East Lothian
Health & Social Care
Partnership

STRATEGIC PLAN

2015 – 2025

A FIRST CONSULTATION DRAFT

November 2014

Best Health, Best Care,
Best Value across our Communities

East Lothian Council

NHS Lothian

> It will be based on what we learn from listening to local people – patients, carers, members of the public, clinicians and professionals and other partner organisations – as we consult and engage on drafts of the plan

Foreword

People are living longer than ever and the trend is set to continue into the future. Increased life expectancy is something that we should all celebrate, but longevity means that we need to plan ahead, both collectively and individually, to ensure that we in East Lothian can maximise the benefits and positive experiences of a long life.

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

This is our first consultation draft of a Strategic Plan as an emergent Health and Social Care Partnership and it builds on the progress that has already been made by NHS Lothian, East Lothian Council and partners to improve local services. The Health and Social Care Partnership in East Lothian has drawn on a wide range of information to form a case for change, and the draft plan describes why we selected each of the strategic aims and includes a review of the financial context in which our plans and ambitions are set. It will also, importantly, be based on what we learn from listening to local people – patients, carers, members of the public, clinicians and professionals and other partner organisations – as we consult and engage on drafts of the plan. Our final Strategic Plan will be supported by more detailed documents which will set out how we will deliver the changes that we want to make. Every year we will produce an annual delivery plan which will describe in detail the progress that we expect to make in the year ahead towards achieving our vision for health and social care locally.

We believe that through strong leadership, innovative thinking, robust planning and by putting the views of patients and service users at the heart of all that we do, we can achieve our ambition of Best Health, Best Care, Best Value for our communities across East Lothian. We will make sure that strong and effective partnerships are established between East Lothian Council and NHS Lothian, colleagues in the third and independent sectors and with other key partner agencies, so that we plan and commission services in a way that puts people at the heart of decision-making. For East Lothian this then makes real and dynamic the vision and values of this Strategic Plan for Adult Services.

This is an exciting time. Through honest and open dialogue with our key stakeholders, together we know we can make a difference.

Mike Ash
Chair of East Lothian Shadow Health and Social Care Partnership Board

Councillor Donald Grant
Chair of East Lothian Strategic Planning Group

Contents

1. Introduction

This Strategic Plan describes how East Lothian Health and Social Care Partnership, an integrated partnership between East Lothian Council and NHS Lothian, will develop health and social care services for adults over the coming ten years.

Health, social care and wellbeing are key factors which impact on communities and individuals. The Council and the NHS locally have a long and successful history of working in partnership and the Plan builds on that history through emphasising the importance of integrating our care services further. This is because ill, vulnerable or disabled people often need support from more than one service and for their care to be effective it needs to be personalised and well coordinated. Integrated care is also essential because gaps or weaknesses in one part of the network of services often affect services elsewhere: for example, weaknesses in community services can cause unnecessary admissions to hospital, while over reliance on hospital or residential care diverts money away from community services, reducing their ability to support people at home. In a time of rising demand for services, growing public expectations and increasing financial constraint it is essential to make sure that social care, primary care, community health and acute hospital services work well together with all our partners, including the voluntary and independent sectors, in a truly integrated way.

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

We recognise that our health and care system is challenged and we need to be a strong and effective planner and commissioner in order to drive improvements in performance and deliver the efficiencies required for the future. Nowhere is this more apparent than in our acute hospitals where we have not yet secured the urgent care system that any of us want to see for the future. This has to change and our plans aim to address this issue through immediate action plans, medium term plans and through a longer term sustainability plan, all delivered through our locally driven programmes.

In further developing this Strategic Plan we will undertake an extensive public engagement programme, culminating in the development of an initial delivery plan as part of the wider 10 year vision. Our plan will be developed with, and through, our localities, our clinicians and professionals, our wider workforce and the population of East Lothian; this is key to our future success.

The Strategic Plan needs to reflect the context within which we operate - a health and care economy with a need to reshape quality services for the future with less reliance on hospital care. Our plan is shaped around our vision *"to enable all adults to live their lives as well as possible, achieving their potential to live independently and exercising choice over the services they use".*

This draft Plan for consultation has a number of strategic aims which will be delivered through three areas of transformation, each of which has multiple initiatives within it. If agreed, this will provide the focus for our work from 2015 – 2017. We have also ensured alignment of our draft Strategic Plan with those of NHS Lothian and East Lothian Council.

Draft key priorities for East Lothian are tackling the rise in unscheduled hospital admissions and delayed discharges from hospitals, tackling variation in the use and delivery of health and social care services, developing a strong focus on prevention and ensuring best value for the public purse.

We know that any plan that is not fully grounded in its local context is more likely to fail and we will ensure this is recognised through planning for localities. To be successful as a partnership we also need a successful and sustainable workforce, and their development is a crucial element of this plan.

We will continue to engage with the public with regard to our plans. We have some challenges ahead as a new Health and Social Care Partnership and being open and transparent will characterise how we work in responding to these challenges and taking on the difficult decisions that this demands.

Our values – professional and honest, working in partnership, listening and learning, being open and transparent and respecting and caring – encapsulate the way that we will work and we will not compromise on these to achieve our aims of Best Health, Best Care and Best Value across our communities.

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

2. Who we are

2.1 What is a Health and Social Care Partnership?

From 2015, Health and Social Care Partnerships (HSCPs) will replace Community Health Partnerships (CHPs). In East Lothian, the HSCP has been established in shadow form since late 2013. Health and Social Care Partnerships will be accountable for delivering a range of nationally agreed outcomes which will apply across adult health and social care.

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

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

2.2 What is the Strategic Plan?

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

It will provide the strategic direction for how health and social care services will be shaped in this area in the coming years and describes the key transformational changes that will be required to achieve this vision.

The Plan is about innovation and professionally led service redesign with sustained financial stability; it is equally about services which meet the needs of our population and are not just fit for purpose, but the best for purpose and fit for the future.

The Plan will integrate all the major changes and work to be undertaken over the next few years by the HSCP to improve the quality and safety of services, to improve the health of local people, and to innovate in how services are delivered to meet the tough financial challenges we all face; it will equally demonstrate that optimum use is being made of existing resources across East Lothian.

2.3 Locality Planning

Geographically the Strategic Plan covers the area within East Lothian Council's boundaries and it sets out the service delivery intentions of our partnership for the medium-term. It identifies priorities for joint working during the next ten years, improving quality and strengthening joint arrangements.

Strategic planning as described in the Public Bodies (Joint Working) (Scotland) Act 2014 requires that our services should be provided in a way in which, as far as possible, takes account of the particular needs of recipients from different parts of the county and is planned in a way which is engaged with the community and with

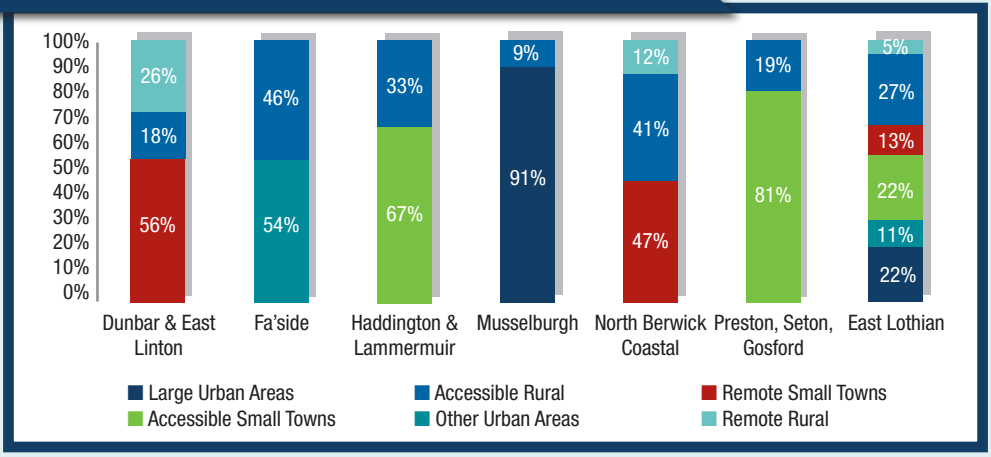
local professionals. There is a requirement for each new Health and Social Care Partnership to clearly identify a minimum of two localities within their partnership boundary.

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

We will, therefore, initially consider strategic planning within these two defined localities and identify how services and resources could be targeted to better meet the needs within these populations.

In doing so, however, it is also important to recognise that East Lothian has a significant population living in more rural areas as identified in Table 1 below.

Table 1: East Lothian 2012 Locality Population by Urban/Rural



The availability, choice and range of services found within rural areas are often very different to those available in urban towns and cities. Rural communities may not have a doctors' surgery or pharmacy nearby, hospital treatment may involve long journeys, emergency care may take time or social care and support services may be more difficult to access. We therefore need to recognise within this Plan and its associated localities that differences and inequalities in access to health, social care and other services, their relative availability and range of facilities may have a detrimental effect on the lifestyle, opportunities, and in particular the health and wellbeing of rural communities specifically.

2.4 What services will the Strategic Plan cover?

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

The regulations which underpin the Act clearly set out which health and social care functions and services must be delegated to the HSCP. The Act limits the functions that can be included in the "must be delegated" list to services provided to people over the age of 18. The effect of this is that the primary legislation ensures that no children's health and social care services will be required to be integrated and it is up to local systems to decide whether to integrate children's services as well as adult services. In East Lothian we have agreed a clear ambition to integrate children's services into the HSCP within a short timescale after establishment but that the initial focus for service integration for 2015/16, and therefore this Strategic Plan, is for adult services only.

A key feature of legislation is that integration must include adult social care, adult primary and community health care services, and elements of adult hospital care which offer the best opportunities for service redesign. Other services can also be included in integrated arrangements if there is local agreement to do so; in East Lothian an example of this is the agreement to include criminal justice social work in the scope of the new partnership.

The social care services relating to adults which must be delegated to the HSCP are:

- **Social work services for adults and older people**
- **Services and support for adults with physical disabilities and learning disabilities**
- **Mental health services**
- **Drug and alcohol services**
- **Adult protection and domestic abuse**
- **Carers support services**
- **Community care assessment teams**
- **Support services**
- **Care home services**
- **Adult placement services**
- **Health improvement services**
- **Aspects of housing support, including aids and adaptations**
- **Day services**
- **Local area co-ordination**

- **Respite provision**
- **Occupational therapy services**
- **Re-ablement services, equipment and telecare**

Each Health Board must also delegate all adult primary and community health services, along with a proportion of hospital sector provision. Health services which must be delegated to the HSCP are:

- **District nursing services.**
- **Substance misuse services.**
- **Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.**
- **The public dental service.**
- **Primary medical services.**
- **General dental services.**
- **Ophthalmic services.**
- **Community geriatric medicine services.**
- **Community palliative care services.**
- **Community learning disability services.**
- **Community mental health services.**
- **Community continence services.**
- **Kidney dialysis services provided outwith a hospital.**
- **Services provided by health professionals that promote public health.**

Hospital services

In regulations Scottish Government has also identified which aspects of acute hospital care offer the best opportunity for improvement under health and social care integration. These are:

- **Accident and Emergency services provided in a hospital.**
- **Inpatient hospital services relating to:**
  - general medicine
  - geriatric medicine
  - rehabilitation medicine
  - respiratory medicine
  - psychiatry of learning disability
- **Palliative care services provided in a hospital.**
- **Inpatient hospital services provided by GPs.**
- **Services provided in a hospital in relation to an addiction or substance dependence.**
- **Mental health services provided in a hospital, except secure forensic mental health services.**

New Integration Authorities will therefore be responsible for strategic planning of these services which are the ones most commonly associated with the emergency care pathway - that is, hospital specialties which demonstrate a predominance of unplanned hospital bed day use for adults.

Within the context of integration, "unplanned" refers to those stays that are potentially avoidable with the provision of some sort of preventative care.

Housing

The interface with housing will be crucial to the success of the integration agenda. Whilst only certain limited aspects relating to housing are included within the current scope of services delegated to the HSCP we believe that it is vital that this Strategic Plan links effectively to the strategic housing needs assessments carried out by East Lothian Council.

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

- **Providing information and advice on housing options**
- **Facilitating or directly providing "fit for purpose" housing that gives people choice and a suitable home environment**
- **Providing low level, preventative services**
- **Building capacity in local communities**
- **Undertaking effective strategic housing planning**

The integration of adult health and social care now brings opportunities to strengthen the connections between housing and health and social care, to improve the alignment of joint planning, to support the shift to prevention and to incorporate arrangements for housing support and homelessness services. We will, therefore, actively consult with and work with housing colleagues in the development of the final version of this Strategic Plan.

In defining the scope of services – particularly acute hospital services - for which new Integration Authorities will assume responsibility for planning, legislation is driving a major policy change which supports a shift in the balance of care and the move towards care delivered in the community.

This policy shift is outlined further in Section 8 of this consultation draft plan.

3. The Conversation

How will the HSCP develop and agree this plan?

The Integrated Joint Board, the HSCPs governing body, will replace the former Community Health Partnership committee and has been meeting in shadow form since October 2013. This draft Strategic Plan is a joint statement, the initial development of which has been overseen by the Shadow Board and the shadow Strategic Planning Group which has representation from NHS, local authority, clinicians, service users, carers, voluntary sector and the independent sector. In writing the draft plan we have reviewed information about health needs, issues and concerns raised by local people and current service delivery and discussed and refined our plans and priorities.

From this work we have developed this document which is a consultation draft of the Strategic Plan. We want to listen to as many stakeholders as possible so that when we prepare the final version of the Strategic Plan we are confident that we have actively encouraged contributions. We intend to consult widely on the significant strategic themes following which we will review and finalise the plan.

Equality and Diversity

The planning and delivery of good quality healthcare, social care and housing, as well as appropriate information, advice and support services in East Lothian embraces the principles of equal opportunities, following the lead of our partners' Equalities Schemes.

This means that all our partners will strive to encourage equal opportunities, responding to the different needs and service requirements of people regardless of sex, race, disability, age, creed or sexual orientation.

Transparency and accountability

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

4. The Case for Change

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

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

RISING DEMAND

To illustrate the scale of the challenge, with our projected population growth and the rise in long term health conditions if current delivery and funding models continue as they are the majority of the health and social care budget by 2025 will need to be spent on building new hospitals and care homes rather than providing care close to people's homes.

HIGH COSTS

People with long term health conditions account for 70% of overall health and care spend. They are higher users of health services, representing 80% of GP appointments, 60% of outpatients and A&E attendances, 70% of emergency (unscheduled) hospital admissions and 80% of all prescribed medicines. Long term conditions also shape elements of home care, equipment and housing support, carer support issues and long term institutional care needs. As the incidence of long term conditions increases, so will these associated cost pressures.

REDUCED BUDGETS

Across Scotland our ageing population is predicted to increase demand for health and social care services by between 18 and 28% between 2010 and 2030. This equates to a potential funding gap in the order of £2.5 billion against current levels of investment. The context for developing integrated services is not about being able to reduce public expenditure on health and social care - it is about doing more; it's about dealing with increasing demand within existing resources to improve outcomes.

POOR OUTCOMES

People in East Lothian with long term conditions experience higher than average rates of occupied hospital bed days for unplanned admission.

Against this backdrop we have identified 6 key reasons supporting the need for change and the priorities for this Strategic Plan. How we respond to these will be key to shaping the decisions for the future configuration of adult services.

REASON 1
THE NEED TO BE BETTER AT PREVENTING ILL HEALTH

The population of East Lothian can become a healthier community through prevention of ill health and the promotion of health and wellbeing.

It is encouraging to see these trends, but they will remain important measures to maintain greater progress in as we focus on prevention of poor health and the active promotion of wellbeing.

An estimated 20 % of adults smoke in East Lothian which is below the Scottish average of 25.0%. Alcohol deaths are below the Scottish average and the proportion of the population hospitalised because of alcohol or drugs is also significantly lower than the Scottish average.

A recent bed utilisation audit in NHS Lothian showed that on the day in question 29% of people did not require an acute hospital bed and could have been better treated or cared for in the community with appropriate support. Of this number over 60% had been in hospital for more than seven days.

REASON 2
THE IMPORTANCE OF CARE CLOSER TO HOME

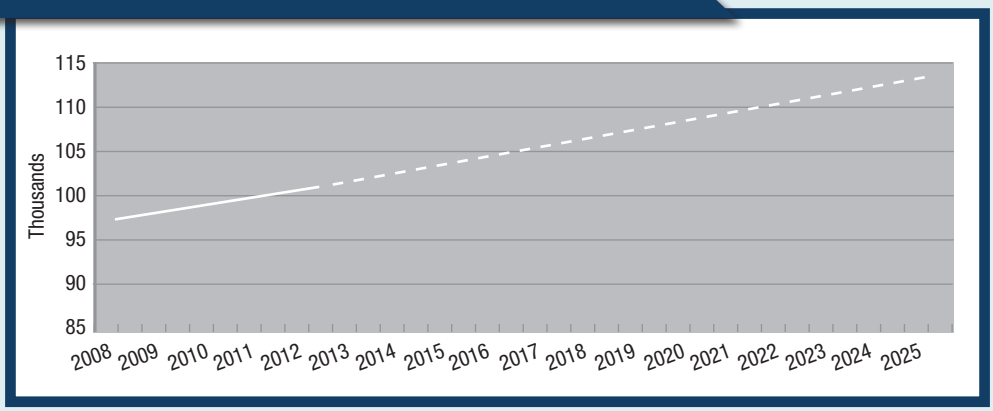
There is good evidence that people are best cared for as close to home as possible and, indeed, you have told us you agree with this through previous consultations. Inpatient hospital care will always be an important part of how care is provided, but it is only best for someone with acute medical needs. There are many benefits associated with delivering care within people's homes and providing choice about where they are cared for is vital.

The care closer to home approach is not about challenging hospital provision but about clearly defining the role of hospitals in meeting the needs of the population. The real prize is to provide community alternatives which improve care and experience.

