East Lothian
Integration Joint Board

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 28 February 2019

BY: Interim Chief Officer

SUBJECT: East Lothian Integration Joint Board
Draft 2019-2022 Strategic Plan

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1 PURPOSE

1.1 To present to the Integration Joint Board a further draft of the 2019-2022 Strategic Plan, developed following initial stages of engagement.

1.2 Any member wishing additional information should contact the author of the report in advance of the meeting.

2 RECOMMENDATIONS

The IJB is asked to:

2.1 Note that based on feedback received to date the latest draft of the Strategic Plan has been updated since the previous version, discussed at the IJB Development Day on 24 January 2018.

2.2 Note that the plan will continue to develop as engagement progresses and as comments are received.

2.3 Note that all feedback is being recorded. At the end of the Strategic Plan drafting process a report will be provided detailing the comments received and what was done in response to the feedback.

2.4 Note that the final version of the Strategic Plan must be issued by 31 March 2019. For this reason the IJB will be asked to formally agree the final draft of the Strategic Plan at its meeting on 28 March 2019.

2.5 Agree that a summary version of the Strategic Plan should be produced to accompany the full plan in order to make the plan's contents available to as wide an audience as possible.

3 BACKGROUND

3.1 Each Integration Joint Board is required to develop a 3 year Strategic Plan to set out their strategic priorities and how these will be delivered, taking into account all relevant local and national factors and how progress will be monitored and reported on.

3.2 The Strategic Plan needs to comply with Scottish Government integration planning and delivery principles which require that HSCP services:

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

3.3 In developing and delivering on strategic priorities, the Strategic Plan must also deliver on:

- National Health and Wellbeing Outcomes
- National Health and Social Care Standards
- Ministerial Group Indicators on Integration.

3.4 In February 2018 the IJB agreed that the HSCP needed to focus its energies in 2018-2019 and beyond on priority work in order to deliver against financial pressures and to support service change and delivery of local, regional and national priorities. The agreed priorities are:

- deliver the Primary Care Strategy/New GP Contract Improvement Plan,
- development and delivery of the Financial Plan for 2018/19 and beyond
- commence reprovision of Abbey and Eskgreen care homes and Edington and Belhaven hospitals and provision of extra care housing
- review Community Services for adults with complex needs
- review of services for adults with mental health and substance misuse issues
- implement the Carers Strategy
- review actions intended to deliver delayed discharges/emergency admissions/A&E improvements.

3.5 To support delivery of these priorities a new strategic planning structure was established, with six 'Change Boards' formed towards the end of 2018 focussed on:

- primary care
- adults with complex needs
- mental health and substance misuse
- shifting the balance of care
- reprovision programmes
- carers.

3.6 Each Change Board is chaired by a senior HSCP Officer and co-chaired by an IJB member. The deliberations of the Change Board is informed by a reference group with a wide membership reflecting the focus of work.

3.7 The Change Boards have been invited to contribute to the development of the Strategic Plan to ensure the plan reflects their strategic priorities.

3.8 A mechanism for on-going engagement is built into the Change Board structure in the form of multi-stakeholder Reference Groups.

3.9 Robust links will be established between Directions issued, the resulting transformational change reported to a relevant Change Board and performance measuring. Reporting will fully assess the positive differences the Directions and resulting changes in services are achieving.

4 ENGAGEMENT

4.1 A number of meetings have been arranged with teams from across the Health and Social Care Partnership's and invitations have been extended to area partnerships, community groups, primary care clusters and the third sector. An engagement event in the Brunton Hall on 7 March hopes to attract a wide range of participants from across the county.

4.2 A summary document setting out the plan's proposed priorities and an online survey have been publicised to partners and via the East Lothian Council 'Consultation Hub'. The survey ends on the 28th February, after which the comments within and the survey's findings will be used to inform the strategy redrafting process.

4.3 On completion, the Strategic Plan will be widely distributed in electronic form and publicised through local media and internally to staff as well as through the NHS Lothian and East Lothian Council internet and intranet sites. A limited print run will be arranged for the full and summary versions of the plan to improve accessibility.

5 POLICY IMPLICATIONS

5.1 The policy implications of the Strategic Plan will be considered and acted on as part of its ongoing implementation and monitoring.

6 INTEGRATED IMPACT ASSESSMENT

6.1 The finalised Strategic Plan will be the subject of an Integrated Impact Assessment to assess how the plan will influence the wellbeing of the community and what effect it might have on equality, the environment or economy.

7 RESOURCE IMPLICATIONS

7.1 Financial – There are some limited venue and catering costs associated with the organisation of engagement events and in the design and printing of paper copies of the full and summary document. The majority of the distribution will be carried out through electronic channels at no cost.

7.2 Personnel – The engagement plans for the Strategic Plan and the production of the final and summary documents is being carried out 'in-house' by the HSCP team. This team will also produce the summary plan and will oversee distribution of the final approved plan.

7.3 Other – None.

8 BACKGROUND PAPERS

8.1 None.

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DATE	19-02-19

Appendix 1 – Draft 2019-2022 Strategic Plan

DRAFT

Strategic Plan

2019-2022

East Lothian
Integration Joint Board

East Lothian
Health & Social Care Partnership

19-02-19

Contents

Foreword

As we approach the end of the three years of the first East Lothian Integration Joint Board (IJB) Strategic Plan it is worth taking a moment to reflect on what we have achieved and to acknowledge that there is still much work to be done.

In the last three years the East Lothian IJB has developed its high-level strategic change role. The development and issuing of Directions to both NHS Lothian and East Lothian Council has allowed the IJB to drive change and improvement in the health and social care services used by the people of East Lothian.

We have many examples of service improvement and development and associated engagement over the last three years including developing a strategy for carers, finalising an improvement plan for primary care, transforming community services and shaping a vision for future provision of housing with care in East Lothian.

The role of the IJB and how it issues Directions to support and achieve positive change will be the focus for review early in the life of the next Strategic Plan. There is a strong commitment to better evidencing and understanding the positive difference the Directions are making to the lives of people who come into contact with services.

There is a renewed emphasis on a commitment to integrated health and social care delivery. We will strive to build upon integrated approaches in order to improve people's experience of services and to use our resources efficiently.

We are working in a very challenging financial climate coupled with increasing demand on health and social care services. However we are taking every opportunity to improve services, particularly by targeting those most in need and through the benefits of integration we are meeting need faster and ever more effectively.

We are committed to working in partnership to improve services through collaborative working. This will include the commissioning of sustainable services from the third and independent sector.

In 2018 the East Lothian IJB agreed six strategic priority areas for change. These focus on: primary care, adults with complex needs, adults affected by mental health and substance misuse issues, shifting care from acute hospitals to the community and support to carers. These six areas, along with our updated Strategic Objectives and a range of 'Golden Threads' will form the basis of transformational change over the next three years underpinned and supported by this Strategic Plan.

We have established a 'Change Board' structure in order to monitor delivery of our priorities. A crucial element of the new structure are the reference groups which facilitate on-going stakeholder involvement in strategic planning and development over the coming three years.

Peter Murray
Chair, East Lothian IJB

Alison Macdonald
Chief Officer, East Lothian IJB

Background

East Lothian Health and Social Care Partnership

The East Lothian Health and Social Care Partnership (HSCP) was established in 'shadow' form late in 2013, becoming legally established in July 2015 to provide services within the local authority area of East Lothian Council. In 2016, the IJB published its first Strategic Plan covering the period 2016 to 2019. This second plan applies from 1st April 2019 to 31st March 2022.

HSCPs were formed across Scotland in a joint endeavour between Health Boards and Local Authorities in order to establish and develop integrated adult health and social care services (with aligned budgets) and to more closely involve clinicians, care professionals, the third and independent sectors, in the planning and delivery of a range of prescribed services. HSCPs also aim to shift the balance of care from institutional to community settings. In developing and delivering integrated health and care arrangements HSCPs are expected to achieve a range of nationally agreed outcomes and targets.

In East Lothian the HSCP was established as a 'Body Corporate', making it a legal entity separate from East Lothian Council and NHS Lothian.

East Lothian Integration Joint Board

Governance of the HSCP is the responsibility of the East Lothian Integration Joint Board (IJB - sometimes referred to as an Integration Authority). The arrangements for the HSCP and the IJB are set out in the IJB's Integration Scheme approved by Scottish Ministers, East Lothian Council and NHS Lothian in the Integration Joint Board's Final Integration Scheme of 29 May 2015.

(https://www.eastlothian.gov.uk/downloads/file/27201/integration_scheme).

The 2015 Integration Scheme states the key functions of the East Lothian IJB are to:

- prepare a Strategic Plan for all delegated functions
- allocate the integrated budget in accordance with the Strategic Plan
- oversee the delivery of services in scope.

East Lothian Integration Joint Board has eight voting members appointed equally between elected members of East Lothian Council and non-executive Directors of NHS Lothian. The Chair of the IJB alternates between an East Lothian Council or NHS Lothian representative every two years.

The IJB also has a number of other appointees representing service users, carers, third and independent sector organisations, clinicians and staff. In addition, a range of officers and professionals including the Chief Officer, Chief Finance Officer, Chief Social Work Officer, Clinical Director and Chief Nurse provide professional advice to the IJB.

Integration Joint Board responsibilities

Under the 2014 Act, each Health Board and Local Authority within their boundary must delegate certain functions to an Integration Joint Board which is given the responsibility for integrated planning and delivery arrangements for health and social care services. In East Lothian IJB, services are planned and provided within the geographical area covered by East Lothian Council.

The legislation which established IJBs requires that adult social care services, adult primary and community health care services, and "elements of adult hospital care which offer the best opportunities for service redesign" are included in the scope of service planning. For East Lothian IJB this means strategic planning covers directly managed and locally delivered services as well as acute hospital services that handle high levels of unplanned bed day use for adults. In agreement with East Lothian Council, East Lothian IJB also manages criminal justice social work.

The functions and services delegated to East Lothian's Health and Social Care Partnership are outlined in table 1 in terms of NHS Lothian services, East Lothian Council services and a locally agreed service. These will apply over the lifetime of this Strategic Plan

There is no requirement under the Act for IJBs to provide services to people under the age of 18. Any decision to include children's health and social care services in the scope of IJB service delivery is for partners to agree. Although health visiting and school nursing are delegated, in early 2019 the decision was taken not to integrate children's wellbeing (social care) services into the HSCP.

Table 1

NHS Lothian services delegated to East Lothian IJB[#]:

[#]As a decision was reached in January 2019 not to include children's wellbeing services in the IJB's responsibilities, this Strategic Plan does not cover children's services.

Accident and Emergency and Combined Assessment *
General Medicine *
Geriatric Medicine *
Rehabilitation Medicine *
Respiratory Medicine *
Palliative Care *
All Community Hospitals (Roodlands, Herdmanflat, Edington and Belhaven)
Mental health inpatient services [3]
Community nursing (inc. children's community health services - district nursing, health visiting and school nursing)
Community mental health services
Community learning disability services
Community addictions services
Allied Health Professionals
Primary Care – General Medical Services, General Dental Services, General Ophthalmic services, Community Pharmacy [1]
Lothian Unscheduled Care Service [1]
Public Dental Service [2]
Palliative care provided outwith a hospital
Psychology services [2]
Community Continence [3]
Kidney dialysis services provided outwith a hospital
Community Complex Care
Sexual Health [4]

East Lothian Council services delegated to East Lothian IJB:

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

Additional local services delegated to East Lothian IJB

Criminal Justice Social Work services

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

º Midlothian HSCP hosts (manages) dietetics and art therapy services on behalf of all Lothian HSCPs.

[1] In mid-2018, East Lothian HSCP transferred management of primary care and Lothian Unscheduled Care Service to NHS Lothian to manage these on behalf of the 4 HSCPs.

[2] West Lothian HSCP hosts (manages) clinical psychology, the public dental service, podiatry and orthotics on behalf of all Lothian HSCPs.

[3] City of Edinburgh HSCP hosts (manages) adult acute mental health services, adult psychiatric rehabilitation and continence services on behalf of all Lothian HSCPs.

[4] Most sexual health services are delivered in primary care. Specialist sexual and reproductive health services in Lothian are hosted by City of Edinburgh HSCP on behalf of the Lothian HSCPs.

Equality and diversity

The Integration Joint Board and its partners carry out integrated impact assessments of planned service change to ensure developments do not unfairly disadvantage groups or individuals.

In delivering its services the HSCP strives to provide these across its whole population regardless of age, disability, gender identity and gender re-assignment, marriage and civil partnership, pregnancy and maternity, ethnicity, religion and belief, sex and sexual orientation.

Locality planning

The Public Bodies (Joint Working) (Scotland) Act 2014 requires that Strategic planning by IJB takes account of the needs of people from different parts of the county and engages with communities professionals. The Act also requires HSCPs to have a minimum of two localities. In East Lothian there is a West Locality (comprising Musselburgh, Fa'side and Preston, Seton and Gosford council wards, with a population of circa 60,000) and East Locality (comprising Haddington and Lammermuir, North Berwick Coastal and Dunbar and East Linton wards, with a population of 39,000).

Introduction

This Strategic Plan sets out the next stage of development for East Lothian Health and Social Care Partnership in the delivery of all of its services to improve quality and client outcomes and to reflect local need, local priorities and national and local policies, strategies and action plans.

Although this Draft Strategic Plan sets out intentions for the next 3 years, it needs to be flexible enough to make necessary changes, including reprioritisation to reflect changes in local and national policy and in local demand and need. To do so effectively will require continuous monitoring of the strategy's priorities, and progress against these, combined with consideration of the impact on the Strategic Plan of all new policies and strategies.

As in previous years, the Strategic Plan and work that flows from it needs to comply with Scottish Government integration planning and delivery principles. These require that all the services HSCPs are responsible for:

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

Policy drivers

Our recent and current priorities of efficient service delivery, improved outcomes, support close to home, early intervention and prevention and tackling inequalities are all driven by a range of policies.

