

# **West Lothian Integration Joint Board**

## **Strategic Plan 2016-26**

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## Foreword

This plan describes the strategic vision and direction for West Lothian Integration Joint Board (IJB) from 2016-26 to deliver positive outcomes for the people of West Lothian.

NHS Lothian and West Lothian Council have a long history of working in partnership to meet the health and social care needs of the people of West Lothian and has a well-earned reputation for delivering ground-breaking and quality-driven public services to local people. We will continue this tradition by bringing health and social care services closer together wherever possible and working in partnership to deliver more accessible, integrated and high quality services which are jointly planned and community focused.

This strategy addresses our vision **to increase wellbeing and reduce health inequalities across all communities in West Lothian**. The main challenges to improving health in West Lothian are the ageing population, persistent health inequalities, the continuing shift in the pattern of disease towards long term conditions and growing numbers of people with multiple conditions and complex needs.

We are fully committed to working with individuals, local communities, staff and our community planning and other partners to make effective use of all of our resources. To do this, the expertise, knowledge and skills of colleagues, along with input from service users, providers and other stakeholders, will all help to drive new and more innovative ways of working at a local level.

In order to tackle the challenge of reducing the health inequalities gap in West Lothian, we are strongly committed to the development of a preventative outcomes-based approach, with an emphasis on effective early interventions to tackle social inequalities and improve wellbeing in communities.

To this end our strategy focuses on prevention, early intervention and collaborative working to ensure services are planned, co-ordinated and evaluated on the delivery of outcomes; and resources are targeted to achieve the greatest impact on those most in need.

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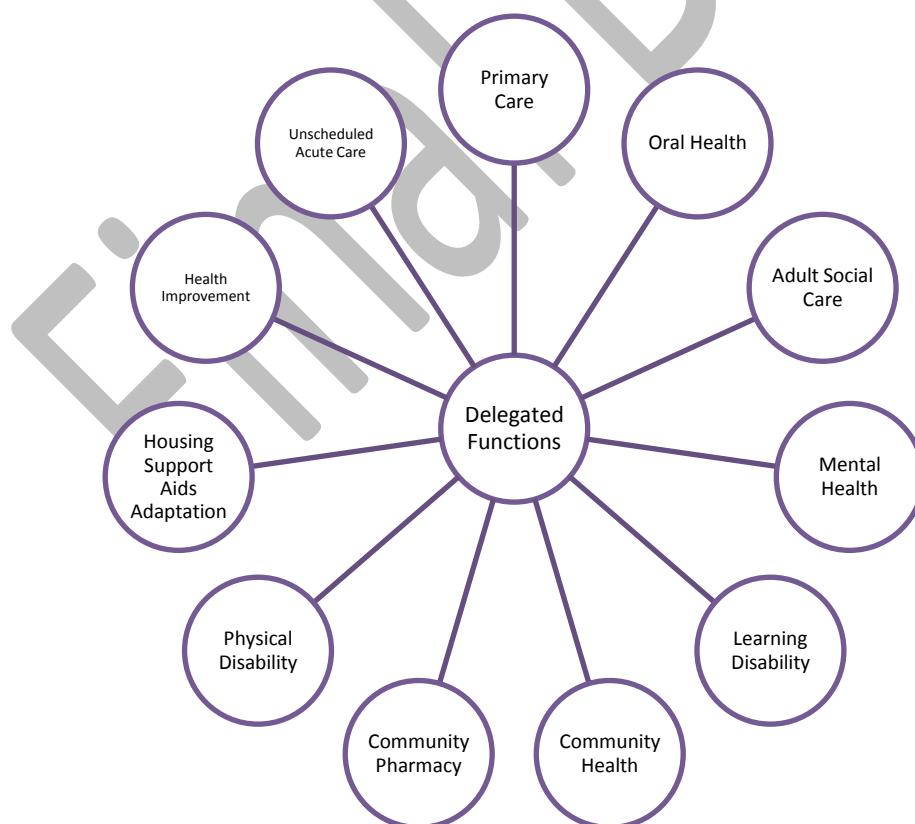
**Councillor Frank Toner**  
**IJB Chair**

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**Jim Forrest**  
**Director**

# 1 Introduction

- 1.1 It has been recognised both nationally and locally that whilst the health and care needs of individuals are closely intertwined, the services put in place to meet those needs can be disjointed and not as well coordinated as they could be. The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care in Scotland and sets out the requirements for public service reform and a bottom-up, outcomes-based approach to improve performance and reduce costs. The Act requires each Health Board and Local Authority to delegate some of its functions to new Integration Authorities. In West Lothian this is the Integration Joint Board (IJB).
- 1.2 The IJB is a separate legal entity from NHS Lothian and West Lothian Council and the arrangements for the IJB's operation, remit and governance are set out in the Integration Scheme which has been approved by West Lothian Council, NHS Lothian and the Scottish Government.
- 1.3 The IJB brings together the planning, resources and operational oversight for a substantial range of adult health and social care functions into a single system which will ensure services are built around the needs of patients and service users and supports service redesign with a focus on preventative and anticipatory care in communities. The functions to be delegated are summarised in figure 1 with the full list detailed in Appendix 1.



