**REPORT TO:** East Lothian Integration Joint Board

**MEETING DATE:** 27 June 2024

**BY:** Chief Officer

**SUBJECT:** IJB Strategic Plan - Annual Delivery Plan for 2024-25

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## 1 PURPOSE

1.1 To present a summary of the Annual Delivery Plan for 2024-25 to the IJB for information.

## 2 RECOMMENDATIONS

The IJB is asked to:

2.1 Note the development of the 2024/25 Annual Delivery Plan outlining planned activity across East Lothian Health and Social Care Partnership (ELHSCP) services to support delivery of the IJB's strategic objectives as detailed in its 2022-2025 Strategic Plan.

2.2 Note that a 6-month progress report, covering the period from 1 April to 30 September, will be presented to a future meeting of the IJB.

## 3 BACKGROUND

3.1 The East Lothian IJB Strategic Plan for 2022-25 outlines the IJB's strategic objectives and related delivery priorities over a three year period.

The appended 2024-25 Annual Delivery Plan (ADP) provides a summary of the key activities anticipated in relation to each of the strategic objectives and related delivery priorities (this is the second ADP linked to the current IJB Strategic Plan). A more detailed version of the ADP was approved at a meeting of the Strategic Planning Group earlier in June. The ADP is a working document and as such will continue to develop throughout the year as further activity evolves.

3.2 This is the second ADP in relation to the current IJB Strategic Plan. The IJB 2023/24 Annual Performance Report describes progress in relation to individual delivery priorities outlined in the previous ADP (covering 2023/24).

3.3 A 6-month progress report on the 2024/25 ADP, covering the period from 1 April to 30 of September, will be presented to a meeting of the IJB later in the year.

## 4 ENGAGEMENT

4.1 Engagement/involvement of stakeholders will take place in relation to specific actions/activities where appropriate.

## 5 POLICY IMPLICATIONS

5.1 The Annual Delivery Plan outlines how HSCP services will contribute to the delivery of the strategic objectives contained in the East Lothian IJB Strategic Plan for 2022-25.

## 6 INTEGRATED IMPACT ASSESSMENT

6.1 The Annual Delivery Plan contains details of a wide range of HSCP activity, much of which will either have been the subject of an IIA or will require an IIA to be carried out before further development takes place.

## 7 DIRECTIONS

7.1 The development of specific activities detailed in the Annual Delivery Plan may necessitate revisions to current Directions or the introduction of additional Directions. Recommendations regarding changes to Directions will be made as and when required.

## 8 RESOURCE IMPLICATIONS

8.1 Financial – Planned activity outlined in the ADP may need to be revised in line with any changes to available resources once budget settlements are confirmed.

8.2 Personnel – None

8.3 Other – None

## 9 BACKGROUND PAPERS

9.1 East Lothian IJB Strategic Plan 2022-25

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| **DATE** | 15 June 2024 |

Appendix 1

# East Lothian IJB Strategic Plan
# Annual Delivery Plan 2024-25 (Summary Version)

# Contents

| STRATEGIC OBJECTIVE 1 – Develop services that are sustainable and proportionate to need | | |
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| **Delivery Priority** | **Key activities** | **Planned activity for 2024/25** |
| **1.1 Planning for an ageing population** | **1.1.1 Delivery of Planning Older People's Services Project.** | • Completion of options appraisal exercise – August 2024.<br>• Further public engagement in relation to appraised options via roundtable events and public consultation – September – November 2024.<br>• Presentation of final recommendations to the IJB in early 2025. |
| **1.2 Developing Intermediate Care** | **1.2.1 Ongoing consolidation and development of range of Intermediate Care services.** | • Continued review and development of interim care services (including care at home pilot – see 1.2.2).<br>• Further development and expansion of Home Care / Hospital to Home integrated service to create additional capacity, fully utilising One Plan, and reviews process. |
| | **1.2.2 Delivery of programme to review and redesign Care at Home service provision.** | • Presentation of recommendations to SPG / IJB regarding a Test of Change Flexible Locality Model – May 2024.<br>• Formation of Project Team to develop and implement the Flexible Locality Model – June 2024.<br>• Delivery of Test of Change project in North Berwick – June 2024 to June 2025.<br>• Evaluation / review of Test of Change project and identified of recommendations for future provision based on learning. |
| | **1.2.3 Development of East Lothian Community First Service (delivered by VCEL with ELHSCP funding / support).** | • See 2.2.4 below. |

