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East Lothian Council

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This document accompanies the report to Council on 23 February 2016 - Integration Joint Board Strategic Plan

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East Lothian
Health & Social Care Partnership

STRATEGIC PLAN

for Health and Social Care

2016 – 2019

A SECOND DRAFT

December 2015

East Lothian
Integration Joint Board

Best Health, Best Care,
Best Value across our Communities

The East Lothian Strategic Plan is a dynamic working document and is developed throughout its life.

It will be based on what we learn from listening to local people - those who use our services, carers, clinicians and professionals and other partner organisations – as we continuously consult and engage.

Foreword

People are living longer than ever, and the trend is set to continue into the future.

Increased life expectancy is something that we should all celebrate, but longevity means that we need to plan ahead, both collectively and individually, to ensure that we in East Lothian can maximise the benefits and positive experiences of a long life.

Our population in East Lothian is as diverse in their circumstances, interests, activities and abilities as the rest of the population and so we want to create a local health and care system which is more personalised and which places importance on improving outcomes for our service users.

This is our second consultation draft of a Strategic Plan as an emergent Health and Social Care Partnership and it builds on the progress that has already been made by NHS Lothian, East Lothian Council and partners to improve local services. The Health and Social Care Partnership has drawn on a wide range of information to form a case for change: the draft plan describes why we selected each of the strategic aims and includes a review of the financial context in which our plans and ambitions are set. It has also, importantly, been based on what we have learned from listening to local people – patients, carers, members of the public, clinicians and professionals and other partner organisations – as we have consulted and engaged on initial drafts of the plan.

We believe that through innovative thinking, intelligent planning and by putting the views of our service users at the heart of all that we do, we can achieve our ambition of Best Health, Best Care, Best Value for our communities across East Lothian. Our ambition is also brave and clear in stating the intention to shift resources from institutional or acute care into our communities within a short timeframe, and in doing so delivering better outcomes. We also believe that we can design innovative new care models, but they won't become a reality unless we have a workforce with the right numbers, skills and values to deliver. Supporting and developing our workforce across all sectors is key to our success.

We will make sure that strong and effective partnerships are established between East Lothian Council and NHS Lothian, colleagues in the third and independent sectors and with other key partner agencies, so that we plan and commission services in a way that puts people at the heart of decision making. For East Lothian this then makes real and dynamic the vision and values of this Strategic Plan.

Councillor Donald Grant
Chair
East Lothian Integration Joint Board

Mike Ash
Chair
East Lothian Strategic Planning Group

Contents

1. Introduction

This Strategic Plan describes how the Integration Joint Board of East Lothian Health and Social Care Partnership will develop health and social care services for adults over the coming years.

Health, social care and wellbeing are key factors which impact on communities and individuals. The Council and the NHS locally have a long and successful history of working in partnership and the Plan builds on that history through emphasising the importance of integrating our care services further. This is because ill, vulnerable or disabled people often need support from more than one service and, for their care to be effective, it needs to be personalised and well co-coordinated.

Integrated care is also essential because gaps or weaknesses in one part of the network of services often affect services elsewhere: for example, weaknesses in community services can cause unnecessary admissions to hospital, while over reliance on hospital or residential care diverts money away from community services, reducing their ability to support people at home.

In a time of rising demand for services, growing public expectations and increasing financial constraint it is essential to make sure that social care, primary care, community health and acute hospital services work well together with all our partners, including the voluntary and independent sectors, in a truly integrated way.

Making the case for change is at the centre of this Plan. It is not a critique of current provision but rather a recognition that the existing model of care needs to change in order to meet current and future challenges. There are no neutral decisions – if we do nothing the health and care system will not be able, in its current form, to continue to deliver the high quality service we expect to meet the needs of the East Lothian population. We recognise that we need a sustainable strategy to address:

Best health - the health and wellbeing gap across East Lothian: if we fail to get serious about prevention then recent progress in healthy life expectancy will stall, health inequalities will widen and our ability to fund new treatments will be affected by the need to spend budget on avoidable illness or ill health.

Best care - the care and quality gap: unless we reshape care delivery and drive down variation in quality, people's changing needs will go unmet and unacceptable variation in outcomes will persist.

Best value - the funding and efficiency gap: if we fail to match funding levels with wide-ranging and, at times, controversial system efficiencies, this will impact on services, staff, and deficits.

We aim to address this through immediate action plans, medium term plans and through a longer term sustainability plan, all delivered through our locally driven programmes. These will be developed with, and through, our localities, our clinicians and professionals, our wider workforce and the population of East Lothian; this partnership working is key to our future success.

We recognise that integrated care is often talked about but not always delivered. The integration of health and social care in Scotland offers an unprecedented opportunity to develop and implement different ways of working to achieve shared goals, better experiences and better outcomes – that's the ambition of this Strategic Plan.

Following extensive consultation and feedback on our first draft plan, immediate key priorities for East Lothian in the short term will focus on:

- Delivering more care closer to home - actively tackling the rise in unplanned or avoidable hospital admissions, and significantly reducing delayed discharges from hospitals to home or a homely setting
- Addressing the variation in the use and delivery of health and social care services across the county and tackling inequality

- Developing a strong focus on prevention and “low level” support
- Ensuring best value for the public purse through more effective partnership working

We will consult further on this second draft of our Strategic Plan before a final version is developed and presented for approval by the Integration Joint Board at its meeting on XX/XX/2016. East Lothian Council and NHS Lothian will thereafter agree to delegate the functions included within our Integration Scheme to the Board on 1st April 2016.

2. A new way of working

2.1 East Lothian Health and Social Care Partnership

In accordance with the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014, Health and Social Care Partnerships (HSCPs) replace Community Health Partnerships (CHPs). In East Lothian the HSCP functioned in shadow form from late 2013 and was formally and legally established in July 2015. Health and Social Care Partnerships will be accountable for delivering a range of nationally agreed outcomes which will apply across adult health and social care services.

The establishment of HSCPs will also see a requirement on Health Boards and Local Authorities to integrate adult health and social care budgets and to strengthen the role of clinicians and care professionals in the statutory services, along with those in the third and independent sectors, in the planning and delivery of services.

The policy aim in developing HSCPs is to ensure that adult health and social care budgets are used efficiently and effectively to achieve quality and consistency, and to realise a decisive shift in the balance of care from institutional to community based settings.

In East Lothian the Partnership has been established as a Body Corporate – that is a separate legal entity from both East Lothian Council and NHS Lothian with responsibility for its governance lying with an Integration Joint Board (IJB). The arrangements for the operation, remit, scope and governance of the IJB are set out in the Integration Scheme approved by Scottish Ministers, East Lothian Council and NHS Lothian.

The key functions of the IJB are to:

- Prepare a Strategic Plan for delegated functions
- Allocate the integrated budget in accordance with the Strategic Plan
- Oversee the delivery of services in scope

2.2 Integration Joint Board Membership

The Integration Joint Board (IJB) in East Lothian has eight voting members appointed equally between elected members of East Lothian Council and non executive Directors of NHS Lothian. In addition to voting members, there are a number of other appointees representing service users, carers, third and independent sector organisations, clinicians and staff. The IJB will be advised by a range of officers and professionals including the Chief Officer, Chief Finance Officer, Chief Social Worker, Clinical Director and Chief Nurse.

2.3 The Strategic Plan

The Strategic Plan describes the changes and improvements in health and social care services that East Lothian HSCP wants to make over the next few years. It explains what our priorities are, why and how we have decided them, and how we intend to make a difference working closely with partners in and beyond East Lothian. The plan is underpinned by a number of national and local policies, strategies and action plans.

It will provide the strategic direction for how health and social care services will be shaped in this area in the coming years and describes the key transformational changes that will be required to achieve this vision. The plan will integrate all the major changes and work to be undertaken over the next few years to improve the quality and safety of services, to improve the health and wellbeing of local people, and to innovate in how services are delivered to meet the tough financial challenges we face. Essentially the Strategic Plan is about how we will develop services which meet the needs of our population and are not just fit for purpose, but the best for purpose and fit for the future.

The Strategic Plan should be read in conjunction with the Programme Delivery Plans in Section 12 which contain detailed objectives.

2.4 Strategic Planning Process and Principles

This second draft Strategic Plan is a joint statement, the initial development of which has been overseen by the Integration Joint Board and its Strategic Planning Group which has representation from NHS, local authority, clinicians, service users, carers, voluntary sector and the independent sector. In writing the draft plan we have reviewed information about health needs, issues and concerns raised by local people and current service delivery and discussed and refined our plans and priorities.

From this work we have developed this document which is a second draft of the Strategic Plan. We want to listen to as many stakeholders as possible so that when we prepare the final version of the Strategic Plan we are confident that we have encouraged as many contributions as possible.

The Strategic Planning process and governance is outlined in detail in Appendix 1.

2.4.1 Integration Planning Principles

Scottish Government has outlined integration planning and delivery principles for Partnerships which are the lens through which all integration activity should be focused in order to achieve the national health and wellbeing outcomes. They set the ethos for delivering a reformed way of working and inform how services should be planned and delivered in the future.

This Strategic Plan takes cognisance of these principles in order to ensure that services are planned and provided in ways which:

- Are integrated from the point of view of our service-users
- Take account of the particular needs of different service-users
- Take account of the particular needs of service-users in different parts of the county
- Take account of the particular characteristics and circumstances of different service-users
- Respect the rights of our service-users
- Take account of the dignity of our service-users
- Take account of the participation by our service-users in the community in which service-users live
- Protect and improve the safety of our service-users
- Improve the quality of our services
- Are planned and led locally in a way which is engaged with our communities
- Best anticipates needs and prevents them arising
- Make the best use of the available facilities, people and other resources

2.4.2 Equality and Diversity

The planning and delivery of good quality health and social care, as well as appropriate information, advice and support services in East Lothian embraces the principles of equal opportunities, following the lead of our partners' Equality Outcome and Mainstreaming Reports 2013 -2017.

This means that the Integration Joint Board and all our partners will strive to encourage equal opportunities and human rights, responding to the different needs and service requirements of people regardless of age, disability, gender re-assignment, marriage and civil partnership, (restricted to elimination of unlawful discrimination in employment) pregnancy and maternity, race, religion and belief, sex and sexual orientation.

2.4.3 Transparency and accountability

East Lothian HSCP is an accountable public body. Therefore, in addition to the engagement we will undertake as part of developing this plan we will regularly publish information on how we are progressing in its delivery and continue to consult on how we best implement the current and future changes described.

2.5 Locality Planning

Geographically the Strategic Plan covers the area within East Lothian Council's boundaries.

Strategic planning as described in the Public Bodies (Joint Working) (Scotland) Act 2014 requires that our services should be provided in a way in which, as far as possible, takes account of the particular needs of people from different parts of the county and is planned in a way which is engaged with the community and with local professionals. There is a requirement for each new Health and Social Care Partnership to clearly identify a minimum of two localities within their partnership boundary.

Within East Lothian there are six established local area partnerships centred on the main towns and communities. However the need to redesign and reshape care delivery within a partnership the size of East Lothian allows the opportunity to consider a more appropriate level of health and social care planning based on two localities – West (Musselburgh, Fa'side and Preston, Seton and Gosford wards) and East (Haddington and Lammermuir, North Berwick Coastal and Dunbar and East Linton wards). Whilst this gives two localities of different proportions (West has a population of approximately 60,000, East of approximately 39,000) it recognises the broadly differing demographics of the two areas.

Locality planning is outlined in greater detail in Section 11 and in Appendix 3.

2.6 Scope and Delegated Functions

The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care in Scotland and requires each Health Board and Local Authority to delegate some of their functions to the new Integration Authorities. By delegating responsibility for these functions the objective is to create a single system for local joint planning and delivery of health and social care services which is built around the needs of local service users and which supports service redesign in favour of preventative and anticipatory care in communities.

The regulations which underpin the Act clearly set out which health and social care functions and services must be delegated to the Partnership. The Act limits the functions that can be included in the "must be delegated" list to services provided to people over the age of 18.

The effect of this is that the primary legislation ensures that no children's health and social care services will be required to be integrated and it is up to local Partnerships to decide whether to integrate children's services as well as adult services. In East Lothian we have agreed that children's health services (health visiting and school nursing) will be delegated from establishment, with a clear ambition to integrate children's wellbeing (social care) services into the Partnership within a short timescale afterwards. The initial focus for service integration and therefore this Strategic Plan is for adult services only.

When agreement is reached to delegate children's wellbeing services, the Strategic Plan will be reviewed and updated to incorporate this with a full, supporting period of consultation.

A key feature of legislation is that integration must include adult social care services, adult primary and community health care services, and, importantly, "elements of adult hospital care which offer the best opportunities for service redesign". Integration Authorities will be responsible for strategic planning of acute hospital services which are the ones most commonly associated with the emergency care pathway - that is hospital specialties which exhibit a high level of unplanned bed day use for adults. Within the context of integration "unplanned" refers to those stays that are unplanned and potentially avoidable with the provision of some sort of preventative care. This is central to a key Scottish Government priority for integration to "Shift the Balance of Care" from hospital or institutional settings to communities.

Other services can also be included in integrated arrangements if there is local agreement to do so; in East Lothian an example of this is the agreement to include criminal justice social work in the scope of the Partnership.

The functions and services to be delegated to East Lothian's Health and Social Care Partnership are outlined in detail in Appendix 2.

When the Strategic Plan is agreed the Chief Officer will formally direct NHS Lothian and East Lothian Council to delegate the functions in scope to the IJB.

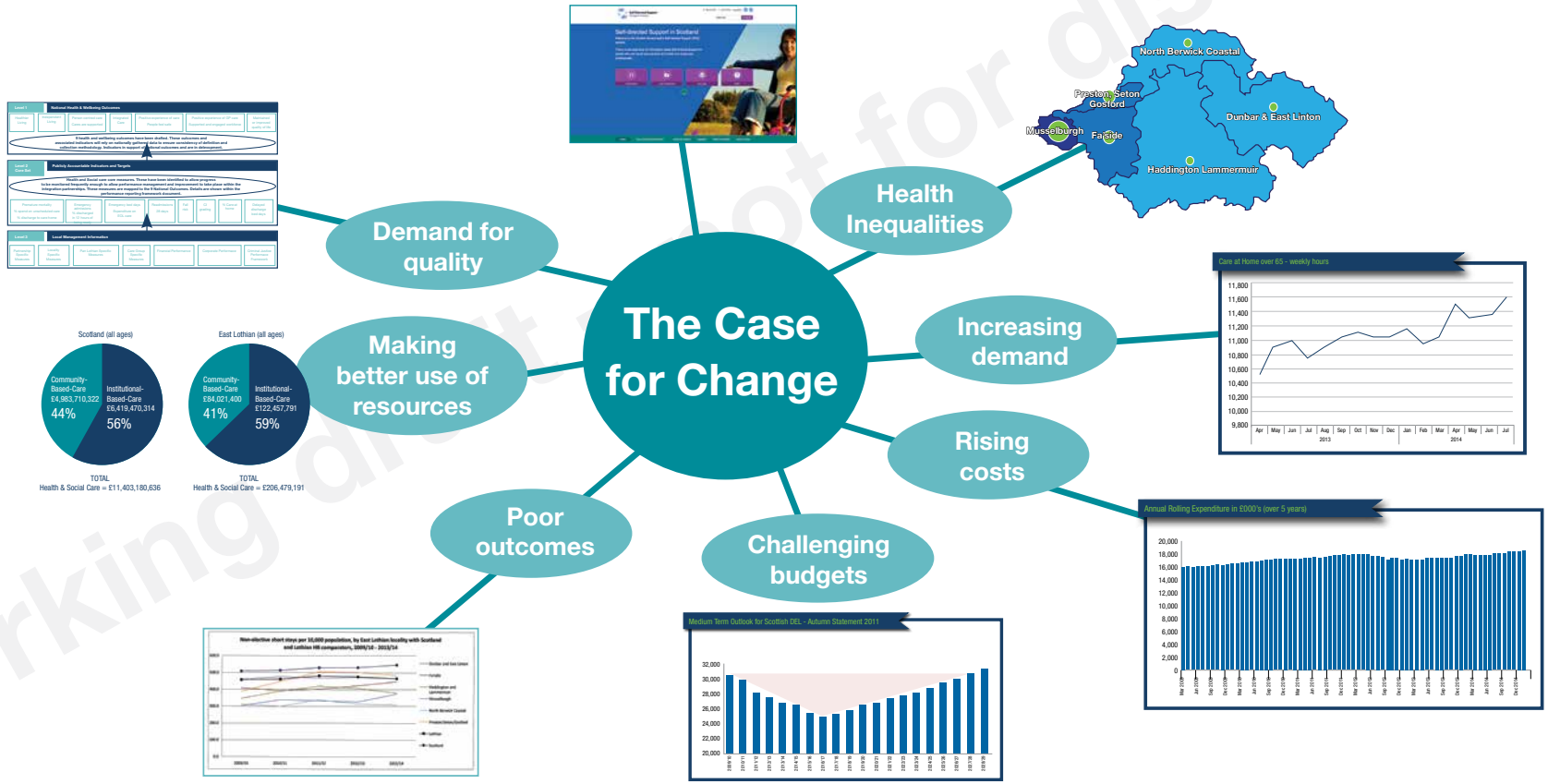
3. The Case for Change

Making the case for change is at the centre of this Plan. It is not a critique of current provision but rather a fundamental recognition that the existing model of care needs to change in order to meet future challenges. There are no neutral decisions – if we do nothing the health and care system will not be able, in its current form, to continue to deliver the high quality service we expect to meet the needs of the East Lothian population.

Ultimately our case for change is built on a number of key drivers which are articulated throughout this draft plan. These are shown below.

We have identified these key reasons supporting the need for change and the priorities for this Strategic Plan. How we respond to these will be key to shaping the decisions for the future configuration of adult services.

Figure 1

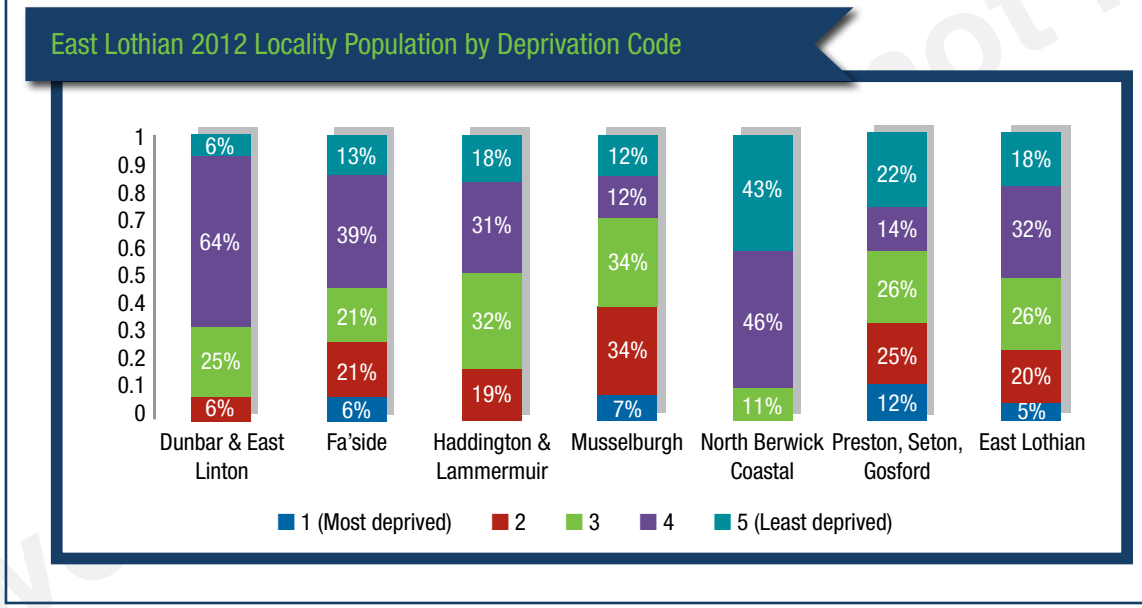


3.1 Health Inequalities

Inequalities in health outcomes between the most affluent and disadvantaged members of society are longstanding, deep-seated and have proved difficult to change. Scotland's health is improving rapidly but it is not improving fast enough for the poorest sections of our society: health inequalities remain a major challenge.

Figure 2

Overall 5% of the East Lothian population live in the most deprived Scottish quintile, whilst 18% live in the least deprived quintile. This varies by locality, with North Berwick Coastal locality having no residents in the two most deprived Scottish quintiles.

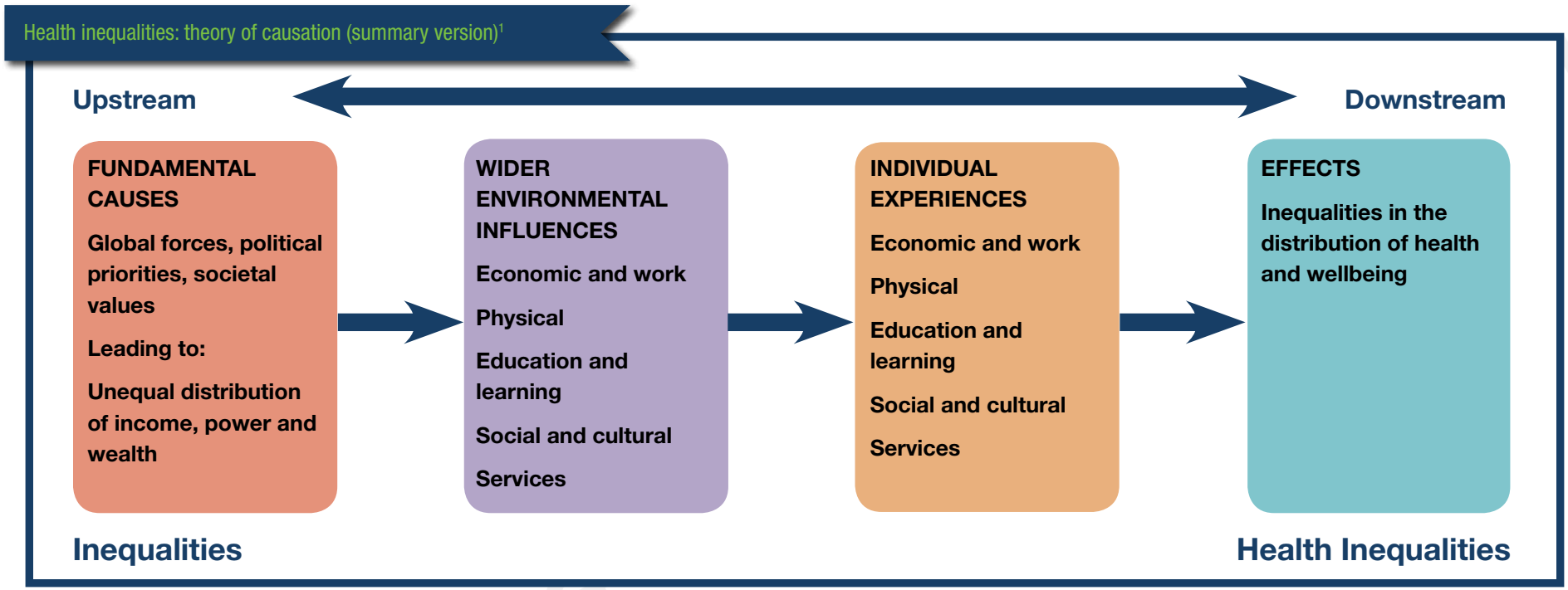


Across East Lothian people living in the poorest neighbourhoods, can, on average, expect to die 4 years earlier than people living in the richest neighbourhoods and spend more of their lives with ill health.

Poor mental health and wellbeing are also associated with an increased likelihood of poor physical health. In Scotland in 2006, people who had a low household income had on average lower scores on a scale of mental wellbeing than those with a high household income.

Those living in the most deprived areas of Scotland have a suicide risk double that of the Scottish average and these inequalities appear to be increasing over time.

Figure 3



Health Scotland theory of causation of health inequalities[2]

Such inequalities are due to a complex mix of social, economic, cultural and political reasons with unequal provision of health and social care responsible for only a proportion.

The real starting point, therefore, is to acknowledge that population health and wellbeing is not just a matter for the health and social care system. It certainly begins with the individual and the choices they make, but improving health and reducing health inequalities also require joint action and partnership working.

Factors or interventions can only be addressed effectively through real partnerships across the NHS, Council, the voluntary sector, local communities and private sector organisations. A sustainable model of adult health and social care services needs to place greater emphasis on maintaining people's independence and resilience, preventing deterioration into substantial or critical categories of need.

As a new Partnership, therefore, we will actively work with colleagues in housing, education and a range of other sectors in order to address such inequalities as a priority.

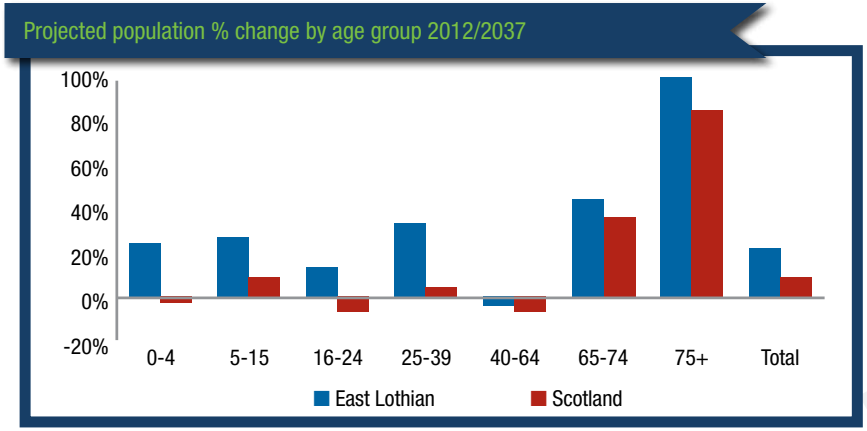
[1] http://www.gov.scot/Publications/2014/03/2561/5

[2] http://www.scotlandscensus.gov.uk/documents/censusresults/outputsprospectusaugust2013.pdf

3.2 Increasing demand

In 2012, there were 100,850 people living in East Lothian, and this is projected to grow by 23% between now and 2037. This is one of the highest increases in any local authority area in Scotland.

Figure 4



All our demographic trends indicate that in future we will be in the fortunate position of more older people living longer. However we also anticipate that a smaller working age population will be available to supply the care sector workforce we will need to look after people. The higher level of dependence on institutional and hospital care for older people in particular not only accounts for a high level of health and social care expenditure, it also requires a skilled and quality workforce to deliver the increased levels of care.

Figures 5 and 6 demonstrate the increasing levels of demand on adult wellbeing services in East Lothian.

The projected changes to the population and household trends provide a striking view of the future; they point to a shift towards a higher level of dependence within our population whilst the rise of single person households indicates that there will be less informal family support and a greater reliance on care services.

Figure 5

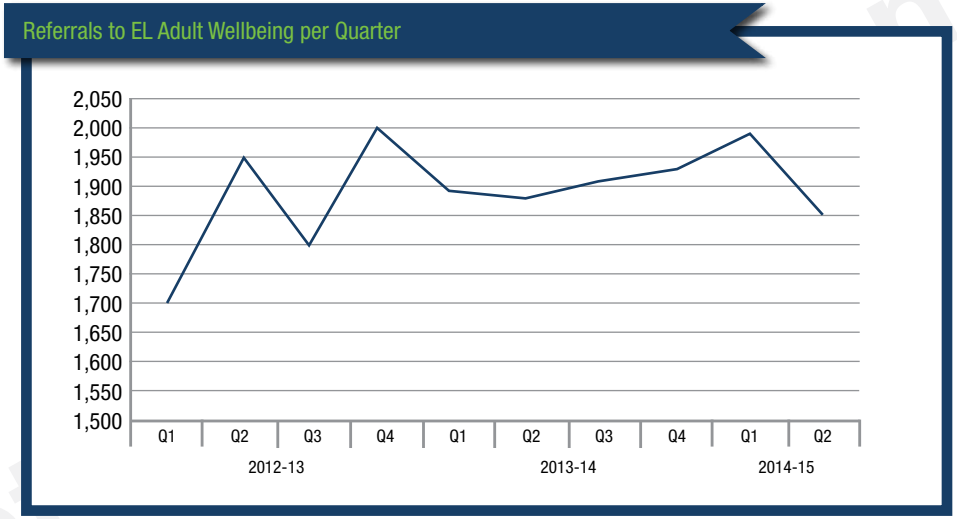
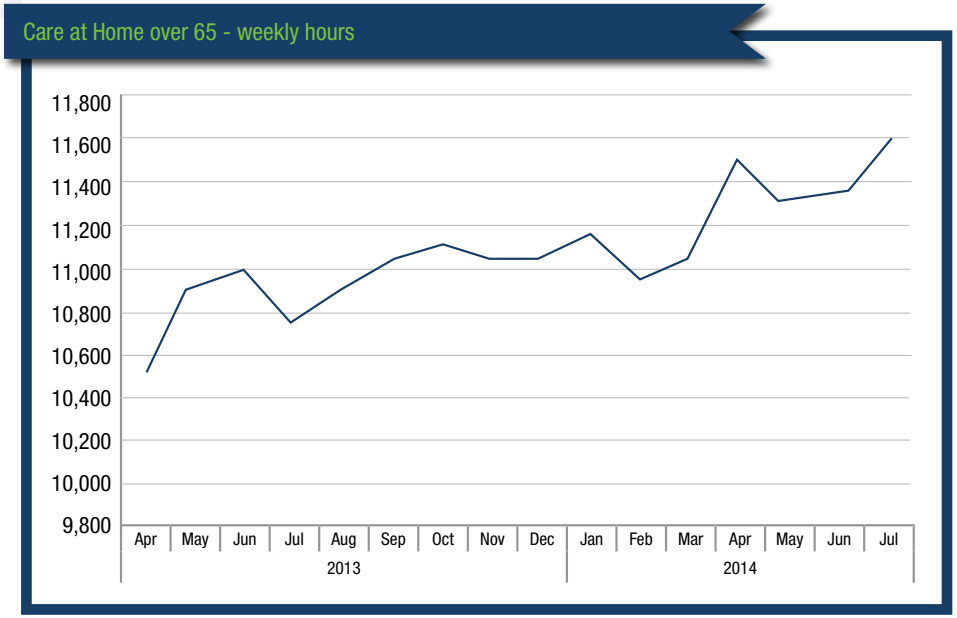


Figure 6



3.3 Rising Costs

Over two million people in Scotland have long term conditions and this number is projected to rise as the population ages and as a consequence of increasing levels of risk factors for chronic disease at all ages.

Current evidence suggests that deprivation influences both the amount and the type of multiple conditions that people experience and multimorbidity occurs 10 -15 years earlier in deprived areas compared to affluent areas.

A greater mix of mental and physical health problems is seen as deprivation increases; this combination of physical and mental health conditions has a strong association with health inequalities and negative outcomes for individuals and families. Figure 7 demonstrates this across East Lothian.

Emergency admissions to hospital, attendance at A&E and prescribing costs are rising as a result of this, particularly in areas with a high prevalence of multimorbidity. Annual adult health and social care spend is projected to rise with this increasing demand. We have strong evidence of all this across East Lothian.

Figure 7

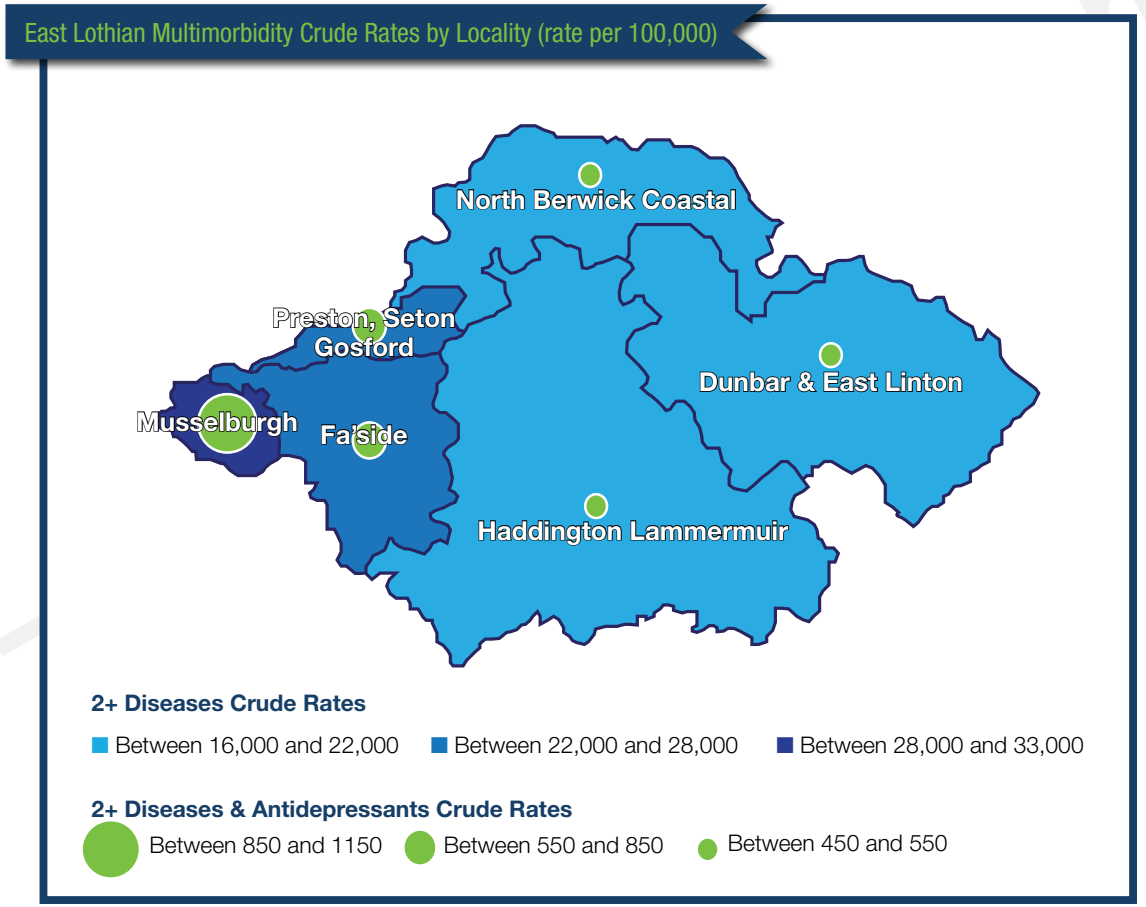


Figure 8

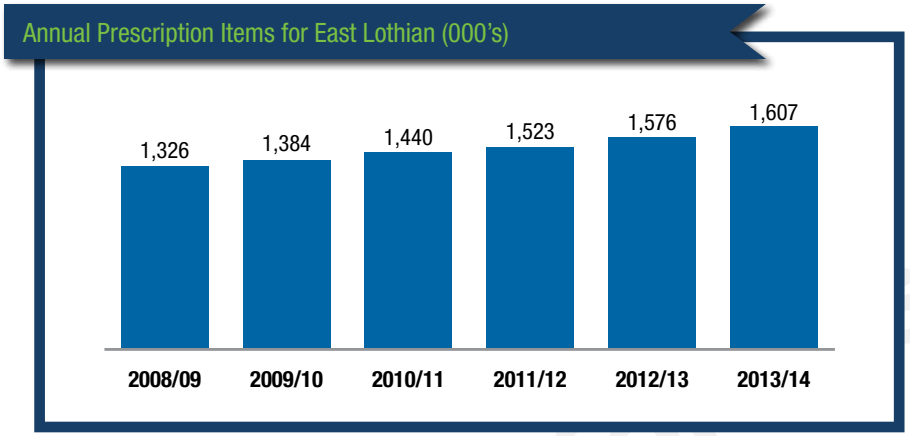
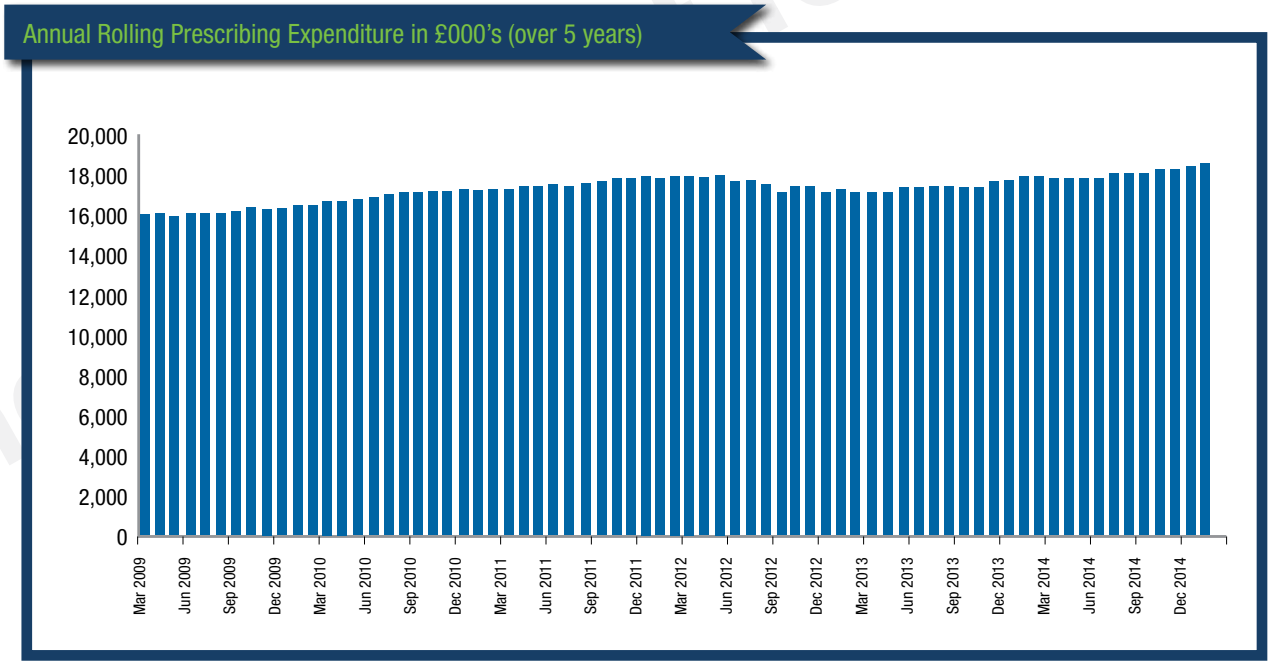


Figure 9



3.4 Financial and human resources

3.4.1 Financial resources

In recent years public services have faced an unprecedented period of financial constraint which continues. The effects have been felt most strongly by local authorities, including social care services, with the NHS relatively protected. The medium-term outlook suggests that public spending will remain constrained for the foreseeable future.

