compared to seven 'peer group' local authorities and the national average

INDICATOR	East Lothian	*Peer Group Average*	*Scotland*
1. Percentage of adults able to look after their health very well or quite well	95.2%	*94.6%*	*94.0%*
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.	86.3%	*81.9%*	*84.0%*
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	83.4%	*77.6%*	*79.0%*
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.	81.7%	*76.7%*	*75.0%*
5. Percentage of adults receiving any care or support who rate it as excellent or good	83.9%	*80.7%*	*81.0%*
6. Percentage of people with positive experience of care at their GP practice.	84.7%	*86.7%*	*87.0%*
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	92.4%	*83.7%*	*84.0%*
8. Percentage of carers who feel supported to continue in their caring role.	47.7%	*42.6%*	*41.0%*
9. Percentage of adults supported at home who agree they felt safe.	87.9%	*82.9%*	*84.0%*
10. Percentage of staff who say they would recommend their workplace as a good place to work.	*Not yet available.*		
11. Premature mortality rate (per 100,000 population)	319.9	406.5	440.5
12. Rate of emergency admissions for adults (per 100,000)	9,398.0	12,373.4	12,037.0
13. Rate of emergency bed days for adults (per 100,000)	114,152.0	121,572.1	119,649.0
14. Readmissions to hospital within 28 days of discharge (per 1,000)	95.20	101.09	95.30
15. Proportion of last 6 months of life spent at home or in community setting.	86.20	87.54	87.50
16. Falls rate per 1,000 population in over 65s.	18.50	19.94	20.90
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.	77%	82%	83%
18. Percentage of adults with intensive needs receiving care at home.	66%	64%	61%
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged. (per 1,000)	1164.0	879.6	842.0
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.	23.3%	23.9%	22.8%
21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.	*Not yet available.*		
22. Percentage of people who are discharged from hospital within 72 hours of being ready.	*Not yet available.*		
23. Expenditure on end of life care.	*Not yet available.*		

Shaded data cells show where the most recent Scotland figure is not yet available, so the Scotland figure for the previous year is shown
Data shown above is for the most recent year available

Delayed discharge performance

East Lothian's performance for hospital delayed discharges has steadily improved since August 2016. The actions taken to achieve this improvement include:

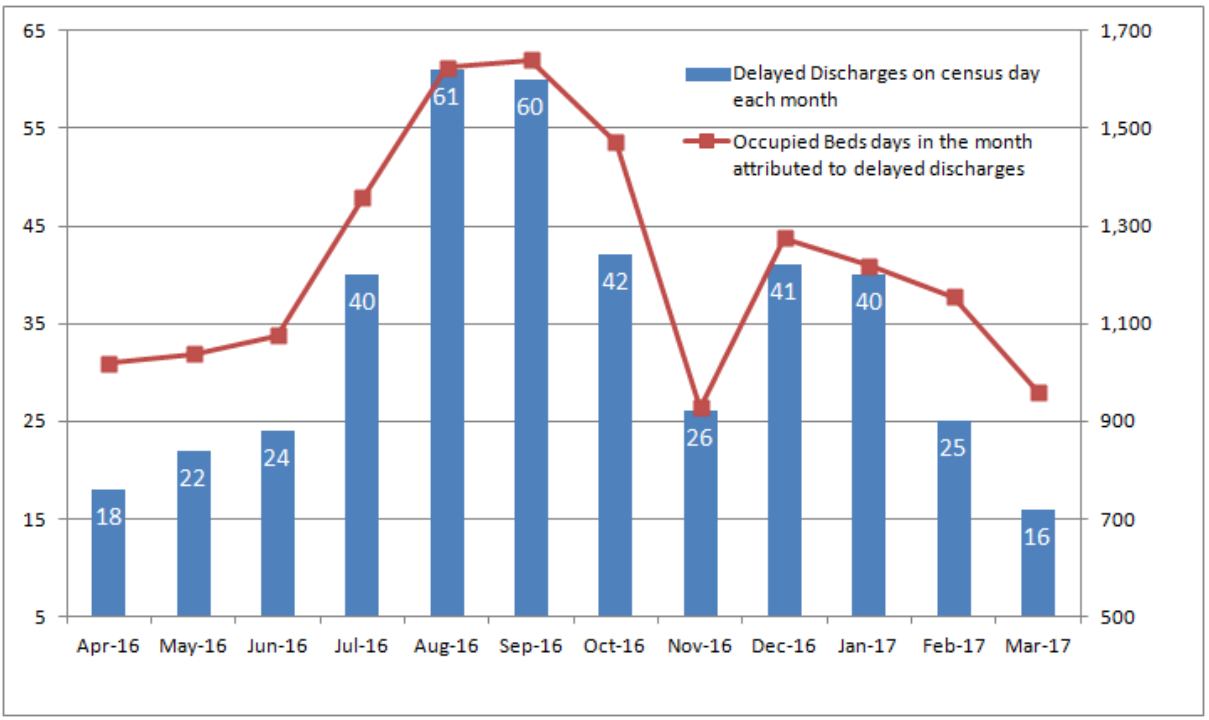
- A 20% increase in the Hospital to Home team to avoid unnecessary hospital admissions
- Implementation and continued support by the Partnership of the Living Wage, helping to stabilise workforce numbers within the home care sector
- A weekly Delayed Discharge Task group and daily HUB and patient flow meetings to assist in finding next stage of care solutions for all patients/clients with a delayed discharge
- A 20% increase in capacity of ELSIE (East Lothian Service for Integrated Care for the Elderly), to further improve its effectiveness in avoiding admission and in supporting the return home of patients
- Continuing use of the Partnership's step down capacity to enable patients to be moved out of acute hospitals expeditiously.

What is 'delayed discharge'?

A delayed discharge is any hospital inpatient who is ready for discharge but is delayed in hospital care because they don't have care in place to return home or to a homely care setting.

Being delayed in hospital can be debilitating, reduce independence and slow down ongoing recovery.

The graph below shows the number of inpatients recorded as a delayed discharge at each monthly census point (blue column). The red line shows the cumulative number of bed days occupied in a month by all patients whose discharge was delayed. Both measures have improved across the last year.