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| **1.3 Supporting the acute sector** | **1.3.1 Delivery of approaches / activity to reduce admissions and support timely hospital discharge / hospital flow.** | • Ongoing delivery / development of multidisciplinary ICAT approach.<br>• Ongoing delivery / development of Daily Flow Huddle.<br>• Embedding of East Lothian multi-disciplinary team (MDT) in Royal Infirmary of Edinburgh (RIE), providing Physiotherapy and Occupational Therapy assessment and MDT case management.<br>• Continuation of East Lothian Inreach model for a further 12months with funding from ELHSCP.<br>• Carrying out a programme of 'Ward Workshops' for ELCH Wards – focusing on multi-disciplinary approaches, implementation of Discharge Without Delay principles, etc.<br>• Implementation of Ward Development Plans on the back of Ward Workshop sessions.<br>• Activity to further develop the use of data to inform operational delivery and decision making. |
| | **1.3.2 Delivery of approaches to reduce mental health bed use and admissions.** | • Ongoing development and delivery of actions to reduce admissions and length of stay.<br>• Continued development of mental health clinical nurse specialist role. |
| | **1.3.3 HSCP management of services at the Chalmers Centre, Astley Ainslie Hospital, and the Robert Fergusson Unit on a 'hosted services' basis on behalf of Lothian IJBs.** | • Ongoing management of hosted services and related development activities. |
| | **1.3.4 Provision of Orthopaedic Rehabilitation Ward at East Lothian Community Hospital for pan Lothian patients.** | • Ongoing delivery of orthopaedic rehabilitation in Ward 5 of ELCH. |

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| **1.4 Commissioning** | **1.4.1 Development and implementation of Commissioning Strategy.** | • Review and update of Commissioning Strategy and Market Facilitation Statement – 2025. |
| **1.5 Supporting effective and sustainable Primary Care** | **1.5.1 Support the development of General Practice Cluster work to improve the quality of primary care services in East Lothian.** | • Scale and spread of successful subgroup Frailty Project to involve other practices in East Lothian.<br>• Development of Practice Nurse Subgroup to improve respiratory chronic disease management.<br>• Agree a cluster wide area of focus to maximise impact of improvement work for 2024/25. |
| | **1.5.2 Work with General Practice, NHS Lothian, and Public Health Scotland to improve data access and quality and to use this data to improve patient experience.** | • Continued work with Lothian Analytic Service (LAS) to standardise and improve coding in East Lothian primary care.<br>• LIST and LAS attendance and input at cluster meetings.<br>• Improvement work based on Lothian Data Quality Framework measures. Measurement of change over time under development.<br>• Development of East Lothian frailty register and dashboard.<br>• Involvement of Dunbar, East Linton and Prestonpans practices in Scottish Government pilot re telephony (to inform potential development of telephony framework).<br>• Ongoing work to develop data portal and expansion to cover additional primary care services (specifically District Nursing and Practice Nursing). |
| | **Carry out work to optimise use of premises across East Lothian to provide sustainable, accessible primary care.** | • Ongoing work regarding efficient use of health and social care estate in East Lothian.<br>• Ongoing involvement of HSCP in East Lothian Council Capital Investment and Asset Management Group. |
| | **Work with General Practice to facilitate sharing of good practice to optimise workload management and build resilience within primary care services.** | • Continuation of workstream to support GP practice resilience (specific actions to be added as they emerge).<br>• Ongoing support of work by GP Practices to bring Practice boundaries in line with East Lothian boundaries (to improve patient pathways and to help ensure resilience and sustainability of Practices). |

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| | **1.5.3 Improving patient engagement in primary care**. | • Roll out of professional to professional linkage to support patients supported by adult mental health services to access primary care. |
| **1.6 Delivering a community model for mental health and learning disability provision** | **1.6.1 Deliver a community model for mental health rehabilitation and learning disability beds in line with phase 2 of the Royal Edinburgh Hospital Campus.** | • To be confirmed |
| **1.7 Supporting delivery of sustainable Care Home provision** | **1.7.1 Continue to monitor quality and support improvement activity within care home provision.** | • Ongoing delivery and further development of the Care Home Huddle to support a multi-agency approach to monitoring care home quality and supporting improvement work.<br>• Carry out review of charging in local authority care homes to bring in line with CRAG (Charging for Residential Accommodation Guide)<br>• Continue to deliver range of Quality Improvement (QI) activities, to include - falls and frailty support; pain management; embedding of HOPE workbook (spiritual care plan); and delivering My Health, My Care, My Home framework (future care planning) |
| | **1.7.2 Develop approach to ensure that the best use is made of available care home capacity by effectively matching provision to need.** | • Development of an agile Social Work Hospital Discharge Team to carry out early assessment and care package design to help identify alternatives to care home admission.<br>• Carry out management scrutiny of care home referrals through a resource panel to ensure care home places filled by those with the highest level of need.<br>• Track hospital admissions to identify any that could have been prevented and to reduce the risk of readmission once people discharged home. |
| | **1.7.3 Closure of the Abbey Care Home.** | • Establish Steering Group and develop detailed project plan for staged closure of care home. To include key focus on communication and ongoing engagement with staff, residents, and families.<br>• Progress to be reported to Financial Overview Group. |