Such spending constraints on social care have led a number of local authorities to tighten eligibility criteria, resulting in a potential increase in unmet need and onward pressure on services downstream. Rapid growth in the numbers of frail older people and younger people with disabilities has outstripped any increased funding and seen a growing gap between needs and resources. The net result of these trends is that the publicly funded system is becoming more focused on those with the highest needs.

With acute hospitals having benefited most from any recent increases in NHS spending, partly driven by the requirement to meet ambitious national targets, improvements in care in the community are now most likely to depend on how successful health and social care systems are in reducing unscheduled acute pressure and releasing resources from hospitals to invest in new services closer to home. This is particularly important in East Lothian given the current proportions of total health and social care spend in institutional and community settings.

Figure 10

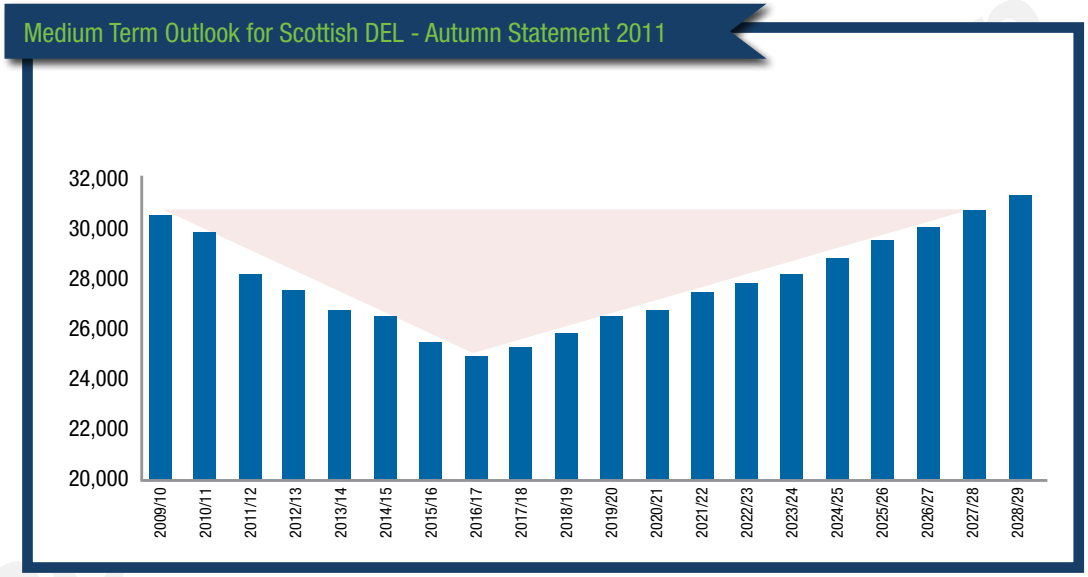
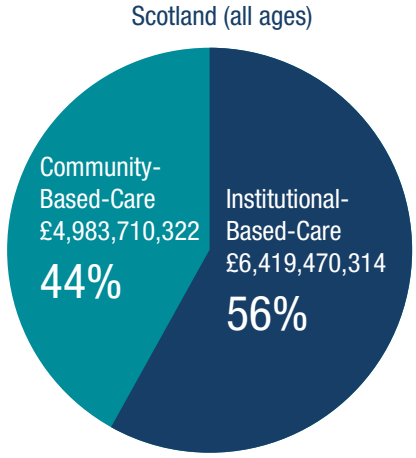
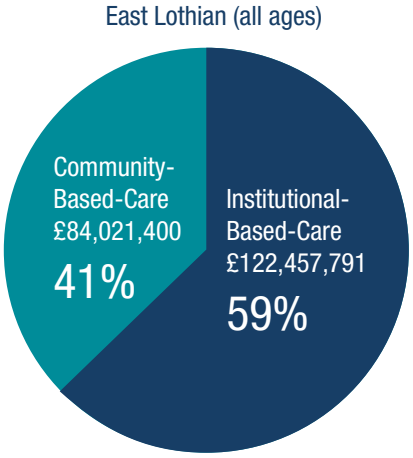


Figure 11



TOTAL
Health & Social Care = £11,403,180,636

Figure 12



TOTAL
Health & Social Care = £206,479,191

3.4.2 Human resources

A significant proportion of health and social care spending goes on human resources. The age profile of our health care workforce means that many will be retiring over the next 10–15 years, particularly health visitors and midwives. Without action now this has the potential to lead to shortages in the number of trained staff, but more likely to a shortage of experienced staff to take on leadership and supervisory roles. In social care, while the workforce is older in comparison with the total working population, there is no evidence that it is getting older and, if anything, the range of ages is widening[3]

A further challenge is aligning the skills of our workforce, now and in the future, with the needs of patients and service users. There is a growing awareness that the current workforce is not well matched to needs and demands, and the training pipeline, particularly of doctors, may exacerbate these problems. It has been predicted that, by 2020, as the workforce ages, the NHS is likely to have an oversupply of hospital doctors but a shortfall in the number of GPs[4]. We have also yet to see a significant shift from acute to community sector based working, particularly in the numbers of nurses working in the community.

The broad reach of health and social care integration includes relationships beyond traditional NHS and local authority providers. The majority of social care services, for example, are delivered by the independent sector and integration of services is as relevant and important for them as it is for wider public services such as housing and leisure.

The independent sector is the largest social services employer in Scotland as a whole and 45% of the care delivery workforce in East Lothian is employed in this way. They have a pivotal role in supporting care at home and in care homes and the contribution and participation of the sector in service planning is fully recognised.

Nonetheless, social care as a vocation has sometimes been viewed as demanding but low paid, and recruitment and retention challenging. We face a potential crisis in the provision of care and support services over the coming years, with a growing population of older people but with fewer people coming into a labour market that is increasingly competitive.

This has already led at times to challenges in ensuring care and resources are focused on getting the services that meet people's needs across some areas of the county. Addressing this will be a key enabler in delivering our strategic change programme.

3.5 Poor Outcomes

Given the increasing and changing nature of our population, changing practices in medicine and care and increased expectations of the public, the gap between demand for services and current provision is widening.

Our Joint Strategic Needs Assessment tells a powerful story of unscheduled care patterns in East Lothian and we recognise that historically there has been an over reliance on hospital services. East Lothian does have an overall lower unplanned admission rate than the Scottish average which is very positive, but the average length of stay in hospital for someone from East Lothian is longer, accounting for a greater proportion of occupied bed days in hospital. For this and for a range of other markers such as multiple hospital admissions and readmissions the picture also varies significantly across localities.

An emergency admission to hospital is a disruptive and unsettling experience, particularly for older people, exposing them to new clinical and psychological risks and increasing their dependency. Alongside improving the way we support emergency and unplanned admissions to hospital we must also

[3] www.skillsforcare.org.uk/research/research_reports/state_of_ the_adult_social_care_workforce_reports.aspx

[4] www.cfwi.org.uk/publications/leaders-report-shape-of-the-medical- workforce

strengthen significantly what we do in East Lothian to prevent people being admitted to hospital in the first place. Aids and adaptations in the home, befriending services, early intervention and effective information and advice, delivered on a timely basis, all have an important part to play in helping to maintain people's health and wellbeing, reducing unnecessary hospital activity

The real measure of success for both our service users and for the health and social care partnership should be safe and supported "bed days at home" – a measure inversely related to hospital bed days. In simple terms we know it is possible and it's better to provide services closer to home, yet we continue to use hospitals. This is an unsustainable and undesirable model and this draft Strategic Plan sets out priority measures to address this.

We also know that we need to perform much better at reducing our delayed discharge figures - when people are delayed in a hospital bed whilst waiting for care or support closer to home. Timely discharge from hospital and its role in helping people to regain and maintain their independence is a priority for our health and social care services locally yet the number of bed days occupied by delayed discharges for East Lothian patients has been significantly higher than the Scottish average for some time and at a cost to the system of over £1 million.

Our performance is improving but with known increasing populations, increasing demand and complexities of care, increasing financial implications and poor outcomes for people a clear, sustained focus on addressing admissions and delayed discharges as immediate priorities is required.

Figure 13

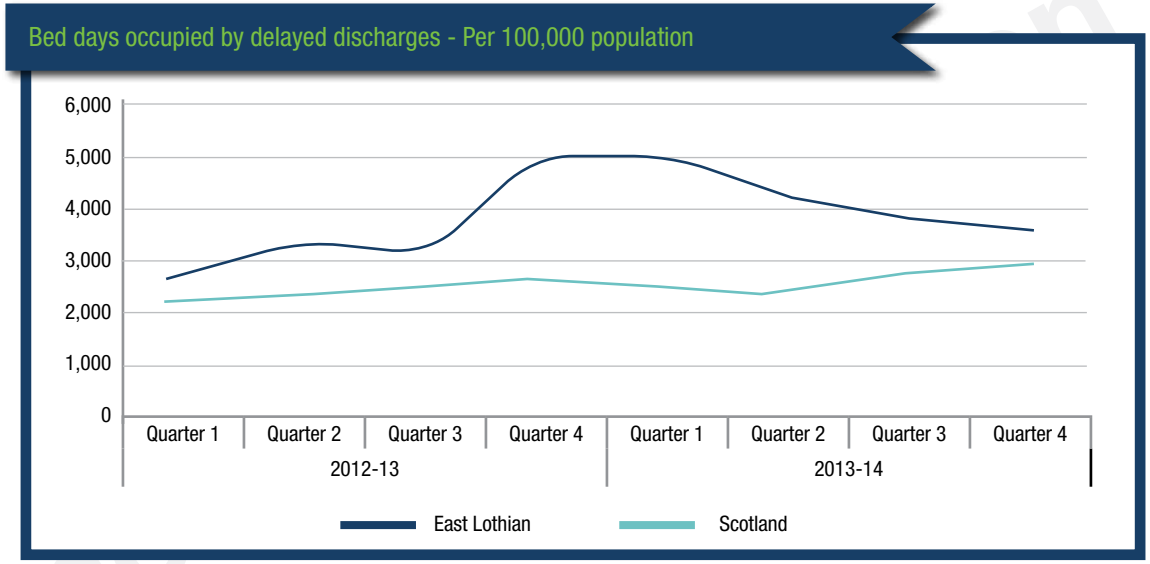
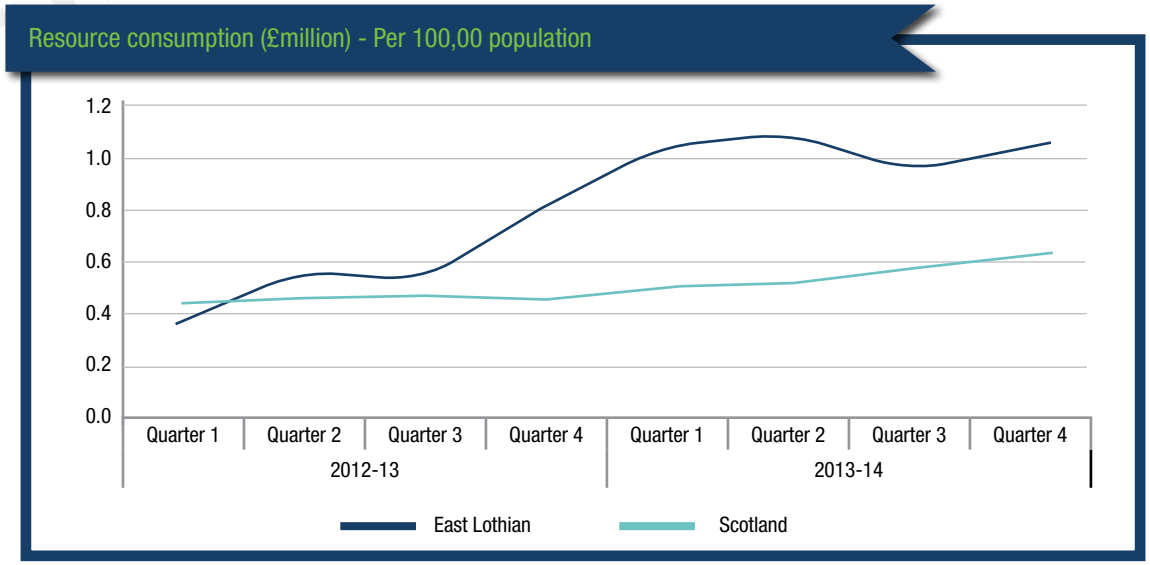


Figure 14



3.6 Demand for quality

People and the quality of care they receive is the focus of everything we do. We will ensure that we plan and commission services based on the quality of care they deliver and ensure that individuals are empowered to choose services on the basis of quality and outcomes. This involves providing clear information to the public about the quality of services planned or commissioned on their behalf including information about poor quality or unexplained variation.

Quality and professionalism will be at the core of everything we do. To ensure this, appropriately skilled and qualified people with the personal attributes to be in a role that has dignity and respect as essential requirements will be needed.

Locally this will mean supporting and developing all our staff and care providers to operate within our own quality and professional frameworks and with other agencies such as the Care Inspectorate and Health Improvement Scotland as regulatory and inspection bodies.

3.7 Policy

Both this case for change and our joint strategic needs assessment (Section 6) outline a wide range of policy drivers which provide the context for this Strategic Plan. These include tackling inequalities, a focus on efficiency, care closer to home and prevention and early intervention.

Self Directed Support and the policy move towards personalisation provide further context. Personalisation aims to enable people to plan and choose social care support that can better suit their individual needs. Self Directed Support aims to empower people to direct their own care and support and to make informed choices about how their support is provided.

Co-Production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Co-Production is intended to encourage people and communities to use the range of human skills and experiences they have to help and support the delivery of public or voluntary services.

Both Self Directed Support and a Co-Production approach will change the way the Partnership considers planning and commissioning in the future with a need to embed these principles in everything we do.

3.8 The Case for Change: A Summary

In all of this we are not any different to other areas. Whilst there are unique factors at play in East Lothian impacting on the demand for services, a number of these issues are common across the country.

Consequently East Lothian cannot insulate itself from the need for change and this Strategic Plan presents an opportunity to consider a more integrated model for the health and social care system that allows us to deliver an excellent and equitable service to the population of the county.

The Partnership believes that the case for change is unassailable. It highlights the pressures currently faced by our health and social care system and the demands that will be placed upon it in the future. If we continue to deliver services as we currently do they will not meet the needs of our population and will not be sustainable for the years to come. Changes are needed to meet future health and social care needs. In looking to recommend new models, the Health and Social Care Partnership has reviewed data and research evidence to inform the changes that are required. We will also engage widely with the public, clinicians, providers and interest groups to further inform our thinking. The aim throughout will be to consider what changes will make the greatest difference to outcomes for patients, users and carers.

4. Strategic vision, values and objectives

4.1 Our Vision

Our Best Health, Best Care, Best Value ambition focuses on a joint vision for adult social care and health services in East Lothian which will enable all adults to ***live the lives they want as well as possible, achieving their potential to live independently and exercising choice over the services they use.***

Improving the health and care of individuals and reducing health inequalities is a key element of this vision. We will ensure that tackling inequalities in health and social care is embedded in our planning processes. This means recognising the different needs of vulnerable groups when designing and delivering services.

4.2 Our Values

The values that will underpin delivery of the Integration Joint Board's vision and outcomes are:

- To give people control over what happens to them is in itself promoting good health and wellbeing. We will seek to maximise people's control over their lives as an integral part of the safe, caring and respectful services we provide
- It is better to prevent health and social problems than to deal with them once they have occurred. We will focus our attention and resources on prevention and early intervention.
- Some people's social and economic circumstances lead to them having poorer health, wellbeing and life chances than others. We will work to tackle these inequalities by focusing our efforts on those at greatest risk and being mindful of individuals' choices.
- It is right to offer people services as close to home as safe and practicable.
- We will promote working in partnership.
- In a single health and social care economy for East Lothian we will invest our resources wherever they will have the greatest impact on meeting our shared objectives.
- We will recognise the interdependencies of services and will take a holistic approach to service provision, respectfully considering each individual in the context of their circumstances.
- We will value the views of people who use our services.
- We will value the diversity of East Lothian. We will work closely with our communities to ensure they can contribute to the health and wellbeing of the population.

4.3 Strategic objectives and immediate priorities

The Strategic Plan for East Lothian has been designed with meeting our vision and in doing this meeting the outcomes and performance measures for integration within Scottish Government's National Performance Framework. These are outlined in detail in Section 10.

Success in delivering against each of these ambitious outcomes will mean making real, positive improvements in the care and wellbeing of local people. Specific local objectives are required which will shape the way the Partnership responds locally to the challenges of rising demand, rising expectations and financial constraint. These key local objectives will help us to deliver the national outcomes and will be further developed throughout the period of the Strategic Plan for adult services.

4.3.1 East Lothian HSCP's strategic objectives are:

A. To make universal services more accessible and develop our communities

We want to improve access to our services, but equally to help people and communities to help and support themselves too.

B. To improve prevention and early intervention

We want to shift and focus services towards the prevention of ill health, to anticipate at an early stage the need for support and to react where possible to prevent crises.

C. To reduce unscheduled care

We want to reduce unnecessary demand for services including hospital care.

D. To provide care closer to home

We want to deliver safe and effective care as close to home as possible, allowing people to remain in their homes and communities for as long as they can.

E. To deliver services within an integrated care model

We recognise the need to make people's journey through all our services smoother and more efficient.

F. To enable people to have more choice and control

We recognise the importance of person centred and outcomes focused care planning.

G. To further optimise efficiency and effectiveness

We want to improve the quality of our services whilst recognising and addressing the challenging financial constraints we face.

H. To reduce health inequalities

We want to reduce inequalities, break the cycle and impact of deprivation and support and protect the vulnerable in our communities.

I. To build and support partnership working

We recognise the importance of developing effective and wide ranging strategic partnerships in delivering our ambition, vision and values.

4.3.2 Immediate Priorities

Based on our strategic needs assessment and early performance measures, the Integration Joint Board has prioritised key areas of work for immediate action and focus in this first Strategic Plan, each of which is reflected in the wider strategic objectives. These are:

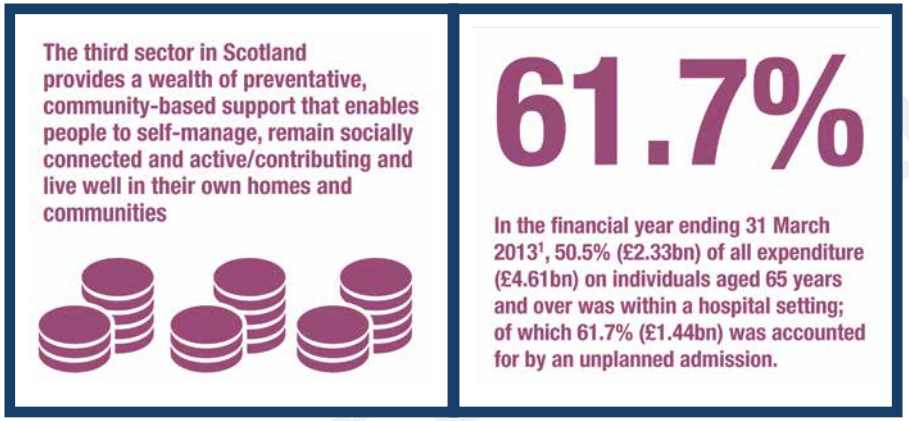
1. Delivering more care closer to home - actively tackling the rise in unplanned or avoidable hospital admissions and significantly reducing delayed discharges from hospitals to home or a homely setting. This recognises the significant impact of high levels of institutional activity and associated spend on integrated budgets and - for the first time - the levers afforded by integration to release resource from acute services into the community over time.

96%

Research shows that 96% of the bed days associated with delayed discharge will be under the commissioning control of Integration Authorities.

2. Addressing the variation in the use and delivery of health and social care services across the county and tackling inequality.

3. Developing a strong focus on prevention and "low level" support for those most at risk as an enabling strategy for the above and in recognition of the need to implement longer term strategies and real and sustainable change.
4. Ensuring best value for the public purse.



5. How will we achieve this? The model of care

This Strategic Plan will look to an integrated approach to service planning which seeks to maximise health gain and the improvement of care outcomes. The Plan should equally deliver on the ambition of the Health and Social Care Partnership to promote integrated planning and to encourage integrated working.

The Plan aims to enhance the capacity of the whole system to improve outcomes, providing the tools for communities and a range of organisations to promote and improve health and wellbeing. The delivery of the Plan should therefore result in the development of sustainable skills, structures and resources which maximise opportunities for wellbeing and reduce inequality at every opportunity.

In East Lothian our approach to planning, redesigning and building many of our services will be based on a "Well Connected" approach – sometimes called a pathway approach.

The traditional divide between primary care, community services and hospitals is increasingly a barrier to the personalised services people need. And just as GPs and hospitals tend to be demarcated, so too are social care and mental health services even though people increasingly need all of these. Long term conditions are now a central task for us; caring for all these needs requires a partnership over the long term rather than providing single, unconnected "episodes of care".

We have also traditionally commissioned or planned services based on a general categorisation of client groups such as services for older people, people with mental health problems, people with physical and sensory impairments or services for carers. This Strategic Plan recognises that every adult is an individual who may identify with more than one of these traditional groupings and our holistic approach to care will look to frame evidence based practice in the context of an individual's life circumstances. We need to ensure that care and support arrangements are tailored to individual needs and not restricted, so that transitions between services are as seamless as possible.

We cannot assume the same set of problems exist for all population groups and we aim to be mindful that the interface issues can be different for the adult populations. For instance, for people experiencing mental ill-health or who have a learning disability, the interface with employment is crucial, where access to supportive employability services, good public transport and the benefits system becomes crucial. Similarly for people with drug or alcohol addictions, often a complex relationship exists within the family unit, and interface issues here are as focused as much on the criminal justice system, or the housing system, as any relationship between community care and acute hospital provision.

The underlying principles of this model – integrating services, removing distinctions between services and agencies and taking a proactive approach to managing care - are key to a model of care which meets people's different levels of need at different stages and different times of life.

The key building blocks of our model of care are:

HEALTHY ACTIVE AGEING AND SUPPORT FOR INDEPENDENCE ACROSS THE LIFESPAN

The future health of our children, and the sustainability of our health and care system depend on a radical upgrade in prevention and public health. Our services will aim to inform and educate our population about lifestyle choices and self management, raising awareness of how to access services if needed. This will include targeted health improvement for those with risk factors for long term conditions as well as population wide prevention and health improvement.

SUPPORT TO LIVE WELL WITH LONG TERM CONDITIONS

Our primary care of the future will support and build on the strengths of general practice, proactively targeting services at people with complex, ongoing needs such as the frail elderly or those with chronic conditions. We intend to expand this model to include nurses, therapists and other community based professionals. We also need to offer some care in fundamentally different ways, making fuller use of digital technologies.

However, even people with long term conditions who can be frequent users of services are likely to spend less than 1% of their time in contact with health professionals. The rest of the time they, their carers and their families manage on their own. Our local services, therefore, need to support families, carers and communities and improve the information to which people have access..

Our aim is to inform and support people to manage their condition and to recognise that some people will have additional social, psychological and economic factors that increase the complexity of their needs. As a Partnership we recognise the close links between physical and mental health and the need to embed care systems which treat them as one. This requires a fully integrated response across health, social care, housing, employment, benefits and voluntary sector partners and our revised planning structures will reflect this.

ACCESSIBLE AND EFFECTIVE SUPPORT AT TIMES OF CRISIS

Helping people get the right care, at the right time, in the right place seven days a week will be a yardstick for the Partnership.

At times of crisis our services need to be well coordinated with timely access to a range of professionals across care settings and agencies. As well as increased involvement of acute hospital services we need to deliver effective packages of care and equipment that proactively and continually support people with complex needs and their carers. This will require an integrated approach to planning, workforce development and care delivery as well as effective use of telehealthcare and systems for information sharing.

To deliver this we will develop the new East Lothian Community Hospital as a central, single point of contact hub for community health and care services, including the wider ELSIE team and a range of intermediate care and third sector services which will effectively bridge the gap between home and hospital. We also fully recognise that both paid and unpaid carers are important members of the extended community team and will need enhanced support to manage care at home, including better access to respite care.

EXCELLENT POST CRISIS SUPPORT

Rehabilitation and re-ablement is a continuum of enabling interventions and involves supporting maintenance or recovery of function, including, importantly, social participation. Rehabilitation and reablement are important for a variety of reasons: to promote safety and independence for high risk, vulnerable people and to reduce dependency on health and social care support and associated costs.

For example, around 120 people from East Lothian come home from hospital having had a stroke each year and whilst there are established, collaborative services available to support early discharge and community rehabilitation, the potential to deliver more locality based services according to need is clear. The development of a new East Lothian Community Hospital will bring earlier post stroke inpatient rehabilitation closer to home for many. We will also work with East Lothian Council and ENJOY leisure to further develop pathways into exercise post stroke and we will strategically target AHPs within East Lothian localities to provide specialist stroke rehabilitation.

Another example is that one in six people aged 85 or over are living permanently in a care home yet evidence suggests that had more active rehabilitation support been available some people discharged from hospital to care homes could have avoided permanent admission and been supported to live at home. We therefore recognise the need to refocus activity and attention and we will work with colleagues across health, social care, voluntary and independent sectors to fully embed a reablement culture across our services that empowers and enables. We will also further develop our intermediate care services including both “Step Up” and “Step Down” bed based models and our successful Discharge to Assess system.

PERSON CENTRED AND DIGNIFIED LONG TERM CARE

Coordinated, multi professional and multi agency care that supports informed choice for individuals and those who care for them is crucial to our model of care.

To deliver this we will provide more integrated home based care, particularly for end of life care, by enhancing integrated community teams and timely access to specialist expertise. We will equally develop these services to support our care homes in delivering high quality long term care by developing new models of in-reach support.

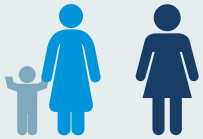
Our planning framework and service redesign programmes will articulate and develop this model or network of care as implementation of the Strategic Plan progresses.

To further illustrate our thinking and to constantly test our responses we will also use fictitious users of health and social care services – Callum, Hannah and Scott.

HANNAH

I'm Hannah. I'm 59 and I've lived in Musselburgh all my life. I live with my husband John and our 20 year old son, Simon, who has a moderate learning disability. My 81 year old Mum lives in sheltered housing nearby and our daughter lives on the other side of town. I've grown up in this town and all my friends still live here.

CARING



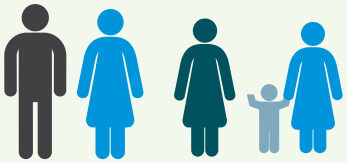
Simon requires support in most aspects of daily living and Hannah is his principal carer.
She visits her elderly Mum every day and is first responder to her telecare alarm.
Hannah also looks after her 4 year old granddaughter twice a week to allow her daughter to return to work.

HOME

Lives in modern, rented social housing. The family rely on public transport.

FAMILY

Three weeks ago John suffered a stroke and is currently in hospital in Edinburgh waiting to be discharged. He is having physiotherapy and speech and language therapy to help him recover as much as possible. John had recently retired and had a history of depression.
Hannah's Mum has early dementia and falls occasionally.
She's dependent on Hannah for shopping and for socialisation.
Simon particularly enjoys his volunteer placement which he hopes will lead to paid employment in time.



WORK

Hannah works part time shifts in the local supermarket

HEALTH

Has multiple co-morbidities including high blood pressure, arthritis, anxiety and depression and a past history of breast cancer.
Hannah takes multiple medications and is a heavy smoker.

COMMUNITY

Hannah knows many people in the community and still has friends from school living nearby.

SCOTT

I'm Scott. I'm 75 and live in Aberlady with my wife Joan. We retired here 10 years ago. Our two daughters live in England and come to see us when they can but it's difficult with their own families to look after and their busy lives. They gave me one of those tablet things to help keep us in touch but it's not really the same.

CARING

Scott's wife Joan was diagnosed with dementia last year and there has been a marked deterioration in her cognition over the last few months. She has become very confused whilst out shopping on her own or when Scott has gone out to visit friends and she has been left in the house.

HOME

Scott lives in a 4 bedroomed house which he owns. It's on the edge of the village and has a large garden which he loves but is finding increasingly difficult to maintain. He sold his car recently as he had lost confidence in driving and they rely on friends and public transport to get about.

FAMILY

Other than Joan and his daughters and grandchildren who live in England, Scott has no close family nearby.

HEALTH

Scott has a heart condition and takes warfarin for this. He was admitted to hospital recently after a fall and feels he's lost confidence since then. Joan was also admitted to hospital after a urinary tract infection.

COMMUNITY

Scott and Joan were active members of the community when they first retired to the village but have found it harder to get out and get involved in the past couple of years.

CALLUM

I'm Callum and I'm 27. I was born in Ormiston where my Mum and sister still live.

CARING

Callum has a daughter aged 8 years from a previous relationship but has had very little participation in her life since she was around 6 months old.
Periodically Callum seeks to re-establish contact with his daughter but never pursues this on a serious basis.

HOME

Callum was living in a shared, rented flat in Prestonpans but left after an argument with his flatmate. He's currently "sofa surfing" between friends and has no fixed abode.

FAMILY

Callum's Dad died suddenly at the age of 63 and when Callum was 14. He grew apart from his Mum and moved out of the family home when he was 18. He hasn't been in contact with his Mum or sister for some time.

HEALTH

Callum has a history of alcohol abuse.
He had a recent suicide attempt which resulted in an emergency hospital admission. He's asthmatic and a frequent attender at A&E because of this.
Callum tried to register with the local GP practice near where he's currently living but couldn't as the practice list was "closed".
Callum also suffers from back pain and doesn't always have enough medication to manage his conditions which is one of the reasons for his frequent A&E attendances.

COMMUNITY

Callum spends most of his time with a small circle of people.

6. Joint Strategic Needs Assessment: A Tale of Two Communities?

6.1 What is a Joint Strategic Needs Assessment?

In understanding the drivers and in developing this draft Strategic Plan we have utilised a wide range of information to consider where we need to focus and what our priorities should be. The most significant sources of information were our Joint Strategic Needs Assessment, a suite of national and local strategies and policies, and public, partner and clinical feedback.

Our Joint Strategic Needs Assessment (JSNA) describes the underlying demographics, health and health and care needs of the East Lothian adult population. A summary of the JSNA process is attached to this document as Appendix 4 and the more detailed reports will be available on the Partnership's website when finalised.

The JSNA is a holistic analysis of the needs of our communities, and its purpose is to form the basis of intelligence led strategic decision making within East Lothian. This assessment and analysis shows the many health and wellbeing drivers which can impact on an individual's or a population's demand for health and social care. Such a relationship is complex, but examining certain parameters such as life expectancy, disease prevalence or lifestyle factors can give an indication of the likely need for health and social care; a good JSNA also considers current levels of services which are being delivered and any subsequent gap analysis. The JSNA, therefore, should allow better identification of areas that need more detailed examination and inform any required reprioritisation or service reconfiguration, commissioning and /or decommissioning of services in the most effective way.

As we move forward with joint planning in the Partnership the continuing work on the JSNA will become central to efforts in transforming the planning and commissioning process. For now it provides the basis, alongside the policy drivers set out in Section 6.2, for this draft Strategic Plan's approach and priority setting.

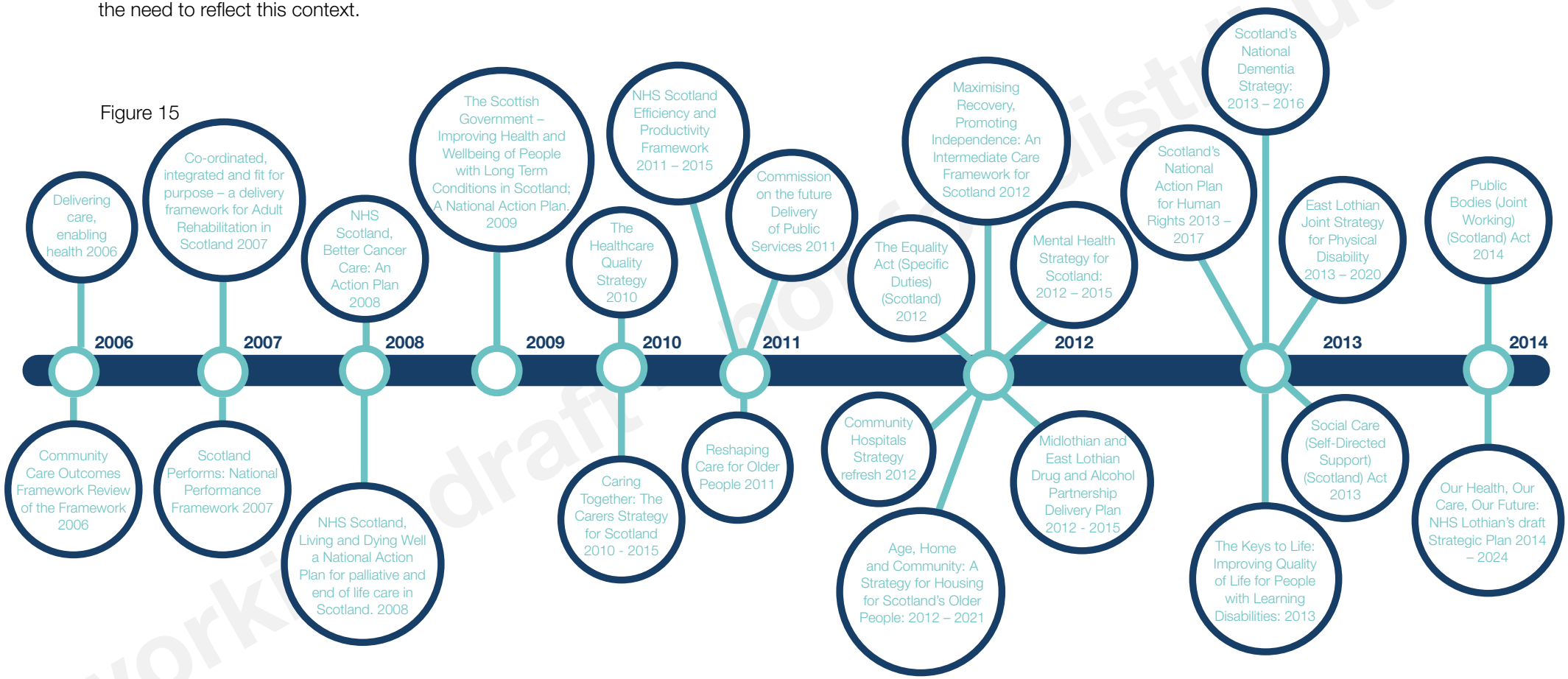
Fundamentally the JSNA demonstrates that for many of the services we currently commission or deliver we cannot maintain our ways of working into the future. Instead we need to take a "transformational" approach to our service planning so that the greatest use of all the resources available to us is directed more effectively at areas of need.

6.2 Legal, Regulatory, National and Local Policy Context

The services that we plan and commission are delivered within a rapidly changing policy environment which includes national legislation and strategies as well as Lothian wide and local plans. This draft Strategic Plan recognises the need to reflect this context.

National, regional and local policy across health and social care is undergoing a period of major change. Key among these changes which have informed this Strategic Plan for East Lothian are

Figure 15



6.2.1 National Strategic Context

The Scottish Government has clearly set out its goals and policy framework for improving health and wellbeing through a number of key strategic statements. These are ambitious in scope and will accelerate radical reform in the way public services are delivered. Priorities include

- Maximising scarce resources by utilising all available resources from the public, private and third sectors, individuals, groups and communities
- Concentrating the efforts of all services on delivering integrated services that deliver results
- Prioritising preventative measures to reduce demand and lessen inequalities

6.2.2 Regional Strategic Context

NHS Lothian's Strategic Plan recognises the challenges of demographic change, quality aspirations and resource constraints and describes what the Health Board proposes to do over the coming decade to address these challenges whilst providing a high quality and sustainable healthcare system for its citizens.

Like our local draft Strategic Plan, NHS Lothian's articulates a vision of services designed around people with multiple conditions, located in communities, coordinated and integrated, and preventative in focus. It addresses the quality and sustainability of specialist hospital services and the challenges of unscheduled admissions and delayed discharge; importantly NHS Lothian's Strategic Plan recognises the need to rebalance investment across acute hospitals and community services as well as the need for urgent action on areas for disinvestment in order to drive service quality.