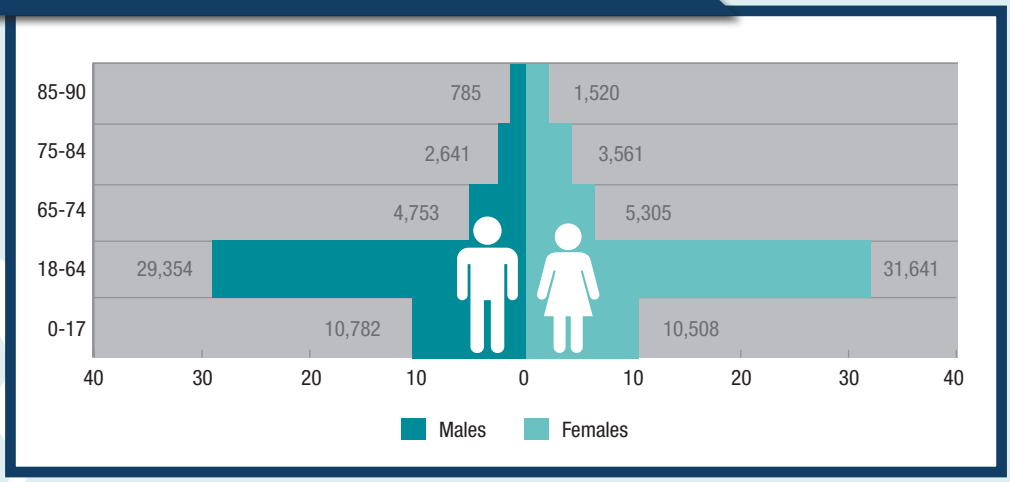
REASON 3
INCREASING DEMAND

In 2012, there were 100,850 people living in East Lothian, and this is projected to grow by 12% between now and 2025.

East Lothian Population in 2008-2025



East Lothian 2012 Population by Age Band and Sex



Longer life expectancy is something to celebrate. Many older people enjoy good health and continue to make a significant contribution to society as carers, learners, workers and volunteers. The health and social care system has a key role in enabling people to live as full and healthy a life as possible and caring for the most vulnerable when needs change.

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

Defining a new model of care which fully meets the needs of all people is therefore a priority and our services need to reform and modernise in order to respond to this growing demand, with an increased emphasis on personal, community based services.

We also know that there are increasing numbers of people of all ages with long term (sometimes called chronic) conditions such as heart disease, lung disease and diabetes. In East Lothian we have higher rates of hypertension (high blood pressure), asthma, cancer, stroke and dementia than the Scottish average.[1]

QOF register	East Lothian Patients on this QOF register	East Lothian Prevalence rate (per 100 patients)	Scotland Prevalence rate (per 100 patients)
"Smoking" (conditions assessed for smoking)	26,351	**25.27**	24.74
Hypertension	14,549	**14.39**	13.94
Obesity	6,773	6.70	8.05
Asthma	6,634	**6.56**	6.10
Depression: New diagnosis of depression	5,005	5.21	5.81
Diabetes	4,462	4.41	4.79
CHD (Coronary Heart Disease)	4,279	4.23	4.26
Hypothyroidism	3,653	3.61	3.80
CKD (Chronic Kidney Disease)	2,671	2.64	3.23
CVD (Primary Prevention of Cardiovascular Disease)	2,550	2.45	2.48
Cancer	2,461	**2.43**	2.18
Stroke & Transient Ischaemic Attack (TIA)	2,289	**2.26**	2.16
COPD (Chronic Obstructive Pulmonary Disease)	1,997	1.98	2.18
Atrial Fibrillation	1,867	**1.79**	1.59
Dementia	985	0.97	0.79
Peripheral Arterial Disease	924	0.91	0.89
Heart Failure	790	0.78	0.83
Mental Health	750	0.74	0.88
Rheumatoid arthritis	664	0.66	0.59
Epilepsy	618	0.61	0.75
Learning Disabilities	504	0.50	0.48
Osteoporosis	262	0.26	0.22
Palliative Care	251	0.25	0.22
LVD (Left Ventricular Dysfunction)	178	0.17	0.27

[°] https://isdscotland.scot.nhs.uk/Health-Topics/General-Practice/Publications/2014-09-30/QOF_Scot_201314_CHPs_all_prevalence.xls

All our data describes an increase in these long term conditions in East Lothian. People with a long term condition very often have multiple conditions – around 25% of people with a long term condition have at least three or more – and our care delivery system does not always deal with such multiple conditions in a person centred, integrated way. This can mean people engaging with multiple clinicians and multiple services which are not always effectively "joined up".

Finally, best practice in health and social care is developing constantly. There are new technologies, new care pathways, new drugs and new regulations and our population will expect ready access to these improvements. It has been estimated that the demand for services will be growing by around 4% per year by 2015[2]. The need to better understand demand patterns and to ensure safe and effective management of demand will equally be a central issue in the future.

The Strategic Plan, therefore, needs to recognise all of these demands and effectively lead the necessary service transformations to address them.

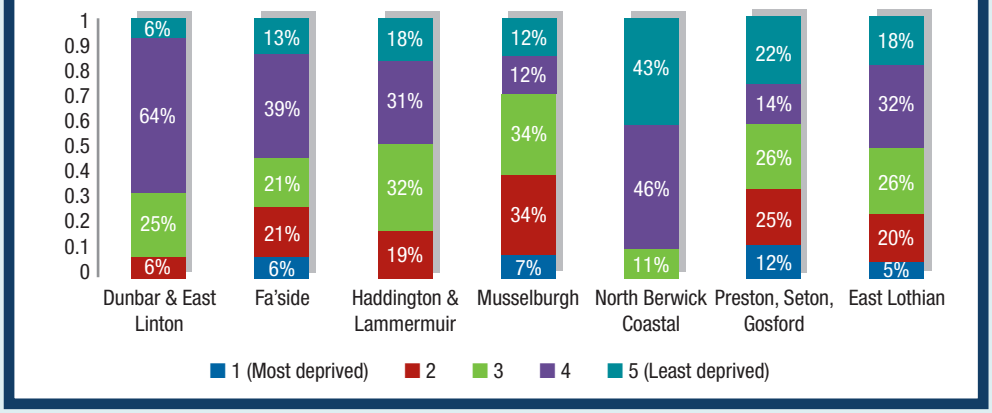
REASON 4
HEALTH INEQUALITIES IN OUR POPULATION

Inequalities in health outcomes between the most affluent and disadvantaged members of society are longstanding, deep-seated and have proved difficult to change.

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

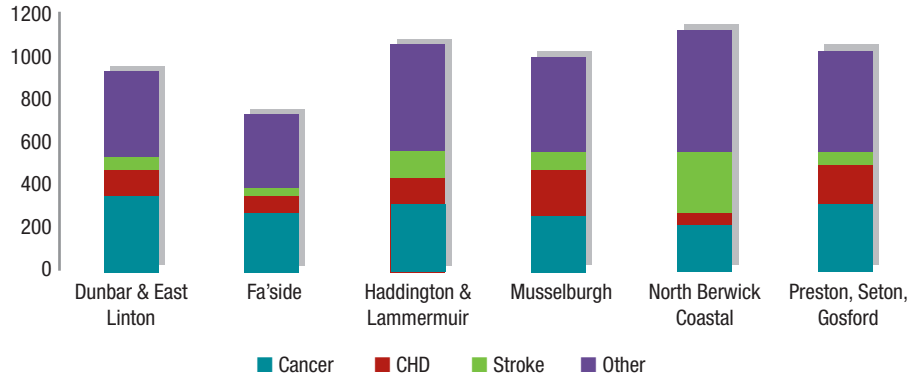
[2] Reshaping the System (2010). McKinsey

East Lothian 2012 Locality Population by Deprivation Code



Across East Lothian people living in the poorest neighbourhoods, can, on average, expect to die 4 years earlier than people living in the richest neighbourhoods and spend more of their lives with ill health. Such inequalities are due to a complex mix of social, economic, cultural and political reasons with unequal provision of healthcare responsible for only a proportion. As a health and social care partnership, however, we now need to actively work with colleagues in housing, education and a range of other sectors in order to address such inequalities as a priority.

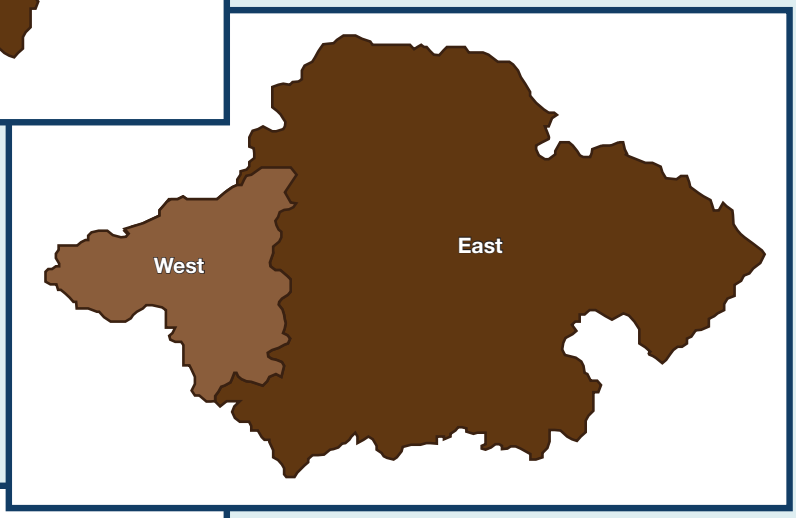
Deaths per 100,000 population



East Lothian Female Life Expectancy in 2011 by Locality

Female Life Expectancy in 2011

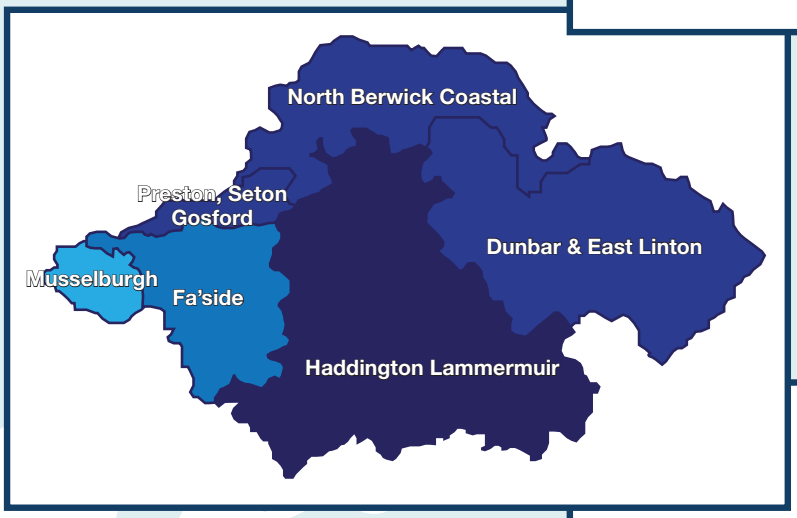
- Between 80 and 81
- Between 81 and 82
- Between 82 and 83



East Lothian Male Life Expectancy in 2011 by Locality

Male Life Expectancy in 2011

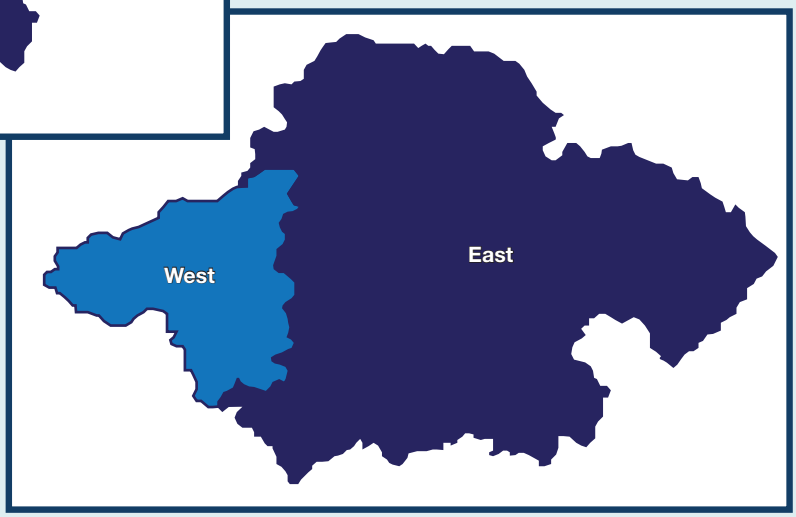
- Between 76 and 77
- Between 77 and 78
- Between 78 and 79
- Between 79 and 80



East Lothian Female Life Expectancy in 2011 by Sub-Partnership

Female Life Expectancy in 2011

- Between 80 and 81
- Between 81 and 82.5



East Lothian Male Life Expectancy in 2011 by Sub-Partnership

Male Life Expectancy in 2011

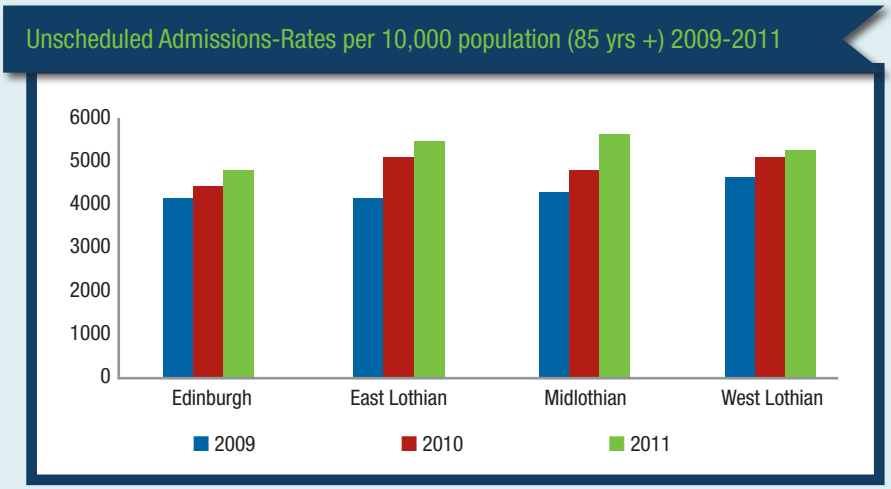
- Between 77 and 78
- Between 78 and 79

Health and social care alone cannot fully address the inequalities issue. If we are to deliver effectively on improving the health of our population we need meaningful partnerships and a common agenda to be developed with housing and education colleagues and with our local communities. It is, however, incumbent on us as a Health and Social Care Partnership to look at how we effectively contribute to better outcomes for all our citizens.

REASON 5
SUSTAINABILITY AND QUALITY OF HOSPITAL SERVICES

Given the increasing and changing nature of our population, changing practices in medicine and increased expectations of the public, the gap between demand for services and current provision is widening. We know we cannot continue to provide services as they currently are. The choice is stark; it is not principally about money but about sustainability and about evidence.

Historically in East Lothian there has been an over reliance on hospital services. Over recent years more of our older people in East Lothian have been admitted to our hospitals than from other areas in Lothian.



East Lothian does have an overall lower unplanned admission rate than the Scottish average which is very positive, but the average length of stay in hospital for someone from East Lothian is longer, accounting for a greater proportion of occupied bed days in hospital. We also know that East Lothian needs to perform better at reducing our delayed discharge figures - when people are delayed in a hospital bed whilst waiting for care or support closer to home.

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

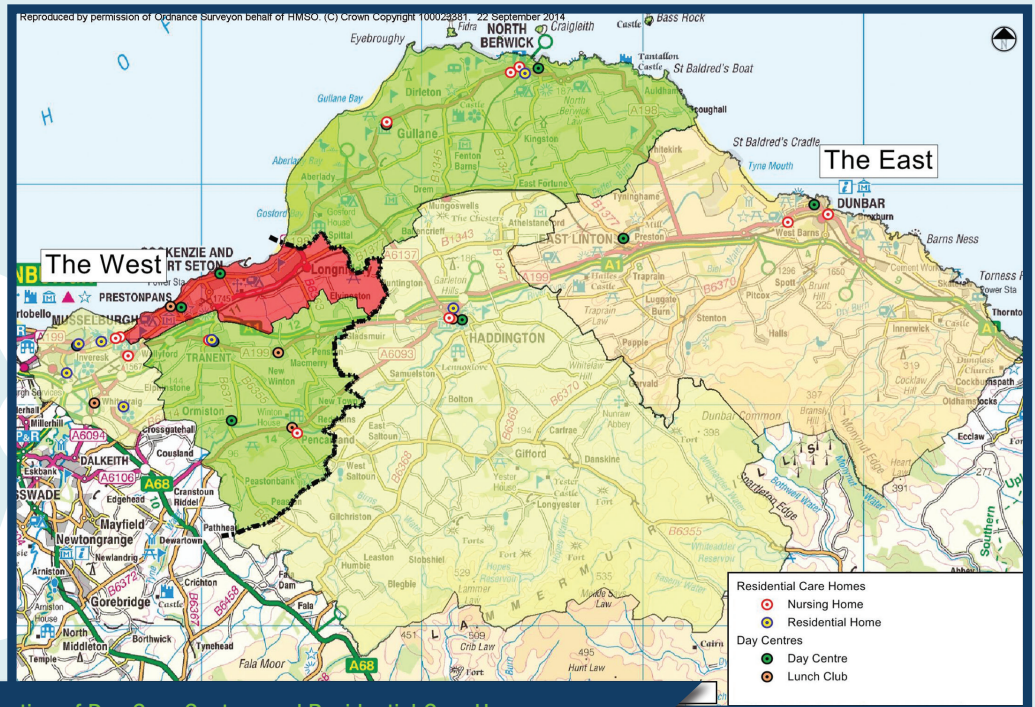
REASON 6
MAKING BEST USE OF RESOURCES AVAILABLE

This Strategic Plan is not about money and recognises that any discussion on resources has the potential to produce diverging views and opinions. The Strategic Plan does, however, consider our joint resources, how we use them and consequent efficiency and productivity – in essence how we best spend our resource to achieve maximum benefit.