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| | **1.7.4 Closure of Blossom House Care Home.** | • Establish Steering Group and develop detailed project plan for staged closure of care home. To include key focus on communication and ongoing engagement with staff, residents, and families.<br>• Progress to be reported to Financial Overview Group. |

| STRATEGIC OBJECTIVE 2 – Deliver new models of community provision, working collaboratively with communities | | |
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| **Strategic Delivery Priority** | **Key activities** | **Planned activity for 2024/25** |
| **2.1 Transforming Community Support Services** | **2.1.1 Extension of community Resource Co-ordinator service in Dunbar and North Berwick for under 65s with complex needs and ongoing development of overall service.** | • Development and agreement of staffing model – timescale to be agreed. |
| | **2.1.2 Work with East Lothian Works, the Local Employability Partnership, and Third Sector to oversee delivery of pilot. employability project with Enable.** | • Scottish Government is now devolving funds directly to Local Authorities. A subgroup of the Local Employability Partnership, with HSCP representation, to develop proposals (funding levels are still to be confirmed). |
| | **2.1.3 Work with partners to deliver a service for mental health employability support targeting hard to reach people supported by the Community Mental Health Team (CMHT)** | • Long term funding arrangements to be taken forward by the East Lothian Local Employability Partnership subgroup. |
| | **2.1.4 Complete options appraisal for building based services for adults under 65 with complex needs.** | • To be confirmed. |
| | **2.1.5 Continue to develop the Hardgate respite service for people with profound and multiple learning disabilities (PMLD).** | • Carry out an evaluation of the Hardgate provision, including gathering service user feedback. |
| **2. 2 Working with Communities** | **2.2.1 Develop and implement a Participation and Engagement Strategy.** | • Continue to carry out participation and engagement activities to inform the development and delivery of services in line with the Participation and Engagement Strategy. |
| | **2.2.2 Further develop engagement with Area Partnership Health and Wellbeing Subgroups.** | • Continue to develop further opportunities for engagement with Health and Wellbeing Subgroups.<br>• Establish clear reporting / communication link between IJB / SPG and Health and Wellbeing Subgroups. |

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| | **2.2.3 Support the development of new (Dementia) Meeting Centres (focus on Musselburgh with proposals for satellites).** | • Extension of Musselburgh Meeting Centre provision by adding an additional 7 hour session from summer 2024.<br>• Delivery of development work to support other local areas for develop 'satellites' (to be led by Dementia Friendly East Lothian). |
| | **2.2.4 Development of East Lothian Community First Service (delivered by VCEL with ELHSCP funding / support).** | • Ongoing development and monitoring of impact. |
| | **2.2.5 East Lothian Rehabilitation Services (ELRS) to work on co-production of services in partnership with community stakeholders.** | • Continue development and ongoing evaluation of referral rates and themes.<br>• Consider potential expansion of inclusion criteria beyond long-term conditions.<br>• Collaboration with Counterweight and diabetes prevention services.<br>• Carry out service user evaluation and ongoing engagement with community stakeholders (via the IIA process). |

| STRATEGIC OBJECTIVE 3 – Focus on prevention and early intervention | | |
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| **Strategic Delivery Priority** | **Key activities** | **Planned activity for 2024/25** |
| **3.1 East Lothian Rehabilitation Service development** | **3.1.1 Further development of community based multidisciplinary clinics, including Technology Enabled Care (TEC) clinics.** | • Launch of ELRS multi-professional-led clinics in Dunbar – by August 2024.<br>• Tranent to remain primary TEC clinic. |
| | **3.1.2 Embedding of TEC across all workstreams within ELRS.** | • Redesign TEC training to have a core programme available to all HSCP staff (August 2024) and an advanced clinical application course for ELRS staff (September 2024).<br>• Train Telecare Team in installing of and ELRS Digital Champions in use of new remote monitoring technology for a community pilot (May 2024). |
| | **3.1.3 Continue to improve and support single point of contact for all ELRS provision.** | • Scope potential additional routes for access to services, including online self-referral – May 2024. |
| | **3.1.4 Promote use of digital platform to support education and patient self-management.** | • Transfer digital platform from external provider site to ELHSCP website (now complete).<br>• Monitor activity levels and feedback to inform ongoing development of platform.<br>• Carry out scoping of online referral – May 2024.<br>• Launch online referral – November 2024. |
| | **3.1.5 Further development of data analytics to understand impact / trends / make projections / inform future service development.** | • Continue to resource clinician to lead on informatics development.<br>• Invest in informatics skills development for senior clinicians and management team (e.g., Excel training).<br>• Ongoing development of centralised databases to inform DCAQ (Demand, Capacity, Activity, Queue). |