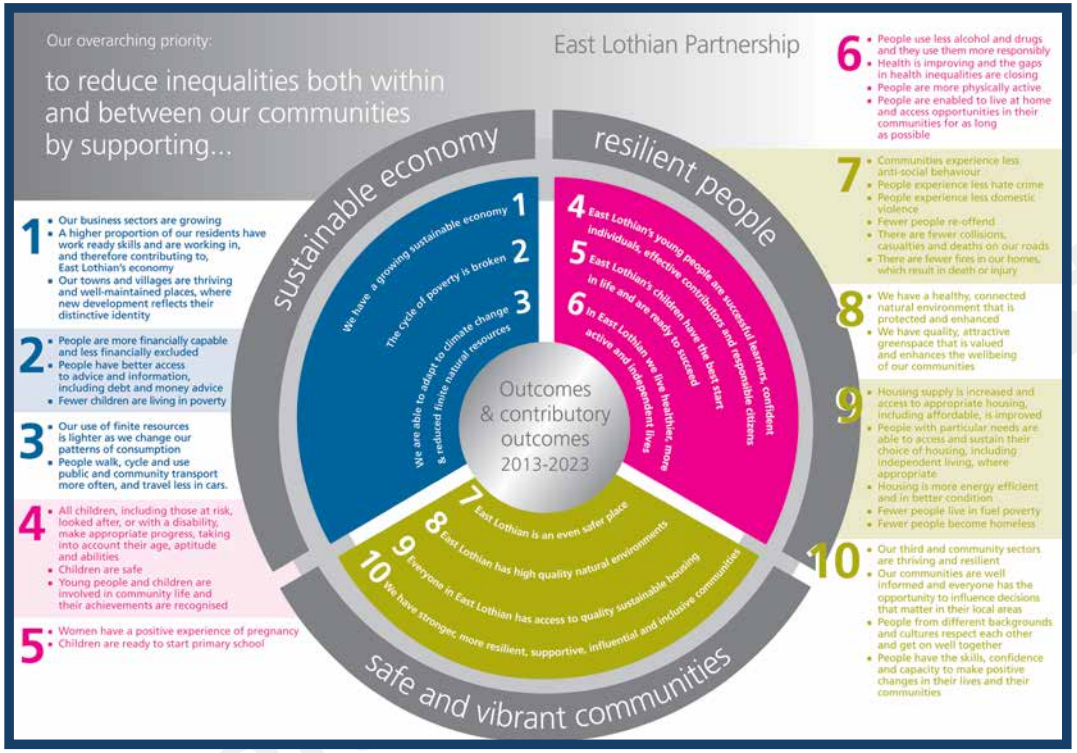
NHS Lothian provides services across four Health and Social Care Partnerships - East Lothian, Midlothian, West Lothian and City of Edinburgh. As such, NHS Lothian's Strategic Plan will be informed by each partnership Strategic Plan, and vice versa; equally our own local plan must take cognisance of the other Lothian Partnership plans in order to ensure maximum synergies, effectiveness and best use of resources. We will actively work with NHS Lothian and neighbouring partnerships to ensure optimal impact.

6.2.3 Local Strategic Context

The East Lothian Plan: Single Outcome Agreement (SOA) 2013 – 2023 sets out East Lothian Council's strategic plan to improve the lives and opportunities for the East Lothian population and to reduce inequalities within our communities. The SOA, which has been developed with 21 partner organisations, lays out 3 strategic objectives - a Sustainable Economy, Safe and Vibrant Communities and Resilient People – with a range of contributory outcomes.

The Health and Social Care Partnership's draft Strategic Plan has ensured alignment with these national and local policies and as planning progresses we will ensure this alignment is continuously tested.

Figure 16



Current East Lothian Joint Strategies

Adults with Learning Disabilities

National statistics gathered by the Scottish Consortium of Learning Disability record East Lothian as having a higher population of adults with a learning disability than the Scottish average. Whilst adults with a learning disability living in East Lothian are more likely to have education and employment opportunities than many other areas of Scotland, there is more to be done to improve life opportunities and reduce health and social inequalities across the region.

East Lothian's Learning Disability Strategy 2013 – 2018 sets out how East Lothian Council and its partners will deliver health and social care services to people with a learning disability and their families and carers. Through the available data and by gathering the views and experiences of people impacted by learning disability, the Learning Disability Joint Planning Group has identified key individual and strategic outcomes for delivery through the Strategic Plan.

East Lothian accepts, along with wider Lothian partners, that a small number of specialist services for people with learning disability, whilst accountable

to all local partnerships, will continue to be delivered on a Lothian wide basis. These services include the specialist hospital based assessment and treatment services, very small clinical services plus those services forming part of the intermediate tier, for example. Forensic services, Mental Health Intensive Support Team and the Behavioural Support Team.

The Lothian Learning Disability Collaboration – the pan Lothian strategic forum - will continue to set the strategic direction for the development of these centrally managed services, ensuring delivery of services in line with the respective strategic plans of all partners. The Collaboration will also be responsible for Lothian wide performance management, accountability and service development which continues to respond to the principles and ambitions of integrated service planning and delivery. Within the range of required services for people with learning disability, particularly for those with intensive or complex support needs, it is recognised that in some instances the most appropriate service response may continue to be a Partnership response, on occasion pan Lothian. It is agreed that specialist strategic service developments will be progressed through the Lothian Learning Disability Collaboration in the first instance

The East Lothian Learning Disability Planning Group acknowledges the priority outcomes could and should relate to all members of a community. However, people with a learning disability have a unique comprehension of the information, people and environment around them; this quality can require careful, skilled and experienced advocacy and close regard to both health and social models of care. Information and consultation will aim to be meaningful to the individual and increase the involvement of people with profound and multiple learning disabilities.

Priority issues:
People with a learning disability and families/ carers can access information and support from a single point of contact. Integrated services will ensure that information and advice is coordinated, accessible, understandable and localised. New technologies, community resources and advocacy services will provide information and independent advice to people in their own homes and communities in ways that involve individuals.

Key Action: We will establish an accessible virtual and physical information hub in East Lothian

People will be supported to maintain and develop friendships, natural supports, community links and steps towards independence. It is important to people with a learning disability that the integration of health and social care services embeds inclusion and creates community based opportunities that promote independence. People who are using services will have opportunities to have a say in service design and a choice in who provides support and how support is delivered. Health and social care service providers will promote personalised services tailored towards meeting individual outcomes.

Key Action: We will support and commission community led and community based activities.

There will be more early intervention and prevention supports in place which highlight carers health needs. Carers, carers' organisations and carer legislation demand improved carers support planning as part of the 'cared for' support planning process. Consultation with carers and carer organisations will inform and shape future carers support plans and will include young carers transitioning into adult carers. Health and social care agencies will work together to forward plan life stage and health transitions that people with a learning disability and their carers are experiencing.

Key Action: Carers will be offered outcomes focused Carers Support Plans aligned with the cared for's support plan.

People with a learning disability will have opportunities to engage in meaningful activities, greater access to further education and employment. Personal support plans will make creative use of Self Directed Support that

involves people with a learning disability, their carers and families in improving their life opportunities. Community services will be planned around data and local mapping of services. Links with education and employment agencies will value the skills and qualities of people with a learning disability in paid and unpaid work. Communities will be enabled to attend, create and shape local services.

Key Action: We will build inclusive communities based on evidence based mapping of services.

People can access relevant healthcare services locally when required.

Health and social needs assessments will take a holistic view of individuals needs and will take an enabling approach when planning medical and social prescriptions and services. Technology, Tele health care and local clinics will be evaluated with a view to supporting people more effectively and efficiently in their own homes and community.

Key Action: Local clinics will be established and supported

Different types of housing and support models will be available. Health and social care agencies will develop housing and bespoke living environments by working in partnership with other local authorities, private and third sector organisations and by involving people with or caring for someone with a learning disability. New housing developments will consider the wider needs of communities and work with communities to reduce inequalities and stigma. Pan Lothian partnerships will continue to work together to consider and plan for a residential development for people with complex care needs.

Key Action: Homes for people with learning disabilities and complex needs will promote independent living

People will feel safer in their communities and feel safe within their communities and have relationships based on their own choices. Everyone should feel safe in their own home, in their communities and when receiving services. Links with Public Protection Unit will establish a hate crime agenda and publicise and distribute material that will improve people's understanding of issues around learning disability. Service organisations will ensure individuals know how to report, complain and raise awareness of living well, independently and safely.

Key Action: Hate Crime information and awareness sessions will be delivered in partnership with the Public Protection Unit.

The proportion of people in Scotland who reported a long-term activity-limiting health problem or disability in the Census was 20%, the same proportion as reported in 2001. That's over one million people.

20%

East Lothian Autism Strategy - Adults

East Lothian's Autism Strategy 2015 – 2024 commits to improving the life opportunities and quality of life for people with autism. Key to the success of the strategy will be the establishment of the Autism Strategy Implementation Group (ASIG) and the associated delivery plan. ASIG will be a platform for voice, collective action and an agent for change.

44%

An Inclusion Scotland survey (2014)[1] found that 44% of respondents said that the treatment they receive for their mental health condition is rarely or never adequate in meeting their needs and 42% said that their treatment has got worse over the last five years.

East Lothian's commitment to reduce health inequalities and build inclusive communities requires both multi agency and community responses; for example, we know that only 15% of adults with autism are employed. Health and social care agencies must work in partnership with support organisations, the third sector and communities to enable employers to better understand autism.

Early diagnosis and earlier intervention is known to improve the lives, physical and mental health of people with autism. By getting it right through childhood the educational and employment opportunities widen and living as independently as possible is realised.

To achieve this change across life stages East Lothian's autism strategy has set six priority areas of action:

- Improved Diagnostic Pathway
- Emotional Wellbeing and Mental Health
- Education and Transition into Adult Life
- Supported Living and Accommodation
- Training and Awareness Raising for Autism
- Employment

These key actions are informed by consultation and involvement of people impacted by and with an interest in autism. The commitments within the strategy will be resourced by partnership resources and community engagement.

Adults with Physical Disability

Opportunity and Independence', East Lothian's joint strategy for people with a physical disability or hearing or sight loss, underlines our commitment to work collaboratively to ensure that there is an integrated network of care and support in East Lothian which is provided to a high standard. We intend to make sure that anyone can access services and other resources when they need them, regardless of income or where they live.

Research regarding incidence and prevalence figures for physical disability indicates no projected spikes in particular conditions or illnesses that predict a significant increase in numbers of young people and/or adults who have a physical disability. The consistent indicator of increase in physical disability is age-related - the increase in volume and intensity of need because of physical disability relates directly to the increase in the demographic of older people. In East Lothian we know that our older population is predicted to increase significantly and our strategies need to plan and take account of this.

The strategy focuses on four main themes:

- Raising awareness of the impact of physical disability on the lives of East Lothian residents
- Ensuring access to information and opportunities
- Promoting self-management: developing services which focus on supporting people to manage long-term conditions and disabilities themselves
- Ensuring access to intensive day support for people with complex disability.

Our priorities contribute to achieving outcomes which relate directly to the SOA.

In East Lothian we live healthier, more active and more independent lives

Key actions

- We will support people to self-manage long-term conditions
- We will continue to gather information about the level of disability and the diversity of need in East Lothian including complex sensory loss, speech loss and other communication difficulties
- We will promote uptake of SDS and Scottish Independent Living Fund by people with a physical disability or long term condition
- We will disinvest from current day service models to deliver redesigned services to support individual choice
- We will implement the national sensory impairment strategy
- We will contribute to the redesign of pan Lothian specialist services including amputee rehabilitation, SMART services (wheelchair, prosthesis, driving assessment centre etc.), rehabilitation including neuro-rehabilitation, acquired brain injury and progressive neurological conditions

- We will implement the pan Lothian neurological care improvement plan ensuring the pathways begin and end within localities.

Fewer people are the victims of crime, disorder or abuse in East Lothian

Key action: We will develop a specialist independent advocacy service for people with a physical disability.

In East Lothian, people in housing need are able to access and sustain their choice of housing including independent living, where appropriate

Key actions: We will raise awareness of innovative and radical approaches to telecare and telehealthcare.

We will enable people with a physical disability to live independently in their own homes by increasing access to and uptake of specialised equipment and adaptations through uptake of self directed support.

Mental Health

Mental illness is the single largest cause of disability in the UK. We know that:

- At least 1 in 4 adults will experience a mental health problem at some point in their lives
- Almost half of all adults will experience at least one episode of depression during their lifetime
- One in ten new mothers experience post natal depression
- Depression affects 1 in 5 older people living in the community and 2 in 5 living in care homes
- The highest level of depression is found in those over 75 but recognition rates are poor
- The incidence of mental health issues can increase in times of economic uncertainty as can the rate of suicide
- Our population is increasing, with a corresponding increase in the number of those at risk of dementia and depression
- 12 - 18% of all expenditure on long term physical conditions is linked to poor mental health and wellbeing.

Physical and mental health are closely linked - people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people and is a significant marker of health inequality. Good mental health and resilience are therefore at the heart of our social wellbeing and we have a local ambition to ensure that physical health and mental health are given equal status and priority.

As a Partnership we understand the impact of social deprivation on mental and physical health, and as a priority we will identify and support people whose social circumstances make them unwell. We will work with East Lothian Council and NHS Lothian so that East Lothian makes mental wellbeing a priority in the way policies are developed. Housing, employment, and availability of rehabilitation closer to home are key issues we will focus on in this domain.

For the wider vision and goals for improved mental health to be achieved a number of key actions requiring greater focus and attention have been agreed locally and will be prioritised within the timeline of the Strategic Plan. These are:

- We will ensure that people have timely access to emergency mental health care through improvements to intensive home treatment services and inpatient care. We will specifically strengthen leadership arrangements for home treatment services.
- We will develop and implement an open access self referral system of initial assessment for people with mental health concerns. We will prioritise partnership working across the statutory and third sectors to this end, paralleling organisational development in integrated health and social care.
- We will accelerate current work to ensure we provide crisis support to those in emotional distress. The development of community alternatives

for people in emotional crisis will move this out of the scope of specialist mental health teams where this is helpful

- Where psychological therapy is required we will accelerate a local action and delivery plan in order to ensure this starts within 18 weeks (the national A12 target). We will work rapidly to have more efficient systems and teams using tools like automated text messaging to reduce non attendance. Our access to therapies will recognise the need to further develop the provision of psychological services for older people.
- We will continue to use the established continuity of care model which means people are cared for by the same consultant led teams as outpatients, in home and hospital treatment.
- We will rapidly develop in-reach models of care
- We will maximise use of the "step up, step down" support available in Cameron Cottage.
- We will improve and streamline day services for people with mental health problems.
- We will specifically increase support for ELSIE where mental health expertise is required to allow more people to be cared for at home rather than in hospital.
- Ensuring that the transition from child and adolescent to adult mental health services is effective and seamless requires greater local focus and improvement. Equally we will ensure equality of service for those with function and mental ilness regardless of age.
- The contribution of carers and the need to support them to stay mentally well, as well as physically well, is a key priority and will be embedded in the work of mental health planning.

The joint planning framework to support this work, as with all elements of the Strategic Plan, will continue to be based on the three principles of patient and carer perspectives and values, clinical knowledge and expertise, and knowledge derived from evidence.

Substance Misuse

Midlothian and East Lothian Drugs and Alcohol Partnership (MELDAP) commissions a number of services from NHS Lothian, East Lothian Council and third sector providers to support people who misuse alcohol and drugs as well as people affected by someone's substance use.

The main services for adults misusing alcohol and drugs which can be accessed through the recovery gateways are:

The Substance Misuse Service which provides a range of services for adults who wish to regain control over the substance use and make positive changes in their lives. Services include:

- Specialist prescribing
- Drug and alcohol detoxification (community and inpatient)
- Access to residential rehabilitation, normally through the Lothian and Edinburgh Abstinence Programme (LEAP). MELDAP currently purchases 10 places annually for East Lothian residents.
- Psychological interventions, blood borne virus screening, immunisation and advice.
- Needle Exchange Outreach Network.
- Adolescent Substance Misuse Service
- Substance Misuse Social Worker.
- The Royal Edinburgh Hospital (Ritson Clinic), a 12-bedded detoxification ward

MELDAP also work with and commission services from a wide range of third sector partners, including:

- Mid and East Lothian Drugs (MELD).
- Edinburgh and Lothians Council on Alcohol (ELCA).
- Recovery College, in partnership with Access to Industry
- Starfish Recovery Cafe.

The MELDAP 2015-18 Delivery Plan describes how the partnership will tackle a broad range of issues associated with the use and misuse of alcohol and drugs and its impact on individuals, families and communities. The plan is structured around the seven national outcomes for alcohol and drug partnerships, which can be group under four broad themes. These are:

- Preventing future harm caused by the misuse of alcohol and drugs
- Reducing harm and promoting recovery
- Protecting and safeguarding children, young people and communities
- Commissioning and assuring high quality, cost effective and outcomes focused services.

There are a number of planned initiatives for each thematic area. These include:

- Promoting more responsible attitudes and behaviour to the use of alcohol and reducing the harm caused by the misuse of drugs
- Establishing a Recovery Orientated Integrated System of Care (ROISC) and working with people with lived experience to develop and build recovery communities and services
- Ensuring that services work together to ensure children are kept safe from the harm caused by parental substance misuse
- Ensuring that high quality, cost effective, person centred services are based around the needs of services users and their families.

Carers

Carers play a crucial role in the delivery of the health and social care system and this role will become more important as a result of the demographic changes we outline in the Plan. Carers, therefore, need to be at the heart of a reformed health and social care system which promotes a shift from residential, institutional and crisis care to community care, early intervention and preventative care. In making these changes to the care system it is crucial that carers should not be burdened, but supported and sustained in their caring role.

Caring Together: The Carers Strategy for Scotland 2010 – 2015 identifies a broad number of areas where action is recommended to increase support to unpaid carers. These include carer identification, access to information and support, and breaks from caring.

There has been an ongoing process of reviewing and redeveloping the plan which identifies the key priorities for carers and carer support locally. However, the Carers (Scotland) Bill was introduced to the Scottish Parliament in March, 2015 and as this progresses through the system local priority work will be informed by the policy direction this provides.

The Bill aims to extend and enhance the rights of carers and young carers and includes measures to:

- replace the current carer's assessment with a new adult carer support plan (ACSP) and provide a young carer statement (YCS) for all young carers
- provide for the establishment of an information and advice service for carers in each local authority area which includes a short breaks services statement
- introduce a duty to support carers whose needs cannot be met by general services in the community (including an information and advice service)
- require local authorities to prepare local carer strategies for their areas
- require local authorities and health boards to involve carers in carer services

Carer support will be a key, cross cutting theme through all our strategic change programmes and as the Strategic Planning process develops the Carers (Scotland) Bill will direct and inform the development of a revised dedicated carer strategy for East Lothian which prioritises and addresses the need for significantly enhanced rates of identification, assessment, aligned outcomes focused support and education.

Older People

In 2011, East Lothian published an ambitious joint Older People's Strategy which outlined a redesign programme focusing on a range of supports for independent living, response and re-ablement services and crisis care.

A pivotal element of this strategy centred on redesigning bed based models of care with plans to provide both local authority residential care and NHS continuing care on new, purpose built and existing sites. Equally, the strategy required a new approach to institutional care, particularly hospital based care, in order to yield economies and release of significant resources to be invested into a network of community care services in the county.

The joint Older People's Strategy as published was a complex programme of major transformational change affecting health and social care services. There is a recognition that whilst key elements have been delivered, progress has been slow and that implementing the programme has proved challenging. In part this has been because we must continue to meet people's current care needs and plan future services whilst managing the known pressures on existing services, but equally there has been little evidence of progress in moving money from bed based models to community-based services.

Improving care for older people and joining up services has been, and remains, a policy focus in East Lothian. Whilst local performance on key measures such as delayed transfers of care and unscheduled admissions to hospitals has been challenging, there is a clearly improving picture. We have been redesigning our services to meet the challenges of unscheduled or unplanned care and crisis support and amongst a number of innovative new services and approaches have developed the "ELSIE" (East Lothian Service for Integrated Care of the Elderly) whole system pathway. ELSIE provides an integrated service of Hospital at Home, emergency social care and care at home, carer support, and the addition of twenty intermediate care beds in Tranent. It aims specifically to support people safely in their own homes at time of crisis or to smooth delayed transfers of care from hospital to home or a homely setting.

However we equally recognise that the population of East Lothian is forecast to grow at one of the fastest rates of all 32 local authorities in Scotland and specifically the number of people aged over 65 is forecast to grow by 72.2% between 2012 and 2037. Such demographics mean that we need to accelerate the required changes and enhance successful developments, working with partners to clearly plan how resources will move from institutions such as hospitals into the community. The integration of health and social care with integrated budgets allows us the opportunity to now take this significant agenda forward in a meaningful way.

For this reason it is proposed that the revised planning framework for this Strategic Plan and its associated operational plans, supported by new joint management structures, will assume responsibility for reviewing key elements of the extant Older People's Strategy. This will embed these into the overarching Strategic Planning and management processes, ensuring integrated thinking, making it fit for future planning processes and bringing clear accountability for delivery. In reviewing the Older People's Strategy a renewed focus will also be given to developing new models of care for our frail elderly in the community, provision of day care, dementia care, reablement, respite care and bed capacity across the county (See Section 6.3)

Criminal Justice Social Work

There is evidence that people who have, or who are at risk of offending are more likely to suffer from multiple and complex health issues, including mental and physical health problems, learning difficulties and substance misuse. They are three times more likely to die prematurely and ten times more likely to commit suicide. Inclusion of criminal justice social work services in the delegated functions of the Partnership therefore provides an opportunity for more focused and integrated work to address such inequalities.

Our criminal justice services are provided in a framework of social and community initiatives intended to enhance quality of life and increase community safety in East Lothian.

The key objective of Criminal Justice Services is to achieve a reduction in re-offending, increase social inclusion of former offenders and provide support for victims of crime. However, the key factors which lead to offending are complex and should be seen within the wider context of community planning.

Figure 17 - **Repeat offenders may have a range of needs**

Criminal Justice Social Work Services are funded by direct grant from the Scottish Government which can be used for no other purpose. Services funded in this way are subject to National Outcomes and Standards in the Criminal Justice System which define the content and quality of services to be provided.

The main aims of Criminal Justice Social Work Services include:

- tackling criminal behaviour and reducing risk of re-offending
- supervising offenders in the community
- assisting prisoners re-settle into the community after release from custody.

Social Work Services responsibilities include:

- providing effective supervision of offenders in the community
- challenging offending behaviour and helping offenders realise the impact of their behaviour on themselves, their families, the community and their victims
- assisting with problems that may contribute to offending, for example, drug or alcohol misuse
- providing courts with a range of alternatives to prison in appropriate circumstances
- promoting community safety and public protection

East Lothian Council Adult Wellbeing is the main provider of criminal justice social work locally, but works in partnership with voluntary organisations and community groups in the provision of criminal justice services in the county.

The service currently operates within Lothian and Borders Community Justice Authority (CJA), which brings together a broad range of agencies and a coordinated approach to delivering services for offenders and their families.

The CJA works to an overarching strategic plan (the Area Plan) with supporting action plans and key priorities which relate directly to the National Outcomes and Standards.

Public Protection

East and Midlothian Public Protection Committee (EMPPC) was established in 2014 and incorporates the Adult Protection Committee, Child Protection Committee, Offender Management Committee and Violence against Women Partnership. Robust links have also been established with Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP).

East and Midlothian Public Protection Team works across East Lothian and Midlothian and supports operational staff across partner agencies by providing a level of expert advice and promoting consistency of practice. The team includes staff from Adult Support and Protection, Child Protection and Violence against Women and Girls and is co-located with Police Scotland in the Public Protection Office, Brunton Hall, Musselburgh. This "hub" with a staff presence from Social Work, Police and Health, allows us to take forward our vision of an integrated approach to all aspects of Public Protection "across the lifespan" and promotes the understanding of the impact of trauma at all ages and stages of life.

This strategic approach to public protection is endorsed by East and Midlothian Critical Services Oversight Group (CSOG) comprising chief officers of all our partner agencies, who have led its evolution and who continue to provide governance and scrutiny of this critical area of work locally.

Sexual Health

The Lothian Sexual Health and HIV Strategy articulates a joined-up approach to improving sexual health and tackling blood borne viruses (BBVs) in Lothian.

The plan Lothian strategy has a focus on:

- reducing and responding to teenage pregnancy as well as unintended pregnancies for those over 20 years of age
- increasing the uptake of long acting reversible contraception (LARC) in all settings
- increasing access to early abortion services
- reducing infection and transmission of sexually transmitted infections (STIs) and BBVs (primarily HIV and Hepatitis B and C)
- improving gender reassignment services
- improving sexual health and relationship education in schools and community settings
- improved understanding of health needs of men who have sex with men amongst primary care and other staff groups
- increased access to integrated services in both a central location and in areas of high deprivation focusing on addressing health inequalities.

The Lothian Sexual Health Strategic Programme Board will direct this wider work while continuing to pursue an integrated approach with other service areas in order to maximise opportunities for long term positive sexual health outcomes for priority groups. This requires integrated work at a strategic and a locality level. Integrated service planning and delivery with drug and alcohol services and violence against women services will be specifically pursued in year 1.

Work will continue to improve access to services in both primary care and specialist services. Specialist sexual health and BBV services are delivered from hospital sites, the Chalmers Centre and clinics in localities delivered by staff from Chalmers. Patients will continue to be redirected to general practice where appropriate and information and advice made available on Lothian Sexual and Reproductive Health websites.

In addition to these wider service developments, in East Lothian the provision of Healthy Respect drop-in sessions and a Healthy Respect Plus clinic for young people in Tranent will be further developed and reviewed. Improved integration with drug and alcohol and violence against women services in East Lothian will also be developed.

Edinburgh IJB will continue to host the planning and commissioning of specialist sexual health and BBV services for Lothian. Ongoing research, monitoring and evaluation work will assist the Programme Board and East Lothian IJB to ensure that locally based services continue to meet the needs of the local populations and will assist in the identification of emerging trends.

Palliative and End of Life Care

The majority of clinicians and social care workers routinely provide end of life and palliative care services and support as part of their job, whether a GP, community nurse, the wider multidisciplinary team, social worker or care assistants. This is important as high quality palliative and end of life care needs to be delivered in all settings and not just in hospitals.

Local hospitals provide end of life care and we benefit from a dedicated palliative care community nursing team who provide specialist support across the county. East Lothian residents also have access to two specialist palliative care units in Edinburgh at Marie Cure and St Columba's Hospices who also provide day services and community support.

We know that approximately 40% of deaths receive some form of specialist palliative care support and almost all people who die (sudden deaths aside) are likely to receive some end of life care in the last year of life from general practice, community or social care staff. Most support remains cancer related although non-malignant activity, including dementia, frailty and neurological disease, is increasing yearly. We also know that future demands on services will be associated not only with a rise in the number of deaths due to the growth in our older population in East Lothian, but also with increased care complexity due to multimorbidity and an increasing focus on palliative care for these non-cancer conditions.

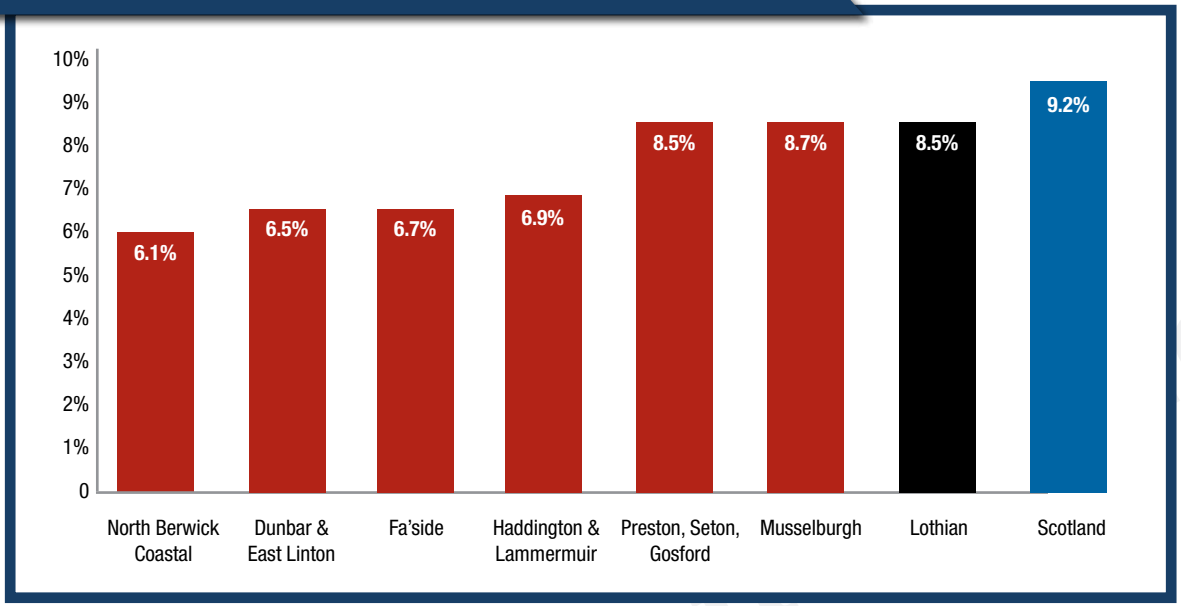
Lothian's Palliative and End of Life Care strategy "Living and Dying Well in Lothian" sets out strategic priorities mirrored locally which are aimed at improving care in all settings. The strategy articulates a clear direction of travel towards earlier identification of palliative care and support needs and the provision of integrated care.

In line with what people have told us, our clear strategic aim is also to shift the balance of palliative and end of life care increasingly towards community or residential based care provision and to decrease the time spent in and number of deaths occurring in acute hospital settings. We want to decrease the number of acute hospital bed days in the last year of life by supporting and improving the quality of palliative and end of life care provided in people's homes, care homes and community hospitals.

In East Lothian we perform relatively well in supporting appropriate end of life care outside hospitals compared to other areas, although within the county there remains significant variation which we need to address.

Figure 18

Percentage of last 6 months of life span spent in hospital, by East Lothian, Sub-partnership area, with Lothian HB and Scotland, 2013/14



To address this we will continue to plan services in collaboration with the pan Lothian Palliative Care Redesign Programme Board and Managed Clinical Network and prioritise workstreams.

Key actions:

- To promote early identification of people needing palliative care in a primary care setting using existing IT infrastructure
- To extend the use of Anticipatory Care Questionnaires within care home settings
- To embed a specialist training programme for care home and care at home staff
- To expand the ELSIE team to include enhanced specialist end of life care and specialist care home liaison teams
- To support pan Lothian work on the model of care for services from Marie Cure Edinburgh Hospice

East Lothian Health Improvement Alliance

The East Lothian Health Improvement Alliance (ELHIA) includes representatives from NHS Lothian (Public Health and Health Promotion), East Lothian Council, STRiVE (Third Sector Interface) and the Voluntary Sector. The Alliance aims to support population health improvement and tackle health inequalities in the area.

The Alliance has four overarching objectives to support work on reducing health inequalities in East Lothian:

- To ensure that strategy promotes health and reduces inequalities in all policies and supporting completion of Combined Impact Assessments on strategies, policies and action plans.
- To provide a coherent focus for public health policymaking in East Lothian. To provide advice on health intelligence and evidence-informed action to improve health;
- To ensure there is a programme of health improvement activity across East Lothian that is appropriately formulated to reduce health inequalities.
- To develop capacity and resources for health improvement and reducing inequalities. For example, to provide training and support for partnerships to prioritise key actions that address inequalities including using an assets-based approach.

In line with these objectives, the Alliance has developed an inequalities strategy alongside partners in East Lothian Council. ELHIA also provides strategic support to the delivery of Health Improvement Funded projects in East Lothian, and supports four sub-groups and an Early Years Partnership - Food and Health, Tobacco, Physical Activity and Health, Sexual Health & HIV and Support from the Start Early Years Partnership.

NHS Lothian's Health Promotion Service currently funds a development worker to work alongside Area Partnerships to support work to reduce inequalities within and between communities in East Lothian. The Health Promotion Service is also a funder of the East Lothian Ageing Well project.

East Lothian Community Hospital

NHS Lothian has a long term strategy to develop and improve patient facilities in the community in keeping with a 21st century acute, primary and community care service. Community hospitals will play a key role in delivering a significant change in the provision of both health and social care in Scotland, expanding the range of options that may be provided in a community setting as part of an integrated health and social care system.

Roodlands and Herdmanflat Hospitals currently accommodate all the acute General Medical and Mental Health services in East Lothian as well as being the base for a large number of services delivered in the community. They do so in accommodation that is dispersed, aging, non-compliant and below required capacity, both current and as anticipated against our predicted population and service growth.

NHS Lothian's proposal to meet the needs of the local population by providing a range of acute (General and Mental Health specialties) inpatient, day surgery, outpatient, day hospital, diagnostic therapy, and community services within a single site Community Hospital which acts as a hub for health and social care is in line with NHS Scotland's strategic direction.

Planning and development work is active and ongoing and the strategic planning objectives in delivering a new East Lothian Community Hospital include:

To provide adequate acute "step-down" and direct access capacity to meet current and future needs due to population growth

To provide the optimum, safe, care capacity as close to home as possible

To address the severe shortcomings of current accommodation infrastructure and non-compliance

To provide single site, fit for purpose, accommodation for integrated community Health and Social Care services at the heart of the community and to provide for partner agency and third sector partner access.

To provide fit for purpose accommodation for in-patient, day-surgery, day hospital, outpatient and therapy services to relieve pressures on acute centres of excellence in Lothian through shifting the balance of care

To improve access by providing a range of services and therapies, linked to Primary Care in fit for purpose accommodation in an integrated facility appropriately located in the community

To provide improved and more accessible accommodation for hospital and community mental health services in East Lothian

The development of East Lothian Community Hospital is being led by a dedicated programme board in order to drive delivery, with the support of Scottish Government and NHS Lothian, within the lifetime of the Strategic Plan.

6.3 Gap analysis

A good needs assessment should also identify key gaps in service planning and service delivery. An effective gap analysis allows an organisation to consider how it needs to develop and prioritise in order to move from its current state to an agreed or desirable "future" state.

The main components of health and social care services for adults have been laid down in policy guidance and are regularly reviewed for all services by NHS Lothian and East Lothian Council, both jointly and separately. Those covered by national guidance are therefore largely in place in East Lothian and have been articulated in Section 6.2.

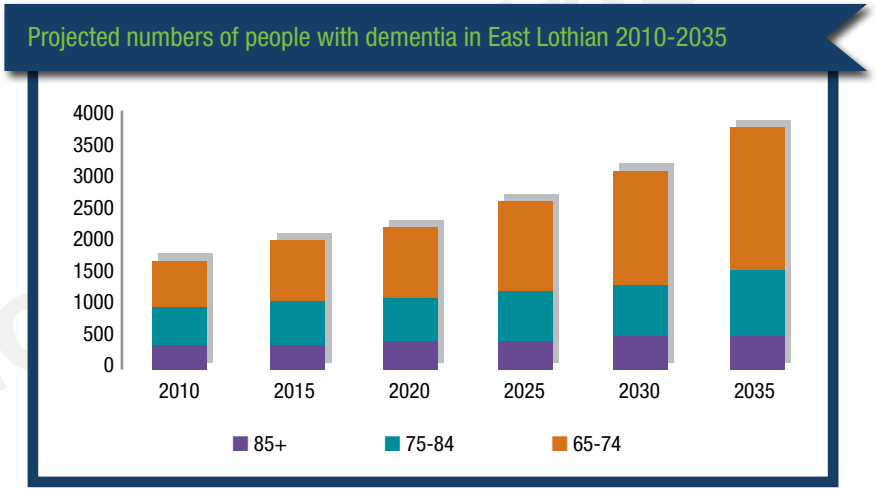
The main areas where there are planning and/or service gaps or where the JSNA has indicated a need for greater focus and activity locally have been identified. Equally, a number of new or additional services are delegated to IJBs and effective strategic planning, assessment and performance systems for these services need be embedded in the overarching Strategic Plan. In order to better understand the actions required to address these gaps a prioritisation framework, outlined in Appendix 9, has been applied to help focus priorities for this plan.

The key overarching strategic priorities outlined in the case for change are clear and focus on addressing the poor outcomes associated with delayed discharges, unplanned admissions, inequalities and variation, and also on embedding a wider culture of prevention and early intervention. In order to meet these challenges, and in order to meet the national health and wellbeing outcomes and our own strategic objectives as a Partnership a number of key, specific service or planning gaps now need to be addressed in addition to the ongoing workplans outlined in Section 6.2. These include:

Dementia care

Whilst we know the numbers of people in East Lothian diagnosed with dementia from our GP registers, our needs assessment uses population projections from the General Register Office for Scotland and applies dementia prevalence rates taken from the EuroCoDe study[1]. This tells us that by 2020 the number of people in East Lothian with dementia will be estimated to increase by 1,855 (from 1,687 in 2010 to 3,542 in 2035) - an increase of 110%.

Figure 19



We recognise that if we are going to support people and address this increase we need to work closely with all our partners in the statutory, voluntary and private sectors in order to identify the best levers for changing and improving the entire system of dementia care locally.

At each stage of the journey of someone's dementia there are things we need to do better – in our early diagnosis rates, in providing information and advocacy, in training provision, consistency in the quality of post-diagnosis support and in improving the experience of those with dementia and their carers in all settings, including our communities. We recognise we urgently need to develop a consistent, high quality, responsive pathway and support

[2] (Alzheimer Europe (2009) EuroCoDe: prevalence of dementia in Europe Alzheimer Europe – Consensual Prevalence Rateshttp://dementiascotland.org/news/statistics-number-of-people-with-dementia-in-scotland-2012)

system in East Lothian for all people diagnosed with dementia and for their carers and families, regardless of age. We also need to directly acknowledge the relationship and overlaps between dementia and frailty and the joint service provision we need to develop to support people. including closer working between a range of services.