Self-Directed Support has been a statutory duty since 2014. It is now well established within health and social care delivery, with individuals assessed and their support planned and delivered with an ever-growing focus on personal outcomes. This puts people at the centre of decision-making about their care. This approach creates a more flexible way of working, provides a client focussed approach to support and care arrangements and so makes a real difference to a person's care experience and their life.

As part of reviewing and developing services we continue to take all opportunities to include service users, carers and other stakeholders in the broader planning, delivery and review of health and social care services. We also encourage honest and transparent conversations about the opportunities and limitations in all service areas under discussion. This co-production approach ensures services reflect where possible the wishes of professionals, service delivery partners, communities, people using services and their families.

Current principles that support all decisions made in relation to service delivery include:

- National Health & Wellbeing Outcomes
- National Health & Social Care Standards
- Ministerial Group Indicators on Integration.

Our priority areas for 2019 - 2022

In February 2018 the IJB agreed that the HSCP needed to focus its energies in 2018-2019 and beyond on priority work to deliver against financial pressures and to support service change and delivery of local, regional and national priorities and those of national or local priority:

- deliver the Primary Care Strategy/New GP Contract Implementation Plan, following completion of the Primary Care Improvement Plan by July 2018. This sets out the phasing of clear priorities developed in agreement with the GP sub-committee and NHS Lothian
- development and delivery of the Financial Plan for 2018/19 and beyond, by developing the IJB role in taking the decisions required to operate within the resources available
- commence reprovision of Abbey and Eskgreen care homes and Edington and Belhaven hospitals and provision of extra care housing after reaching a final decision on the strategic direction and priority actions by locations following conclusion of consultation in June 2018. This will establish projects to produce and implement business cases, with a target date of March 2019 for production of the first business case
- review Community Services for adults with complex needs to develop a transformation programme - this will include: day services; housing; repatriation of out of area placements; night-time support/use of technology enabled care; alternatives to statutory services; and Royal Edinburgh Hospital bed numbers
- review services for adults with mental health and substance misuse issue, through joint working with all relevant partners
- implement the Carers Strategy, in conjunction with all relevant partners
- review actions intended to deliver delayed discharges/emergency admissions/A&E improvements, including: delayed discharge trends; impact of Hospital at Home 24/7 on A&E and admissions; proposed use of empty beds at East Lothian Community Hospital to support whole system capacity and a review of the impact on set aside budgets.

Transformation programmes

To deliver these priorities the strategic planning structure for the partnership was reviewed, with agreement reached to establish six 'Change Boards' towards the end of 2018 as shown in figure 1. The revised structure supports the projects and programmes arising from our strategic priorities, operational priorities and IJB Directions to deliver transformational change.

This new structure ensures the work of the Strategic Planning Group is informed by the input of reference groups and change boards with service user, carers, professional, operational, management, and planning representatives. The Change Boards cover:

- primary care
- adults with complex needs
- mental health and substance misuse
- shifting the balance of care
- reprovision programmes
- carers.

Each Change Board is chaired by a senior HSCP Officer and co-chaired by an IJB member and has a wide membership, reflecting the work it focusses on to:

- provide a structured and accountable approach to delivery of programmes, projects and workstreams
- ensure a culture of involvement, engagement and appropriate consultation in all work programmes
- ensure a clear line of sight to the priorities as set out in the IJB Directions and Strategic Plan (table 1)
- report in line with the agreed terms of operation
- set the tone and direction for partnership working
- support the delivery of all relevant national and local targets and performance requirements in respect of health and social care
- maintain effective links with other partnerships in areas of joint interest.

Golden Threads

Each Change Board has to take into account in its work key principles or 'Golden Threads'. These are: early intervention and prevention; carers needs, Self-Directed Support rights; tackling health inequalities; re-ablement/recovery; needs of people with dementia; health promotion; community justice; and tackling social isolation.

Integration measures

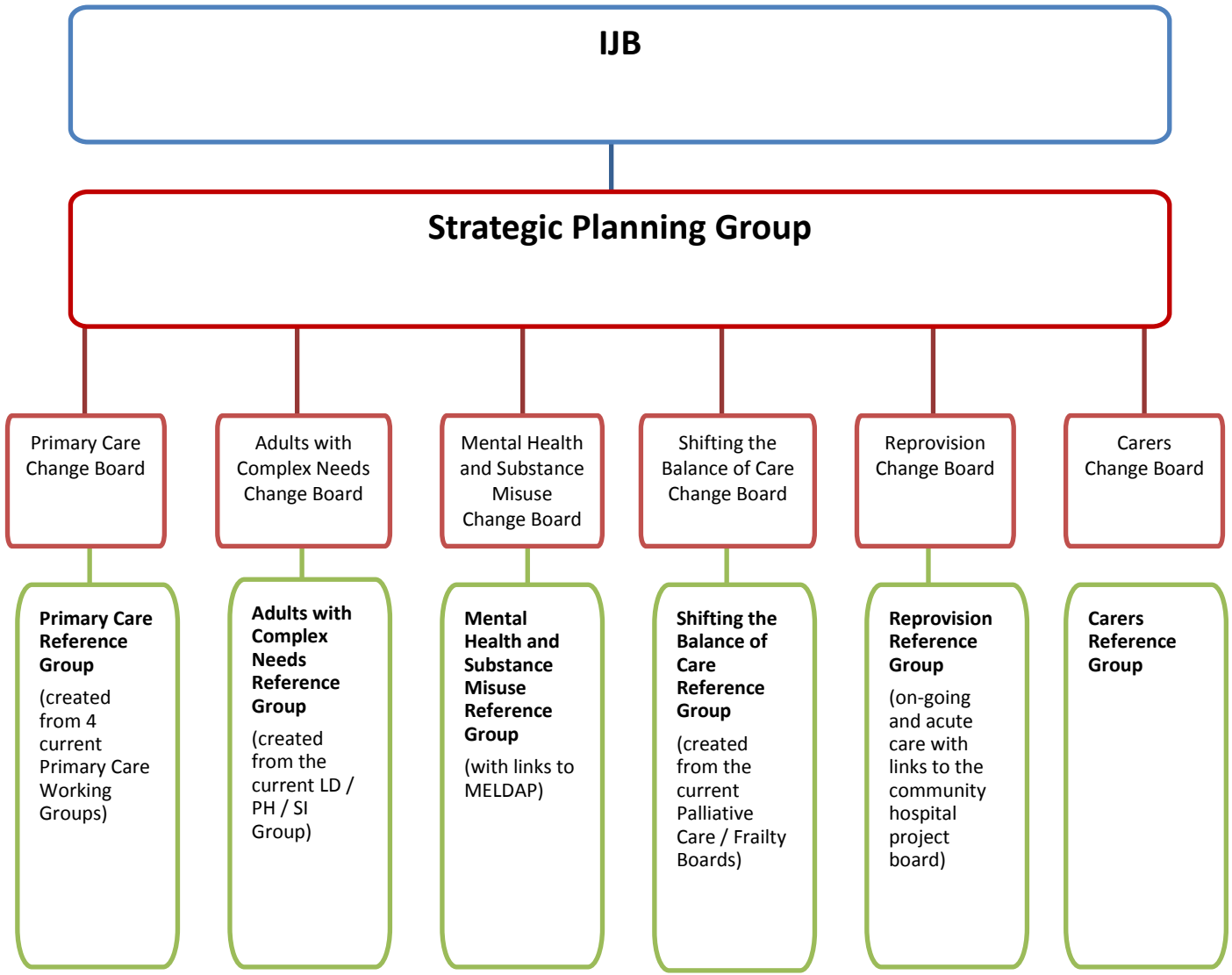
From January 2017 the Ministerial Strategic Group for Health and Community Care (MSG) began tracking performance by Integration Authorities in delivering integration through the monitoring of six measures, reported on by ISD (Information Services Division):

1. unplanned admissions
2. occupied bed days for unscheduled care
3. A&E performance
4. delayed discharges
5. end of life care
6. the balance of spend across institutional and community services.

Each IJB across the country was asked to agree its local targets for the six measures and ISD issued regular data updates to monitor progress.

East Lothian's targets for 2018-19 are shown in appendix 1. These targets are likely to apply through 2019-20.

Figure 1 – strategic planning structure



Our strategic objectives for 2019-2022

The strategic objectives developed for the 2016-2019 plan shown below remain relevant to the development of all aspects of the partnership's ambitions, however we have updated these for the coming three years:

A. to make health and social care services more sustainable and proportionate to need and to develop our communities

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

B. to explore new models of community provision which involve local communities and encourage less reliance on health and social care services

We will build capacity in communities through partnership working.

C. to improve prevention and early intervention

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

We will achieve this through strengthened links with the community and the community planning structures and partnerships. We will continue to commission service which support early intervention and prevention.

D. to reduce unscheduled care and delayed discharges

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

We are committed to keeping the numbers of people delayed in hospital as low as possible as well as exploring other means to reduce reliance on hospitals.

E. to provide care closer to home

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

We will review how people are supported in the community closely linked to any local housing strategy and exploration of new models of housing with care. We will remain committed to providing good quality care at home services.

F. to deliver services within an integrated care model

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

We will develop a range of means of integrated working, not necessarily through the integrating of a team but often through other means such as integrated approaches or pathways.

G. to enable people to have more choice and control

We recognise the importance of person centred and outcomes focused care planning and service delivery ensuring people are involved in planning their care and support journey.

Positive Personal Outcomes will increasingly be the focus of what we aim to achieve.

H. to reduce health inequalities

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

We want to support positive health promotion in order to support physical and mental wellbeing.

I. to build and support partnership working

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

J. to support change and improvement across our services

We recognise the need to deliver integrated services and transformational change.

Developing this strategic plan

This Strategic Plan is being jointly developed by the East Lothian Integration Joint Board and the Strategic Planning Group. Between them, the groups bring together representatives of NHS Lothian non-executives and East Lothian Council elected members, clinicians, service users, carers, voluntary sector and the independent sectors and senior managers from health and social care.

The 2019-2022 plan is a development of the previous plan and is based on consideration of the many factors that have an impact on the delivery of health and social care services, the experience of service users and assessment of need.

The next stage of the plan's development will come from engagement and consultation with communities, service users, across the county. This will ensure the draft plan is brought to the attention of as wide an audience as possible. It will also allow the IJB to hear of, and where possible incorporate, the views and priorities of East Lothian's communities, partners and stakeholders in service development and delivery.

Engagement will also allow the IJB to describe all factors that guide and may limit the opportunities for service change and development over the lifetime of the Strategic Plan.

This plan aims to further develop integrated service planning and service delivery between health and social care to attain and maintain improved health and wellbeing outcomes for all East Lothian residents, whatever their needs.

The plan will support the continuing development of services focussed on new ways of working to identify and act on client need, working to break down the boundaries between different health and social care services in all settings, whether these are provided in primary care, the community or in hospitals.

Service arrangements also need to respond to increasing complexity in the health and social care needs of clients, ensuring coordination between providers of different elements of care to deliver the best outcomes for all service users.

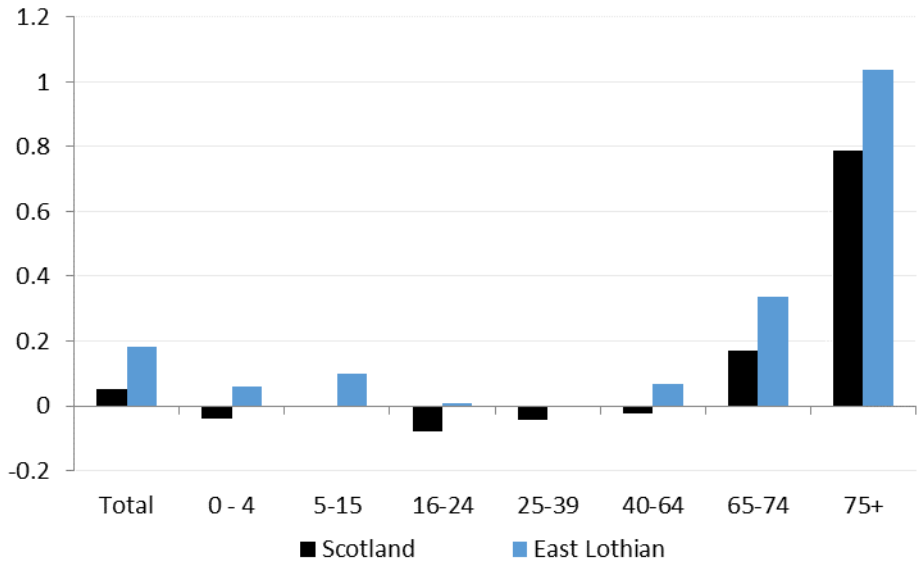
Understanding the needs of our communities

The Strategic Plan also needs to respond to the varied needs across a population of 104,070 (estimate for 2017) which is in a phase of population growth with an expected increase of around 23% up to 2041. East Lothian will continue to see population growth in coming decades, with the highest growth in the 65-74 and 75+ age bands.

East Lothian Health and Social Care Partnership faces current and future demands from this ageing and growing population. It has further challenges in meeting the needs of a range of communities in the populous and urban west and the rural communities in the east and south of the county.

The charts that follow present information on the characteristics of the population served by the services provided by the HSCP.

Chart 1 - projected population % change by age group 2016 to 2041



Around 23% of the population are classed as living in a large urban area, focussed on the Musselburgh locality. Almost 24% of the population live in accessible rural areas (chart 2 and figure 2).