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| | **3.1.6 Development of new carers pathway to provide early intervention and maximising occupational performance of informal carers.** | • Develop a group programme to deliver Occupational Therapy (OT) focused interventions for carers (face to face and remote).<br>• Develop an early intervention resource pack for carers of young people transitioning from child to adult services.<br>• Develop competencies for OT specific skills and training in the Carers Pathway.<br>• Develop education resources relating to caregivers for OTs and other professionals.<br>• Trial the 'PAMIS' passport for unpaid carers and promote use across the HSCP. |
| **3.2 Falls prevention and management** | **3.2.1 Development and implementation of new integrated falls prevention and management pathway** | • Continued development of core data set to monitor activity and impact.<br>• Develop Outpatient Falls Clinics.<br>• Extension of 'Steady On' class referrals to Primary Care.<br>• Establishment of high level 'Strength and Balance; classes within the PACE service.<br>• Development of dedicated vestibular rehabilitation within ELRS. |
| **3.3 Mental health and wellbeing (prevention & early intervention activity)** | **3.3.1 Deliver ongoing programme to review access to adult mental health services across primary care and adult community mental health services.** | • Implementation of single point of contact.<br>• See also Delivery Priority 5.2.1 below. |
| | **3.3.2 Ongoing development of CWIC Mental Health service (in line with review of access to mental health services recommendations).** | • Ongoing development of the CWIC Mental Health service. |
| | **3.3.3 Introduction of new Distress Brief Intervention (DBI) programme** | • Ongoing delivery and development of Distress Brief Intervention programme during 2024/25. |
| | **3.3.4 Improve the availability and accessibility of information in relation to mental health and substance use (including alcohol) to promote self-management and access to services.** | • Development of Eastspace resource, including information based on the 6 EL localities and transport information.<br>• Promotion of Eastspace in libraires and other community spaces.<br>• Ongoing delivery of weekly Wellbeing Resource Hub at ELCH and development to roll out this model in community settings across East Lothian. |

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| | **3.3.5 Improve accessibility and expand delivery of mental health physiotherapy support.** | • Explore links with Live Well for further exercise support options.<br>• Consider scope of geographic locations for exercise therapy classes. |
| **3.4 Improving the management of long-term conditions** | **3.4.1 Develop a programme with the Cluster and the HSCP to improve long term condition management.** | • Carry out cluster work with practices nurses around respiratory prescribing. Evaluate based on National Therapeutic Indicators benchmarking data. |
| | **3.4.2 Develop a programme with general practice and pharmacotherapy service to optimise medicine management for different patient groups.** | • Increase available clinical time for pharmacists to support long term condition management and polypharmacy reviews.<br>• Continue to increase the serial prescribing uptake to streamline workload.<br>• Explore more efficient ways of delivering Level 1 pharmacotherapy workload using Quality Improvement methodology. |
| **3.5 Annual Health Checks for people with learning disabilities** | **3.5.1 Deliver a programme to offer Annual Health Checks for people the learning disabilities.** | • Local implementation group, consisting of senior management and Primary Care representatives, to oversee delivery and report back to the Scottish Government and NHS Lothian. |

| STRATEGIC OBJECTIVE 4 - Enable people to have more choice and control and provide care closer to home as appropriate | | |
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| **Strategic Delivery Priority** | **Key activities** | **Planned activity for 2024/25** |
| **4.1 Primary Care Services** | **4.1.1 Develop PCIP services to optimise choice and control and, where possible, provide care closer to home; to reflect staffing and financial resources available; and to meet priorities collaboratively developed with General Practice colleagues.** | • Carry out a review of HSCP primary care services to establish whether there is fair distribution and fair utilisation of services across East Lothian and identify action needed to address and issues – September 2024. |
| | **4.1.2 Development of direct access to the CWIC (Care When it Counts) service.** | • Delivery of CWIC direct access project with Inveresk Medical Practice (IMP) to allow patients to contact CWIC directly for self-referral – from May 2024.<br>• Expansion CWIC direct access project to cover Harbours and Tranent practices (timescales to be confirmed).<br>• Aim to cover 4 practices in the west of East Lothian by December 2024 (Inveresk, Harbours, Tranent, Riverside).<br>• Pilot the introduction of a direct access phoneline to CWIC for patients attending the Substance Use Service at the Esk Centre.<br>• Expand direct access phoneline to include patients accessing the Intensive Home Treatment Team (IHTT) from April 2024. |
| | **4.1.3 Shift towards face to face (F2F) model of delivery within MSK services.** | • Carry out service evaluation to ensure best use of available capacity across the East Lothian.<br>• Continue development of onward referral pathways.<br>• Explore use of 'Vision Anywhere' following GP migration to cloud-based systems. |
| | **4.1.4 Develop a pharmacotherapy hub.** | • Develop a pharmacotherapy hub where pharmacy technicians can support GP practices remotely, freeing up space in practice; enabling collaborative working and mentorship; and giving pharmacists ring-fenced clinical time. |