Public Health and Health Improvement

The IJB worked closely with partners in identifying and addressing population health needs. The public health professionals supporting this work include: a Public Health Practitioner; a number of Health Promotion experts; Public Health Consultants and Public Health Policy Officers.

All HSCP activity influences population health either directly or indirectly. However, many of the broader determinants of health and wellbeing sit outwith the HSCP (see figure below). To address these, public health colleagues work with partners across East Lothian's wider Community Planning Partnership and other settings. They provide health improvement and health intelligence expertise and support partners in taking an evidence-informed, person-centred approach which considers the impact of policy and interventions on health and health inequalities.

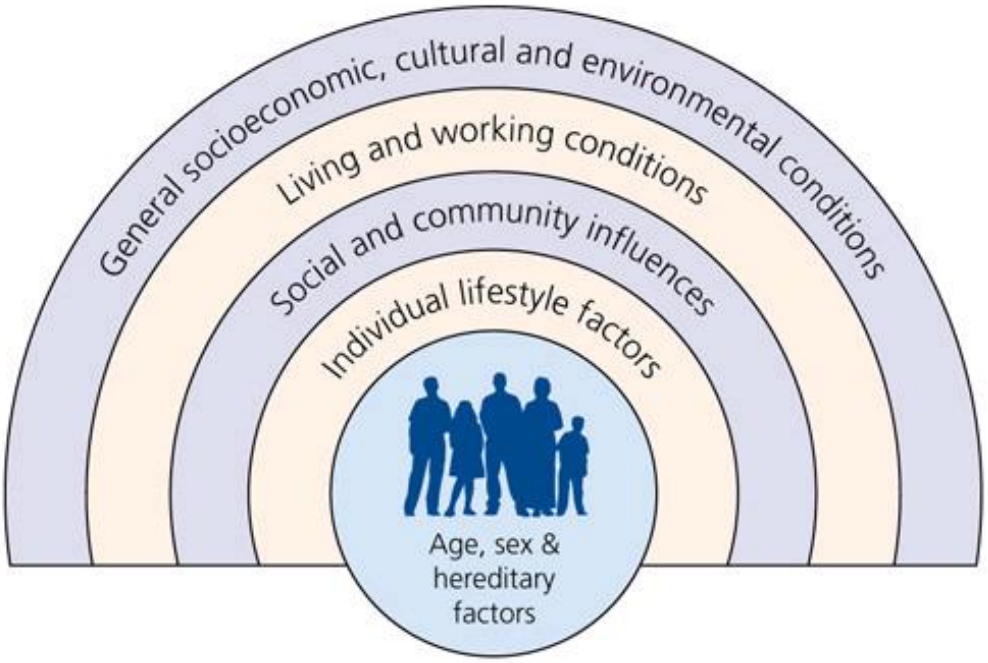


Figure: The Broader Determinants of Health and Wellbeing, Dhalgren and Whitehead, 1991

Health improvement and health inequalities work in East Lothian is often (but not exclusively) co-ordinated through the East Lothian Health Improvement Alliance. This group brings together organisations from the public, community and third sectors with an interest in improving health and reducing inequalities. The group reports to, develops and presents papers to the Resilient People Partnership, one of the community planning groups. Public health colleagues are also represented at a strategic level on the HSCP Strategic Planning Group and HSCP Strategic Plan Programme Board and the various strategy groups which sit under these.

National Health and Wellbeing Outcome 1

People are able to look after and improve their own health and wellbeing and live in good health for longer

95% of adults are able to look after their health very well or quite well (Scotland 94%)

84% of adults receiving any care or support rated it as excellent or good (Scotland 81%)

85% of people had a positive experience of the care provided by their GP practice (Scotland 87%)

Health improvement

Physical activity

In East Lothian, there are sports and leisure centres in each of the six main towns and well-maintained pitches and greens. The county also offers numerous cycle trails, walking and hill walking opportunities. The HSCP has a strong working relationship with East Lothian Council's Sport, Countryside and Leisure service and has worked with them to develop a Physical Activity Framework and Action Plan 2016-19. The service runs a number of walking groups through Ageing Well, walking football for the over-50s and has recently installed outdoor gym equipment along the River Tyne Walkway in Haddington.

We promote physical activity for older people through our physiotherapy services and place emphasis on physical activity in our care homes (both our own and partner providers').

Physical activity indicators

	Indicator	Weighted count	East Lothian proportion	Scotland average	Scotland Local Authority lowest	Scotland range	Scotland Local Authority highest
7	Recreational walking participation in adults	243	66	65	55		83
8	Frequency of active participation	154	52	48	33		70
9	Active recreation in older people*						
10	Attendance at leisure facilities	146	40	30	23		44
11	Active travel to school*						
12	Satisfaction with leisure facilities	210	57	53	37		87
13	Greenspace accessibility	308	84	68	52		89
14	Adult active travel	119	66	67	39		86
15	Community safety for play*						
16	Safety of neighbourhood for walking	554	73	74	65		89
17	Active volunteering workforce*						
18	Sports participation - adults	213	58	52	41		62

East Lothian Citizens' Panel Results

A Citizens' Panel survey in 2016 with a total of 795 respondents had a number of physical activity related questions. 67% of respondents thought they would benefit from slightly (43%) or significantly (24%) increasing their levels of physical activity.

The majority of respondents said that the following benefits of physical activity would motivate them to do either a lot or a little more physical activity:

- *Benefits overall health (94%)*
- *Improves sleep (82%)*
- *Maintains healthy weight (92%)*
- *Benefits mental health (86%)*
- *Improves quality of life (92%)*

The majority of respondents (74%) said they were aware of the benefits of physical activity. Related to the percentage reduction in risk of specific conditions, 42% of respondents indicated the risk reduction was higher than they expected whilst 55% said it was what they expected. 71% of respondents said that seeing the percentage risk reduction in specific conditions would encourage them to increase their levels of regular physical activity.

The biggest reason cited that would encourage respondents to increase their levels of physical activity was having more time (60%) followed by having cheaper local facilities/activities (42%) and having better local facilities that meet their needs/reflect their interests (40%).

