East Lothian
Integration Joint Board

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 26 October 2017

BY: Chief Officer

SUBJECT: HSCP Performance Report and Directions Update

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1 PURPOSE

1.1 To update the Integration Joint Board (IJB) on the East Lothian Health and Social Care Partnership's (HSCP's) performance against the agreed suite of indicators.

1.2 To inform the IJB of progress in developing a report template on performance against all the Directions applying in 2017/18. Some of these are continuing Directions from 2016/17, others are new Directions introduced in 2017/18.

1.3 Any member wishing additional information should contact the authors of the report in advance of the meeting.

2 RECOMMENDATIONS

The IJB is asked to:

2.1 Discuss the attached September 2017 performance report (appendix 1) and note changes in some indicators since the last report up to the period June 2017.

2.2 Note the development of a monitoring template (appendix 2) for the Directions and the intention to continue development of Directions reporting through the year.

2.3 Allow the development of more informative trend data, which is intended to be more informative than some of the current data. An example would be table 2 in this report which as currently formatted shows a snapshot in time and can be difficult to interpret, an alternative layout which allows for trends to be displayed is being developed and will be brought before IJB. Through the offices of the Group Service Manager for Planning and Performance a Data Performance Group has been established, which is tasked with both reviewing the HSCP regular reporting needs and better analysing and dissemination techniques.

3 BACKGROUND

3.1 As previously reflected on, joint work between HSCP officers, the Local Intelligence Support Team (LIST) and the Information Services Division (ISD) Health and Social Care Team developed a combined dataset to provide information on service users' journeys through the health and social care system, the associated costs of this service utilisation and users' demography.

3.3 The resulting data has provided East Lothian HSCP with a rich resource which was used in the development of the IJB Strategic Plan and other strategies, has supported performance monitoring across a range of measures and was utilised in the development of Directions.

3.4 The first Performance Report was considered by the IJB in August 2016. The last report, up to July 2017, was considered by the IJB in August 2017.

3.5 The September 2017 Performance Report presents analysis on 19 of the 23 National Indicators (table 1). As previously reported, data is not yet available for indicators: 10, 21, 22, and 23.

Indicator	Performance Jun 2017	Performance Sep 2017
1. Percentage of adults able to look after their health very well or quite well	95.2%	95.2%
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible	86.3%	86.3%
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	83.4%	83.4%
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	81.7%	81.7%
5. Percentage of adults receiving any care or support who rate it as excellent or good	83.9%	83.9%
6. Percentage of people with positive experience of care at their GP practice	84.7%	84.7%
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	92.4%	92.4%
8. Percentage of carers who feel supported to continue in their caring role.	47.7%	47.7%
9. Percentage of adults supported at home who agree they felt safe.	87.9%	87.9%
11. Premature mortality rate (per 100,000 population)	319.9	374.6
12. Rate of emergency admissions for adults (per 100,000)	9,398	9,562.5
13. Rate of emergency bed days for adults (per 100,000)	114,152	119,762.9
14. Readmissions to hospital within 28 days of discharge (per 1,000)	95.2	99.8
15. Proportion of last 6 months of life spent at home or in community setting	86.2	86.0
16. Falls rate per 1,000 population in over 65s.	18.5	18.78
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections	76.2	77%
18. Percentage of adults with intensive needs receiving care at home. (2015/16)	65.6%	66%
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000)	1,164	1,163.9
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency	23.3%	23.8%

National Indicators

3.6 Indicators 1 to 9 come from the 2015/16 Health and Care Experience Survey (which replaced the GP and Local NHS Services Patient Experience Survey) published by the Scottish Government in July 2016. It remains the case that as the survey only reports every two years, new data will not be available to update the tables until 2018. Data is also still awaited for indicator 10 – 'Percentage of staff who say they would recommend their workplace as a good place to work' which has not yet been reported on. Similarly, measures 21, 22 and 23 do not yet have data available (covering '% of people admitted to hospital from home, who are discharged to a care home', '% of people discharged from hospital within 72 hours of being ready', and 'expenditure on end of life care.'

3.7 Indicators 11 to 20 come from the ISD Health and Social Care Team's *'Core Suite of Indicators for Integration'* dataset. AS noted in a previous report some data is not directly comparable to the August 2016 Performance Report as updated methodology is used for some indicators.

3.8 The RAG (red/amber/green) status in table 1 is used to show performance against the Scottish average. Green indicates that the East Lothian HSCP has a value of at least 2.5% better than the Scottish average; amber indicates that the performance is within 5% of the Scottish average and red is based on the performance being 2.5% worse than the Scottish average. These percentage bands were agreed by the Partnership.

3.9 For measure 8 – 'Percentage of carers who feel supported to continue in their caring role' IJB members will recollect there was strong comment at the February 2017 meeting that this important measure had unacceptably low attainment but because of the RAG approach described above was given a green, and therefore misleading status. For this reason, this measure has not been given a RAG label.

3.10 Table 2 presents the performance for East Lothian in comparison to Scotland and a peer group of equivalent local authority areas. It also looks at community prescribing, expenditure on social care and support to people over 65. East Lothian performs particularly well on the prescribing indicators.

Applicable Performance Measures

3.11 Further performance measures are in the process of being incorporated into the existing local performance monitoring processes.

These measures cover:

- Those Directions which are in operation and require monitoring during 2017/18;
- National Health and Wellbeing Outcomes for Integration Joint Boards;
- Integration Planning and Delivery Principles;

- East Lothian Health and Social Care Partnership Strategic Objectives;
- Health and Social Care Delivery Plan Actions;
- Integration Priorities;
- Measuring Performance under Integration.

Measuring Performance Under Integration

3.12 The last and newest of this suite of measures 'Measuring Performance under Integration' is the focus of current development by the Scottish Government Ministerial Steering Group. Associated validated data is provided by ISD to each HSCP. Appendix 3 shows the latest East Lothian performance for the first four of the six measures for the period October 2014 to June 2017:

- Unplanned admissions.
- Occupied bed days for unscheduled care.
- A&E performance.
- Delayed discharges.

Charts will be available in due course for the remaining two measures:

- End of life care.
- The balance of spend across institutional and community services.

Directions

3.13 The Directions operating in 2017/18 comprise those 2016/17 Directions which were continued into the following year and new Directions (appendix 2).

3.14 NHS Lothian has allocated to named officers responsibility for delivering and reporting on specific Directions. A similar arrangement is not considered necessary for Directions allocated to East Lothian Council as most delivery is through the Chief Officer in their role as Director of Health and Social Care.

3.15 Work continues on all Directions. Areas which have made notable progress during this year include: development of the community hospital (D01a) carers' strategy (D02d & D14a) primary care (D01a&b,D10a to c) housing with care (D12b):

- The community hospital build at Roodlands is delivering to the agreed timetable, with the outpatients department scheduled for completion in early 2018. As this completes it will assist in delivering those Directions supporting repatriation of patients from Edinburgh
- Preparatory work for the Carers' Strategy is underway including engagement with stakeholders
- The Musselburgh Primary Care Access Service continues to progress through its development phase
- The care home team service is to extend its service to the Gullane and Haddington areas

- LEGup support has been allocated to three practices to support population growth.
- Work is accelerating on the development of a vision for the future of Eskgreen, Abbey, Edington and Belhaven and engagement with stakeholders has commenced.

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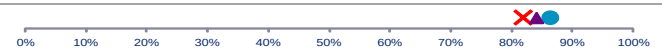
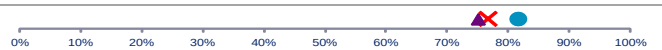
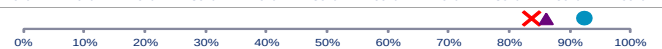
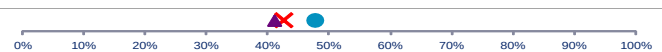
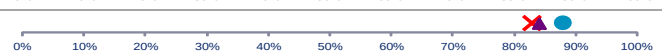
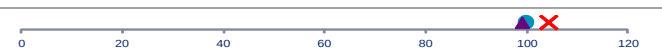
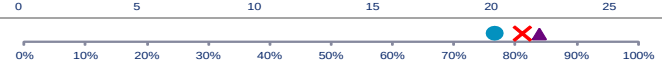
Table 2 - Comparison of each National Indicator between East Lothian HSCP/Peer Group/Scotland Performance

INDICATOR	East Lothian	*Peer Group Average*	*Scotland*	
1. Percentage of adults able to look after their health very well or quite well	95.2%	*94.6%*	*94.0%*	
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.	86.3%	*81.9%*	*84.0%*	
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	83.4%	*77.6%*	*79.0%*	
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.	81.7%	*76.7%*	*75.0%*	
5. Percentage of adults receiving any care or support who rate it as excellent or good	83.9%	*80.7%*	*81.0%*	
6. Percentage of people with positive experience of care at their GP practice.	84.7%	*86.7%*	*87.0%*	
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	92.4%	*83.7%*	*84.0%*	
8. Percentage of carers who feel supported to continue in their caring role.	47.7%	*42.6%*	*41.0%*	
9. Percentage of adults supported at home who agree they felt safe.	87.9%	*82.9%*	*84.0%*	
*10. Percentage of staff who say they would recommend their workplace as a good place to work.**	*Not yet available.*			
11. Premature mortality rate (per 100,000 population)	374.6	412.0	439.7	
12. Rate of emergency admissions for adults (per 100,000)	9,562.5	12,524.9	12,264.9	
13. Rate of emergency bed days for adults (per 100,000)	119,762.9	125,922.7	124,663.4	
14. Readmissions to hospital within 28 days of discharge (per 1,000)	99.83	104.34	98.99	
15. Proportion of last 6 months of life spent at home or in community setting.	86.02	87.35	87.24	
16. Falls rate per 1,000 population in over 65s.	18.78	20.17	21.62	
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.	77%	81%	84%	
18. Percentage of adults with intensive needs receiving care at home.	66%	64%	62%	
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged. (per 1,000)	1163.9	879.8	841.6	
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.	23.8%	25.3%	24.7%	
*21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.**	*Not yet available.*			
*22. Percentage of people who are discharged from hospital within 72 hours of being ready.**	*Not yet available.*			
*23. Expenditure on end of life care.**	*Not yet available.*			

Shaded data cells show where the most recent Scotland figure is not yet available, so the previous year's figure is shown

4 POLICY IMPLICATIONS

4.1 There are no new policy implications arising from this paper.

5 INTEGRATED IMPACT ASSESSMENT

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

6 RESOURCE IMPLICATIONS

6.1 Finance

6.1.1 There are no financial resource implications arising from this report.

6.2 Personnel

6.2.1 Processes are being developed as part of the restructure of the planning and performance function of the Health and Social Care Partnership which will monitor and regularly report on the indicators within the performance report which will incorporate new measures as these arise.

7 BACKGROUND PAPERS

7.1 Appendix 1 - HSCP Performance Report Update.

7.2 Appendix 2 - Monitoring template for performance - East Lothian Integration Joint Board Directions for 2016/17 and 2017/18.

7.3 Appendix 3 - Measuring Performance under Integration Measures

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Appendix 1 - HSCP Performance Report Update

East Lothian Health & Social Care Partnership Performance Report for the Integration Joint Board September 2017 update

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Contents

Introduction

With the creation of the Health and Social Care Partnerships in Scotland there has been a need for data intelligence to support planning, decision making and service redesign to meet the needs of local communities.
The East Lothian Health and Social Care Partnership has worked closely with the Local Intelligence Support Team (LIST) and the Health and Social Care Team within Information Services Division (ISD) in linking and integrating the NHS and Social Care datasets. This new dataset provides information on each person's journey through the health and social care system with associated costs and service utilisation, as well as providing demographic information.
The integrated health and social care dataset offers the Partnership a deeper understanding of care needs within communities and awareness of the different pathways that people travel through within the NHS and Social Care. This intelligence feeds into the Strategic Plan and other strategies and helped to inform the development of Directions for East Lothian Health and Social Partnership to deliver best value while ensuring the population receives the best health and social care services.
This is the fourth Performance Report produced for the East Lothian Integration Joint Board and presents analysis on:

- National Indicator results for East Lothian
- Community Prescribing
- End of Life
- Home care for people aged 65 +
- Healthcare Expenditure.

Subsequent performance reports will need to take into account new performance requirements and outcome measures arising from the recent Health and Social Care Delivery Plan and joint SG/COSLA letters concerning performance monitoring.
Please note that this report is for Management Information purposes only.
Data for East Lothian and its associated Local Authority peer group have been presented for the most up to date financial year, 2016/17. There are exceptions to this which have been stated within the notes of each indicator.
Scotland results for 2016/17 have been presented if the indicator has been officially released into the public domain by ISD. If the indicator has not been officially published for 2016/17, then the most recent published data has been included.

Core Suite of Indicators for Integration

Context

The National Health and Wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services. This suite of

outcomes focuses on improving the experiences and quality of services for people using those services, carers and their families. These outcomes focus on improving how services are provided, as well as, the difference that integrated health and social care services should make, for individuals. The nine Health and Wellbeing Outcomes are:

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 reducing 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.

More information about the outcomes is available at:
www.gov.scot/Publications/2015/02/9966/downloads
Integration Authorities are responsible for planning and delivering a wide range of health and social care services and accountable for delivering the national health and wellbeing outcomes. Each Integration Authority will be required to publish an annual performance report, which will set out how the national health and wellbeing outcomes are being improved. The first Performance Report for the East Lothian Integration Joint Board should be published by July 2017.
Several of the indicators reflect progress towards more than one of the national health & wellbeing outcomes. All of the outcomes and indicators are considered as important as each other, and so the suite needs to be considered as a package and not a set of individual unrelated indicators.

Core indicators

The indicators have been developed in consultation with a wide range of stakeholders across all sectors, with significant input from COSLA and agreement of the Ministerial Steering Group. It should be noted that the

indicators will develop and improve over time, and that some of them still require data development.

The indicators have been, or will be, 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. While national user feedback will only be available every 2 years, it is expected that Integration Authorities' performance reports will be supplemented each year with related information.

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 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.*

(b) **Indicators derived from organisational / system data** primarily collected for other reasons.

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 and care at home services rated 'good' 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 year, 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.*

***** Indicator under development by the Scottish Government and ISD

The Health and Social Care team within ISD will publish the National Indicators on a quarterly basis before the first performance reports are due by July 2017. The first publication was on 2nd August 2016 and was based on 13/14 data. The publication was updated in November 2016 and the indicators are now based on 15/16 data.
All Partnerships have been benchmarked against one another, however the analysis has not been broken down by locality as the SOURCE team have processed data to this geography level yet. The Local Intelligence Support Team (LIST) has supported the East Lothian Health and Social Care Partnership by providing timely data and comparing each indicator to East Lothian's peer group as well as Scotland. The audience can see if East Lothian is comparing well to its peers, or if further improvement is required.

Differences from June 2017 Report

For the National Indicators, the data has now been taken from the ISD Health & Social Care team's (SOURCE) Core Suite of Indicators for Integration dataset. This is different from the June 2017 Performance Report, as the SOURCE team has now published the indicators for 2016/17. The methodology for some indicators has since been clarified and updated since the August 2016 report.
Table 1 below shows the differences between the June report and the September 2017 report.

Table 1: Summary view of changes from June.

INDICATOR	Updates to Data from June
1. Percentage of adults able to look after their health very well or quite well	NA
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.	NA
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	NA
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.	NA
5. Percentage of adults receiving any care or support who rate it as excellent or good	NA
6. Percentage of people with positive experience of care at their GP practice.	NA
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.	NA
8. Percentage of carers who feel supported to continue in their caring role.	NA
9. Percentage of adults supported at home who agree they felt safe.	NA
11. Premature mortality rate (per 100,000 population)	Updated with 2016
12. Rate of emergency admissions for adults (per 100,000)	Updated for 16/17
13. Rate of emergency bed days for adults (per 100,000)	Updated for 16/17
14. Readmissions to hospital within 28 days of discharge (per 1,000)	Updated for 16/17

15. Proportion of last 6 months of life spent at home or in community setting.	Updated for 16/17
16. Falls rate per 1,000 population in over 65s.	Updated for 16/17
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.	Updated for 16/17
18. Percentage of adults with intensive needs receiving care at home.	Updated for 15/16
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged. (per 1,000)	Updated for 16/17
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.	Updated for 16/17

National Indicators for East Lothian Health and Social Care Partnership

Table 2 below shows a breakdown of the National Core Indicators for Integration for East Lothian Health & Social Care Partnership. The data for indicators 1 to 9 have come from the 2015/16 Health and Care Experience Survey which was published by the Scottish Government in July 2016. This survey is published bi-annually with the next publication due in 2017/18. Data for Indicators 11 onwards is for 2016/17 unless otherwise specified.