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| | **4.1.5 Review and redesign of Community Link Worker Programme.** | • Review existing provision and develop new delivery model.<br>• Carry out retendering process to secure a new provider – to be operational by October 2024. |
| **4.2 East Lothian Community Hospital Outpatient and Day Services** | **4.2.1 Ongoing development and enhancement of outpatient and day services at ELCH.** | • Carry out an in-depth review of outpatient provision at ELCH to inform ongoing delivery and development planning.<br>• Continue work with NHS Lothian to further develop the outpatient offer at ELCH.<br>• Explore opportunities to further develop training / teaching at ELCH. |
| | **4.2.2 Further development of role ELCH plays in relation to teaching, training and staff development.** | • Ongoing development of teaching / training by the Endoscopy and Day Service Unit at ELCH. |

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| **4.3 Re-imagining Adult Social Work** | **4.3.1 Continue to progress and develop a responsive, strength-based social work service.** | • Implementation and monitoring of new outcome-based assessment and recording tools.<br>• Identification of benefits / impact of early intervention and prevention activity undertaken through the duty system. |
| | **4.3.2 Development of work to strengthen social work governance, data, and assurance processes to support improvement.** | • Collate data and intelligence that supports performance and improvement work and demonstrates improved outcomes.<br>• Develop Social Work Risk Register that track risks and addresses them through preventative controls and corrective actions.<br>• Implement programme of audits and self – evaluation against national standards, evidencing collaboration in identification of strengths and areas for improvement. |
| | **4.3.3 Implementation of Self-Directed Support (SDS) Improvement Plan.** | • Implementation of SDS Improvement Plan.<br>• Implementation of Replacement Care Policy.<br>• Activity to improve communication, public engagement and understanding of SDS.<br>• Updating of website to reflect the customer journey.<br>• Roll out of outcome based training sessions for staff.<br>• Revision of SDS Option 2 and exploration of how to make best use of this.<br>• Crossover work to take place with ELC Children's Services. |
| | **4.3.4 Development of Community Brokerage model.** | • Development of Community Brokerage model that provides support to individuals in their own communities, through early intervention and maximising the use of community resources. |
| **4.4 Dementia Support** | **4.4.1 Development and implementation of Dementia Strategy** | • Development of Implementation Plan to being from April 2024 as further information is known regarding the available budget. |
| | **4.4.2 Development and delivery of Meeting Centre in Musselburgh and satellite sites** | • See 2.2.3 above. |

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| | **4.4.3 Tender of the Post Diagnostic Support (PDS) Contract to continue the 5 Pillar Model** | • Ongoing monitoring of provision of 5 pillar model (in terms of activity level and waiting list).<br>• Work with Alzheimer Scotland to develop 6 weekly Post Diagnostic Support Groups for people on the waiting list for the formal PDS service.<br>• Review of 5 pillar model of provision with a view to developing provision based on 8 pillar model (reflecting increased complexity of cases). |
| | **4.4.4 Development of new service to extend provision of support for those with more complex needs following completion of 1 year Post Diagnostic Support. Exploration of possible Multi-Disciplinary Team within Community Mental Health Team (CMHT)** | • Identification of a lead and core group to work on potential service design – initial discussions to take place April 2024. |
| **4.5 Supporting Carers** | **4.5.1 Development and implementation of Carers Strategy.** | • Progress report to be submitted to Carers Change Board in April 2024 and to Carers Panel in May 2024. |
| | **4.5.2 Publish and report on budget allocated by local authority to support delivery of Carers Strategy.** | • Publish and report on budget allocated by local authority to support delivery of Carers Strategy. |
| | **4.5.3 Review, update and implement Adult Carer Support Plans – to include identification of carer outcomes.** | • Increase in joint working between the HSCP, CoEL and other partners to improve carers' experience.<br>• Carry out 6 monthly audit of completed ACSPs from September 2024.<br>• Work to develop reporting on progress towards outcomes identified in ACSPs, with potential inclusion in carers census submission – October 2023. |
| | **4.5.4 Develop plans for the provision of residential respite with proposed introduction of 'the right to a break'.** | • Working Group to be established to work with carers to develop 'short breaks' options. |
| | **4.5.5 Increase choice and availability of community-based support, for example through new meeting** | • Musselburgh Meeting Centre will deliver an additional day of provision per week from summer 2024. |