Both East Lothian Council and NHS Lothian promote health and wellbeing activities for staff through initiatives like Healthy Working Lives.

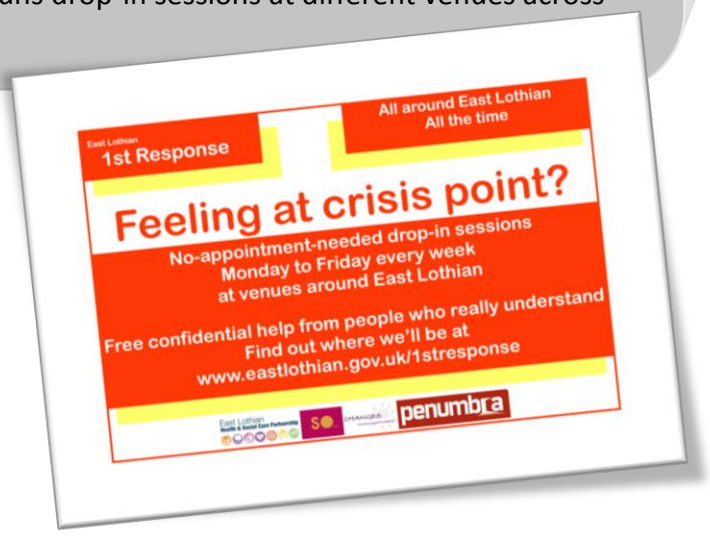
Good mental health

We work with key partners, such as CHANGES in Musselburgh, to help people achieve better mental health, and we also provide counselling and other therapies at Herdmanflat Hospital in Haddington. People can refer themselves to counselling and other therapeutic services at CHANGES but must be referred to NHS services. The demand for these services is high and there are waiting lists.

In 2016-17, we reviewed mental health services. This underlined both growing demand and too great a centralisation of services. This is exacerbated by patchy public transport, financial pressures on people affected by welfare reform/poverty, the financial impact of unpaid caring and the current focus on austerity in relation to public sector funding.

ELHSCP supports CHANGES to deliver ASIST programmes that help workers and members of the public to be better able to identify when people are at risk of suicide and what they need to do to support them and get professional help quickly.

1st Response – Penumbra, Changes and Stepping Out, with funding from East Lothian Health and Care Partnership, launched the new 1st Response service for people who feel they are reaching crisis point. 1st Response provides face-to-face support throughout East Lothian. The project helps people resolve their crisis through sensitive and non-judgmental support based on individual needs, and helps people to access other services. It provides information about other organisations which could help (such as health services, social work, benefits advice and other support) and helps people to develop skills to manage their mental health. It runs drop-in sessions at different venues across East Lothian five days a week.



Health promotion

We actively supported health improvement initiatives to promote healthy eating, smoking cessation, physical activity and sensible drinking.

Substance misuse

While the misuse of alcohol and drugs affects all communities the negative impact is greatest in our most deprived communities. It is estimated that annually for East Lothian between 20 and 50 children are born with Foetal Alcohol Spectrum Disorder. Over 2016-17 a total of 333 Alcohol Brief Interventions were conducted. In that period there were 412 alcohol related hospital stays and 14 alcohol related deaths.

It is estimated that 880 individuals in East Lothian have problem drug use (580 males 300 female). Access to treatment services was good with some 88% of clients being seen with 3 weeks from initial referral (HEAT A11 Standard). East Lothian services provided treatment for 376 (187 drugs and 189 alcohol) clients and 10 East Lothian clients were offered a place at the residential Lothian and Edinburgh Abstinence Programme.

At the January 2017 IJB meeting, it was agreed to refocus the work of Midlothian and East Lothian Drugs and Alcohol Partnership (MELDAP) onto promoting recovery through the commission of services such as the Recovery College, Starfish Recovery café and Recovery Connections. This is now underway and we hope to be able to report the initial impact of this work in next year's Annual Report.

Self-management

HILDA

The HILDA (Help with Independent Living and Daily Activity) website provides its users with information they can trust on equipment that they can buy or borrow to help them maintain and improve mobility. It offers an easy to follow online self-assessment to help pinpoint what kind of support would be useful and puts people in touch with activities, exercise and advice to help keep them moving and enjoying life.

Registering enables users to get the most out of HILDA. This means they can plan and set goals that will help improve their mobility. They can change their goals as their needs change and

they can also create a plan for friends or relatives. Assessments, advice and details of equipment can be 'pinned' to their plan for future reference.

Accessing primary care

We began work aiming to get people to rethink how they use primary care services. Instead of routinely seeking a GP for health concerns, we aimed to offer appropriate access to other clinical professionals, to make them aware of services to which they can self-refer and to make more use of NHS Inform and NHS 24 to help in self management. It has been agreed to take this forward with NHS Lothian to ensure consistency of message across the Lothians.

Developing primary care

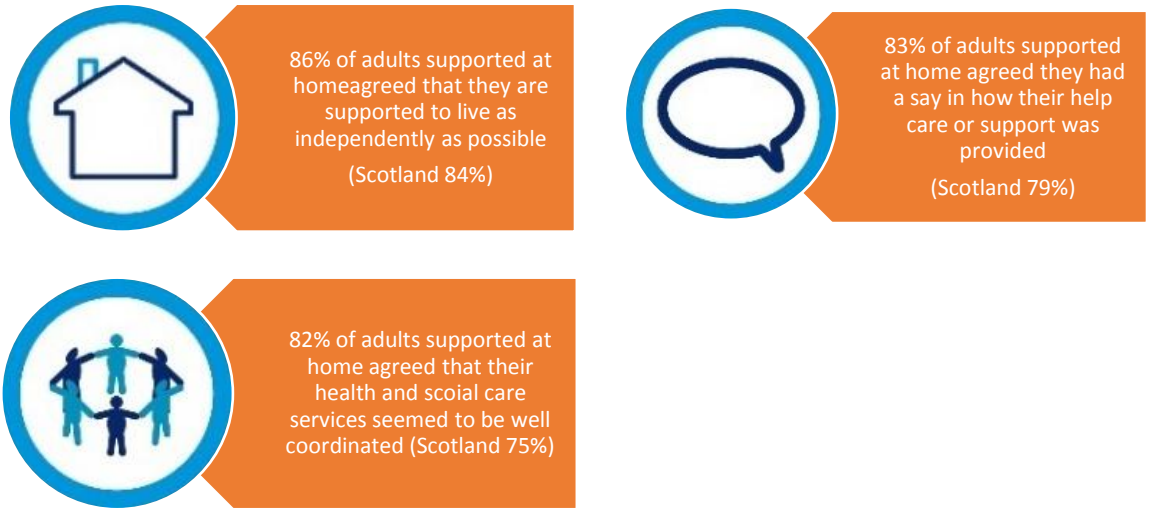
In 2016/17, we started work to develop a new primary care telephone triage service in partnership with NHS 24. In the first instance this will operate out of Musselburgh Primary Care Centre. It is intended to begin a pilot project in autumn 2017.