Chart 2 - East Lothian 2016 ward population by urban/rural

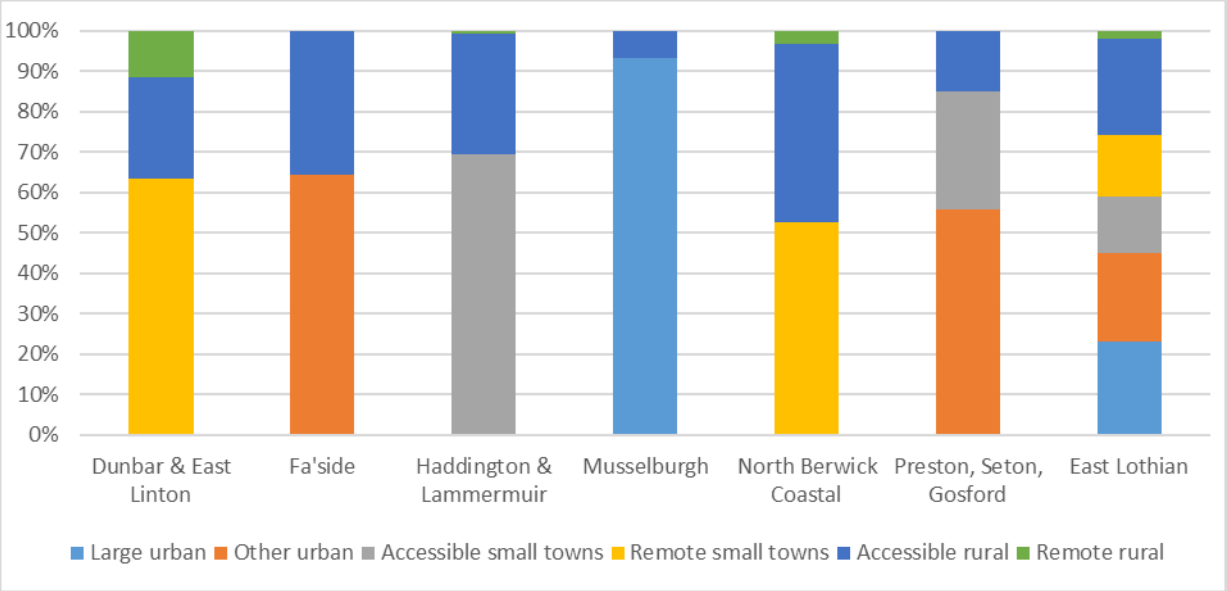
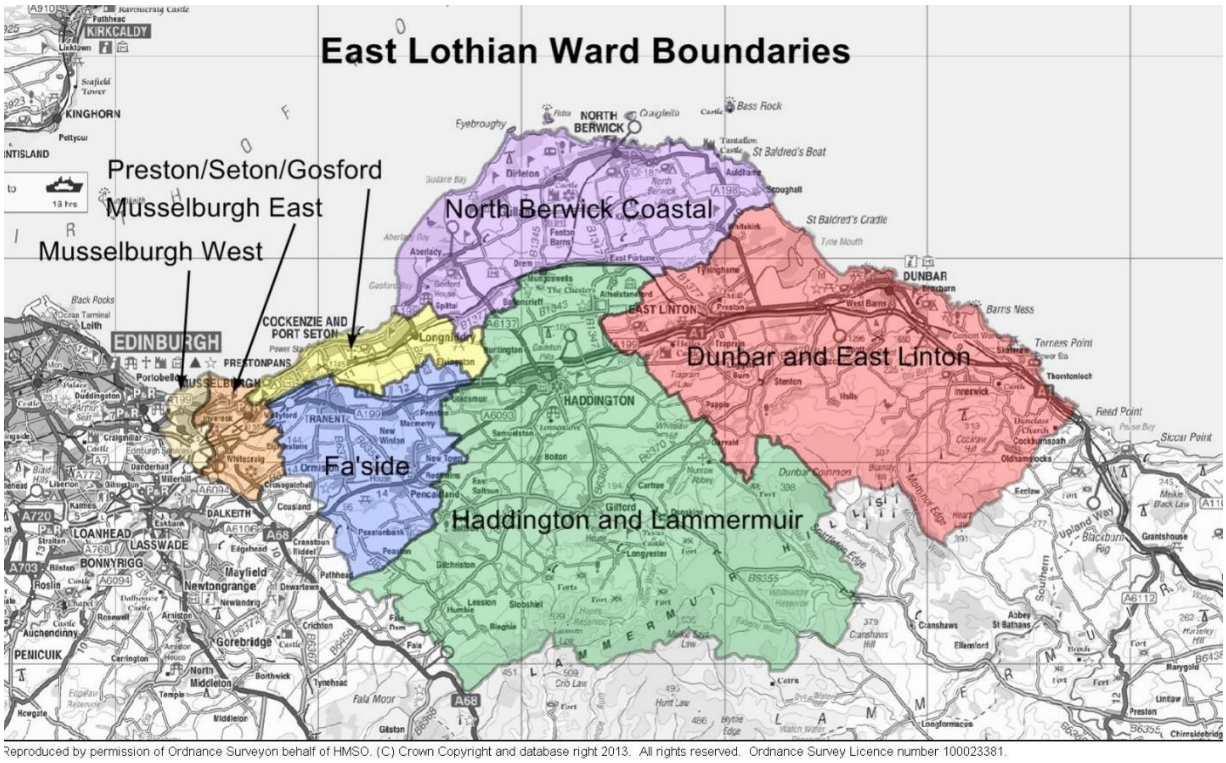


Figure 2 - East Lothian council wards (**updated map awaited**)



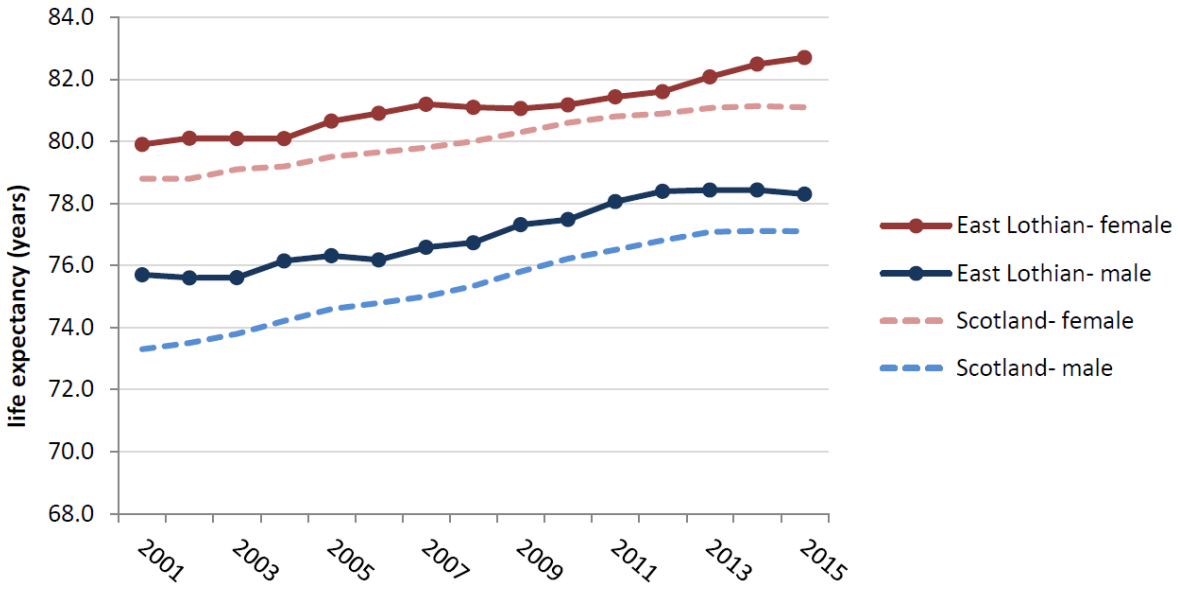
Life expectancy for both males and females in East Lothian was above the Scotland average in 2014-16, at 78.3 compared to 77.1 for males and 82.7 compared to 81.1 for females (table 1 and chart 3). There is variation between areas of low and high deprivation (chart 4). Over this period, life expectancy has been consistently higher than the national figures.

Table 1 - life expectancy in East Lothian (and Scotland)

	2010-12	2011-13	2012-14	2013-15	2014-16
Female, at birth	81.4	81.6	82.1	82.5	82.7
Male, at birth	78.1	78.4	78.4	78.4	78.3

Data source: NRS - https://www.nrscotland.gov.uk

Chart 3 - male and female life expectancy in East Lothian and Scotland



Data source: National Records Scotland

Chart 4 - male and female life expectancy in East Lothian - most and least deprived areas

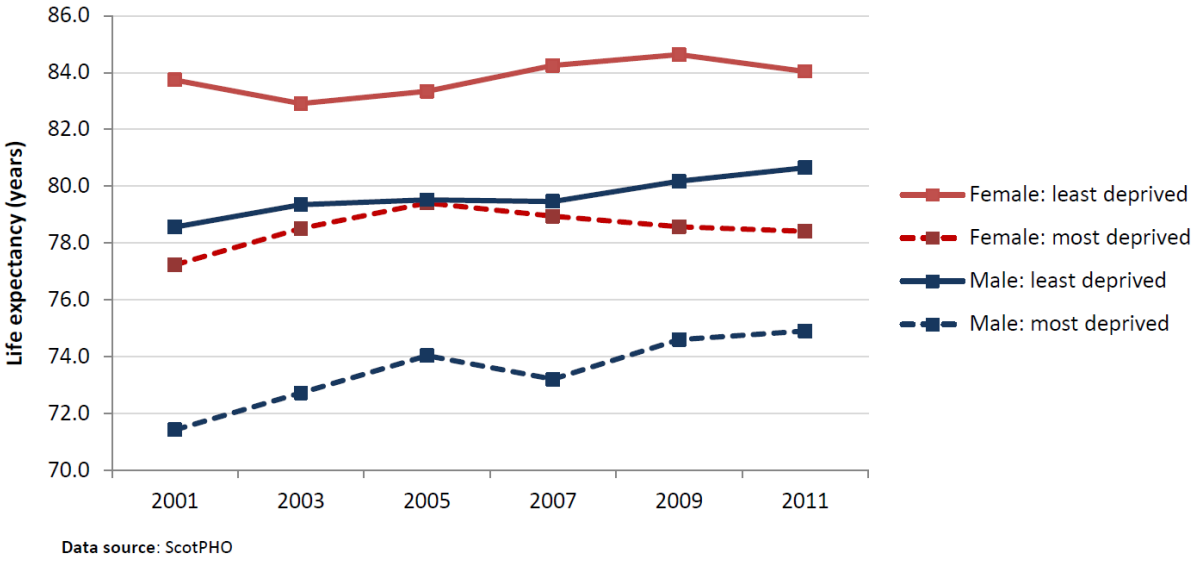
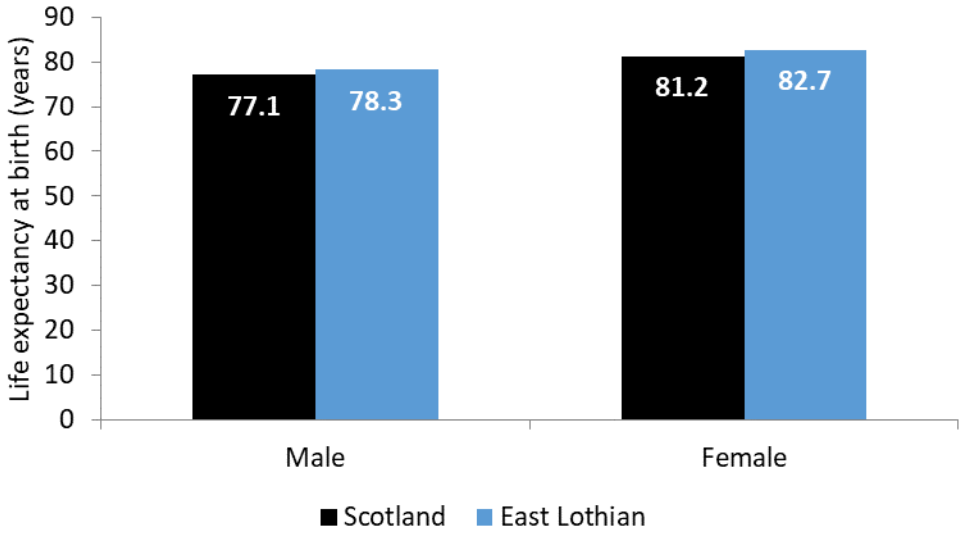


Chart 5 - East Lothian male/female life expectancy compared to Scotland, 2014-16



In 2017, there were 104,840 people living in East Lothian, 52.1% females and 47.9% males. The East Lothian population is projected to grow by 18% between the years 2016 and 2041. Almost 20% of the population are aged 65 and over. Currently, 21% of the population lives in the Tranent, Wallyford and Macmerry locality, while only 13% are in the North Berwick Coastal locality

Table 2 - population distribution

Locality*	**2017 Population Estimate**	**% 2017 Population**
Musselburgh	19,491	19%
Preston, Seton and Gosford	18,030	17%
Tranent, Wallyford and Macmerry	21,772	21%
North Berwick Coastal	13,226	13%
Haddington and Lammermuir	17,915	17%
Dunbar and East Linton	14,406	14%
East Lothian	**104,840**	