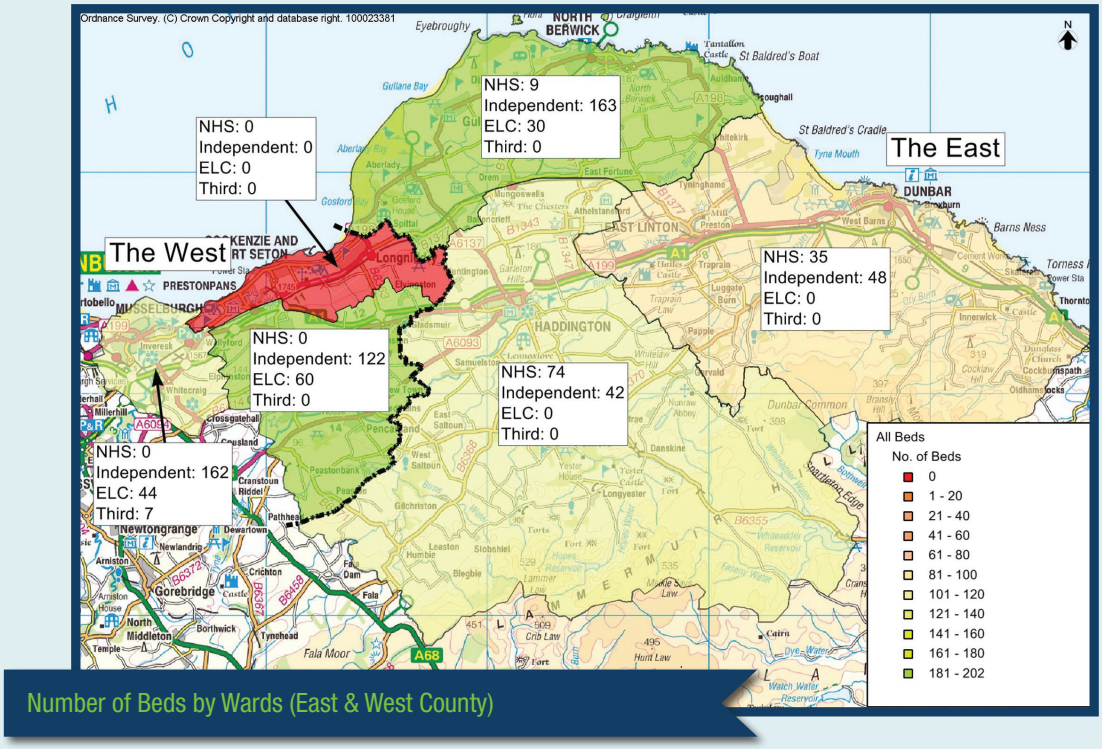
In that regard it is difficult not to conclude that, with the overall level of resources available we should have the ability, in time, to provide a better service. With pressure from demand and changing population as outlined above change is necessary. The challenge presented is simply how best to spend the joint resource to achieve maximum benefits.

Best Use of Estate

We currently have access to 3 large acute hospitals in Lothian and 3 local hospitals and community hospital facilities in East Lothian. In addition to this there are residential and nursing homes for older people and a range of day centres and health centres.



Location of Day Care Centres and Residential Care Homes



Number of Beds by Wards (East & West County)

Any future models of care should, therefore, take into consideration the best use of the total health and social care estate that is currently available to us in East Lothian. It should not, necessarily concentrate on the preservation of the existing building stock but rather consider and present new service models which could deliver more care throughout our communities.

Best Use of Staff

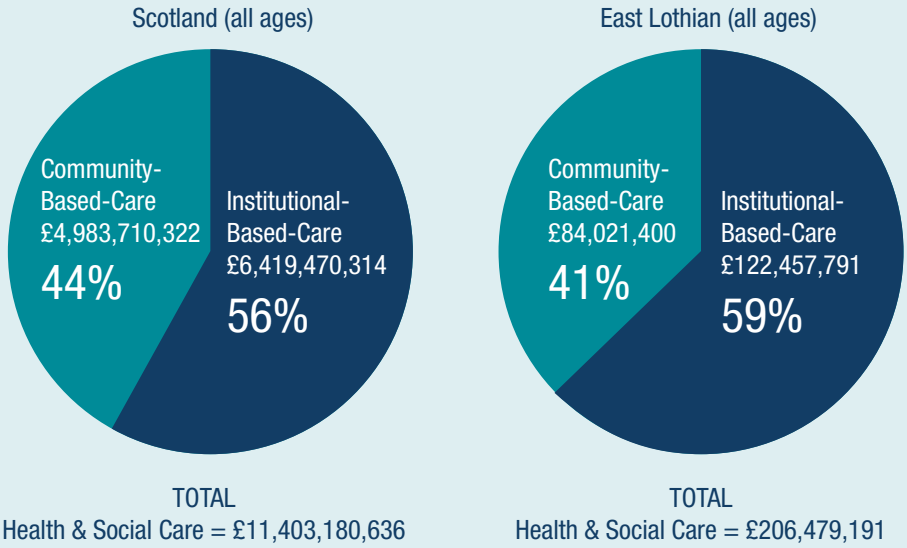
Better joined up and integrated services to meet the needs of people and communities is a key ambition for East Lothian HSCP and we recognise that true integration will not work without our workforce. However it's also crucial to recognise the broad reach of health and social care integration which includes relationships beyond traditional NHS and local authority providers. The majority of social care services, for example, are delivered by the independent sector and integration of services is as relevant and important for them as it is for wider public services such as housing and leisure.

The independent sector is the largest social services employer in Scotland as a whole and 45% of the care delivery workforce in East Lothian is currently employed in this way. Given their pivotal role in both supporting care at home and in care homes this Strategic Plan must recognise the contribution of the independent sector and ensure their active participation in future service planning.

In considering workforce support, workforce development and service modernisation, this Strategic Plan also recognises the roles of independent contractors - such as GPs, community pharmacists, dentists and optometrists - and the voluntary sector. Each provides a highly significant workforce which supports and delivers health and social care for our population and we need to ensure active and meaningful involvement of all in our planning and development.

Best Use of Money

East Lothian HSCP has a higher percentage spend on institutional care than the Scottish average as highlighted below[3].



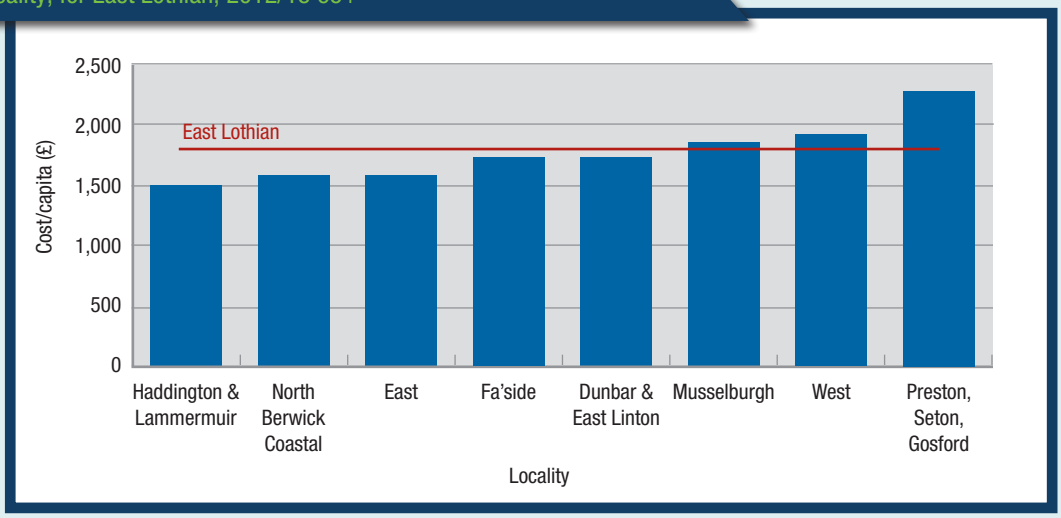
There will always be a need for hospitals and care homes, particularly as people get older, but the policy focus is on ensuring that these specialist services are used appropriately to meet people's needs. This data therefore highlights the need to focus on significantly realigning resources to provide more community based planning and activity.

Equally within our own HSCP there is significant variation in activity and costs associated with hospital activity.

[3] https://isdscotland.scot.nhs.uk/Products-and-Services/Health-and-Social-Care-Integration/Routine-Reporting/secure/SCOTLAND/IRF-Delayed-Discharge-Costs-2012-13.xls?

Institutional based care is defined as all hospital based care and accommodation based social care services; community based care is defined as all NHS community based services, family health services including GP prescribing and all social care services excluding accommodation based services.

Cost per weighted capita of unscheduled hospital admissions; by locality; for East Lothian; 2012/13 65+



Addressing the reasons for this variation may require changes to be made which ensure resources are actively focused in the areas with greatest need. Such changes in how we deliver care in the future will be necessary in order to deliver best value for the public purse.

The Case for Change: A Summary

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

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

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

5. Strategic Vision, Ambition and Outcomes

Our Best Health, Best Care, Best Value ambition focuses on a joint draft vision for adult social care and health services in East Lothian which will enable all adults ***to live their lives as well as possible, achieving their potential to live independently and exercising choice over the services they use.*** Improving the health of individuals and reducing health inequalities is a key element of this vision and we will ensure that tackling inequalities in health and social care is embedded in our planning processes. This means recognising the different needs of vulnerable groups when designing and delivering services.

The draft Strategic Plan for Health and Social Care in East Lothian has been designed with meeting this ambition and in doing this meeting the outcomes and performance measures for integration within Scottish Government's National Performance Framework. These are outlined below.

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

Integrated health and social care services must be planned for, and delivered, in person-centred ways that enable and support people to look after and improve their own health and wellbeing. Our aim is to promote action to support a Scotland where people have the information, means, motivation, and opportunity to live a healthy life for as long as possible. Integrated health and social care services can influence this by the provision of appropriate information, and by working with individuals to identify how the assets the individual has, or can access in their local family/community, could support people to make those changes happen.

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

Successful integration of health and social care services will provide for more people to be cared for and supported at home or in a homely setting. This outcome aims to ensure delivery of community based services, with a focus on prevention and anticipatory care, to mitigate against inappropriate admission to hospital or long term care settings. It recognises that independent living is key to improving health and wellbeing.

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

It is important that health and social care services take full account of the needs and aspirations of the people who use services. Person centred planning and delivery of services will ensure that people receive the right service at the right time, in the right place, and services are planned for and delivered for the benefit of people who use the service. For people who use care and support services, their experience of those services should be positive, and should be delivered for the person rather than to the person.

4 Health and social care services are centred on helping to maintain or improve the quality of life of service users.

There is unwarranted variation and inconsistency in the quality of care and support for people across Scotland. Everyone should receive the same quality of service no matter where they live. It is therefore important that we continue to improve the quality of our care services and address inconsistencies. This national health and wellbeing outcome provides for an on-going focus on continuous improvement in relation to health and social care services.

5 Health and social care services contribute to reducing health inequalities.

Health inequalities can be described as the unjust differences in health which occur between groups occupying different positions in society. This outcome reflects the contributory role that health and social care services have in addressing health inequalities.

6 People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.

Scottish Ministers recognise the key role played by unpaid carers. This outcome reflects the importance of ensuring that health and social care services are planned and delivered with a strong focus on the wellbeing of unpaid carers.

7 People who use health and social care services are safe from harm.

In carrying out their responsibilities, Health Boards, Local Authorities and Integration Authorities must ensure that the planning and provision of health and social care services protects people from harm.

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

It is important that the people who work in health and social care services are supported to carry out their vitally important role to a high standard, and that they feel engaged with the work they do and the people for whom they care.

9 Resources are used effectively in the provision of health and social care services, without waste.

Preventative and anticipatory care can play a particularly important role in achieving better outcomes for people with multiple complex needs, helping to avoid or delay admission to institutional care settings and enabling people to stay in their own homes and communities for as long as possible. If people's needs are not anticipated and opportunities to prevent the need for institutional care are not met, people can find themselves in institutional care too early, and for too long. Not only does this situation represent a poor outcome for the person, it is also a poor use of resources that could

be better deployed on other forms of care for that person and the wider community. Health and social care services must therefore be planned for, and delivered, in ways that make best use of available resource while at the same time optimising outcomes for patients and service users. Such considerations must be taken account of by Integration Authorities in fulfilling their legal duty to achieve best value.

What will success look like in East Lothian?

Success in delivering against each of these ambitious outcomes will mean making real, positive improvements in the care and wellbeing of local people. Within the suite of national outcome measures, some specific supporting objectives will therefore shape the way the Council, NHS and partners respond locally to the challenges of rising demand, rising expectations and financial constraint. These key local objectives, which will help us deliver the national outcomes and which we intend to develop through the Strategic Plan are:

OUR LOCAL STRATEGIC OBJECTIVES

1. TO MAKE UNIVERSAL SERVICES MORE ACCESSIBLE AND DEVELOP OUR COMMUNITIES

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

2. 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.

3. TO REDUCE UNSCHEDULED CARE

   We want to reduce unnecessary demand for services including hospital care

4. 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.

5. 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.

6. TO ENABLE PEOPLE TO HAVE MORE CHOICE AND CONTROL

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

7. TO FURTHER OPTIMISE EFFICIENCY AND EFFECTIVENESS

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

8. 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.

Rather than address these objectives independently, this Strategic Plan will look innovatively to an integrated approach which seeks to maximise health gain and the improvement of social care outcomes. The Plan should therefore deliver on the ambition of the Health and Social Care Partnership to promote integrated planning and to encourage integrated working.

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

How will we do this?

As we outline in more detail in both the Case for Change and the Joint Strategic Needs Assessment, more people in East Lothian are living longer but with more long term conditions. As a result, demand for services is increasing and forecast to continue to further increase, but this is set against the context of financial constraint in both health and social care.

There is good evidence to demonstrate that integrated care is a key route to more effectively addressing these “demand challenges”: it makes sense for those who use our services and their carers, it means a better experience, better outcomes, less confusion and complexity, and, because it is mostly focused on care closer to home and the community, it can present a more efficient way of delivering a good heath and social care system – that’s our Best Health, Best Care, Best Value.

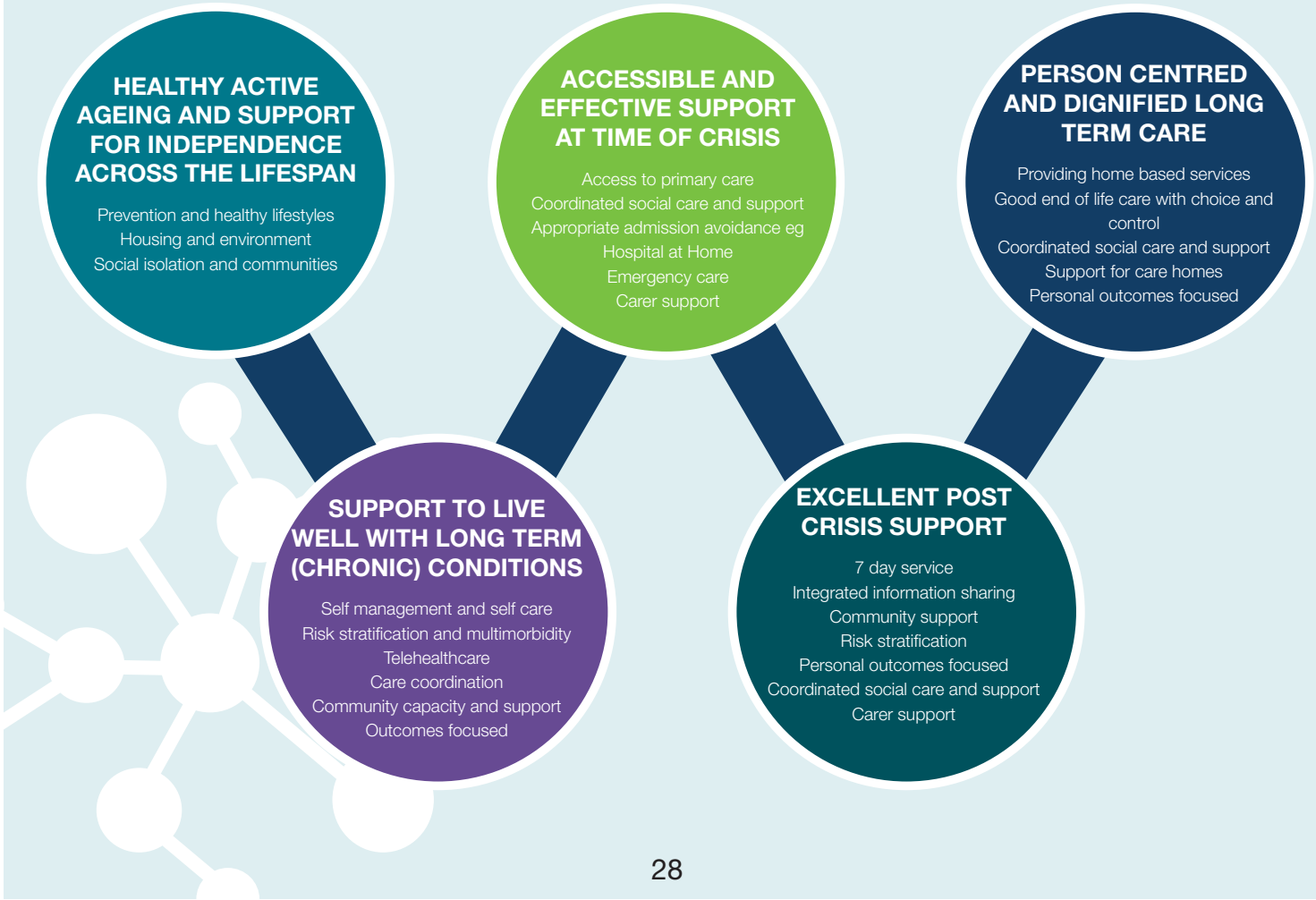
5. Strategic Vision, Ambition and Outcomes

With the integration of health and social care in Scotland we now have a golden opportunity to develop and deliver different ways of working to achieve these shared goals. In East Lothian our approach to planning, redesigning and building many of our services will be based on a "Well Connected" approach – sometimes called a pathway approach.

We have traditionally commissioned or planned services based on a general categorisation of client groups such as services for older people, people with mental health problems, people with physical and sensory impairments or services for carers. This Strategic Plan recognises, however, that every adult is an individual who may identify with more than one of these traditional "groupings". We therefore need to ensure that care and support arrangements are tailored to individual needs and not restricted so that transitions between services are as seamless as possible.