Looking ahead

It is planned to establish a Mental Health Strategy Group, comprising of key stakeholders, to work on a mental health strategy. This will involve active engagement with a wide range of stakeholders during its development. The planned strategy will focus on how to deliver more resource closer to home, enabling people to manage better mental health for themselves and providing earlier intervention and support.

National Health and Wellbeing Outcome 2

People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.



Older Peoples' Day Care Review

The project, to review day care provision for older people examined a number of the challenges linked to long standing care at home provision such as a lack of capacity, some low Care Inspectorate grades attainment by providers and coverage across the county.

Throughout 2016/17 a co-production approach was taken to the review, which involved HSCP officers working with the East Lothian Association of Day Centres, the ten third sector day centres and other stakeholders including elected members. The project looked at key elements of day care provision including the model of care, training, transport, data collection and the role of the association. Several events were held where these were explored in detail and reported back.

In early 2017, following conclusion of the review, the IJB accepted a proposal to develop day centre provision for a three year period in the first instance. The proposal was to develop the centres as health and social care centres with more formal links to in-house teams to provide opportunities to improve service delivery by taking pressure off care at home provision, providing one stop shops to allow centre users to access a range of professions and services, providing respite opportunities for carers and preventing delayed discharge through the use of emergency places.

Further investment arising from the review will ensure all ten day centres are funded more equitably based on the number of registered places they offer and their occupancy rate. As all day centres are registered to provide complex personal care it is important to support them equally. Building quality, leasing and maintenance arrangements have also been broadly standardised as a result of the project. This ensures the buildings they are operating in are fit for purpose.

It is planned to develop the centres over the next 6-12 months in order to support what could well be a unique model in Scotland by which ten small charities (each led by a committee whose members are all over 65) run all older peoples' day care provision. This means older people provide support to other older people with increased needs in very local communities.

Review of Care at Home Provision

The review allowed us to move from two service delivery frameworks, one providing care at home to older people over 65 and the other providing care at home to adults with specialist support needs to a single framework providing care at home support to all clients regardless of age or support need.

The project also developed a client focused approach by providers to provide tailored care and support to achieve personal outcomes agreed between the provider and the client and funded through a Personal Budget. This exciting development is a departure from previous approaches which directed how support was delivered by the day and hour and provides Self Directed Support style independence for those opting for option 3.

The personal budget model will drive up quality as only providers with grade 4 or above Care Inspectorate assessments will qualify to work in this way. The linkage of support to an improvement in quality is crucial not only for the service the client receives but also reduces the need to provide resource intensive support to providers whose grades fall or who end up under close monitoring or large scale investigation.

Under the contract providers are asked to identify ways of delivering efficiencies. Should they successfully identify and achieve a reduction in costs then they are eligible to receive a share of the savings. This incentivises the achievement of efficient service delivery on an ongoing basis.

Hospital at home and hospital to home

Hospital to Home is a proactive and flexible service to support patients care need. If a patient's needs alter once home, then the service can increase their care until things improve and they return to their normal. It works on a re-ablement model that leads to a reduction in the need for care through time. It maximises, maintains and can improve on a person's

independence by empowering them to manage their activities of daily living. The service has received excellent feedback from patients, relatives and other professionals, with the most recent patient satisfaction audit scoring 96.7%.

Hospital at Home seeks to avoid unnecessary hospital admissions and support patients' prompt discharge from hospital back to their own home in the community. Its multi-disciplinary team implements a care plan for each patient that is reviewed and monitored on a daily basis at the morning 'huddle'. To date the team have supported over 774 patients since February 2014, the average length of stay depends on the patients presenting condition this can be from 1 Day to up to 50 days. The team will support the patients in the community to remain in their own home and environment. The benefits of this approach include:

- Patients remain in their own home, surrounded by their family and carers.
- Patients are not admitted and therefore do not lose their package of care and have a further delay of having to be reallocated a package further down the line when available, if a complex package of care patients can wait some considerable months.
- Reduced bed days allowing the service to close 13 beds.
- Allowing the service to ensure that the patient receives the right treatment in the right place at the right time.
- The patient benefits from a multi-professional approach to care.
- Strengthened links with social care and mental health.

This model was cited as a national good practice case study by the Accounts Commission as an example of 'overcoming workforce challenges to providing new care models'. (*Changing models of health and social care*, prepared by Audit Scotland, 2016).

Telecare

In 2016/17, we focused on

- Supporting service redesign to ensure technology enabled care (TEC) is embedded at all key points in the integrated care pathway
- Increasing the number of awareness sessions for staff and stakeholders to incorporate and promote the use of technology to improve outcomes
- Identifying limitations of certain TEC solutions and reinforcing that technology augments but does not replace human intervention
- Encouraging a shift from the technology itself to care supported by technology.
- Trialing new digital equipment to prepare for the transition from analogue to digital technology
- Supporting people to make greater use of mainstream technology where possible utilising their own devices or advice regarding possible options.