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| | **centres and extension of services offered by day centres for older people.** | • Dementia Friendly East Lothian (DFEL) to support other local areas ot develop 'satellite' meeting centres.<br>• Older Peoples Day Centres to continue to develop Day Centre Outreach Services in local communities<br>• Outreach Service to be developed with new provider of Musselburgh Day Centre during 2024. |
| | **4.5.6 Continue to develop the Hardgate respite service for people with profound and multiple learning disabilities (PMLD).** | • See 2.1.5 above. |
| **4.6 Palliative and end-of-life care** | **4.6.1 Carrying out of review and scoping in relation to provision of palliative care.** | • Carry out a scoping exercise re future delivery of palliative and end of life care, involving the Palliative Care Strategy Group and other stakeholders and working closely with third sector – August 2024.<br>• Development of recommendations following scoping exercise. |
| | **4.6.2 Further development of collaborative working with St Columba's in relation to Hospice at Home service.** | • Ongoing development of collaborative working between Hospital to Home and Care at Home services and Hospice at Home to provide care packages related to palliative and end-of-life care. |
| | **4.6.3 Delivery and evaluation of piloting of palliative care beds in local nursing homes.** | • Plans for future provision to be confirmed. |
| | **4.6.4 Roll out of palliative and end-of-life care education / training programme for staff.** | • Further development and delivery of training during 2024/25.<br>• |
| **4.7 The Right to Advocacy** | **4.7.1 Develop and implement an Independent Advocacy Strategic Plan** | • Review and update existing independent advocacy service specifications for commissioned services (learning disability, autism, mental health, physical disability, and older people) taking into consideration financial context. |
| **4.8 Meeting Complex Needs closer to home** | **4.8.1 Crookston Care Home service redesign.** | • Carry out a comprehensive redesign programme to develop and deliver a specialist unit providing care for people with more complex needs. |

| STRATEGIC OBJECTIVE 5 – Further develop / embed integrated approaches and services | | |
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| **Strategic Delivery Priority** | **Key activities** | **Planned activity for 2024/25** |
| **5.1 Integrated Teams and Approaches** | **5.1.1 Integration of Hospital to Home and Home Care teams to support shared care.** | • Ongoing development of Home Care / Hospital to Home integrated service to create additional capacity.<br>• Explore option to integrate Hospital at Home within a wider service (using One Plan / Shared Care Plans). |
| | **5.1.2 Integration of Site and Capacity and Patient Flow.** | • Further development to clarify role and remit of the integrated Site and Capacity and Patient Flow team. |
| | **5.1.3 Deliver enhanced Learning Disability Service.** | • Ongoing development of enhanced Learning Disability Service. |
| | **5.1.4 Development and implementation of Autism Strategy.** | • Ongoing delivery of autism / neurodiversity framework.<br>• Work with other HSCPs at a Lothian level to help address challenges faced, including in relation to waiting lists. |
| | **5.1.5 Mental Health Partners Group** | • Continued development of relaunched Mental Health Partners Group bringing together Third Sector, NHS, and local authority colleagues to strengthen links and support collaboration – ongoing. |
| **5.2 Pathway Reviews / Improvements** | **5.2.1 Review patient pathways for Hospital Based Complex Clinical Care (HBCCC) and access to Ward 1.** | • Roll out to Ward 2 at ELCH.<br>• Review data to understand current provision of palliative care in Ward 1 (as part of wider palliative care work – see priority 4.6 above). |
| | **5.2.2 Deliver ongoing programme to review access to adult mental health services across primary care and adult community mental health services.** | • See delivery priority 3.3.1 above. |
| | **5.2.3 Carry out a review of Older Adult Mental Health (OAMH) services.** | • Explore other service provision options such as ageless IHTT (Intensive Home Treatment Team) model that incorporates Dementia care or an enhanced Duty |