**Figure 1: Functions Delegated to the IJB**

- 1.4 Our Strategic Plan builds upon joint planning foundations established through our Community Planning and Health and Social Care Partnership under which joint strategies and plans have been developed and are being implemented for a range of services and client groups. The plan outlines our vision for health and social care services for the people of West Lothian; what our priorities are and how we will build on a foundation of strong partnership working to deliver them.
- 1.5 We are working within an environment where there are increasing demands for services and growing public expectations at a time of significant resource challenges and financial constraints. The recent and forecast demographic changes, alongside the short to medium term investment position, means we need to ensure that social care, primary care, community health and acute hospital services work well together and in a more integrated way with all our partners, including Housing and the Third and Independent Sectors to maximise our resources and deliver on our strategic priorities.
- 1.6 Tackling health inequalities has been prioritised at both a national and local level as an issue requiring urgent action. We recognise that health and wellbeing inequalities are not likely to be significantly changed by health policies or health services working in isolation. These inequalities require to be challenged by a “joined up” co-ordinated approach by a wide range of public services and we will continue to work with our partners to address these.
- 1.7 With responsibility for the strategic planning of some acute hospital care services including emergency care and inpatient services relating to general medicine, geriatric medicine and rehabilitation, we will identify opportunities to design and deliver services which ensure care is delivered in the right place, at the right time, by the right person.
- 1.8 We recognise the way health and social care services are delivered locally can have a significant impact on shifting the balance of care from hospital to community, reducing health inequalities and reducing emergency admissions. Through this strategic plan we aim to ensure:
- ✚ More care and support is delivered at home or closer to home rather than in hospital or other institutions
  - ✚ Care is person centred, with focus on the whole person and not just a problem or condition
  - ✚ There is more joined up working across professions and agencies
  - ✚ Citizens, communities and staff involved in providing health and social care services will have a greater say in how those services are planned and delivered.
- 1.9 In order to meet the challenges we will work together to create a culture of cooperation, coproduction and coordination across all partners and through working with people, their families and the wider community, we can create effective and sustainable solutions and achieve the best outcomes for the people of West Lothian.

### Strategic Scope

- 1.10 With a focus on achieving the best outcomes for people living in West Lothian we will build on our experience in commissioning a wide range of health and care services. The scope of the

plan includes

- ✚ Adult social care services
- ✚ Primary care and community health services
- ✚ Some Adult acute services
- ✚ Some NHS Lothian Hosted Services.

- 1.11 The plan covers the whole geographical area of West Lothian and as set out in the legislation<sup>1</sup> we have defined two localities across which our health and care services will be planned. The importance of the localities in determining the strategic direction of health and social care planning is reflected throughout the plan.

### Strategic Development

- 1.12 This Strategic Plan has been developed in conjunction with the IJB Strategic Planning Group with membership from key stakeholders including West Lothian Council, NHS Lothian, Third and Independent sectors, health and social care professionals, staff trade unions, and representatives of service users and carers.
- 1.13 The strategy aligns with Delivering Better Outcomes, West Lothian Council's Corporate Plan 2013-17; Our Health, Our Care, Our Future, NHS Lothian's Strategic Plan 2014-24; the Local Delivery Plan and our Commissioning Strategy and Care Group Commissioning Plans.
- 1.14 When commissioning services we will ensure we fulfil our statutory duty to achieve best value and will adopt a personalised approach when commissioning services to meet need. To achieve this, we will work closely with a range of strategic partners such as Housing, Building and Construction Services, Education and the Police as well as the Third and Independent sectors.

### Consultation

- 1.15 Consultation on the draft strategic plan has been undertaken between 1 November 2015 and 31 December 2015. The consultation included a wide range of stakeholders as well as users of the services commissioned by the IJB including
- ✚ Health professionals;
  - ✚ Users of health care and their carers
  - ✚ Commercial and non-commercial providers of health care;
  - ✚ Social Care professionals;
  - ✚ Users of social care and their carers;
  - ✚ Commercial and non-commercial providers of social care;
  - ✚ Non-commercial providers of social housing;
  - ✚ Third sector bodies carrying out activities related to health and social care.