The Strategic Plan will therefore have a strong focus on dementia through each of the Strategic Change Programmes and delivery plans outlined in Section 14. Specifically as key elements of pathway development we will prioritise integrated intensive case management support, linking to carer support and assistive technologies. Equally priority focus will be given to supporting care homes and specialist bed based models (See Section 9).

Primary Care

We need to ensure that people in East Lothian with health and social care needs benefit to the full from mainstream services and resources such as primary healthcare.

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS. It has been a cornerstone of the NHS since its inception and its delivery model has evolved through the years. However primary care is under severe strain; even as demand is rising the number of people choosing to become or remain a GP is not keeping pace with it, in part because primary care services have been under resourced compared to hospitals.

With the demands all services are facing at a time of changing populations with increasing health and wellbeing needs, primary care needs to equally address the challenges of variation in access to services and a changing workforce profile. GPs their practices and the models and delivery of care will, therefore, play an important role in influencing and shaping this Strategic Plan and its outcomes.

Over the next few years, primary medical service providers will be faced with new challenges in terms of demand, capacity and access. This will make it essential that the Health and Social Care Partnership works in a supportive and collaborative way with primary care. The timing of this Strategic Plan is therefore important in actively supporting GPs and primary care improvement and to provide assurance that the HSCP is striving for excellence in primary care.

“Out of Hours” primary care in East Lothian is currently delivered by Lothian Unscheduled Care Service (LUCS). This service is “hosted” or managed by East Lothian on behalf of NHS Lothian. LUCS is a pivotal service for consideration in the Strategic Plan providing urgent, non-emergency primary medical services to our population when GP practices are closed; in essence this is care provision for 70% of the week.

In East Lothian there is a recognition that this “out of hours” period is significant and that LUCS has, over time, become the default provider of medical care within the community and across a range of settings out with normal GP working hours. As with almost every other service LUCS has experienced a significant increase in workload over time exacerbated by a national and local shortage of GPs working in the out of hours environment. A national review of out of hours GP services is currently being undertaken and a local focus on this service delivery and what it means for East Lothian is now required.

Primary care is not simply about general practice, though, and includes community pharmacy, dentistry and optometry independent practitioners who provide essential services for our population. The Health and Social Care Partnership therefore must explore opportunities to work with all professionals to ensure they are an integral part of our planning and care delivery.

The Strategic Plan will therefore have a focus on primary care through each of the Strategic Change Programmes and delivery plans outlined in Section 14.

Falls

A fall is a symptom, not a diagnosis. It can be a marker for the onset of frailty, the first indication of a new or worsening health problem and can represent a tipping point in a person's life, triggering a downward decline in independence. Falls among older people in particular are a major and growing concern for our health and social care system and the concern is set to rise over the next decade as our population ages and the proportion with multimorbidity, frailty and polypharmacy grows.

The impact of falls on a person's independence and quality of life, and the repercussions for family and friends is significant. However many falls and fractures can and should be prevented by well organised services and organisations working in partnership with the person and their carers.

In East Lothian we know that our hospital admission rates for people who have fallen is lower than the Scottish average, but if admitted people remain in hospital longer with the poorer overall outcomes associated with hospital stays in general. We also recognise that there has been progress in the implementation of local care pathways for people who have fallen, but that there remains significant variation in service provision and quality across the county.

There is, therefore, a need to accelerate the pace of implementing local integrated falls and fragility fracture pathways and to embed a consistent, inclusive, systematic and evidence based approach to falls prevention and management. This will mirror our wider model of care and include:

- Supporting active ageing, health improvement and self management
- Identifying those at high risk of falls or fragility fractures
- The response to fallers who require immediate assistance
- Co-ordinated management after a fall including specialist assessment

The development and full implementation of the local integrated falls pathway which links across agencies will be a key early priority action in the Strategic Plan.

Respite care

Short breaks from unpaid caring, more traditionally known as respite, is a key component of integrated services which will support a shift in the balance of care from hospital and residential care to community based services. Respite is also an integral part of our investment in preventative services.

Carers play a crucial role in the delivery of our health and social care system and a key component of our work will be to support them in sustaining their role. Short breaks from caring act as an essential way of allowing carers to continue to care for longer and in better health; they can also delay or prevent the need for a hospital or care home admission.

In East Lothian, there are a number of ways in which breaks from caring are made available and these vary in terms of duration, location and type of short break. Traditionally local authority data collection systems have not been able to fully capture all activity given the many different ways breaks from caring can occur and how they are recorded. We recognise that we need to improve data collection systems and will continue to take steps to support this at both a local and national level.

In 2013-14, over 10,000 nights and over 31,000 daytime hours of respite were provided to people of all ages in East Lothian[2]. As a per-capita rate East Lothian provides 21.2 weeks per 1000 of the population compared to the Scottish average of 38.1 weeks, clearly suggesting that we need to do more in terms of provision, but equally in understanding unmet need.

The majority of adults in East Lothian will have a break in a care home although increasingly through the implementation of Self Directed Support, more flexible and creative breaks from caring are being taken. We anticipate that this will be a growing trend and recognise we need to actively provide and support innovative solutions to respite care.

[2] This excludes direct payments used for respite provision. Information from Respite Care, Scotland, 2014.

Medical respite is provided on inpatient hospital sites across East Lothian for people who require specialist clinical input or who could benefit from active rehabilitation during short term respite.

As a priority action of the strategic planning process we will undertake a comprehensive needs assessment which will be used to inform the wider planning and commissioning of respite service provision. This strategic joint approach will include the delivery of both planned and emergency respite, assessment, eligibility criteria, training and information as well as a wider understanding of appropriate and effective use of NHS beds and the need for medical respite provision.

Reablement

A rehabilitation or re-ablement approach is central to future local delivery of health and social care services as we address the demographic demands and financial pressures ahead. Supporting people to live independently for as long as they can needs us to consider not only their health and social care needs but also to look holistically at other factors such as housing and employability which can impact significantly on independence.

Re-ablement is about giving people the opportunity to re-learn or regain some of the skills they may have lost as a consequence of poor health, disability or frailty and to gain new skills that help them to maintain their independence. This approach to service delivery also ensures that people receive the right level of service to meet their continuing or changing needs.

Care services are primarily directed at those with the greatest needs, but to meet increasing demand for service provision there is now a stronger local focus on providing help at an earlier point in order to help delay or prevent a hospital or care home admission and to support any appropriate reduction in care needs.

Re-ablement is not a new concept and in East Lothian there has been some action taken to transform our health and social care services in an effort to support more people to remain in their community for longer. The Duty, Response and Rehabilitation Team (DRRT), the Hospital to Home and Discharge to Assess services all have a strong reablement focus. The Council operated Home Care Service has also historically provided a re-ablement approach by delivering care for a time limited period before transferring service users to an alternative care provider for longer term support; this area of work has not, however been sustained or developed and is a known gap.

We recognise that priority work is now needed to create universal access to an integrated re-ablement model and will be reflected In the Strategic Change Programmes and delivery plans outlined in Section 14.

Care at Home

One of the major shifts in service delivery over recent years has been the increase in independent sector provision of care - both care homes and care at home. Good quality, consistent care at home is critical to the achievement of both personal and integration outcomes and without the valuable contribution of the independent sector and its workforce the health and social care system would be challenged. Effective planning and commissioning of these services is therefore vital to the ambition of this plan.

Care at home services in East Lothian are currently provided through two types of framework agreements with service providers: the specialist provider framework and the Help to Live at Home (HTLAH) framework. The specialist framework contract provides care and support to people at home who have complex needs including learning disability, physical disability and mental ill health and has been extended until 31st March 2016. A number of challenges have been identified within the specialist framework locally, not least lack of capacity, in particular for complex needs, the need to more effectively horizon scan for those in transition, and cost inefficiencies.

Work is ongoing to develop a new, co-produced commissioning and tendering process for specialist services which will support comprehensive

service redesign, more innovative, integrated solutions, greater resource efficiency and service user satisfaction within a defined timescale. Self Directed Support (SDS) will be a key element of consideration in this in order to allow for dynamic choice within the finished commissioning arrangements. An appropriate timescale for effectively scoping, co-producing, business modelling and transitioning such a process will mean that the commissioning exercise will be effectively undertaken after the date when functions will be delegated to the IJB. It is therefore proposed that the commissioning of specialist services is undertaken under the authority of the IJB who will provide directions to East Lothian Council.

The wider HTLAH framework mainly provides care at home services for older people and current service provision is delivered in a number of ways. The internal Council managed domiciliary care services aim to provide 1,388 hours of support weekly. External services are currently provided through a framework of nine service providers delivering 7,643 hours of care weekly across six area wards. This service is provided through independent and third sector organisations and three service providers currently provide 75% of total support provided through HTLAH. Maintaining a good quality of care across the sector is critical and a performance monitoring scorecard is used to measure the quality and performance of care delivered.

There are three key challenges significantly impacting on providing consistent, good quality care at home in East Lothian.

- Recruitment and retention of care staff: there are compounding difficulties in recruiting into the care sector which is viewed as low paid but with high responsibilities and close scrutiny. There are a limited number of people working in the care sector across Lothian; when one organisation recruits, as a broad generalisation this removes staff from another provider in the county and overall capacity across the region remains relatively static. The high mobility of carers across the sector causes additional disruption to service users and providers and increases employment related costs for providers and commissioners of services.
- The level of restructuring and acquisitions taking place across the care at home sector: within the current frameworks national organisations have grown by acquiring or merging with other care at home providers. In East Lothian this process has historically caused significant disruption to clients. When mergers occur between members of the HTLAH framework this does not necessarily increase the capacity of the framework.
- The ability to meet the high level of need across East Lothian within a sector which is experiencing change, and within increasing financial pressures: currently there is significant unmet need not addressed in a consistent way through the care at home frameworks. Significantly, approximately 10% of this unmet need is preventing people from returning to home from hospital. This is clearly not the best use of limited resources, places additional strain on hospitals and is not a positive outcome for people who could be living more independently in their own home or homely setting.

Whilst some of this is outwith the direct sphere of influence of the IJB, as key priority actions in the overall timeline of this Strategic Plan we will monitor and maximise care capacity through the framework and rapidly restore elements of a reablement function to care at home delivery to proactively support this. We will maximise our Hospital to Home and Emergency Care services in order to provide short term bridging support only when required.

In addition, the HTLAH commissioning framework commenced on 1st April 2014 and expires on 31st March 2017 with the option of being extended for an additional two years at the Council's discretion. The experience and learning from the approach to retendering of the specialist provider services will be embedded at the earliest stage in a parallel approach to the development of a longer term, sustainable commissioning strategy which provides sufficient, high quality capacity for care at home across all localities as soon as practicable.

Transitions of Care

Transition is the period when young people with additional support needs - a learning disability, autism, sensory impairments, mental health, emotional and behavioural issues, exceptional health care needs and young people in care, amongst many others - grow from children to young adults.

Transition is an active process which unfolds over a number of years and is not a single event. Transitions for children with additional support needs happen concurrently across a range of services, including health, education, housing and welfare and social care and as such is an important element of the work of the health and social care partnership both in terms of service planning and financial planning.

In East Lothian, there is a trend of an increasing number of young people with more complex needs and support requirements transitioning into adulthood and adult services. Currently around 60 young people are identified as transitioning into adult services and requiring lifelong packages of support. Approximately 50% of these young people require services with high annual costs which will result in an increased annual budgetary spend of £2.5 million in the integrated budget from 2016 – 2018 and beyond.

A report to East Lothian Resilient People's Partnership has identified key strengths and gaps in the local processes including access to jointly funded complex care equipment and services requiring care and health funding. As a priority action of the strategic planning process we will review the multiagency planning arrangements to ensure clear and timely horizon scanning and planning, including financial planning. As a key action of the Strategic Plan we will also review policies and procedures to ensure that a consistent approach is taken to access, eligibility, resource use and commissioning across partner agencies.

Self Directed Support (SDS)

Self directed support is about assisting individuals who may need support to have maximum choice and control over how that support is planned and provided.. Involvement, collaboration, informed choice and assistance are key to effective spread and sustainability of the principles of SDS and the duties for local authorities are clear in outlining promotion of SDS. The integration of health and social care provides real opportunity for greater collaboration in support planning and shared resources.

Across East Lothian there is a recognition that promotion of SDS within assessment processes needs to be significantly accelerated and increased and this will be reflected as a key action in the Strategic Planning framework.

Estates and bed use

We have a range and variety of bed based models across the county, provided and supported by NHS, local authority and independent and third sector; these bed based services also support a range of need and complexities. Any needs assessment and strategic planning for future models of care should take into consideration the best use of the total health and social care estate that is currently available to us in East Lothian and which best meets both current and future projections of need.

The Strategic Plan will therefore have a focus on the efficient and effective use of our assets and resources through each of the Strategic Change Programmes and delivery plans outlined in Section 12. This is further articulated in Section 9.

Shifting the Balance of Care

Scottish Government has clearly outlined in regulations which aspects of acute hospital care offer the best opportunity for improvement under integration and whose functions should be delegated to Health and Social Care Partnerships. Integration Authorities will be responsible for strategic planning of those services most commonly associated with the emergency care pathway - that is hospital specialties which exhibit a predominance of unplanned bed day use for adults. Within the context of integration "unplanned" refers to those hospital stays that are unplanned and potentially avoidable with the provision of some sort of preventative care.

The potential of an integrated financial resource associated with Health and Social Care Partnerships and the acute hospital services delegated to them should drive the required policy changes more than any previous policy and presents an exciting opportunity for local communities to shape care delivery. This is the "Gear Shift" required to release resources tied up in institutional settings over time and shift the balance of care to community settings.

Nonetheless, our Health and Social Care Partnership is a new entity with new structures, developing new ways of working. There is a need to develop further technical and analytical capacities and capabilities to map cost and activity data and support effective planning for these new service responsibilities. There will also be a need to develop local business intelligence functions to identify and deliver on key metrics and monitor changes and, importantly, sufficient capacity to deliver the transformational programmes.

The Strategic Plan will therefore have a focus on understanding and analysing unscheduled care pathways, including high resource users, through the Strategic Change Programmes and delivery plans outlined in Section 12. This will maximise the impact of strategies to release resource and establish the Health and Social Care Partnership as a fit for purpose, intelligence led body within a short timescale.

Health and Social Care Strategic Planning and Housing

Health and Social Care integration is not just about health and social care services, and some 'housing' functions will become part of the integration arrangements. This recognises the importance of people's homes to their health and wellbeing and the vital role played by housing in sustaining and improving that.

The integration of health and social care brings an opportunity to further align strategic planning and operational delivery and support the shift to preventative services. This will build on long standing existing partnerships between housing, health and social care.

The housing sector makes a significant contribution to the national health and wellbeing outcomes by:

- Providing a fit for purpose housing stock, that gives people choice and a suitable home environment:
  - arranging and undertaking adaptations to the home,
  - undertaking repairs and upgrades and assisting private home owners to carry out repairs and maintenance,
  - providing combined housing with care or support services in a variety of different models, from traditional sheltered housing to extra care, core and cluster models,
  - making homes warmer and cheaper to run by improving the energy efficiency of the housing stock and providing support and advice to reduce fuel poverty.
- Providing information and advice - on housing options, welfare advice, advocacy support, befriending services and assistance in providing alternative housing.
  - In particular a reduction of homelessness, which is known to have impacts beyond the immediate housing issues. Insecure or poor housing conditions have wider social and economic impacts including physical and mental health impacts for adults and children, increased risk of injury and being a victim of crime and reduced life expectancy.
- Providing low level, preventative services – housing support, community alarms and telecare, handyperson services, stair cleaning, odd jobs services, garden maintenance, addressing social isolation.
- Building capacity in local communities – housing services are provided at a local level and East Lothian Housing providers actively promote participation of tenants in local activities.

Housing support and the provision of a good quality home environment are important strands of the housing contribution towards the delivery of an integrated approach to improved health and well-being outcomes. Helping prevent avoidable admissions to hospital and care homes and facilitating a quick return to home from hospital are dependent on this. East Lothian housing providers are committed to the Scottish Government aims to help older and disabled people to live safely, independently and comfortably in their own homes.

Housing and housing support services are key components of shifting the balance of care from hospital-based to preventative, anticipatory care provided in the wider community setting. Housing support can assist with a range of day to day activities from low level services to more intensive support, including assistance to claim benefits, manage a budget, keep the home safe and secure, and help with shopping and housework. There are currently a number of providers delivering housing support packages to service users in East Lothian. The highest numbers of packages are delivered to the older people client group with a significant number also provided to adults with learning disabilities.

Each local authority in Scotland has a statutory duty to produce a Local Housing Strategy (LHS) which is supported by an assessment of need and demand. The East Lothian LHS 2012-17 was approved in March 2012.

Through the LHS the local strategic vision for housing is that by 2017:

'Everyone in East Lothian has access to quality sustainable housing, which meets the changing and diverse needs of households, within safe, inclusive and vibrant communities.'

The East Lothian Local Housing Strategy (LHS) 2012-17 sets out five outcomes including 'People with particular needs are able to access and sustain their choice of housing including independent living, where appropriate'. This is underpinned by six actions, each of which will require to be revised in light of the rapidly changing context brought about by Health and Social Care integration and with revised guidance from the Scottish Government, designed to shape the next iteration of Local Housing Strategies.

This guidance was published in 2014 and states that *"the LHS has a key role to play in contributing to the effective integration of health and social care. It should set out clearly the contribution that housing can make in support of this agenda through the design and delivery of housing and housing related services that are capable of responding to the needs of individuals as and when they arise"*

East Lothian Council works in partnership with key stakeholders on strategic housing planning. Production and consultation on East Lothian's new Local Housing Strategy will take place in 2016 in line with this guidance, with a new LHS in place in 2017.

Initial priority for housing, health and social care principally focuses on those aspects of the legislation that are required under the integration scheme to be delegated - housing support services, where they form part of a care package and housing adaptations. Early priority will be on how the planning and delivery of services relating to adaptations can best be implemented for the benefit of all individuals assessed as requiring support.

The housing functions delegated to the Integration Authority are:

- The duty to assess for an adaption (as for equipment and other care related needs of adults). This is the work that in most cases is undertaken by occupational therapists in local social work departments.
- The planning for and resources to undertake adaptations (both in the private sector through the Scheme of Assistance and for local authority tenants via the Housing Revenue Account).

This means that Local Authorities will require to identify the relevant component of their overall budgets, as it relates to adaptations. Integration Authorities will also have powers and associated budgets delegated for the planning and delivery of advice and assistance to housing associations (RSLs) in relation to adaptations, although East Lothian Council have not used this provision to date.

The IJB and East Lothian Council, along with other relevant partners, will now need to consider how the delegation of these functions can best be implemented for the benefit of all individuals in East Lothian assessed as requiring support.

The integration of health and social care brings an opportunity to build better connections between health, social care and housing, particularly in aligning strategic planning and supporting the shift to preventative services.

The Strategic Plan will therefore have a focus on closer alignment and information and intelligence needs; this will include the development of our local Housing Contribution Statement.

7. Strategic Partnerships

Partnership working is about developing inclusive, mutually beneficial relationships that improve the quality and experience of care. This includes the relationships between individuals, their carers and service providers. It is also about relationships within and between organisations and services involved in planning and delivering health and social care in the statutory, voluntary, community and independent sectors. Effective partnership working should result in good quality care and support for people and their carers.

We recognise the need to build strong and effective relationships and partnerships both locally in East Lothian and more widely. The benefits should not simply be the closer integration of services and decisions that are better aligned with the needs of the people of East Lothian, but improved health and wellbeing as the overarching goal.

Key partnerships integral to our success will be:

7.1 Partnership with our workforce

The changing nature of adult health and social care is complex and challenging. As a Partnership we will seek to ensure that our workforce is motivated, knowledgeable and skilled and able to respond to the changes we envisage.

Critical to delivering this Strategic Plan and making it real is the need to explicitly involve, support and develop our workforce. We will, therefore, continue to develop a local Organisational Development Plan which supports these aims (See Section 10).

7.2 Partnership with our service users and carers

The idea that people should have a stronger voice in decisions about their health and care, and that services should better reflect their needs and preferences, has been a policy goal for many years. Evidence shows that when service users are involved in planning, decisions are better, health and health outcomes improve, and resources are allocated more efficiently. As a Partnership we recognise we need to promote and emphasise the need for greater personalisation of care and support for people closer to their own communities.

Personalisation means recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. Personalised approaches such as self-directed support involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives. People need access to information, advocacy and advice so they can make informed decisions.

Personalisation is also about making sure there is an integrated, community-based approach for everyone. This involves building community capacity and local strategic planning and commissioning so that people have a good choice of support regardless of age or disability.

Self-Directed Support: A National Strategy for Scotland has been developed to help take forward and embed this person centred approach in the delivery of health and social care services.

As a responsive Partnership we will look to embed this approach in all our planning and commissioning. The growing emphasis on personalisation and personal outcomes has significance for those who work in or with health, social care and support services and for the skills they will require to undertake new functions and tasks. The development of our workforce to recognise and support a personal outcomes approach is crucial and we will address this through our developing Organisational Development Plan.

In addition, we will complete a review of our strategic planning processes to ensure effective involvement and a genuine co-production approach to service planning (Appendix 1). We will also embed the actions of our (draft) communications and engagement plan in our work (See Section 10).

7.3 Partnership with localities and communities

Scottish Government's Public Service reform agenda is based upon the 'Four Pillars' of Reform – Place, Prevention, Performance and People. This agenda proposes a new relationship between citizens and public services in which communities and individuals are empowered to take a real stake in the planning and delivery of public services in a way which best meets local needs and priorities.

It is our Partnership's intention that the health and care needs of each locality will be the major driver for shaping the way in which services and resources are planned and delivered, working with local stakeholders and communities.

To address this we will ensure locality representation within the Strategic Planning Group and continued, active consultation and engagement through our area partnership network.

7.4 Partnership with the Third (Voluntary) sector

The third (voluntary) sector has a crucial role to play in creating a sustainable health and social care system. As a Partnership we have experience of some excellent examples of joint working through the Change Fund and Integrated Care Fund and evidence that by engaging the third sector and focusing on preventative services we can improve the sustainability of the care system.

Only by all sectors working together will we be able to fulfil our potential. To address we have ensured that third sector partners, through the local Third Sector Interface, play a full role as partners on both the IJB and Strategic Planning Group.

7.5 Partnership with the Independent Sector

The independent sector, both care home and care at home providers, are key partners in health and social care given the services they support and provide. Overall the independent sector has become the largest provider of social care delivery across Scotland and the assurance of delivery of quality care through the sector and the need to support this is an important consideration for the Partnership.

In order to address this we will ensure the independent sector plays a full role in the ongoing development of the Partnership through membership of both the IJB and the Strategic Planning Group. We will also continue to actively support and participate in the East Lothian Independent Sector (ELIS) workforce development forum and our local Providers forum.

7.6 Partnership with Independent Contractors

7.6.1 General Practice

The Partnership recognises that the changing demographic of our growing population requires assertive action and supports an agenda of improving preventative care and reducing avoidable hospital admissions. However there remain challenges to ensure that the medical capacity outside of our hospitals is supported to accommodate this change in delivery of care.

It is clear that clinical leadership and involvement will be essential to the planning and delivery of care and that the most effective way to integrate these services is to closely involve clinicians in the development and implementation of strategic plans.

To address this a GP is a non voting member of the IJB and GPs are represented on the Strategic Planning Group.

7.6.2 Community Pharmacy

Pharmacists are experts in medicines and provide a unique contribution to improving care. Pharmacy contractors provide NHS services as independent contractors in a similar way to GPs and the managed service of NHS Scotland employs pharmacists in primary and secondary settings with specialist pharmacists in many therapeutic areas. Pharmacists also have a role in public health with health promotion and disease prevention.

7.6.3 Dentistry

Most primary dental care in East Lothian is provided by independent contractors who are located extensively throughout the county. The service has an important role in providing treatment to a diverse range of people and a key objective is to continue to improve the oral health of the people of East Lothian, more especially those vulnerable groups for whom health inequalities still exist.

7.6.4 Optometry

Community optometrists, along with other independent contractors, are an important part of primary health care, providing a service which is accessible, convenient and flexible. Optometrists play a key role in the prevention of sight loss and also in the management of those with sight loss. The importance of optometrists in providing regular eye health checks and their role in early intervention, detection and prevention of sight loss is valued.

Given the influence which primary healthcare, prescribing and medicines, dentistry and optometry have on overall patient care and wellbeing the Partnership believes that a strong collaboration and relationship with each of these services is desirable and necessary to drive the improved outcomes agenda forward. To address this we will establish an Independent Contractors Forum which will have key representation on the Strategic Planning Group.

7.7 Partnership with Community Planning

Community planning is a process which helps public agencies work together with communities to plan and deliver better services. The broad aim of community planning is to improve outcomes for the people and communities across East Lothian by ensuring that public services work in a more integrated and effective way. The shared commitment of both the Health and Social Care Partnership and East Lothian Partnership to reducing inequality means it is essential that these groups drive greater collaboration, The relationship between the Health and Social Care Partnership and East Lothian's Community Planning Partnership (CPP) is therefore one of clear synergy and shared objectives whose delivery will be enhanced by integrated working.

The Health and Social Care Partnership will have a key role within East Lothian's Community Planning Partnership and in delivering specific Single Outcome Agreement results. We will therefore establish clear and robust planning and reporting arrangements with the CPP and its thematic groups.

7.8 Partnership with other Health and Social Care Partnerships

NHS Lothian provides services across four Health and Social Care Partnerships - East Lothian, Midlothian, West Lothian and City of Edinburgh. East Lothian's Health and Social Care Partnership will also lead some health services on a pan Lothian basis on behalf of these other partnerships and as such our own local plan must take cognisance of the other Lothian plans in order to ensure maximum effectiveness and best use of resources. Given East Lothian's close proximity to Borders Health and Social Care Partnership the need to establish a working link with this area is also desirable.

7.8.1 Hosted Services

Each Partnership in Lothian hosts or manages a range of services provided on a pan Lothian basis on behalf of the other Partnerships. These are outlined in Appendix 2.

Embedding effective two way working relationships and communication with all hosted services and host partnerships is paramount, not only to influence strategic planning and redesign but to ensure the right services are developed and delivered for people in East Lothian.

We will actively work with NHS Lothian and the neighbouring partnerships to ensure optimal influence and impact.

7.9 Partnership with NHS acute sector

East Lothian Partnership has a shared interest with the NHS Lothian acute sector in maximising the efficiency of our hospital systems. Equally, acute hospitals are seldom used solely by the population of the local authority territory in which the hospital is situated and therefore consideration also needs to be given to how all partnerships within Lothian can contribute to strategic planning initiatives at Health Board level. It is clear that there is a responsibility to collaborate with each other, especially in respect of service redesign initiatives which impact on acute services that operate across Partnerships.

In recognition of this, we will be equal and active partners in NHS Lothian's supra-partnership forum around the strategic development of the Lothian Hospitals Strategic Plan. We have also ensured acute sector representation at both IJB and Strategic Planning Group levels.

7.10 Housing

Health and Social Care Integration is not just about health and social care services and some 'housing' functions will become part of the integration arrangements. Housing is widely recognised as an essential feature of health and wellbeing beyond simply bricks and mortar. Social housing providers provide a critical link to the wider community, have a strong neighbourhood management role and deliver a variety of projects that contribute to individual and community well-being.

In recognition of this, we have ensured that housing is represented as a key stakeholder on the Strategic Planning Group.

8. Financial Context

8.1 Background

This draft Strategic Plan is intended to be viewed as a continuum of work, with much still to be done to make the vision of the plan a reality. The plan provides the strategic framework for the development of health and care services and lays the foundation for the integration of the plan into the core work of NHS, council and partners with priorities and proposals reflected in the business plans of each organisation.

There is, therefore, a requirement to identify and develop an aligned resource strategy, including a clear financial framework which will support delivery of the plan. Equally, there is clear recognition by NHS and council partners that whilst our aims and aspirations are extensive, the Strategic Plan and its associated programmes will have to be delivered within the resources available.

Both partner organisations have complex financial arrangements focusing primarily but not exclusively on annual budget plans. Consequently, the forecast of a longer term financial plan to match the delivery programmes outlined in this document is challenging and not without risk; this section does, however, seek to describe the financial position of both the NHS in East Lothian and adult wellbeing services in East Lothian Council and the planned approach in relation to the delivery of this Strategic Plan.

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

The 2016/17 financial year will be the first full year of operation as a 'stand alone' legal body and the IJB is required both to deliver financial balance in each and every year and to financially plan to deliver recurrent balance

Our plans have gone one step further to recognise and plan for the potential financial risks faced in this first year of a new joint architecture. We recognise that central to all this is the need to ensure that the IJB creates financial headroom to ensure it can remain financially resilient going forward. Achieving a firm financial footing on day one is critical to the success of the IJB and our Strategic Plan and to its ability to drive system-wide reforms such that it can deliver against its financial duties whilst improving outcomes for the East Lothian population.

The IJB has therefore established a financial strategy which is built on all the above requirements whilst ensuring the delivery of our ambition to shift resources within the lifetime of this Plan and investment in our strategic priorities.

Our financial plans are designed to be robust and ensure that the IJB achieves financial stability from the outset, establishing a strong platform to deliver change and support reform within the local health and care economy. Our plans make explicit our key priorities for investments, which are linked to our key strategic priority areas.

As a new organisation, it is imperative that we demonstrate the credibility of our financial plans and performance targets as the methods for delivering our strategic direction over the medium term. If this is to be achieved consistently it is important that our plans remain flexible in order to mitigate any local pressures arising from adverse demands.

We aim to transform care in East Lothian by shifting more provision from a hospital-based setting into a community setting, with many more people receiving care closer to home where this is clinically appropriate for their individual needs. Our financial plans will reflect this shift of service provision between these care settings.

8.2 Service Change, Finance and Activity

The main focus for 2016/17 is to ensure that we manage the increasing demands on our resources in the most effective way. Our overarching aim is to find different ways of delivering and commissioning high quality services cost effectively, and to improve the health of the population to safely and appropriately reduce health and care need.

This focus will specifically include diverting money away from acute hospitals over the lifetime of this Plan and moving it into community care and primary care. To prevent unnecessary admissions to hospital, to ensure system stability and to improve safety and patient experience we will work with all our partner organisations, service users and carers to ensure we commission the best possible care for our localities.

8.3 Investments

Planned or anticipated investments are set out under the strategic change programmes within the Plan. All areas of investment will be drawn down via formal business cases or proposals to the IJB and supported by aligned directions to either NHS Lothian or East Lothian Council as appropriate. In this way all applications for investment monies will be subject to financial scrutiny.

The IJB recognises that planned investments are one of the areas where we need to maintain flexibility given our exposure to risks within the first year of this new planning and delivery structure.

8.4 Shifting resources

A number of factors including an over reliance on hospital care has seriously challenged our local health and social care economy over recent years, with managing increasing demand at the core. The IJB recognises that these demands are not only placed on the hospital system, but also on General Practice, social care systems and communities and a clear ambition to shift resources is at the heart of this Plan. Our plans to shift resources from acute and institutional spend to an increased community spend are based on the transformational reform programmes outlined in this Strategic Plan and specifically highlighted in this section, in Section 12 and Appendix 7 (Draft Directions)

It is important, however, that across the four IJBs in Lothian a set of 'system conditions' are agreed which will foster joint working and support to enable the release of significant efficiencies whilst not destabilising partners during this period of system reform.

8.5 Key risks and mitigation strategy

The IJB acknowledges that there may be inherent risk within the health and social care system, either at a national, regional or local level. The key aim of the IJB is to inject pace into reforming local services to deliver our change agenda whilst ensuring that financial resilience is achieved across local partners.

Historically, sources of in-year financial risk in East Lothian have been driven by additional activity demand in:

- secondary care – predominantly unscheduled care;
- an increasing number of people with multiple, complex needs requiring high cost support services or treatments including prescribing
- specialist services.

Our financial plan acknowledges that such risks will remain and the need to plan contingency on a prudent and realistic basis; it equally recognises the importance of current risk sharing strategies across Lothian.

8.6 Triangulation of Activity and Cost

The IJB has examined a number of factors to estimate anticipated growth including population and non-demographic growth, estimated looking at historical trends and extrapolated. Our plans acknowledge rising year-on-year activity and growth demand.

The IJB will continue to undertake further analysis of the assumptions applied as they develop including:

1. Whether the total budget and activity aligned to each programme is realistic and achievable
2. Whether the split of budget and activity assumed for individual programmes is sensible
3. Further examination of thresholds and any assumed increases or reductions

8.7 The Financial Challenge

The medium term financial outlook for wider public sector remains challenging as the wider financial austerity measures continue, directly impacting on the overall grant settlement for both NHS and Council budgets. There will be a need to continue to develop ongoing future sustainable budgets within a reduced cost base, allowing more resources to be invested in community based models in line with the wider strategic direction whilst continuing to meet new and emerging cost and demand pressures.

The indicative budgets to be delegated to the IJB for the period 2016-19 are currently in development and will be available for publication of the final version of the Strategic Plan. These will be subject to agreement through both the Council and NHS annual budget processes, and both will be reviewed and informed by the annual and future settlements arising from the forthcoming UK and Scottish Government Comprehensive Spending Reviews.

8.8 How we spend our money

The starting point for the IJB's allocation for commissioning health and social care in 2016/17 is its forecast spend in 2015/16, adjusted for additional services transferring to the IJB and for growth. The IJB will receive a recurrent allocation based on a baseline exercise conducted in September 2015.

The IJBs budget is agreed in line with legislation and aligned services and resources are identified across four broad categories:

- The Adult Wellbeing (social care) budget determined and agreed by East Lothian Council
- The former CHP budget including community nursing, AHPs, community hospitals, GMS and prescribing
- Delegated hosted services, managed on a pan Lothian basis by the Partnerships.
- Acute services (set aside), held by NHS Lothian on the IJBs behalf but subject to IJB directions

A summary overview of the **indicative** budget for 2016/17 is outlined below. More detailed analyses and projections will be included in the final version of the Strategic Plan as they become available.

*** Integrated Care Fund**

The Integrated Care Fund builds on Scottish Government's Reshaping Care for Older People Change Fund and has been made available to Partnerships for three years only from the 2015–16 financial year. The Integrated Care Fund relates more broadly to adult care and support services and aims to help Partnerships drive the shift towards prevention and early intervention.

East Lothian has been allocated £1.76 million annually for three years and it has been agreed locally that this will be used to drive the transformation phase and the change programmes outlined in this Strategic Plan. This will

Care Programmes	Health	Adult Wellbeing	Total 2015/16	Indicative Budget 2016/17 (millions)
Older Peoples Services	9,822	22,489	32,311	
Children's Services	1,203		1,203	
Learning Disabilities	3,720	12,855	16,575	
Physical Disabilities	1,077	4,382	5,459	
Mental Health	7,070	1,539	8,609	
Primary Care	30,300		30,300	
Other	10,272	4,573	14,845	
Acute Set Aside	18,613		18,613	
Integrated Care* and Delayed Discharge funds**	2,288		2,288	
	84,367	45,838	130,205	£130,098

focus on prevention and early intervention and on providing care closer to home. All Integrated Care Fund projects will be monitored and evaluated throughout the year as part of the strategic planning process.

**** Delayed Discharge funding**

Tackling delayed discharge is a key priority both nationally and locally and Scottish Government has provided £100 million over the next three years to address this challenge.

The funding forms part of Scottish Government's commitment to implementing the integration of health and social care services to deliver reductions in the level of delayed discharges and bed days associated with them, and therefore delivering the right care to people in the right place at the right time. East Lothian's share of national funding equates to £1.76 million over 3 years.

8.9 Resource alignment over time

The aligned resources to deliver the Strategic Plan will be subject to directions to both NHS Lothian and East Lothian Council (Appendix 5). Whilst the detail of directions is being developed currently, to be agreed and issued in advance of delegation of functions on 1st April 2016, the ambition of this Strategic Plan for East Lothian is clear and unambivalent in its principles that there is currently no additional planned investment in those acute services delegated to the IJB.

The provider landscape for East Lothian health and social care services delegated to the IJB is made up of community staff across health and social care, NHS independent contractor provision, some hospital care, mental health care and some independent sector and third sector providers.