*Locality is the same as electoral ward

Chart 6 - projected population growth

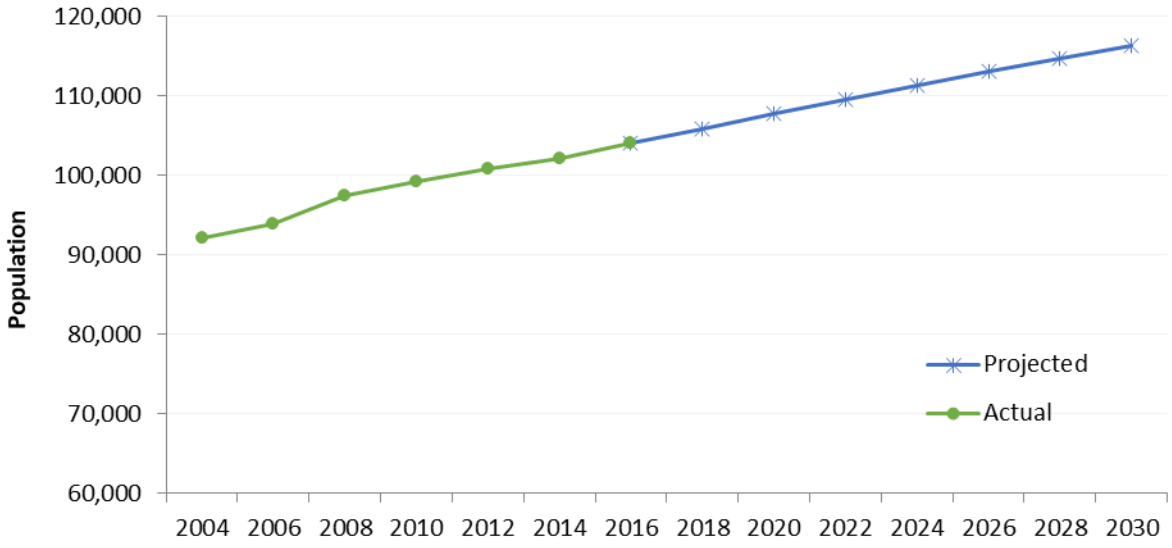


Chart 7 - age profile East Lothian compared with Scotland

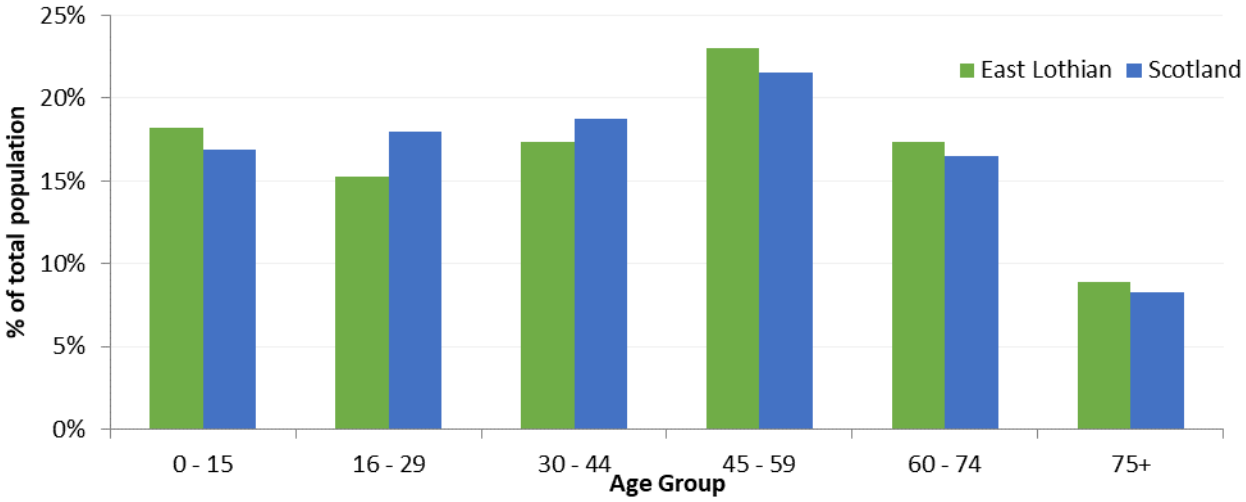


Chart 8 - East Lothian 2016 population by age band and Sex

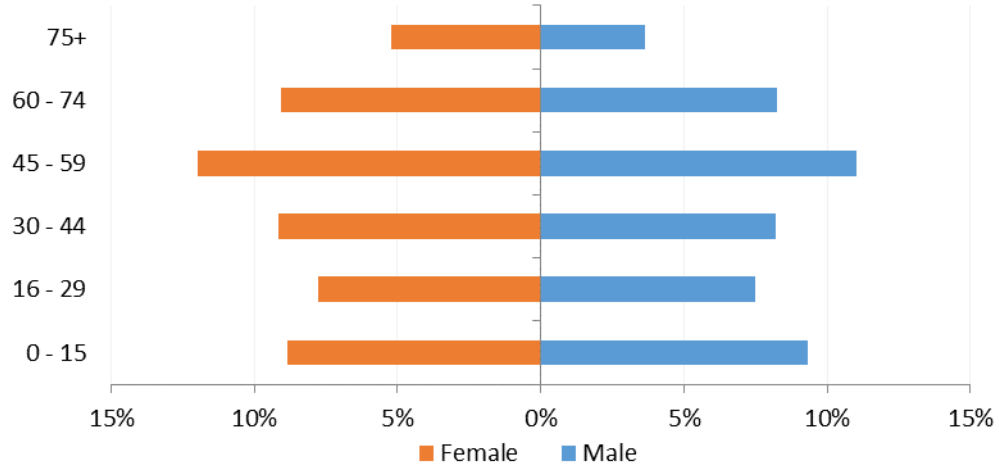
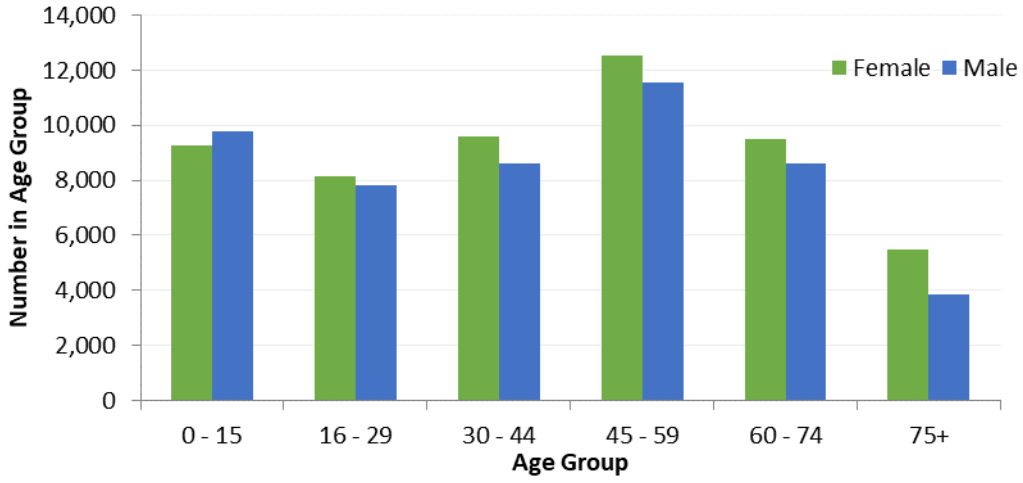


Chart 9 - gender profile



Deprivation across East Lothian

Overall, 4% of the East Lothian population live in the most deprived Scottish quintile (based on the Scottish Index of Multiple Deprivation (SIMD) while 20% live in the least deprived quintile. This varies by locality, with only Fa'side and Preston, Seton and Gosford areas having residents in the most deprived quintile (chart 9 and table 3).

Chart 10 - SIMD 2016 locality population for East Lothian - % (uses 2014 population figures)

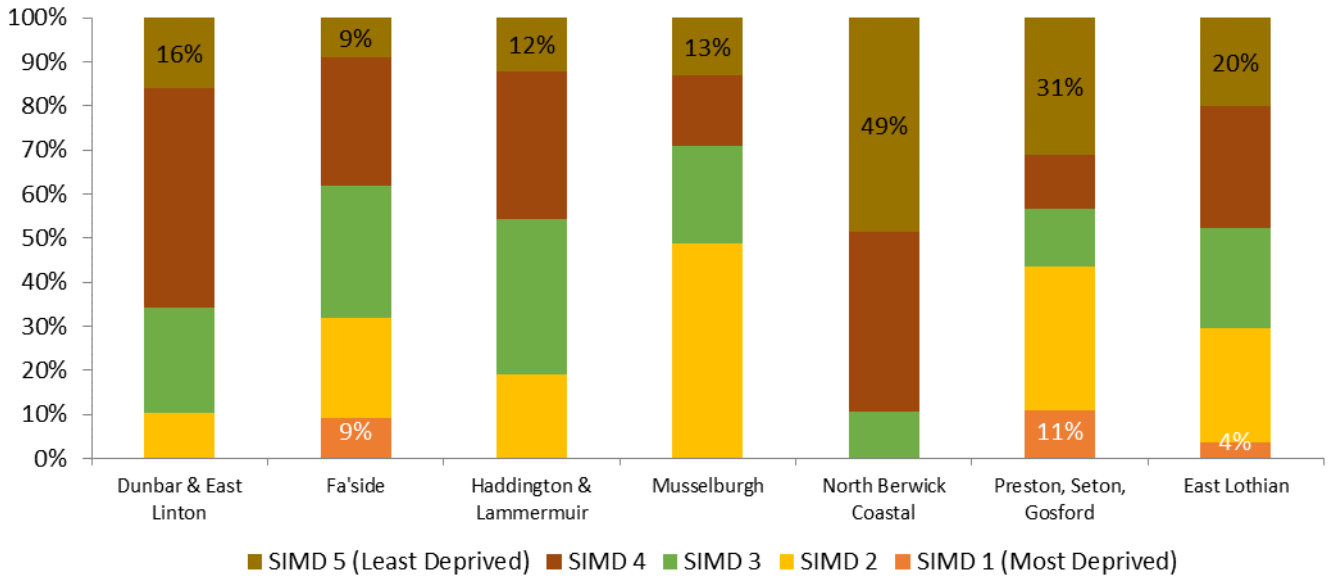


Table 3 - SIMD 2016 locality population for East Lothian - numbers

SIMD Quintile	Dunbar & East Linton	Fa'side	Haddington & Lammermuir	Musselburgh	North Berwick Coastal	Preston, Seton, Gosford	East Lothian
SIMD 1 (Most Deprived)	-	1,754	-	-	-	1,981	3,735
SIMD 2	1,392	4,393	2,506	12,430	-	5,871	26,592
SIMD 3	3,265	5,740	4,627	5,571	1,337	2,362	22,902
SIMD 4	6,769	5,647	4,390	4,072	5,178	2,186	28,242
SIMD 5 (Least Deprived)	2,160	1,715	1,584	3,346	6,144	5,630	20,579

Mortality/Cause of Death

East Lothian HSCP has a rate of 305 deaths per 100,000 population (European Age Standardised Rates (EASR)). In 2014-2016 cancer was the main cause of death. This is below the Scottish rate of 324 deaths per 100,000, but it has historically been higher than the Scotland rate.

Chart 11 - EASR deaths per 100,000 population by East Lothian sub-partnership area compared with Scotland and Lothian Health Board

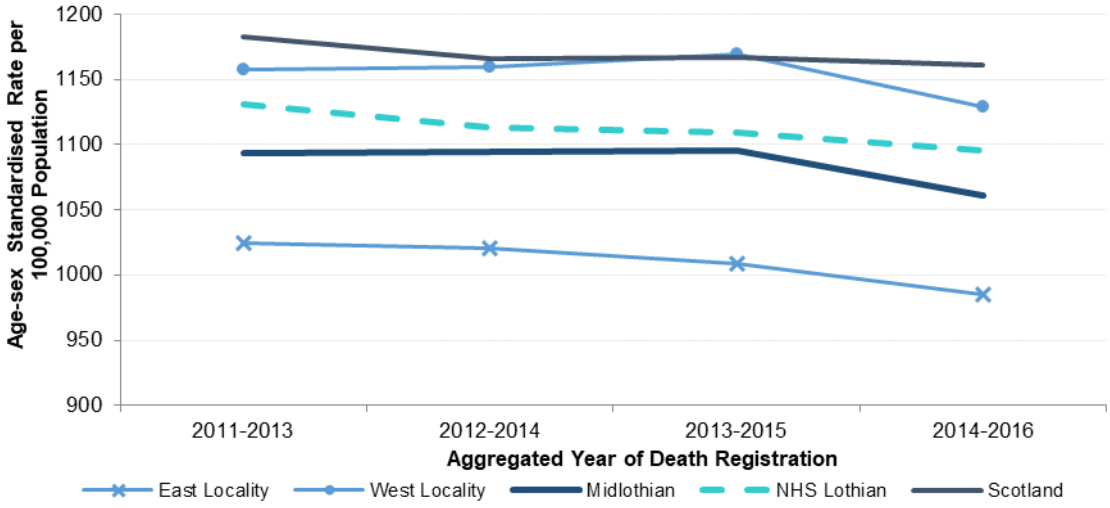
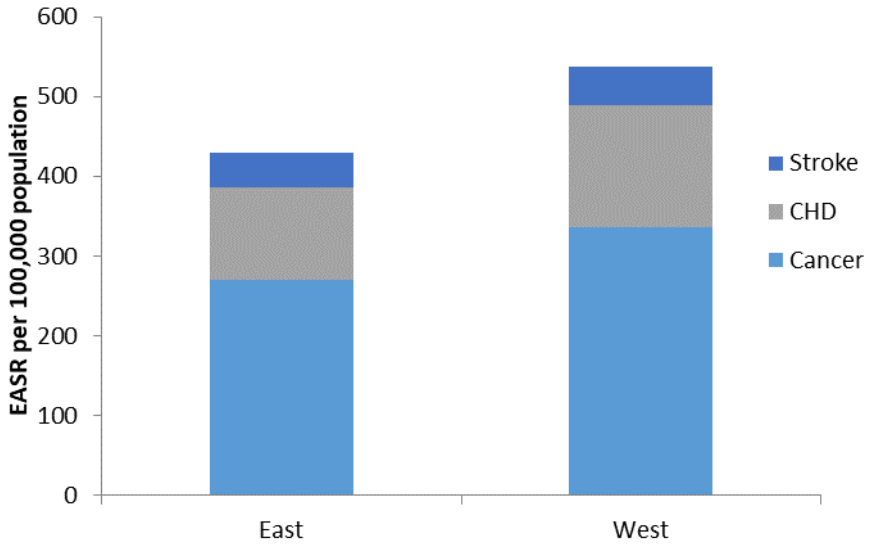


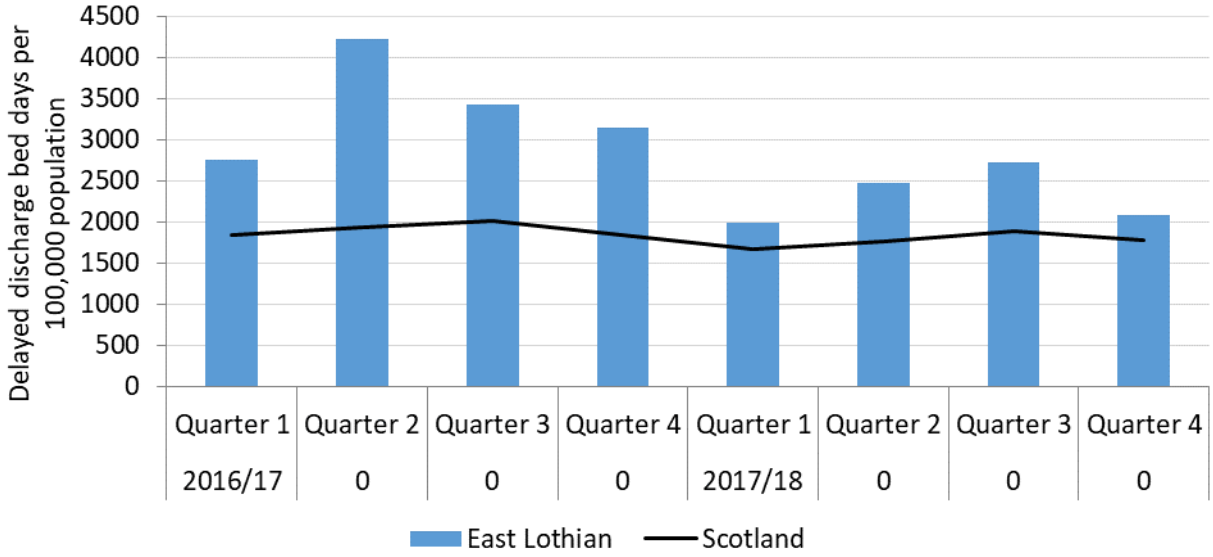
Chart 12 - deaths per 100,000 population, by main 3 causes in East Lothian, 2013/14 by sub-Partnerships



Delayed Discharge

Considerable progress has been made in reducing delays for East Lothian patients who are ready to be discharged from acute hospitals. This has been achieved through multidisciplinary team working across services and the support of the Hospital at Home and Hospital to Home Teams, working together to prevent admissions and to reduce length of stay.