The HSCP received an award of £50,000 from the Scottish Government to develop a strategic partnership approach to technology enabled care, which is intended to fund a 12 month development post

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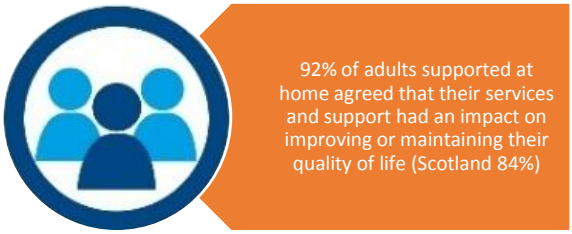
National Health and Wellbeing Outcome 3

People who use health and social care service have positive experiences of those services, and have their dignity respected



Patient/service-user feedback

East Lothian Council received 57 complaints between April 2016 and March 2017 about its Adult Social Care Services and it received 49 written unsolicited compliments.

East Lothian Health and Social Care Engagement Group

East Lothian Health and Social Care Partnership, East Lothian Council Community Learning and Development and the Scottish Health Council worked together to develop an independent service-user group to provide feedback on their experience of using HSCP services.

Big Conversation

Since the establishment of the HSCP, we have held an annual strategic engagement event called 'The Big Conversation'. We held Big Conversation 2 - #OverToYou our second annual consultation event for stakeholders in health and social care integration in East Lothian in October 2016. Our keynote speaker Professor Brendan McCormack from Queen Margaret University spoke about developing a 'culture of generosity' in integrated health and social care. Participants used a series of case studies to examine approaches to meeting client needs. Some outcomes of the event can be seen on the Big Conversation video channel.

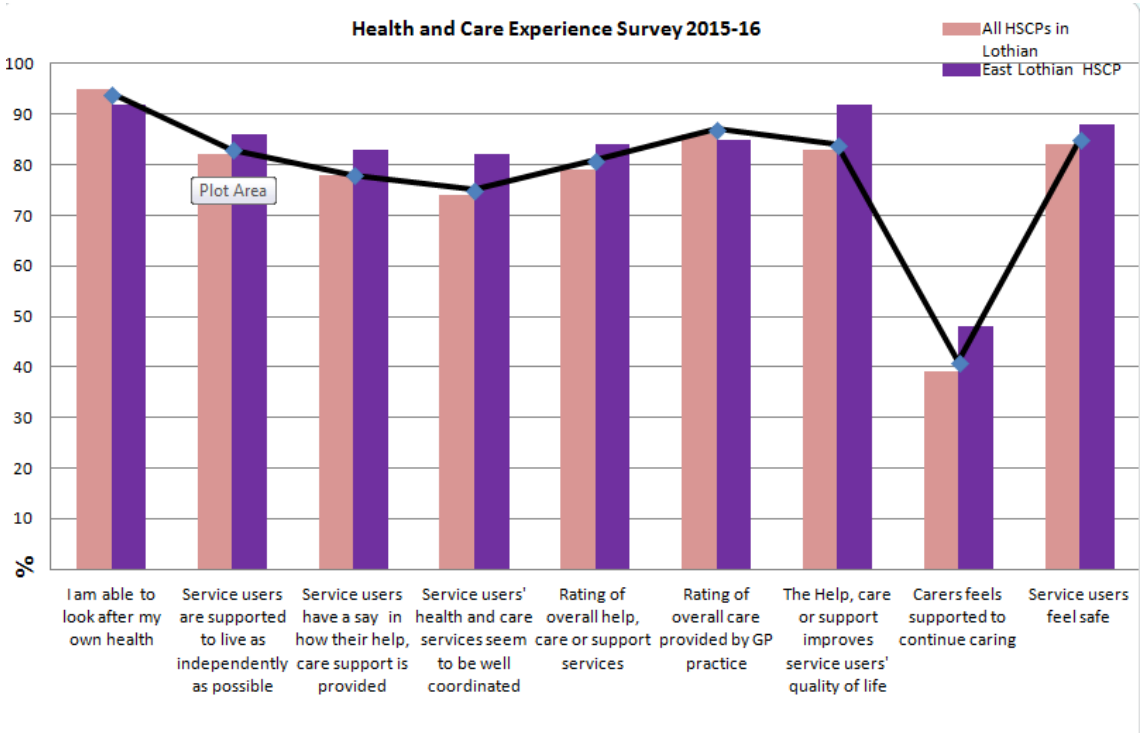
Allied events

We also supported and/or hosted events on themes that inform our wider strategic planning, for example, carer identification and the East Lothian Autism Strategy – one year on.

Health and Care Experience Survey

This national survey, published in 2016 and covering the 2015/16 period focuses on patients' experiences of their GP practice, out of hours health services and care and support.

East Lothian had the most favourable responses in Lothian and was better than the National average.



Patient Participation Groups (PPGs)

There are three PPGs already operating in GP practices across East Lothian. However, we would like to stimulate development of further primary care patient groups. The HSCP is currently negotiating the establishment of further groups at Eskbridge and Riverside medical practices in Musselburgh. Eventually, we would like to arrive at model for all practices in East Lothian to consider, enabling patients to comment on practice matters at local meetings and to come together to engage on HSCP strategic matters at larger joint meetings.

Looking ahead – East Lothian strategy groups

East Lothian Health and Social Care Partnership has set up seven new strategy groups to help it to deliver its strategic directions. The new strategic groups each comprise a multi-stakeholder themed Strategic Group and a corresponding Working Group, which consists of key officers from the Partnership. Each group has a proposed-focused remit as set out below. Remits will be finalised and agreed when each group is established and the first meeting held. The groups are:

1. **Dementia Strategic Group and Dementia Working Group** - remit focus: Development of a local Dementia Strategy and work plan
2. **Carers Strategic Group Carers Working Group** - remit focus: Development of a local Carers Strategy and work plan
3. **Mental Health Strategic Group and Mental Health Working Group** - remit focus: East Lothian Mental Health Strategy/Develop links with local Autism Strategy/Develop Suicide Prevention Strategy and work plan
4. **Learning Disability Strategic Group and Learning Disability Working Group** - remit focus: East Lothian Learning Disability strategy and work plan.
5. **Physical Disability and Sensory Impairment Strategy and Working Group** - remit focus: East Lothian Physical Disability & Sensory Impairment strategy and work plan

> *'This is a real milestone in ELHSCP's development. It means that we can start working closely with stakeholders to plan for what's happening this year, next year and for years ahead. Working strategically will help us to make the best of our resources, which is critical in the current financial climate. More importantly, the planning groups give us the opportunity to make sure that stakeholders are equal partners in planning, enabling us to develop innovative, flexible and responsive answers that really meet the health and social care needs of people in East Lothian.'*
>
> **David Small, Director, ELHSCP**

6. **Palliative Care Strategic Group and Palliative Care Working Group** - remit focus: This will focus on the target 'That no more than 10% of the last six months in life is spent on average in the large hospital setting by 2018/19'.