9.1 Workforce and services analysis

9.1.1 Adult Wellbeing Workforce

	Headcount	WTE
Criminal Justice	20.00	18.10
Community Care	120.00	106.99
Business Support	13.00	12.30
Management Team & Support Services	3.00	3.00
Planning & Commissioning	12.00	10.40
Services for Adults	54.00	49.03
Services for Older People	279.00	176.21
Directorate	1.00	1.00
TOTAL	**502.00**	**377.03**

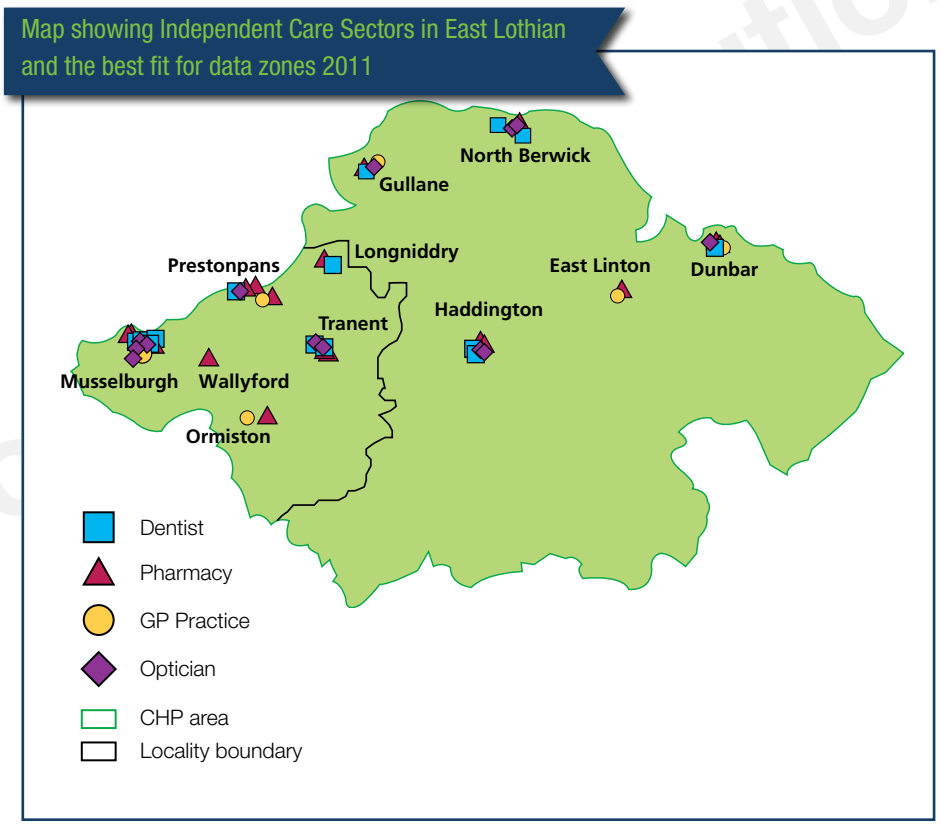
9.1.2 NHS Workforce

Service	WTE (Whole time equivalents)
Older Peoples Services	253.30
Children's Services	44.36
Learning Disabilities	55.07
Physical Disabilities	27.09
Mental Health	125.74
Primary Care	23.19
Other	167.56
Acute (Set Aside)	370.59
Total	**1066.90**

9.1.3 Independent contractors

Figure 20

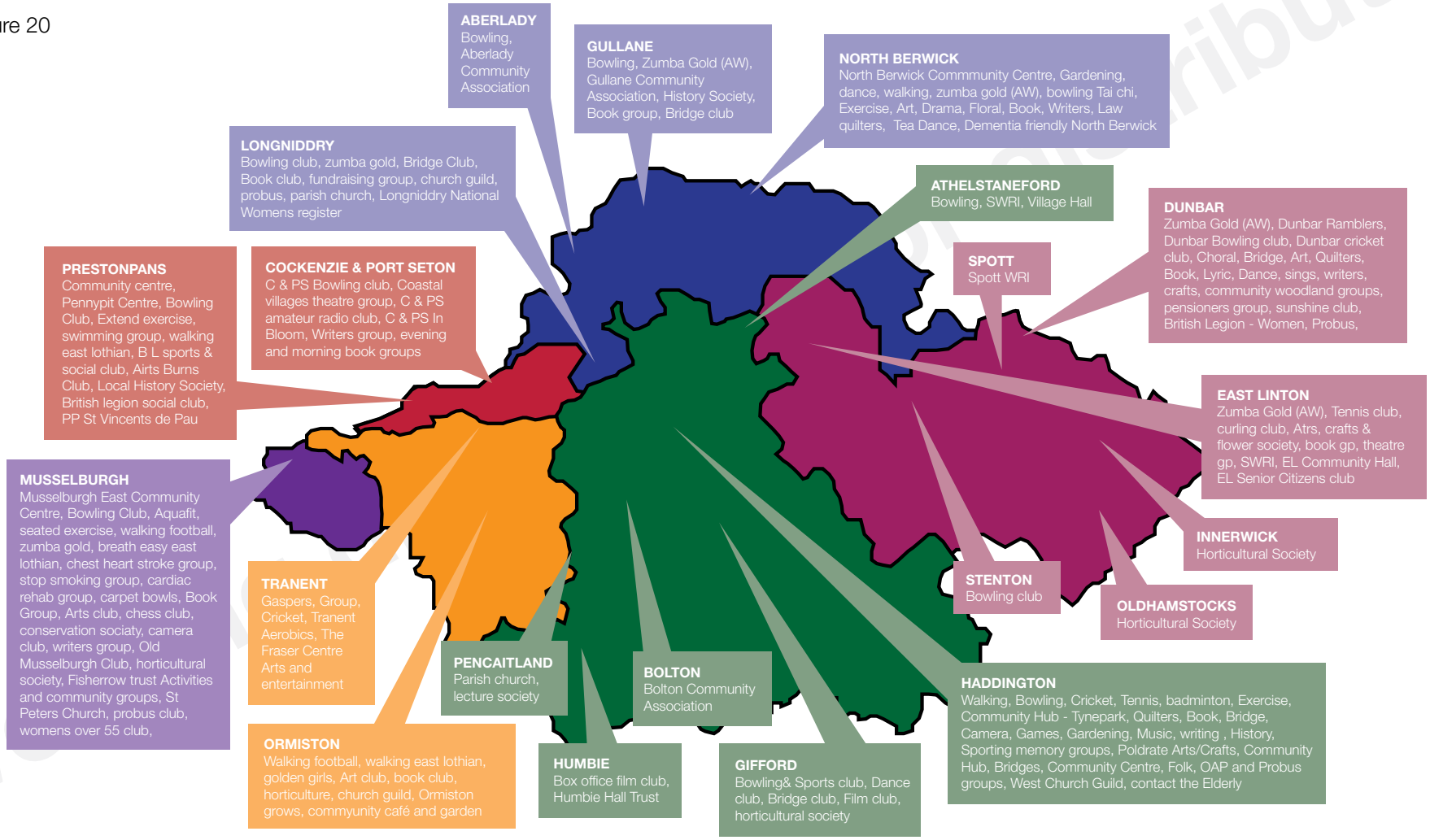
Map showing Independent Care Sectors in East Lothian and the best fit for data zones 2011



9.1.4 Third sector and community provision

There is a recognition locally that even the best formal services cannot effectively tackle health and wellbeing, social isolation or exclusion by themselves. Third sector support, good social networks and connected, inclusive communities are vital and Figure 20 outlines only a few of the vibrant centres, services, associations and communities across East Lothian. As a Partnership we will aim to further create and support the conditions for happier, healthier communities.

Figure 20

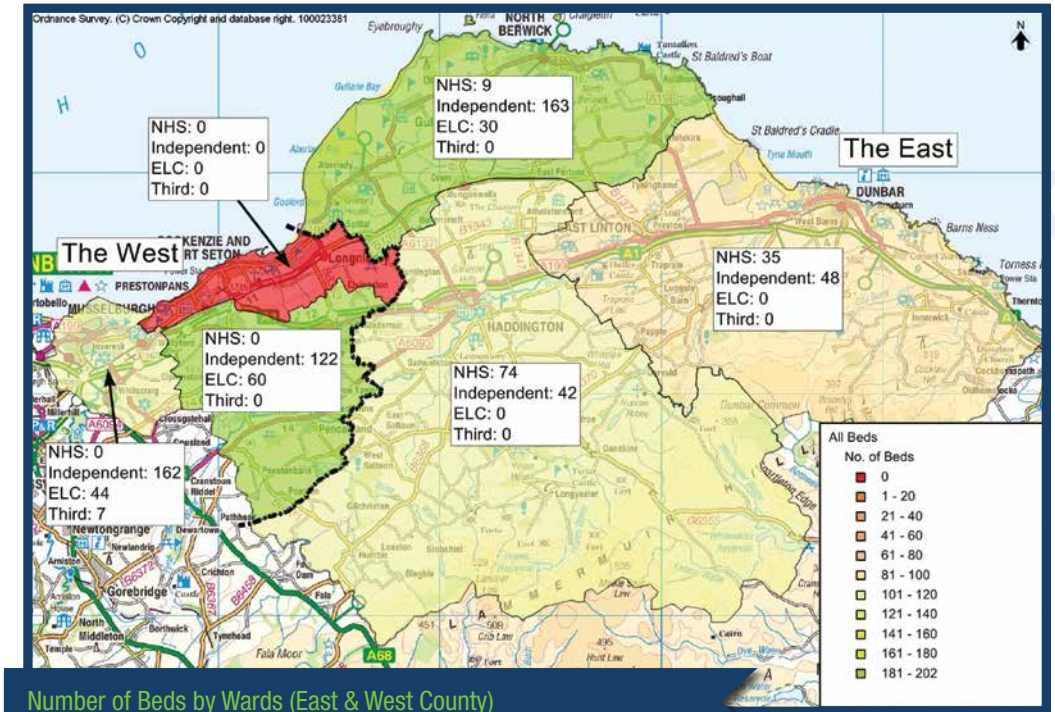


9.2 Estates

9.2.1 Bed base

East Lothian residents currently have access to 3 large acute hospitals across Lothian, rehabilitation and continuing care beds in a number of Edinburgh hospital sites and 3 local hospitals and community hospital facilities in East Lothian. In addition to this there are residential and nursing homes for older people and a range of day centres and health centres across the county.

Figure 21 - Bed bases



Number of Beds by Wards (East & West County)

NHS Lothian's Strategic Plan recognises that the current hospital premises based in East Lothian are housed in old buildings which may be inadequate to safely meet the needs of patients or of a growing population. This is seen as a barrier to reprovision of integrated health and social care services in the county.

Equally, local care professionals acknowledge that our wider community bed provision has a number of issues which require urgent consideration and review; this includes variable admission rights and geographic spread and availability in addition to the quality of the estate and variation in costs. This leads to a poor strategic fit with modern care models across health and social care. Any future models of care we plan for should, therefore, take into consideration the best use of the total health and social care estate that is currently available to us in East Lothian. It should not necessarily concentrate on the preservation of the existing building stock for the same purposes but rather consider and present new service models which could deliver more care, more equitably throughout our communities and directed at need.

There are also a number of external factors which will impact on local strategic developments. These include the outcomes of the national review of NHS Continuing Care criteria and eligibility for (free) NHS care, which has the potential to lead to a shift from NHS care to Social Care.

NHS Lothian's Strategic Plan envisages that all hospital sites other than the main acute sites should be seen as "integrated care facilities" delivering joint services. The vision developing in that Plan is for flexible use of bed capacity for both NHS and Social Care where the status of a patient or resident can change and financial assessment and charging can be applied without them having to move.

As a Partnership we need to plan now for delivering such a model in the new East Lothian Community Hospital. We equally need to address a number of key priorities arising from NHS Lothian's Strategic Plan and our own local needs assessment. These priorities are:

- The repatriation of East Lothian residents from Liberton Hospital in Edinburgh and Midlothian Community Hospital within the lifespan of this Strategic Plan, with the associated shift in aligned resources to match this activity.
- Plan for enhanced local provision and use of intermediate care services and facilities to prevent unscheduled admissions, actively facilitate early supported discharge from acute settings and address delayed discharge from acute hospitals. This will include the development of "Step Up" beds in addition to the existing "Step Down" bed resource. This model of care will be delivered within the overall existing health and social care bed resource (including the bed complement associated with a new East Lothian Community Hospital)
- Plan for enhanced local provision to support respite care
- Plan for increased local provision and service redesign to support end of life care at or close to home.
- Plan for local provision to support specialist dementia care

The ongoing development of plans for a new East Lothian Community Hospital allows the opportunity to commission and conduct a wider community bed review across the totality of health and social care which is reflective of local needs across the county and ensures allocation of resources in the right place. In terms of estate this planned review will specifically consider bed bases and models of care in the new East Lothian Community Hospital, Edington Hospital, Belhaven Hospital and nursing home, Abbey Residential Home and Eskgreen Residential Home as well as future need and provision of independent sector nursing home bed bases. The review, to be carried out over the course of 2016/17 will ensure best use of health and social care resources and consider:

- The utilisation of existing bed provision and future need
- The appropriateness of different types of provision by locality
- The economic feasibility of new or different models of care delivery and options for reprovision
- Existing estates, including ongoing costs, any investment required or disinvestment/reinvestment potential.

A crucial element of this planned review will consider local populations' concerns, requests and need across the county as an integral part of the process.

9.2.2 Housing

Housing has a central role in enabling people to live independently in the community. In particular, it has long been recognised that a lack of suitably designed or adapted housing can escalate health and care needs and trigger events such as falls that result in hospital admission and reduce a person's ability and confidence to live independently and safely in the community.

Provision of suitable housing and housing related services are a cost effective way of enabling older people in particular to have greater choice and to live independently. Housing support and the provision of a fit for purpose housing stock in East Lothian are therefore important strands of the housing contribution towards the delivery of an integrated approach to care.

Technological advances and the development of community based health and care services now provide an opportunity for housing

to be more closely linked with health and social care planning and In the planning and development of specialist housing. Although the great majority of people with different needs live in “ordinary housing” a proportion of people with particular needs require specialist accommodation, 91% of East Lothian’s 65+ population is estimated to live in ordinary housing, similar to the national average. In some cases additional support or property adaptation can be provided to enable independent living and typically around 75 adaptations to private sector stock and around 90 adaptations in Council stock are carried out each year depending on assessed needs.

An integral element, therefore, of the review of beds and future demand across the county is the need to consider both aids and adaptations and specialist housing for those with more complex needs. This is consistent with the experience of a range of accommodation and service providers who report a shift towards higher and more complex needs across a range of groups. The role of housing, and extra care housing in particular, will be built in as part of the wider resource review exercise and as a component of the Housing Contribution Statement which will be jointly developed during late 2015 and early 2016. The Housing Contribution Statement will set out more specifically and clearly the vital role of the housing sector in helping to meet the Strategic Plan priorities and its contribution to improving the health and well-being of our communities.

10. Key enablers

In support of the Strategic Plan we have identified five crucial areas which will support the changes needed for better care, closer to home. The following sections outline our plans around each of these key enablers.

10.1 Good governance

All national and local outcomes, improvement measures and performance targets which are connected exclusively with delegated functions will become the responsibility of the Integration Joint Board to deliver. Delivery of these priorities and the ambitious targets set in the national health and wellbeing outcomes will require implementation of a range of actions and the IJB will require assurance that progress is being made in delivering these in a safe and effective manner. The need for sound governance, performance and scrutiny arrangements is paramount.

10.1.1 Risk management

As an organisation the Partnership will continuously consider the risks that can impact on delivery of the Strategic Plan which will form part of the overarching risk management strategy and framework for the Integration Joint Board.

The strategic risk register for the Strategic Plan is attached as Appendix 8.

10.1.2 Monitoring and Performance: Process

An integration dataset is being created for the Integration Joint Board which will include information on the data gathering, reporting requirements and accountability for each of these measures and targets.

The indicators we monitor will be aligned with the priority areas identified in the joint strategic needs assessment and the Strategic Plan and will be refined as these documents are reviewed and refreshed.

The Integration Joint Board will undertake and publish an annual, in-depth review of its performance in delivery of the integration dataset, particularly the national health and wellbeing outcomes and local strategic ambition and will adjust operational plans accordingly.

The IJB will also receive a quarterly report against the strategic vision and goals using a limited set of key indicators of performance. At this level of monitoring the IJB will be looking to ensure the Strategic Plan is the correct one and having the impact it is designed to have.

Monitoring Delivery of the Strategic Change Programmes

In addition, each of our strategic change programmes will be monitored against a performance dashboard and the deliverables required in the business action plans. The Strategic Planning Programme Board, chaired by the Chief Officer will review this quarterly, taking action to mitigate concerns and report progress to both the IJB and the Strategic Planning Group as part of regular reporting. This level of monitoring will provide assurance that the organisation is implementing the approved strategy and that action is being taken quickly to ensure progress continues to be made and problems are overcome.

Strategic Plan Review

This Strategic Plan has been written for the period 2016 – 2019 recognising probable future incorporation of social care Children's Services into delegated functions of the IJB within this period. At the point of incorporation the Strategic Plan will be reviewed and rewritten to reflect this substantive change and a consultation exercise undertaken.

Until that point the Strategic Plan will be reviewed on at least an annual basis. The first review will be undertaken in the first calendar quarter of 2017 and an updated document presented to the IJB for approval in April 2017.

10.1.3 Clinical and Care Governance

Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality of care and support is the responsibility of everyone working in the organisation.

These processes provide assurance to Integration Joint Boards, Health Boards and Local Authorities. Embedded from frontline staff through to boards, good governance should define, drive and provide oversight of the culture, processes and accountabilities of those delivering care.

The Public Bodies (Joint Working) Scotland Act 2014 contains a number of principles and outcomes for Health and Social Care Partnerships outlined throughout this Strategic Plan. To achieve these our workforce will need to work in an integrated way to ensure that the different skills, experience, knowledge and perspectives they bring are best used and aligned; this will require a clear governance framework within which professionals and the wider workforce will operate.

The Act does not, however, change the current or future regulatory framework within which health and social care professionals practice, or the established professional accountabilities that are currently in place within the NHS and local government.

The full detail of East Lothian Health and Social Care Partnership's approach to clinical and care governance is outlined in the Integration Scheme. The intention of using existing NHS Lothian and East Lothian Council internal governance as a primary source of assurance is to recognise that they have continuing governance responsibilities for both delegated and non-delegated functions, and that there is a wish to minimise unnecessary bureaucracy.

Within its existing framework, NHS Lothian has healthcare and staff governance processes and supports which provide assurance that NHS Lothian meets all its statutory responsibilities and quality standards.

Within East Lothian Council, the Chief Social Work Officer has overall responsibility for the professional standards of the Council's social work and social care staff. The workforce is also regulated by the Scottish Social Services Council (SSSC), and all professional staff must by law be registered with this body. This registration requirement will, in due course, extend to all social care staff employed by the Council and the voluntary and independent sectors.

The Chief Social Work Officer reports annually to the Council on governance arrangements. These reports comply with national guidance issued by Scottish Government and copies of these annual reports will be submitted to the Integration Joint Board as part of overarching governance.

Overall the Integration Joint Board will use Scottish Government's Clinical and Care Governance Framework to test its approach to governance and to create an organisational culture that values partnership working and affirms the contribution of staff.

10.1.4 Data sharing and Information Governance

Better data sharing across health and social care will play a key role in the integration agenda. As a Partnership we will need to be able to assess and forecast need, link investment to outcomes, consider options for alternative interventions and plan for the range, nature and quality of future services.

Effective information systems are necessary to ensure that good intelligence underpins our process of local strategic planning and decision making. To support this, Scottish Government has commissioned the Information and Statistics Division (ISD), part of NHS National Services Scotland, to work with NHS Boards, Local Authorities and others to develop a linked individual level dataset for partnerships. As a Partnership East Lothian are actively working with ISD to support the development of this Strategic Plan.

All of the work developed and delivered as part of this Health and Social Care Data Information and Intelligence Project (HSCDIIP) will be underpinned by a national Information Sharing Protocol (ISP) that meets the requirements of the Scottish Accord on the Sharing of Personal Information (SASPI). The SASPI framework enables NHS and Local Authorities directly concerned with the safeguarding, welfare and protection of the wider public to share personal information between them in a lawful and intelligent way.

In addition, there is a long standing Pan-Lothian and Borders General Information Sharing Protocol, to which NHS Lothian, City of Edinburgh Council, East Lothian Council, Midlothian Council and West Lothian Council are signatories. This Protocol has been reviewed and updated by a sub group on behalf of the Pan-Lothian Data Sharing Partnership. Further detail on information sharing and data handling is outlined in East Lothian IJB's Integration Scheme.

10.1.5 Financial Governance

Both East Lothian Council and NHS Lothian will make a formal allocation of financial resources (the 'budget') to the IJB which will represent the resources available to undertake the functions delegated. This formal allocation – which will be for 2016/17, 2017/18 and 2018/19 – will be constrained by the overall resources available to the Local Authority and the Health Board and will have to be clearly understood by the IJB in terms of the financial risks and challenges inherent in this 'budget'

A detailed financial assurance exercise has been carried out by the IJB which examines the budgets on offer and which considers what risk mitigation actions might be necessary and available..

The Strategic Plan will also be accompanied by an Annual Financial Statement which will establish the directions the IJB gives to East Lothian Council and NHS Lothian and lays out how the ambitions of the Strategic Plan will be resourced. The financial statement will run over the three years of the plan.

10.2 Performance Framework

The integration of health and social care has two key objectives which are mutually reinforcing - securing better outcomes and experiences for individuals and communities and obtaining better use of resources across health, care and support systems at national and local levels.

The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services. They focus on the experiences and quality of services for people using those services, carers and their families. More information about the outcomes is available at: http://www.gov.scot/Publications/2015/02/9966/downloads

The IJB will be responsible for planning and delivering a wide range of health and social care services, and will be accountable for delivering the National Health and Wellbeing Outcomes. The IJB will also be required to publish an annual performance report which will set out how we are improving the National Health and Wellbeing Outcomes. These reports will include information about the core suite of indicators, supported by local measures and contextualising data to provide a broader picture of local performance.

10.2.1 National Health and Wellbeing Outcomes

The National Health and Wellbeing Outcomes reflect this and provide a framework for the planning and delivery of health and social care services and a focus on the experiences and quality of services for people using those services, carers and their families.

There are nine national outcomes. The indicators have been developed from national data sources so that the measurement approach is consistent across all areas. They can be grouped into two types of complementary measures:

A. Outcome indicators based on survey feedback, to emphasise the importance of a personal outcomes approach and the key role of user feedback in improving quality.

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
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.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
7. People who use health and social care services are safe from harm.
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.
9. Resources are used effectively and efficiently in the provision of health and social care services.

B. Related to these outcomes is a suite of core indicators.

1. Percentage of adults able to look after their health very well or quite well.
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5. Percentage of adults receiving any care or support who rate it as excellent or good
6. Percentage of people with positive experience of care at their GP practice.
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.
8. Percentage of carers who feel supported to continue in their caring role.
9. Percentage of adults supported at home who agree they felt safe.
10. Percentage of staff who say they would recommend their workplace as a good place to work.
11. Premature mortality rate.
12. Rate of emergency admissions for adults.
13. Rate of emergency bed days for adults.
14. Readmissions to hospital within 28 days of discharge.
15. Proportion of last 6 months of life spent at home or in community setting.
16. Falls rate per 1,000 population in over 65s.
17. Proportion of care services graded ‘good’ (4) or better in Care Inspectorate Inspections.
18. Percentage of adults with intensive needs receiving care at home.
19. Number of days people spend in hospital when they are ready to be discharged.

20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
21. Percentage of people admitted from home to hospital during the years, who are discharged to a care home.
22. Percentage of people who are discharged from hospital within 72 hours of being ready
23. Expenditure on end of life care

This suite of indicators will provide an indication of progress that can be compared across partnerships.

10.2.2 Performance Framework

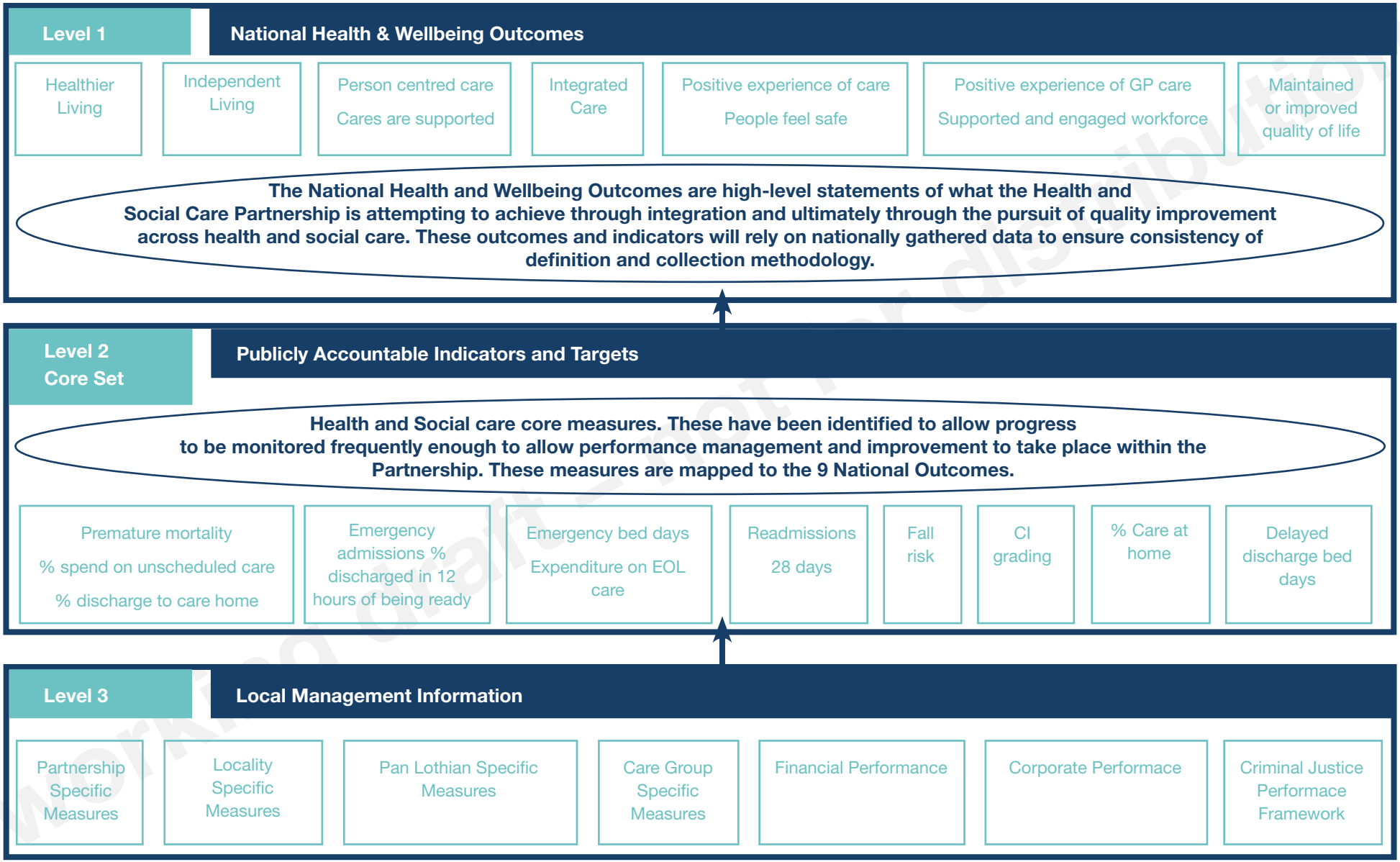
Whilst the national suite of measures will provide an indication of progress they will not provide the full picture. As a Partnership we will need to collect and understand a wide range of data and feedback that helps understand the system at locality level, and manage and improve services.

The overall performance framework for the IJB therefore needs to reflect objectives and help to monitor:

- Progress on the delivery of national outcomes and indicators
- How the strategic planning arrangements have contributed to delivering services which reflect the integration principles
- Transformation of individual outcomes and experience
- Transformation of local health, care and support systems
- Change in local process including:
  - effective engagement of housing and other services including the third sector and independent sector
  - in care models
  - in whole systems planning and investment
  - evidence based models of care.

Given the many elements of integrated care and the wide range of services delegated to Health and Social Care Partnerships it will be important to ensure our performance framework addresses as many of the key local dimensions as possible, including specific sub-sets of indicators for particular groups of service users and also information at a locality level. This wider dataset is currently in development but can be reflected schematically in general terms (below).

Figure 22



10.3 People and Organisational Development

Our Strategic Plan is comprehensive and ambitious but it will not be deliverable unless we change how we work across each part of the health and social care system. This level of change requires individual organisations to encourage and achieve change within each of their teams as well as to support change in areas of collective working. In East Lothian we start from a strong base - there is a collective recognition of the need to change how we work across social care, community and acute providers. In collaboration with all our partners and stakeholders the Health and Social Care Partnership now aims to ensure that the workforce of tomorrow, both paid and voluntary, are knowledgeable and skilled and able to respond to the changes outlined in this Strategic Plan.

To meet these challenges and deliver the vision for adult health and social care we expect the workforce to continue to diversify. They will be employed by individual employers, small to medium enterprises and large organisations across the NHS, local authority, voluntary and independent sectors as well as in local communities. The continued transformation of our care delivery will also result in a workforce that is deployed in a wider range of ways, including through integration with health, social care and, potentially in time, other public sector team arrangements.

As a Partnership we recognise that an engaged and supported workforce underpins the delivery of our vision and that a key priority for the Strategic Plan is, therefore, the development of a supporting organisational development (OD) strategy. The OD plan is in development and will be designed to show how the Partnership will grow as an organisation in order to deliver its vision and objectives. Clearly the plan will need to change and evolve as the Partnership develops but critical to delivering this and making it real is the need to develop leadership and vision that is shared and understood and linked explicitly to organisational development. Among others key work-streams within this will be workforce capacity and capability, shared culture and training and development. A first step will be to map in detail the workforce and development requirements to deliver system reform and develop a detailed economy workforce plan. It is anticipated this will be completed over the course of 2016.

10.4 Communication and Engagement

The Health and Social Care Partnership is committed to the principles of effective communication and engagement with our staff, service users and carers, partners and the public. This means having a clear framework in place to promote systematic and meaningful engagement and involves engaging a population that is interested in their health and care, empowered to make healthier choices, has a voice in the design of local services, and uses services appropriately.

It is vital that as a Partnership we develop our stakeholder relations and the way we seek and use their feedback to inform decision making. This is an important element of our development process and one that will help to ensure the future success of the Partnership.

It is also important that the widest variety of people are engaged and consulted, particularly people who are traditionally harder to reach or who have not been involved in consultation before. We therefore want to take a fresh and innovative approach to communication and engagement. Our developing communication and engagement strategy will set out how the Partnership will inform, engage and involve local people, partners, stakeholders and care professionals. It will identify who we need to inform and involve, how we will do this, the outcomes we want to achieve and will clearly reflect the commitment to meaningful engagement with our key audiences, communities of interest and the wider public about the development of health and social care services in East Lothian:

10.5 Information tools

Fragmented IT systems can affect the quality of care we provide. At present, information about people's needs is often collected manually rather than electronically which restricts sharing of information; as a result, care can be fragmented, transfers between settings and sectors of care - for example discharge from hospital - are often poorly managed, and people are frustrated as they are repeatedly asked for the same information from different parts of the health and social care systems

Information technology is therefore critical to the integration and coordination of care and we are committed to developing solutions that enable pragmatic information sharing with informed consent and appropriate information governance. We are equally committed to enhancing the use of new technologies and technology enabled care to support our priorities and to improve outcomes. We will do this through the development of a joint Information Management and Technology strategy over the lifetime of the Strategic Plan.

11. Locality planning

11.1 Context

As a Partnership we aspire to have effective local services planned in conjunction with local people which make the best use of the assets available within our area.

A pivotal aspect of the integration agenda is the development of locality working and locality planning within each partnership area. There is a requirement for each new Health and Social Care Partnership to identify a minimum of two localities within their boundary and to develop an approach which engages all the clinical and professional practitioners, partners, stakeholders, and populations within each locality.

Strategic planning for health and social care is rooted within individual locality plans and aggregated up so that these help to shape the final Strategic Plan that connects with the Partnership's vision, aims and outcomes. This Strategic Plan therefore needs to demonstrate how it has reflected the priorities for each of its localities and set these out clearly.

Localities, as far as possible, should also reflect natural communities and boundaries as well as established service operating boundaries and should centre on populations around whose needs service redesign can effectively occur.

11.2 Identifying and defining localities

There has been long experience of joint working and collaboration in health and social care across East Lothian and, although the operational boundaries and communities have been aligned in slightly different ways and configurations, the natural communities and characteristics have remained relatively consistent.

Within local authority planning structures there have traditionally been clear and consistent boundaries around administrative areas and electoral wards. This suggests the importance of the current six area partnerships retaining identity in terms of consultation and engagement.

The role of localities within the context of the wider Health and Social Care Strategic Plan, the accountability of the Partnership in delivering outcomes through this plan and the need to redesign and reshape care delivery within a partnership the size of East Lothian allows us the opportunity to consider a different level of locality planning along health inequality or socioeconomic lines.

Some issues in health and social care can best be addressed across East Lothian as a whole; equally, some issues more naturally fall into two "localities" – for example, socio economic deprivation and inequalities in the West and rurality in the East.

It has been agreed that the Partnership will take a staged approach to localities in the initial work on the Strategic Plan. This means using the 6 area partnerships for engagement and consultation but building the Strategic Plan based on two "localities" – West (Musselburgh, Fa'side and Preston Seton, Gosford wards) and East (Haddington and Lammermuir, North Berwick Coastal, Dunbar and East Linton wards).

As area partnerships mature and progressively develop plans at partnership / locality level, future iterations of the Strategic Plan will increasingly reflect these 6 areas.

Further locality profiles are detailed in Appendix 3.

Figure 23

Map showing East Lothian localities and the best fit for data zones 2011

11.3 Locality leadership

It is one thing to identify localities and to define how they look and their characteristics. It will be equally important to identify locality leadership capacity in order to enable effective locality planning to be driven forward.

The health and care needs of each locality will be a driver for shaping the way in which services and resources are planned and delivered, and professionally and clinically led. Discussions are also required with our other key strategic partners within the third and independent sectors to understand how this locality alignment can be further enhanced.

It will be important that locality leadership roles are enabling and supportive, assisting professional and community leaders to develop and deliver change and improvement in health and social care.

To address this, leadership development will be a key component of the supporting organisational development plan.

12. Implementation plans

12.1 Context

We have described our case for change through an analysis of our current health economy, the strategic aims based on this analysis, the financial context in which we work and a gap analysis which has allowed us to focus on local priorities.

In this section we set out what we are hoping to do specifically to start to bring about the transformation of local health services in the coming years. This section provides a description of how we think health and social care in East Lothian could look as a result of each of our strategic objectives and will describe the change programmes that will bring this about.

Fuller detail on the change programmes will be set out each year in dedicated delivery plans and our business action plan.

The Strategic Change Programme for East Lothian will retain a focus on local and national outcomes and local strategic objectives and will address them through work programmes overseen by senior officers who will be accountable for delivery. The draft programmes are based on our Best Health, Best Care, Best Value ambition.

None of these change programmes will work in isolation from each other - they are linked, are mutually supporting and should be considered as equal elements of the total health and social care system we aim to deliver in East Lothian.

The change programmes are “Well Connected” and we will establish planning and accountability structures to ensure this connectivity for consistent integrated care.

12.2 The Route Map to Transformation

The Route Map is a framework for action to develop a sustainable health and care system in East Lothian. It identifies areas that require progress in order to improve health, wellbeing and outcomes and make changes future proof. It describes the roles we need to play and where we can continue to make a difference.

The Route Map runs over three time periods.

1. Current state – where understanding the context and what needs to be done is important, and where action needs to begin
2. Transformation phase – where change and sustainability is becoming the norm and we are on the way to a more effective and sustainable health and care system
3. Future state – where better, more effective care, better outcomes and better ways of working and sustainability have become routine.

These three phases are designed as a journey from where we are now, to where we need to be.

The Joint Strategic Needs Assessment and the Strategic Plan outline the “current state” and the high level “future state”; the Programme Delivery Plans in this section focus on the transformation phase. In developing this the following principles have been agreed:

One strategy
The Strategic Plan for East Lothian should bring together all our strategies and plans for transformation of health and adult social care

One change programme
The strategic change programmes and projects outlined in this section have been identified as necessary to deliver the strategic plan and will be brought together under a single programme management process which reports to the Strategic Planning Group and to the Integration Joint Board

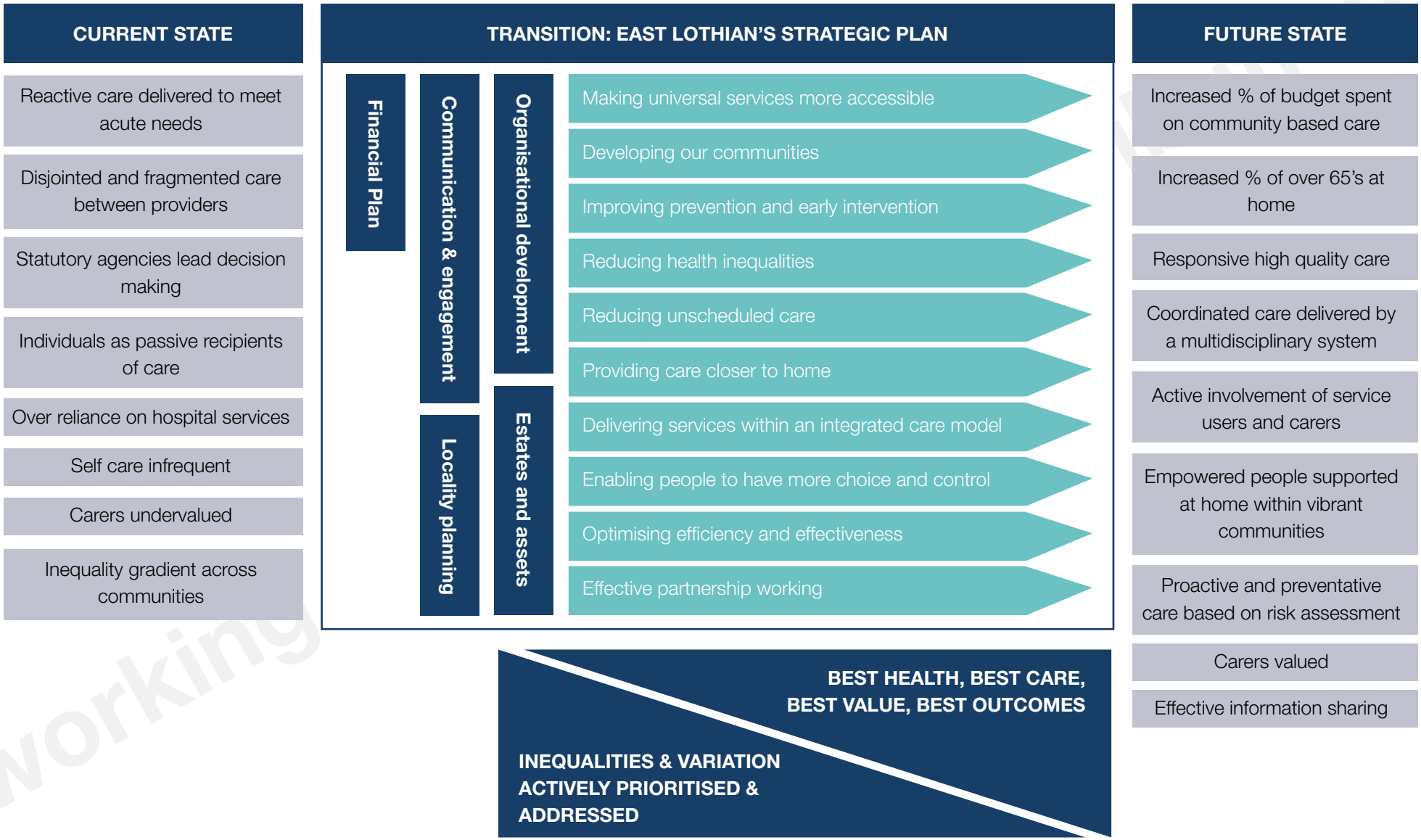
Focus and priorities
There will be an agreed number of top priority change projects with identified delivery timeframes spread across the next three years.