Feedback from the consultation has been considered and used to inform the final version of the strategic plan.

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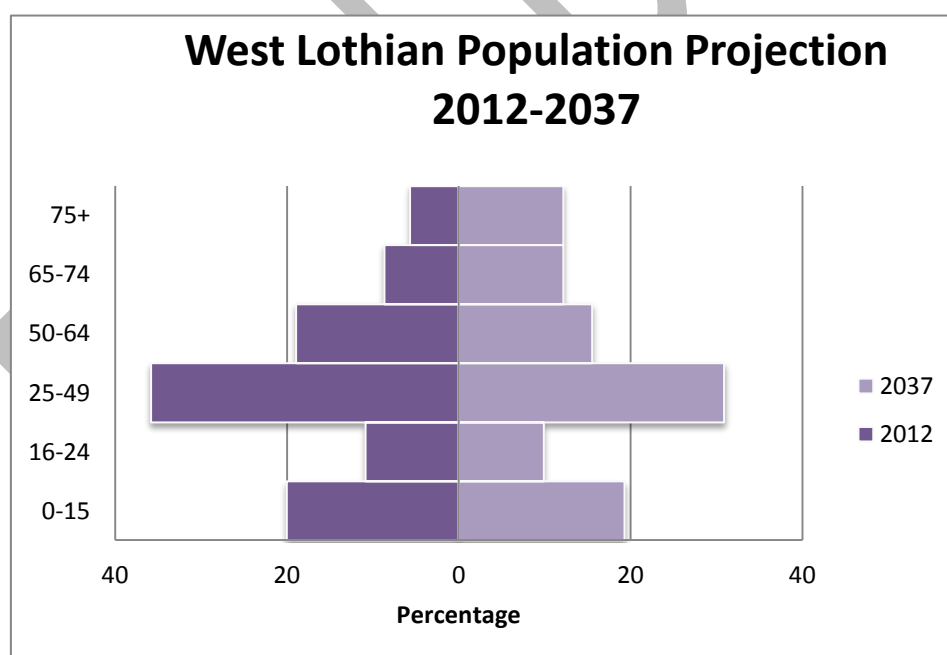
<sup>1</sup> The Public Bodies (Joint Working) (Scotland) Act 2014

## 2 Understanding Our Population's Needs

- 2.1 In preparing our plan we have undertaken a comprehensive review of all the health, social and economic data which is relevant to integration planning and the integration process. The following major key issues have emerged from the analysis of strategic needs.

### Population Projections

- 2.2 As of 2014 West Lothian had a population of 177,150<sup>2</sup> which accounts for 3.3% of the total population of Scotland. Of this population 19.8% were children (0-15 years), 59.4% were aged 16 to 59 years and 20.8% were aged 60 years and over. West Lothian's population is currently growing at a faster rate than the overall Scottish rate of growth and this trend is expected to continue over the lifetime of this plan.
- 2.3 It is estimated that West Lothian's overall population will increase by 12% from 175,990 in 2012 to 196,664 by 2037. However increases will not be seen across all age groups, in the 25 year period there will be an overall net reduction of 11.9% in persons aged 25-64, the mid to older working age group whilst there will be increases in the number of younger residents aged 0-15 (7.7%) and 16-24 (1.8%). However the growth in the older age groups will be the most significant with the 65-74 age groups increasing by 57%, and the over 75 age group increasing by 140%. (Figure 2).