A RAG (red/amber/green) status has been used as a means to compare the performance of the East Lothian Health and Social Care Partnership to the Scottish average. Green indicates that the Partnership has a value of at least 2.5% better than the Scottish average; amber indicates that the performance is within 5% of the Scottish average and red is based on the performance being 2.5% worse than the Scottish average. The percentage points were decided by the Partnership.

It remains the case that no data has yet been published for indicators 10, 21, 22 and 23 as the data sources and methodology are still being developed by the Scottish Government and ISD.

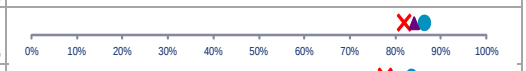
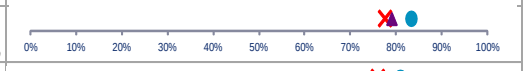
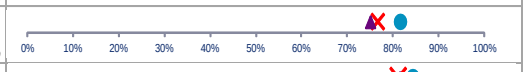
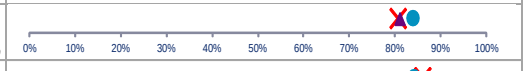
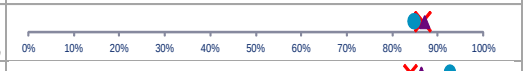
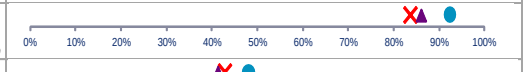
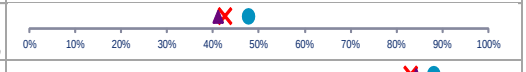
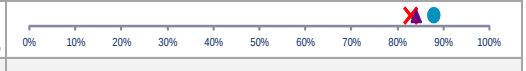
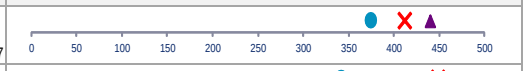
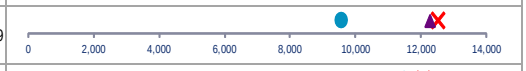
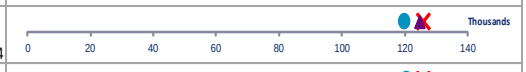
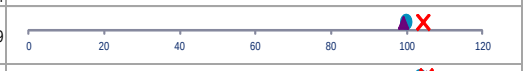
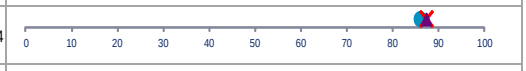
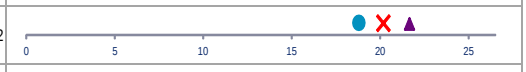
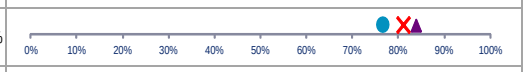
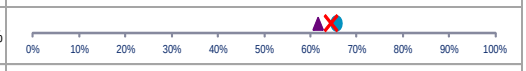
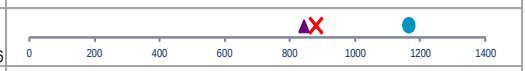
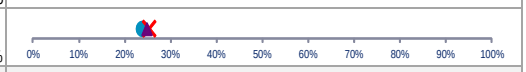
Table 2: Breakdown of National Indicators for East Lothian H&SCP

Indicator	Performance Jun 2017	Performance Sep 2017
1. Percentage of adults able to look after their health very well or quite well	95.2%	95.2%
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible	86.3%	86.3%
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	83.4%	83.4%
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	81.7%	81.7%
5. Percentage of adults receiving any care or support who rate it as excellent or good	83.9%	83.9%
6. Percentage of people with positive experience of care at their GP practice	84.7%	84.7%
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	92.4%	92.4%
8. Percentage of carers who feel supported to continue in their caring role.	47.7%	47.7%
9. Percentage of adults supported at home who agree they felt safe.	87.9%	87.9%
11. Premature mortality rate (per 100,000 population)	319.9	374.6
12. Rate of emergency admissions for adults (per 100,000)	9,398	9,563
13. Rate of emergency bed days for adults (per 100,000)	114,152	119,763
14. Readmissions to hospital within 28 days of discharge (per 1,000)	95.2	99.8
15. Proportion of last 6 months of life spent at home or in community setting	86.2	86.0
16. Falls rate per 1,000 population in over 65s.	18.5	18.8
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections	76.2	77%
18. Percentage of adults with intensive needs receiving care at home. (2015/16)	65.6%	66%
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000)	1,164	1,164
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency	23.3%	23.8%

East Lothian in comparison to Scotland & Peer Group

Table 3 compares the outcome of each indicator to that of a peer group and Scotland.
The scatter plots to the right of the table illustrate where East Lothian (the blue dot) lies in relation to both the Peer Group (red cross) average and the Scotland (purple triangle) values.

Table 3: Comparison of each National Indicator result for East Lothian Partnership to the peer group and Scotland

INDICATOR	East Lothian	Peer Group Average	Scotland	
1. Percentage of adults able to look after their health very well or quite well	95.2%	94.6%	94.0%	
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.	86.3%	81.9%	84.0%	
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	83.4%	77.6%	79.0%	
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.	81.7%	76.7%	75.0%	
5. Percentage of adults receiving any care or support who rate it as excellent or good	83.9%	80.7%	81.0%	
6. Percentage of people with positive experience of care at their GP practice.	84.7%	86.7%	87.0%	
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	92.4%	83.7%	84.0%	
8. Percentage of carers who feel supported to continue in their caring role.	47.7%	42.6%	41.0%	
9. Percentage of adults supported at home who agree they felt safe.	87.9%	82.9%	84.0%	
*10. Percentage of staff who say they would recommend their workplace as a good place to work.**	*Not yet available.*			
11. Premature mortality rate (per 100,000 population)	374.6	412.0	439.7	
12. Rate of emergency admissions for adults (per 100,000)	9,562.5	12,524.9	12,264.9	
13. Rate of emergency bed days for adults (per 100,000)	119,762.9	125,922.7	124,663.4	
14. Readmissions to hospital within 28 days of discharge (per 1,000)	99.83	104.34	98.99	
15. Proportion of last 6 months of life spent at home or in community setting.	86.02	87.35	87.24	
16. Falls rate per 1,000 population in over 65s.	18.78	20.17	21.62	
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.	77%	81%	84%	
18. Percentage of adults with intensive needs receiving care at home.	66%	64%	62%	
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged. (per 1,000)	1163.9	879.8	841.6	
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.	23.8%	25.3%	24.7%	
*21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.**	*Not yet available.*			
*22. Percentage of people who are discharged from hospital within 72 hours of being ready.**	*Not yet available.*			
*23. Expenditure on end of life care.**	*Not yet available.*			

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

Individual Indicators

Indicators 1 – 9:

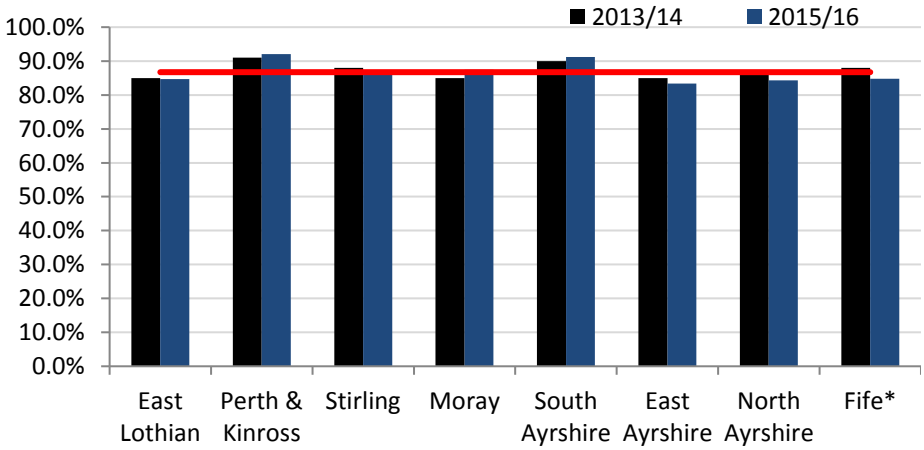
The data for these indicators is from the Scottish Government's Health and Care Experience Survey, the most recent data of which is available at: http://www.hace15.quality-health.co.uk/.

This survey is sent to a random sample of patients registered with Scottish practices, of which 1,921 replied for East Lothian (out of 9,345 sent to East Lothian residents). Of those who replied:

- 40% were male and 60% were female;
- 9% were aged 17-34, 17% were aged 35-49, 34% were aged 50-64 and 41% were 65 and over;
- 65% did not have any limiting illness or disability.

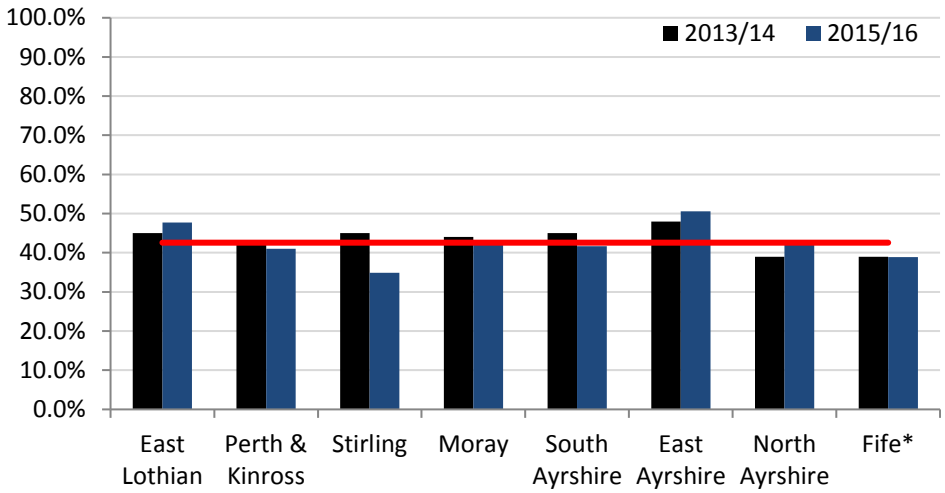
East Lothian responses are generally more positive than for both the peer group and Scotland as a whole. The two shown below are those where there is either a lower number than the Scotland average, or where the positive response rate was low in general (i.e. both for East Lothian and across Scotland as a whole).

Chart 1: Percentage of people with positive experience of care at their GP practice.



The red line in Chart 1 shows the peer group average for the 2015/16 survey response. Not only does East Lothian have a lower positive response than the peer group in general, but there has been a decrease compared to the 2013/14 response.

Chart 2: Percentage of carers who feel supported to continue in their caring role.



East Lothian has shown a positive gain for the new survey; however the number of carers who feel supported is still low. The rate across Scotland as a whole is 41%, which East Lothian is above. Further work needs to be carried out to understand why carers feel unsupported, and what can be done to help them in this challenging role.
A breakdown of the remaining indicators is available on request.

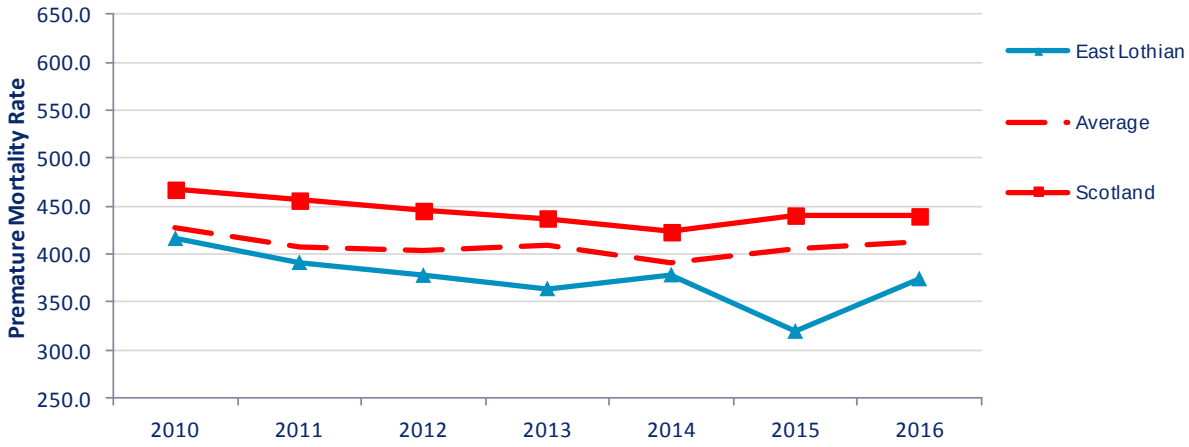
Indicator 10: Percentage of staff who say they would recommend their workplace as a good place to work

This indicator is under development by the Scottish Government.

Indicator 11 – Premature Mortality

Chart three below shows that the premature mortality rate in East Lothian lies below both the peer group average and the Scotland level , showing that East Lothian is doing well in keeping premature mortality low, as is the peer group as a whole. The rate for East Lothian shows an increase in 2016, but otherwise has shown a downwards trend over the last 6 years.

Chart 3: Premature mortality rate (per 100,000 population).

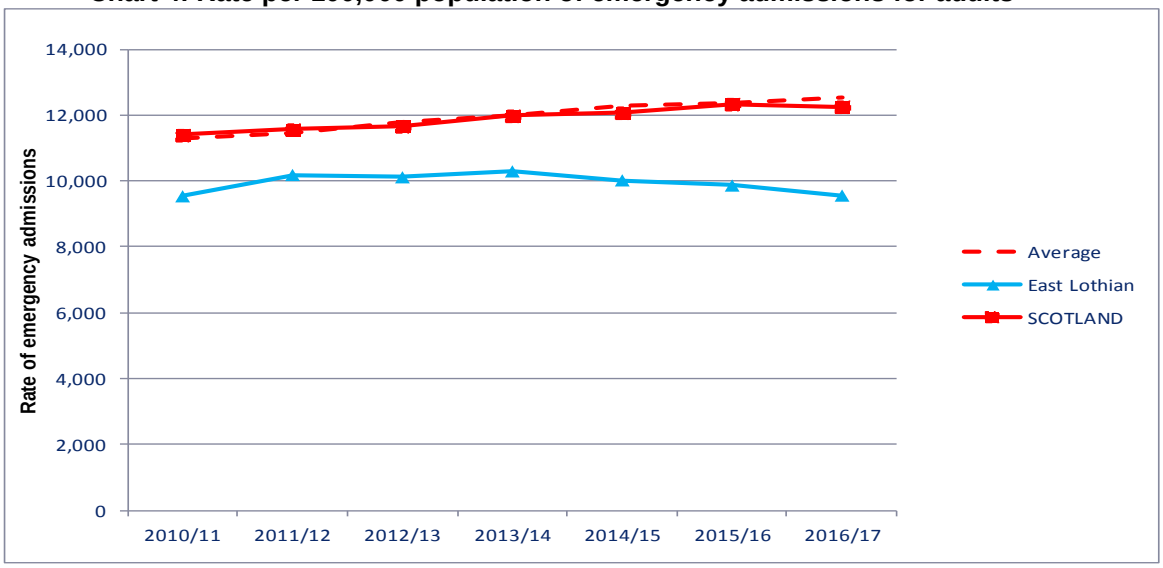


Indicator 12: Emergency Admissions

Chart 4 shows emergency admissions for Scotland and the peer group have been gradually increasing since 2010/11, however for East Lothian the rate

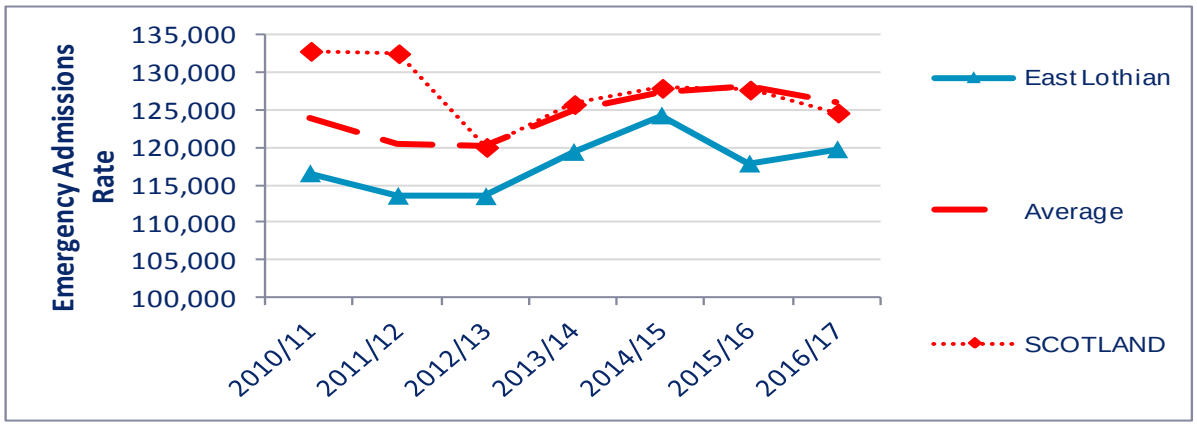
has been dropping slightly from 2013/14. The rate for East Lothian is below the Scotland level and peer group average.