Enablers
Critical cross sector enabling projects will be identified and resourced.

Ownership
All strategic change programmes will have a clearly identified senior responsible officer

Decision making
Ultimate approval of strategic change programmes and projects and commitment of funding sits with the Integration Joint Board.

Figure 24 - The Roue Map to Transformation



East Lothian Strategic Objective

A: TO MAKE UNIVERSAL SERVICES MORE ACCESSIBLE AND DEVELOP OUR COMMUNITIES

We want to improve access to our services, but equally to help people and communities to help and support themselves too.

Links to National Health and Wellbeing Outcomes

1, 2, 3, 5, 6

Links to Model of Care

a, b

Why is change needed?

- We need to ensure that people with health and social care needs benefit to the full from mainstream services and resources such as primary healthcare, information, support and advice.
- In East Lothian there is significant variation across our GP practices in terms of satisfaction with arrangements to see a GP. We need to understand this variation and support our practices in dealing with significant demand, capacity and access challenges.
- Much of East Lothian is rural and this can present challenges in accessing care, particularly in areas south of the A1. Rural communities don't have a GP surgery or pharmacy nearby, hospital treatment may involve long journeys and we know that social care and support services in our rural areas are harder to provide.
- We also know that people in communities have a critical role to play in supporting each other and in designing services to meet local needs. We need to work harder to listen to local people, service users and carers to understand the needs of geographical communities as well as of communities of interest.
- Our sustainable communities should also be healthy communities which support people in making healthy choices, being physically active and remaining engaged.

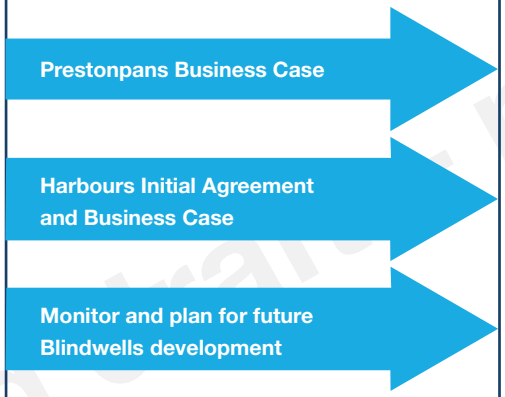
Performance Indicators

Performance indicators will be developed in detail as part of ongoing Strategy development, but will focus on improving the following outcomes and outputs, many of which link to other programmes:

- Percentage of people with positive experience of the care provided by their GP practice
- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Rate of emergency admissions for adults
- Rate of emergency bed days for adults.
- Readmissions to hospital within 28 days of discharge.

Additional resource implications

	2016/17	2017/18	2018/19
Integrated Care Fund: Primary Care Strategy Development	£48,000	£48,000	
GP premises investment	c£646,232 capital £39,000 revenue	c£1.8m capital £149,000 revenue	
Primary Care Transformation Fund:	Business case In development		
Integrated Care Fund: GP Access to Care Transport scheme	£54,000	£54,000	

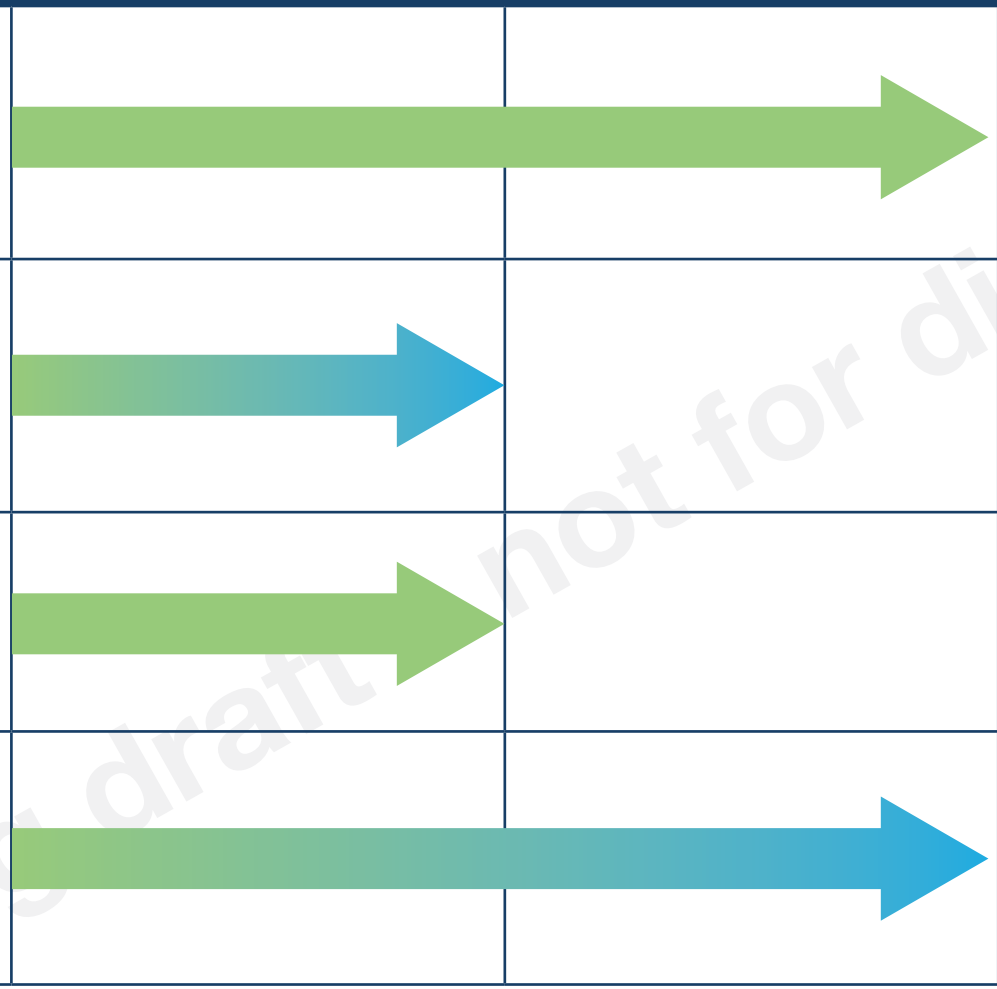
ACTION	2016/17	2017/18	2018/19
Working with key stakeholders we will develop an East Lothian Primary Care Development strategy which recognises contractual changes, demand and capacity issues , addresses variation and considers potential new models of care to meet these challenges.			
Specifically we will: Implement East Lothian Primary Care Premises Strategy and progress business case development processes including those which address future housing developments			
Commission a demand and capacity review across East Lothian General Practices			

KEY: West Locality | East Locality | All East Lothian

ACTION	2016/17	2017/18	2018/19
Support increased practice list sizes through the Lothian LEGUP scheme where practices request this.			
Develop and evaluate a pilot GP cluster model (see Figure 4) to embed LINKS workers/ community connectors and mental health support into primary care. This will include befriending, address social isolation, community support and volunteering and build on and link with the Total Place work locally.	Musselburgh cluster Tranent Prestonpans		
Establish and evaluate a pilot to understand the impact of specialist pharmacist input on GP workload and improved outcomes	Prestonpans Musselburgh		

KEY: West Locality | East Locality | All East Lothian

ACTION	2016/17	2017/18	2018/19
Expand the RVS GP transport system to include wider access to health care, including hospital care. This will have an initial focus on rurality			
Develop a local "Right Care, Right Time, Right Place" public information programme to address demand and capacity issue safely and appropriately.			
Establish and evaluate an optometry pilot which signposts appropriate care from general practice to community optometrists.			
Explore innovative new service models to support general practice in delivering care to frail elderly people in the community, including in nursing and care homes			



KEY: West Locality East Locality All East Lothian

ACTION	2016/17	2017/18	2018/19
Support and work with Dementia Friendly East Lothian (DFEL) to expand dementia friendly communities across the county and establish joint, integrated planning and support for dementia.			

KEY: West Locality East Locality All East Lothian

East Lothian Strategic Objective

B: TO IMPROVE PREVENTION AND EARLY INTERVENTION

We want to shift and focus services towards the prevention of ill health, to anticipate at an early stage the need for support and to react where possible to prevent crises.

Links to National Health and Wellbeing Outcomes

1, 2, 3, 4, 5, 6

Links to Model of Care

a, b, c, d

Why is change needed?

- Prevention is always better than cure whether primary - that is avoiding the problem occurring, or secondary - that is arresting the problem or preventing further deterioration. Prevention enables individuals to make better health and wellbeing decisions and it is an important determinant in optimising better outcomes. In East Lothian we know where our patterns and levels of multimorbidity are high. As multimorbidity increases, our need to coordinate and integrate the care of the most vulnerable and at risk people in our communities grows in importance.
- We recognise the vital role played by carers and need to make sure that carers remain in good health, and that their health-related quality of life does not deteriorate as a result of their caring responsibilities. In the 2011 census almost 10,000 people in East Lothian reported being in a caring role but we believe many are unknown to support services.
- We know that dementia prevalence rates in East Lothian are amongst the highest in Scotland; we also know that by 2020 this is predicted to increase by over 100%.Early intervention and support in dementia care can help to better prepare individuals and their families.
- Falls are a major cause of disability. In East Lothian our hospital admission rates for falls are relatively low, but if someone from the county is admitted they stay in hospital longer than average
- There are also important links to be made and reinforced with existing strategies and plans supporting people with poor mental health, physical disabilities, learning disabilities and those with drug and alcohol problems

Performance Indicators

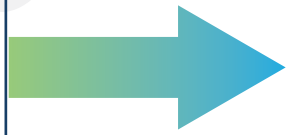
Performance indicators will be developed in detail as part of the Strategy development, but will focus on improving the following outcomes and outputs, many of which link to other programmes:

- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.

- Premature mortality rate.
- Rate of emergency admissions for adults
- Rate of emergency bed days for adults.
- Readmissions to hospital within 28 days of discharge.
- Proportion of last 6 months of life spent at home or in community setting.
- Falls rate per 1,000 population in over 65s.

Additional resource implications

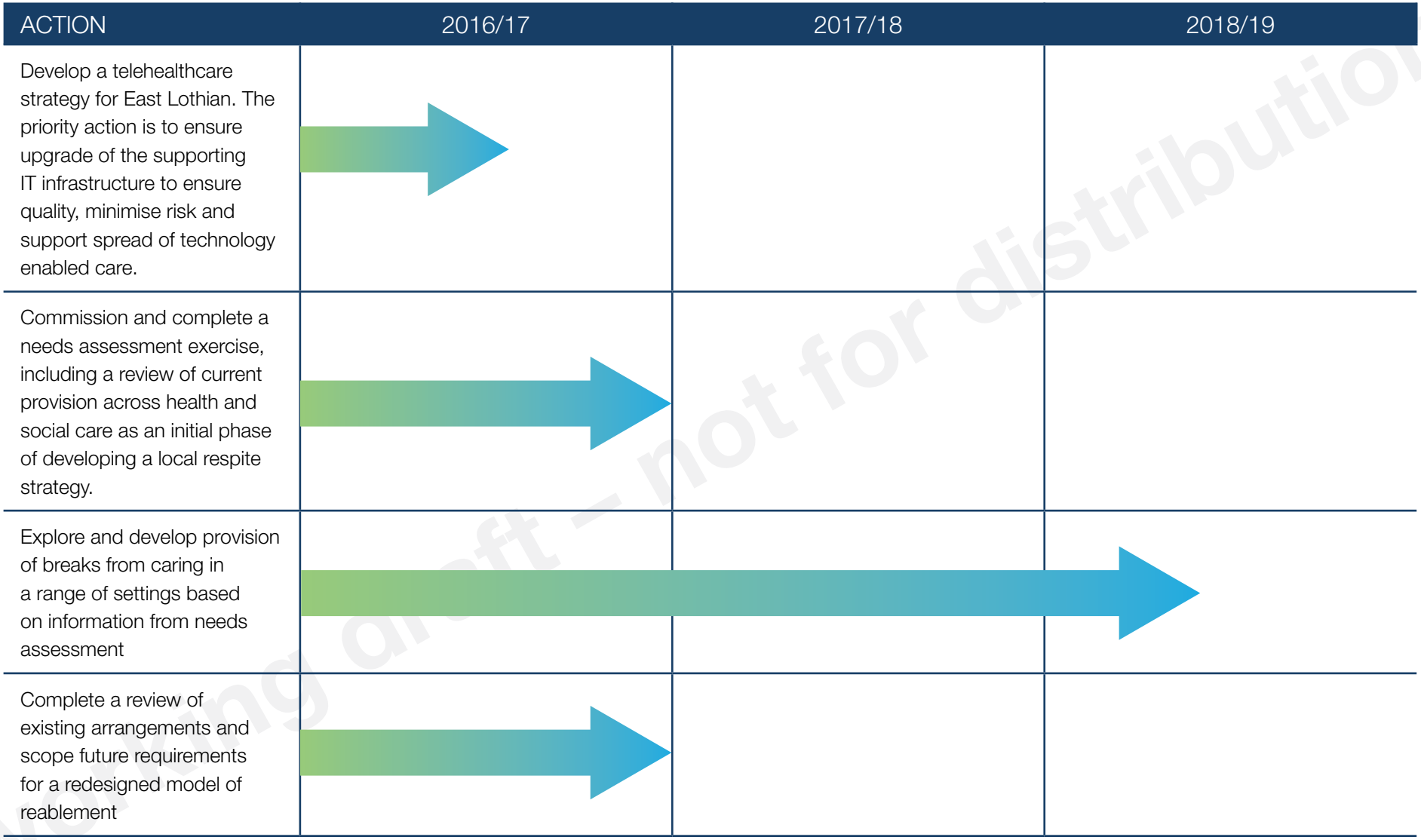
	2016/17	2017/18	2018/19
Integrated Care Fund: Carer support (includes LTC fund)	£119,500	£119,500	
Integrated Care Fund Dementia post diagnostic support	£68,000	£68,000	
Integrated Care Fund: Links workers	£145,698	£145,698	
Integrated Care Fund Telehealthcare	£80,000		

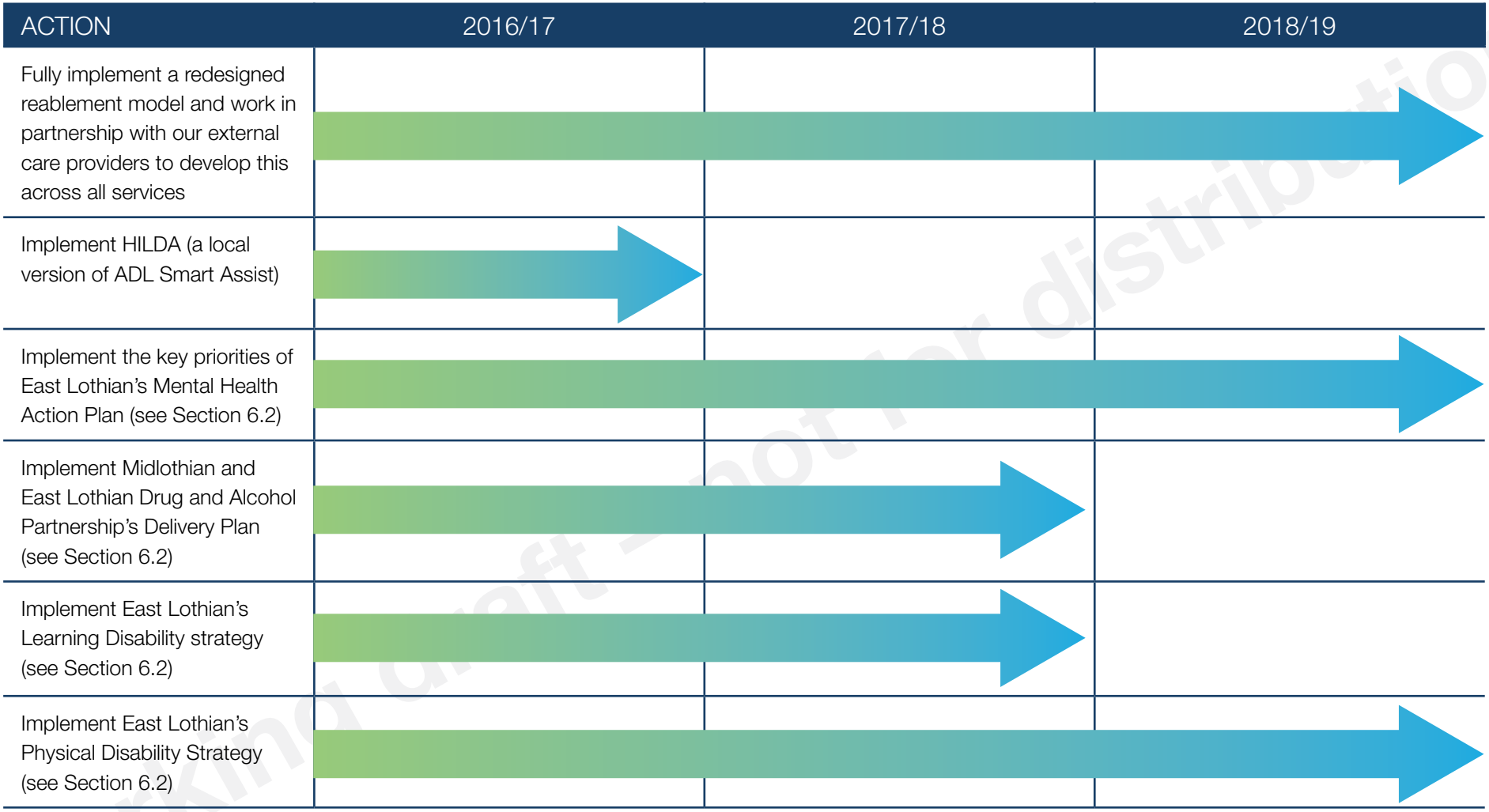
ACTION	2016/17	2017/18	2018/19
Work with Information and Statistics Division of NHSS (ISD) to develop a risk prediction system which uses health and social care data.			
Develop more detailed health and social care data profiles for both localities			
Develop and implement a systematic integrated falls pathway for East Lothian which identifies fallers at an early stage, embeds a preventative approach and which provides a consistent multidisciplinary, multiagency response for people who fall, including specialist assessment			
Jointly develop a Physical Activity strategy in collaboration with Community Planning partners which recognises the role of physical activity in preventative care			

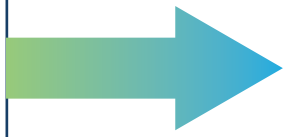
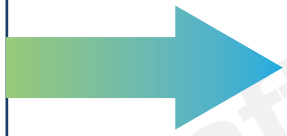
KEY: West Locality East Locality All East Lothian

ACTION	2016/17	2017/18	2018/19
Develop and implement a renewed Carers Strategy for East Lothian in line with the Carers (Scotland) Bill.			
Work with all agencies providing carer support to deliver the priority actions of further carer identification and increased assessment rates achieved through 1. A workforce education programme 2. An integrated communication strategy			
Work with all agencies providing carer support to further develop a short breaks service			
Appoint a post diagnostic support worker for dementia	**COMPLETED MAY 2015**		
Commission, complete and implement a consistent, integrated dementia pathway across East Lothian			

KEY: West Locality | East Locality | All East Lothian





ACTION	2016/17	2017/18	2018/19
Support the Association of East Lothian Day Centres and its constituent members to gain Care Inspectorate registration			
Develop and implement a modernisation strategy for day services for older people which recognises need, geography, resources and capacity			
Implement new strategic planning structures which focus on prevention and early intervention and which ensure effective links with planning, health promotion, health improvement, housing and public health.			

KEY: West Locality East Locality All East Lothian

East Lothian Strategic Objective

C: TO REDUCE UNSCHEDULED CARE
We want to reduce unnecessary demand for services including hospital care.

D: TO PROVIDE CARE CLOSER TO HOME
We want to deliver safe and effective care as close to home as possible, allowing people to remain in their homes and communities for as long as they can.

E: TO DELIVER SERVICES WITHIN AN INTEGRATED CARE MODEL
We recognise the need to make people's journey through all our services smoother and more efficient.

F: TO ENABLE PEOPLE TO HAVE MORE CHOICE AND CONTROL
We recognise the importance of person centred and outcomes focused care planning.

Links to National Health and Wellbeing Outcomes

1, 2, 3, 4, 5, 6, 7, 8, 9

Links to Model of Care

b, c, d, e

Why is change needed?

Currently, our health system in East Lothian appears to be overly dependent on hospital services; people can end up in hospital when they don't need to be there and equally have difficulty getting home again in a timely fashion.

- In East Lothian we have a higher overall rate of unscheduled hospital admissions than the Lothian average and longer stays in hospital. For these and for a range of other markers such as multiple hospital admissions and readmissions the picture varies significantly across our localities.
- East Lothian performs poorly compared to other Scottish Partnerships in terms of delayed discharges from hospitals
- Care for people nearing the end of life is one of the most important challenges we face. End of life care can be excellent no matter where it is delivered – in the community, in hospices or hospitals. In East Lothian we perform relatively well in supporting good end of life care outside hospitals, but there is significant variation across the county which we need to address.

Performance Indicators

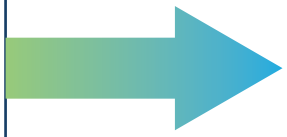
Performance indicators will be developed in detail as part of ongoing Strategy development, but will focus on improving the following outcomes and outputs, many of which link to other programmes:

- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.

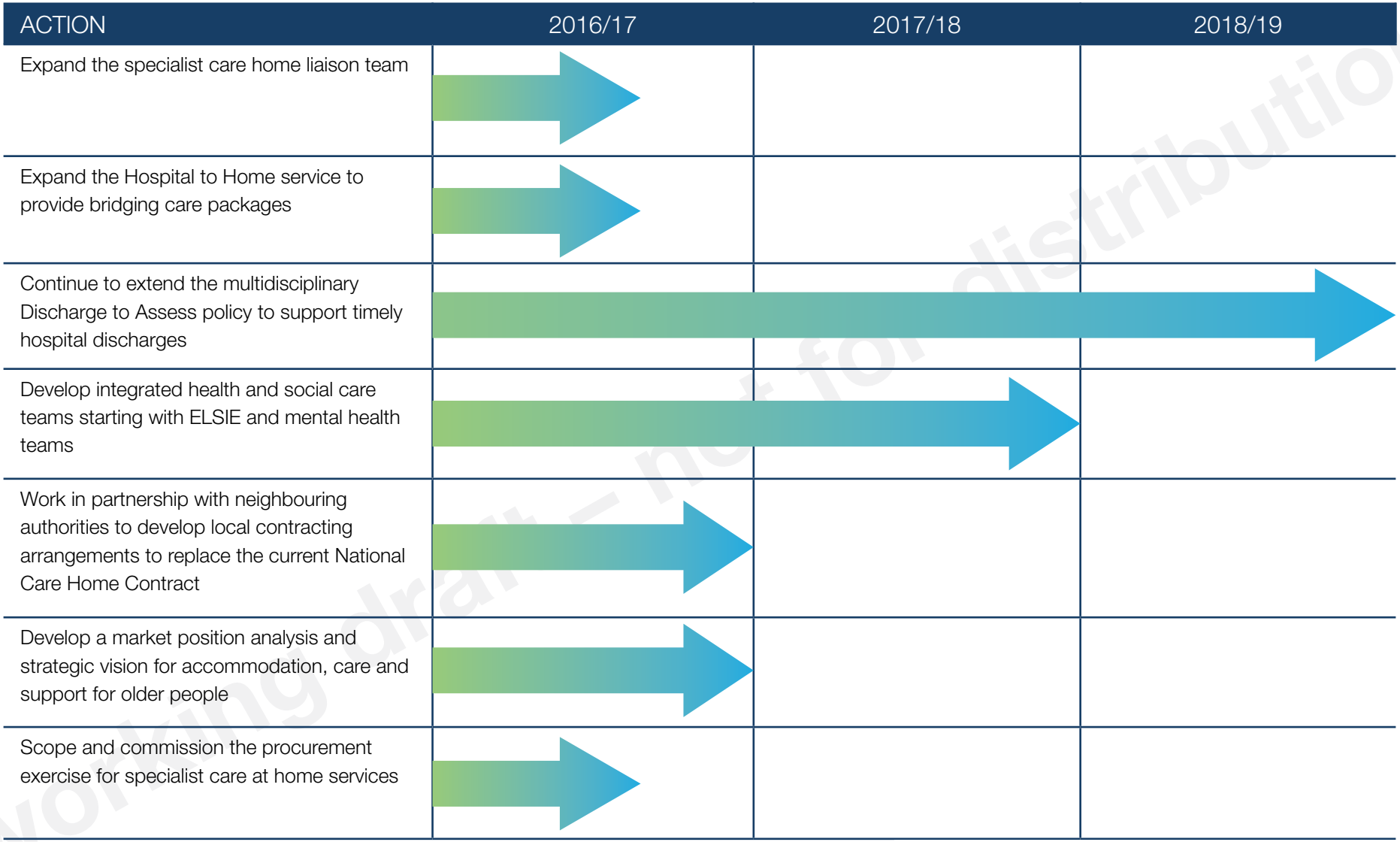
- Percentage of carers who feel supported to continue in their caring role.
- Rate of emergency admissions for adults.
- Rate of emergency bed days for adults.
- Readmissions to hospital within 28 days of discharge
- Proportion of last 6 months of life spent at home or in community setting.
- Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
- Percentage of adults with intensive needs receiving care at home.
- Number of days people spend in hospital when they are ready to be discharged.
- Percentage of people admitted from home to hospital during the year, who are discharged to a care home.
- Percentage of people who are discharged from hospital within 72 hours of being ready.

Additional resource implications

	2016/17	2017/18	2018/19
Integrated Care Fund ELSIE expansion	£800,000	£800,000	
Delayed Discharge fund: care home liaison team and Hospital to Home	£500,000	£500,000	
Mental Health Innovation fund: crisis support	£33,000		

ACTION	2016/17	2017/18	2018/19
Deliver a new East Lothian Community Hospital which provides comprehensive, safe, quality care closer to home for the population of East Lothian. Progress Outline Business Case (November 2015) Progress financial modelling Incorporate feedback from public consultation into planning application Progress bespoke workstreams on day surgery and endoscopy Progress workstream on integrated care facility modelling to consider flexible bed use Investigate and implement preferred options associated with the redevelopment of East Lothian Community Hospital which will support repatriation of East Lothian patients from Liberton and Midlothian Community Hospitals during 2017.			
Expand ELSIE (East Lothian Service for Integrated Care of the Elderly) to deliver: Specialist admission avoidance service 24/7 Specialist dementia care and support Specialist end of life care			

KEY: West Locality | East Locality | All East Lothian



ACTION	2016/17	2017/18	2018/19
Initiate early scoping, developmental and engagement work for the HTLAH contract framework			
Support the implementation of Self Directed Support in line with the national and local work plans.			

KEY: West Locality East Locality All East Lothian

Strategic Change Programme: Enterprise

East Lothian Strategic Objective

G: TO FURTHER OPTIMISE EFFICIENCY AND EFFECTIVENESS

Links to National Health and Wellbeing Outcomes

5, 7, 8, 9

Why is change needed?

We want to improve the quality of our services whilst recognising and addressing the challenging financial constraints we face.

Across all Partnerships in Scotland in 2013 East Lothian had the highest percentage of its total health and social care budget spent on unscheduled hospital admissions.

- Our needs assessment shows significant variation in rates and costs for hospital admissions across our localities.
- We have a range and variety of bed based models across the county. We need to consider the best use of the total health and social care estate available to us which most effectively meets current and future projections of need
- Health and Social Care Partnerships will be new entities. There is a need to develop technical and analytical capacity to map cost and activity data and to support planning for new service responsibilities
- The financial plan which underpins the Strategic Plan focuses on investment in those areas where we believe we can obtain maximum return in terms of quality, safety, responsiveness and equity. As a responsible and accountable organisation we will also look at areas of potential disinvestment where these parameters are not always met.

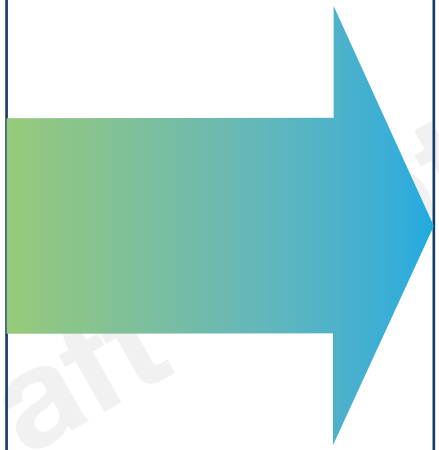
Performance Indicators

Performance indicators will be developed in detail as part of ongoing Strategy development, but will focus on improving the following outcomes and outputs, many of which link to other programmes:

- Percentage of staff who say they would recommend their workplace as a good place to work.*
- Proportion of last 6 months of life spent at home or in community setting.
- Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
- Number of days people spend in hospital when they are ready to be discharged.
- Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
- Percentage of people admitted from home to hospital who are discharged to a care home.
- Percentage of people who are discharged from hospital within 72 hours of being ready.
- Expenditure on end of life care.

Additional resource implications

	2016/17	2017/18	2018/19
Repatriation of East Lothian patients from Liberton Hospital			c£800,000 resource transfer to East Lothian
Repatriation of East Lothian patients from Midlothian Community Hospital			£1 million resource transfer to East Lothian
Public Sector Improvement framework development	£32,000	£32,000	TBA

ACTION	2016/17	2017/18	2018/19
Commission and complete a bed modelling exercise which scopes: 1. An understanding of the utilisation of existing provision and potential future need for community beds in a quality environment across health and social care in East Lothian 2. The appropriateness of different types of provision by locality 3. Local populations concerns, requests and need (consultation and engagement) 4. The economic feasibility of different models of existing, new or different models of care delivery 5. Existing estates including ongoing costs and investment, reinvestment or disinvestment required. This will specifically focus on the reprovided East Lothian Community Hospital ,on Edington, Belhaven, Abbey and Eskgreen facilities and deliver recommendations for future configurations of bed based models across the county. 6. A needs assessment for the Housing Contribution Statement aligned to the Strategic Plan			

KEY: West Locality East Locality All East Lothian

ACTION	2016/17	2017/18	2018/19
Commission and complete a financial exercise to better understand variation in spend and costs across localities and within the HSCP			
Commission and complete an exercise to map high resource use of health and social care services			
Continue to review, monitor and performance manage all externally provided services against Best Value principles			
Continue to performance monitor the relevant Care at Home framework to take account of integration and support the implementation of reablement			
Implement the annual East Lothian Prescribing Plan			
Embed the Public Sector Improvement Framework methodology into NHS services initially to establish an evidence based system of self evaluation which drives continuous improvement			
Develop a longer term financial strategy for the Partnership.			

KEY: West Locality East Locality All East Lothian

ACTION	2016/17	2017/18	2018/19
Develop a risk register for the Partnership			
Develop a Business Continuity Plan for the Partnership			
Develop a horizon scanning process for the Partnership in order to anticipate change, future proof planning and financial models			
Publish an annual Performance Report			

KEY: West Locality East Locality All East Lothian

East Lothian Strategic Objective

H: TO REDUCE THE HEALTH INEQUALITY GRADIENT

We want to reduce inequalities, break the cycle and impact of deprivation and support and protect the vulnerable in our communities.

Links to National Health and Wellbeing Outcomes

1, 2, 4, 5, 7, 9

Links to Model of Care

a, b

Why is change needed?

- The divisions in health expectations and outcomes between the most and least wealthy, powerful, educated and housed have existed and been acknowledged for a long time. We know these exist in East Lothian and addressing such inequalities and reducing the differences between those with the best outcomes and those with the poorest is a priority.
- The primary causes of health inequalities are complex and, although East Lothian's health is improving, attempts to address inequalities in our health and wellbeing have, so far, met with only limited success
- The least well-off and most vulnerable individuals and communities have the poorest access to primary health services and this remains an issue that the Partnership will need to consider.
- The Partnership recognises the need to consistently look at variation and distribution of services in line with need.

Performance Indicators

Performance indicators will be developed in detail as part of ongoing Strategy development, but will focus on improving the following outcomes and outputs, many of which link to other programmes:

- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- Percentage of people with positive experience of care at their GP practice.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Percentage of adults supported at home who agree they felt safe.
- Premature mortality rate.
- Rate of emergency admissions for adults
- Rate of emergency bed days for adults.
- Readmissions to hospital within 28 days of discharge.

Additional resource implications

	2015/16	2016/17	2017/18	2018/19
Health Promotion Funding: Area Partnership worker	£24,995			

ACTION	2016/17	2017/18	2018/19
Update the health and social care strategic needs assessment at least every 3 years at both locality and area partnership level			
Publish an annual report on the national health and care survey with a focus on access to care.			
Promote inequalities sensitive practice through our organisational development plan			
Undertake equality impact assessments as new health and social care strategies and policies are developed.			

KEY: West Locality East Locality All East Lothian

East Lothian Strategic Objective

I: TO BUILD AND SUPPORT PARTNERSHIP WORKING

We recognise the importance of developing effective and wide ranging strategic partnerships in delivering our ambition, vision and values.

Links to National Health and Wellbeing Outcomes

3, 4, 5, 6, 8

Why is change needed?

We recognise the need to build strong and effective relationships and partnerships both locally in East Lothian and more widely. The benefits should not simply be the closer integration of services and decisions that are better aligned with the needs of the people of East Lothian, but improved health and wellbeing as the overarching goal.

Performance Indicators

Performance indicators will be developed in detail as part of ongoing Strategy development, but will focus on improving the following outcomes and outputs, many of which link to other programmes:

- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good
- Percentage of people with positive experience of care at their GP practice.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Percentage of staff who say they would recommend their workplace as a good place to work.
- Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.

ACTION	2015/16	2016/17
The Integration Joint Board will establish a working partnership with East Lothian Community Planning Partnership in order to support achievement of the Single Outcome Agreement		
The Integration Joint Board will develop a working partnership with NHS Lothian in order to deliver the Lothian Hospital Strategic Plan		
The Integration Joint Board will develop a working partnership with the wider housing sector and housing providers to develop a Housing Contribution Statement and inform the Local Housing Strategy.		
The Integration Joint Board will work in partnership with the IJBs in Midlothian, West Lothian and City of Edinburgh to ensure consistency and effectiveness in pan Lothian services		
The Partnership will develop an organisational development plan which recognises the importance of partnership with our workforce		
The Partnership will develop a communication and engagement strategy which recognises the importance of partnership with service users and carers and staff		

KEY: West Locality East Locality All East Lothian

ACTION	2015/16	2016/17
The Partnership will establish an Independent Contractors Forum		
The Partnership will continue to develop close relationships with the third (voluntary) sector through the Third Sector Interface and other fora		
The Partnership will continue to support and work with ELIS (East Lothian Independent Sector) forum.		

KEY: West Locality East Locality All East Lothian

What will this mean?

The Strategic Plan has outlined the ambitions and strategic objectives of the IJB and a proposed set of transformation programmes which, as partners, we believe define the key aspects of what we are trying to achieve together. We recognise the enormity of the task ahead and realise that the Strategic Plan only gives a high level blueprint to work from. Implementing the Strategic Plan should, however, result in real change and improved outcomes for our population.

The wider performance framework will continuously monitor progress against the core suite of specific measures both qualitative and quantitative as outlined In Section 11. The IJB also need to consider wider impact measures to demonstrate a genuine shift in the balance of care over time. In order to demonstrate this shift we have adopted key overarching core measures, namely:

STRATEGIC IMPACT STATEMENT	Rationale	Where are we now?	Where do we want to be in 3 years?	Where do we want to be in 10 years?
% over 65s living safely at home This measure will be an amalgamated indicator of unscheduled acute bed days, including delayed discharges, care home utilisation and care at home hours	The Partnership wants to improve the experience and outcomes for our most vulnerable residents, enabling them to live more independent lives where possible and actively contributing to the wider community when they can. This measures the benefit to individuals from effective care closer to home services, including ELSIE, reablement, rehabilitation and intermediate care. It is intended to capture the joint work of health, social care, third and independent sector services as well as wider community support.	In development	TBA	TBA

STRATEGIC IMPACT STATEMENT	Rationale	Where are we now?	Where do we want to be in 3 years?	Where do we want to be in 10 years?
% spend of integrated budget on institutional care vs. community	Our commitment to shifting the balance of care from institutional to community based settings, as clinically appropriate, will only be achievable when we can work within the entirety of the resource committed to services including that used in acute hospitals. A shift in the balance of care requires a decisive shift in patterns of resource allocation and utilisation.	In development	TBA	TBA
Additional years of life / health inequality gradient	The Partnership wants to build healthier and more resilient communities and tackle the root causes of ill health. The measure is currently in development in conjunction with Public Health and ISD	TBA	TBA	TBA

Our change programmes will also use our fictitious residents, Callum, Hannah and Scott to test our thinking and our progress; success in delivering the Strategic Plan should mean real change for them. We will use our ongoing engagement and consultation processes to test what East Lothian people think our services should look like for Hannah, Scott and Callum and use this to inform the final version of our Strategic Plan.