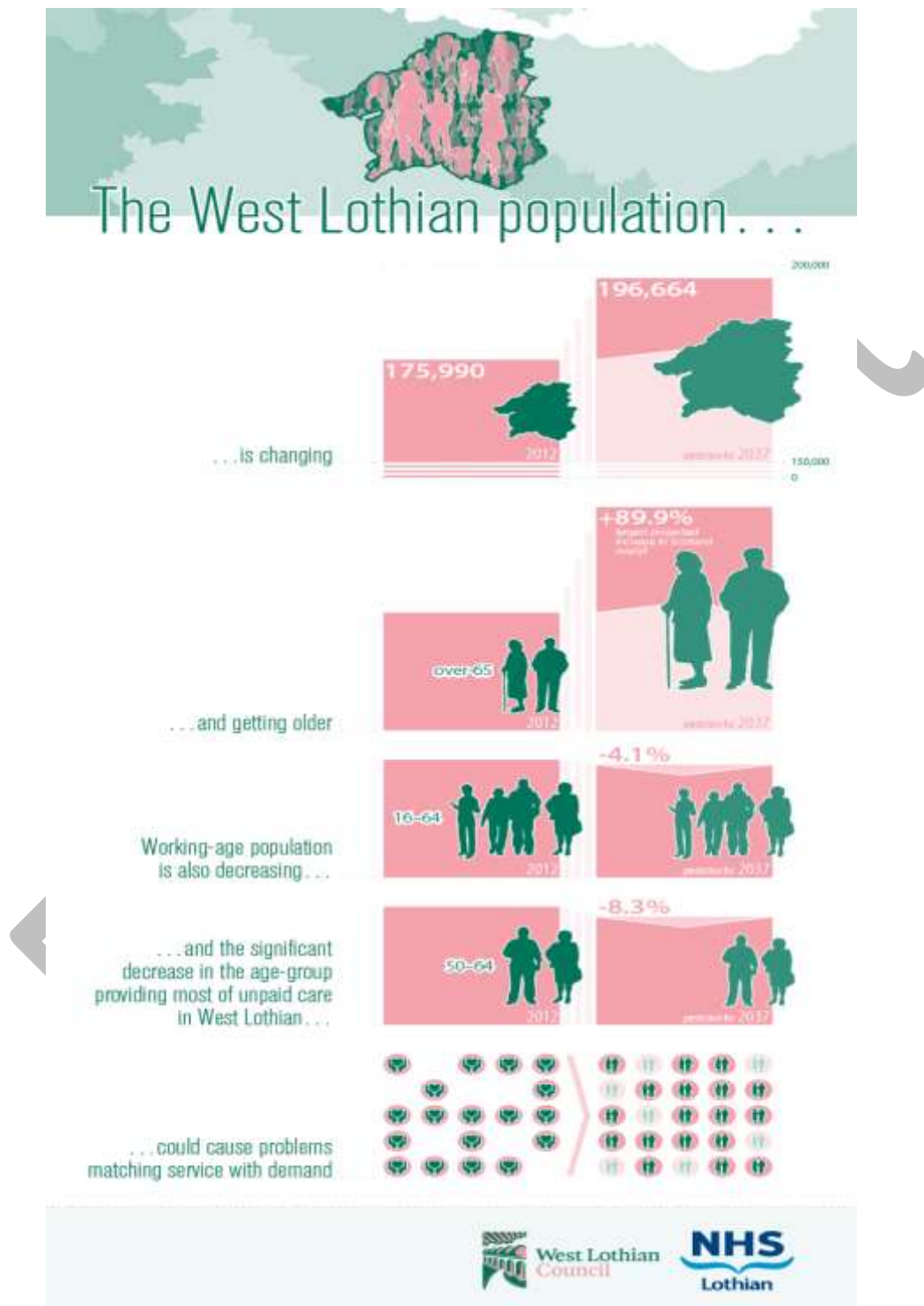
**Figure 2: Population Projections, 2012-2037<sup>3</sup>**

- 2.4 The projected increase in the over 65 age group is likely to place particular strain on both the

<sup>2</sup> Council Area Profiles; National Records of Scotland

<sup>3</sup> National Records of Scotland 2012-based Population Projections

NHS and social care services. Alongside the projected reduction in the working age population, and in particular the 50-64 age group who provide most of the unpaid care, these demographic changes will present a significant challenge for the provision of health and social care (Figure 3).



**Figure 3: West Lothian Population Projections & Impact**

(Source: Information Services Division (ISD) Scotland)



## Life Expectancy

- 2.5 Life expectancy at birth has increased among both males and females in the last 10 years with latest figures showing that babies born in West Lothian during 2012-14 can expect to live 77.9 years for males and 80.5 years for females. At age 65, females can expect to live for 19 years whilst males can expect to live for 17.5 years.
- 2.6 There are differences in life expectancy within West Lothian e.g. Life expectancy for women ranges from 87 years in Linlithgow to 76.6 years in Dedridge and for men from 82.6 years in Linlithgow to 74.9 years in Breich. The gap in life expectancy reflects wider socio-economic differences.
- 2.7 Healthy life expectancy is the number of years an individual is expected to live in good health. The difference between healthy life expectancy and life expectancy highlights the length of time an individual is expected to live in poor health. On average, males in West Lothian are expected to live for 12 years in poorer health while females are expected to live for 14 years in poorer health<sup>4</sup>.
- 2.8 Whilst healthy life expectancy (i.e. the length of time people live in a healthy way) has been increasing, overall life expectancy has been increasing faster. This means people are living longer but in the final years of life are more likely to experience complex and inter-related problems in their physical and mental health and are the most frequent users of health and social care services.