Chart 4: Rate per 100,000 population of emergency admissions for adults



Indicator 13: Bed Days for Emergency Admissions

Chart 5: Rate per 100,000 of occupied bed days following an emergency admission for adults

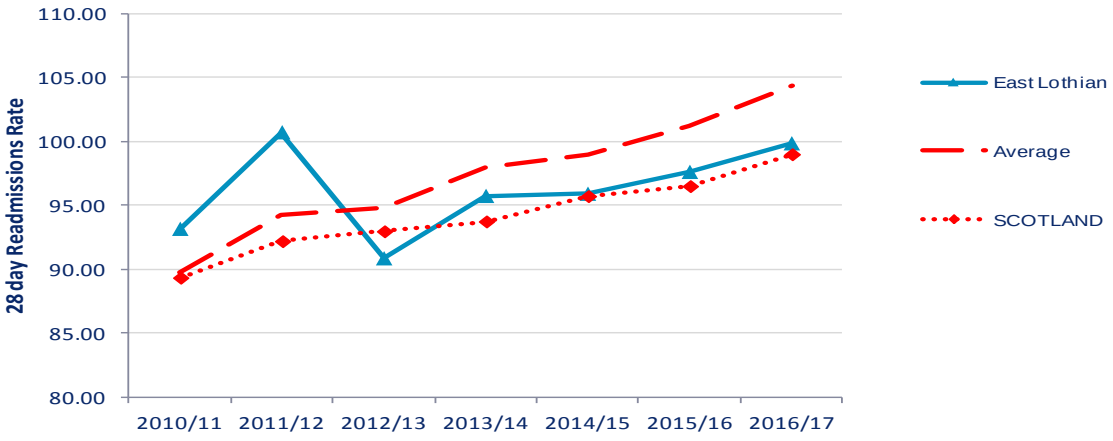


Compared to emergency admissions, which was shown in Chart 4, the emergency bed day rate for East Lothian is more in line with the Scotland average, indicating while there are less emergency admissions in the first place, the people are then staying in hospital as long as in other areas. The rate has been fluctuating over the years, while near the peer and Scotland levels in 2013/14 and 2014/15 it then dropped well below in 2015/16 but increased again in 2016/17.

Indicator 14 – Readmissions

East Lothian lies generally around the Scotland average, and the rate of readmissions appears to have flattened off, as with Scotland, from 2013/14.

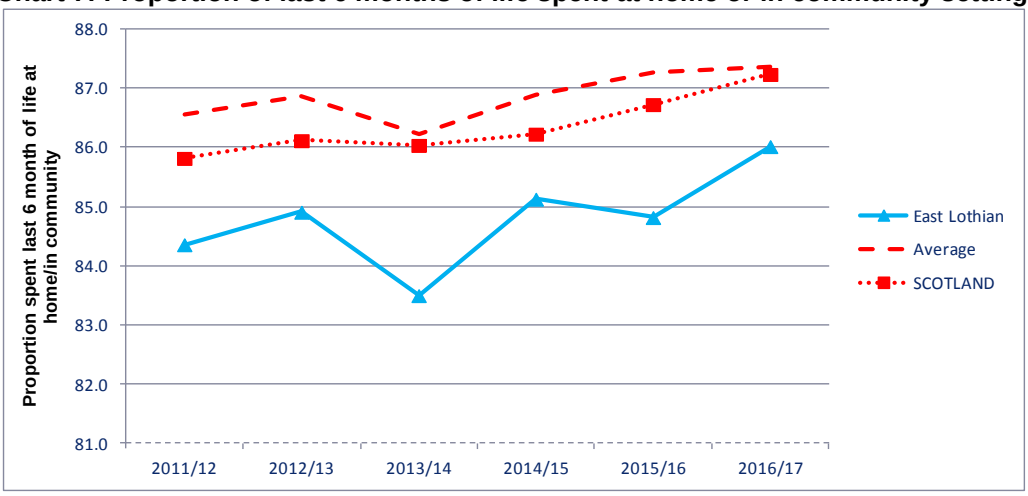
Chart 6 – Readmissions to hospital within 28 days of discharge



Indicator 15 – Last 6 months spent at home

Chart 7 shows East Lothian's performance is below that of Scotland and the peer group for the proportion of the last six months of life spent at home. There is a higher proportion of people spending this time within hospital instead of being managed within the community.

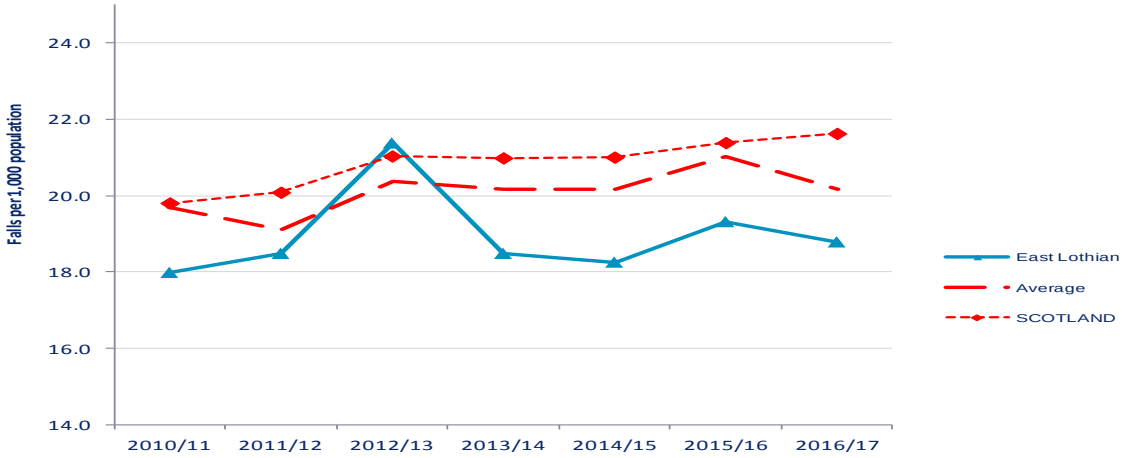
Chart 7: Proportion of last 6 months of life spent at home or in community setting



Indicator 16 – Hospital admission following a fall for over 65s

From Chart 8 it can be seen that East Lothian on the whole has been lower than Scotland, for the rate of falls in the 65+ age group, although there was a peak in 2012/13. While the rate has fluctuated slightly, it has remained below Scotland and the peer group average from 2012/13 onwards.

Chart 8: Falls rate per 1,000 population in over 65s.



Indicator 17 – Care services graded 'good' or better

This data comes from the Care Inspectorate, who advise this indicator is developmental. They are keen to engage with any stakeholders regarding the definition for this indicator.

Chart 9: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

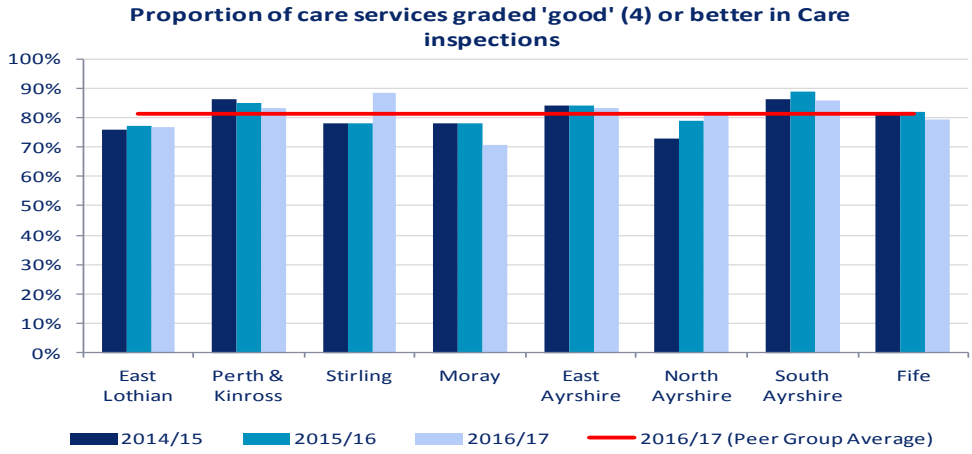
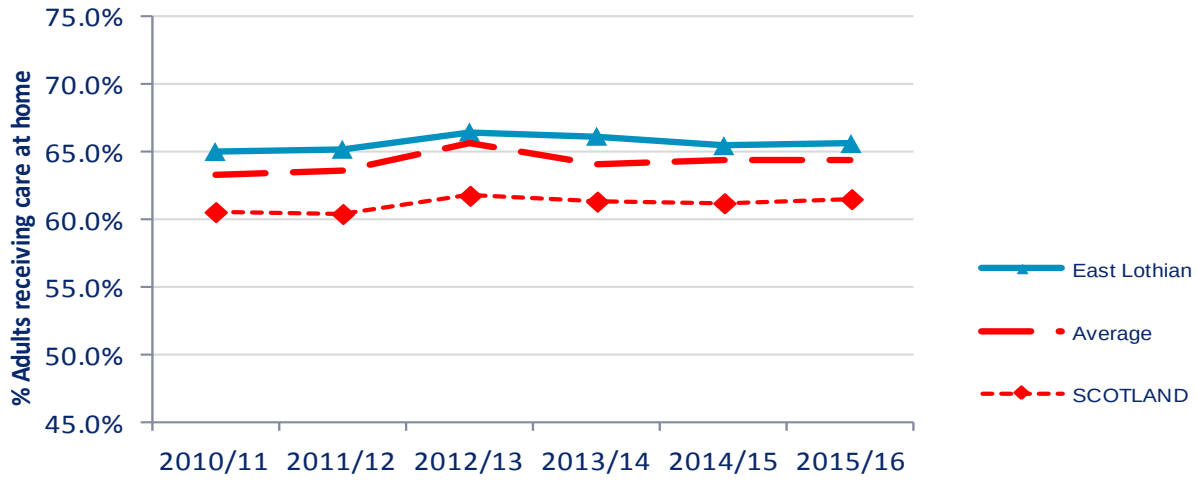


Chart 9 above shows that East Lothian does not have as many services graded good or above in inspections as their peer group (the average is shown by the red line). The Scotland average is very similar to the peer group average. There has, however, been a slight increase from the previous year.

Indicator 18 – Adults with intensive needs receiving care at home.

Chart 10 shows that both East Lothian and the peer group are well above the Scotland level. There has been very little fluctuation over the six years shown, although figures now are slightly higher than they were in 2010/11.

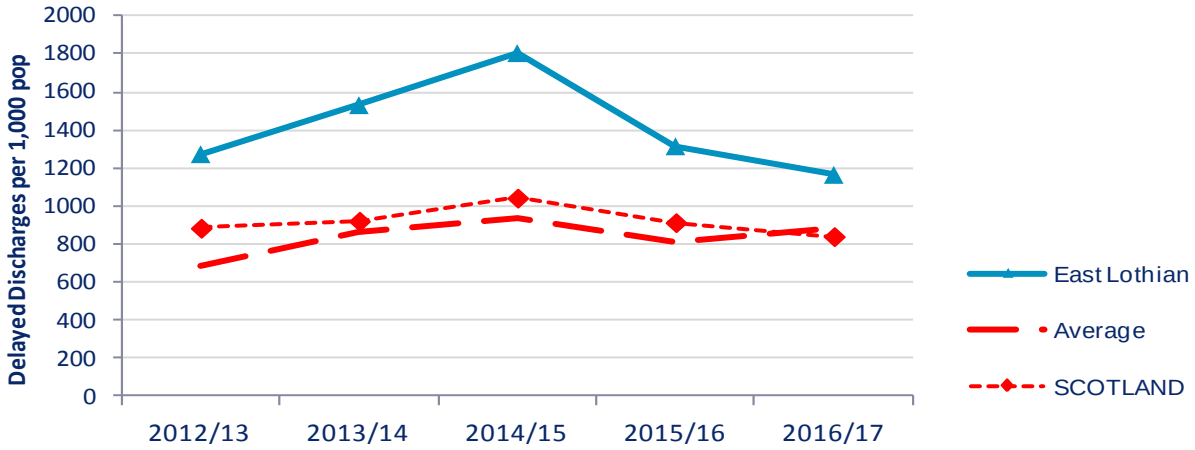
Chart 10: Percentage of adults with intensive needs receiving care at home.



Indicator 19: Number of days people aged 75+ spend in hospital when they are ready to be discharged.

Chart 11 shows that for occupied bed days per 1,000 of people aged 75+, East Lothian has shown considerably higher levels than the peer group; and also well above the Scotland level. However there has been a significant drop in the last two years indicating that interventions are beginning to have an impact on reducing delays, with East Lothian no longer the highest in the peer group.

Chart 11: Number of days per 1,000 people aged 75+ spend in hospital when they are ready to be discharged.



Delayed Discharges: Occupied Bed Days and Costs

Table 4 and chart 12 below compares the number of occupied bed days (OBDs) and total cost of delayed discharges from 2012/13 to 2016/17 for patients aged 18 and above, and aged 75 and above for all specialties and all delay reasons.

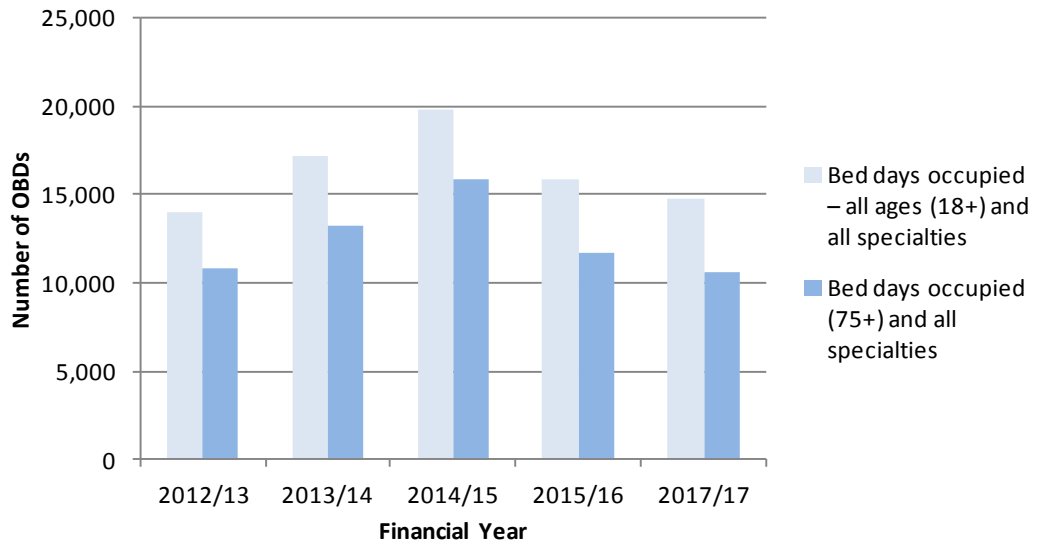
The number of OBDs increased by 40% between 2012/13 and 2014/15 from 14,044 to 19,800. However, since 2015/16, the number of OBDs has decreased by 25% to 14,762. This decrease can partly be attributed to a change in definitions and guidance in July 2016.