Appendix 1

Strategic Planning Process

A1.1 Background

The Community Empowerment and Renewal Act and the Public Bodies (Joint Working) (Scotland) Act 2014 place a duty on Health and Social Care Partnerships to involve and engage with local professionals, the third and independent sectors, community representatives, service users and carers in the planning of health and social care services. In simple terms, this will require us to have effective, local services, planned in conjunction with local people which make the best use of the assets available within that locality.

There is also a requirement for each Partnership to identify a minimum of two localities within their partnership boundary.

The Public Bodies (Joint Working) (Scotland) Act requires each Integration Authority to establish a Strategic Planning Group, and includes the legislative requirements for membership of this group. The role of the Strategic Planning Group is in developing and finalising the Strategic Plan and in continuing to review progress measured against the statutory outcomes for health and wellbeing. The strategic plan should be revised as necessary (and at least every three years) with the involvement of the Strategic Planning Group.

A1.2 Local Process

A writing group of senior officers in health and social care has been established to draft initial versions of the Strategic Plan as part of a wider Strategic Planning Advisory Group chaired by the Joint Director.

Draft versions reflected the priorities identified in the Joint Strategic Needs Assessment and set out clearly the proposed outcomes and priorities for action.

As determined by statute, the Strategic Planning Group have reviewed and commented on iterations of the drafts of the Strategic Plan. There is a recognition of the need to demonstrate how local people have been involved in the consultation, engagement and development of the Plan and to support the Strategic Planning Group a wide consultation exercise was undertaken for the first draft and feedback considered (Appendix 6). This will be repeated for all future iterations.

A1.3 Strategic Planning Group Membership

Minimum membership of the Group is determined by Regulations. In East Lothian the shadow IJB has agreed additional membership to better reflect localities, priorities and key strategic links.

The group is chaired by Mike Ash, Vice Chair of the Integration Joint Board and is supported by senior officers of the Partnership responsible for developing drafts of the Strategic Plan. Membership of the Strategic Planning Group at September 2015 is outlined in Table 3.

Minimum membership required by regulations	Current Member (at September 2015)
Health professional who operates within the Local Authority area (this should be an individual, representative of health professionals, including doctors, nurses, allied health professionals)	Dr Jon Turvill
User of health care who resides within the Local Authority area (this should be an individual, representative of people who use health or social care services); User of social care who resides within the Local Authority area	Keith Maloney
Carer of users of health care who resides within the Local Authority area (this should be an individual, representative of carers of people who use health services); Carer of users of social care who resides within the Local Authority area	Margaret McKay
Commercial provider of health care who operates within the Local Authority area (this should be an individual, representative of the independent 'for profit' providers of health care services)	Position currently vacant. with nomination to be sought from the Independent Contractors Forum when established
Non-commercial provider of health care who operates within the Local Authority area (this should be an individual, representative of 'third sector', 'voluntary' or 'not for profit' providers of health care services)	Position currently vacant with nomination being sought via TSI for third sector provider of healthcare
Social care professional who operates within the Local Authority area (this should be a social service professional, with relevant social care)	Acting Chief Social Work Officer
Non-commercial provider of social housing within the Local Authority area	Esther Wilson
Third sector bodies within the Local Authority carrying out activities related to health or social care (this should be an individual, representative of interest groups, social enterprises or community organisations who are active in the area of health or social care).	Gayle Bell, STRiVE
Commercial provider of social care who operates within the Local Authority area (this should be an individual, representative of the independent 'for profit' providers of social care services);	Andrew Parfery representing ELIS (East Lothian Independent Sector forum)
IJB Health Board nomination	Professor Alex McMahon
IJB Local Authority nomination	Councillor Donald Grant
Localities (East locality and West locality as defined in the draft Strategic Plan): to secure effective and meaningful community involvement and engagement, and to embed the nuances of locality planning and priorities.	Positions currently vacant with nominations being sought via Area Partnership network
Additional Membership Role and Rationale	

Minimum membership required by regulations	Current Member (at September 2015)
NHS Lothian acute services: to ensure effective two way planning and implementation in key priorities and unscheduled care pathways	Dr Kay Anderson
Finance: to ensure congruence between the Strategic Plan and resources	David King
Strategic Change Programme leads as defined in the draft Strategic Plan: to ensure scrutiny and accountability for delivery.	Alison MacDonald
Consultant in Public Health medicine to ensure a consistent focus on inequalities.	Dr. Philip Conaglen
Registered Social Landlord (RSL) representative in line with Housing Advice Note	Anne Browning

A1.5 Supporting Planning Frameworks

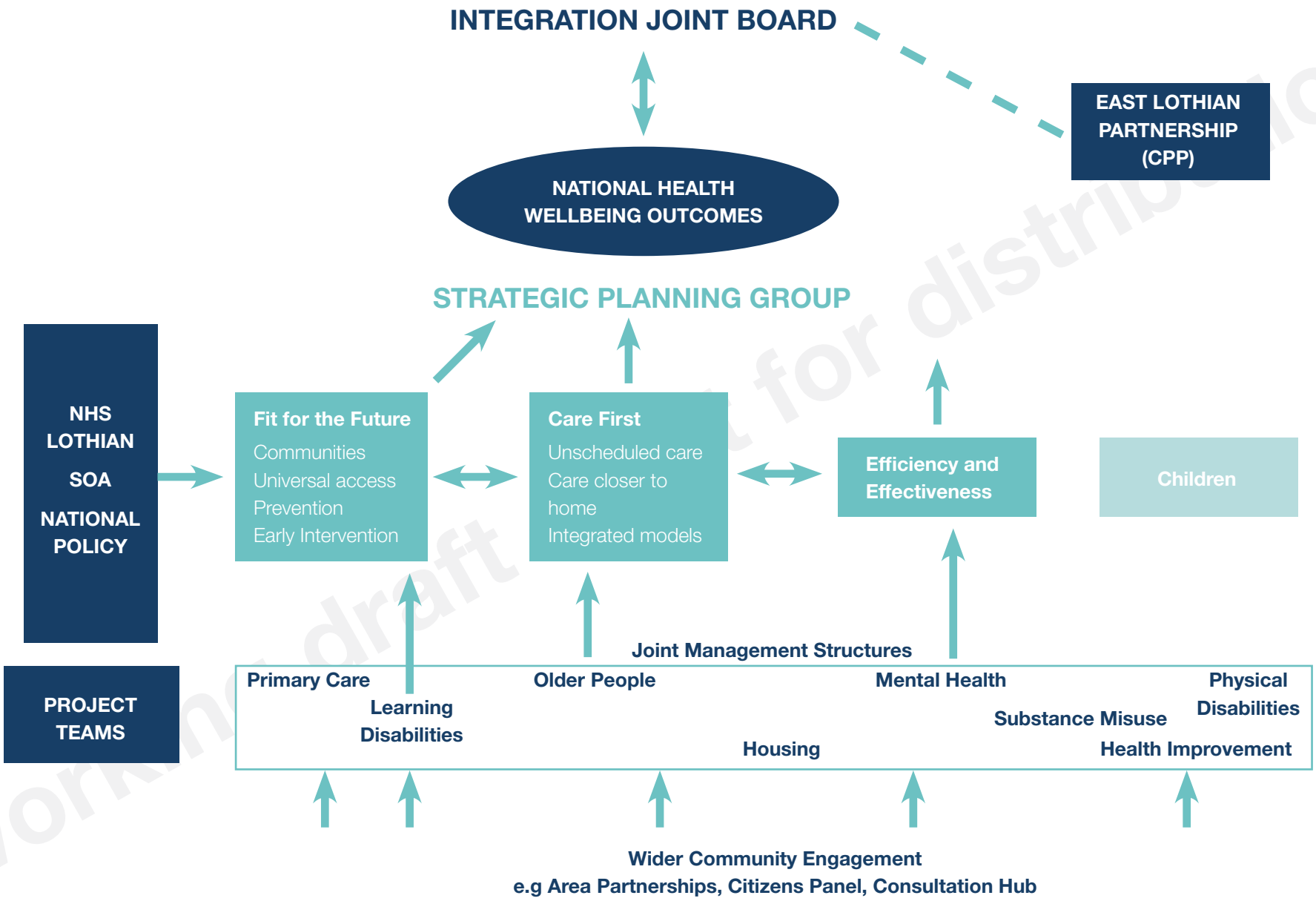
The IJB requires an effective strategic planning process which provides a framework to make decisions on how to allocate significant resources, meet objectives, address challenges and take advantage of opportunities that arise along the way. This framework also needs to align a wide range of plans, policies and resources within an overarching Strategic Plan.

In considering a planning framework for the Partnership a number of best practice markers were considered. The framework for delivering the Partnership's Strategic Plan needs to:

- Consistently have sight of the priorities for achieving our vision
- Have clear and agreed critical success factors - programmes of work which when completed, ensure the success of meeting the priorities.
- Track progress: it is important to report progress throughout the organisation and particularly at board level.
- Engage: Giving communities an effective voice, input and responsibility engages membership as active participants in the Strategic Plan

As a key development of integration locally, joint management structures for health and social care services are being embedded which broadly align with current client / care groups but which also recognise the additional services in scope for Health and Social Care Partnerships. Budgets will be aligned with this management structure.

The draft Strategic Plan also recognises the need to develop greater planning capacity and capability around cross cutting themes rather than being based solely on single care groups. An overall planning framework within the Partnership is currently being consulted on and is summarised below. This recognises the links between engagement, planning, plans and accountabilities at all levels of the Partnership.



Delegated Functions in Scope

Delegated functions relate to all adult services provided by the Health and Social Care Partnership delivered within the geographical boundaries of the Partnership. Relevant delegated inpatient and outpatient services in scope will also be delegated as described below.

A2.1 Services provided by the Health Board which will be delegated to the IJBs across Lothian are:

Accident and Emergency and Combined Assessment*
General Medicine*
Geriatric Medicine*
Rehabilitation Medicine*
Respiratory Medicine*
Palliative Care*
All Community Hospitals (Roodlands, Herdmanflat, Edington and Belhaven in East Lothian)
Mental health inpatient services[3]

Community nursing including children's community health services (district nursing, health visiting and school nursing)
Community mental health services
Community learning disability services
Community addictions services
Allied Health Professionals

Primary Care – General Medical Services, General Dental Services, General Ophthalmic services, Community Pharmacy[1]
Lothian Unscheduled Care Service[1]
Public Dental Service[2]
Palliative care provided outwith a hospital
Psychology services[2]
Community Continence[3]
Kidney dialysis services provided outwith a hospital
Community Complex Care

Sexual Health[3]

A2.2 Services provided by the Local Authority which will be delegated to the IJB are:

Social work services for adults and older people
Services and supports for adults with physical disabilities
Services and supports for adults with learning disabilities
Mental health services
Drug and alcohol services
Adult protection and domestic abuse
Carers support services
Community care assessment teams
Care home services
Adult placement services
Housing support services: aids and adaptations
Day services
Local area coordination
Respite provision
Occupational therapy services
Reablement services
Telecare

A2.3 Local additions

Criminal Justice Social Work services

A2.4 Specialist and Hosted Services

*East Lothian Partnership will work with NHS Lothian, Midlothian, West Lothian and City of Edinburgh Partnerships to develop the Lothian Hospitals Strategic Plan

[o]Midlothian Health and Social Care Partnership will host (manage) dietetics and art therapy services on behalf of the other Lothian Partnerships

[1]East Lothian Health and Social Care Partnership will host (manage) Primary Care and Lothian Unscheduled Care Service on behalf of the other Lothian Partnerships

[2]West Lothian Health and Social Care Partnership will host (manage) clinical psychology, the public dental service, podiatry and orthoptics on behalf of the other Lothian Partnerships

[3]City of Edinburgh Health and Social Care Partnership will host (manage) adult acute mental health services, adult psychiatric rehabilitation, continence services on behalf of the other Lothian Partnerships.

[3]Most sexual health services are delivered through General Medical Services in primary care. The specialist integrated sexual and reproductive health service in Lothian will be hosted by City of Edinburgh on behalf of the other Lothian Partnerships.

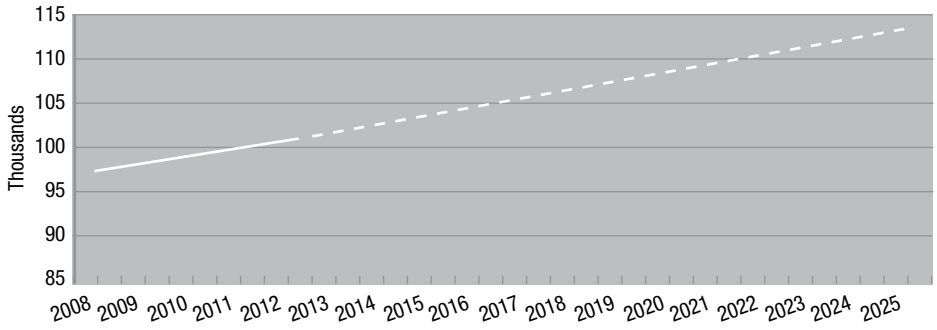
Locality Profiles

This Strategic Plan is based on two "localities" – West (Musselburgh, Fa'side and Preston Seton, Gosford wards) and East (Haddington and Lammermuir, North Berwick Coastal, Dunbar and East Linton wards).

Map showing East Lothian localities and the best fit for data zones 2011

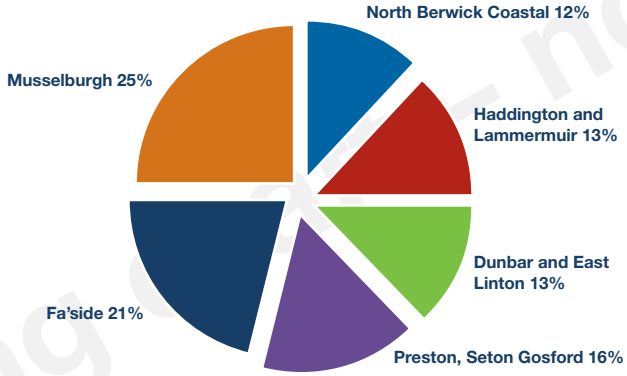
Locality	2012 Population	% 2012 Population
North Berwick Coastal	12,600	13%
Haddington and Lammermuir	13,106	13%
Dunbar and East Linton	13,356	13%
Preston, Seton, Gosford	16,566	16%
Fa'side	20,727	21%
Musselburgh	24,495	24%
East Lothian	**100,850**	

East Lothian Population in 2008-2025



A3.1 Demographics

Summary



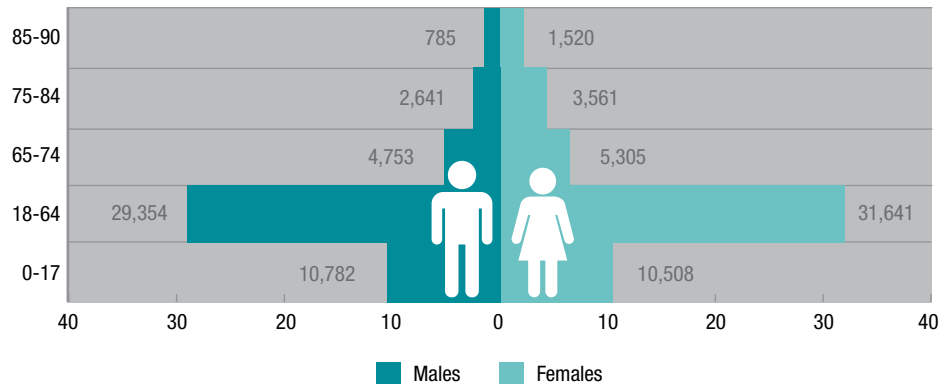
- In 2012, there were 100,850 people living in East Lothian, 52% females and 48% males.
- The East Lothian population is projected to grow by 12% between the years 2012 and 2025.
- Almost 20% of the population are aged 65 and over.
- Currently, approximately a quarter (24%) of the population live in the Musselburgh locality.

A3.2 Deprivation

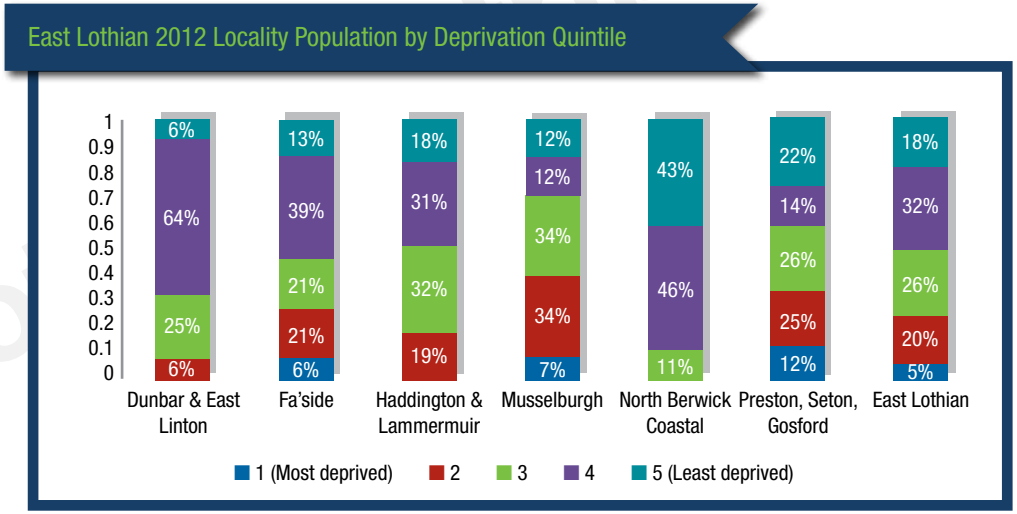
Summary

- Currently, approximately a quarter (24%) of the population live in the Musselburgh locality.
- Overall, 5% of the East Lothian population live in the most deprived Scottish quintile, while 18% live in the least deprived quintile. This varies by locality, with North Berwick Coastal locality having no residents in the most deprived quintiles.

East Lothian 2012 Population by Age Band and Sex



East Lothian 2012 Locality Population by Deprivation Quintile

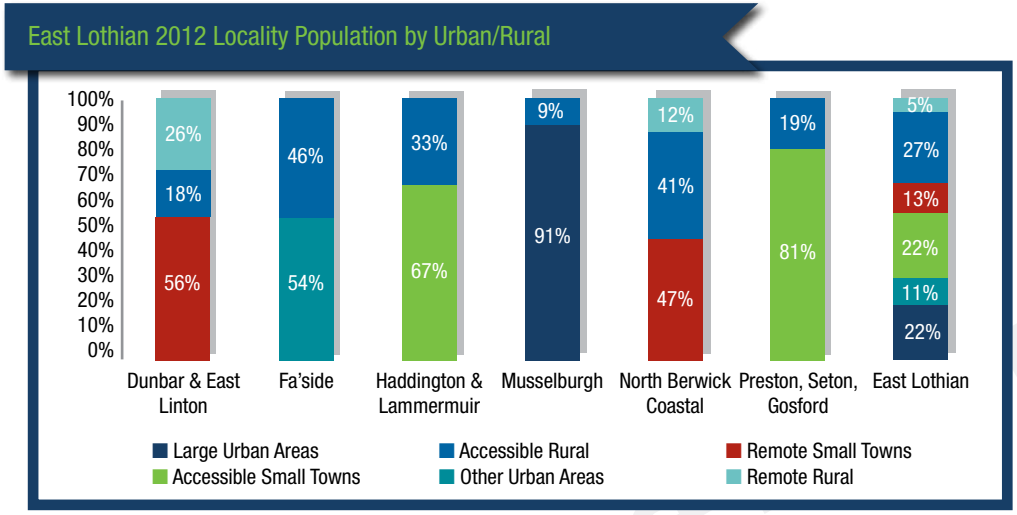


East Lothian 2012 Locality Population by Deprivation Quintiles

Deprevation Code		Dunbar & East Linton	Fa'side	Haddington & Lammermuir	Musselburgh	North Berwick Coastal	Preston, Seton, Gosford	East Lothian
	1 Most deprived	-	1,283	-	1,644	-	2,035	4,962
	2	742	4,302	2,469	8,391	-	4,166	20,070
	3	3,289	4,304	4,135	8,348	1,383	4,389	25,848
	4	8,563	8,153	4,109	3,052	5,833	2,336	32,046
	5 Least deprived	762	2,685	2,393	3,060	5,384	3,640	17,924

A3.3 Access: urban/rural

- Around 22% of the population are classed as living in a Large Urban Area. All of these residents are in the Musselburgh locality. Almost 27% of the population live in Accessible Rural areas.



Note: Population date by gender, age band, deprivation and urban/rural classification are sourced from NRS 2012 small area population.

For further information on Urban/Rural Classification see:

http://www.scotland.gov.uk/Topics/Statistics/About/Methodology/UrbanRuralClassification

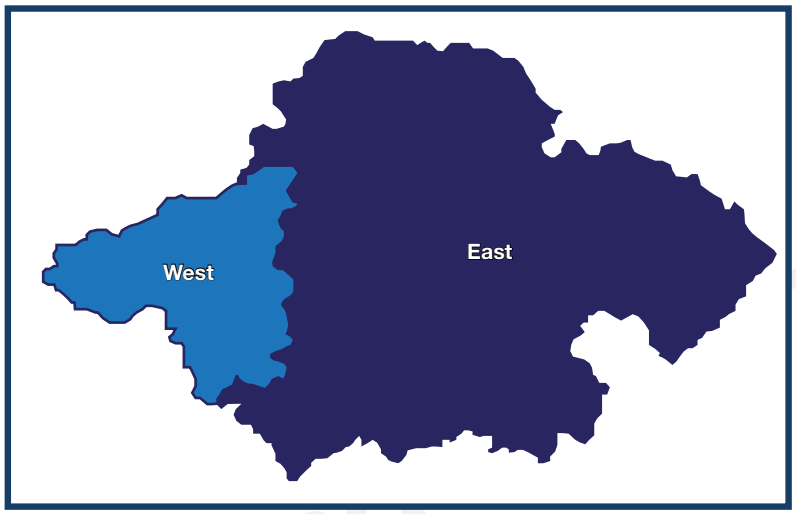
East Lothian 2012 Locality Population by Deprivation Quintiles

	Dunbar & East Linton	Fa'side	Haddington & Lammermuir	Musselburgh	North Berwick Coastal	Preston, Seton, Gosford	East Lothian
Large Urban Areas	-	-	-	22,268	-	-	22,268
Other Urban Areas	-	11,129	-	-	-	-	11,129
Accessible Small Towns	-	-	8,829	-	-	13,443	22,272
Remote Small Towns	7,371	-	-	-	5,934	-	13,305
Very Remote Small Towns	-	-	-	-	-	-	-
Accessible Rural	2,447	9,598	4,277	2,227	5,149	3,123	26,821
Remote Rural	3,538	-	-	-	1,517	-	5,055
Very Remote Rural	-	-	-	-	-	-	-

A3.4 Life Expectancy

- Life expectancy for both males and females in East Lothian was above the Scotland figure in 2011, 78.2 compared to 76.6 for males and 81.5 compared to 80.8 for females.
- The East sub-partnership area has had higher life expectancies than the West area for both males and females consistently since 2001.

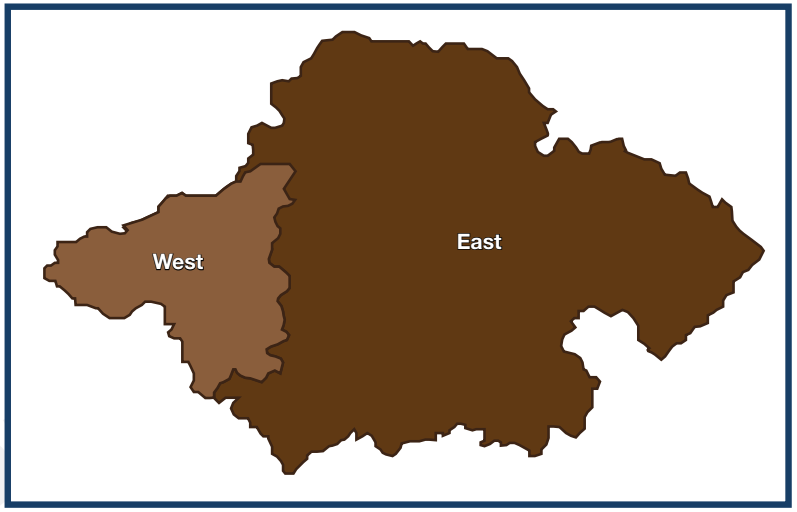
East Lothian Male Life Expectancy in 2011 by Sub-Partnership



Male Life Expectancy in 2011

■ Between 77 and 78 ■ Between 78 and 79

East Lothian Female Life Expectancy in 2011 by Sub-Partnership

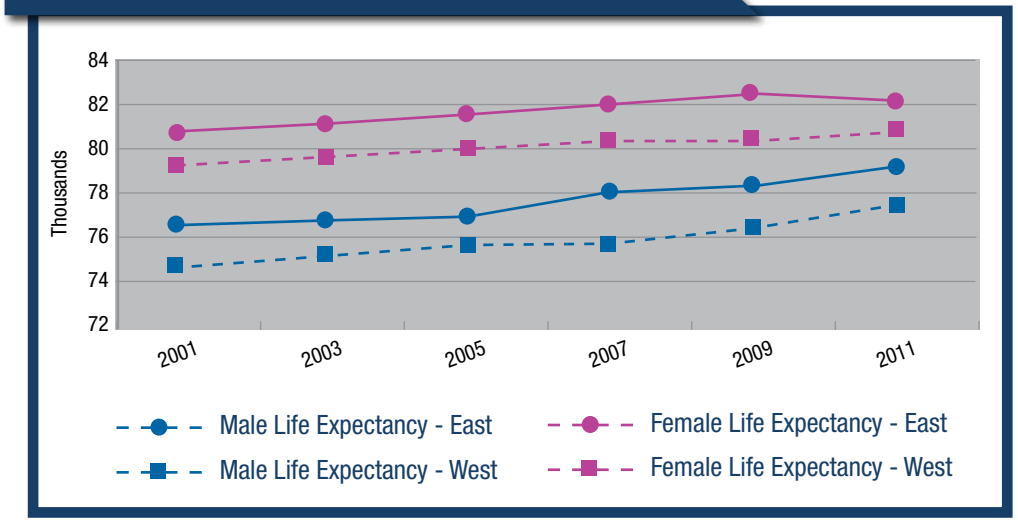


Female Life Expectancy in 2011

■ Between 80 and 81

■ Between 81 and 82.5

East Lothian Male/Female Life Expectancy by Sub-Partnership



East Lothian Male Life Expectancy in 2011 by Locality

Male Life Expectancy in 2011

- Between 76 and 77
- Between 77 and 78
- Between 78 and 79
- Between 79 and 80

East Lothian Female Life Expectancy in 2011 by Locality

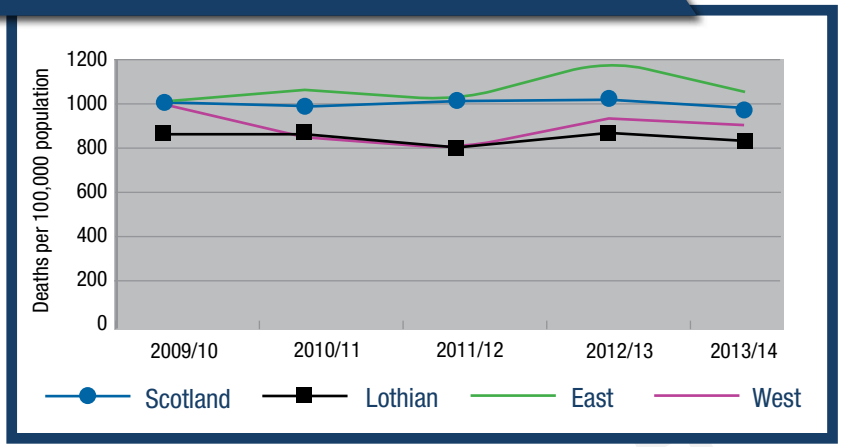
Female Life Expectancy in 2011

- Between 80 and 81
- Between 81 and 82
- Between 82 and 83

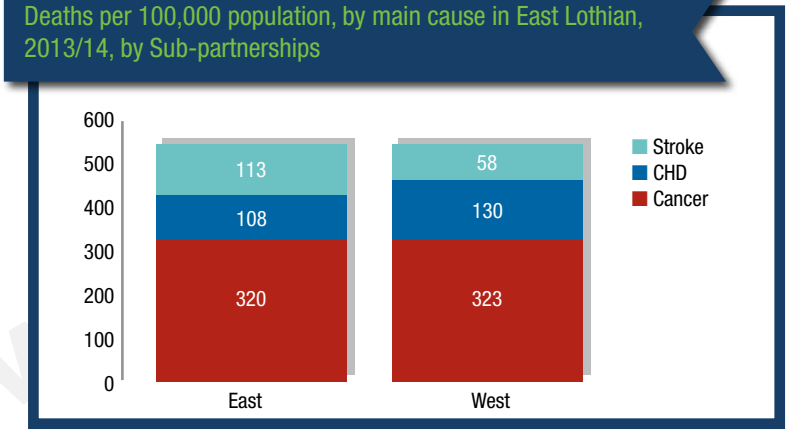
A3.5 Cause of Death

- 322 deaths per 100,000 population in East Lothian CHP in 2013/14 had cancer as the main cause of death. This is above the Scottish rate (293 deaths per 100,000).

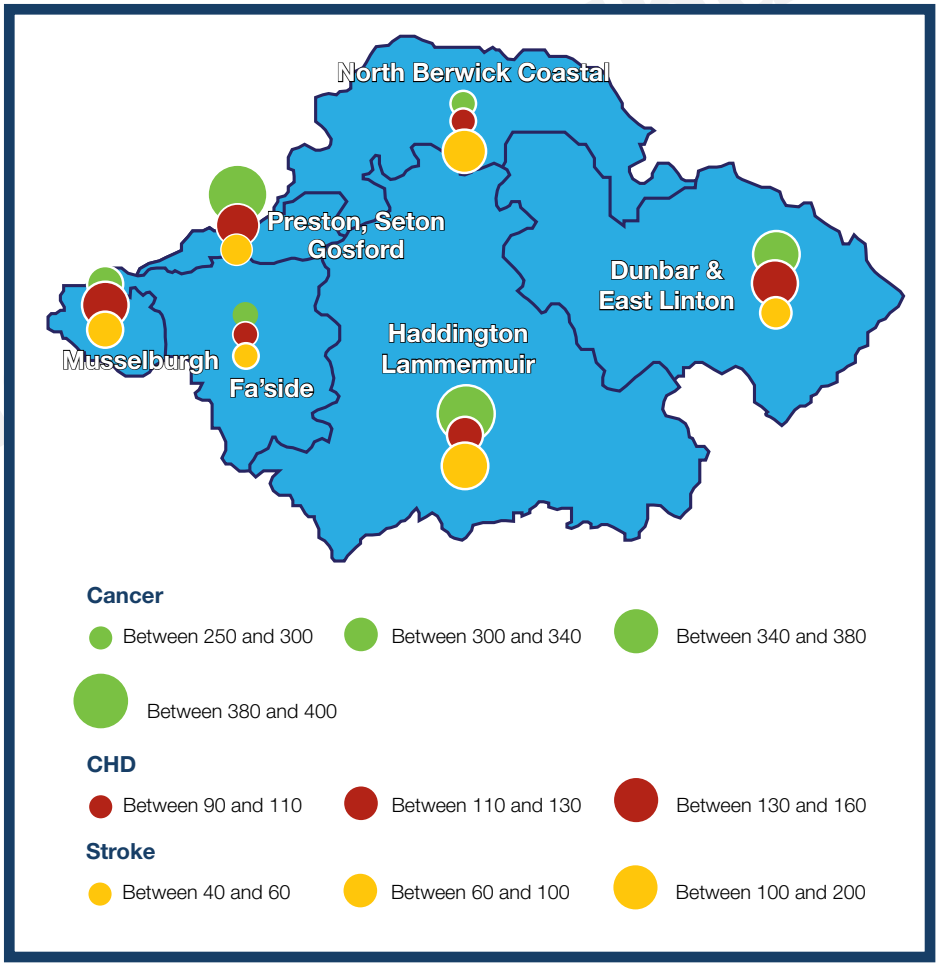
Deaths per 100,000 population by East Lothian sub-partnership area with Scotland and Lothian HB comparators



Deaths per 100,000 population, by main cause in East Lothian, 2013/14, by Sub-partnerships



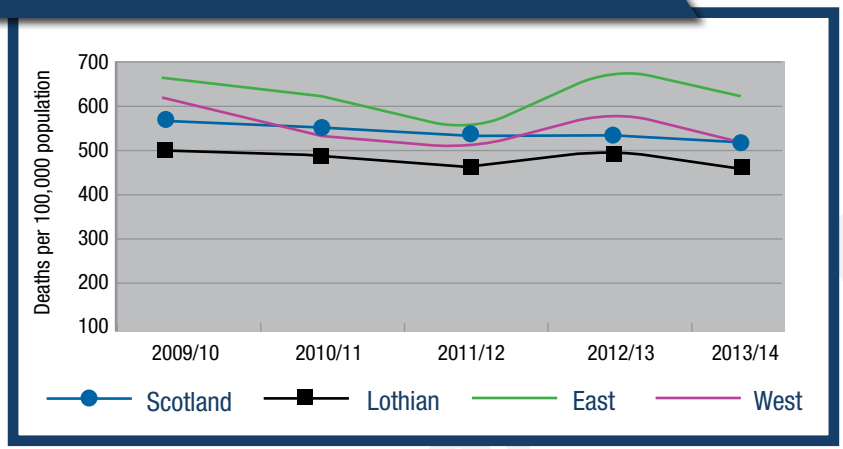
- East Lothian CHP is below the Scottish average for CHD as main cause of death in 2013/14, and close to the Scottish average for Stroke.



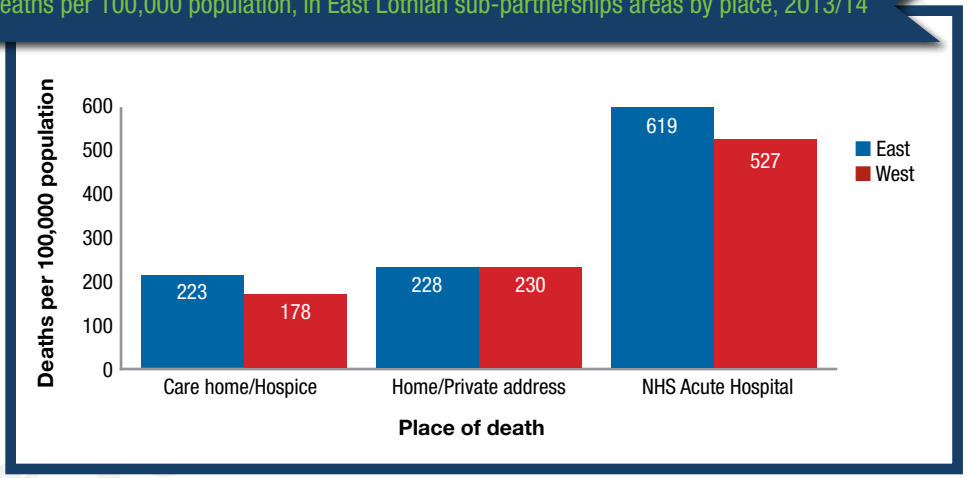
A3.6 Place of Death

- The rate of deaths which occur in NHS Acute Hospitals in East Lothian CHP (526.4 per 100,000 population) is above Scottish average (524.2 per 100,000 population).
- At sub-partnership level, the East area had a higher rate of deaths in NHS Acute Hospitals.

Deaths in Acute Hospital per 100,000 population by East Lothian sub-partnership area with Scotland and Lothian HB comparators



Deaths per 100,000 population, in East Lothian sub-partnerships areas by place, 2013/14



East Lothian's Joint Strategic Needs Assessment Process

A Joint Strategic Needs Assessment (JSNA) is an overview of the health and social care needs of an area. These assessments are not intended to be an exhaustive statement of everything we know about our county, it is more a narrative on the evidence gathered to identify the needs of our population now and in the future.