## Long Term Conditions, Multiple Conditions and Complex Needs

- 2.9 Over a third of people living in West Lothian report living with one or more long term condition<sup>5</sup>. A long term condition is any condition which has lasted or is expected to last at least 12 months. At the 2011 Census the majority (83%) of West Lothian's population rated their general health as "very good" or "good" however over a third (35%) reported that they had one or more long term health condition. The presence of one or more long term condition increased significantly with age and had a direct impact on the person's perception of their general health with only 5.6% of those over 85 years reporting they were in "very good health" .
- 2.10 West Lothian's carers are providing more care. 9.5% of the census population reported that they provided regular unpaid help or care to someone either within or out with their household due to the person's long term health condition, disability or problems relating to old age. This is a similar proportion to the national average of 9.3% and has not changed since the 2001 Census. However there has been a significant increase (35%) of the amount of care provided with nearly 7,800 people providing unpaid care for 20 or more hours a week and 4,600 of these for 50 hours or more<sup>6</sup>.

<sup>4</sup> ScotPHO LE/HLE estimates based on self-assessed health from the 2011 Census December 2015

<sup>5</sup> Census 2011

<sup>6</sup> Vocal <https://www.vocal.org.uk/.../JointPressRelease202014.pdf>

- 2.11 More people will be affected by dementia in future. The World Health Organisation states that “Dementia is one of the major causes of disability and dependency among older people worldwide” and that “dementia has physical, psychological, social and economical impact on care givers, families and society”<sup>7</sup>.
- 2.12 In West Lothian it is estimated that at 2013 there were 2101 people affected by dementia<sup>8</sup>. With more people living longer, this figure is predicted to increase over the next 15 years by approximately 40%. The impact of this increase in the number of people affected by dementia, on the people themselves, their carers and families, and on services providing care and support cannot be underestimated.
- 2.13 Almost all people who die (sudden deaths aside) are likely to receive some end of life care in the last year of life from general practice, community or social care staff. Future demands on services will be associated not only with a rise in the number of deaths due to the growth in our older population but also with increased care complexity due to multimorbidity and an increasing focus on palliative care.
- 2.14 The percentage of the last 6 months of life spent at home or in a community setting focuses on measuring the impact of “Living and Dying Well: A National Action Plan for Palliative and End of Life Care in Scotland”. It focuses on producing achievable and measurable changes which will ensure quality improvement and enhance patient and carer experience. In West Lothian we have seen a steady increase in the proportion of the last 6 months of life spent either at home or in a community setting between 2007/08 where it was 87.8% to 91.1% in 2013/14 demonstrating an increase in community care provision and decrease in the time spent in acute hospital settings.

### Health Inequalities

- 2.15 Inequalities in health outcomes between the most affluent and disadvantaged members of society are longstanding, deep-seated and difficult to change. The physical, mental and social wellbeing of the local population is influenced by the wider determinants of health; these include material deprivation, employment/unemployment, education, housing and the environment.
- 2.16 Not everyone experiencing health inequalities lives in the most deprived areas. A range of issues can have an impact including income, work conditions, education and skills, living conditions, as well as individual characteristics and experiences such as age, gender, disability and ethnicity.
- 2.17 West Lothian has a higher proportion of people living in the most deprived areas than other

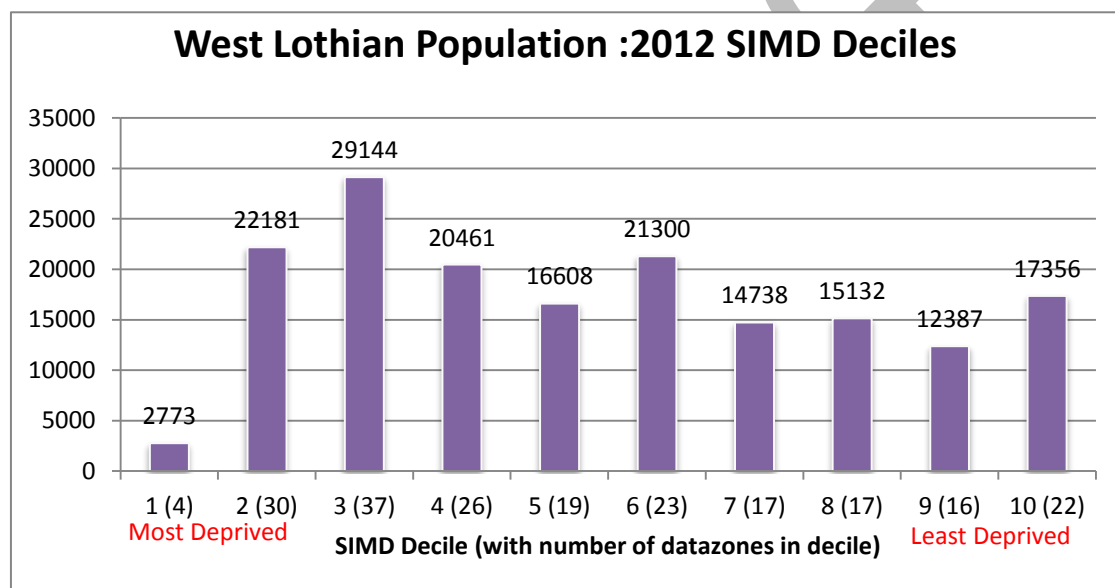
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<sup>7</sup> World Health Organization and Alzheimer’s Disease International, Dementia A Public Health Priority