Table 4: Comparison of occupied bed days and expenditure for delayed discharges in East Lothian from 2012/13 to 2015/16

	2012/13	2013/14	2014/15	2015/16	2016/17
Bed days occupied – ages 18+, all specialties and all delay reasons	14,044	17,179	19,800	15,829	14,762
Bed days occupied 75+, all specialties and all delay reasons	10,829	13,259	15,868	11,710	10,609
Total Cost – all ages 18+, all specialties and all delay reasons	£2,357,855	£4,133,833	£4,504,033	£3,345,195*	£3,119,702*
Total Cost 75+,all specialties and all delay reasons	£1,759,477	£2,397,444	£3,492,529	£2,189,770*	£1,992,347*

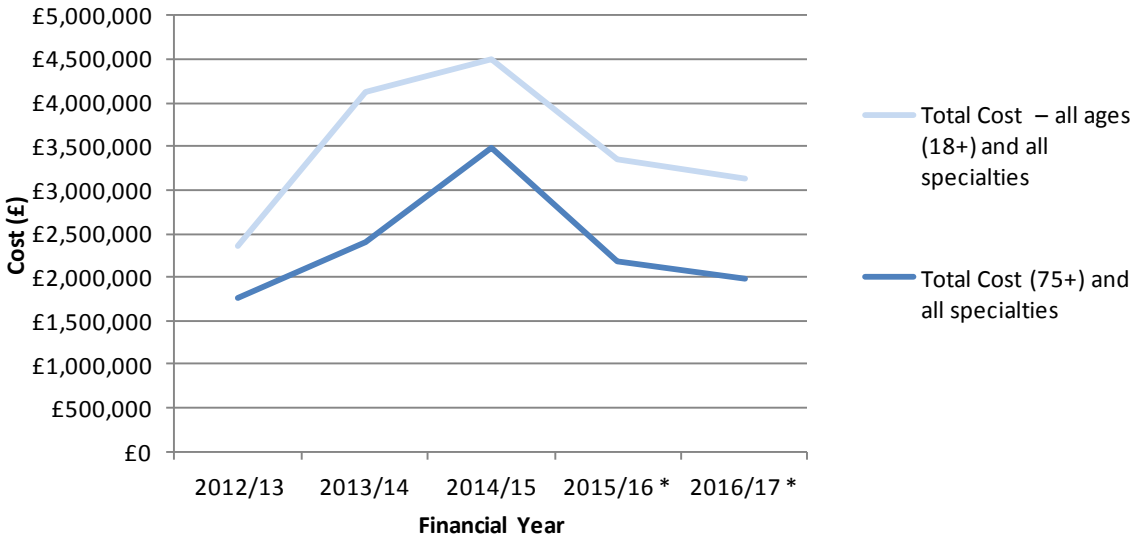
** Costs for 2015/16 and 2016/17 have not been published and have been estimated from the average bed day cost between 2012/13 to 2014/15.*

Chart 12: Number of days per 1,000 people aged 75+ spend in hospital when they are ready to be discharged.



The expenditure on delayed discharges between 2013/14 and 2012/13 nearly doubled, yet the bed days did not increase at the same rate. This may be due to delays in certain specialties being more expensive than others. It is also worthy of note that the costs for older people is half of the total expenditure, yet they account for around 43% of the occupied bed days. This shows that the cost per bed day for older people is more expensive than for people aged 74 years and below.

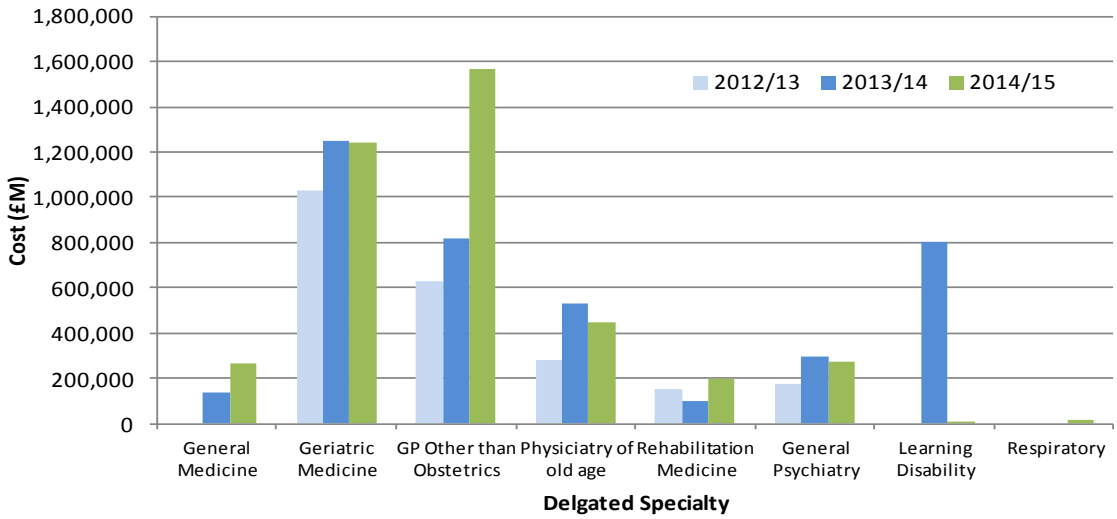
Chart 13: Comparison of expenditure on Delayed Discharges between 2012/13 and 2016/17



Costs of delayed discharges by delegated specialty for patients aged 18 and above

The data for chart 14 below has not been updated since the August 2016 report as ISD has not published costs data for 2015/16 onwards.
Just over £4 million was spent on Delayed Discharges in 2014/15 on patients aged 18 and above who were admitted to a Delegated Specialty. This represents 88% of the total expenditure of Delayed Discharges across all specialties (£4.5 million in 2014/15). The highest expenditure was within GP other than Obstetrics with a total expenditure of £1.5 million.

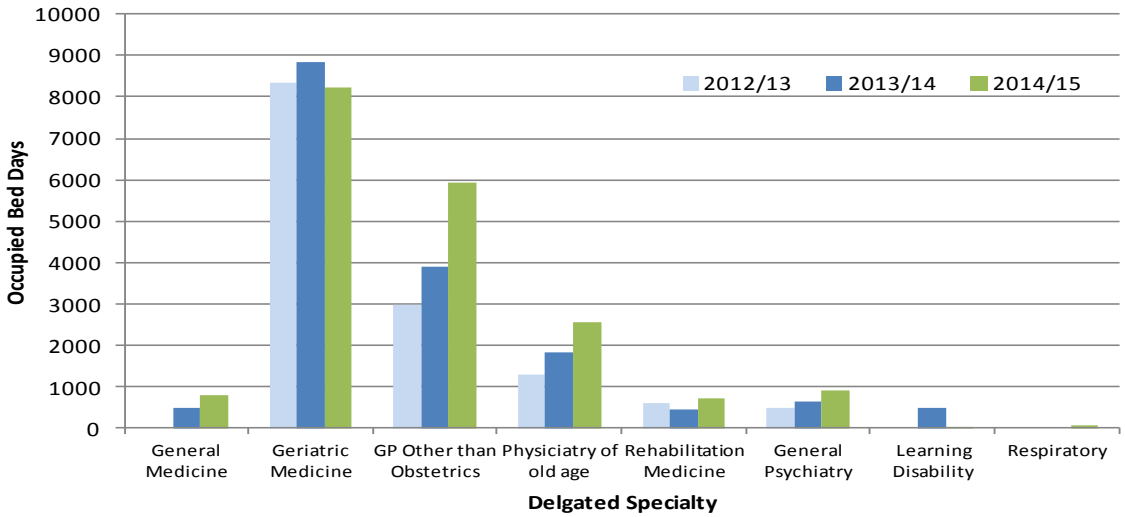
Chart 14: Expenditure on delayed discharges split by delegated specialty



Number of occupied bed days by delegated specialty

The data for chart 15 below has not been updated since the August 2016 report as ISD has not published costs data for 2015/16 onwards. It shows the number of occupied bed days by delegated specialty for patients aged 18 and above.

Chart 15: Occupied bed days for delayed discharges for patients aged 18 and above by delegated specialty

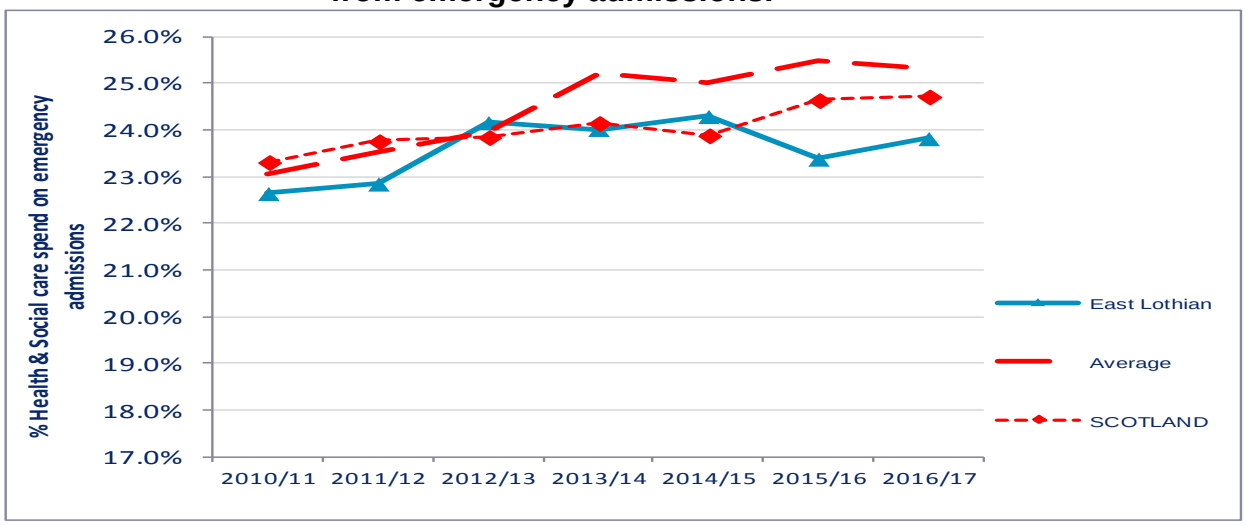


Geriatric medicine has the highest proportion of occupied bed days, although the number has decreased below the 2012/13 level.

Indicator 20: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.

Chart 16 shows an increasing variation in the percent spend on emergency admissions over the last seven years. East Lothian in particular has seen some fluctuation in recent years, with a drop of over 2% in 2015/16, then an increase again in 2016/17.

Chart 16: Percentage of health and care resource spent on hospital stays from emergency admissions.



Sources

1. National Health and Wellbeing Indicators 1 to 20: ISD Health and Social Care Team publication of Core Indicators for Integration. Available on a password protection section of the ISD website – for access contact nss.Source@nhs.net.
2. Delayed Discharges costs and occupied bed days: Health and Social Care Team, Source Tableau Outputs, Delayed Discharges workbook and ISD Delayed Discharges publication:
3. End of Life: ISD, Patient Level Information Costings System file on patient activity and costs, 2014/15
4. Healthcare Expenditure for East Lothian Partnership: ISD publication:
5. Community Prescribing: Prescribing Information System
6. Percentage of people receiving care at home aged 65 and above: These figures are taken from a variety of sources, including ISD's care homes publication, the Scottish Government's Home Care publication, NRS for population data and SMR01 for bed days.

Further Information

The majority of the information presented in this report was sourced from published national data from the following organisations.

Information Services Division: www.isdscotland.org
Scottish Government: www.gov.scot/Topics/Statistics
National Records of Scotland: www.nrscotland.gov.uk
See the Notes and Caveats section for details of specific sources.

Appendix 2 - Monitoring template for performance - East Lothian Integration Joint Board Directions for 2016/17 and 2017/18

2016/17 Directions

01 - Directions on Community Hospital Developments

D01a - Deliver a new integrated East Lothian Community Hospital, with an agreed bed base and a defined range of safe and effective inpatient and outpatient services fit for future demographic growth within a deliverable financial model.

D01b - Continue to support a 'decant programme' aligned to a new East Lothian Community Hospital to facilitate early reprovision and earliest repatriation of East Lothian patients from Liberton and Midlothian Hospitals

D01c - Replaced by Direction D12e

D01d - Deliver business cases for Prestonpans and Harbours Medical Practices in line with the East Lothian Primary Care Premises Strategy.

D01e - Replaced by Direction D10a.

D01f - Replaced by Direction D10a.

D01g - Develop and implement a prescribing budget calculation which more accurately reflects demographic change and need across Lothian.

02 - Directions on Community Delivered Care Services

D02a - Replaced by Direction D12a.

D02b - Replaced by Direction D12a.

D02c - Replaced by Direction D12d.

D02d - Develop and implement a new Carers Strategy for East Lothian and an aligned commissioning strategy by December 2016 meeting the requirements of the Carers (Scotland) Bill and the principles of Best Value.

D02e - Replaced by Direction D12c.

D02f - Establish a housing and health and social care planning interface group to deliver the key actions and priorities from the Strategic Plan's Housing Contribution Statement and needs assessment, including a clear understanding and recognition of delegated functions and budgets as they pertain to the IJB.

D02g - Complete a scoping exercise and bring forward operational and funding proposals to the IJB for a redesigned model of reablement by September 2016.

D02h - Complete a review of all current Section 10 grants against an agreed prioritisation framework to ensure strategic fit and best value and bring forward proposals for investment and disinvestment to the IJB by December 2016.

03 - Directions on Repatriation of East Lothian Residents

D03a - Ensure the repatriation of East Lothian residents from Liberton Hospital in Edinburgh accompanied by an associated shift in aligned financial resources to the IJB.

D03b - Ensure the repatriation of East Lothian residents from Midlothian Community Hospital with the associated shift in aligned financial resources to the IJB.

04 - Directions on Primary Care

D04a - Delivery of the key recommendations of the national review of primary care out of hours services.

D04b - Delivery of the key actions of the Transitional Quality Arrangements for the GMS contract in Scotland.

05 - Directions on Resource Transfer

D05a - Payments by NHS Lothian to East Lothian Council in line with the agreed payment schedule.

D05b - Provision by East Lothian Council of services as outlined and in accordance with the agreed budgets.

06 - Direction on the Integrated Care Fund

D06 - Replaced by Direction D12e.

07 - Direction on the Delayed Discharge Fund

D07 - Replaced by Direction D11c.08 - Direction on the Integration Fund

D08 - Delegation of the agreed budget for the Integration (Social Care) Fund to the IJB.

09 - Direction on the Strategic Programme Budget

D09 - Identification of human and financial resources and activity within NHS Lothian's Strategic Programmes budget within the financial year 2015/16.

2017-18 Directions

10 - Directions to NHS Lothian on Primary Care

D10a - Preparations for the New GMS Arrangements **(supersedes D01e and D01f, aligned with D01g, Do4a, D04b)**

D10b - Support to Primary Care Quality Clusters **(new Direction)**

D10c - Primary Care Strategy **(new Direction)**

11 - Directions to NHS Lothian and ELC on reducing use of acute services and increasing community provision

D11a - Emergency Assessment Services and Emergency Admissions **(new Direction)**

D11b - Occupied Bed Days **(new Direction)**

D11c - Delayed Discharges **(supersedes D07)**

D11d - End of Life Care **(new Direction)**

D11e - Transfer of AHP resource from Secondary Care **(new Direction)**

D11f - Contracts for Care at Home **(new Direction)**

12 - Directions to NHS Lothian and ELC on shifting the balance of care for care groups

D12a - ELC delivered care at home services **(supersedes D02a and D02b)**

D12b - Extra care housing **(new Direction)**

D12c - Day services for older people **(supersedes D02e)**

D12d - Reprovision of Eskgreen and Abbey care homes and Edington and Belhaven hospitals **(supersedes D01c and D02c)**

D12e - Integrated Care Fund Review **(supersedes D06)**

13 - Direction to NHS Lothian to support delivery of Modern Outpatients recommendations

D13a - Redesign of diabetes services and further development of care of Type 2 diabetes in primary care **(new Direction)**

14 - Direction to NHS Lothian and ELC on support to carers

D14a - Finalisation and implementation of the East Lothian Carers' Strategy and preparation for the Carers' Act **(aligned with D02d)**

15 - Directions to NHS Lothian on drug and alcohol services and mental health

D15a - Allocation to ELHSCP of the full 12% of Drug and Alcohol funding **(new Direction)**

D15b - Redesign of MELDAP **(new Direction)**

D15c - Provision of adult mental health services **(new Direction)**

D15d - Provision of older adult mental health services **(new Direction)**

16 - Direction to NHS Lothian and ELC on Community Justice

D16a - Work with the Reducing Reoffending Board **(new Direction)**

All directions remain in place until varied, revoked or superseded by a later direction in respect of the same function.