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| | | Nurse system to provide a more intense community based treatment option as opposed to a hospital admission.<br>• Review Stress and Distress training / approach and introduce any improvements or further developments needed. |
| | **5.2.4 Provide clear public and patient information to help people to get to the right primary care service** | • Ongoing work with communications team to ensure people are aware of range of primary care services and how and when to access them. |
| | **5.2.5 Strengthen opportunities for direct access to PCIP (Primary Care Improvement Plan) services to reduce the need to contact general practice first** | • Continue to look at options to strengthen direct access to primary care services managed by the HSCP. |
| **5.3 Meeting Housing Needs** | **5.3.1 Involvement in development of East Lothian Local Housing Strategy (LHS)** | • Develop and agree Housing Contribution Statement formalising link between IJB Strategic Plan and the Local Housing Strategy for 2024-29 – by autumn 2024.<br>• Ongoing delivery of the Housing, Health, and Social Care Strategy Group. |
| | **5.3.2 Develop and deliver housing models to support people with learning disabilities / mental health issues** | • Ongoing collaboration between ELC Housing and HSCP to develop housing options, including for people with mental health conditions being discharged from hospital. |
| **5.4 Transitions** | **5.4.1 Implement Transitions Framework** | • Ongoing implementation of Transitions Framework. |

| STRATEGIC OBJECTIVE 6 – Keep people safe from harm | | |
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| **Strategic Delivery Priority** | **Key activities** | **Planned activity for 2024/25** |
| **6.1 Public Protection** | **6.1.1 Delivery of Improvement Plan for Adult Support & Protection (ASP)** | • Ongoing delivery of Improvement Plan – action can be closed. |
| | **6.1.2 Implementation of changes to Adult Support and Protection (ASP) procedures to align with revised national Code of Practice** | • Ongoing implementation of updated Adult Support and Protection procedures – action can be closed. |
| | **6.1.3 Implementation of the ASP National Minimum Data Set** | • Implementation of version 2 of the National Minimum Dataset – from April 2024. |
| | **Implementation of Escalating Concerns Protocol** | • Review of the use of the Escalating Concerns Protocol – June 2024. |
| | **6.1.4 HSCP staff to participate in development of Equally Safe Strategy and associated plan for East Lothian to ensure that all 4 priorities are addressed** | • HSCP to participate in the development of a local Equally Safe Strategy (led by East Lothian Council) – timescale to be confirmed. |
| **6.2 Reducing harm from substance use** | **6.2.1 Delivery and implementation of MAT (Medication Assisted Treatment) standards.** | • Continue to embed MAT 1-5<br>• Phase 2 of implementation of MAT 6-10<br>• Ongoing gathering / analysis of experiential information.<br>• Development of Trauma Informed Practise Implementation Group to promote service improvement |
| | **6.2.2 Delivery of Contact Service to improve access to alcohol and drug services.** | • Ongoing development and delivery of Contact Service, with a focus on collaborative, multi-disciplinary working.<br>• Employment of Band 6 Outreach Nurse by Justice Social Work to support Substance Use Service. |
| | **6.2.3 Improve the availability and accessibility of information in relation to mental health and substance** | • See 3.3.4 above. |

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| | **use (including alcohol) to promote self-management and access to services.** | |
| | **6.2.4 Provide access to physiotherapy to support management of physical aspects of substance use.** | • Physiotherapist included in the substance use team – timescales to be agreed |
| **6.3 Justice Social Work** | **6.3.1 Deliver Justice Social Work (JSW) Annual Report 2022/23 Improvement Plan** | • Delivery of 2024-27 Justice Social Work Service Plan – throughout year.<br>• Completion of Annual Report / Improvement Plan – November. |
| | **6.3.2 Deliver JSW Evaluation Report** | • Development and delivery of 2023-25 Evaluation Programme – ongoing.<br>• Completion of individual Evaluation Reports for specific JSW activities – throughout year.<br>• Delivery of annual / bi-annual report. |
| | **6.3.3 Review available projects and / or options for unpaid work / other activity of Community Payback Orders** | • Increase placement options for unpaid work / Community Payback Orders (building on engagement with Council managers via the One Council presentations) – throughout the year.<br>• Manage outstanding hours by increasing instructions for group work – through the year.<br>• Review and continue to develop placements – ongoing. |
| | **6.3.4 Develop interventions to address adult male offending behaviour** | • Continue to develop training modules addressing adult male offending – throughout the year.<br>• Facilitate offence focused group work for the Caledonian System (addressing domestic abuse) – throughout the year. |
| **6.4 Supporting children, young people, and families** | **6.4.1 Embed a 'whole family approach' in relation to service delivery.** | • Delivery of awareness raising / training by Children's Services colleagues – timescales to be agreed. |
| | **6.4.2 Embed trauma informed approach to service delivery.** | • Ongoing rollout of Trauma Informed training and awareness raising to HSCP staff.<br>• Training of HSCP staff to deliver Trauma Informed and Trauma Skilled training on a face to face basis. |