<sup>8</sup> Alzheimer Scotland Action on Dementia: Statistics: Number of people with Dementia in Scotland 2013

parts of Lothian and for almost every health indicator there is a clear gradient showing progressively poorer health with decreasing affluence and influence.

- 2.18 The Scottish Index of Multiple Deprivation (SIMD) is an area-based measure of deprivation which ranks all datazones in Scotland from 1 (most deprived) to 6,505 (least deprived) and is the Scottish Government's official tool for identifying areas of multiple deprivation
- 2.19 West Lothian has 211 datazones, 13 of which fall within the worst 15% of the 2012 SIMD. As West Lothian also has a number of datazones which fall slightly short of the worst 15% we have considered the ranking in terms of deciles (tenths), with decile 1 being the most deprived and decile 10 being the least deprived (Figure 4)



**Figure 4 Distribution of West Lothian Population in 2012 SIMD Deciles<sup>9</sup>**

- 2.20 SIMD pulls together data on 7 indicators: Employment; Income; Health; Education; Access; Crime; Housing. Each of these indicators are given their own individual ranking which makes it possible to compare different geographies based on individual indicators (Table 1)
- 2.21 Examination of the SIMD reveals that health is the worst indicator for West Lothian with 38 datazones falling within the worst 15% in Scotland compared to only 13 in the overall ranking. 3 of the datazones are within the worst 5% in Scotland for health: 2 in Craigshill and 1 in Bathgate East. Bathgate East (S01006416) is the worst ranked datazone overall.
- 2.22 It is well recognised that health and wellbeing inequalities are not likely to be significantly changed by health policies or health services working in isolation. Building individual and community resilience to cope with everyday challenges and support improved health and wellbeing is most likely to attain the greatest benefit. The starting point is to identify the assets that exist in both individuals and communities.

<sup>9</sup> SIMD 2012

Indicator	No. West Lothian Datazones in the worst 15% in Scotland 2012	Comments
<b>Employment</b> (SIMD Weighting 28%)	16	Blackburn (S01006350) at rank 338 is lowest ranked West Lothian datazone
<b>Income</b> (SIMD Weighting 28%)	13	Bathgate East (S01006416) at rank 313 has the lowest income in the area.
<b>Health</b> (SIMD Weighting 14%)	38	3 datazones: Bathgate East (S01006416), Craigshill (S01006401 and S01006402); fall within the bottom 5%. A further 20 datazones fall within the bottom 10%. Bathgate East (S01006416) ranks the lowest for health in West Lothian and 109 <sup>th</sup> out of 6505 in Scotland
<b>Education</b> (SIMD Weighting 14%)	20	Blackburn (S01006349) for education
<b>Access</b> (SIMD Weighting 9%)	20	Breich Valley (S01006295) is the lowest ranked datazone
<b>Crime</b> (SIMD Weighting 5%)	22	Bathgate East (S01006416) & Howden (S01006361) rank very low at 34 <sup>th</sup> and 60 <sup>th</sup> in Scotland. 8 datazones fall within the worst 5% in Scotland and a further 5 within the worst 10%
<b>Housing</b> (SIMD Weighting 2%)	0	No datazones in the worst 15%
<b>Table 1</b>		Source SIMD 2012 Analysis ISD

- 2.23 There is increasing evidence that using an asset based approach can enhance the quality of collected information by focusing on the perceptions held by local people. This leads to the development of support for what people themselves say they need. This approach encourages a partnership approach which involves local people in decision making about service delivery and empowers them and increases independence rather than being passive recipients of services.
- 2.24 Within West Lothian the Community Planning Partnership has identified eight local regeneration areas. For each of these areas a local regeneration plan will be developed and implemented to tackle deprivation and inequality utilising asset based, community development approaches.