Directions for 2016-17

Directions on Community Hospital Developments (D01a, D01b, D01c (replaced by Direction D12e), D01d, D01e (replaced by Direction D10a) D01f (replaced by Direction 10a), D01g)

Function(s) - Integrated function.
Direction D01a. - Continue to support an Outline Business Case, Final Business Case and Financial Close for a new integrated East Lothian Community Hospital which includes an agreed bed base and a defined range of safe and effective inpatient and outpatient services fit for future demographic growth within a deliverable financial model.
Target - Delivery of the new Community Hospital. **Measurement -** Completion of the business case and commencement and successful completion of the 4 phases of the building within the planned timeframe.
Performance - The new integrated East Lothian Community Hospital business case reached financial close in October 2016. This allowed commencement of the construction of the new hospital within the currents Roodlands Hospital grounds. A new car park was completed in February 2017 as the first of 4 phases of development. Phase 2, a new outpatient department is due to complete in February 2018. Phase 3 will see the rest of the hospital constructed by late 2019 and under Phase 4 the remaining buildings will be demolished and further parking and landscaping completed early in 2020. The hospital bed model is based on current requirements including the repatriation from Edinburgh hospitals of appropriate East Lothian patients who can be cared for locally. The bed base will have the capacity to expand for expected demographic and population growth in East Lothian. It is anticipated that by 2023-2032 a further 20 beds will be opened in the new hospital. An increase in the Outpatient Department will assist with further repatriation of services and work is ongoing to develop this in time for a 2019 opening.

The financial model continues to be reviewed by both the IJB and NHSL
Function(s) - Integrated function.
Direction D01b. - Continue to support, develop and agree a 'decant programme' aligned to a new East Lothian Community Hospital to facilitate early reprovision and earliest repatriation of East Lothian patients from Liberton and Midlothian Hospitals.
Target -. No specific closure date has been set for Liberton, but the wider NHS Lothian Strategic Plan expects it to cease inpatient activity during 2018. **Measurement –** Tracking of patient numbers and locations.
Performance – In the past up to 30% of admissions to Liberton 124 beds specialising in care for the frail elderly were direct GP referrals. Increasingly, as a result of system pressures acute patients were transferred from the Royal Infirmary of Edinburgh. Liberton was also the main site for ongoing frailty and orthogeriatric rehabilitation taking patients from Midlothian, East Lothian and north Edinburgh. Liberton currently accommodates East Lothian (20 beds) and City of Edinburgh HSCP patients who have completed their acute and rehabilitation episode of care. A new model of intermediate care with GP cover has been developed for those patients who no longer require acute hospital care and who are clinically stable but have ongoing rehabilitation needs that cannot be met at home. It also has a 'step down' unit for patients on the journey back to community based care. Following the competition of the East Lothian Community Hospital in early 2020, it is expected that East Lothian HSCP patients will move from the Liberton site. Arrangements are in place with the LIST ISD team to track patients on a weekly basis during the transitional phase.

Function(s) - Integrated function.
Direction D01d. - Deliver business cases for Prestonpans and Harbours Medical Practices in line with the East Lothian Primary Care Premises Strategy.
Target - To provide each practice with suitable extensions to modernise, extend and improve existing practice facilities and to provide sufficient flexibility to respond to predicted local population growth. **Measurement –** Availability of premises.
Performance – Prestonpans Medical Practice: During 2016/17 work commenced on a £2 million extension and refurbishment to provide purpose-built spaces for patients and staff. This comprised new treatment rooms, a community consulting room and health care assistant rooms. The extension opened in April 2017. Harbours Medical Practice, Cockenzie: In August 2017, following approval of the business case earlier in the year Lothian Capital Investment Group approved funding to support the formal design and planning of an extension to the practice to provide a modern, fit for purpose extension. Work on this aspect of the project is now underway

Function(s) - Integrated function.
Direction D01g. - Develop and implement a prescribing budget calculation which more accurately reflects demographic change and need across Lothian.
Target - . **Measurement -** .
Performance - The NHS Lothian Prescribing Forum is currently invited to consider a model of budget setting for future approaches to setting Practice budgets in Lothian. East Lothian is represented on the Forum. A model for 18/19 is being considered by a small group with representation from finance, medicines management team and pharmacy. East Lothian would welcome the opportunity to contribute to this group. During the year a deep dive exercise was performed by the prescribing advisor on two practices in East Lothian. This revealed that a few expensive medicines can make a significant impact on budget performance. The fact that the model does not take into account high cost medicines may accounts for some of the overspend in practices using the weighted capitation budget model.

Directions on Community Delivered Care Services (D02.a (replaced by Direction D12a) D02b (replaced by Direction D12a) D02c (replaced by Direction D12d) D02d, D02e - Replaced by Direction D12c) D02f, D02g)

Function(s) - Integrated function.
Direction D02d. - Develop and implement a new Carers Strategy for East Lothian and an aligned commissioning strategy by December 2016 which fully address the requirements of the Carers (Scotland) Bill and the principles of Best Value.
Target - . **Measurement -** .
Performance - Development and preparation for the East Lothian Carers' Strategy continues and is expected to be finalised by 1st April 2018 as set down in the Carers (Scotland) Act 2016. To date activities have included a 'Big Breakfast' event attended by relevant stakeholders, care support service providers from public, third and voluntary sectors, carers and cared-for people. Following event feedback the Eligibility Criteria Framework, broadly based upon the National Carer Organisations framework, was accepted by the Core Management Team as a model of best practice. The Eligibility Criteria was published in-line with legislative requirements and is out to consultation from 1st October 2017 to 31st December 2017. A Working Group meets fortnightly and includes within its remit; programme management, governance of the project and finance and demand of service requirements. It will also develop specific workstreams as the project progresses: communications and public awareness; real choice and commissioning; Third Sector role; workforce support, training and development; information and systems and monitoring and evaluation A workstream will also be established to address issues regarding supply of data and information for the Scottish Government's Carers Census. The Carers Census consultation that East Lothian participated in identified a number of gaps in data and information provision within East Lothian and the working group will look to address these.

A Carers' Strategic Group (with representation from a number of public, third and voluntary sector organisations) will look at the delivery of duties that include: adult carer support plans; young carer statements; local eligibility criteria; carer involvement; local carer strategy and information and advice services for carers. It will also develop and maintain relationships with other relevant strategic programmes to ensure progress on the Carers Strategy is publicised.

A development session on the Carers Strategy, led by an IJB Board member with responsibility for Carers Strategy was attended by Carers of East Lothian, East Lothian Young Carers and ELHSCP officers.

Adult carer support plans are currently being piloted by Carers of East Lothian and Adult Wellbeing, ELHSCP. Young Carer statements are under development by Young People and Children's Services and relevant carer organisations, as well as young carers.

Function(s) - Integrated function.

Direction D02f. - Establish a housing and health and social care planning interface group to deliver the key actions and priorities from the Strategic Plan's Housing Contribution Statement and needs assessment, including a clear understanding and recognition of delegated functions and budgets as they pertain to the IJB.

Target -.

Measurement -.

Performance - A Housing and Health and Social Care Planning Interface Group will be established, to initially consider and approve the draft report referred to in IJB Direction 12b. The first inaugural meeting of the Group will take place during the Local Housing Strategy formal Consultation period (January-February 2018) and meet a minimum of twice a year thereafter.

- Proposed terms of reference for the Group are drafted and will be agreed at the first formal meeting.

Function(s) - Integrated function.
Direction D02g. - Complete a scoping exercise and bring forward operational and funding proposals to the IJB for a redesigned model of reablement by September 2016.
Target -. **Measurement -**.
Performance - The scoping exercise is complete and the report making recommendations for operational change was submitted at the end of August 2017 as planned. This was presented to the Senior Management Team and accepted. The next steps will be to set up a Project Board by the end of the year to implement the changes. The first step following the Board's establishment will be to identify a small area to pilot the model.

Function(s) - Integrated function.
Direction D02h. - Complete a review of all current Section 10 grants against an agreed prioritisation framework to ensure strategic fit and best value and bring forward proposals for investment and disinvestment to the IJB by December 2016.
Target - **Measurement -**.
Performance - Best Value and Strategic Fit Reviews have commenced and one review, of Individual Cash Management Solutions (ICMS) has completed. The PID for external provision review has been agreed by the HSCP Procurement Board, which has also agreed to review external commissioned services together with the review of Internal Day Resources centres, including Shared Lives. A Communication Plan and Project Plan are being developed, including a 'political think piece' - to be presented in November 2017. Stakeholder engagement on the review of external commissioned services and the review of Internal Day Resources centres will take place at the same time. A Needs Assessment (for 'Services to Support Community Outcomes') will be completed by February 2018, taking into account a number of factors, including: financial model for community provision, charging and transport policy and future need. A recommendation will be made in March 2018 and redesign and commissioning of services will take place over 2018/19. Community planning and Area Partnerships will be asked to join the project team as the project develops. Finance will be involved at an early stage to assist with cost modelling.

Directions on Repatriation of East Lothian Residents (D03a, D03b)

Function(s) - Set aside.
Direction D03a. - Within the framework and objectives of the plan being developed by the joint Liberton Hospital group ensure the repatriation of East Lothian residents from Liberton Hospital in Edinburgh with the associated shift in aligned financial resources to the IJB, based on agreed activity data, to match this. The indicative financial resource is c.£540k.
Target - No specific timeframe **Measurement -** Shift in the financial resource
Performance – The repatriation of East Lothian patients from Liberton Hospital has largely been completed. The cohort of patients still moving through the 20 beds on the site are transitioning from acute care to community based care, either in their own home, a care home or 'step down' unit.

Function(s) - Set aside.
Direction D03b. - As part of an agreed decant programme ensure the repatriation of East Lothian residents from Midlothian Community Hospital with the associated shift in aligned financial resources to the IJB, based on agreed activity data to match this. The indicative financial resource is c. £1 million.
Target - . **Measurement -** .
Performance – Repatriation of East Lothian patients from Midlothian Community Hospital is progressing with patients moving into East Lothian based accommodation. It is expected that in the run up to competition of the East Lothian Community Hospital in 2020 East Lothian HSCP will have repatriated all patients currently in Midlothian Community Hospital. Arrangements are in place with the LIST ISD team to track Patients to monitor progress in their relocation.

Directions to NHS Lothian on Primary Care (D04a, D04b)

Function(s) - Integrated (hosted)
Direction D04a. - Continue to work collaboratively to support and accelerate local delivery of the key recommendations of the National Review of Primary Care Out of Hours Services**.**
Targets - . **Measurement -** .
Performance – A Programme Manager was appointed by Lothian Unscheduled Care Service in August 2018. This colleague is in the process of meeting with representatives of services to review current provision and to inform planning to deliver the recommendations of the National Review. HSCP colleagues will continue to work with LUCS and will, as required, engage with the Lothian working group for the National Review.

Function(s) - Integrated (hosted)
Direction D04b. - Continue to work collaboratively to support and accelerate local delivery of the key actions of the Transitional Quality Arrangements for the GMS contract in Scotland.
Target - . **Measurement -** .
Performance – The HSCP successfully delivered the required GMS Transitional Quality Arrangements actions with the support of the Primary Care Contracts Organisation.

Directions on Resource Transfer (D05a, D05b)

Function(s) - Integrated function.
Direction D05a. - East Lothian Integration Joint Board directs NHS Lothian to make payments to East Lothian Council in line with the payment schedule outlined in Section 10 of this Direction.
Target - . **Measurement -**.
Performance - A separate overarching finance paper will be discussed at the 26th October 2017 IJB meeting

Function(s) - Integrated function.
Direction D05b. - East Lothian Integration Joint Board direct East Lothian Council to provide services as outlined and within and in accordance with the budgets outlined in Section 10 of this Direction.
Target - . **Measurement -** .
Performance - A separate overarching finance paper will be discussed at the 26th October 2017 IJB meeting

Direction D06 on the Integrated Care Fund - Replaced by Direction D12e.

Direction D07 on the Delayed Discharge Fund - Replaced by Direction D11c.

Direction on the Integration Fund - D08

Function(s) – Integrated function.
Direction D08. - East Lothian Integration Joint Board directs NHS Lothian to delegate the agreed budget for the Integration (Social Care) Fund to the IJB in line with the proposal from East Lothian Council.
Target - . **Measurement -** .
Performance - A separate overarching finance paper will be discussed at the 26th October 2017 IJB meeting

Direction to NHS Lothian on the Strategic Programme Budget - D09

Function(s) – Integrated function.
Direction D09. - Provide a full analysis on the detail of human and financial resources identified within NHS Lothian's Strategic Programmes budget within the financial year 2015/16, including an analysis of resource and activity as it relates to all delegated functions. The analysis should be available by September 2016.
Target - . **Measurement -** .
Performance - A separate overarching finance paper will be discussed at the 26th October 2017 IJB meeting

Directions for 2017-18

10 - Directions to NHS Lothian on Primary Care (D10a, D10b, D10c)

Function(s) - All East Lothian independent contractor managed GP services (Sections 17j and 17c) and East Lothian Health and Social Care Partnership directly managed services (Section 2c). Service priorities as set out in the developing East Lothian Primary Care Strategy.
Direction D10a. - NHS Lothian to work with East Lothian Health and Social Care Partnership, GPs and their representatives, Primary Care Contractor Organisation and partners to prepare for the introduction of the elements of the New GP Contract in 2017 while maintaining support to practice teams across the county to meet the primary care needs of patients.
Target - A target or targets will be agreed once information is received from the Scottish Government on the requirements of the new GP contract. This information is expected to be released in stages in April and October 2017. **Measurement -** Approaches will be developed as appropriate to monitor progress against the agreed targets.
Performance – Progress on this Direction has not been possible as formal information has not yet been received on the new GP contract arrangements. Necessary action will be undertaken with the Primary Care Contracts Organisation, the local HSCPs and other partners once information is available.

Function(s) - The development of East Lothian's two GP Quality Clusters in the west and the east of the county.
Direction D10b. - NHS Lothian to allocate to East Lothian Health and Social Care Partnership its proportionate share of all funds allocated for the development and support of GP Quality Clusters and to work with the partnership to develop quality improvement activities in general practice.
Target - Production of a workplan by East Lothian Quality Clusters setting out planned actions to improve quality in individual practices and across the cluster areas. **Measurement -** Monitoring of delivery of quality improvement actions within each area against the workplan and their outcomes.
Performance - Two Cluster Groups were established in the west and east of the county and lead members of the Clusters have received Quality Improvement Training. The Cluster groups meet regularly and are developing a workplan on key areas. Quality improvement projects have been launched across the Clusters relating to pain management, respiratory disease, wound management and prescribing. Projects are ongoing looking at efficiency of service delivery in primary care – including analysing High Health Gain data, improving administrative processes and patient signposting. Outcomes of projects are being analysed using a quality improvement methodology.

Function(s) - All East Lothian independent contractor services (General Practice, Pharmacy, Dentistry and Optometry) and East Lothian Health and Social Care Partnership directly managed primary care services.
Direction D10c. - NHS Lothian to develop with partners a primary care strategy to prioritise actions across all primary care services in East Lothian to stabilise and develop these services, through service redesign and quality improvements, in order to respond to population growth, increasing demand on services and increasing complexity of care.
Target - Completion of an East Lothian primary care strategy by December 2017 **Measurement -** Monitoring of delivery of the actions set out in the strategy against the relevant timeframes.
Performance - Aspects of primary care service redesign continue, most notably within the Musselburgh area where a test of change has been initiated with the Musselburgh Primary Care Access Service in partnership with NHS 24. The Care Home Team has now expanded and is working within new areas, including Gullane and will extend into Haddington soon to support the newly built care home. Work continues with individual practices to support population growth and to respond to acute needs by providing support. A new Primary Care Strategic Group is being set up in anticipation of the imminent recruitment of the Primary Care Services Manager. This group will involve relevant stakeholders and help formalise a strategy. The Quality Improvement projects at present involve the testing of utilisation of Allied Health Professional staff to deliver primary care services in a non-GP dependent model. Areas undergoing evaluation include patient satisfaction with access, referrals, admissions, prescribing and other outcome measures.