Chart 13 - bed days occupied by delayed discharges - per 100,000 population



Dementia

In 2017, Scottish Government published its third national strategy on dementia. This outlined the models and focus for dementia care across Scotland with an expectation that we deliver the 5 Pillars of dementia care[1]. We are focussed on retaining the progress made in supporting individuals with dementia, and their families. This includes extending the 12 month post-diagnostic support role as well as concentrating on specialist units and care homes. This is reflected in the current work developing in East Lothian.

As East Lothian is the fastest growing local authority area in Scotland the new housing and communities that are being created should be aware of the needs of people with dementia. The dementia friendly East Lothian work that is developing will assist in this, and will become increasingly important as new families and individuals make East Lothian their home. This will involve working in partnership with Community Planning, housing and the third sector to ensure that dementia friendly communities become part of development agendas.

This partnership across Community Planning and Health and Social Care, as well as the Third Sector is also significant in bringing a focus to those affected by inequality or poverty who have a diagnosis of dementia. As noted, East Lothian has a diverse population in an area of mixed urban and rural communities, some affected by deprivation. These factors impact on

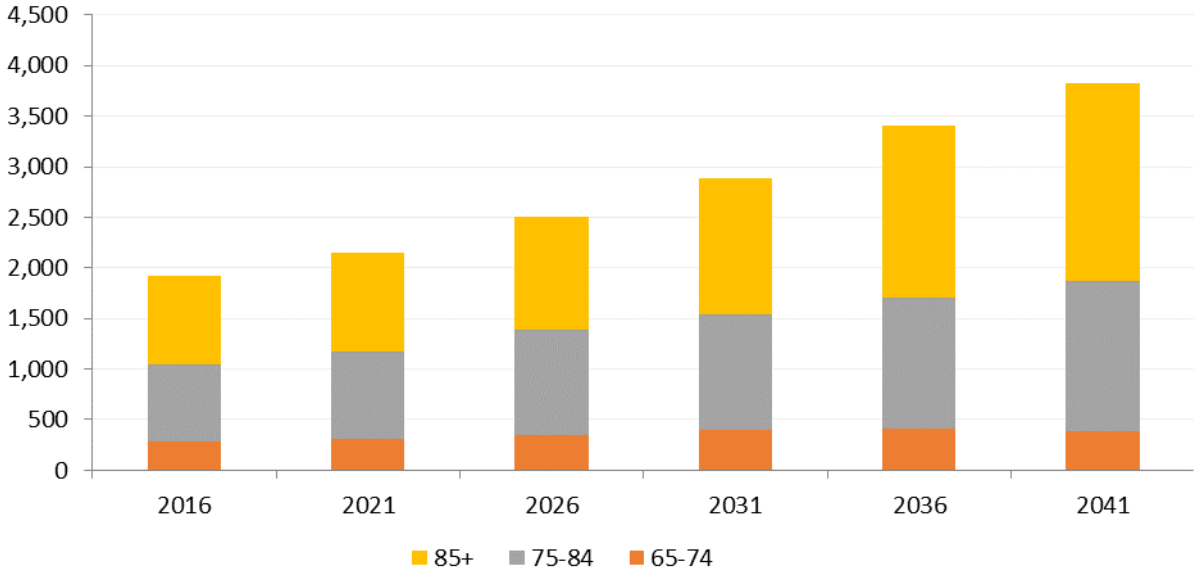
1

how easily people with dementia can access services. This focus needs to be brought into the local dementia care pathway to best support individuals and families within the county.

Table 4 - dementia prevalence projections for East Lothian

Age band	2016	2021	2026	2031	2036	2041	% increase
65-74	287.7	313.7	346.2	393.4	408.7	384.9	34%
75-84	757.7	858.0	1038.4	1151.2	1300.8	1488.4	96%
85+	875.5	981.8	1119.8	1342.5	1696.0	1956.8	124%
Total	1920.9	2153.4	2504.4	2887.0	3405.5	3830.1	99%

Chart 14 - projected numbers of people with dementia in East Lothian 2016 – 2041



Actions proposed in dementia work

Initial planning to outline possibilities for best use of Midlothian and East Lothian community hospital services for people with a diagnosis of dementia. This work is being developed in conjunction with Midlothian Health and Social Care Partnership.

- to analysis data on use and need for East Lothian individuals using Midlothian Community Hospital
- to outline options and consider model of repatriation of East Lothian individuals with a diagnosis of dementia requiring in- patient care from Midlothian Community Hospital to East Lothian (new) Community Hospital.
- to outline options for a local dementia specialist care home in East Lothian
- to review and develop the existing local dementia care pathway to ensure high quality care at each part of the pathway, as well as consider the impact of barriers and inequalities that affect access to support
- to review and develop the post diagnostic support for people given a diagnosis of dementia.

Health inequalities, public health and health improvement

NHS Lothian supports the East Lothian Health and Social Care Partnership (HSCP) in identifying and addressing population health needs in a number of ways, with input from public health professionals including: Public Health Consultants, a Policy Officer, a Public Health Practitioner and Health Promotion Specialists (HPS).

The public health team aims to bring health improvement and health intelligence expertise to support partners in taking an evidence-informed, person-centred approach which considers the impact of policy and interventions on health and health inequalities e.g. tobacco prevention, alcohol licensing, food and health, poverty, violence against women, children and young people's mental health, perinatal and infant mental health. This includes supporting the 'golden threads' within HSCP planning to reduce inequalities and focus on prevention and early intervention.

NHS Lothian also provide funding for health improvement activity within the county. For example, health improvement projects that have a focus on children and young people and Ageing Well which focusses on physical activity in later life.

East Lothian Health Improvement Alliance

The East Lothian Health Improvement Alliance (ELHIA) is where health improvement and health inequalities work is often co-ordinated, although this is not exclusively carried out by this group. ELHIA seeks to bring together organisations from the public, community and third sectors with an interest in improving health and reducing inequalities.

The Alliance has three overarching objectives to reduce health inequalities in East Lothian:

- ensure strategy across East Lothian Partnership promotes health and reduces inequalities through advocating for health in all policies and supporting the completion of Integrated Impact Assessments on all strategies, policies and action plans
- develop support and resources for health improvement and reducing inequalities through training, seminars and sharing information on the causes of inequalities and what works to ease, reduce and prevent the impact
- support health improvement activity across East Lothian that is evidence based and health inequality focused e.g. advising on the delivery of Health Improvement Funded projects in East Lothian.

In line with this work the Public Health team continue to develop partnerships in the county both within the HSCP and the wider East Lothian Partnership to raise awareness of inequalities and influence policy and strategy development around the broader determinants of health and inequalities. One such example would be contributing to the development of the East Lothian Local Housing Strategy which is, in and of itself, an excellent example of a 'Health in all Policies' approach.

Rapid Rehousing Transition Plan[2] (awaited)

[2] **Reference/document location needed**

Primary Care

July 2018 saw the completion of the East Lothian Primary Care Improvement Plan (PCIP) in line with the requirements of the new GP contract developed by the Scottish Government and the British Medical Association. Following this, an 'implementation period' commenced to run until April 2021. During this period, the HSCP's primary care team will implement, evaluate and expand new models of service delivery across East Lothian. Having already led significant change, East Lothian has been at the forefront of Primary Care Improvement in a national context. Recent developments have included:

- the nurse-led Care Home Team – working directly with care home staff and GP practices to deliver prompt and continuous care to residents of care homes. Nursing expertise, augmented with clinical decision-making capabilities and prescribing, has led to more seamless ongoing and acute care. The service is being evaluated by Health Improvement Scotland. It currently covers care homes in Musselburgh, Wallyford, Gullane and Haddington, with further expansion planned
- CWIC (Collaborative Working for Immediate Care) has now completed its first year operating from Musselburgh Primary Care Centre. CWIC works in partnership with Riverside Medical Practice and NHS 24 to deliver care to patients using a team of Nurse Practitioners, Advanced Physiotherapy Practitioners, Mental Health Nurses, Mental Health Occupational Therapists and Advanced Nurse Practitioners. Evaluation so far has shown reductions in prescribing and in outpatient referral numbers
- practice pharmacists continue to provide services for patient of several practices in East Lothian
- evaluation of current primary care nursing services (including Practice Nursing, treatment room services, Health Care Assistants and phlebotomy) within existing GP practices. These services are currently provided through a mixture of ELHSCP led and GP led arrangements
- support from partners in the LIST (Local Intelligence Support Team) to provide data and help with analysis, so ensuring that planning is built around activity and need and to evaluate outcomes of service developments.

The PCIP will support significant changes in how patients access primary care services, and how these services are delivered to them. It will give patients a greater choice of access options and importantly, that they see the right professional for their problem at the outset.

By training and recruiting a broad multi-disciplinary team and by modernising access models, patients should benefit from this new approach to Primary Care. The PCIP is also designed to balance out the differences in access and service delivery that are seen in different parts of the county. ELHSCP wants to ensure that all patients in the county experience the same high quality service, delivered through safe and well governed pathways. The PCIP aspires to create a seamlessness between services. This extends to secondary care services, especially Hospital@Home and East Lothian Community Hospital outpatient services.

The next phase of the PCIP implementation and the overall strategy for Primary Care will include:

- expansion of the Care Home team to ensure that we provide the best possible care for one of the most frail populations. The HSCP intends to grow this team and allow all care home residents in the county to benefit from it. Consideration will be given to expanding the service to cover all days of the week
- expansion of the CWIC service. This 'Musselburgh Model' already serves nearly a fifth of the population of the county (circa 20,000 patients). NHS 24 has already committed to expand their input using extra investment from the Scottish Government. Three neighbouring practices are already in discussion regarding adopting the model bringing the potential number of patients benefiting from this service to over 50,000
- support and investment in training new staff to extend their roles in delivering primary care services
- design of a 'CWIC-lite' model in recognition of the needs of those parts of the county where levels of demand on Primary Care do not create issues with access for patients. This model will focus on providing support from musculoskeletal and mental health practitioners
- new models of home visiting, including Paramedic Practitioners and Allied Health Professionals. This will allow the HSCP to respond to acute illness as well as complex cases of frailty and will allow development of improved pathways into secondary care and social services to access support as necessary
- testing and implementation of Community Treatment and Care Services (CTACS). These new centres, as envisaged by the new GP contract will deliver nursing services on behalf of primary care and will be designed and run by the HSCP
- development of the 'pharmacotherapy' (pharmacy) team. Once existing pharmacist-led services have been evaluated and to support the requirements the GP contract, ELHSCP will establish a team of pharmacists, pharmacy technicians and administrative support
- review of Out of Hours services (provided by Lothian Unscheduled Care Service) to ensure that current models best serve local needs and that communication between in hours and out of hours care is minimised to improve the access journey for patients
- development of a strategy to prepare primary care's response to meet the needs of a growing and ageing population, and the different demands they will place on services
- further expansion of the Links Worker services across primary care
- ensure that existing GP services are better equipped to respond to patients need utilising all members of the Primary Care team
- investment in telephony and eHealth services to support developments. Currently patient data sits within individual GP practices only. Consideration is being given to

establishment of shared IT services, allowing much improved sharing of data between services where appropriate, ensuring improved continuity of care

- development of transport to ensure that patients who currently experience difficulties in accessing services are not disadvantaged and to consider those who are at risk of becoming disadvantaged by any future service changes.

Providing primary care services around the clock

When GP practices are closed (between 6pm and 8am Monday to Friday, all of Saturday and Sunday and on public holidays) urgent primary care services are provided out of hours (OOH) by Lothian Unscheduled Care Service. Better known as LUCS, this is a Lothian-wide service which works on behalf of local primary care in East Lothian. Patients who need care access LUCS after initially contacting NHS24 by telephone for their concern to be assessed.

Patients can be seen by LUCS staff in the Outpatient Department at East Lothian Community Hospital. In addition to this, LUCS provides home visiting and telephone support and care to patients in East Lothian where that is required.