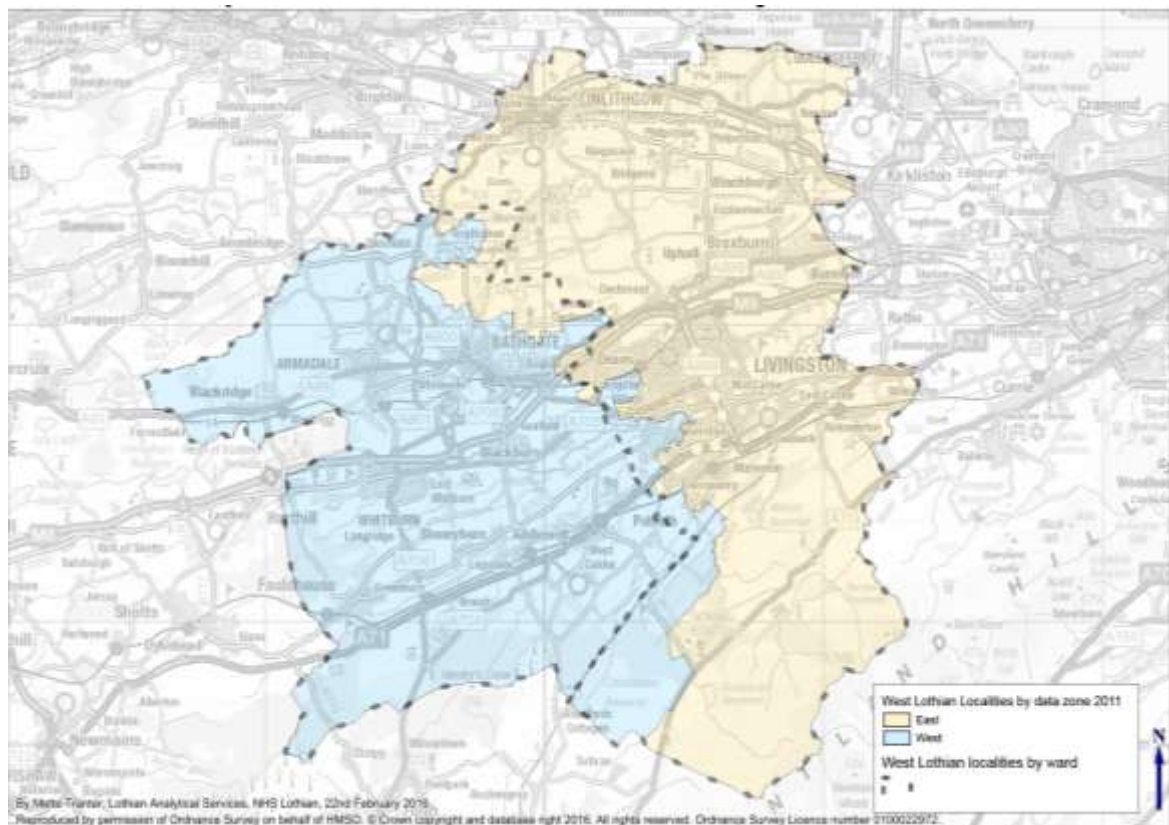
### Locality Planning

- 2.25 This plan covers the geographical area of West Lothian and in accordance with the legislation<sup>10</sup> we have defined two localities across which health and social care services will be planned and

<sup>10</sup> Public Bodies (Joint Working) (Scotland) Act 2014

delivered (Figure 5). The localities will provide a key mechanism for strong local, clinical, professional and community leadership, ensuring that services are planned and led locally in a way that is engaged with the community and contributing to effective strategic commissioning.

- 2.26 In line with the Scottish Government's guidance the localities have been built up from the 2011 datazones to support data capture for planning purposes and aligned as best fit to General Practice (GP) populations and multi-member wards to support development of integrated models around GP Practice clusters and communities.