The "Well Connected" metaphor is based on individual components of care but by focusing on needs rather than planning around specific service structures it illustrates a total system approach needed to improve care, emphasising the interdependency of each part – that's integrated care.

This Strategic Plan will articulate and develop this thinking with examples throughout the document, but key building blocks in this approach are:



……All supported by a care planning process to deliver seamless, "joined up" care as much as possible. Our aim will be that support should ideally be provided through a collaborative network of voluntary and independent sector organisations, communities, and self-help groups as well as statutory health, social care and housing services.

We will use the "Well Connected" thinking throughout this draft Strategic Plan. In considering this we will be mindful that we cannot assume the same set of problems exist for all population groups and that interface issues can be different for individuals and for our adult populations. For instance, for people experiencing mental ill-health or who have a learning disability, the interface with employment is important, where access to supportive employability services, good public transport and the benefits system becomes crucial. For other care groups interfaces with housing services or education are paramount or change at different points in life.

"Well Connected" planning therefore should consider the holistic needs of all people at all points of contact and all stages and we will embed this approach in our strategic planning approaches.

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

In developing this draft Strategic Plan we have utilised a wide range of information to consider where we need to focus and what our priorities should be. The most significant sources of information to date have been our Joint Strategic Needs Assessment, a suite of national and local strategies and policies, the financial context in which the HSCP will work and a gap analysis. Importantly as part of ongoing consultation we will continuously seek public, partner and clinical feedback to further inform the development of the Plan.

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

Our JSNA will be published separately, but for the purposes of this consultation draft it has provided a wide range of information on health profiles by locality, demographics and population projections, health care and social care provision, hospital and unscheduled care activity, variation in activity and costs and some survey information. We have also worked closely with colleagues in the third and independent sectors in order to understand and map the spread and diversity of care and service provision provided by these partners and therefore give us a more total picture of our provider landscape and understand any potential gaps.

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

A good needs assessment should also identify key gaps in service planning and delivery. An effective gap analysis allows an organisation to consider how it needs to develop and prioritise in order to move from it's current state to an agreed or desirable "future state" and we have carried out such an exercise for the Health and Social Care Partnership.

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

We know that the main components of health and social care services for adults have been laid down in policy guidance and are regularly reviewed for all services by NHS Lothian and East Lothian Council, both jointly and separately. Those covered by national guidance are therefore largely in place in East Lothian. The main areas where there are gaps or where our JSNA has indicated a need for greater focus and activity have been identified. In order to better understand the actions we need to take now to address these service planning gaps we have used criteria, outlined in Appendix 2, to help us focus our priorities for this plan.

Whilst the key overarching priorities appear to be health inequalities, unscheduled hospital admission activity and delayed discharges from hospitals, the additional planning gaps we have identified include:

- **Dementia**
- **Primary Care**
- **Carers**
- **Day Centres**
- **Integrated working**
- **Information and Data sharing**
- **Anticipatory Care and Prevention**
- **Transition between services**
- **Estates and bed modelling**
- **Potential unmet need**

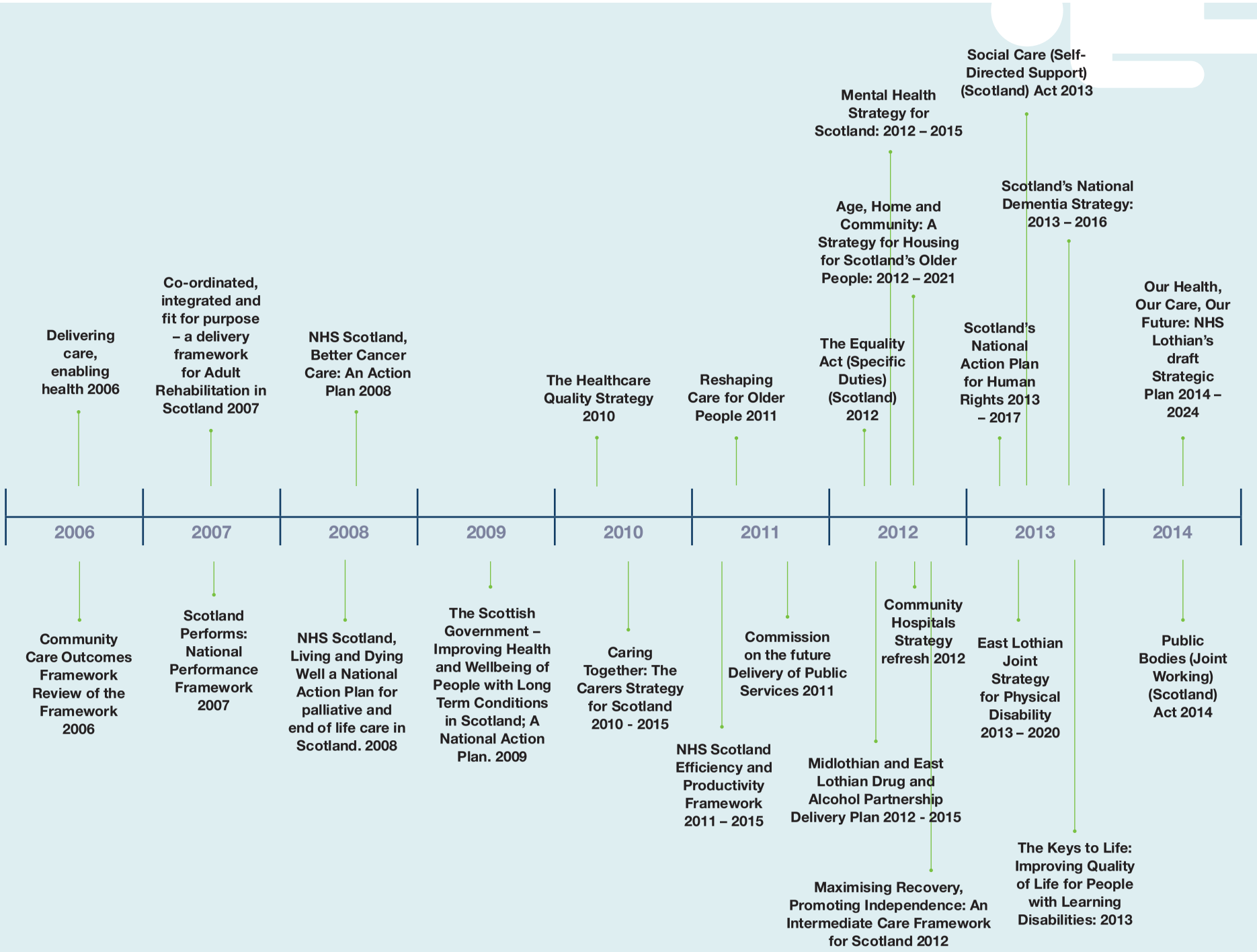
This draft consultation outlines how the Health and Social Care Partnership propose to address the key priorities over the next few years and equally address what we believe are important gaps in how we plan for services locally in order to deliver Best Health, Best Care, Best Value for our communities.

As we move forward with joint planning the continuing work on the JSNA will enable stronger partnership working and it will become central to our efforts in transforming the planning and commissioning processes. For now it provides the basis, alongside the policy context, for this draft Strategic Plan's approach and priority setting.

Policy Context

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

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


2006
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2008
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Delivering care, enabling health 2006
Co-ordinated, integrated and fit for purpose – a delivery framework for Adult Rehabilitation in Scotland 2007
NHS Scotland, Better Cancer Care: An Action Plan 2008
The Healthcare Quality Strategy 2010
Reshaping Care for Older People 2011
The Equality Act (Specific Duties) (Scotland) 2012
Mental Health Strategy for Scotland: 2012 – 2015
Age, Home and Community: A Strategy for Housing for Scotland's Older People: 2012 – 2021
Scotland's National Action Plan for Human Rights 2013 – 2017
Social Care (Self-Directed Support) (Scotland) Act 2013
Scotland's National Dementia Strategy: 2013 – 2016
Our Health, Our Care, Our Future: NHS Lothian's draft Strategic Plan 2014 – 2024
Community Care Outcomes Framework Review of the Framework 2006
Scotland Performs: National Performance Framework 2007
NHS Scotland, Living and Dying Well a National Action Plan for palliative and end of life care in Scotland. 2008
The Scottish Government – Improving Health and Wellbeing of People with Long Term Conditions in Scotland; A National Action Plan. 2009
Caring Together: The Carers Strategy for Scotland 2010 - 2015
NHS Scotland Efficiency and Productivity Framework 2011 – 2015
Commission on the future Delivery of Public Services 2011
Midlothian and East Lothian Drug and Alcohol Partnership Delivery Plan 2012 - 2015
Community Hospitals Strategy refresh 2012
Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland 2012
East Lothian Joint Strategy for Physical Disability 2013 – 2020
The Keys to Life: Improving Quality of Life for People with Learning Disabilities: 2013
Public Bodies (Joint Working) (Scotland) Act 2014

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

National Strategic Context

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

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

Regional Strategic Context

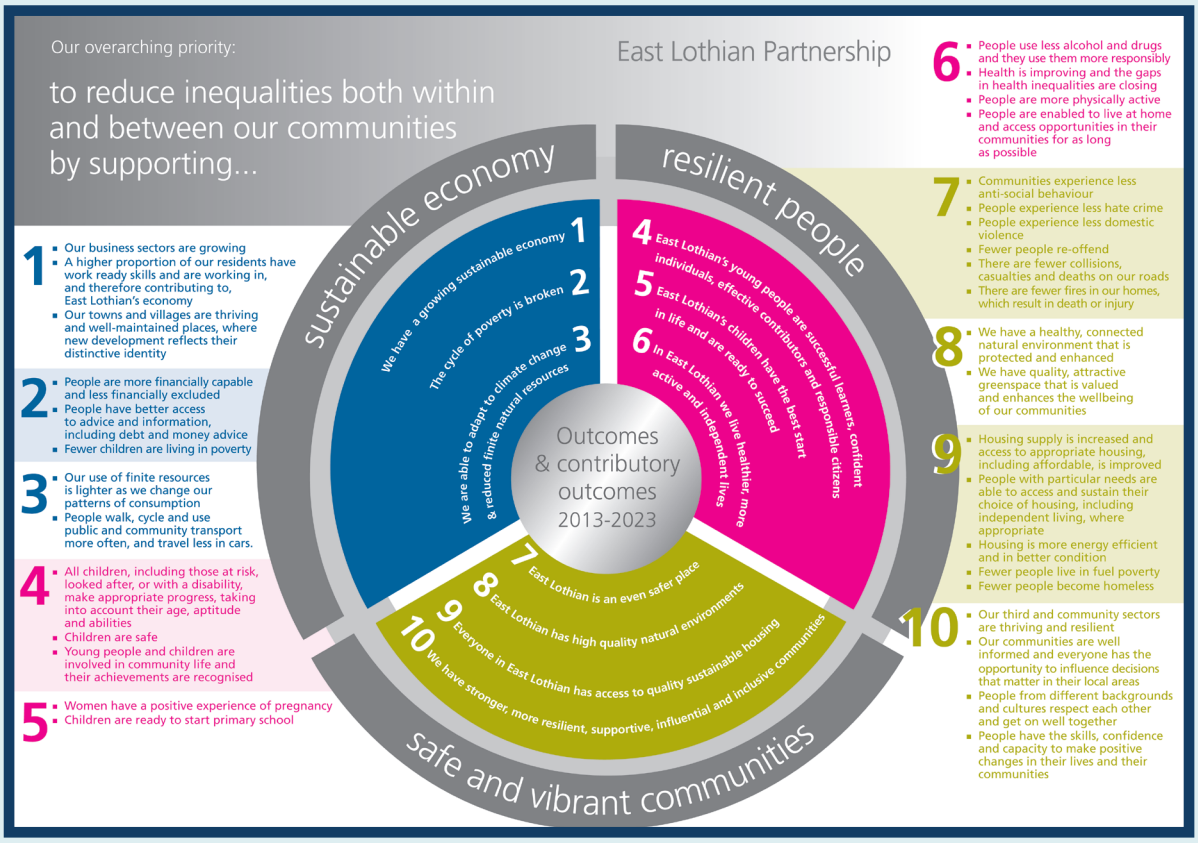
NHS Lothian's draft Strategic Plan recognises the challenges of demographic change, quality aspirations and resource constraints and describes what NHS Lothian proposes to do over the coming decade to address these challenges whilst providing a high quality and sustainable healthcare system for its citizens.

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

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

Local Strategic Context

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



As the Health and Social Care Partnership further develop this Strategic Plan we will ensure close alignment with all these relevant policies and strategies.

In East Lothian, organisations and communities do already work in partnership to address key health and care needs for adults, focusing on priority groups. There are a wide range of joint strategies and plans already in place and this Strategic Plan neither replaces nor revises any of the current, live plans; it will, however, focus on the priority actions and encompass these in our delivery programmes. Current local joint strategies include:

East Lothian's Joint **Learning Disability Strategy** recognises that the number of our population with a learning disability is projected to increase by 11% over the coming 10 years. A highly positive projection is an increase in life expectancy across this population, but with this will come an associated increase in the prevalence of dementia and the need to plan and provide services to support this.

The policy context for the strategy is clearly based on the entitlement of life within a community and providing care close to home through an integrated service model. Key priorities include enhanced services to support people with challenging behaviour in a more preventative manner and the development of local on call and crisis response services

Local planning also identifies the need for a creative alternative to continuing care for people with a learning disability, recognising that for a very small number of individuals there will be long term requirements. This model and any subsequent funding requirements will be further clarified as work on strategic planning for learning disabilities progresses.

Opportunity and Independence', East Lothian's joint strategy for people aged 16 and over with a **physical disability** or hearing or sight loss, underlines our commitment to work collaboratively to ensure that there is an integrated network of care and support locally. Through this strategy we intend to make sure that anyone can access services and other resources when they need them, regardless of income or where they live.

The physical disability strategy focuses on four main themes:

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

Midlothian and East Lothian **Drug and Alcohol** Partnership's strategic commissioning strategy 2012 – 2015 outlines the national policy context and the need for sustained action in four key areas;

- reduced alcohol consumption
- supporting families and communities
- positive public attitudes and positive choices
- improved treatment and support.

The strategy outlines a vision of a healthier, happier and safer East Lothian free from the harm caused by alcohol and drugs misuse where integrated, coordinated and high quality services are based around the needs of individuals, families and communities.

The primary aim of the local strategy is to describe MELDAP's vision for improving the quality of its commissioned services by:

- Enabling more people living in East Lothian to adopt a more responsible approach to alcohol
- Enabling people with substance problems to recover from them and live healthy crime free lives
- Reducing the harm related to young people's substance misuse

- Protecting communities from the harmful effects of substance misuse
- Developing services for young people, adults and families which are equitable, readily accessible and designed around their needs.

In 2011 East Lothian signed up to a Lothian wide strategy, "A sense of belonging". **The Mental Health and Wellbeing Strategy**, "This sets out a clear view, principles and planned ways of working on mental health and wellbeing in East Lothian during the next five years.

The public, people who have experience of mental health problems, people who use services, carers, the Third sector, four local authorities and NHS Lothian are working together, using the strategy to improve mental health and wellbeing for people. Both elements are crucial in people's lives as well as the need to promote mental health and wellbeing in our local authority area.

The strategy looks at all stages of life, considering the needs of people of all ages: early years, school age, working age and older people. It aims to achieve results by addressing four linked "Commitment to Change" areas:-

Tackling health inequalities by focusing on individuals and communities who are at greater risk of experiencing difficulties.

Building social capital and wellbeing by supporting people to look beyond health and care services and to make changes in their own communities.

Embedding recovery, which for some may not mean full recovery but instead staying in control of their life and living well despite experiencing a mental health problem.

Improving services. want to have excellent services for people when and where they need them – in the right place at the right time delivered by the right people.

Older People

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

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

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

has been little evidence of progress in moving money from bed based models to community-based services.

Improving care for older people and joining up services has been a policy focus in East Lothian for several years but progress has been slow and we recognise that monitoring of its implementation and impact needs to improve. Given the growing pressure on services we now need to accelerate the required change and to work with our partners to clearly plan how resources will move from institutions such as hospitals into the community.

We need clear, renewed plans setting out in detail how this will happen in practice. The integration of health and social care, with integrated budgets and strong local leadership and vision allows us the opportunity to now take this significant agenda forward in a meaningful way.

For this reason it is proposed that the planning framework for this Strategic Plan and its associated operational plans will assume responsibility for reviewing key elements of the extant Older People's Strategy and embedding these into the overarching Strategic Planning process, ensuring integrated thinking, making it fit for future planning processes and, crucially, bringing accountability for delivery.

Carers

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

Caring Together: The Carers Strategy for Scotland 2010 – 2015 identifies a broad number of areas where action is recommended to increase support to unpaid carers. East Lothian is currently in the process of reviewing and redeveloping the local joint Carer Strategy which will identify the key priorities for carers and carer support locally as we move towards integration. This will be referenced frequently throughout this Strategic Plan and form a key plank of future local priorities.