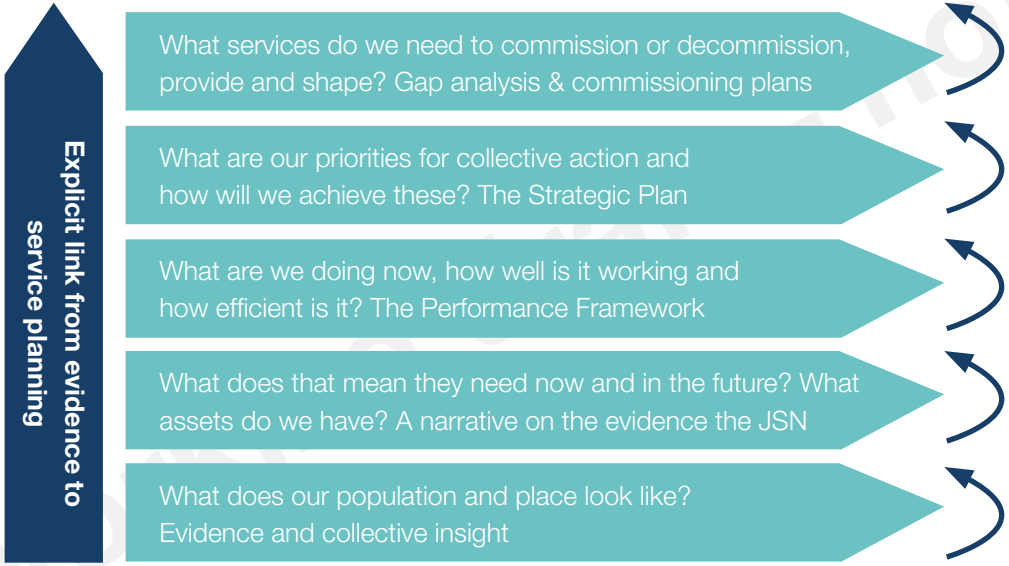
A JSNA is a part of the cycle which starts at assessing need, moves through to identifying priorities, embeds these in strategy and commissioning plans and then assesses outcomes and need, so starting the cycle again.

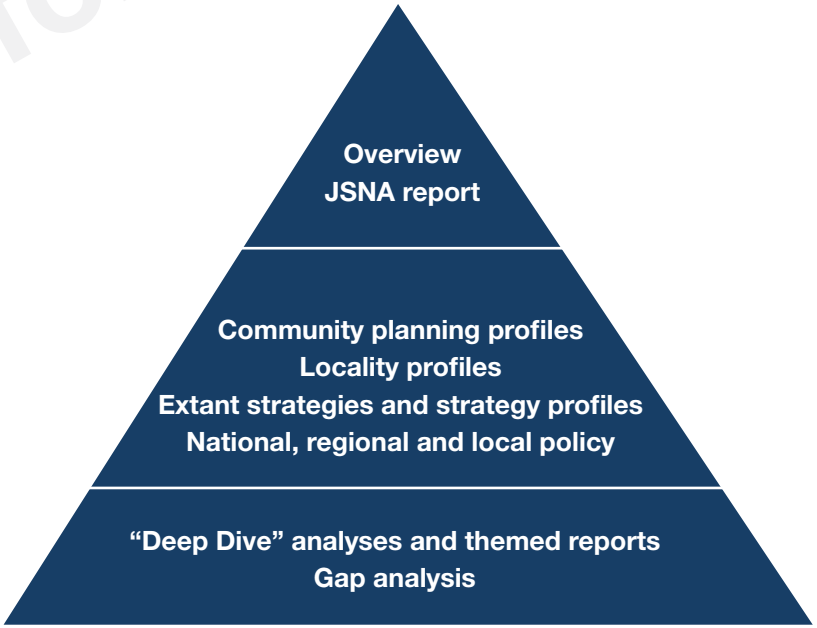
The JSNA, therefore, is just one step in the cycle - it identifies need. The next stages are for the Strategic Plan to be produced from agreed priorities identified from the assessment, and for these to be embedded into implementation or commissioning plans.

The identification of agreed priorities comes after an analysis of efficacy, evidence and resources to identify what can best address the needs of the population within resource and policy constraints.

The structure we have adopted for our JSNA approach is a "pyramidal" one, because of the size and complexity of East Lothian; when completed each level will provide a higher level of detail.

The full JSNA will be published on our website.





Draft Directions

The Public Bodies (Joint Working)(Scotland) Act describes how the Integration Joint Board will action its Strategic Plan by issuing "directions" to both the local authority and the Health Board as appropriate. Directions should be issued for each delegated function, including the associated financial resource.

In practice, Lothian Health Board and East Lothian Council will make payments to the IJB in respect of delegated functions and the IJB, via the mechanism of the Strategic Plan, will issue directions and make payment for delivery of the services in line with the Plan. Detailed work is ongoing in East Lothian to map directions to the detail of the Strategic Plan and delegated services; it is currently anticipated that a summary of directions from the IJB will be published with a final version of the Plan.

It is, however, anticipated that directions for 2016/17 will be a mixture of continuity and change. For the great majority of services it is likely (at time of writing) that the IJB will direct that services should continue as they are, but with a clear and consistent message of no change in investment or disinvestment without specific IJB direction..

In a small number of service areas it is anticipated at this stage that the IJB will require to direct change In Its first year of operation, whether through legislative imperative or as an immediate identified priority through the needs assessment and strategic planning processes.

Examples of anticipated change are outlined below.

Service change	Policy for 3 year period	Service(s) offered	Investment / Financial implications	Workforce implications	Estate implications
Unscheduled care activity	**Strategic intention** To reduce the rate of emergency admissions and related bed days per 100,000 of our 65+ population in the specialities of geriatric medicine, general medicine, rehabilitation medicine, psychiatry of old age and respiratory medicine over the course of this Strategic Plan. The IJB will issue a direction to NHS Lothian which matches this strategic intention with the aligned resource in the set aside budget over the period 2016-2019, allowing for demographic growth.	ELSIE expansion to 24/7 with enhanced specialist functions and support. Baseline and activity measurement and analysis by specialty. HRI mapping and analysis Aligned anticipatory care planning with HRIs at GP practice level	Integrated Care Fund £800,000 per annum 2015 - 2018	In line with ELSIE expansion	N/A
Bed base	**Strategic Intention 1** To ensure repatriation of East Lothian patients from Liberton Hospital and Midlothian Community Hospital to East Lothian by 2017 and the aligned financial resource **Strategic intention 2** To complete a review of Eskgreen and Abbey residential homes, Belhaven Hospital and Edington Hospital. The IJB will issue directions to NHS Lothian and East Lothian Council which match these strategic intentions with the aligned resource in the relevant budgets over the period 2016-2019.	Bed modelling and review in line with Strategic Plan, to include implications for Housing Contribution Statement	Release of aligned resource from East Lothian activity in Liberton Hospital and Midlothian Community Hospital to IJB		In line with outcomes of bed modelling / estate review

Service change	Policy for 3 year period	Service(s) offered	Investment / Financial implications	Workforce implications	Estate implications
Day Care services for Older People	**Strategic Intention:** To develop a modernisation strategy for the future of day services for older people in East Lothian which recognises need, geography and resource implications The IJB will issue a direction to East Lothian Council which matches this strategic intention with the aligned resource in the relevant budgets over the period 2016-2019.		TBD	Pressure on volunteer workforce Third sector capacity	In line with outputs of modernisation strategy and recommendations
Specialist Care at Home	**Strategic Intention:** To develop a co-produced, innovative model of care as the basis for a procurement exercise for specialist care at home services in East Lothian. The IJB will issue directions to East Lothian Council and NHS Lothian which matches this strategic intention with the aligned resource in the relevant budgets over the period 2016-2017		TBD		
Carers Strategy	**Strategic Intention:** To develop a fully revised Carers Strategy for East Lothian which recognises the importance of carers and which addresses the requirements of legislation The IJB will issue directions to East Lothian Council and NHS Lothian which matches this strategic intention with the aligned resource in the relevant budgets over the period 2016-2019		TBD in line with the financial memorandum	Likely to be significant in terms of enhanced assessment and support	

The Conversation: draft consultation feedback

A6.1 Consultation process

We are committed to engaging widely with the public and our partners to ensure we commission health and social care services that are in the best interests of the local population and patients.

Our intention is to develop this first Strategic Plan through listening to people who both deliver and use our services and we have already undertaken wide consultation on the first draft of the Plan to inform this next version. Amongst others, presentations have been given to third, independent sector and housing colleagues through forum meetings, workshops and networking events, to senior managers and clinicians in the health and social care sectors, to elected members, the shadow board and its strategic planning group, the six local area partnerships and their local communities and also to a number of smaller groups of interest. The draft Plan and consultation questions have been widely advertised and available on consultation hubs in East Lothian Council and NHS Lothian for staff, service users, carers and the public to make individual comments.

With events in each corner of the county, meetings with local groups and an online survey, we spoke directly to over 500 residents, professionals, service users, care providers and staff. Further detail on the consultation exercise and feedback can be found at http://www.eastlothian.gov.uk/downloads/file/10268/no_decision_about_me_without_me

A6.2 Consultation feedback

Overall, there was a high degree of support for the Partnership's draft ambitions and priorities. In particular, respondents felt that reducing health inequalities and creating a public sense of responsibility for their own health and care is important. There was much support for the plan to deliver more services in the local community.

Local groups highlighted the need for the continued development of constructive and supportive alternatives to hospital for people who wish to remain independent. However, care will need to be taken to ensure that achieving any targets we set around this does not overshadow individual patient-focused care.

We heard that that more education is needed for the public about the costs of unscheduled care and about using some services more appropriately. We also heard a strong view that all services and sectors need to plan and work better together to ensure that support is readily available in the community on a 24/7 basis to prevent crises. The provision and availability of equitable local services to serve the needs of all East Lothian people was also a strong and consistent message.

As well as treating physical conditions, there was much support for the focus on the link between long-term conditions and mental health problems. Mental health services, particularly lower level support, was a recurring theme locally, as was support for carers and their own health.

During the consultation exercise there was a clear and consistent theme that the new Health and Social Care Partnership has a unique opportunity to build relationships and partnerships from the outset; this includes partnerships with the public and local communities, with service users and carers, with staff and with neighbouring HSCPs.

The success of the HSCP in delivering health and wellbeing outcomes will be dependent on establishing such strong relationships and partnerships, so in line with consultation feedback this has been added as an additional key strategic priority for the Strategic Plan.

More detail on how we plan to engage with our stakeholders and how we want to develop such engagement further will be found in our Communication and Engagement Plan which will be published when agreed in early 2016.

Housing Contribution Statement

The Housing Contribution Statement is a key enabler of this Strategic Plan and will be further developed and finalised for inclusion in the final Plan.

The draft Housing Contribution Statement will be published as a separate Appendix on our consultation website.

Strategic Risk Register

Risk Management framework

All organisations should consider the major risks, both external and internal, that could impact on delivery of their Strategic Plan. For East Lothian's Health and Social Care Partnership these are described below with mitigating actions.

A9.1 Financial risk

Risk	Mitigation
Demand pressures Additional demand above that anticipated through modelling historical data and current demographic trends	Build in contingency Develop risk share arrangements Close monitoring of performance
Demand pressures Other partners' actions require specific additional investments	Build in contingency Develop a horizon scanning strategy
Demand pressures Implementation of full range of efficiency and productivity plans are delayed or do not yield full cost savings	Close monitoring and reporting of performance
Allocation pressures Financial imbalance caused by additional costs (e.g. transition costs, resource allocation modelling, overheads, analysis of set aside)	Horizon scanning strategy as part of risk management Performance monitoring & reporting Data analysis

A9.2 Quality risk

Risk	Mitigation
The quality of planned, redesigned or commissioned services is inadequate	Close contract and performance monitoring and reporting framework of providers Align and review services to national quality / best practice frameworks Establish PSIF (Public Sector Improvement Framework) as the joint quality performance framework for the Partnership.
Fragmentation of pathways of care through extending choice	Review mechanisms for tracking quality across pathways of care Commission integrated care models
New arrangements result in loss of "organisational memory"	Establish a succession planning process Establish a quality assurance process to continuously develop, review and revise policies and procedures jointly and severally.

A9.3 Organisational and reputational risk

Risk	Mitigation
Capacity and capability of the Strategic Planning Group is insufficient to oversee the development and monitoring of the Strategic Plan	Establish a needs assessment and training and development plan for both the IJB and Strategic Planning Group.
The IJB fails to engage effectively with key stakeholders in sharing the vision of the Strategic Plan and the case for change.	Establish a clear and agreed communication and engagement strategy Establish clear governance structures Engage public early in the case for change Develop a strong clinically led case for change

Prioritisation Framework

Impact

1. Severity: Does the issue or priority significantly affect well being?
2. Size: What is the number of people directly affected by the issue or proposal?
3. Will action have a positive impact on vulnerable groups?
4. Will action address improvement over multiple outcomes?
5. How significant will that improvement be?
6. Are there some critical gaps to which we need to give more attention?

Evidence and Strategic Fit

1. How strong is the evidence that we can:
   - Address the issue or priority through local action?
   - Lessen the severity of the issue being addressed?
2. Are there national, professional or organisational policies which set out what should be done?

Acceptability of possible changes

1. Does the issue or priority require whole partnership collective action?
2. Are plans and actions already in place? Does more need to be done?
3. Will the target groups or populations accept the need to change or the proposed action?

Feasibility

1. What levels of resources are required to implement the proposal?
2. Does it provide value for the investment required?
3. What are the impacts on other issues or priorities and programmes of action?

Contribution : Will the proposed priority and or actions facilitate the following?

1. Focus on narrowing the outcomes gap between individuals, groups and localities
2. Develop community capacity and resilience
3. Utilise population insight and intelligence to target programmes of action
4. Strengthen the role of early intervention and prevention in mitigating harm
5. Which issues are most important following consultation with our staff and with people who use our services?

Glossary

A&E: Accident and Emergency services are consultant-led services that are based within the main Hospitals. The main A&E services used by people from East Lothian are the Royal Infirmary and Western General Hospitals in Edinburgh.

Access: the availability of services – "getting the care you need"

Accountability: everything done by those who work in the statutory sectors must be able to stand the test of scrutiny, public judgement and professional codes of conduct.

Acute care: care provided by the larger general hospitals

Admissions: when a patient is admitted to hospital

Advocacy: the process of supporting someone to say how they feel about a specific issue that affects them or that they are concerned about. It might be about supporting someone in a meeting, helping someone to express their rights, helping someone to access service and information or helping someone to explore different options.

Allied Health Practitioner: A person registered as an Allied Health Professional with the Health Professions Council; they work in health care teams providing a range of diagnostic, technical, therapeutic and direct care and support services and include physiotherapists, dieticians, speech and language therapists, psychologists, occupational therapists, podiatrists, audiologists.

Asset-Based Approach: Mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits. The approach aims to empower individuals, enabling them to rely less on public services.

Assessment: Assessment of someone's health and social care needs, considering the circumstances of an individual, family, group or community when looking at a future plan of action.

Aids and Adaptations: Aids and adaptations can help older and disabled people to love independently in their own homes. They can reduce the risk of falls and other accidents in the home and can also reduce the need for home care or long-term admissions to a care home.

ALISS: A Local Information System for Scotland: A search and collaboration tool for Health and Wellbeing resources in Scotland. It helps signpost people to useful community support.

Anticipatory Care: anticipatory care can take many forms and is expected to help reduce avoidable and unscheduled acute admissions for people with pre-existing conditions. The purpose of advanced/ anticipatory care planning is to support the individual to have greater choice and control of care preferences through communication across the support team, across agencies and across care settings.

Beds: the number of beds in a ward or department which are staffed

Bed blocking: (also known as delayed discharge) where people who are medically fit to be discharged remain in acute hospital beds when other more suitable forms of care cannot be provided.

Benchmarking: a method used to gauge performance by comparing it to similar organisations

Best Value: a formal performance framework for Scottish Government to ensure a balance between cost and quality considerations in service provision across all public services.

BME: Black and minority ethnic groups

Body Corporate Model: The Body Corporate Model is a model of integration where a Health Board and Local Authority have both delegated the responsibility for planning and resourcing service provision for health and social care services to an Integration Joint Board, established as a separate entity.

Business plan: a plan setting out goals and identifying the resources and actions needed to achieve them.

Caldicott Guardian: All NHS organisations are required to appoint a Caldicott Guardian – a person who has responsibility for policies that safeguard the confidentiality of patient information.

Care Package: a term used to describe all the different types of care that make up the total care received by an individual. For example, they may receive support from Community Alarms and have home care. All these services together make up the 'Care Package'.

Care Pathway: the route followed by the service user into, through and out of NHS and social care services.

Care Plan: A single, overarching plan that records the outcome of discussion between the individual and the professional. It could be electronically stored or written on paper. It should be accessible to the individual in whatever form is suitable to them.

Carer: someone who spends a significant proportion of their time providing unpaid support to family or friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.

Change Fund: as part of the Reshaping Care for Older People initiative short-term funding was provided to NHS Boards and local authorities to refocus the health and social care of older people towards prevention and early intervention. The fund stopped in April 2015 with some services sustained as part of the mainstream health and social care services.

Change Management: Change management is a systematic approach to dealing with change of an organisation. There are three different aspects of change management; adapting to change, controlling change, and effecting change.

Chief Officer: Where the body corporate model is adopted a Chief Officer of the Integration Joint Board will be appointed to provide a single point of management for the integrated budget and integrated service delivery. They are accountable to the Integration Joint Board and to the Chief Executives of their Health Board and Local Authority for the delivery of integrated services.

Choice and control: Choice and control is about shaping serves to meet people's needs, rather than allocating people to fit around services.

Clinical Governance: a framework through which NHS organisations are accountable for continuously improving the quality of services and safeguarding standards of care.

Clinician: a health professional directly involved in the care and treatment of patients

CMHT: Community Mental Health Team

Co-creation: Involving users in service design (see co-production).

CoEL: Carers of East Lothian. Third Sector service providing support to carers.

Collaborative: working in partnership across organisations

Co-location: Co-located services are those that are established physically and organisationally as part of an integrated service. Co-location can be a key enabler in the development of integrated working at a service user's level.

Community Capacity: Activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take effective action and leading roles in the development of communities.

Community Planning: Community Planning is a process by which public agencies work in partnership with communities, the private and Third Sector to plan and deliver better services.

Co-morbidity: a term used to signify multiple illnesses

Commissioning: a process in which a service identifies need, assesses that need against provision and purchases services through contracts and service agreements.

Community capacity: activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take action and leading roles in the development of their communities

Community care: a network of services provided by local authorities in conjunction with the NHS and third sector to support people

Community health services: care and treatment provided locally, normally by district nurses, health visitors, midwives and community psychiatric nurses.

COPD: COPD (Chronic obstructive pulmonary disease) is the name for a collection of lung diseases. The main cause of COPD is smoking.

Co-production: Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way both services and neighbourhoods become more effective agents.

There is a difference between co-production and participation which means being consulted, while co-production means being equal partners and co-creators.

CoSLA: The Convention of Scottish Local Authorities is the representative voice of Scottish local government and also acts as the employers' association on behalf of all 32 Scottish Councils.

Delayed Discharges: Delayed discharges occur when a patient ready for discharge cannot leave hospital because the necessary care, support or accommodation is not available.

Delegation: Delegation is the process used to integrate functions, by giving responsibility for health and social care functions to a single body.

Demography: demography is the science of human populations – their size, composition and distribution – and the process through which populations change

Deprivation: a measure of material poverty based on a number of criteria such as income, economic circumstances and environment

Dietician: Dietetics is the interpretation and communication of nutrition science to enable people to make informed and practical choices about foods and lifestyle in health and disease.

DRRT: Duty Response and Rehabilitation Team. A multidisciplinary team within Adult Wellbeing who provide crisis intervention, aim to prevent admissions to hospital and care homes, facilitate hospital discharge and provide rehabilitation.

Early intervention: getting help for problems when they start which can prevent them developing into a more serious illness or situation

EL HSCP: East Lothian Health and Social Care Partnership: The Health and Social Care Partnership Is replacing existing Community Health Partnerships across Scotland.

ELC: East Lothian Council.

Elective Admissions: Planned admissions to hospital inpatient and day care services.

ELIS: East Lothian Independent Sector: The independent sector is the largest social services employer in Scotland as a whole. They employ 45% of the care delivery workforce in East Lothian.

ELP: East Lothian Partnership (Community Planning). The overarching partnership responsible for community planning in East Lothian.

ELSIE: East Lothian Service for Integrated Care of the Elderly. An integrated, co-located multi-disciplinary team incorporating 'Hospital at Home' and 'Hospital to Home' that provides urgent assessment, rapid response (health and social care), and rehabilitation for older people at time of crisis.

ELTRP: East Lothian Tenants and Resident's Panel. The independent umbrella organisation for tenants and residents groups in East Lothian.

Emergency admission: a hospital admission at short notice because of clinical need or because alternative care is not available

EMPCC: East & Midlothian Public Protection Committee. The East and Midlothian Public Protection Committee is the key strategic group dealing with public protection matters across East and Midlothian and includes representatives from key partners (Social Work, Police Scotland, NHS Lothian, Education, Housing, 3rd Sector).

EOL: end of life

Equality and Diversity Impact Assessment (EQIA); is a strategic process to be considered when planning a new, or redesigning an existing policy, function or service.

GDS: General Dental Services

Getting it Right for Every Child (GIRFEC): Getting it Right for Every Child (GIRFEC) is a programme of reform to place the child at the centre of service provision in Scotland.

GMS: General Medical Services

GP: General Practitioner – a doctor who works at a local surgery and provides medical advice and treatment.

Health Economy: a term used to embrace all the organisations whose activities have an effect on people's health in a local area. It can include the NHS and local authority services such as transport, environmental health, housing associations and voluntary organisations.

Health inequality: the term used to describe the fact that people living in deprived areas usually have poorer health than people living in more affluent areas. This can also apply to differences in the health of the people of various ethnic groups. Social inequalities operate through an unequal distribution of multiple resources, including income, wealth and power.

Healthy life expectancy: an estimate of how many years a person might be expected to live in 'full health' – that is, excluding the years lived in less than full health due to disease and/or injury.

HEAT Targets: The HEAT performance management system sets out the targets and measures against which Health Boards are publicly monitored and evaluated. HEAT is an acronym for Health Improvement, Efficiency and Governance, Access and Treatment - the four areas being targeted.

HILDA: Health and Independent Living with Daily Activities. A digital platform being developed by the Occupational Therapy (OT) service within Adult Wellbeing, to give good access to information regarding OT adaptive equipment and other health and social care services.

H@H: Hospital at Home. Alternative to hospital admission. Where appropriate, medical care is provided in the person's home or place of residence by an NHS Lothian medical and nursing team.

Home care or care at home: help provided directly to a service user in their own home. Home carers are people employed to provide direct

personal, physical, emotional, social or health care and support to service users, and are accountable for dealing with routine aspects of a care plan or service.

Hosted: responsible to a single statutory organisation but providing a service to a number of organisations

Hub: Area where principal community-based services will be concentrated. likely to cross several locality and neighbourhood areas.

IG: Information Governance ensures safeguards for the use of information.

Independent living: Independent living means having the same freedom, choice, dignity and control as other citizens at home, at work and in the community. It does not necessarily mean living by yourself or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life.

Independent sector: The Independent Sector encompasses individuals, employers and organisations contributing to needs assessment, design, planning, commissioning and delivery of a broad spectrum of health and social care, who are wholly or partially independent of the public sector. This includes care homes, private hospitals and home care providers as well as consultancy and research work.

Integrated Care Pathway: improving the route for treatment through different health and care systems by better coordination

Integration: Integration is the combination of processes, methods and tools that facilitate integrated care.

Integration Authority: An Integration Authority is the body that is responsible for planning integrated care. It will decide which integrated services will be provided, how they will be funded and what they should look like. and also direct the Health Board and Local Authority to deliver those services. The body that acts as the Integration Authority for a particular area will be determined by reference to the model of integration used in that area.

Integrated care: Integrated care focuses on improving services in relation to access, quality, user satisfaction and efficiency. The aim is to enable better coordinated, joined-up and more continuous care, resulting in improved patient experience whilst achieving greater efficiency and value from health and social care delivery systems.

Integrated Care Fund: A national fund which supports the delivery of improved outcomes from health and social care integration, helps to drive the shift towards prevention and further strengthen the Partnership's approach to tackling inequalities.

Integrated functions: The services that Integration Authorities will be responsible for planning are described in the Act as integration functions. The legislation sets out which NHS and social care services must, may and cannot be delegated as part of the integration arrangements.

Integration Joint Board: Where the Body Corporate model is adopted, the NHS Board and Local Authority will create an Integration Joint Board (IJB) made up of representatives from the Health Board, the Local Authority, the Third and Independent Sectors and those who use health and social care services. The Integration Joint Board, through its Chief Officer, will have the responsibility for the planning, resourcing and the operational oversight of integrated services within the strategic plan. The Integration Joint Board will exercise control over a significant number of functions and a significant amount of resource.

Integration Scheme: An Integration Scheme is the agreement made between the Health Board and the Local Authority. It sets out the make-up of the Integration Authority and how it will work. The Health Board and the Local Authority must submit their draft Integration Scheme to Scottish Ministers for approval by 1 April 2015. Integration Schemes

must be reviewed by the Health Board and Local Authority at least every five years.

Intermediate care: care for people who are not unwell enough to be in an acute hospital but not well enough to be at home without support.

Intermediate Care services support people to improve their independence and aim to provide a range of enabling, rehabilitative and treatment services in community and residential settings. The term has been defined as a "range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living"

ISD: Information and Statistics Division. The information Services Division is part of NHS National Services Scotland and provides health information, health intelligence, statistical services and advice that supports quality improvement in health and care and facilitates robust planning and decision making.

Joint Strategic Commissioning (JSC): The term used for all the activities involved in assessing and forecasting needs, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget.

JSNA: a Joint Strategic Needs Assessment pulls together all the information available on the needs of a local population and analyses them to identify the major issues to be addressed regarding health and wellbeing. The main goal of a JSNA is to accurately assess the health and care needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities.

Lead Agency Model: The Lead Agency Model of integration where the Health Board or the Local Authority takes the lead responsibility for planning, resourcing and delivering integrated adult health and social care services.

Locality Planning: Locality planning is intended to keep the focus of integration on improving care in the local communities. Every IJB must define at least two localities within its boundaries for the purpose of locality planning.

Long term conditions: Long-term conditions are conditions that last a year or longer, impact on many aspects of a person's life, and may require ongoing care and support. The definition does not relate to any one condition, care group or age category, so it covers adults and older people as well as children and those with physical and mental health issues. Long-term conditions become more prevalent with age. Common long-term conditions include epilepsy, diabetes, some mental health problems, heart disease, chronic pain, arthritis, asthma and chronic obstructive pulmonary disease.

LUCS: Lothian Unscheduled Care Services. NHS Lothian out of hours service.

Managed Clinical Network/Managed Care Network (MCNs): Linked groups of health professionals and organisations from primary, secondary and tertiary care working in a co-ordinated manner. A clinical network is usually based around single or linked condition (cardiac, stroke, diabetes etc.) but at national and regional level can be even more precise. A care network focuses on care groups such as older people.

Market Facilitation: Mark facilitation is a key aspect of the strategic commissioning cycle. Authorities will undertake a range of activities to promote the successful development of services to meet the needs of the local population effectively. These activities should include the development of an accurate picture of local need and markets, published as a Market Facilitation Plan.

MELDAP: Midlothian & East Lothian Drug and Alcohol Partnership. A Partnership, which includes Midlothian and East Lothian Councils, NHS Lothian, Lothian and Borders Police and the voluntary sector to raise awareness of the work that is being done to reduce the harm caused to individuals, families and communities by the misuse of alcohol and drugs.

Morbidity: The incidence or prevalence of a disease or of all diseases in a population.

Mortality: The death rate, which reflects the number of deaths per unit of population in any specific region, age group, disease, or other classification, usually expressed as deaths per 1000, 10,000 or 100,000.

Multidisciplinary Team (MDT): A team made up of professionals across health, social care and Third Sector who work together to address the holistic needs of their patient service users/clients in order to improve delivery of care and reduce fragmentation.

Multimorbidity: Multimorbidity is the presence of two or more long-term health conditions.

National Health and Wellbeing Outcomes: The nine national health and wellbeing outcomes provide a national framework for measuring the effect of integrated health and social care services on the health and wellbeing of individuals.

Occupational Therapy: Occupational Therapy gives people the tools and the skills to promote health, wellbeing and independence through participation in activities or occupation. Occupational Therapists will analyse someone's physical, psychological, social, cognitive and environmental needs, and provide rehabilitation or develop new strategies to enable people to continue to do the activities they need or want to do.

Organisational Development Plan: Deliberately planned, organisation-wide effort to increase an organisation's effectiveness and/or efficiency to enable the organisation to achieve its strategic goals.

Personal Outcomes: Personal outcomes are about the impact or end result of services, support or activity on a person's life.

Personalisation: Personalisation is a means of giving service users more control over the services and support they receive, and includes Self Directed Support, asset management and co-production. Personalisation reinforces the idea that the individual is best placed to know what they need and how those needs can best be met. It means that people can be responsible for themselves and can make their own decisions about what they require, but that they should also have information and support to enable them to do so.

Person-centred: Person-centred is an approach to working with people which respects and values the uniqueness of the individual and puts the individual's needs and aspirations firmly at the centre of the process.

Physiotherapist: Physiotherapists support people with physical problems caused by illness, accident or ageing. A physiotherapist's core skills include manual therapy, therapeutic exercise and the application of electro-physical modalities.

Planning and delivery principles: The principles that underpin the making of arrangements for integration, and the strategic planning of integrated services, will inform how services are planned and delivered. They explain what people using services and their carers can expect from integrated services and the behaviours and priorities expected of organisations and people planning and delivering care and support.

Podiatry: Podiatrists/chiropodists diagnose and treat abnormalities of the lower limb. They offer professional advice on preventing foot problems and care.

PCCO: Primary Care Contractors Organisation. A department of NHS Lothian that agrees contracts for General Medical, Dental, Ophthalmic and pharmacy services.

Prevention (Primary, Secondary and Tertiary): Primary Prevention includes health promotion and requires action on the determinants of health to prevent disease occurring. Secondary Prevention is essentially the early detection of disease, followed by appropriate intervention, such as health promotion or treatment. Tertiary Prevention aims to reduce the impact of the disease and promote quality of life through active rehabilitation.

Preventative interventions: Action taken to support people to do things for themselves as much as possible.

Primary Care: Health care provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment. Main primary care services are provided by GP Practices, dental practices, community pharmacies and high street optometrists, as well as community nurses and allied health professionals.

Programme Budgeting Marginal Analysis: A method for separating healthcare spending into categories for analysis. It looks at the marginal benefits that can be made by moving investment to more cost-effective programmes or interventions. PBMA information could inform discussions such as:

Could better value for money be achieved by expanding investment in preventative activities?

Does the distribution of expenditure between programmes reflect the priorities for the Partnership?

Could better value for money be obtained by redistributing among programmes?

Proportionate Universalism: The opposite of the inverse care law, i.e. reducing health inequalities through universal actions that are delivered with a scale and intensity that is proportionate to the level of disadvantage.

Psychology: Psychology is the scientific study of human thought and behaviour. Clinical psychologists help a wide range of people of all ages with all sorts of problems, such as emotional or mental health problems, and people with difficulties with their thinking, such as problems with memory or perception after a head injury, a learning disability or dementia.

Quality Strategy: The Healthcare Quality Strategy for Scotland is the approach and shared focus for all work to realise the 2020 Vision. It aims to deliver the highest quality healthcare to the people of Scotland to ensure that the NHS, Local Authorities and the Third Sector work together, and with patients, carers and the public, towards a shared goal of world leading healthcare.

RCOP: Reshaping Care for Older People. A Scottish Government initiative aimed at improving services for older people by shifting care towards anticipatory care and prevention.

Reablement: Reablement is about giving people the opportunity and the confidence to relearn or regain some of the skills they may have lost as a result of poor health, disability, impairment or entry into hospital or residential care. As well as regaining skill, reablement supports service-users to gain new skills to help them maintain their independence.

Scottish Patients at Risk of Readmission (SPARRA): A tool which predicts a patient's risk of emergency admission and therefore can be used to identify those people at greatest risk of emergency admission to hospital over the following year.

Secondary Care: Medical care provided by a specialist or facility. Referral would be made by a primary care physician that requires more specialised knowledge, skill or equipment.

Self-Directed Support (SDS): The support individuals and families have after making an informed choice on how their individual budget is used to meet the outcomes they have agreed.

There are four options that Partnerships will have a duty to offer;

- the local authority makes a direct payment to the supported person in order that the person can then use that payment to arrange their support.
- the supported person chooses their support and the local authority makes arrangements for the support on behalf of the supported person.
- the local authority selects the appropriate support and makes arrangements for its provision by the local authority.
- a mix of options 1,2 and 3 for specific aspects of a person's support.

Self-management: Self management encourages people to take decisions and make choices that improve their health, wellbeing and health-related behaviours.

Shadow Integration Board: Interim local shadow Integration Boards have been set up to manage transitional integration arrangements until integration goes live from April 2016

Shifting the balance of care: Changes at different levels across health and care systems intended to bring about better health outcomes for people.

Single Outcome Agreement: The Single Outcome Agreement is an agreement between the Community Planning Partnership and the Scottish Government. The SOA also includes an action plan to show how performance targets and Performance Indicators measure progress.

Speech and Language Therapy: Speech and Language Therapy assesses, treats and helps to prevent speech, language and swallowing difficulties.

Staff Governance (NHS Scotland): Staff Governance is an NHS Scotland system of corporate accountability for the fair and effective management of staff. It requires that staff are well informed, appropriately trained, involved in decisions, treated fairly and consistently and provided with a continually improving and safe working environment.

Staff Partnership: Staff Partnership describes the process of engaging staff and their representatives at all levels in the early stage of the decision-making process.

Strategic Commissioning: Strategic Commissioning is a way to describe all the activities involved in:

- assessing and forecasting needs
- links investment to agreed desired outcomes
- planning the nature, range and quality of future services; and
- working in partnership to put these in place

This is the process that informs the Integration Authorities' Strategic Plans.

Strategic Plan: The Strategic Plan is at the heart of integration and is intended to be the means by which services are redesigned in an integrated way to improve the quality and coherence of care for people using them.

Each Integration Authority must put in place a Strategic Plan for functions and budgets under its control.

STRiVE: Third Sector Interface (TSI) in East Lothian.

Supported Living: Supported living is an alternative to residential care or living with family members that enables adults with disabilities to live in their own home with the help they need to be independent.

Technology Enabled Care/Telehealth Care: Telecare and telehealth is technology that can be used to help service users live safely and independently in their home. 'Telehealthcare' is used as an overarching terms to describe both telehealth and telecare together.

Third Sector: 'Third Sector organisations' is a term used to describe the range of organisations that are neither public sector nor private sector.

It includes voluntary and community organisations, social enterprises, mutuals and co-operatives. It also includes local intermediary organisations (Third Sector Interfaces).

Tertiary Care: Highly specialised medical care involving advanced and complex procedures and treatments performed by medical specialists working in a centre that has personnel and facilities for special investigation and treatment. Referrals are usually made from secondary medical care personnel, but occasionally from primary care personnel.

Transformational Leadership: As opposed to the management of the delivery of services, Transformational Leadership relates to the ability to inspire, motivate and engage.

Equality Impact Assessment

An Equality Impact Assessment exercise on the Strategic Plan is being carried out in November 2015. The results of this will be published on our website when completed and used to inform the final version of the Plan for East Lothian.

Get involved!

Thank you for reading this second consultation draft of East Lothian Health and Social Care Partnership's Strategic Plan for adult services. We have also summarised the full draft Strategic Plan which is available on our website

www.eastlothian.gov.uk/info/200497/integrating_health_and_social_care

We want to hear as many views as possible to help shape our final Strategic Plan and ensure that it meets the needs of people in East Lothian.

Our questionnaire seeks your views on the draft Strategic Plan being proposed. It is an opportunity for you, and everyone who uses health and social care services, to shape the development of the new Health and Social Care Partnership in East Lothian so we can deliver the best possible services for our communities. Your views are really important to our success.

Now you've read the Plan, why not take part in our online survey at the East Lothian Council Consultation Hub at

https://eastlothianconsultations.co.uk

or at the NHS Lothian Consultation zone at

http://www.nhslothian.scot.nhs.uk/OurOrganisation/Consultations/Pages/defau!t.aspx

Alternatively you can answer the following questions and either email your comments to us at consultations@eastlothian.gov.uk

or

send them to the address provided at the end of this form

You can also get a further paper copy of the questionnaire by emailing us at consultations@eastlothian.gov.uk or phoning us on 01620 827138.

This consultation ends on January 26th 2016.

QI. Which version of the draft Strategic Plan did you read?

- ☐ Summary version only
- ☐ Full version only
- ☐ Both the summary and full versions

Q2 The draft strategic objectives in the Plan for adult services are :

- ☐ Making universal services more accessible and developing our communities
- ☐ Improving prevention and early intervention
- ☐ Reducing unscheduled care
- ☐ Providing care closer to home
- ☐ Delivering our services in a more integrated way
- ☐ Enabling people to have more choice and control
- ☐ Optimising efficiency and effectiveness
- ☐ Reducing health inequalities
- ☐ To build and support partnership working

To what extent do you agree that these should be our priority areas?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ I don't know

Comments

Q3. The actions (the strategic change programmes) in the draft plan are intended to address these priority areas effectively. Do you agree that what we intend to do will help achieve thee changes needed over the next three years? Do you:

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ I don't know

Comments

Q4. Implementing the Strategic Plan will help to improve outcomes for people in East Lothian. Do you:

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ I don't know

Comments

Q5. Have we missed anything that is really significant? If so, what?

Q6. Do you have any other comments to help in the development of the final version of the StrategicPlan?

Q7. Which group do you belong to?

- ☐ NHS / Council staff
- ☐ Voluntary sector
- ☐ Independent sector
- ☐ Member of the public
- ☐ Other

Thank you!

Please send this form by email to :consultations@eastlothian.gov.uk or post to:
East Lothian Strategic Plan Consultation
c/o Transformation and Integration Manager
East Lothian Health and Social Care Partnership
John Muir House
Brewery Park
HADDINGTON
East Lothian