7. **Primary Care Strategic Group and Primary Care Working Group** - remit focus: Produce a strategy to support and develop work within the quality clusters and to develop service delivery models to support primary care services across the county.

National Health and Wellbeing Outcome 4

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

85% of the last 6 months of life is spent at home or in a community setting (Scotland 87%)

77% of care services have been graded "good" (4) or better in Care Inspectorate inspections (Scotland 83%)

66% of adults with intensive care needs are receiving care at home (Scotland 62%)

Inspections

Care Inspection Grades

Care homes

70% are graded at level 4 (good) or above

24% are graded at level 3 (adequate)

6% are graded at level 2 (weak)

0% are graded at level 1 (unsatisafactory)

Care at home services

92% are graded at level 4 or above

8% are graded at level 3

None is graded below level 3

Day Centres

6 out of the 10 day centres have had grades awarded, with the remaining 4 to still be inspected. Of the 6 available, all are now listed at grade 4 or above.

Older People's Services Inspection Action Plan

East Lothian Health and Social Care services for older people were inspected by the Care Inspectorate in October 2015 and the findings (shown below) were reported in May 2016.

Quality indicator	Evaluation
1 Key performance outcomes	**Adequate**
2 Getting help at the right time	**Adequate**
3 Impact on staff	**Good**
4 Impact on the community	**Adequate**
5 Delivery of key processes	**Adequate**
6Policy development and plans to support improvement in service	**Good**
7Management and support of staff	**Adequate**
8 Partnership working	**Adequate**
9 Leadership and direction	**Good**

We agreed an action plan with the Care Inspectorate in August 2016 and through the remainder of the year focused on delivering against all the actions. Our ongoing focus will continue to be consolidation of this plan to enable us to deliver consistent good quality experiences and outcomes for older people in East Lothian.

National Health and Wellbeing Outcome 5

Health and social care services contribute to reducing health inequalities

Households in poverty in East Lothian (Source: East Lothian Poverty Report)

Health services located in Edinburgh are more difficult for non-car owners in East Lothian to access because of expense and, in some cases, lack of public transport, particularly from outlying areas.

De-centralising services

Against this background, one of the major contributions that ELHSCP can make is to bring care closer to home or deliver care at home.

East Lothian Community Hospital

Work started on the new East Lothian Community Hospital in October 2016 after extensive consultation with stakeholders about the design of the facility and what services it should provide.

The consultation is now focusing on the interior design of the hospital. The conversation will continue throughout construction and delivery and thereafter. By 2020, the hospital will be fully operational and able to deliver a range of services previously delivered by hospitals and clinics in Edinburgh.

Public health initiatives

During the year, the public health team led on or contributed to numerous strands of work including:

- Participating in the physical activity strategic group and physical activity implementation group:
    - Working alongside East Lothian Council and QMU developed a physical activity programme plan for East Lothian
    - Developed an application for the Health Improvement Fund and allocated money to physical activity in East Lothian via the Start Well project.
- Supported the East Lothian Ageing Well, East Lothian Start Well and East Lothian Roots and Fruits projects and participated in the respective project steering groups
- Provided expert input to the East Lothian Poverty Commission
- Facilitated an Integrated Impact Assessment for the HSCP Strategic Plan

- Developed and delivered training to council elected members on health inequalities, co-facilitated a workshop regarding health inequalities with Day Centres and delivered a Health Literacy awareness session for Primary Care
- Supported workplace health, enabling two companies to maintain their Healthy Working Lives gold awards and one to maintain their bronze
- Supported other companies through training and health and safety visits.

Measuring the impact of public health activity on health and wellbeing

As the benefits of health improvement work and health inequalities input to policy and interventions is often diffuse, it is challenging to measure outcomes. The public health team will continue active working with colleagues to identify improved measures of the impact of health improvement work.

Link workers

We commissioned STRiVE, East Lothian's 3rd Sector interface organisation, to provide link workers in 4 surgeries in the east of the county. These workers are based in the surgeries and help patients access a wide range of advice and support relating to their health condition or that of someone that they care for. This includes advice on housing, benefits, specialist health support agencies and local organisations that can provide further support. They offer in-depth support, extended consultations and follow-up meetings.

Looking ahead

There are a number of work-streams in East Lothian which Public Health partners actively lead or contribute to on an ongoing basis. These will continue into 2017/18 and include:

- Violence again women:
    - Working with the Violence Again Women Group Delivery Group East & Midlothian to deliver on Equally Safe, the Scottish Government's framework to address violence against women and girls. Current work includes: supporting delivery of the SMILE service; delivering awareness raising training to frontline staff; leading on a short-life working group to assess the extent of and address commercial sexual exploitation across the region; supporting the development

of work in primary schools to raise awareness around gender inequality and its links to gender based violence

- Gypsy Travellers:
    - Leading on work to to coordinate and support activities aimed at improving the health and wellbeing of Gypsy Travellers in Lothian
- Smoking prevention and cessation work including the ASSIST programme with schools, work with Edinburgh college (which has a campus in East Lothian) and smoke-free homes
- Children and young people's health and wellbeing including working with education and the third sector
- Mental Health and Perinatal Mental Health:
    - Involvement in the coordination of suicide prevention locally, linked to Lothian wide programmes
    - Providing input into development of local crisis service development, as an early intervention model
    - Co-leading / providing input to group supporting young people's mental health
    - Co-leading development work focused on rehabilitation and mental health – in part using an early intervention model
    - Focusing on young people, transition and mental health with particular attention to Looked After and Accommodated Children
    - Focusing on mental health in minority ethnic communities
    - Working with Queen Margaret University to raise awareness of mental health/ wellbeing
- Working with East Lothian Housing colleagues on joint strategic needs assessment.