Housing

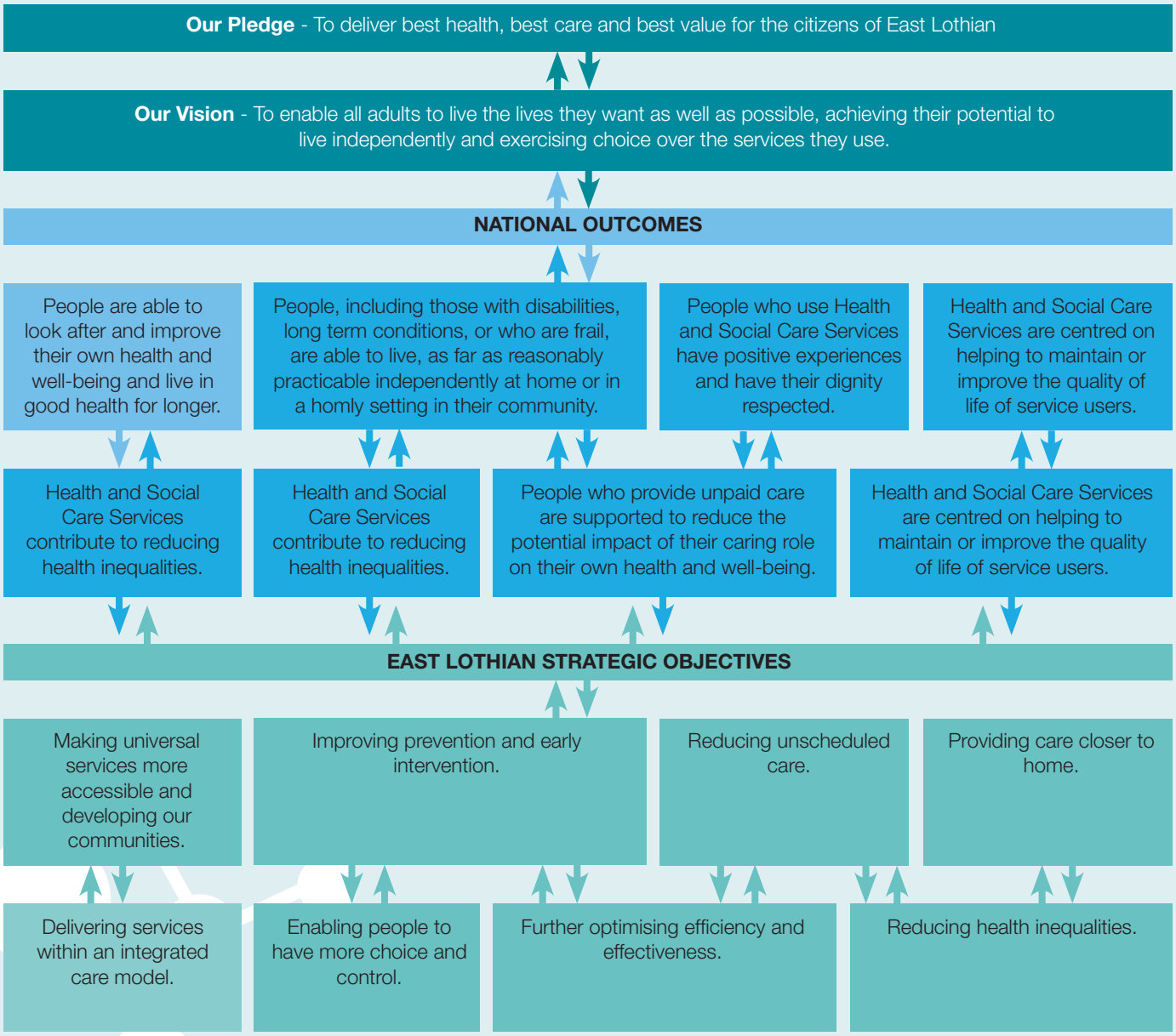
The East Lothian Local Housing Strategy (LHS) 2012-17 sets out five outcomes, one of which aligns clearly with national health and wellbeing outcomes and this draft Plan: "people with particular needs are able to access and sustain their choice of housing including independent living where appropriate". This is underpinned by a number of key actions including:

- To establish systems to enable ongoing analysis of information in relation to particular needs groups
- Develop initiatives to address current and future housing and housing support needs through a needs assessment
- Review the provision of new build affordable housing for particular needs groups
- Improve joint working to ensure housing is integrated into the strategic planning for particular needs groups
- Work in partnership to develop housing support services with a focus on preventative support

For the local housing strategy an ageing population is also considered to be a key challenge with regard to investment in housing and service delivery. The strategy identifies that this is likely to result in increased demand for housing and housing related services with more accessible homes required across all tenures. and an efficient and effective redesign of existing services is identified as a key driver. The LHS equally identifies key priority areas of affordability, adaptations and fuel poverty as wider determinants of health and wellbeing which would benefit from more integrated planning and service design.

Making the Connections

From all of the above it is apparent that the planning and policy landscape is complex. In order to effect maximum impact and positive improvements we therefore need to ensure a "Golden Thread" runs through all our planning and all our work - that it's well connected. The diagram and table below illustrate the links between our vision, policy, objectives and outcomes.



Financial Context

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

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

Both partner organisations have complex financial arrangements focusing primarily on annual budget plans. Consequently, the forecast of a three year financial plan to match the delivery programmes outlined in this document is challenging and not without risk; this section will be further developed as we progress towards establishment of the HSCP and will seek to describe the financial position of both the NHS in East Lothian and adult social care services in East Lothian Council and the planned approach in relation to the delivery of this Strategic Plan.

The clear imperative already derived from initial financial analysis, however, is that as a Health and Social Care Partnership we must embed new ways of working which divert significant financial resources from expensive bed based models where clinically safe and appropriate, into community based services. We equally need to critically and robustly appraise and challenge our current local models of service delivery across the county to ensure we are focusing our combined resources on areas of most need and greatest impact.

7. Draft Strategic Change Programmes

We have described our case for change through an analysis of our current health and social care outcomes, the strategic aims based on this analysis, the financial context in which we work and a gap analysis which has allowed us to focus on local priorities. Now, in this section we set out at broad strategic level what we are hoping to do specifically to start to bring about the transformation of local health services in the coming years.

This section provides a description of how we think health and social care in East Lothian could look in three years' time as a result of each of our strategic objectives, and will describe the change programmes that will bring this about. Fuller detail on the change programmes, when agreed, will be set out each year in dedicated delivery plans and our business action plan.

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

BEST HEALTH:
A "Fit for the Future" strategic programme which will deliver objectives:

Making universal services more accessible and developing our communities

Improving prevention and early intervention

Reducing health inequalities

BEST CARE:
A "Care First" strategic programme which will deliver objectives:

Reducing unscheduled care

Providing care closer to home

Delivering services within an integrated care model

Enabling people to have more choice and control

Reducing health inequalities

BEST VALUE:
An "Enterprise" strategic programme which will deliver objectives:

Further optimising efficiency and effectiveness

Reducing health inequalities

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

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

BEST HEALTH

Our FIT FOR THE FUTURE Programme

Strategic Objective:
MAKING UNIVERSAL SERVICES MORE ACCESSIBLE and DEVELOPING OUR COMMUNITIES

We need to ensure that people with health and social care needs benefit to the full from mainstream services and resources such as primary healthcare, housing, information, support and advice.

Primary care, and in particular care delivered by general practice has been a cornerstone of the NHS since its inception and its delivery model has evolved through the years. With the demands all services are facing at a time of changing populations with increasing health and wellbeing needs, primary care needs to equally address the challenges of variation in access to services and a changing workforce profile. GPs and their practices will, therefore, play an important role in influencing and shaping this Strategic Plan and its outcomes.

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

"Out of Hours" primary care in East Lothian is currently delivered by Lothian Unscheduled Care Service (LUCS). This service is "hosted" or managed by East Lothian on behalf of NHS Lothian. LUCS is a pivotal service for consideration in the Strategic Plan providing urgent, non-emergency primary medical services to our population when GP practices are closed; in essence this is care provision for 70% of the week. In East Lothian there is a recognition that this "out of hours" period is significant and that LUCS has, over time, become the default provider of medical care within the community and across a range of settings out with normal GP working hours. As with almost every other service LUCS has experienced a significant increase in workload over time exacerbated by a national and local shortage of GPs working in the out of hours environment. A pan Lothian review of the service is currently being undertaken and a local focus on this service delivery and what it means for East Lothian is now required.

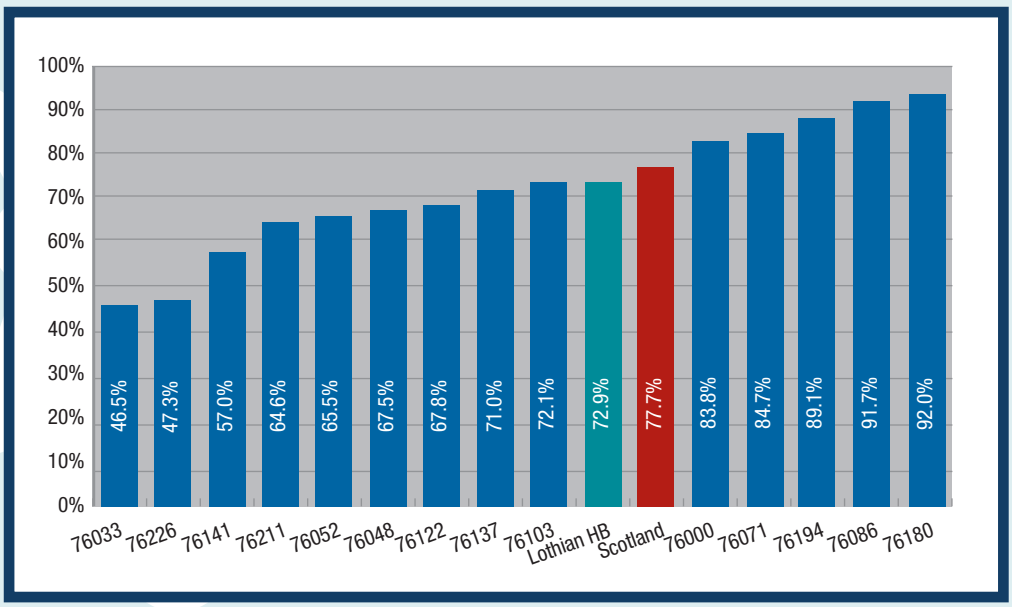
Primary care is not simply about general practice, though, and includes community pharmacy, dentistry and optometry independent practitioners who provide essential services for our population. The Health and Social Care Partnership therefore must explore opportunities to work with all professionals to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

Most crucially, however, this strategic objective focuses not simply on how access to health and social care services will be supported but equally on the way all services connect between themselves and connect people into their local communities.

Achieving our priorities will be dependent on maximising the use of all available resources. Therefore this Plan will be supported by a model which seeks to develop communities and build resilience within the provision of community (universal) services and to intervene early where individuals, families and carers require additional support.
By having clear and consistent themes of community capacity and resilience running through all our programmes, we aim to make it easier for everyone to work together. By getting organisations to work together more closely, sharing resources and information so as to provide a better network of local support, we aim to create such resilient communities across our county. This is to make sure that everyone can be a part of a community and experience the friendships, sense of belonging, support and care that can come from families, friends, neighbours and communities. Through this, our aspiration is that people and communities will be better equipped to do more for themselves. As well as reducing inequalities and promoting quality of life, these wider supports will play an important role in reducing the need for health and social care support services as well as developing more creative and effective ways of delivering support.

What does our Joint Strategic Needs Assessment tell us?

The recent national Patient Experience Survey demonstrates significant variation across East Lothian GP practices in terms of satisfaction with arrangements to see a GP. We need to understand this variation and support General Practices in dealing with significant demand, capacity and access challenges.



We have also already highlighted the rural nature of much of East Lothian and the challenges this presents in accessing care. The Strategic Plan now needs to address these challenges and support innovative solutions for enhancing access.

The HSCP in East Lothian is committed to working in partnership with the Third and Independent Sectors to focus on prevention and the promotion of health and well-being; Community Groups organised around their own local issues, working and learning together, building relationships and networks in neighbourhoods and communities are a vital resource we must recognise. As part of our Joint Strategic Needs Assessment we have now started to map this often untapped resource.

Our Draft Priorities for Fit for the Future

- **We will develop an East Lothian Primary Care Development strategy which recognises demand and capacity issues, including premises, and which addresses variation**
- **We will establish an East Lothian Independent Contractors Forum which will promote and facilitate engagement with the sectors, driving innovation and care closer to home.**
- **We will work with our Third Sector Interface to provide the key link into, and to be an equal partner in, health and social care strategic planning.**
- **We will develop and embed an access to care transport solution with our Third Sector partners.**
- **We will work with Dementia Friendly East Lothian to establish joint, integrated planning and support for dementia across our communities.**
- **We will develop a local assessment and review of out of hours activity including the need for minor injury provision.**
- **We will develop a local "Right Care, Right Time, Right Place" public information programme to address demand and capacity issue safely and appropriately.**

Strategic Objective

IMPROVING PREVENTION and EARLY INTERVENTION

Prevention is always better than cure whether primary - that is avoiding the problem occurring, or secondary - that is arresting the problem or preventing further deterioration.

Prevention is integral to the delivery of sustainable health and social care. It enables individuals to make better health and wellbeing decisions and it is an important determinant in optimising better outcomes for our population. Preventative services are a means of ensuring good health, well-being and independence in later life. This means providing information, advice and guidance at the right time and in the right format, ensuring that there are a range of activities and services that help people to stay physically and mentally active and to commission services that enable people to gain or regain their independence in the community.

Preventative services for individuals and their families should ensure that our aim to increase the life expectancy of people is about not just adding years to life but life to years.

All our services across all our sectors, therefore, have a central role to play in promoting healthy lives, building on the thousands of daily personal contacts that they have with people. There is real scope to develop these interventions further, ensuring that advice and support for change is more thoroughly developed, focused and embedded in all our contacts.

The real starting point, however, is to acknowledge that population health and wellbeing is not just a matter for the health and social care system. It certainly begins with the individual and the choices they make, but improving health and reducing health inequalities also requires joint action and partnership working. Factors or interventions can only be addressed effectively through real partnerships across the NHS, Council, the community and voluntary sector, local communities and private sector organisations. A sustainable model of adult health and social care services needs to place greater emphasis on maintaining people's independence and resilience, preventing deterioration into substantial or critical categories of need.

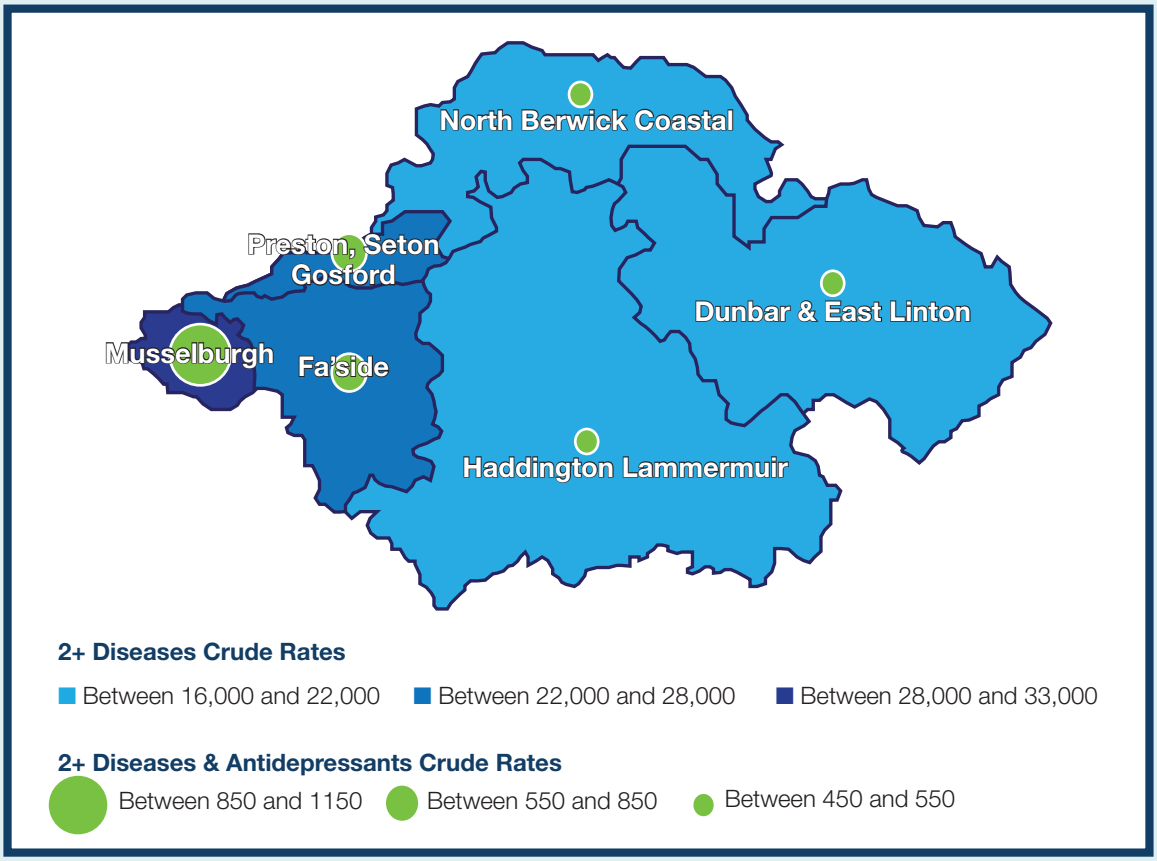
What does our Joint Strategic Needs Assessment tell us?

Emergency admissions to hospital, attendance at Accident and Emergency departments and prescribing costs are rising, particularly in areas with a high prevalence of multimorbidity – the term used for the presence of two or more long term health conditions. Across Scotland annual adult health and social care spend is over £10.9 billion and is projected to rise with this increasing demand.

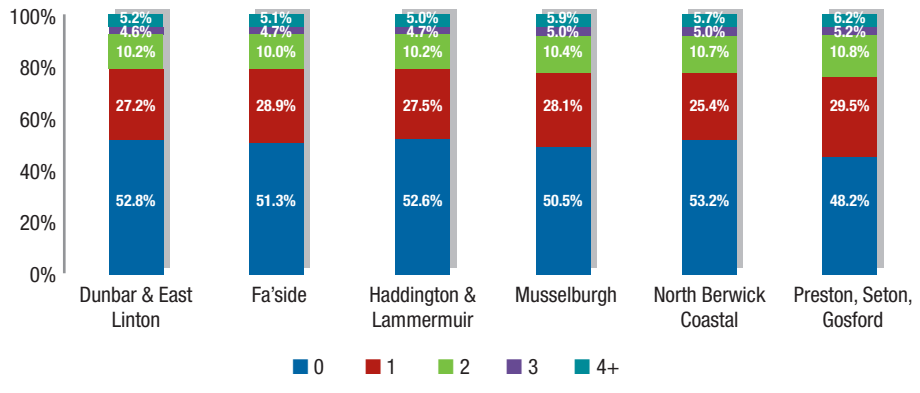
Most people with multimorbidity in Scotland are under 65 years and we know it occurs 10 to 15 years earlier in deprived areas compared to more affluent areas. We also know that the most common co-morbidity in deprived areas is a mental health problem.