Throughout Scotland, OOH primary care services are implementing the recommendations of a National Review, known as the 'Ritchie Review'. The review recommendations include being able to provide more coordinated and supportive care for patients through the creation of Urgent Care Resource Hubs. Such Hubs would coordinate care in the OOH period across a more diverse range of services than is currently available.

Within Lothian, work is advancing to develop plans that will support the Review's recommendations. Forthcoming tests aim to bring other clinical professions into OOH working in a way not seen before. This includes pharmacy and psychiatric nursing services. It is expected this will mean more services are available to patients in East Lothian during the OOH period

LUCS has experienced the same pressures as day time general practice in recruiting and retaining staff. As with daytime services, this has led to some restrictions in access to services. In East Lothian it has sometimes been difficult to fully staff the Out of Hours base at East Lothian Community Hospital, although East Lothian residents have always been able to access the service at other bases and home visits have been maintained.

The frequency of these difficulties increased over 2018. East Lothian HSCP will work with LUCS to improve the situation and maintain local access to primary care out of hours locally through supporting the developments above both financially and operationally and through working with East Lothian GPs to increase support for the service.

Getting the best outcomes for people

Improving the outcomes for people who use health and social care services will continue to be a priority in the next strategic plan. We will increasingly use tools to measure progress against, and the achievement of, outcomes for the people who use our services and the services we commission.

Joint Strategic Needs Assessment

We have considered a wide range of information in deciding on the focus of this strategic plan. The main sources of information were a joint strategic needs assessment and routinely gathered data concerning performance and targets relating to national and local outcomes, strategies and policies.

The joint strategic needs assessment (JSNA) describes the demographics of the East Lothian adult population and the variations in health and care needs across the county, reflecting the differences between the populous and more urban west of the country and the more rural east.

Improving our Services

The Joint Strategic Needs Assessment provides data to inform decisions about development of current or new services. Whether we are seeking to plan and minimise hospital admissions or tackle capacity challenges within care at home delivery we will use the data we hold to maximise the efficient use of resources targeted at those most in need.

The strategic plan retains a commitment to supporting people closer to home, in their own home or in a homely setting. This will be achieved through a number of measures resulting from re-modelling of our own services as well as the services we commission.

Early intervention and prevention will continue to be a priority for East Lothian in the next strategic plan. We remain committed to developing ways to avoid unnecessary admission to hospital or to a residential or nursing home. We will provide packages of support for people to stay for as long as possible in their own homes. One key way in which we will seek to do this is through the development of extra care housing or other supported accommodation arrangements.

As well as new models of housing with care there are a number of other ways that we can support people to retain their independence and well-being for longer. This will increasingly involve the use of commissioned services in relation to early intervention and prevention as well as areas such as Technology Enabled Care (TEC) and Telehealthcare. We will also review the use of equipment and adaptations as a means of supporting people to be cared for at home.

East Lothian Health and Social Care Partnership has made considerable progress in the management of delayed discharge with all-time low numbers of people being delayed in hospital. This is a result of a combination of coordinated efforts across teams.

We will continue to strive to maintain low numbers of people delayed in hospital. As part of improving outcomes for all the people who use our services we will continue to focus on addressing unscheduled care and on avoiding unnecessary admissions.

Gypsy Travellers in East Lothian

There is currently no systematically collated data about the Gypsy Traveller population in East Lothian. This makes it difficult to provide an accurate assessment of numbers and needs. However, health outcomes for Gypsy Travellers are generally poorer than for the wider population and they experience greater levels of stigma and discrimination than other minority ethnic groups.

There is one official encampment at the Old Dalkeith Quarry, which serves the populations of both East Lothian and Midlothian, with pitches for 12 trailers. Some Gypsy Travellers use 'unofficial encampments' across the county, often with limited or no access to resources such as health services, running water and waste disposal. As a consequence, risks to health for this population are often greater than for those who use official encampments. Some Gypsy Travellers also live in permanent housing.

The Gypsy Traveller Steering Group is a multi-agency partnership with representation from: health; education; local authorities; police and the third sector. The group coordinates activities aimed to improve the health and wellbeing of the Gypsy Traveller community across Lothian. The work is governed by an action plan which is based on the priorities set out in a Fairer Scotland for All: Race Equality Action Plan. The plan supports the 'golden threads' within HSCP planning to reduce inequalities and focus on prevention and early intervention.

Over the past year, membership of the group has expanded to include oral health; health visiting; midwifery; Detect Cancer Early; Education; Article 12, a rights based group working with young Gypsy Travellers and; Women's Voices, a project to enable women in the Gypsy Traveller community to achieve their personal aspirations and engage in civic life. In addition, the Steering Group has re-established links with Skills Development Scotland and Shelter.

The priority outcomes for the Gypsy Traveller Steering Group covering the period 2018-2021 are:

- increased involvement of Gypsy Travellers and partners in improving the health and wellbeing of Gypsy Travellers
- increased capacity of staff in public and voluntary sectors to meet the needs of Gypsy Travellers
- Gypsy Travellers have effective healthcare appropriate to their needs and experience
- increased educational attainment among young Gypsy Travellers
- increased literacy and numeracy amongst the adult population
- increased access to employment opportunities for the Gypsy Traveller population in Lothian
- increase in young Gypsy Travellers achieving positive destinations
- Gypsy Travellers and their families are aware of and can access welfare benefits as per entitlement.

Older people

As noted in the first Strategic Plan, East Lothian launched a joint Older People's Strategy in 2011 which prioritised actions to develop independent living crisis care, early response and re-ablement approaches.

A great deal of progress has been made in establishing a coordinated, multidisciplinary approach to identifying and acting on the needs of older people. This is delivered through the Hospital to Home, Hospital at Home and Care Home teams. These teams have reduced demand on secondary care services, but transfer of activity has increased demand for local support.

Our challenge in coming years is to release current funds tied up in secondary care to allow further development of our local services. If we are to respond appropriately to the growth in the number of older people and in those with complex needs more investment will be needed.

Falls

[Content to follow]

Rehabilitation

Services must embrace rehabilitation approaches to respond to current service demands, to support clients in reaching their highest level of functioning and to efficiently utilise workforce and financial resources.

[Content to follow]

ELHSCP facilitates HILDA and develops the use of the Lifecurve™ for a wide range of people to improve their health and wellbeing.

The focus of the Wellwynd Hub is prevention, early intervention and low level support. This will take the form of:

- early assessment of need in an accessible environment where the full range of aids adaptations and technology can be trialled on site
- promotion of HILDA – the online self-assessment tool with informed guidance and support on a range of equipment and advise to support safety and independence in the home
- use of the Lifecurve™ an evidence-based tool within HILDA to support early intervention and promote improved functional ability for clients through exercise and engagement in community activities
- moving and handling demonstrated and taught to carers and staff alike
- specialist advice on adaptations for people with mobility issues
- falls prevention techniques and training
- promotion and showcasing of TEC (**) solutions to assist with risk enablement
- identification of carers and signposting to support
- the HUB will also provide a dedicated resource for staff training within the county enabling preparedness for the challenges of a growing ageing population. The HUB can also be used to demonstrate and safely store training equipment and Technology Enabled Care.

Palliative and end of life care

We remain committed to the delivery of high quality palliative and end of life care through our multidisciplinary teams in home, community and hospital settings. In developing this care we aim to reduce reliance on acute hospital beds in favour of community based care.

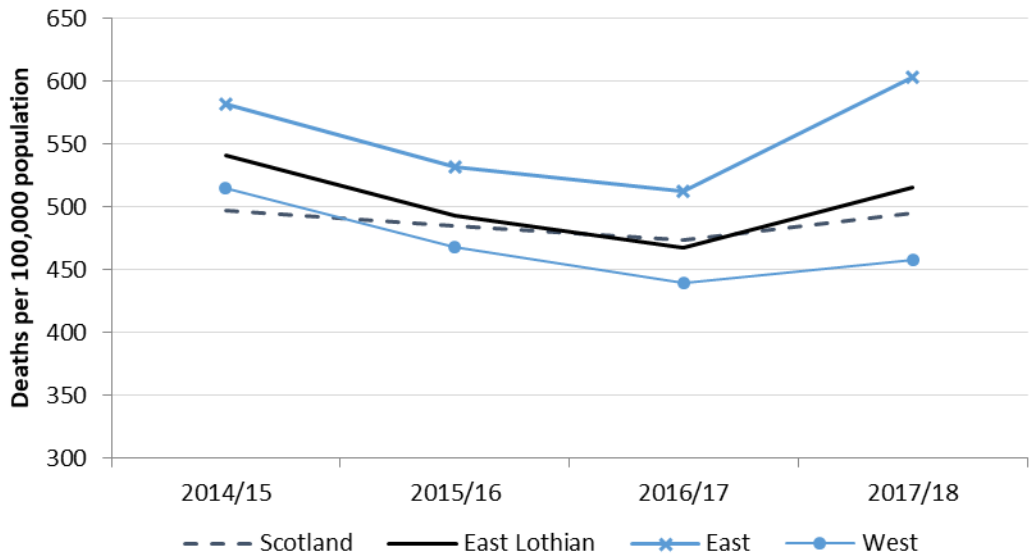
A Macmillan palliative care community nursing team also provide specialist support across the county. East Lothian patients can also access day services and beds in the Marie Curie and St Columba's Hospices.

The Macmillan team has enhanced its membership with the introduction of a Band 4 staff member. This allows the specialist nursing resource to focus on more complex patients whilst also supporting the generic community nursing teams to enhance their skills and knowledge. The provision of an outpatient clinic run jointly by the Macmillan team and St Columba's will ensure that patients can access this specialist resource at local level. This reflects the preferences of patients and carers.

Data tells us that around 40% of deaths have some care input from specialist palliative care services. In addition, general practice, community and social care teams provide important support to patients in the last years of life. Demand for such care will rise as the population ages and as people live with increasing numbers of long term and complex conditions.

The proportion of deaths which occurred in NHS Acute Hospitals in East Lothian for 2017/18 was 515.1 per 100,000, just above the Scottish average of 494.9 per 100,000 population.

Chart 15 - deaths in acute hospital per 100,000 population by East Lothian sub-partnership area with Scotland and Lothian Health Board comparators



Adults with a learning disability and autism

Learning Disability Scotland Statistics 2017 indicates that East Lothian has the second highest number (8.3%) of people with a learning disability per 1,000 of the population. The national average is 5.2%.

We aim to provide every adult with learning disability in East Lothian with the opportunity to live a healthier, more active and independent life, engaged in their local community.

The keys to life is the Scottish Government's ten year learning disability strategy for 2013 – 2022. It takes a human rights approach to addressing inequalities experienced by many people with learning disabilities. The 2015-2017 Implementation Framework presents four strategic objectives – A Healthy Life, Choice and Control, Independence, and Active Citizenship - to frame priority areas for action. The most recent Implementation Framework, for 2018–2020, does the same.

In line with the four strategic objectives the East Lothian Learning Disability Strategy 2013 – 2018 identified 7 key outcomes and actions:

1. people with a learning disability will be supported to maintain and develop, friendships, community links and steps towards independence - Transformation Programme Management Group
2. people with a learning disability and families/carers can access information and support from a single point of contact - Transformation Programme Management Group
3. carers will be appropriately supported and have access to an assessment as a carer - LD Strategic Planning Group (led by Carers Reference Group)
4. people with a learning disability will have greater access to further education, employment opportunities and the opportunity to engage in meaningful activities. - Transformation Programme Management Group
5. people with a learning disability can access required health care service locally - LD Strategic Planning Group
6. different types of housing and supports models will be available to support people with a learning disability to live in East Lothian - LD Strategic Planning Group
7. people with a learning disability will feel safer in their communities and given the chances to develop friendships and relationships based on their own choices - LD Strategic Planning Group.

The Learning Disability Joint Planning Group oversees the implementation plan which supports the local strategy. With the introduction of the Health and Social Care Partnership new planning and governance, structures are emerging. As a result, there has been the creation of reference groups and changes boards.

Members of the planning group identified that there are a number of priority areas which include housing, support for carers and health care services which will continue to sit with the joint planning group.

For service development for and with people with learning disabilities, the planning process below will apply.

East Lothian Health and Social Care Partnership has set up a Transformation Programme which will focus on redesign and developing community supports for adults with complex needs. This includes people with a learning disability and/or autism. The programme will report by April 2019, with a view to new models of service being implemented by April 2020.

This programme will also report to the Adults with Complex Needs Change Board.

This project aims to achieve the following:

- consider outputs from the Big Conversation and Carers Breakfast.
- collection and analysis of data/information to inform us how current commissioned services and internal day services are delivered, which will inform the Needs Assessment and ultimately the future community provision. This will include an analysis of transition data to inform model development for those with complex needs.
- engagement, consultation and co-production with service users, carers and other key stakeholders.
- review of all current legislation and national guidance in respect of day support for those clients with a Learning Disability/Physical Disability/Mental Health and /or Sensory Impairment.
- identify good practice and evidence based models from an international, national and local perspective and complete an options appraisal to consider what would be appropriate and applicable for development within East Lothian.
- development of a robust eligibility criteria, service categories and purchasing model.
- encourage and improve relationships between Health and Social care and other relevant stakeholders e.g. EL Works, Voluntary Sector, Area Partnerships
- establish a model of community provision for the future of commissioned and internally delivered services, ensuring that those with the highest need continue to be able to access building based support.

To further support the integration of health and social care a Learning Disability Leadership and Implementation Group has been established. This group is key to ensuring:

- implementation of East Lothian's Learning Disability Strategy
- implementation of a quality improvement and performance management framework across services
- that there is a robust quality improvement and performance management framework in place
- to monitor operational processes and compliance with operational policies

- to lead and progress the development and management of a multi-disciplinary Positive Behaviour Support transferring the service from Lothian to an East Lothian model
- to maximise opportunities to develop fully integrated multi-disciplinary teams to support those with complex needs
- to support in the planning and commission of community services and housing provision
- to maintain engagement with NHS Lothian learning disability services to support the modernisation and reshaping of these, e.g. specialist in patient learning disability services within the Royal Edinburgh Hospital
- to ensure oversight of all budgets for services for people with learning disability across NHS and East Lothian Council, including relevant commissioning budgets.