There are also a number of other ongoing work-streams, some of which focus on the broader determinants of health, and some of which focus more on individual lifestyle factors (including: Active Travel, Alcohol including the Alcohol Licensing Forum, Community (and Criminal) Justice, Early Years, Food and Health and the Game Changer Public Social Partnership).

National Health and Wellbeing Outcome 6

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce the impact of their caring role on their own health and wellbeing

48% of carers feel supported to continue in their caring role (Scotland 41%)

Carer identification

In 2016, ELHSCP began work on how we could encourage:

- people to identify as themselves as carers
- professionals to recognise/identify carers for the people they support and make sure that they were recorded as carers so that they had better opportunities to receive appropriate support.

Feedback from our 2016 Carer Identification Stakeholder Engagement Event Has been enormously helpful.

East Lothian Carers' Strategy

Our East Lothian Carers' Strategy Implementation Team, which is overseeing the introduction of the new Scottish carers' legislation coming into effect in April 2018, was set up in October 2016, following on from completion of the project specification for the new East Lothian Carers' Strategy by March 2016. This identifies project goals and a full communications and engagement process.

Carers of East Lothian

Carers of East Lothian (CoEL) is funded by the Health and Social Care

... really helped me find a pathway and supported me with information and encouragement so that I finally got help in place accepted by my father. She put things into perspective when I was overwhelmed and gave me practical solutions, thank you, thank you!"

Partnership to provide support to unpaid carers, including helping them to look after their own wellbeing.

CoEL's input with unpaid carers is wide ranging including the provision of information, advice, practical and emotional support on an individual and group basis; workshops, events and specialist sessions e.g. setting up Powers of Attorney; organising and facilitating short breaks for carers including the distribution of grants; financial advice and assistance in claiming entitlements. Other achievements are:

- CoEL has increased the identification of carers in East Lothian by 76% in the past 4 years and directly supported 993 carers last year.
- 84% of carers supported by CoEL report feeling better able to cope with their caring role as a result
- Specific examples of good practice include:
    - ✓ Joint working with the Health and Social Care Partnership on developing a new, outcomes and strength focused tool to pilot the new Adult Carer Support Plans
    - ✓ Generation of £626,267 in annual increased welfare benefits for 182 carers.
    - ✓ Embedding of specialist carer support worker within the HSCP Mental Health Team to provide support for carers of people with mental health issues.

"Because of the information I received from Carers of East Lothian it prompted me to make decisions I would still be pondering over. Carers of East Lothian have been encouraging, exceptionally helpful and very approachable. I feel comfortable knowing I have a contact with people who are caring but also professional. I was a complete stranger to Carers of East Lothian, but after my first telephone conversation and subsequent meetings I knew I was in good hands. Thank you so much"

National Health and Wellbeing Outcome 7

People using health and social care services are free from harm

Keeping our service-users and patients free from harm is central to everything that the East Lothian Health and Social Care Partnership does. In East Lothian, the East and Midlothian Public Protection Office provides leadership across Adult Support and Protection, Child Protection and Violence Against Women. Our Public Protection Structure is based on close collaboration and partnership working with service-users, partner agencies and our communities and is focused on improving outcomes for those in need of support and protection throughout East Lothian.

National Data Set

East Lothian Council/East Lothian HSCP received 509 referrals in 2016/17, an increase of 5% from 493 in 2015/16. Police Scotland continues to be the main referrer. This is reflective of the data collated by Scottish Government with Police Scotland being the biggest referrer to local authorities.

	2014/15	**2015/16**	**2016/17**
Referrals	427	493	520 (5% increase)
Investigations	125	69	151 (119% increase when compared to 15/16, 21% increase when compared to 14/15)
Protection orders	3	3	1
Number of Large Scale Investigations	3	2	2

Frontline practice

Performance Quality Indicators continued to show improvement. Opportunities through joint working to streamline process were identified and developed. Along with immediate changes to processes, longer term initiatives were delivered through the transformation of core process project along with the redesign of care at home project.

Looking ahead

Reviews

The partnership faces continued challenges in undertaking number of social work reviews currently required. For this reason, there will be a whole-system assessment of the current processes, identifying challenges and opportunities to develop more timely and efficient reviews of client care and support needs as well as exploring how these reviews can be undertaken and shared collaboratively between partnership staff and third sector organisations. The project will analyse reviews in care homes, care at home, as well as Direct Payments/Option1 and Adults with Incapacity.

National Health and Wellbeing Outcome 8

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

New ELHSCP management structure

East Lothian and Social Care Partnership engaged with staff regularly over a period of two years from 2014 on the shape and function of its new management structure. Consultation approaches included focus groups, workshops, surveys, information meetings and regular newsletters. Our staff provided a great deal of useful feedback. The consultation influenced changes in the structure, including which senior posts were suitable for particular disciplines – the consensus was that our original vision was too restrictive.

The new structure was finalised in July 2016 and took effect in October that year. The change process will continue through 2017 as we pull teams together in line with the new management structure and we will continue to listen to what staff have to say as this is happening.

Looking ahead

Planning and Performance Team Restructuring

The restructuring of planning and performance commenced in late 2016 to finalise the support and monitoring arrangements for all of the partnership. The areas focused on and being worked on further in the coming year are:

- supporting strategic development
- supporting internal delivery
- supporting external delivery,
- supporting Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP); and
- supporting service improvement.

We will engage with staff in a planned process to develop the necessary team roles to deliver the wider work and priorities.

Staff satisfaction

National Health and Wellbeing Outcome 9

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

Through the year we used our resources wisely and well. Some examples are:

Care at Home Provision

A £20 million Care at Home re-modelling and procurement project ran throughout 2016/17. Key phases of the project during this year included:

- Finalising the scoping phase
- Stakeholder engagement
- Pilot modelling
- Specification development
- A formal procurement exercise
- Assessment of tenders
- Award of new contracts.

Section 10 grant funding

We undertook an audit of services funded though Section 10 grant funding. This provided an opportunity to review a number of the services currently funded and to make adjustments to that funding where appropriate to reflect differences in how support is paid for linked to Self Directed Support. A range of improved processes and paperwork also resulted from the audit.