As part of our needs assessment we have concentrated on understanding multimorbidity and where the greatest support need is across East Lothian. This is outlined in the chart and map below.

East Lothian Multimorbidity Crude Rates by Locality (rate per 100,000)



Percentage of people in East Lothian sub partnerships with co-morbidities, 2013/14



We know that what matters most to people with multiple long term conditions is:

- Coordination and continuity of care
- Trusted relationships
- Accessible information and advice
- Good communication with, and between, staff.

Our current systems are not well geared to deliver these outcomes. Fragmented care from multiple professionals and teams disrupts lives, increases the burden of treatment for individuals, their families and carers and increases costs, waste and risk of harm. Transitions of care are a particular pressure point and we don't always support people to use individual and community assets to build resilience, prevent or delay dependency and reduce demand for more intensive support.

As multimorbidity increases, our need to coordinate and integrate the care of the most vulnerable and at risk people in our communities grows in importance. A risk stratification methodology which recognises multimorbidity as well as other associated risk factors and allows us to identify those in our population at highest risk will be a key tool in the targeted identification of people who will benefit from the better coordination of their care.

For all these reasons this draft Strategic Plan has risk prediction, multimorbidity, prevention and care coordination as priority themes.

We also recognise the vital role played by **carers** and the need to prioritise planning to make sure that carers remain in good health so that their health-related quality of life does not deteriorate as a result of their caring responsibilities. In order to do this we need to maximise the early identification of carers – both early self-identification and by care professionals. We also need to provide personalised support for carers as well as those receiving care and, crucially, support carers to remain healthy.

What does our Joint Strategic Needs Assessment tell us?

The Scottish Household Survey reported that there is a person requiring care from an unpaid carer in 14% of households in Scotland. In the 2011 Census, 492,000 individuals across Scotland identified themselves as caring for somebody, representing 9.3% of the population. In East Lothian, 9477 individuals reported being in a caring role, representing 9.5% of the population

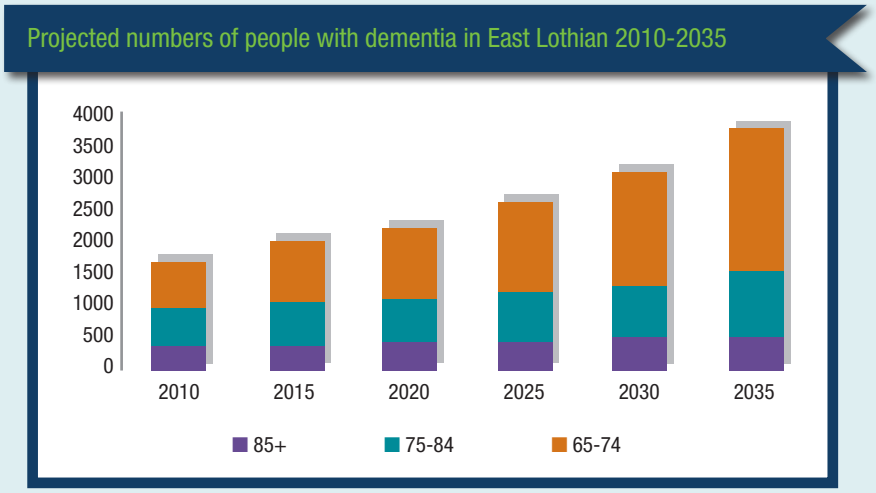
The 2011census did, however, identify a 7% increase across Scotland in carers providing 20 or more hours of care. The census also reveals that almost 19% of carers are aged over 65, representing approximately 1,800 carers in East Lothian.

We know from statistical information provided by carer support organisations that many of these carers are not currently known to or using dedicated support services and we should address this identification of local unmet need as a priority.

Dementia is a national priority and we need to make it a priority for East Lothian Health and Social Care Partnership. Given the challenging times we all face in the next few years in terms of public spending, it is important that we tackle this agenda strategically now if we are to begin to fundamentally reshape the model of dementia care - especially as we expect the number of people with dementia to double over the next 25 years.

What does our Joint Strategic Needs Assessment tell us?

Whilst we know the numbers of people in East Lothian with dementia from our GP registers, our needs assessment uses population projections from the General Register Office for Scotland and applies dementia prevalence rates taken from the EuroCoDe study as reported on Alzheimer Scotland's website[4]. This tells us that by 2020 the number of people in East Lothian with dementia will be estimated to increase by 1,855 (from 1,687 in 2010 to 3,542 in 2035) - an increase of 110%.



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

At each stage of the journey of someone's dementia there are things we need to do better – for example in providing consistency in the quality of post-diagnosis support and improving the experience of those with dementia and their carers in all settings including our communities. Evidence also clearly highlights the value of early intervention and diagnosis as up to two thirds of people and their families are living with dementia unaware of its existence[5]. Early intervention can help to slow the progress of dementia and its symptoms. It can also help to better prepare individuals and their families for the future of living with the condition.

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

[5] East Lothian Health and Wellbeing Profile 2010 (http://scotpho.org.uk/web/FILES/Profiles/2010/Rep_CHP_S03000031.pdf) [1] GROS East Lothian Demographic Factsheet (http://www.gro-scotland.gov.uk/files2/stats/council-area-data-sheets/east-lothian-factsheet.pdf East Lothian Health and Wellbeing Profile 2010

The key role played by carers of those with dementia is also recognised and prevention and early intervention to support this crucial role is also important here.

Falls are a major cause of disability and mortality in the UK. Our Joint Strategic Needs assessment tells us that nationally 30% percent of those aged 65 or over who live in the community fall each year, increasing to 45% in those aged 80 or above[7]. Recurrent falls are associated with increased mortality, increased rates of hospitalisation, curtailment of daily activities and higher rates of institutionalisation.

We also know from our needs assessment that whilst East Lothian has a relatively low hospital admission rate for falls, if someone from the county is admitted after a fall they stay in hospital longer than average.

Because falls are one of the largest causes of harm in health care and are a safety and quality priority for our population, falls prevention should be addressed through the priority actions of this Strategic Plan.

Day Centres are an important service in our prevention and early intervention programme. as they aim to help older people stay in their community and function to the fullness of their ability. Day centres in East Lothian are diverse in nature and geographical spread, they cover a diverse range of services and activities, cater for a variety of people and needs, and serve a number of different purposes, most of which are broadly preventive. These include:

- providing social contact and stimulation
- reducing isolation and loneliness
- maintaining and/or restoring independence
- providing a break for carers
- offering activities which provide mental and physical stimulation
- offering low-level support for older people at risk
- providing opportunities for older people to contribute as well as receive.

Effective day centres can play a vital role in supporting individuals and in maintaining their contact with the community; they can address people's need for direct social contact, exercise, to engage in and make contributions to society and to be involved in productive activities. Such services can vastly improve older people's quality of life, promote their health and prevent or delay the need for more costly interventions. As such our local Day Centres are an important element of our preventative agenda and the Strategic Plan should support this.

Finally, with an ageing population and the increasing prevalence of long-term conditions the need for new care models and technologies – such as **telehealth** and **telecare** – to support long-term care has increased. Innovations such as telehealthcare solutions challenge our systems to focus on preventing ill health, supporting self-care, and delivering care closer to people's homes.

[7] Falls and fractures: effective interventions in health and social care, Department of Health, 2009.

Telehealth and telecare innovations have the potential to improve quality of life for users and to reduce unnecessary hospital and care home admissions. The integration of health and social care and the closer working between health, housing and social care organisations now provides an opportunity to consider and adopt innovative and personalised technology-based solutions as part of our formal, integrated care pathways.

Our Draft Priorities for Fit for the Future

We will increase use of risk stratification and case finding at primary care and community level. Our multi-disciplinary teams will focus on providing care to individuals who are at greatest risk of unscheduled admission to hospital. Using IT we will categorise our population by their risk of admission to hospital and by use of social care. We will know which of our population are in the greatest need of our help, and can target our resources – doctors, nurses, social workers, care support and community support - appropriately towards those in greatest need.

We will improve planned care and anticipatory care. A central facet of our plans to transform our local health and care system centres on the development of an expanded and effective primary and community care sector. We want to organise our GP practices into “clusters”; each cluster will have a multi-disciplinary team of integrated, health and community professionals and new care coordinators who will signpost care across third sector support providers. Establishing this will require us to:

- Reorganise our services so that we have the right number of people, with the right skills, in the right place, targeting patients with the highest risk of hospital admission.
- Develop the concept of multi disciplinary neighbourhood teams to support people in the community and reduce reliance on hospital care.

We will develop more primary and community care services in our localities following on from the successful implementation of near patient INR testing (Coaguchek).

We will develop an integrated falls pathway for East Lothian which identifies fallers at an early stage and which provides a multidisciplinary, multiagency response to prevention.

We will jointly develop a Physical Activity strategy with Community Planning partners which recognises the role of physical activity in preventative care and promotes universal access to this.

We will develop a comprehensive, consistent and integrated Carers Support Pathway for East Lothian with carer identification and carer assessment as initial priority actions.

We will appoint a dedicated post diagnostic support worker for Dementia.

We will develop an integrated telehealthcare strategy for East Lothian which ensures spread of technology enabled care.

We will carry out a review of Day Centres in East Lothian in order to address capacity, capability and equity of provision and implement the recommendations of this.

BEST CARE Our CARE FIRST Programme

Strategic Objectives: **REDUCING UNSCHEDULED CARE**
CARE CLOSER to HOME
DELIVERING SERVICES within an INTEGRATED CARE MODEL
ENABLING PEOPLE to have MORE CHOICE AND CONTROL

Unscheduled care is a term used to describe any unplanned treatment, help or advice to people in an emergency or urgent situation. It ranges from emergency hospital treatment to help for individuals to care for themselves at home. Unscheduled care can occur at any time and crosses the traditional boundaries between general practice, community and social care services and hospital services.

Scottish Government has specifically challenged partnerships with targets around unscheduled care, including A&E attendances and unplanned hospital admissions. Currently, our health system appears to be overly dependent on hospital services and people can end up in hospital when they don't need to be there. More generally in both health and social care there is a greater emphasis on providing care at home rather than in institutional settings, with more choice being given to individuals to say how, when and by whom services are provided.

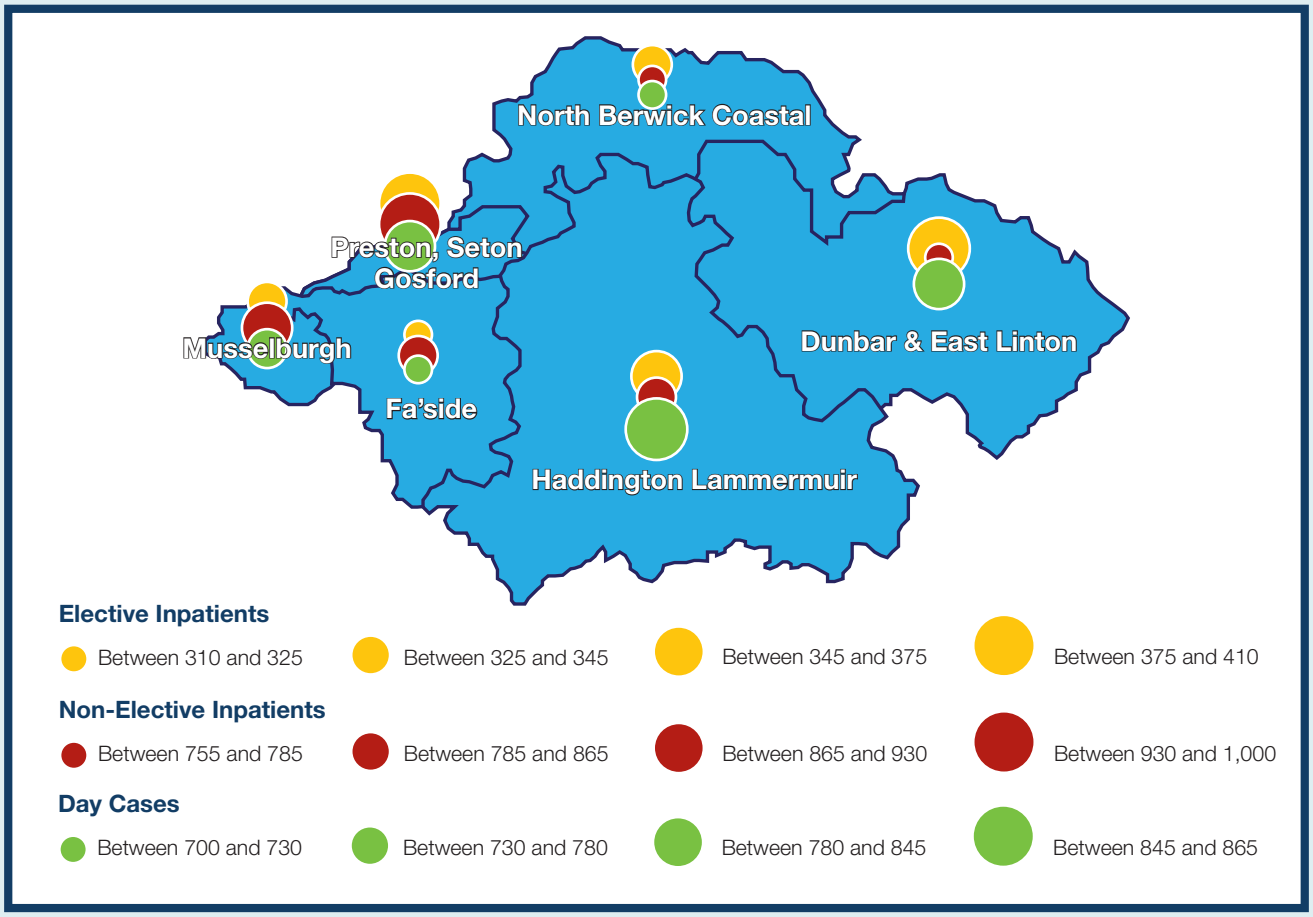
Managing admissions to acute hospital beds, residential and nursing homes is, therefore, a key part of this Strategic Plan and we believe there is a clear case for the transformation of our out of hospital care. The population of East Lothian is changing, people are living longer and this will continue to increase the pressure on acute hospital services and residential care placements unless we transform service delivery.

Some of the key challenges are apparent - the need to develop a more holistic, joined-up approach to how we deliver our care services, and the need to help people better understand the complex array of unscheduled care services so that they access the most appropriate treatment for their needs. This delivery programme of the Strategic Plan gives us the opportunity to develop a coherent, joint modernisation strategy which addresses the challenges of increased unscheduled care attendances and admissions and safely and equitably meet the needs of the public.

What does our Joint Strategic Needs Assessment tell us?

Our Joint Strategic Needs Assessment tells a powerful story of unscheduled care patterns in East Lothian. We have carried out a comprehensive analysis of unscheduled care activity which shows increasing rates over time. East Lothian has higher overall rates of emergency admissions than the Lothian average and longer stays in hospital. For this and for a range of other markers such as multiple hospital admissions and readmissions the picture varies significantly across localities.

East Lothian Localities by Elective Inpatient, Non-elective Inpatient and Day Cases Crude Rates for Admissions in the Financial Year 2013/14 per 10,000 population



Musselburgh, Preston, Seton, Gosford and the West locality in general exhibit higher rates and we need to focus on these differences as we plan services more locally.

In response to the continued growth of unscheduled care attendances and admissions, and in recognition of the opportunity for modernisation integration brings, this draft Strategic Plan has a major focus on the need to redesign services to address this pressure and better meet the needs of our population.

The aims of this strategic programme will be to:

- Ensure that people in need of unscheduled care receive services of consistent high quality
- Ensure that people in need of unscheduled care receive a consistent response regardless of when, where and how they contact the service
- Reduce variation
- Ensure that pre-designed pathways are in place so that the right treatment is provided in the most appropriate place, from the right person, as quickly as possible 24/7

In doing this we will always recognise that carers are the largest group of care providers in Scotland, providing more care than the NHS and local authorities combined. Any redesign of services, therefore, has an impact on people and on the carers who support them. As services shift from hospital and residential settings to greater support within the home and wider community settings more pressure could be placed on carers if their needs are not considered. The Strategic Plan must take account of this at all points and ensure positive outcomes for both carers and the people they care for.

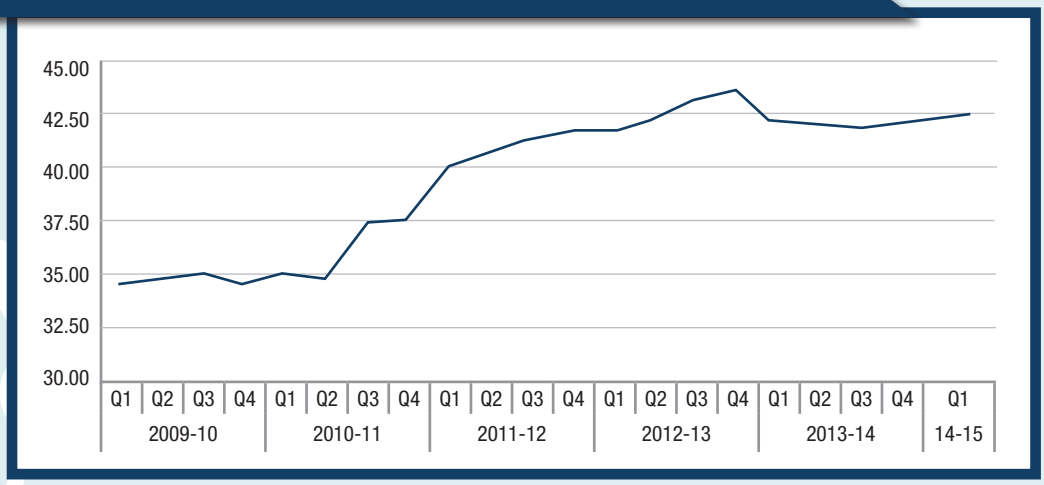
East Lothian also performs relatively poorly compared to other Scottish partnerships in terms of delayed discharges from hospitals and in the subsequent bed days lost to people waiting for transfers of care. Whilst the reasons for this are complex, the availability of appropriate care home places and of packages of care to support people in the community are amongst the main underlying causes.