11 - Directions to NHS Lothian and ELC on reducing use of acute services and increasing community provision (D11a, D11b, D11c, D11d, D11e, D11f)

Function(s) - All Emergency Department (accident and emergency) services planned by East Lothian Integration Joint Board and defined as hospital services, as required by the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 and in East Lothian Integration Joint Board's Final Integration Scheme (February 2015).

Specifically the services concerned are:

- Emergency assessment services in Edinburgh
- Emergency admissions arising from attendance at the Emergency Departments in the two acute hospitals or the Minor Injuries Unit at the Western General Hospital.

Direction D11a. - NHS Lothian and its acute services to work with officers of the East Lothian Health and Social Care Partnership and other HSCPs to review the provision of emergency assessment services in Lothian, with a view to streamlining this provision.

NHS Lothian and its acute services to provide data on the pattern of emergency admission of East Lothian residents to secondary care and to work with officers of the East Lothian Health and Social Care Partnership to develop alternatives, where appropriate, to such admissions. Any resource freed up by a reduction in emergency admissions will be used to support alternative, community based services.

Target - 10% reduction in emergency assessment activity and emergency admissions for East Lothian residents

Measurement - Emergency assessment numbers and emergency admissions arising from A&E presentation

Performance – Since October 2016 the HSCP has seen a reduction in emergency assessment and admissions, predominantly in the 15 to 74 age groups but also in the 75's and over.

Figures covering October 2016 to latest published data, for July 2017 shows a drop of 5%.

Function(s) - Occupied bed days for East Lothian residents arising from all episodes of unscheduled care.
Direction D11b. - NHS Lothian to reduce the length of stay for all patients admitted following unscheduled admission. This is to be achieved by a reduction in delayed discharges, avoidable admission and inappropriately long stays in acute hospital and through the development of locally available community services and facilities.
Target - Reduce occupied bed days by 10% for 2018 compared to 2017. **Measurement -** Occupied Bed Days.
Performance - Across two measures related to Occupied Bed Days, the HSCP is making progress in reducing the length of stay Unscheduled admissions in acute care have reduced by 2% reduction over the period October 2016 to July 2017 Delayed Discharges have reduced by 57% over the period October 2016 to July 2017

Function(s) - All actions intended to reduce delayed discharges (defined as 'a hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date') of East Lothian residents from acute hospital beds.

Also, through these actions move towards delivering reductions in delayed discharges to reliably achieve timely discharge from hospital in order to meet the 2 week standard.

Direction D11c. - NHS Lothian to delegate to the IJB the agreed budget for the Delayed Discharge Fund and working with East Lothian Council to continue to make progress towards delivery of delayed discharge targets and a reduction in occupied bed days, through the provision of alternatives to inpatient care.

Target - Deliver zero delays over 2 weeks by the end of 2017-18 while working towards no delays over 72 hours.

Measurement - Monthly national census reflecting performance by the partnership.

Performance – The target of zero delayed discharges over 2 weeks continues to be challenging in East Lothian. No partnership across Scotland meets the target.

Over the last 12 months the number of delayed discharges has reduced from a high of 61 in August 2016 to 29 in September 2017. The HSCP is working towards having no more than 14 patients delayed in their discharge as well as trying to ensure that no person waits longer than 2 weeks.

Function(s) - Palliative care delivered to East Lothian residents by the East Lothian community palliative care teams, hospice-provided specialist palliative care community services and hospital-based specialist palliative care teams.
Direction D11d. - NHS Lothian to work with the Managed Clinical Network for Palliative Care, hospital, community and third sector palliative care services to provide specialist assessment of East Lothian patients in their own homes, care homes or community hospitals to maximise the delivery of patient-centred end of life care at home or in a homely setting.
Target - Reduce by 10% the number of occupied bed days in the last six months of life that are spent in acute hospital settings **Measurement -** Location of care for people receiving end of life care.
Performance - The partnership has made steady progress in delivering increased care at home or in a homely setting in the last 6 months of life as opposed to in acute hospitals. Such acute hospital delivered care has reduced to 12.2% in 2016-17 from a base figure in 2013-14 of 14.8%. Correspondingly the percentage of people spending their last 6 months of life in the community has increased from 83.5% in 2013/14 to 86.2% in 2016/17. The information above is around % of the adult population, which is not the same as the intended target of a reduction of 10% in Occupied Bed Days. There are acknowledged complications in measuring lengths of stay across hospitals, in care homes, or in their own home as this information can only be measured by accessing records retrospectively following death.

Function(s) - Acute service based Allied Health Professional (AHP) posts and associated services delivered in acute settings.
Direction D11e. - NHS Lothian to provide information on the numbers of AHPs and associated resources in acute settings and to work with East Lothian HSCP to plan for the redeployment of appropriate numbers of these AHPs and associated resources to community settings to avoid admission and to support discharge of East Lothian residents.
Target - East Lothian to receive a proportionate share of the identified AHP resource by the last quarter of 2017/18 **Measurement -** The increase in whole time equivalent AHP numbers in community settings resulting from staff redeployment.
Performance – Discussions continue with leads for centrally provided AHP services to quantify the resource which might be released from acute settings and redirected to East Lothian community settings. A consensus event in October 2017 brought together HSCP and AHP representatives to discuss how best to deliver Directions seeking to bring increased AHP resource into the HSCPs. The formal outcomes of this event are awaited.

Function(s) - All East Lothian Council commissioned care at home services.

Direction D11f. - East Lothian Council to proceed to procure care at home services on the basis of the new and agreed model of care and associated revised commissioning and tendering process.

Target - At the point of contract review all care at home services will be commissioned on the basis of the new model.

Measurement - Number of services delivered under the revised arrangements.

Performance - A new framework for care at home services commenced as planned from 1st April 2017, following a procurement exercise conducted between January 2017 and March 2017. This framework will run for five years with the possibility of an extension for a further two years.

A mix of private and voluntary organisations, a local Social Enterprise organisation and specialist providers (15 providers in total) were awarded a place on to the new Care at Home Framework.

From April 2017 to September 2017 work focussed on supporting transitioning arrangements for the coordination of care delivered to individuals from a provider leaving the framework to new providers coming onto the framework. This process has almost completed within the six month allotted timeframe with transfers relating to two providers over to SDS Option 2 arrangements still to be completed.

Work is now underway to embed the new model of delivery into the on-going care at home service delivery. These include:

- Developing the Personal Budget model with clients in receipt of support from providers at Care Inspectorate Grade 4 and above. This includes developing a budget and support package focussed on client outcomes and providing flexibility for both parties in terms of how this support is delivered.
- Payment of providers delivering personal budget model support on a 13 week schedule.

- Developing the legal paperwork linked to SDS Option 2 contracts and 'Gain Share' mechanism.
- Running collaborative allocation meetings where care runs are reorganised to maximise capacity
- Developing a 7 day 'retainer' mechanism to ensure that packages of care stay open in the community for up to seven days while someone is in hospital.

Monitoring is under development using a balanced scorecard and key performance indicators to highlight good performance and providers that are breaching contract terms. Information will begin to be available from October and will be reported on via the monthly core management performance report.

12 - Directions to NHS Lothian and ELC on shifting balance of care for care groups (Directions 12a, 12b, 12c, 12d, 12e)

Function(s) - All care at home services delivered by East Lothian Council
Direction D12a. - East Lothian Council to develop its protocols to simplify and speed up the process for assessing and acting on an individual client's needs for care at home.
Targets - 1. Clients to be assessed for care at home within 7 days of request/referral. 2. If, following assessment, care at home is required this will be provided within 7 days. 3. Reassessment of clients will be carried out every 3 months **Measurement -** Number of days each client waits for assessment, number of days awaiting care following assessment and percentage reviewed every 3 months.
Performance - The targets identified have not yet been achieved. The current programme of service redesign and the delivery of performance data will assist in addressing the barriers to achieving the target.

Function(s) - All extra care housing for all client groups across East Lothian.

Direction D12b. - East Lothian Council to finalise the extra care housing report and to develop a plan with partners to deliver all its recommendations to improve housing provision for people with care needs.

Target - To finalise by June 2017 the report, associated workplan and delivery timetable.

Measurement - Report production and delivery of recommendations within the agreed timeframe.

Performance – The housing need and demand assessment for older people was completed. One key recommendation of the report was to review all sheltered housing for older people in East Lothian. The exercise will cover all aspects of sheltered housing including council, registered social landlords and private sector stock across the county and will tie into the overall review of housing support services. The project will:

- Undertake a strategic review of sheltered housing for older people in East Lothian by end February 2018, looking at including demand and supply; service provision and delivery; funding arrangements and wider community benefits.

- Provide quantitative and qualitative evidence in the form of a comprehensive review to provide a focus for future investment and action, to maximise the potential of existing sheltered housing

The housing thematic group will receive regular updates on the progress of the review and will sign off the review report before it is brought to the IJB for approval towards the end of the 2017/18 financial year.

The report is nearing completion, however key data currently remains unavailable. Mechanisms are in place to try to access this data in the short-term where possible.

· The report comprises a key element of a suite of documents, prepared to inform and underpin the Local Housing Strategy

2018-23. A six week formal Consultation on the draft Strategy will close in February 2018. During this Consultation period, the draft report will be considered and approved by the newly established Housing, Health and Social Care Planning Interface Group (IJB Direction 2f).

- East Lothian Council and the IJB will subsequently be asked to approve the report as part of a suite of documents underpinning the Local Housing Strategy 2018-23 and as a key source of evidence to inform the forthcoming Strategic Plan, by end March 2018.

Function(s) - East Lothian Council and East Lothian Health and Social Care Partnership delivered day services for older people.
Direction D12c. - East Lothian Council to finalise and implement the strategy for day services for older people in order to improve access to and quality of day services across the county while delivering service efficiencies.
Target - Deliver increased capacity across all areas so reducing waiting times for day services. **Measurement -** Percentage of older people assessed as needing day services that are in receipt of a service.
Performance - Since agreement to further invest in older peoples' day care from April 2017 a number of measures are underway in order to develop the day services and to maximise the range of services being delivered and the extra day service places available. To support the necessary changes various work streams within the development plan are underway in year one of the three year strategy for day centres. Existing service level agreements have been extended in year one while the new service level agreements are put in place. The new funding formula as agreed has been in operation and has seen an increase in funding for a number of day centres as a result of them moving from 4 to 5 days. Work continues to identify suitable premises for two of the day centres and options are currently being explored in relation to one centre while a solution for the other centre has been agreed for the next 2 or so years. Progress has been made in standardising the lease and maintenance arrangements across all of the centres. A capital bid is being developed for day centres for the longer-term needs. Support is being provided from the Local Intelligence Support Team (LIST) from Information Services Division (ISD) to develop robust datasets across all ten centres in order to quantify the increased service provision since investment. It is expected that measures will be available by quarter three.

Function(s) - All services currently delivered through Eskgreen Care Home and Abbey Care Home and Edington Hospital and Belhaven Hospital.
Direction D12d. - NHS Lothian and East Lothian Council to set up projects to deliver the reprovision of Eskgreen and Abbey Care Homes and Edington and Belhaven Hospitals and to deliver on the recommendations of the Housing with Care report.
Target - Complete by January 2018 all reviews of provision across the 4 settings and prepare a plan to develop and coordinate future service provision. **Measurement -** Completion of reviews and production of an agreed delivery plan.
Performance - A strategic vision is under development for the reprovision of Eskgreen and Abbey care homes and Edington and Belhaven hospitals. This vision will set out a proposed model of care as a starting point and this will be widely consulted upon in preparation for the subsequent development of a business case. The vision will take account of the strategic assessment of extra care housing need for older people in East Lothian and the review of Sheltered Housing. It will also take account of the future NHS bed requirements in the East Lothian Community Hospital Business Case, overall care home provision and the size and nature of the care home market in East Lothian. In addition, it will take account of the strategic direction and principles contained in the IJB Strategic Plan, the Council Plan, The Scheme of Establishment, the NHS Lothian Plan and the Health and Social Care Delivery Plan. It is anticipated that the strategic vision will be presented to the IJB in December 2017. If this is agreed then the strategic vision will be consulted upon in early 2018 and a business case developed thereafter.

Function(s) - All delegated functions as they pertain to the annual East Lothian Integrated Care Fund Plan.
Direction D12e. - NHS Lothian to delegate the agreed budget for the Integrated Care Fund to the IJB, to review the achievements of the Integrated Care Fund in 2016/17 and based on this, to develop a revised Integrated Care Fund Plan for 2017/18.
Target - Complete by June 2017 a review of the 2016/17 integrated care fund and prepare a revised Integrated Care Fund plan. **Measurement -** Completion of the review and production of a revised plan.
Performance - A separate overarching finance paper will be discussed at the 26th October 2017 IJB meeting

13 - Directions to NHS Lothian to support delivery of the Modern Outpatients recommendations

Function(s) - All adult diabetes health services planned for and delivered to residents of East Lothian, within the geographical boundaries of the East Lothian Health and Social Care Partnership and elsewhere across Lothian. Specifically the services concerned are:

- Consultant Diabetologist-led outpatient clinics
- Diabetes Specialist Nursing support
- Diabetic Foot Clinic
- Dietetics Services for diabetes
- Diabetic Retinopathy Screening
- Psychology support to people living with diabetes
- Structured education for people living with diabetes
- Professional education on diabetes care to primary care colleagues
- Services provided by health professionals that aim to prevent diabetes.

Direction D13a. - NHS Lothian and its diabetes specialist services to work with officers of the East Lothian Health and Social Care Partnership to maintain delivery of diabetes outpatient clinics within Roodlands hospital and to develop local primary care delivery of high quality diabetes diagnosis, care, treatment and patient education to improve outcomes for people living with diabetes. In carrying out this work, all opportunities will be taken to redirect diabetes resources from acute hospital services to community services.

Target - By the end of 2017/18, all non-complex Type 2 patients from East Lothian currently receiving diabetes care in acute hospital clinics will receive this care in a primary care setting, with appropriate resource following the patient.

Measurement - The SCI-DC diabetes register will be used to identify Type 2 patients receiving care in acute settings at the beginning of 2017/18 and to monitor progress in these patients transferring to primary care.

Performance - The complexity of identifying and re-directing resource has proven to be a rate-limiting step. Consideration is being given to how best to identify a discrete clinical area and invest resource in test of change there, before progressing to the more substantial area of type 2 diabetes. One element being examined is primary care diagnosis of dementia.

14 - Direction to NHS Lothian and ELC on support to carers

Function(s) - All NHS Lothian, East Lothian Council and East Lothian Health and Social Care Partnership delivered services in support of carers.
Direction D14a. - NHS Lothian and East Lothian Council to finalise and implement the East Lothian Carers' Strategy, working with East Lothian Health and Social Care Partnership, third sector and other partners to plan delivery of the strategy's priorities. In addition, partners are to work together to assess unpaid carers' needs, to deliver a range of relevant support services in order to help to reduce any negative impact of a caring role on an individual's own health and well-being and to prepare for the Carers' Act in 2018.
Targets - 1 - Produce a Carers' Strategy by the third quarter of 2017-18 2 - Deliver a needs assessment of unpaid carers' needs by the third quarter of 2017-18 3 - Ensure all unpaid carers receive an assessment of their needs within 4 weeks of referral or self-referral. **Measurement -** Number of needs assessments each month and outcome of assessments.
Performance - Development and preparation for the East Lothian Carers' Strategy continues and is expected to be finalised by 1st April 2018 as set down in the Carers (Scotland) Act 2016. To date activities have included a 'Big Breakfast' event attended by relevant stakeholders, care support service providers from public, third and voluntary sectors, carers and cared-for people. Following event feedback the Eligibility Criteria Framework, broadly based upon the National Carer Organisations framework, was accepted by the Core Management Team as a model of best practice. The Eligibility Criteria was published in-line with legislative requirements and is out to consultation from 1st October 2017 to 31st December 2017. A Working Group meets fortnightly and includes within its remit; programme management, governance of the project and finance and demand of service requirements. It will also develop specific workstreams as the project progresses:

communications and public awareness; real choice and commissioning; Third Sector role; workforce support, training and development; information and systems and monitoring and evaluation

A workstream will also be established to address issues regarding supply of data and information for the Scottish Government's Carers Census. The Carers Census consultation that East Lothian participated in identified a number of gaps in data and information provision within East Lothian and the working group will look to address these.