Adults with physical disability

The Scottish Government report *'A Fairer Scotland for Disabled People'* published in 2017 is the national delivery plan for Scotland until 2021.

In partnership with the local Physical Disability Strategic Planning Group, East Lothian HSCP has developed a draft local implementation plan. This is in the final stages of development and will progress our delivery of the 5 national ambitions.

Key Emerging Actions include:

- in partnership with the Self Directed Support group we will discuss flexibility around short breaks, which will include family visits to maintain relationships
- drive forward a range of initiatives to improve employment opportunities for people with physical disabilities in East Lothian
- promote increased physical accessibility for people with physical disability throughout East Lothian in collaboration with Area Partnerships, and through the establishment of an Access Panel
- continue to work with the Public Protection Office to address and reduce incidences of disability related hate crime
- promote active participation of disabled people in communities and community development.

Carers

Carers need to be at the heart of the reformed health and social care system to promote a shift from residential, institutional and crisis care to community care, early intervention and preventative care. In making these changes to the care system it is crucial that carers should not be burdened, but supported and sustained in their caring role.

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

An ongoing process of reviewing and redeveloping the plan to deliver the Carers Strategy identified the key priorities for carers and carer support.

With the Carers (Scotland) Act coming into force on 1st April 2018 work was undertaken to ensure the Act's requirements were met. As a result we have:

- developed and published an East Lothian Carers Strategy in consultation with carers and third sector organisations. The strategy focuses on 8 outcomes. Awareness of the Act and the new strategy was widely publicised during April to June 2018.
- developed Adult Carer Support Plans and Young Carer Statements in partnership with our local carers organisations. These were trialled with adult and young carers and are now being used by all carer organisations in place of the previous carers assessments. Particular effort was directed to making the young carers statements accessible by making the form easy to read and simple to complete
- developed and published local Carers Eligibility Criteria in consultation with carers and third sector organisations. This will be used against information provided in the Adult Carer Support Plans (ACSPs) and Young Carers Statements (YCS)
- developed and published East Lothian's Short Breaks Statements detailing short break services available across the county – these are split by user group (Adults, Parent Carers and Young Carers all have individual short break statements as the services they access are quite different)
- supported implementation work to prepare our workers for the changes, including providing them with briefings on the new ACSP/YCS tools and eligibility criteria
- rolled-out to social work staff development sessions on EPIC (Equal Partners in Care) 1 & 2. The NHS equivalent – 'Thinkcarer' training is planned for delivery through 2019
- the majority of additional Scottish Government funding associated with Carers Act implementation was passed to our local carers organisations to increase services for carers.

The East Lothian Carers Strategy commits to 8 outcomes with key actions supporting each one. These outcomes are:

- adult, young adult and young carers are identified and can access support
- carers are well informed and have access to tailored and age-appropriate information and advice throughout their caring journey
- carers are supported to maintain their own physical, emotional and mental wellbeing
- breaks from caring are timely and regularly available
- carers can achieve a balance between caring and other aspects of their lives
- young carers are supported to have a life outside their caring role
- Carers and young carers are respected by professionals as partners in care and are appropriately included in the planning and delivery of both the care and support for the people they care for and services locally
- local communities are supported to be carer friendly.

Carer support will continue to be a key, cross cutting theme through all our strategic change programmes. The East Lothian Carers Strategy, under the guidance of the Carers Change Board, will direct and inform the HSCP's priorities across this work area over the lifetime of the Strategic Plan. The Carers Strategy addresses the need for significantly enhanced rates of identification, assessment and outcomes-focused support to ensure carers are able to maintain their own physical, emotional and mental wellbeing and can achieve a balance between caring and other aspects of their lives.

Breaks from caring

Breaks from unpaid caring are a key component of integrated services to support a shift in the balance of care from hospital and residential care to community based services. Breaks from caring are also an integral part of our investment in preventative services.

Carers have a crucial part to play in the delivery of our health and social care system. This emphasises the importance of supporting them in sustaining their role. Breaks from caring are essential in allowing carers to continue their caring role for longer and in better health. Such breaks can also delay or prevent the need for a hospital or care home admission.

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

In the past, local authority data collection systems were unable to fully capture all activity across all the breaks from caring options. Significant work has been completed in respect of improving collection of carer data. However, further work is required to capture those breaks from caring made possible under Self Directed Support funding.

Whilst the strategic planning process has taken into account some elements of a needs assessment to inform the wider planning and commissioning of breaks from caring provision, this will be enhanced by continued improvements in our data collection. The strategic planning process will continue to support the delivery of both planned and emergency breaks from caring through commissioning a range of flexible local opportunities for replacement care and breaks from caring in a variety of settings to suit individual circumstances.

Care at home

In East Lothian, care at home is predominately provided by the Independent sector, with only 5.5% provided via East Lothian Council's Homecare team and the NHS funded Hospital to Home Team. Given the size and value of care at home provision in East Lothian, a project team was set up to:

- deliver good quality care at home to the people of East Lothian regardless of their age or support need through the establishment of one framework rather than having multiple frameworks for different client groups
- establish a link between incentivising providers and in improving quality
- address issues such as the capacity challenges linked with care at home provision in East Lothian through innovation and collaboration
- ensure care at home provision is affordable and is value for money
- develop care at home provision focused on delivering support which reflects each individual's personal outcomes and what they want to achieve in their lives.

The project focussed on a co-production approach to the re-modelling of the framework and carried out significant engagement with key stakeholders including independent and third sector providers, service users, carers, practitioners and the public. The re-modelling culminated in a procurement and tendering exercise for a new care at home framework, with the new arrangements commencing on 1st April 2017. The new framework has 14 care at home providers and will operate for a minimum of 5 years with the option to extend for a further two years.

The Care at Home Framework has a number of innovative solutions to meet the demands of care at home services in East Lothian. These are:

- one service specification for all provision regardless of whether a client is over or under 65, their level of support needs and whether support is delivered from an independent or voluntary sector provider
- development of a link between quality and opportunity for services on the framework by setting a minimum Care Inspectorate grade for providers to attain to qualify to deliver the framework and a minimum grade for providers if they are to work with clients using the personal budget model
- establishment of collaborative allocation meetings to address long-standing capacity challenges for care at home. Through fortnightly meetings all framework providers, social work staff, the Hospital to Home service, senior

operational managers and the East Lothian Council internal homecare service discuss current packages of care and those that need to be provided. This allows providers to reduce the numbers of providers working in one street, so maximising capacity and reducing travel time, while enabling care at home support to be organised across the county in a more efficient way.

- development of the personal budget model, to focus on the achievement of personal outcomes rather than the time and task to be delivered. This provides opportunities for increased choice and independence for supported people under the Framework provision (Option three of the Self Directed Support Act) and a focus on individual's personal outcomes. The approach allows support to be organised by the provider and the supported person, based on what will best meet agreed outcomes, with no prescribed days or times when the care must be delivered. This in turn helps to address capacity challenges as it provides flexibility in how the care is organised and delivered.

There remains a challenge in recruiting and retaining care staff for care at home services. Despite the national implementation of living wage for all care workers, the job is still viewed as low paid but with high levels of responsibility, autonomy yet close scrutiny. There is still high mobility of carers between providers, causing additional disruption to service users and increased costs to providers and commissioners of services.

Alcohol and substance misuse

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

The main services for adults which can be accessed through the Recovery Gateways are the Substance Misuse Service (SMS) which provides a range of services to clients who wish to regain control over their substance use and make positive changes in their lives. SMS offers clients:

- specialist prescribing
- drug and alcohol detoxification (community and inpatient)
- access to residential rehabilitation, normally through the Lothian and Edinburgh Abstinence Programme (LEAP). MELDAP currently purchases 10 places annually for East Lothian residents.
- psychological interventions, blood borne virus screening, immunisation and advice, Take Home Naloxone kits
- Needle Exchange Outreach Network
- Adolescent Substance Use Service
- Substance Misuse Social Worker
- The Ritson Clinic (an 8-bed detoxification ward) in the Royal Edinburgh Hospital.

Other MELDAP commissioned services for adults are:

- Mid and East Lothian Drugs (MELD)
- Edinburgh and Lothian's Council on Alcohol (ELCA)
- Recovery College, in partnership with Access to Industry
- Starfish Recovery Café
- Peer support.

Service priorities from the MELDAP 2015-2018 Delivery Plan are still in place with a 2019-2022 plan in development. Progress from the 2015-18 plan includes:

1. Promoting more responsible attitudes and behaviour to the use of alcohol and reducing the harm caused by the misuse of drugs:
    - continued to fund Alcohol Brief Interventions in primary care
    - support provided to East Lothian Licensing Forum on range of alcohol related issues including the development of an over-provision statement
    - MELDAP funded discreet and targeted work regarding minimising the impact of alcohol and drugs with young people through Crew [Edinburgh]
    - the provision of substance misuse training to a wide range of partner agencies including education, health, police and foster carers

- the development and co-ordination of resource materials on topics such as minimum pricing, Take Home Naloxone and the misuse of prescribed drugs (Xanax).

2. Establishing a Recovery Orientated System of Care (ROSC) and working with people with lived and living experience to develop and build recovery communities and services:
    - implemented phase one of a Recovery Hub in Musselburgh
    - successfully developed the use of Peer Support Workers
    - provided training for some 60 staff working with children affected by parental substance misuse to ensure children are kept safe
    - ensured that high quality, cost effective, person centred services were based around the needs of services users and their families.

In 2016, the Care Inspectorate completed a self-evaluation process with MELDAP (and all other Alcohol Drugs Partnerships) in Scotland.

The Care Inspectorate stated "*The ADP demonstrated a robust approach to self-evaluation and had implemented a quality assurance framework based on the Quality Principles. The outcomes from this work are overseen by an appointed quality assurance officer who highlights any issues of note to the governing groups."*

There is a well-developed programme of Quality Improvement visits to all services provided by the MELDAP Team which is complemented by an annual programme of service presentations to the MELDAP Commissioning and Performance group.

MELDAP has also carried out several service user/carer consultations in this period and have taken suggestions forward as part of the work of the partnership.

Planned developments for MELDAP 2019-2022

The new MELDAP Delivery Plan will set out how the partnership intends to tackle a broad range of issues associated with the use and misuse of alcohol and drugs and its impact on individuals, families and communities. The plan will address the key priorities in the Scottish Government's new alcohol and drugs strategy, Rights, Respect and Recovery.

There are a number of planned initiatives. These include:

- improving pathways to allow access to services particularly for those most at risk due to their misuse of alcohol and drugs by further developing the Recovery Hub service and expansion to provide a Primary Care/Assertive Outreach approach in localities where this provision is required
- further developing the a Recovery Integrated System of Care (ROSC) increasing the role of people with lived experience to develop and build recovery communities and services and further developing advocacy support
- ensuring that services work together to meet the needs of people with substance misuse and mental health issues and ensure that all services recognise the need to keep children safe from the harm caused by parental substance misuse

- ensure that the quality of care, support and treatment provided by all services is of the highest standard and meets the expectations described in the National Quality Principles.

Criminal Justice social work

Data suggests people who have, or who are at risk of offending are more likely to have multiple and complex health issues, including mental and physical health problems, learning difficulties and substance misuse. In addition, they are three times more likely to die prematurely and ten times more likely to commit suicide than the general population.

Criminal justice social work services in East Lothian are provided in a framework of social and community initiatives intended to achieve a reduction in reoffending, increase social inclusion of former offenders and provide support for victims of crime, while increasing community safety.

Work across criminal justice social work services is funded by a ring-fenced direct grant from the Scottish Government and are required to adhere to National Outcomes and Standards and to:

Social Work Services responsibilities include**:**

- provide effective supervision of offenders in the community
- challenge offending behaviour and help offenders realise the impact of their behaviour on themselves, their families, the community and their victims
- assist with problems that may contribute to offending, for example, drug or alcohol misuse
- provide courts with a range of alternatives to prison in appropriate circumstances
- promote community safety and public protection.

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

The service currently operates within the Community Justice agenda, as part of the Scottish Government's National Strategy. The community justice model has been designed to deliver a community-based local solution to achieving improved outcomes for offenders and communities; reducing re-offending; and to support desistance.

The IJB and Local Authority are statutory partners for community justice and are responsible for ensuring that the Local Outcome Improvement Plan is developed and implemented, thus achieving the above outcomes.

Public Protection

The East Lothian and Midlothian Public Protection Committee is a strategic partnership, bringing together responsibility for our inter-agency approach to Adult Support and Protection; Child Protection; Violence Against Women and Girls; and Offender Management. The core functions of the committee are supported by five sub-groups:

- Performance and Quality Improvement sub-group, which is responsible for the oversight and governance of the performance framework and improvement plan
- Learning and Practice Development sub-group, which oversees the development and delivery of the Learning and Development strategy
- Communications Sub-group, which has been re-established to fulfil the functions related to officer and public awareness as per the Adult Support and Protection (Scotland) Act 2007 and the National Guidance for Child Protection in Scotland (2014)
- Violence Against Women and Girls sub-group, which supports the delivery of services and preventative activities
- Offender Management Group, which ensures that the statutory responsibilities placed on local partner agencies for the assessment and management of risk posed by dangerous offenders are discharged effectively.

The Committee and sub-groups are supported by the East Lothian and Midlothian Public Protection Office (EMPPO) sited in the Brunton Hall, Musselburgh. The Public Protection team comprises of a Team Manager, Business Support Staff, Learning and Development Co-ordinator, Lead Officer for Child Protection, Lead Officer for Adult Support and Protection; Violence Against Women Co-ordinator, Multi-Agency Risk Assessment Conference Co-ordinator and Domestic Abuse Advisors. The Domestic Abuse Service is the operational component of the team, providing support and guidance to high-risk victims of gender-based violence.

The Public Protection team is collocated with the Police Scotland 'J Division' Domestic Abuse Investigation Unit, other Police Public Protection Unit personnel and the Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP). Although not co-located with NHS personnel, there is a close interface with members of the NHS Lothian Public Protection Team and other NHS Lothian staff with a broader Public Protection remit to jointly develop work.