Care at home and care homes in East Lothian are pivotal services in ensuring the vision to support people to maintain independence for as long as possible and to enjoy full and positive lives in their home or a homely setting: s such they are key elements of the Strategic Plan.

What does our Joint Strategic Needs Assessment tell us?

The vision to support independence appears to be taking hold although we recognise that more needs to be done. The number of people receiving personal care services in their own homes in East Lothian has increased and risen steadily, showing that people receiving care at home have increasing levels of need.

Balance of Care - East Lothian



The Balance of Care represents the number of people (aged 65+) receiving 10 hours or more care at home (defined as intensive) as a percentage of this number plus all those in residential or nursing placements.

Care at Home over 65 - weekly hours

Nonetheless, social care as a vocation has sometimes been viewed as demanding and recruitment and retention challenging. This has led at times to challenges in ensuring resources are focused on getting the services and placements that meet people's needs across the county; addressing this will be a key enabler for delivering this strategic change programme

Equally, residents in care homes have increasingly complex and high levels of care and support needs and as a partnership we need to ensure we commission the right services in the right place. Since 2007 the strategic development and performance of Care Homes for Older People in East Lothian has been governed by the National Care Home Contract. The contract is negotiated by COSLA and Scottish Care and has traditionally been adopted by all 32 Local Authorities in Scotland. From April 1st 2016 there will no longer be a national agreement and this presents the opportunity for the strategic direction of Care Homes for Older People to be arranged on a more localised basis.This work will be encompassed in the Strategic Plan.

Given the age, frailty and multiple morbidities of care home residents they can be viewed as one of the most complex and vulnerable group of people in our communities which has significant implications for the workforce providing their care and support. As a partnership we need to recognise this and promote and support quality services for all.

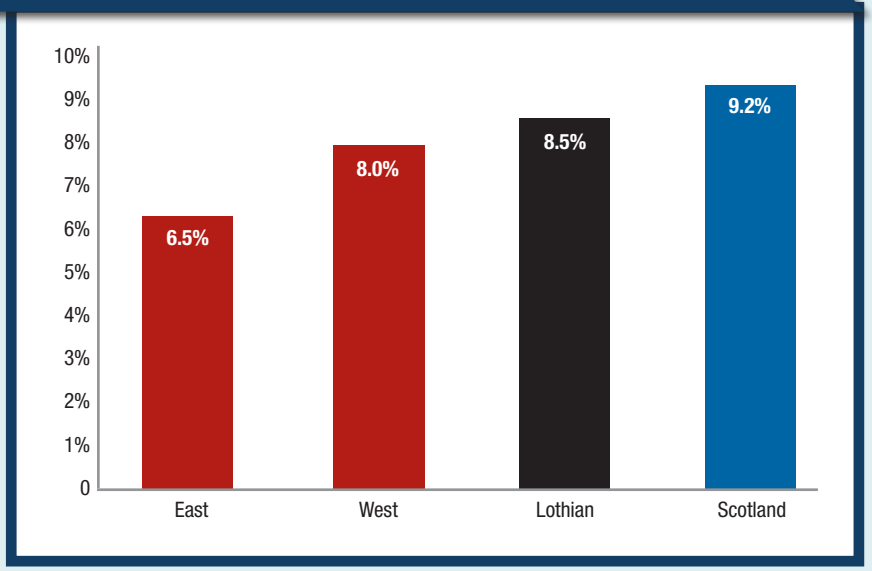
Added to this we know that 21% of our population over 65 have a care home as a place of death, so increasingly palliative and end of life needs need to be met.

Care for people nearing the **end of life** is one of the most important challenges that we face and there are challenges for planning and delivering good, person centred end of life care. This is a complex and multifaceted subject, covering a broad range of conditions and issues. The default position is often overuse of hospitals, but we know that hospital is not a good place to be for many people. However, at its best, end of life care can be really excellent – in the community, in hospices, hospitals and elsewhere. Improving community care and reducing inappropriate hospitalisation is doubly beneficial in end of life care, meeting the wishes of patients and carers.

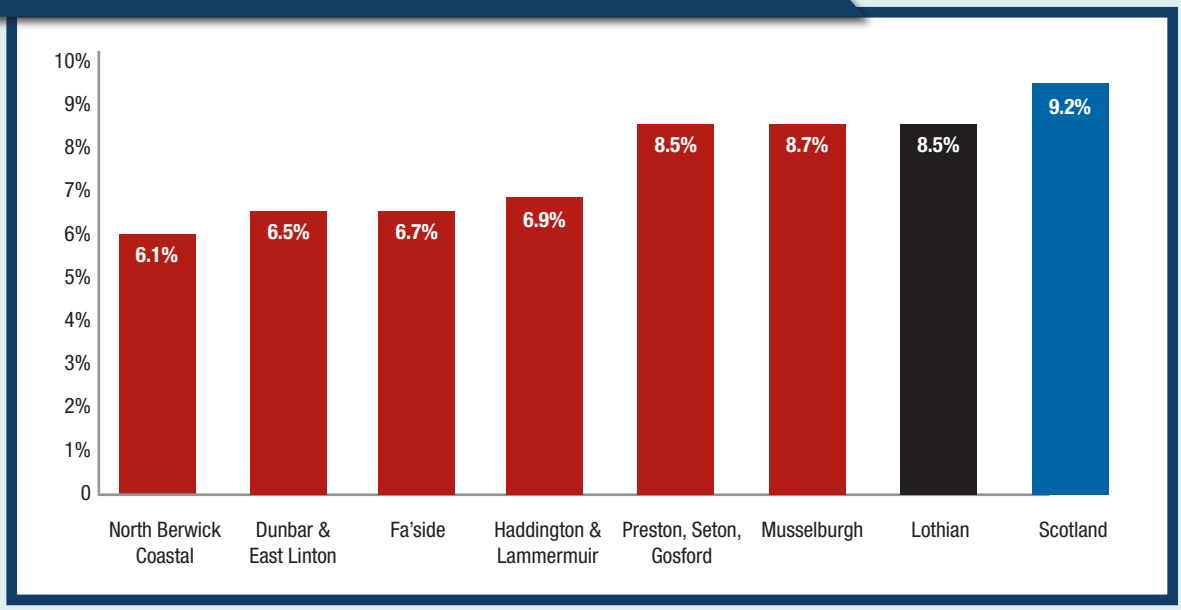
What does our Joint Strategic Needs Assessment tell us?

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

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



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



Overall in this strategic programme our joint ambition is to ensure that the services we plan and deliver are organised as much as possible around our citizens' needs, and not institutional boundaries. If we are to realise this ambition, the principles of choice and control as specified in **Self Directed Support** need to extend across all health and social care services, and the Health and Social Care Partnership and the Strategic Plan should act as enabling forces in this respect.

Our Draft Priorities for Care First objectives

In East Lothian we have been redesigning our services to meet the challenges of unscheduled or unplanned care and crisis support for some time. We have already developed what we call the ELSIE (East Lothian Service for Integrated Care of the Elderly) whole system pathway which provides an integrated service of Hospital at Home, emergency social care and care at home, carer support, befriending and volunteering and, latterly, the addition of twenty intermediate care beds in Tranent. The ELSIE service aims specifically to support people safely in their own homes at time of crisis or to smooth delayed transfers of care from hospital to home or a homely setting. This ELSIE pathway becomes operational from the end of 2014.

However, future progress and service improvement will require a further significant whole system enhancement of services such as this in order to capitalise on the inter-dependencies (and potential efficiencies) between health, social care and the third and independent sectors and our draft priorities for this delivery programme include:

- Further investment in the ELSIE pathway to deliver specialist admissions avoidance care and support 24/7

- Further investment in the ELSIE pathway to deliver specialist dementia care and support
- Further investment in the ELSIE pathway to develop a dedicated integrated care home liaison team

We will pilot a “Discharge to Assess “system.

We will deliver a new East Lothian Community Hospital which provides comprehensive, safe, quality care closer to home for the population of East Lothian. The facility should bring together services from within East Lothian and other areas which will provide significant opportunities to maximise integration. The build should provide facilities wherever possible which can be used flexibly by multiple agencies. to support integrated care.

- We will develop a multidisciplinary education programme for East Lothian care homes with a focus on end of life care.
- We will develop a model of care for care homes which supports and enhances GP practice input.
- We will develop joint, integrated health and social care teams, starting with the ELSIE team and an East Lothian mental health team.
- We will carry out a review and audit of our Care at Home framework.
- We will progress negotiations on Care Home contracts.
- We will seek to increase the number of Palliative Care summaries and Key Information summaries shared with Out of Hours services.
- We will develop a comprehensive, consistent and integrated Carers Support Pathway for East Lothian.

BEST VALUE: Our ENTERPRISE Programme

Strategic Aim: FURTHER OPTIMISING EFFICIENCY AND EFFECTIVENESS

In order to deliver quality care some health and social care services should be viewed as a single, interdependent system. Services designed from this perspective should take into account the whole spectrum of an individual’s needs, and care delivered in response to these needs should be holistic and person centred.

However, both the NHS and local authority are under pressure to find financial efficiencies whilst offering patients and service users the improved choice, control and quality of this kind of care which we aspire to. Pressures on services are exacerbated by an ageing population with chronic conditions and increased public expectations. The need to innovate around service provision is therefore now greater than ever as costs continue to increase.

We have outlined how a whole systems approach to integration can offer the opportunity of efficiencies and service improvements through reduced residential care reduced emergency admissions and reduced delayed discharges from hospital. Integration can also offer operational efficiency through reduced duplication and can facilitate increased productivity — ensuring sustainable services in the face of the known demographic and financial pressures.

For both local authorities and the NHS the financial climate has made delivering significant efficiencies a priority so in many ways there has never been a better time to integrate health and social care services.

East Lothian Health and Social Care Partnership has a duty to the people of the county to provide quality services that are good value for money. Since the onset of the economic downturn, a wide range of studies and reports have been published to shape care planning and there is a consensus that while conventional approaches to good operational and financial management are essential, these approaches of themselves will be insufficient to deliver the depth and duration of efficiency savings required in the medium term. In other words, strategies for cost avoidance and reduction need to be combined with a drive to release resources associated with traditional ways of organising and delivering services. We also need to reduce unwarranted variation in service provision and remove waste.

Whilst each of the delivery programmes prioritised throughout this Plan are designed and intended to deliver the best outcomes for our population, as an accountable body the Health and Social Care Partnership equally needs to ensure best value for the public purse. To this end we will establish a dedicated delivery programme which focuses on efficiency and effectiveness

We understand the importance of strong and sound financial planning and management, and the need to plan effectively to ensure the HSCP is sustainable and ready to take on statutory responsibility for strategic planning from 2015 onwards.

The financial plan which will underpin this Strategic Plan will focus on investment in those areas where we believe we can obtain maximum return in terms of quality, safety, responsiveness, equity, and finance, and which fulfill the vision set out within this document. Equally as a responsible and accountable organisation we will look at areas of potential disinvestment where these parameters are not always met.

Quality

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

7. Draft Strategic Change Programmes

Quality and professionalism need to be clearly at the core of everything that we do. It is an essential element to assure safe practice and positive outcomes for our population. To ensure this quality, people who are providing care and support must be appropriately skilled, qualified and have the personal attributes to be in a role that has dignity and respect as an essential requirement.

Locally, this will mean all our staff and care providers operating within our own quality and professional frameworks and with other agencies such as the Care Inspectorate as a regulatory and inspection body. We will actively promote the development of effective care ,working closely together through audit, support and a focus on quality outcomes.

We want to ensure that care and support provision not only complies with the essential standards of care but that we work collaboratively to ensure that best practice and continuous improvement are assured and vulnerable people remain safe.

What does our Joint Strategic Needs Assessment tell us?

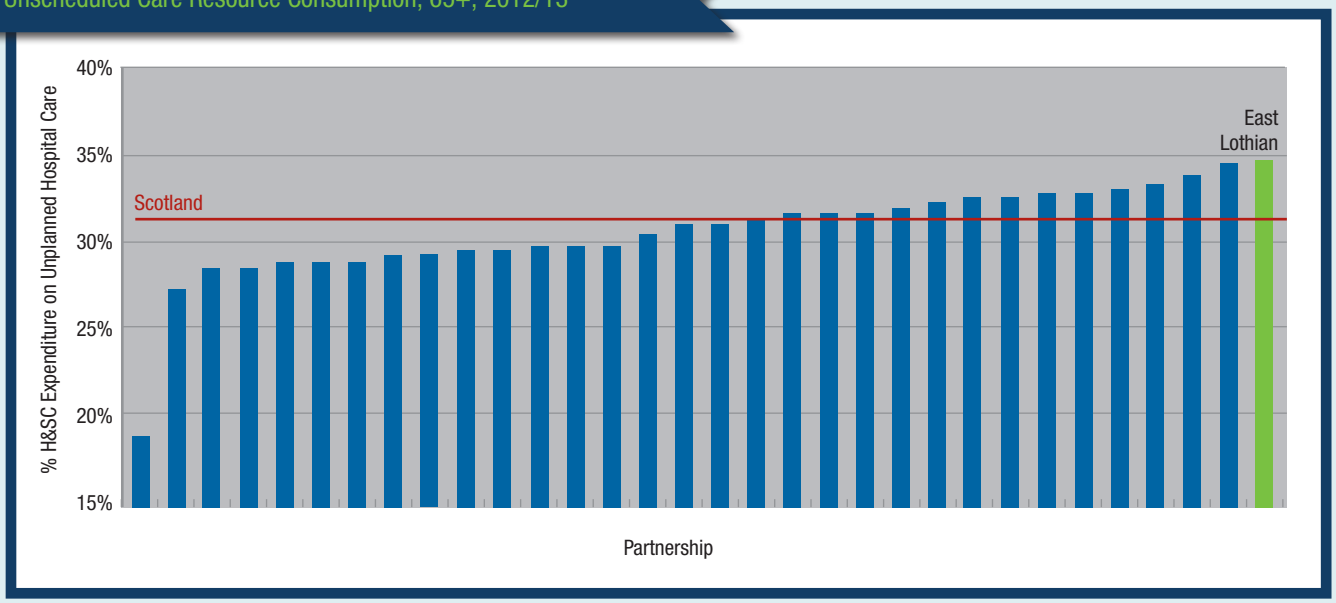
We have a range and variety of bed based models across the county provided and supported by NHS, local authority and independent and third sector; these bed based services also support a range of need and complexities. Any future models of care shouldtake into consideration the best use of the total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

As an accountable body we must ensure that we plan and commission services based on the quality of care they deliver. As well as promoting ongoing quality improvement, as service commissioners we equally need to assure ourselves that existing services meet standards in terms of safety, quality, sustainability, cost effectiveness and financial viability.

As an accountable body we also need to understand variation in our activity and our service delivery.

For example, our needs assessment highlights significant variation in total costs spent on unscheduled admissions across every partnership in Scotland with East Lothian demonstrating the highest percentage figure of total health and social care budget in the country in 2012/13.

Unscheduled Care Resource Consumption; 65+; 2012/13



Our analysis has highlighted the high rates and costs of unscheduled care for East Lothian and the pressing need to shift the balance of care and resources in order to address this. Equally data analysis highlights variation in rates and costs across our localities within East Lothian and at GP practice level. Whilst we would expect a degree of variation it is not clear that these differences are reasonable or directly in response to different local needs. It is important that the Health and Social Care Partnership has a better understanding of this local variation in the types and costs of services in order to plan, change and monitor efficiency.

Cost per weighted capita and per case for unscheduled hospital admissions; by locality; for East Lothian; 2012/13; 65+

Our Draft Priorities

In the draft Strategic Plan for NHS Lothian it is recognised that the current Lothian hospital premises based in East Lothian are housed in old buildings which may be inadequate to safely meet the needs of patients or a growing population. In terms of strategic context, this is seen as a barrier for reprovision of integrated health and social care services in East Lothian.

- **We will therefore commission and complete a bed modelling exercise across the total health and social care landscape to identify current and future need for provision within a quality environment.**
- **We will commission and complete a financial exercise to better understand variation in spend and costs within the HSCP**
- **We will commission and complete an exercise to map high resource use of health and social care services**
- **We will develop and agree an enabling data sharing framework**
- **We will develop a comprehensive performance monitoring framework**

8. Planning for the Future: The GEAR SHIFT

Despite the many successes of the last decade, real integration of the three major blocks of health and social care activity has been limited: the delivery of social care, primary care and secondary care services do not often flow from a single Strategic Plan. Scottish Government's proposals to address this through integration and the Strategic Plan required of Health and Social Care Partnerships is timely and presents a unique opportunity to deliver the policy objective of Shifting the Balance of Care and keeping people living independently in their own homes.

Shifting the Balance of Care describes changes at different levels across both health and social care, all of which are intended to bring about better outcomes for people, providing services which reduce inequalities, promote independence and are quicker, more personal and closer to home. This means we need to develop clinical and care pathways which involve shifting the location where care is delivered, shifting responsibility and who delivers care, and shifting care and support upstream.

The role and importance of Health and Social Care Partnerships in delivering this shift through local improvements in health and care services has been reaffirmed by Scottish Government with the recognition that HSCPs are the key mechanism through which Shifting the Balance of Care will happen.

Shifting the Balance of Care policy outlines a number of high impact changes, one of which recognises that investment and disinvestment decisions by one part of the system can have significant implications and cost pressures on another. This can negate savings across the whole system, and sometimes actually increase cost or resource use. A recent Audit Scotland report noted that there is limited evidence of progress in moving money from acute or institutional care to community-based services and that clear plans for shifting resources to community-based services are now required.

If significant shifts in the total pattern of health and social care are to be realised a single plan which encapsulates the overall vision, future state and the specific changes that will deliver these changes is crucial. A local plan such as this draft Strategic Plan developed in East Lothian needs to focus on shifts in the balance of care not simply as ends in their own right but as an active means of delivering quality improvements, delivering efficiency savings and accommodating the changing needs of the population.