A Carers' Strategic Group (with representation from a number of public, third and voluntary sector organisations) will look at the delivery of duties that include: adult carer support plans; young carer statements; local eligibility criteria; carer involvement; local carer strategy and information and advice services for carers. It will also develop and maintain relationships with other relevant strategic programmes to ensure progress on the Carers Strategy is publicised.

A development session on the Carers Strategy, led by an IJB Board member with responsibility for Carers Strategy was attended by Carers of East Lothian, East Lothian Young Carers and ELHSCP officers.

Adult carer support plans are currently being piloted by Carers of East Lothian and Adult Wellbeing, ELHSCP. Young Carer statements are under development by Young People and Children's Services and relevant carer organisations, as well as young carers.

15 - Directions to NHS Lothian on drug and alcohol services and mental health (Directions 15a, 15b, 15c, 15d)

Function(s) - Alcohol and drug services for residents of East Lothian
Direction D15a. - NHS Lothian to make available to East Lothian IJB, a 12% share of the Scottish Government Drugs and Alcohol Funding for ADPs as well as 12% of the NHS Lothian core budget spent on Alcohol and Drugs.
Target - East Lothian IJB to secure its share of all drug and alcohol monies. **Measurement -** Amount of budget provided through both routes.
Performance - In May 2017, the four Chief Officers of the Integration Joint Boards in Lothian agreed to a phased implementation of the updated NRAC (NHS Scotland Resource Allocation Committee)/prevalence formula used to identify funding streams for alcohol and drugs services. This resulted in East Lothian's previous 10% share of NHS Lothian monies increasing to 11% in 2017/18. This will increase to 12% in 2018/19. In August 2017, MELDAP (Midlothian and East Lothian Drug and Alcohol Partnership) were advised that IJB Chief Officers/Chief Financial Officers had agreed that Alcohol and Drugs Partnership (ADP) funding would continue using the same financial processes as in previous years. It is hoped that agreement can be achieved that all drug and alcohol funding [ADP and NHS Core funding] will be delegated to the area IJB/ADPs for 2018/19.

Function(s) - Alcohol and Drug services for residents of East Lothian

Direction D15b. - NHS Lothian to allocate the available share of ADP and NHS Lothian core funding for the development by MELDAP (within the finances available) of redesigned and locally managed and community delivered prevention, recovery and treatment services to meet the needs of East Lothian residents who are dependent on any substance.

Target - To maintain service delivery while completing the service redesign exercise by August 2017

Measurement - Recording of client numbers and client location following the service redesign in comparison with numbers over the previous year. Ongoing monitoring of service uptake.

Performance – MELDAP (Midlothian and East Lothian Drug and Alcohol Partnership) have been able to suspend proposed savings from local services in East Lothian. As a result, MELDAP will take the opportunity to pilot and then develop a Peer Support service within East Lothian primary care practices. It will also develop a young people's service.

MELDAP will continue with the development of a Recovery Orientated System of Care with improved provision for people with co-occurring disorders by setting up a Recovery Hub and model of service delivery in Musselburgh covering the West Sector with an East Sector Satellite Hub potentially in Haddington. Service development work is underway working towards delivery in Spring 2018.

Since 2012, the MELDAP area has met and exceeded the HEAT (Health Improvement, Efficiency, Access, Treatment) A11 Standard that 90% of people are seen within 3 weeks (referral to treatment).

However, in the fourth quarter of 2016/17, for the first time since 2012, the MELDAP area failed to attain 90%, meaning the NHS Substance Misuse Service in East Lothian is in breach of the standard. The service has advised MELDAP that they have taken remedial action that will aim to meet the standard by the end of quarter 3 - 2017/18.

Achievement of Waiting times for the MELDAP area was 74.86% from January 2017 to March 2017. This reduced to 70.65% from April 2017 to June 2017.

Performance for the East Lothian Substance Misuse Service - Drugs was: 25% in the period January 2017 to March 2017, increasing to 38.46% over the period April 2017 to June 2017.
Performance for the East Lothian Substance Misuse Service – Alcohol was: 33.33% in the period January 2017 to March 2017, decreasing to 23.53% over the period April 2017 to June 2017.

Function(s) - Mental health services for residents of East Lothian

Direction D15c. - NHS Lothian and East Lothian Council to develop an integrated Mental Health Team with a single point of referral and triage to ensure mental health service users receive the right support by the right people at the right time, closer to home. This team is to:

- Develop an assertive in-reach model to Hermitage Ward, to support bed closures at the Royal Edinburgh Hospital and to ensure that inpatients from East Lothian have a safe, timely discharge process, with an appropriate social care package determined by their assessed needs.
- Develop mental health service input to the Musselburgh Primary Care Centre to improve access to mental health support in primary care, in partnership with primary care teams, community mental health teams, NHS 24 and HSCP and East Lothian Council Strategy Officers.
- Work with East Lothian HSCP and Police Scotland to develop mental health 'street triage' as part of responses to the national driver for distress brief interventions.

Target - To maintain all elements of service delivery while developing the street triage approach by April 2017, the assertive in-reach model by May 2017 and the single point of referral by June 2017.

Measurement - Progress against all developments will be assessed using quality improvement methodology (test of change) activity levels and location of service delivery.

Performance - Within the Adult CMHT we are currently operating a single point of referral phase one, next steps is not get to the right person first time as current practice is to be seen by a consultant which in many cases is inappropriate. (discussions required locally)

Street triage is fully implemented and all teaching sessions were well attended, next steps is to go back and evaluate

In reach model continues within Hermitage and early data would suggest this model supports safe, efficient and effective early discharge with the support from IHTT if required

Musselburgh Access Hub - The Mental Health Nurse and Occupational Therapist took up post early September, we have drafted an operational policy which continues to require changes going forward as the balance of care shifts. The hub continues to grow with various professions now in post and staff continue to express there enthusiasm and commitment to the service early feedback from Service Users is very good and encouraging for staff going forward. Further to Mental Health staff we are now in the position to enhance the model to include a band 6 Substance Misuse Nurse post 3 half days per week to support people with Substance Misuse concerns within the Musselburgh area this post like the MH posts will be supported by the local EL SMS in relation to professional links and operationally managed through MPAS.

Function(s) - Older Adults' Mental Health Services for residents of East Lothian

Direction D15d. - NHS Lothian to:

- Work towards closure of Hopetoun Day Unit and the review and redesign of resources to develop an integrated Mental Health Service which will deliver person centred holistic care to older residents of East Lothian.
- Redesign the East Lothian and Midlothian Psychiatric Assessment Team (EMPAT) to further develop the provision of education to all nursing and care homes across the two areas, in support of roll-out of the Newcastle model of Stress and Distress
- Develop Dementia Diagnosis within Primary Care and the provision of support from Alzheimer link workers, or Community Psychiatric Nurse on the day of diagnosis. The approach should initially be piloted in two GP practices, one **in Tranent and one in Ormiston.**

Target - To develop the availability of primary care based dementia diagnosis as well as the provision of one year of post diagnostic support.

To work towards application of the 5 pillars approach.

Measurement - The number of dementia diagnoses and the proportion receiving post-diagnostic support.

Performance -
ELHSCP held a consultation event with staff in relation to the closure of Hopetoun Day Hospital, this went very well with rich discussion and generation of new ideas moving forward. Hopetoun day hospital has now closed operating as a day hospital and has not received referrals since June 2017 and the staff have been on training and enhancing there skills by attending numerous locally held events within Day centres with a key focus on how the staff can support the day centres to manage service users displaying distressful behaviours

New
Empat (Mental Health Care Home Team) remodelling continues we recently met with Richard Murray in relation to the data collection for the Newcastle model as this is included within Psychological therapies Heat Standing. Staff continue to support the Care Homes successfully

The ELHSCP increased the number of Dementia Post Diagnostic Support (PDS) link workers from one to two from April 2017. This will enable the current waiting list for the 12 months post diagnostic support programme to be reduced in size for all people diagnosed with Dementia across EL. NHS Lothian analytical support services via Richard Murray have been id discussion with the service on how best to capture and utilise our data locally to inform service provision. With Alzheimer's Scotland, we held a half day session for dementia carers and their relatives , looking at the sort of service they require and how this fits in with the 3rd Scottish National Dementia Strategy 2017-2020.

16 - Direction to NHS Lothian and ELC on Community Justice

Function(s) - All Health and Social Care Services for people who have committed offences including (but not exclusive to):

- Criminal Justice Social Work
- Alcohol & Drug Services
- Mental Health Services
- GPs
- Public Health Services
- A&E Services
- Prison Health Services.

Direction D16a. - NHS Lothian and East Lothian Council to work with the Reducing Reoffending Board over the course of the financial year 2017-2018, to ensure delivery of:

- Improved Community Understanding and Participation in Community Justice
- Strategic Planning and Partnership Working
- Equitable Access to Services
- Evidence Based Interventions.

Target - Delivery of agreed Community Justice Outcomes

Measurement - A range of Community Justice Indicators

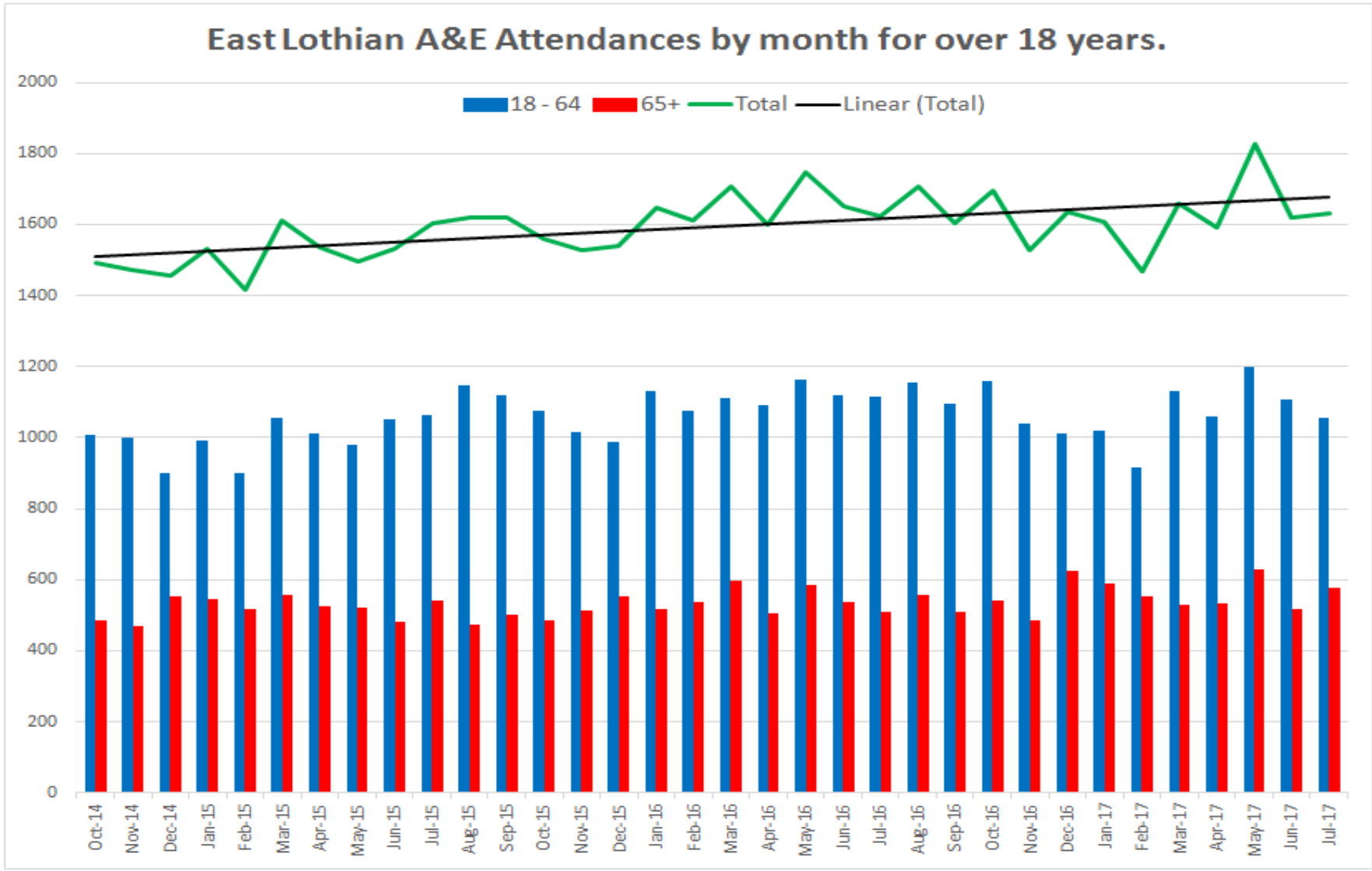
Performance – The East Lothian Community Justice Plan was produced using the views and perceptions of communities, to improve community understanding and participation in community justice and understanding of the unpaid work programme.

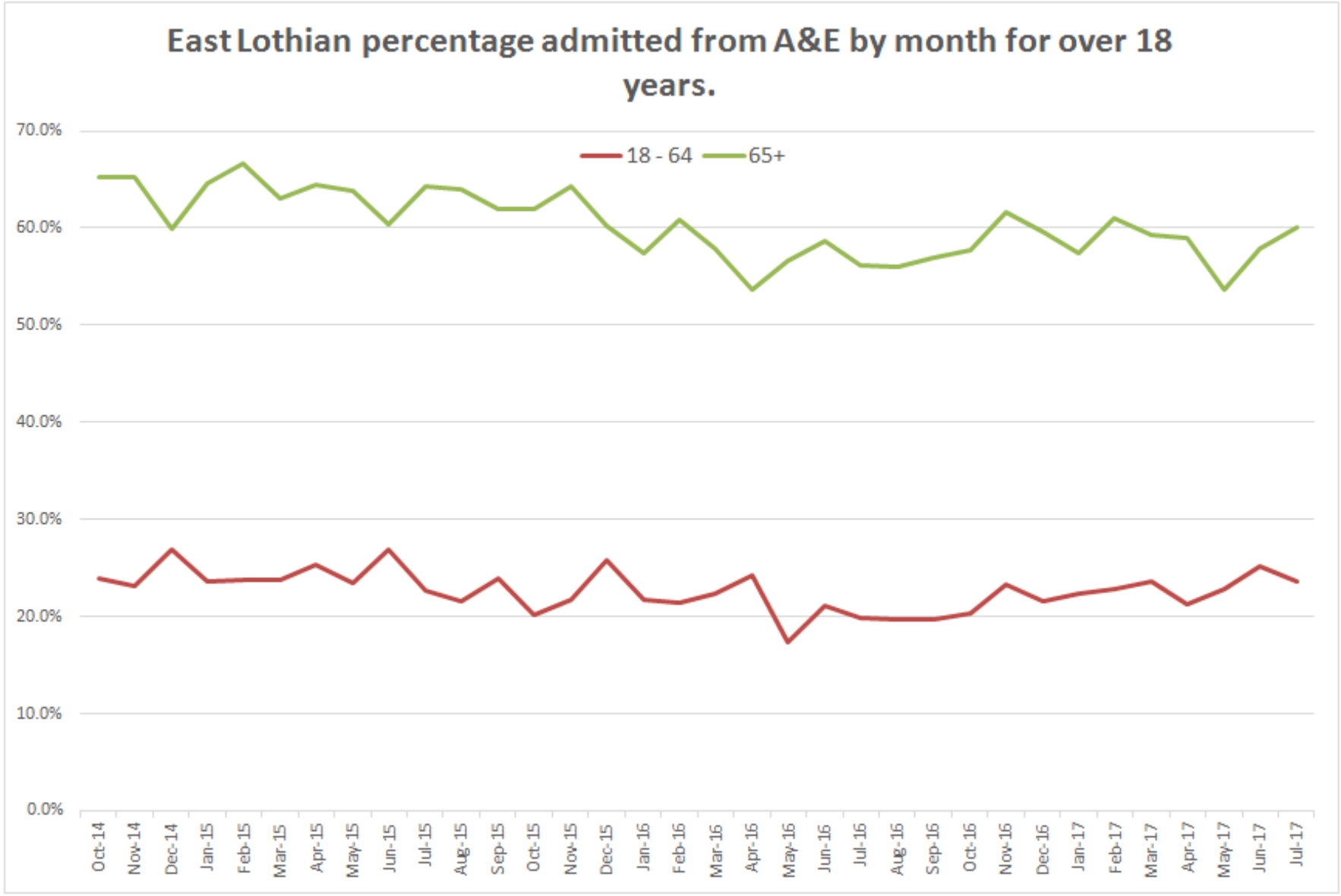
Arrangements are in development to share information and provide appropriate services, on a timely and enabling basis. This will aid partners' in strategic and collaborative planning and delivery of services, so improving access to these services for

people who require: welfare; health and wellbeing; housing or employability support.