Scoping of business support in Adult Social Care

To support the teams in the new HSCP structure a scoping exercise was undertaken on adult social care business support functions

E-invoicing

A pilot during the year introduced a new way for providers to invoice us for the care and support they deliver on our behalf. This has greatly improved the efficiency of financial processing and has freed up staff time. It will also help to support timely and accurate year end forecasting.

Care Homes

We amalgamated the Care Home assessment workers with the Care Home Review social workers/community care workers to develop one streamlined team/process resulting in a more efficient services for users.

Looking ahead

Two of the major challenges facing the partnership are:

- Being able to support our care providers to meet the current Living Wage and any further Living Wage increases
- Staffing, recruitment and retention – both within ELHSCP and partner providers.

We plan to conduct a Best Value and Strategic Fit review in 2017 as well as a community needs assessment with regard to ensuring that the services commissioned in the community of El are providing value for money within the best model of service delivery.

IJB Finances

Financial allocation

In 2016/17 East Lothian IJB received its first financial allocation in respect of the functions delegated to it by East Lothian Council and NHS Lothian. Although East Lothian Council set a 2016/17 budget in February 2016, NHS Lothian did not formally set a budget until June 2016. The IJB undertook a detailed financial assurance process in March 2016 to review the East Lothian Council proposition along with the working proposition from NHS Lothian. The IJB then undertook a further financial assurance process – including a review of the in-year 2016/17 financial information from both partners.

This work highlighted significant financial challenges in both budget offers but as the IJB was keen to progress with the delivery of its strategic plan and to further the transformation process it accepted these budgets contingent on a financial risk sharing agreement with East Lothian Council and NHS Lothian.

Financial risk sharing

The IJB agreed a financial risk sharing arrangement with its partners in 2016/17. This ensured that any overspends incurred in the delivery of the delegated functions by NHS Lothian would be covered on a non recurrent basis. East Lothian Council made an additional £1.0m available to cover any overspends with adult social care.

At 2016/17 year end the IJB was overspent by around £1.649m against its base budgets. NHS Lothian contributed additional resources of £1.054m and East Lothian Council contributed £0.595 million of the £1 million to bring the IJB to a break-even position.

The charges made by East Lothian Council to the IJB are the net direct costs incurred in the delivery of social care services in East Lothian. The charges from NHS Lothian are based on the health budget setting model as agreed by the IJB. That is, charges for the core services are based on the net direct actual costs incurred in East Lothian but charges for hosted and set aside services are based on the total actual costs for these service shared across the IJBs per the budget setting model. East Lothian's share of the total actual costs incurred in 2016/17 for hosted services is 12% and, generally, 12% of the Lothian element of the set aside budgets

The pressures driving these overspends fall into two broad areas:

- Significant overspends against the GP prescribing budget
- A lack of recurrent delivery of efficiency schemes and recovery plans both within those services managed by the partnership (that is the local services delivered

by the Council and NHS Lothian) and the services managed by other teams within NHS Lothian.

2016/17 out-turn – financial performance

The table below provides detail on financial performance in 2016/17:

East Lothian IJB - Budget Performance in 2016/17

	Budget £000's	Actual £000's	Variance £000's
Health Services for inpatients	29,895	29,905	(10)
Primary care	45,135	47,418	(2,283)
Other community health services	33,512	32,273	1,239
Social care services	43,682	44,277	(595)
Non-recurrent support	1,649		1,649
Total	**153,873**	**153,873**	**0**

(Note - variances are underspend/(overspend))

Primary Care expenditure includes:

- GMS – the costs of running the GP service in East Lothian
- GOS – support to the delivery of community ophthalmic (optician) services
- GPS – support to the delivery of community pharmacy services
- GDS – support to the delivery of community dental services
- GP Prescribing – the costs of prescriptions for the 16 East Lothian GP practices.

Part of the budget above includes the Acute Set Aside budget (£21.4m). Acute set aside is the expenditure on functions that are delegated to the IJB but managed by the NHS Lothian acute management team, these budgets being 'set aside' on behalf of the IJB. These are mostly inpatient bed costs but there is also a small element of outpatient services depending on how the delegated function is delivered. This includes the Accident and Emergency service at the RIE.

Included in the social care services above is:-

- Expenditure on social care services on care homes or adult placement - £6.4m
- Expenditure on social care services to support carers – £0.3m

It should be noted that support to carers is a thread that runs through all services, there is not a specific carers budget, nor expenditure identified. The value above is the total of specific providers and workers who provide direct support to carers.

In 2016/17, the Scottish Government announced an 'Integration Fund' of £250m nationally for Integration Joint Boards to develop social care. Half of this fund was allocated to existing pressures, including the delivery of the living wage to be paid to all staff who delivered social care regardless of who employs them. The remaining half was intended to deliver additionality) to provide further social work capacity and to support service transformation. East Lothian IJB's share was £4.37m, supporting the introduction of the living wage for providers of care at home.

Looking ahead

2017/18 – financial challenges and expectations.

In March 2017 the IJB undertook a financial assurance process to review the budget propositions for 2017/18 from East Lothian Council and NHS Lothian. Again this process identified significant challenges but the IJB has accepted this budget although is clear that a financial risk sharing agreement similar to that in 2016/17 will not be possible. NHS Lothian has identified in its financial plan for 2017/18 (as at April 2017) a significant budgetary pressure for which there are, currently, no final plans to manage.

As part of the financial planning process for 2017/18, the financial issues identified above in 2016/17 have been addressed, NHS Lothian has uplifted the GP prescribing baseline to the 2016/17 expenditure level and the social care management team has developed a clear plan to rebalance the budget for learning disabilities services. Despite this, the financial assurance exercise identified pressures within the IJB of around £3.8m of which there are clear plans to deliver £3.2m with further plans being developed to balance the budget.

The challenge is, in financial terms, to continue the transformation of the services to deliver the IJB's delegated functions whilst continuing to deliver high quality health and social care to the population the IJB supports. The IJB has developed an outline financial strategy. This will be developed further into a detailed multi-year financial strategy which will lay out how the IJB will deliver its strategic plan.