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| | **6.4.3 Involvement of HSCP services in Transformation of Children's Services Programme – prioritisation of early intervention for vulnerable children.** | • Specific actions for HSCP services to be added as Transformation Programme develops – timescale to be confirmed |
| | **6.4.4 Participate in development of Equally Safe Strategy.** | • See delivery priority 6.1 'Public Protection'. |
| | **6.4.5 Development and implementation of Carers Strategy in relation to young carers.** | • See delivery priority 4.5 'Supporting Carers'. |
| | **6.4.6 Support young people moving from child to adult services.** | • See delivery priority 5.4 'Transitions'. |
| **6.5 Suicide prevention** | **6.5.1 Support the implementation of the revised national suicide prevention strategy across HSCP and partners.** | • Intensive Home Treatment Team (IHTT) Team Leader to meet with Suicide Prevention leads from Mid and East Lothian to collaborate and explore opportunities for development. |

| STRATEGIC OBJECTIVE 7 – Address Health Inequalities | | |
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| **Strategic Delivery Priority** | **Key activities** | **Planned activity for 2024/25** |
| **7.1 Understanding health inequalities** | **7.1.1 Improve collection and use of data relating to equalities and health inequalities (including protected characteristics and data related to Fairer Scotland duty).** | • Carry out work to map equalities / health inequalities data currently collected by services and to identify improvements. |
| | **7.1.2 Develop Joint Strategic Needs Assessment content (using data existing sources).** | • Carry out refresh / update of JSNA, adding additional equalities data and analysis – autumn 2024.<br>• Continue to update and develop JSNA content on a rolling basis. |
| | **7.1.3 Deliver session on health inequalities to East Lothian IJB / ELHSCP Senior Management Team (SMT)** | • Develop and deliver further sessions on equalities / health inequalities – to be confirmed. |
| **7.2 Taking action to address health inequalities** | **7.2.1 Support effective use of Integrated Impact Assessments (IIAs) by all HSCP services** | • Continued training for staff in relation to carrying out IIAs.<br>• Embedding of 'Equalities Champions' approach.<br>• Ongoing completion of IIAs as required. |
| | **7.2.2 Monitor and report on IIAs completion** | • Ongoing monitoring and reporting in relation to IIAs. |
| | **7.2.3 Consider ELHSCP's potential role as an Anchor Institute** | • Specific actions to be developed as follow up to IJB / SMT sessions.<br>• HSCP involvement in Community Wealth Building Working Group – ongoing. |

## STRATEGIC ENABLERS

| Strategic Enabler | Mechanism for Delivery | Activity |
|---|---|---|
| Workforce | **Delivery of Workforce Plan** | • Strategic Workforce Plan signed off by IJB in February 2023.<br>• Progress report and annual updates presented to IJB – next one due spring 2025. |
| Financial | **Financial planning and delivery of IB Financial Plans** | • IJB Revised Five Year Financial Plan for 2024/25 to 2028/29 presented to IJB – April 2024. |
| Partnership, Participation & Engagement | **Delivery of Participation and Engagement and Commissioning Strategies** | • Participation & Engagement Strategy in place - approved by IJB June 2023.<br>• Commissioning Strategy in place – approved February 2023 – Market Facilitation Statement agreed May 2024. |
| | **Involvement in strategic planning partnerships** | Participation in a range of partnerships including:<br>• NHS Lothian Strategic Development Framework development and delivery.<br>• East Lothian Partnership (Community Planning) and development of East Lothian Plan.<br>• East Lothian Children's Strategic Partnership.<br>• East Lothian Poverty Group and Community Wealth Building Working Group.<br>• East Lothian Community Justice Partnership. |
| Technology | **Delivery of Digital / Technology workstream** | • Development and delivery of Digital and Informatics Change Board and Workstreams. |
| Approaches to Improvement & Innovation | **Development of Transformation Programmes and Performance Framework** | • Development and delivery a range of transformation / change programmes.<br>• Refresh of Change Board structure to oversee delivery of transformation / change programmes.<br>• East Lothian HSCP Performance Framework – presented to IJB – May 2024. |
| **Information Sharing** | **Development of information sharing approach / protocols and reflection of Scottish Digital Strategy** | • Ad hoc / ongoing development of information sharing approaches / protocols related to service requirements.<br>• Ongoing engagement in work at a national level in relation to Scottish Digital Strategy. |