Using our resources efficiently

Financial Resources

The current financial context to the delivery of health and social care services continues to be a challenging one. Budget constraints will continue and the need to identify more efficient ways of working will be a central element to the future planning of services.

Spending constraints have required a tightening of Eligibility Criteria, to prioritise those most in need and a potential increase in unmet need and onward pressure on services downstream. The continuing growth in the numbers of frail older people and of younger people with disabilities has not been matched by any proportionate increase in funding. The result of this mismatch is that HSCP services are increasingly focussed on those with the greatest need.

We continue to review the Eligibility Criteria for accessing social care support in order to prioritise those most in need while also looking at innovative ways of applying preventative approaches and early interventions. The current demographic forecasts is of continuing population growth in East Lothian with the population getting ever older and adults with complex needs living longer. This together with children and young people with complex needs moving into adult services is placing greater pressure on a reducing budget.

The priority now is to evidence more and more the shift in the balance of care with greater amounts of support and interventions taking place in the community away from hospital and acute settings, with a related reduction in unscheduled care. As evidence of this increasingly community-focussed provision is gathered and refined it will more robustly support an argument for the appropriate shifting of resources from acute care settings to the partnership for utilisation in local settings.

Human Resources

As a health and care focussed organisation delivering a wide range of services a significant proportion of the HSCP budget goes on staffing.

As with other HSCPs, the age balance of the East Lothian health and social care workforce (and the opportunity for some nurses to take early retirement) means that many colleagues are eligible to retire over the next 10–15 years.

Workforce plan

The East Lothian Health and Social Partnership is in the process of developing its first Joint Workforce Plan. This plan will enable the Partnership to better match its human resources to those service areas which have the most need. It will also enable the partnership to better forecast and profile the workforce and to make staffing more sustainable. As well as better predicting the future workforce the joint plan will help us to develop the skillset of an integrated workforce to support effective health and social care integration and service innovation

The IJB acknowledges that the health and social care workforce is central to delivering a full range of services to people across the county. As NHS Lothian and East Lothian Council remain the employers of their respective staff who work in the partnership, they are responsible for their own detailed workforce plans. For this reason, the HSCP workforce plan under development will not duplicate the detail of the existing plans, but builds on them to address common issues across the partnership. In addition, third sector and independent sector employers have their own arrangements for their workforce.

In East Lothian HSCP it is recognised there is a need to change how we work across social care, community and acute providers. In collaboration with all our partners and stakeholders the Health and Social Care Partnership aims to ensure that the workforce of tomorrow, both paid and voluntary, are knowledgeable and skilled and able to respond to the changes outlined in the Strategic Plan.

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

The current draft workforce plan commits to a workforce that:

- has the skills, knowledge, experience and motivation to deliver the highest quality services
- is flexible and adaptable around our changing organisational needs
- is resilient to change and able to instigate, as well as adapt to, changes in service delivery
- works in an increasingly integrated way across the Partnership
- celebrates professional roles including professional specialisms and synergies
- delivers services with an emphasis on quality
- is supported to deliver quality services in the most efficient way.

Future workforce planning will need to address all health and social care professions to ensure an adequate supply of these professions and to ensure that each profession has the appropriate skillset to meet current client need. Examples include hospital doctors and GPs, Mental Health Officers (MHOs), District Nurses and Allied Health Professionals. It will also need to include social care staff within the partnership linked to care home provision, support or care at home and day care.

As well as the services delivered within the Partnership itself as lot of health and social care delivery is delivered through external partners. These partners can be in the voluntary sector or the independent sector and include residential and nursing homes, care at home providers and day care providers. The integration of health and social care is as important an agenda to our partnerships as it is to the Partnership.

The voluntary and independent sectors remain the largest social services employers in Scotland. In East Lothian, these sectors employ 45% of the local care delivery workforce. These organisations and their staff are an essential part of arrangements to support people in receipt of care at home and in care homes. For this reason planning for and development of care by the HSCP needs to fully involve service delivery partners. This principle was followed in working with external providers around redesigning care at home services.

There are real challenges to recruiting a social care workforce to work in these settings and within these sectors. National Minimum Wage and Scottish Living Wage standards have helped to attract people to the market but risks remain not least linked to challenges with attracting European workers under any new immigration arrangements.

The workforce plan will take account of these challenges as part of working in partnership with our external agencies.

Financial plan

This Strategic Plan has to apply over a three year period, to support the continuation of established services, the delivery of existing priorities and attainment of targets and outcomes.

The plan provides the strategic framework for the continuing development and integration of health and social care services and the development of close and fruitful relationships with all aspects of NHS, council and partners' services.

An aligned resource strategy and clear financial framework is needed to achieve the ambitions of the strategy. All planned work has to be provided within the resource available. This means on occasions some developments may have to progress at a slower rate than is desirable or may require the delivery of financial and other efficiencies through innovation, redesign or cost savings.

In all our service planning we aim to find different ways of delivering and commissioning high quality and cost effective services to improve the health of the population while appropriately reducing health and social care demand.

As noted in the first Strategic Plan, NHS Lothian and East Lothian Council in the main produce annual budgets, which cannot present a longer term view. This means the three year financial plan in this Strategic Plan will need to adapt in the event that partners' planning changes.

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

Legislation requires that the Integration Joint Board, as a 'stand alone' legal body, must deliver financial balance in each and every year and must financially plan to deliver recurrent balance.

The IJB's financial plans are designed to be robust and to ensure maintenance of financial stability, so providing the bedrock on which to build sustainable and financially efficient services to deliver change and support reform within East Lothian's health and social care system and to improve health outcomes.

The IJB is gaining considerable ground in moving support provision from hospital-based settings into community settings. Many more people are now receiving care closer to home where this is clinically appropriate for their individual needs.

The IJB's next stage of development in finance terms is to work with partners to deliver resource transfer where it can be demonstrated that activity has shifted from centralised provision as a result of the prevention of unnecessary admissions to hospital through the establishment of community based services in East Lothian.

In recent years, despite increasing complexity in presentations for healthcare the number and costs of prescriptions have started to reduce, bringing associated savings to the prescribing budget.

Chart 16 - annual prescription items for East Lothian (in £000s)

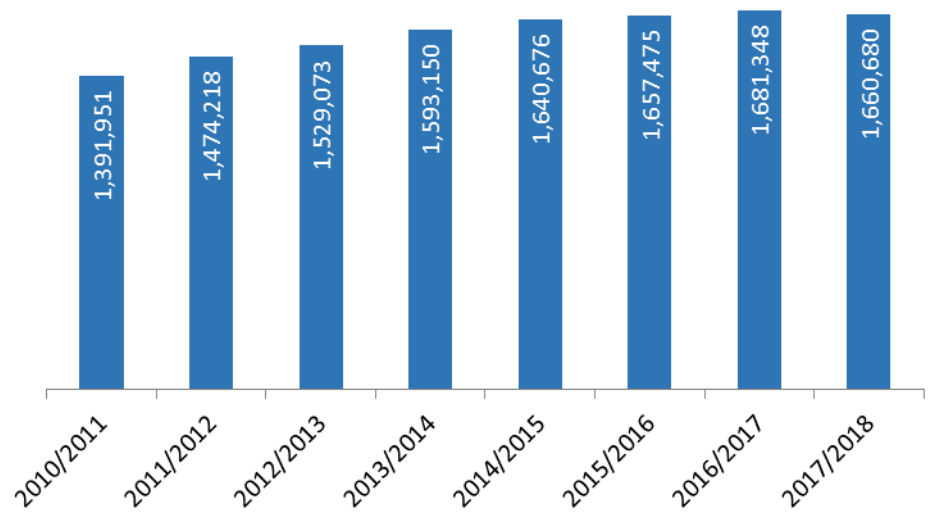
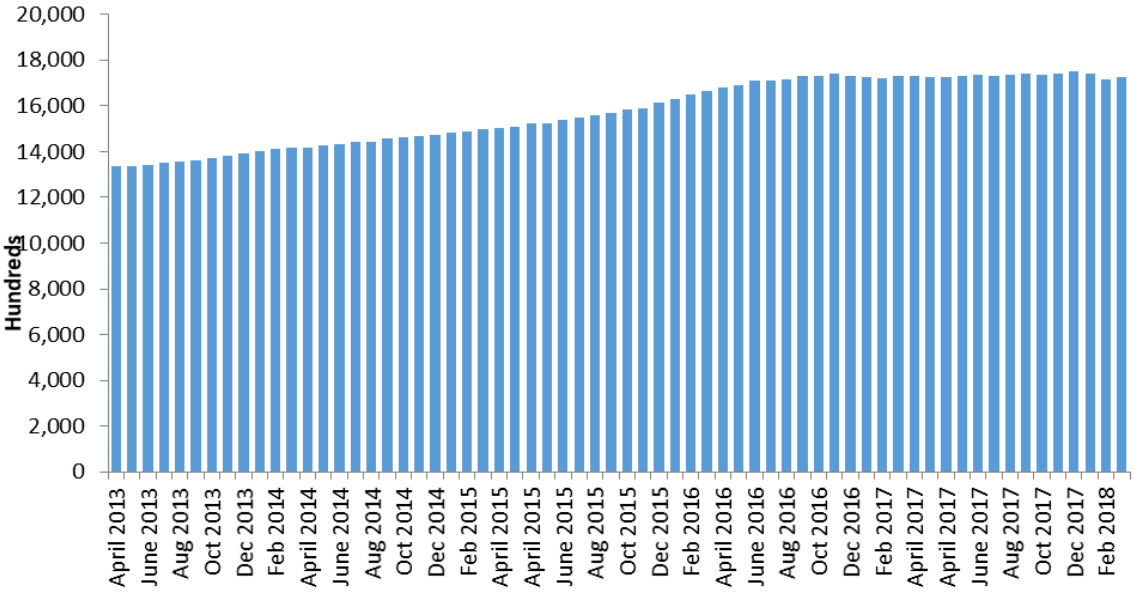


Chart 17 - annual rolling prescribing expenditure (in £000s) over 5 years



Social care costs

information awaited

Shifting resources

The IJB recognises that there was a historical over-reliance on centralised and hospital care at the expense of local and community focussed developments. Under-investment in general practice and pressures on social care and community should be reversed in due course, with contract changes for GP services and if resources are appropriately shifted from acute and institutional spend to support increased community spend.

The previous Strategic Plan reflected on the need for the four Lothian IJBs to work together to avoid the destabilisation of centrally provided services when seeking to transfer resources. This remains an important consideration, but change is needed to ensure sufficient centralised resources follow any sustained transfer of patient activity to East Lothian HSCP provided services.

The financial challenge

The medium term financial outlook for wider public sector remains challenging. This will continue to have a direct impact on the overall grant settlement for NHS and Council budgets.

There remains the need to continue to develop ongoing future sustainable budgets within a reduced cost base. There needs to be a focus on investment in community based models to support the strategic direction whilst responding to new and emerging cost and demand pressures.

Composition of the IJB budget

The IJB receives a recurrent allocation from both Partners for each financial year and a further indicative allocation for the following 2 years.

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

- the Adult Wellbeing (social care) budget determined and agreed by East Lothian Council
- the former CHP budget including community nursing, Allied Health Professionals, community hospitals, General Medical Services and prescribing
- delegated hosted services, managed on a pan-Lothian basis by certain HSCPs
- acute services (set aside) held by NHS Lothian on the IJB's behalf but required to respond to IJB directions.

Financial investments

All areas of investment will be drawn down via formal business cases or proposals to the IJB and supported by IJB approved Directions to either NHS Lothian or East Lothian Council as appropriate. These arrangements will ensure proposals for investment monies are subject to financial scrutiny.

Resource alignment over time

The aligned resources to deliver the Strategic Plan will be subject to Directions to both NHS Lothian and East Lothian Council) which will be issued by the IJB on April 1st each year, with in-year Directions also issued where necessary.

One principle of this Strategic Plan, continued from the previous plan, is that there should be no further investment in acute hospital services for our population without these first being approved by the IJB.

Indicative budgets for 2019/20 cannot be confirmed until budget information is received from partners. More detailed analyses and projections will be included as they become available.

Appendix 1 – integration measures - targets for 2018/19

Proposed 2018/19 Objectives	1. ***Unplanned admissions*** Reduce unplanned admissions by a further 5% in 2018/19.	2. ***Occupied bed days for unscheduled care*** Reduce by 10% in 2018/19 occupied bed days across all areas of unscheduled care.	3. ***A&E*** Reach 4 hour compliance of 95% in Accident and Emergency in 2018/19.	4a & 4b ***Delayed Discharges (including those delayed due to Adults With Incapacity)*** 4a. Continue progress towards delivering a 50% reduction in delayed discharge bed days in 2018/19 compared to 2016/17. 4b. Continue work to deliver a 50% reduction in the number of all cause delayed discharges by end of 2018/19 compared to end of 2016/17.	5. ***End of Life Care (e.g. proportion of last 6 months of life spent at home or in a community setting)*** Achieve and maintain performance of no more than 10% of last 6 months of life spent in a large hospital by end 2018/19.	6. ***Balance of care spend across institutional and community care services*** Maintain performance of 98% of over 75s being supported in non-acute settings through 2018/19.
How will it be achieved?	Through co-ordinated actions of: Primary Care Teams Community Teams Hospital at Home Team Care Home Team Hospital to Home Team taking a proactive role.	Through co-ordinated actions of: Primary Care Teams Community Teams Hospital to Home Team.	Through co-ordinated actions of: A&E Team Acute Team.	Through co-ordinated actions of: Primary Care Teams Community Teams Hospital at Home Team Care Home Team maintaining clients in their care home whilst unwell and not admitting to acute District Nursing Team intervening early to support patients.	Through co-ordinated actions of: Palliative Care Team Hospital at Home Team Care Home Team.	Through co-ordinated actions of: Care of Elderly Team Primary Care Teams Community Teams Hospital to Home Team Hospital at Home Team.++