8. Planning for the Future: The GEAR SHIFT

Identifying areas for disinvestment is central to transforming how services are delivered. Shifting the Balance of Care means shifting from institutional services, such as hospitals and care homes, to care at home or in the community. It requires:

- **a good understanding of how resources are being used at a local level**
- **clarity about what works**
- **a mechanism to move resources**
- **a clear plan about what resources will move, when this will happen and evidence of impact**

The vision of our East Lothian Strategic Plan can only be fully implemented with a substantial shift in the current investment pattern for services. The economic climate and likely financial settlements to Local Authority and NHS over the next few years means that any new investment or realignment of resources should, at the very least, be matched by disinvestment. This means the aspiration to fund new services needs to be matched by reduced spending in other areas. – in acute hospital spend for example.

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

At the same time it is clear that with the delegation of powers there will be a responsibility on Partnerships to collaborate with each other, especially in respect of service redesign initiatives which impact on acute services which operate across Partnerships as in Lothian. Acute hospitals are seldom used solely by the population of the local authority territory in which the hospital is situated and therefore significant thought needs to be given to how all Partnerships can contribute to strategic planning initiatives at a Health Board level.

The Health and Social Care Partnership in East Lothian is committed to taking on the challenges of a changing health agenda with devolved responsibility and greater management of local budgets, making a real difference to the health of our local population. The potential of an integrated financial resource associated with Health and Social Care Partnerships and the acute hospital services delegated to them should drive the required policy changes more than any previous policy and presents an exciting opportunity for local communities to shape care delivery. This is the “Gear Shift” required to shift the balance of care.

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

This draft Strategic Plan proposes that the initial focus for the first two years of the life of the Plan is delivery of the local priorities outlined in this document after consultation and agreement. However a parallel strategic planning and development programme should commence immediately on establishment of the HSCP in order to prepare the organisation for assuming full responsibility for planning delegated acute hospital functions. This will maximise the impact of strategies to release resource and establish the Health and Social Care Partnership as a fit for purpose, intelligence led body within two years.

9. Workforce Development

The changing nature of adult health and social care within the integration agenda is complex and challenging. In collaboration with all our partners and stakeholders East Lothian Health and Social Care Partnership must ensure that the workforce of tomorrow, both paid and voluntary, are knowledgeable and skilled and able to respond to the changes outlined in ths Strategic Plan. This will require flexible and responsive sectors and a workforce that is fit for the future.

To meet these challenges and deliver the vision for adult health and social care we expect the workforce to continue to diversify. They will be employed by individual employers, small to medium enterprises and large organisations across the NHS, local authority, private, voluntary and independent sectors and also in local communities.

The continued transformation of our care delivery will also result in a workforce that is deployed in a wider range of ways, including through integration with health, social care and, potentially, other public sector team arrangements. These teams will need to deliver care which provides more:

- Choice and control
- Self Directed Support
- Support to people with increasingly complex needs

Critical to delivering this and making it real is the need to develop leadership and vision that is shared and understood and linked to effective organisational development and sustainability. This will ensure quality and a commitment to continuous improvement.

Priorities will include the enhancement of workforce capacity and capability in some sectors, the development of community skills and capacity, and equipping people with the appropriate level of skills, competence and capability.

We recognise that an engaged and supported workforce underpins the delivery of our vision and that a key priority for the Strategic Plan is, therefore, the development of a supporting workforce development strategy.

10. Locality planning

In broad terms the role of localities should be to feed into the strategic planning and commissioning processes a collective view on what needs to be made available in respect of their locality and on an on-going basis consider proposals from local professionals, users and communities on ways to improve the delivery of services for the locality.

Through our Joint Strategic Needs Assessment we can clearly see differences in a wide range of outcomes and measures across the six area partnerships established in East Lothian and in more aggregated ways in the two localities we will plan for – the East and West of the county.

We now need to focus on these differences and introduce more localised conversations and more localised service provision to meet the needs of these populations.

We will further analyse our information at a local level and continue to develop more local solutions in the next iteration of the draft Strategic Plan. We will continue to consult on proposals through the area partnership networks in East Lothian in order to allow this level of discussion with local intelligence and local communities.

11. Good Governance

By its nature the Strategic Plan when finalised will provide a framework for the organisation's change agenda and any governance framework will need to monitor the phases of the plan from differing perspectives.

We will establish a clear governance structure and a system of performance management to support delivery of the Strategic Plan once agreed. This will be developed over the coming months and in advance of the establishment of the Health and Social Care Partnership.

In doing so it will be critical that the diverse range of stakeholders, particularly people who use our services, have a clear understanding and engagement in the change programme and where appropriate, focus groups will be established to guide and challenge the change programme on a regular basis.

12. Market Analysis and Provider Landscape

Based on a good understanding of need and demand, market analysis or facilitation is “the process by which strategic planners and commissioners ensure there is sufficient, appropriate service provision available to meet needs and deliver effective outcomes both now and in the future”. In essence it should provide a picture of the current state of supply and areas where partnerships would wish to see services develop.

No service can be commissioned without a proper overview of what is currently being provided, how well this is meeting local needs, and where the gaps lie. Mapping the market’s present capabilities to the resources available helps us meet local needs and deliver value for money. It informs the decision whether to maintain existing provision or adapt, develop, or transform service delivery altogether.

As the Strategic Plan develops we will complete this section which outlines the workforce and functions which deliver the services the Health and Social Care Partnership will have in scope and which we will plan and commission for.

13. Commissioning

Strategic commissioning will help us realise our vision for East Lothian through the way in which we design, develop and deliver improved and effective services that meet the needs of our changing population.

In developing this draft Plan we have already adopted a Strategic Commissioning approach in order to:

- Analyse and understand the evolving needs of our communities, so that we can shape the key strategic priorities that we are committed to deliver against.
- Plan, design, and deliver appropriate services to meet the needs of our communities and secure value for money.

We now need to complete the cycle for services in scope for the new Health and Social Care Partnership, particularly those new, delegated hospital services by:

- Do – Commissioning or directing both in-house (health and social care council) services and any relevant outside providers - from the independent, voluntary and community sectors.
- Review and validate what it is we are doing to deliver against our priorities.

We will complete the detail of this commissioning cycle over the coming months and after consultation with all our stakeholders. The next iteration of the draft Strategic Plan will outline this detail.

14. Strategic impact

Strategic impact evaluations gauge the success of a programme of work. The main purpose of strategic impact evaluation is to determine whether a programme has an impact (on key outcomes), and more specifically, to quantify how large that impact is.

As we further develop this Strategic Plan through consultation and engagement, and refine our priorities and work programmes we will ensure we work in tandem to embed an appropriate evaluation and measurement framework which captures a range of outcomes.

15. Equality Impact Assessment

We will carry out an equality impact assessment after two rounds of consultation and engagement on this plan and before any final iteration is prepared.

16. First Draft Consultation Questions and how to get in touch

Thank you for reading East Lothian Health and Social Care Partnership's first draft consultation Strategic Plan for adult services. To help ensure this plan meets the needs of adults using services within East Lothian, please answer the following questions.

You can write with your comments to the address provided at the end of this form (overleaf) or fill in the online questionnaire.

The consultation on this draft plan will be available on East Lothian Council consultation hub at https://eastlothianconsultations.co.uk/

and NHS Lothian Consultation zone at http://www.nhslothian.scot.nhs.uk/OurOrganisation/Consultations/Pages/default.aspx

Questions

Q1 Does this draft Strategic Plan address the most important issues for East Lothian?

The draft priorities for adult services are

Making universal services more accessible and developing our communities

Improving prevention and early intervention

Reducing unscheduled care

Providing care closer to home

Delivering our services in a more integrated way

Enabling people to have more choice and control

Optimising efficiency and effectiveness

Reducing health inequalities

Do you think these are the right ones for East Lothian?

Yes/No

If no, please give your reasons why not.

Q2. Have we missed anything that is really significant? If so, what?

Q3. We are planning to look at services in 2 localities within East Lothian. (The more rural community in the East of the county and the more urban community in the West)

Do you agree with this approach?

Yes/No/Don't know

If you don't agree with approach, please give reasons why not. Include any suggestions of an alternative approach.

Q4. Is there anything else you would like to tell us before we prepare the next consultation draft of this plan?

Please send this form by email to:consultations@eastlothian.gov.uk

or post to:

East Lothian Joint Strategic Plan Consultation
c/o Transformation and Integration Manager
East Lothian Health and Social Care Partnership
John Muir House
Brewery Park
HADDINGTON
East Lothian
EH41 3HA

Put indicate in box/es below if:

☐ You wish to receive an acknowledgement that your comments have been received.

☐ You wish to be sent a copy of the consultation on the next stage of the draft plan

Please give your name and contact address (email preferred) below

Name

Address/email address

Appendix 1 Glossary

A

A&E	Accident and Emergency Department
Access	The availability of NHS services – 'getting the care you need'.
Accountability	Everything done by those who work in the statutory sectors must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
Acute Care	Care provided by the larger general hospitals.
Acute Hospital	A hospital which provides a range of care that normally takes a short time to complete – e.g. accident and emergency, maternity, surgery, medical, x-ray, radiotherapy, and so on.
Acute Services	Medical and surgical treatment provided mainly in hospitals.
Admissions	When a patient is admitted to hospital
AHP	Allied Health Professional
Ambulatory Care	Services where people do not stay in hospital overnight e.g. outpatients, x-ray, day surgery and medical diagnostics
Assessment	Assessment of a person's health and social care needs. Considering the circumstances of an individual, family, group or community when looking at a future plan of action.

B

Beds	The number of beds in a ward or department which refers to staffed beds used overnight.
Bed blocking	(Also known as delayed discharge) where patients that are fit for discharge remain in acute hospital beds when other more suitable forms of care are not provided.
Benchmarking	A method used by public sector organisation, charities and private companies for gauging their performance by comparing it to that of other organisations, typically of a similar size.
BME	Black and Minority Ethnic groups
Business Plan	A plan setting out the goals of an organisation and identifying the resources and actions needed to achieve them.

C

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

Appendix 1 Glossary

Caldicott Standards	These are a set of standards that regulate the use of patient information throughout the NHS
Care Management	A system of organising care to vulnerable adults. It involves assessing needs, care planning, the organisation of care packages within available resources, monitoring and review and close involvement with service users and carers.
Care Pathways	The route that a patient will take from their first contact with an NHS member of staff (usually their GP), through referral, to the completion of their treatment. You can think of it as a timeline, on which every event relating to treatment can be entered.
Carer	One of six million informal carers that look after elderly, ill or disabled relatives or friends.
CHD	Coronary Heart Disease
CMHT	Community Mental Health Team
Clinical Audit	A cyclical evaluation and measurement by health professionals of the clinical standards they are achieving.
Clinical Governance	A framework through which NHS organisation are accountable for improving continuously the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.
Clinical Team	A clinical team may comprise doctors, nurses and other health staff who provide services of a particular type
Clinician	A health professional who is directly involved in the care and treatment of patients, for example, nurses, doctors, therapists.
Collaborative	Working in partnership across organisations and with various groups.
Co-morbidity	Term used to signify multiple illnesses
Commission / Commissioning	Process in which the service identifies local needs for services and assesses them against the available public and private sector provision Priorities are decided and services are purchased from the most appropriate providers. through contracts and service agreements. As part of the commissioning process services are subject to regular evaluation
Communities	Is a collective term referring to people who share identities, experiences or interests. This might include people living in the same locality, people sharing identities as members of a minority ethnic group or as disabled people, or people who share the experience of being a single mother or living in poverty.

Community Care	A network of services provided by social service departments of local authorities in conjunction with the NHS and volunteers. It supports old people, people who have mental health problems, or people who have learning disabilities, who might previously have been in a long stay hospital. Not to be confused with community health services.
Community Health Services	Care provided locally designed to keep people out of hospital and providing treatment in or near their homes. It is normally given by district nurses, health visitors, community midwives, and community psychiatric nurses, attached to general practice surgeries.
COPD	Chronic Obstructive Pulmonary Disease
Corporate Governance	The rules and regulations within which an organisation works to ensure probity and accountability.

D

Day case admission	Day case patients are admitted for care or treatment which can be completed in a few hours and does not require a hospital bed overnight.
Dashboard	One screen shot of information
Delayed discharge rate	The proportion of patients occupying a hospital bed and are ready for discharge.
Demographic Trends	Changes in age, sex and size of the population over time.
Deprivation	A measure of material poverty based on a number of criteria such as income, economic circumstances, environment etc…

E

Elective Care	Care that is planned in advance as a day case or inpatient.
Elective admission	A patient who is admitted from the waiting list.
Emergency admission	A patient admitted to hospital at short notice because of clinical need or because alternative care is not available.
EOL	End of Life
Executive Directors	Board level senior management employees of the NHS Trust who are accountable for carrying out the work of the organisation.

Appendix 1 Glossary

F

G

GDS	General Dental Services
GMS	General Medical Services – the UK-wide contract between general practices and primary care trusts for delivering primary care services to local communities.
GP	General Practitioner - doctor who usually with colleagues in partnership, works at a local surgery and provides medical advice and treatment to patients

H

Health Community, or Health Economy	A term used to embrace all the organisations, NHS and others, whose activities have an effect on people's health in a local area. It can include local authority function such as services, environmental health and transport, and housing associations, water suppliers, and voluntary organisations.
Health Inequality	The term used to describe the fact that people living in deprived areas usually have poorer health than people living in more affluent areas. This can also apply to differences in the health of the people of various ethnic groups.
Hosted	Responsible to a single statutory organisation but providing a service to a number of organisations.

I

IG	Information Governance - ensures necessary safeguards for, and appropriate use of, patient and personal information.
Integrated Care Pathway	Improving the patient's route for treatment through different health and social care systems by combining resources and co-ordinating working methods to prevent hold-ups and jams.
Integration Inequalities	In the context of this document, 'inequalities' refers to services which are not equally accessible by all geographical areas of client groups.
In-patient	A patient who has been admitted to hospital for treatment and is occupying a hospital bed.

Intermediate Care	Health care for patients who are not ill enough to be in an acute hospital and not well enough to be at home unsupported.

J

Joined up working	When organisations such as councils, the NHS and schools work together to identify and solve local problems, close gaps between public services and improve overall performance.
JSNA	Joint Strategic Needs Assessment – covering health and social care, the purpose of a JSNA is to pull together in a single, ongoing process all the information which is available on the needs of the local population and to analyse them in detail to identify: a) the major issues to be addressed regarding health and well-being, b) the actions that will be taken to address those issues.

K

KPIs	Key Performance Indicators

L

LA	Local Authority
LDP	Local Delivery Plan
Length of Stay	The time from admission to discharge, based on the number of nights in hospital.
LTC	Long Term Conditions - conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. They include diabetes, asthma, and chronic obstructive pulmonary disease.

M

MDT	Multi disciplinary Team. This is a team of professionals drawn from various disciplines within the Trust that combine their expertise to the benefit of patients.
MIU	Minor Injuries Unit

Appendix 1 Glossary

N

NHS Continuing Care	Care provided over an extended period of time to a person aged 18 or over to meet physical or mental health needs which have arisen as the result of disability, accident or illness.
NHS 24	24 hour advice about personal health care. Nurses give callers advice and reassurance or direct them to the service they need, calling an ambulance if necessary.
Nursing Home	A residential home that has qualified nursing staff to provide nursing care.

O

OD	Organisational Development
OOH	Out of Hours – primary care services normally provided by GPs in hours.
Out-patient	A patient who attends hospital for treatment, consultation and advice but does not require a stay in hospital

P

Palliative Care	The care of patients whose disease is no longer curable, for example cancer and motor-neurone disease. It takes into account the physical, psychological, social and spiritual aspects of care of patients, with the aim of providing the best quality of life for them.
Patients	People who are currently using or waiting for health services.
Primary Care	Health services delivered in or near to a person's home to which patients have direct access. These services include those provided in GPs' surgeries, health centres and community hospitals, or in patients' homes, by a team of professional staff including GPs, practice nurses, community nurses, therapists and others.
Primary Health Care Team	Professional staff working in or attached to general practices to provide a range of health care needs. Including GPs and community nursing staff.
Public	A term used to describe everyone who is not part of the organisation or the professional team. We are all members of someone else's 'public'.

Q

QOF	Quality and Outcomes Framework - introduced in 2004 as part of the General Medical Services Contract, the QOF is an incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement.

R

Referral patterns	These describe the number and frequency of patients referred to hospitals by GPs
Risk management	A systematic approach of identifying, analysing, evaluating, treating, monitoring and communicating risks associated with any activity, function or process.
ROI	Return on Investment – a performance measure used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments

S

SALT (S&LT)	Speech and Language Therapy
SCP	Strategic Commissioning Plan
Secondary Care	Patients whose needs are too complex to be managed in primary care are referred to more specialist services. Secondary care includes local hospitals and treatment given away from the hospital setting, such as mental health services, learning disability services and help for older people.
Service level agreements	Agreement between organisations and/or agencies setting out how services must be provided, what their standards will be and how monitoring will take place.
Service user	Anyone who uses or who has used a product or a service. This may mean current users or also include potential users.
Social Care	Social care services are normally run by local councils. Most of us are likely to become clients of social care services at one time or another but some of the main groups using the services include children or families who are under stress, people with disabilities, people with emotional or psychological difficulties, people with financial or housing problems and older people who need help with daily living activities.

Appendix 1 Glossary

Stakeholders	Anyone who has an interest in the way services are delivered, including service users, carers, patients, service providers, staff, health professionals and partner organisations, such as social services, district and borough councils and other community or voluntary groups.
Statutory Organisations	Organisations with powers to fund or provide services, such as local authorities and NHS Trusts.

T

Tertiary Care	Service provided by specialist hospitals which have diagnostic and treatment facilities not available at general hospitals, or given by doctors who are uniquely qualified to treat unusual disorders that do not respond to therapy available at acute hospitals. It can also include hospice care for people who are terminally ill.
Therapy services	These are provided by 'allied health professionals' who include dieticians, hearing therapists, occupational therapists, physiotherapists, podiatrists (chiropodists) and speech and language therapists.
TIA	Transient Ischaemic Attack – stroke

U

V

VTE	Venous thromboembolism

W

Whole System Approach	Term for a strategic, integrated approach to planning and delivering services. A local whole system of care covers all local health and social service provision and any other service that impacts upon health and social care.

X

Y

Z

Appendix 2

Partnership Prioritisation Framework

Impact

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

Evidence and Strategic Fit

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

Acceptability of possible changes

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

Feasibility

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

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

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

East Lothian
Health & Social Care
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