In East Lothian effective interventions are being delivered to prevent and reduce the risk of further offending. These focus on areas such as diversion and peer support and in further developing citizenship in young people.

Appendix 3 - Measuring Performance under Integration Measures




East Lothian percentage admitted from A&E by month for over 18 years.
18 - 64
65+
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
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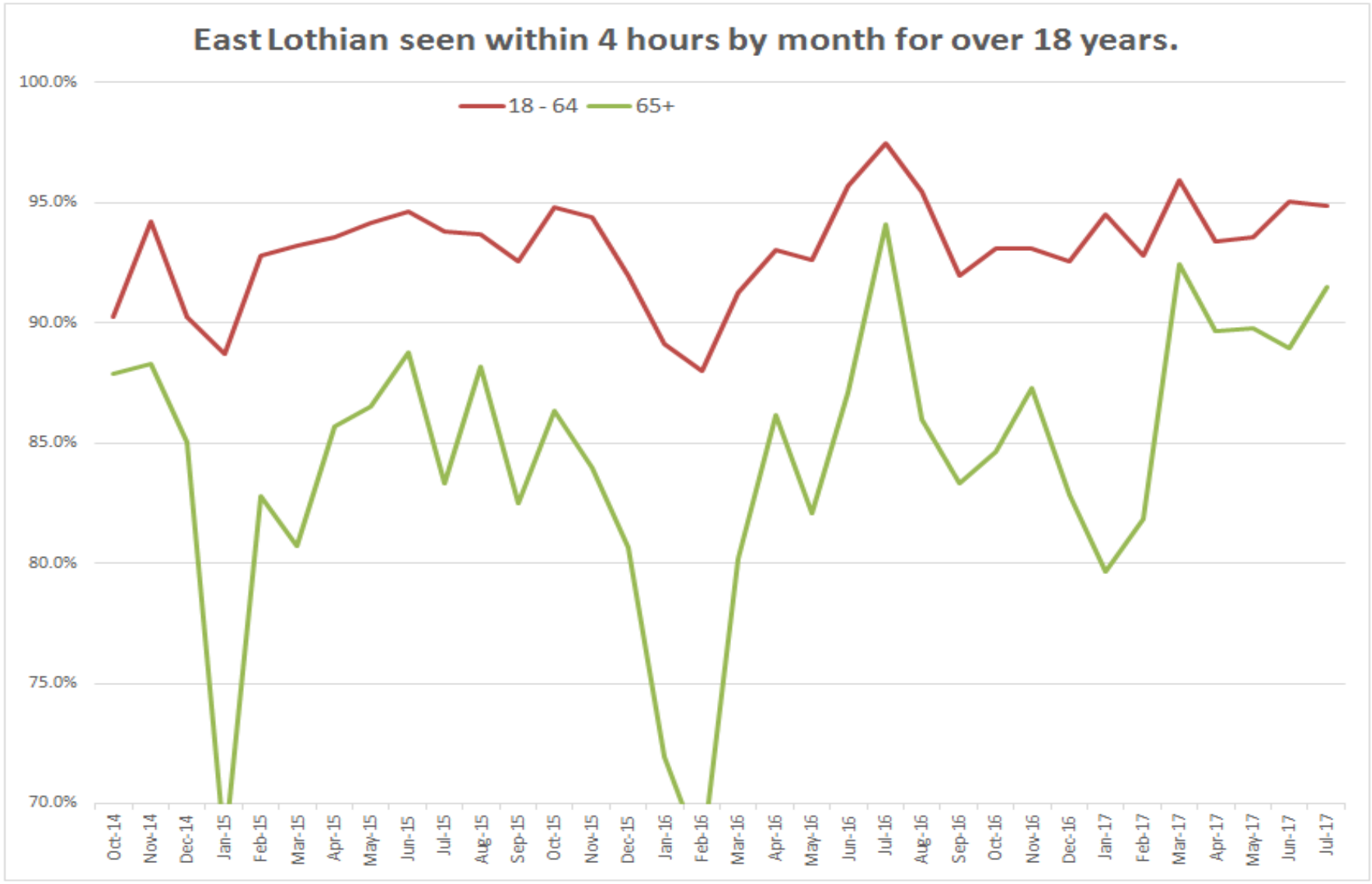
East Lothian seen within 4 hours by month for over 18 years.
18 - 64
65+
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
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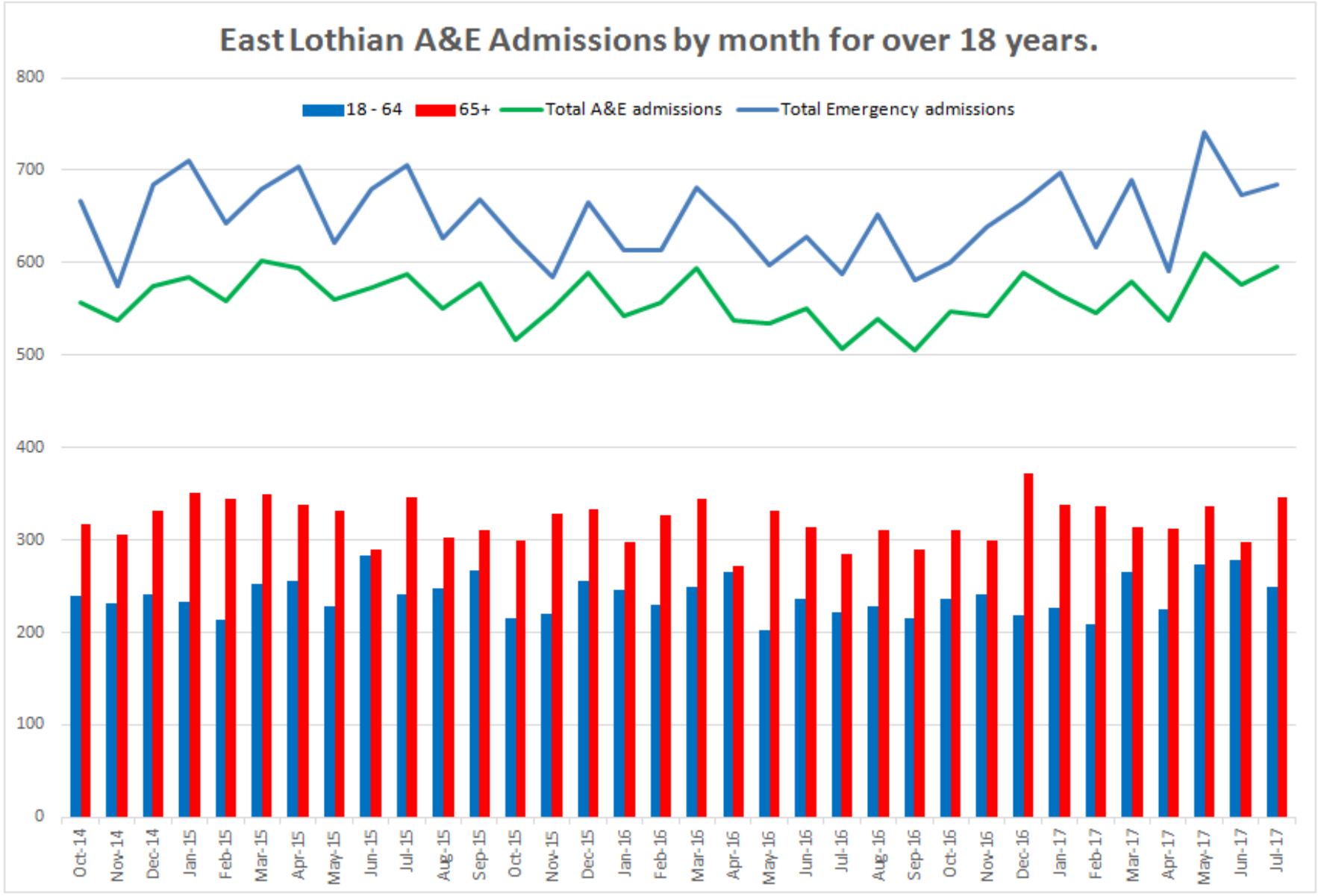
Jul-17


East Lothian A&E Admissions by month for over 18 years.
800
700
600
500
400
300
200
100
0
18 - 64
65+
Total A&E admissions
Total Emergency admissions
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
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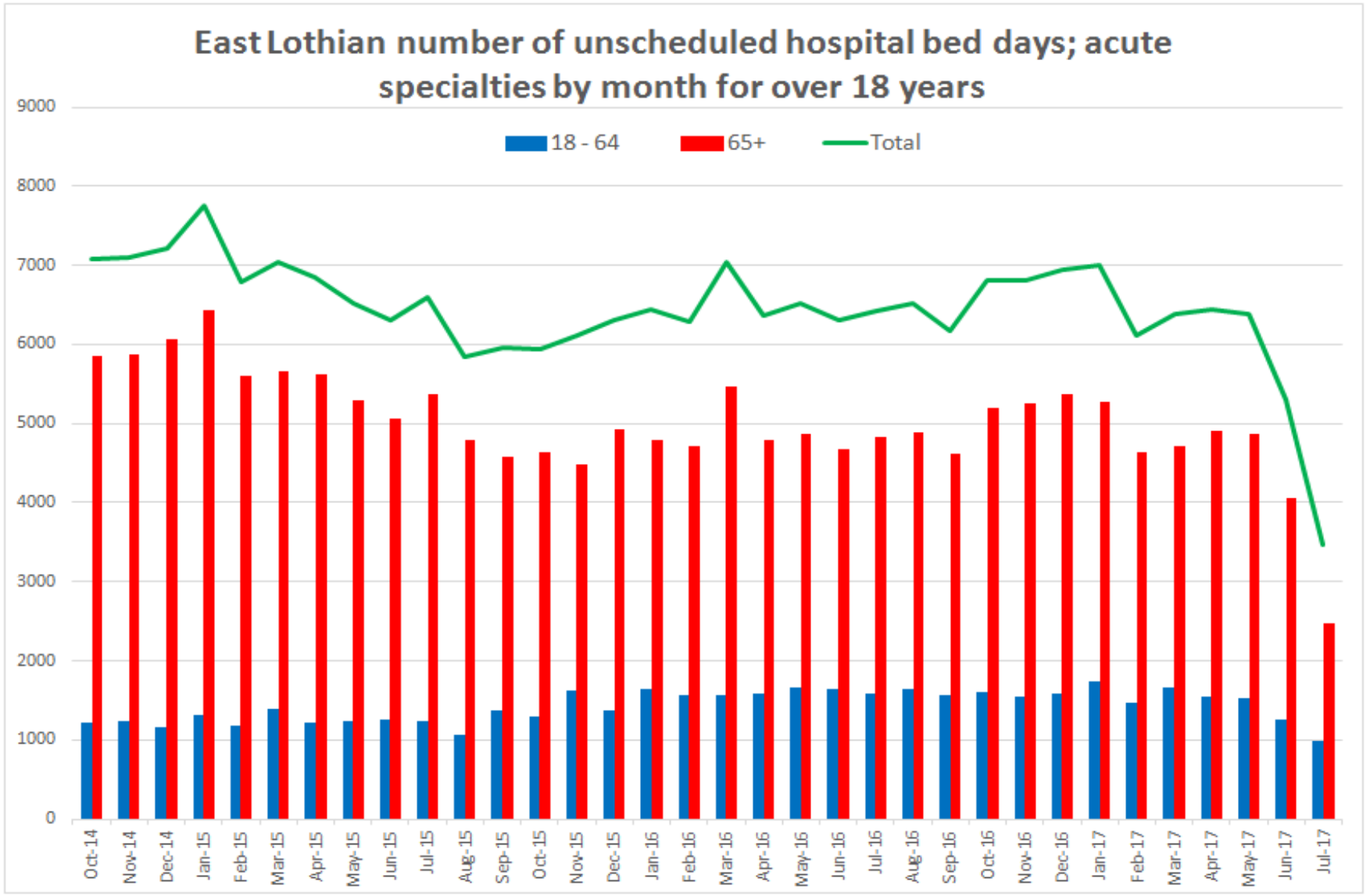
East Lothian number of unscheduled hospital bed days; acute specialties by month for over 18 years
18 - 64
65+
Total
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
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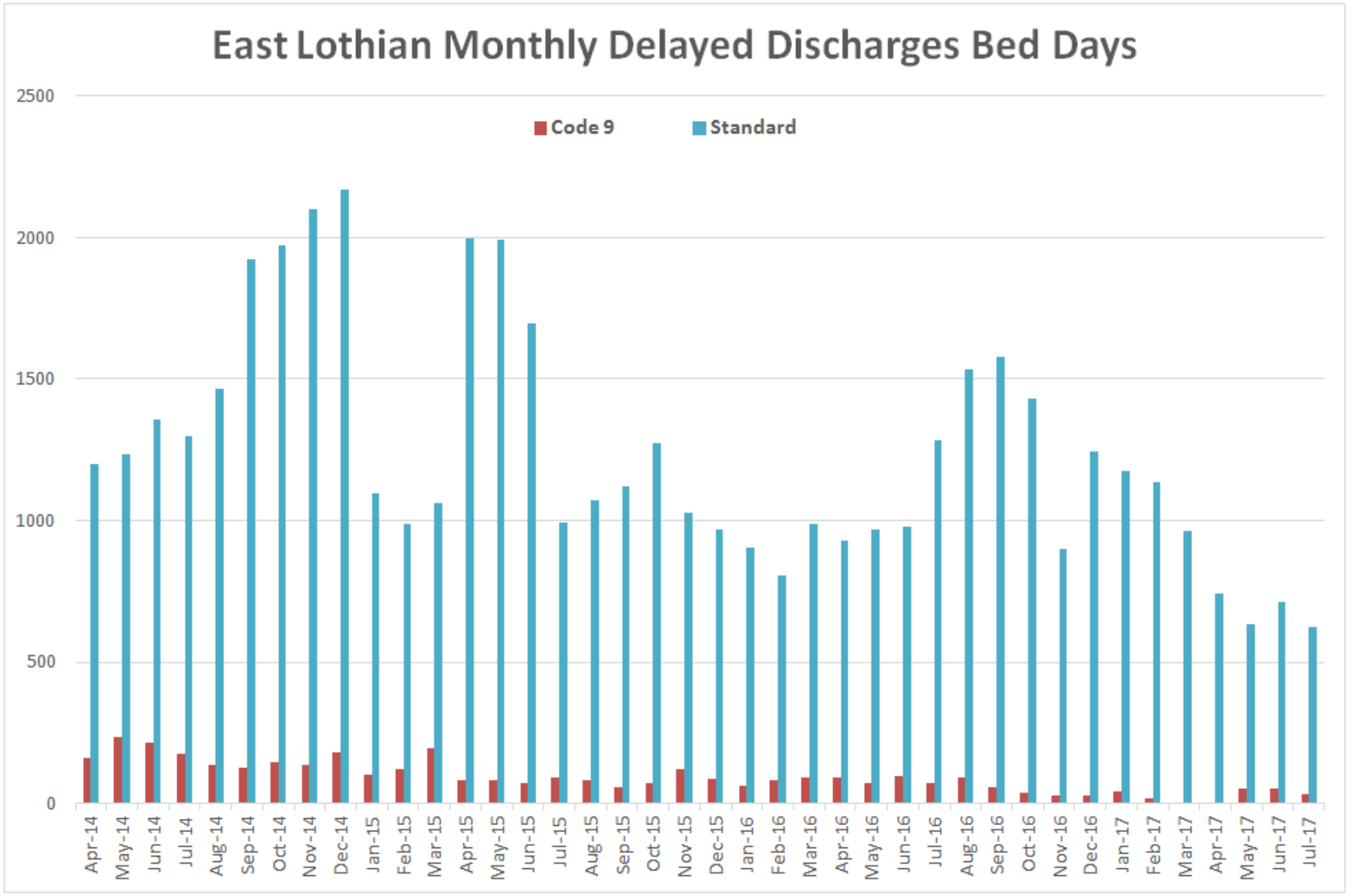
East Lothian Monthly Delayed Discharges Bed Days
Code 9
Standard
2500
2000
1500
1000
500
0
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
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