**Figure 5: Map of East and West Localities<sup>11</sup>**

- 2.27 The West locality contains most of the former coalmining and heavy industrial areas of West Lothian, and shows the continuing impact of these industries and the processes of deindustrialisation and long term unemployment which took place from the 1980s onwards. There are 11 GP practices within the locality and it is aligned to four multi-member wards: Armadale and Blackridge; Bathgate; Whitburn and Blackburn; Fauldhouse and Breich Valley. The Community Planning Partnership has identified 5 local regeneration areas within this locality: Boghall, Whitburn, Blackburn, Armadale and clusters within Fauldhouse and Breich Valley.
- 2.28 The East locality has a considerably larger population whose age profile is increasing more rapidly than the West. A key factor affecting this growth was the establishment of Livingston as a New Town in 1962 and corresponding increase in the working age population. This

<sup>11</sup> Lothian Analytical Services 2015: Ordnance Survey, HMSO 2015

population have now grown older at the same time contributing to a significant demographic change. There are 12 GP practices within the locality and it is aligned to five multi-member wards: Linlithgow; Broxburn, Uphall and Winchburgh; East Livingston and East Calder; Livingston North; Livingston South. The Community Planning Partnership have identified 3 local regeneration areas within this locality: Craigshill, Livingston Central (spine of Livingston North & South, includes datazones in Knightsridge, Dedridge and Ladywell) and Bridgend (to be confirmed) Figure 6 provides a summary of the characteristics of the two localities<sup>12</sup>.



**Figure 6 Summary of Locality Characteristics** (NHS Lothian Analytical Services & ISD)

<sup>12</sup> NHS Lothian Analytical Services and ISD



- 2.29 In general, the issues of an ageing population, poor health, deprivation and unemployment are more significant in the West than in the East<sup>13</sup> with differences in life expectancy, life chances and health and wellbeing. It is also important to recognise for planning purposes that significant differences also exist within localities, not just between the East and West.
- 2.30 Although the West Locality continues to have a larger overall proportion of older people it is noted that there are higher rates of emergency bed days (75+ age group), multiple emergency admissions (65+ age group) and emergency admissions due to falls in the East Locality.
- 2.31 The way health and social care services are delivered locally can have a significant impact on addressing the main health and wellbeing challenges. To ensure the quality of localities' involvement in strategic planning Locality Groups will be formed with the direct involvement and leadership of:
- Health and social care professionals involved in the care of people who use services
  - Representatives of the housing sector
  - Representatives of the third and independent sectors
  - Carers and patients' representatives
  - People managing services.
- 2.32 The views and priorities of the localities will be taken into account in the development of Strategic Commissioning Plans therefore it is essential that strategic and locality level planning work together to create the best working arrangements to enable them to take account of local and deep rooted issues such as inequalities and poverty.
- 2.33 Each Locality Group will develop a locality plan, which will take account of community plans and local regeneration plans within the localities. It is anticipated that locality plans will build upon the insights, experiences and resources in localities to support improvements in local networks, enable development of robust and productive professional relationships and improve health and wellbeing outcomes

## Summary

- 2.34 Our analysis shows that people in West Lothian are living longer. Whilst this is good news, it provides challenges in terms of an ageing population and the incidence of frailty, including dementia and other long term conditions. In addition there are differences in life expectancy and deprivation factors across our localities which can impact on health and wellbeing.

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<sup>13</sup> Population data: National records Scotland 2013 Mid Population estimates by Datazone

### 3 Vision, Values and Outcomes

#### Vision

- 3.1 The Scottish Government's vision for the integration of health and social care is  
 "To ensure better care and support for people, where users of health and social care services can expect to be listened to, to be involved in deciding upon the care they receive and to be an active participant in how it is delivered. This will result in better outcomes for people, enabling them to enjoy better health and wellbeing within their homes and communities."

Recognising the different needs of vulnerable groups when designing and delivering services and ensuring all adults are able to live the lives they want as well as possible, achieve their potential to live independently and exercise choice over the services they use are key elements of our vision **"To increase wellbeing and reduce health inequalities across all communities in West Lothian"**.

- 3.2 Providing integrated care that crosses the boundaries between primary, hospital and social care is a goal of health systems worldwide. Through working with people in their own communities and using our collective resources wisely we will transform how we deliver services to ensure they are high quality, safe, effective, based on achieving personal outcomes and delivered in a way which enhances the health and wellbeing of the people of West Lothian.

#### Values

- 3.3 The Health and Social Care Partnership have an agreed set of values which take account of the values of both NHS Lothian and West Lothian Council. The values underpinning our approach in the planning and delivery of services include:

- ✚ Putting people who use services at the centre of what we do
- ✚ Making services available and accessible across all communities of West Lothian
- ✚ Providing joined-up services as near to where people live as possible
- ✚ Supporting people to do as much as possible for themselves
- ✚ Focusing on fairness and support those with the greatest needs
- ✚ Making health improvement part of everyone's job
- ✚ Supporting staff who deliver services
- ✚ Involving the public more and making service provision more accountable
- ✚ Strengthening accountability
- ✚ Continually improving quality and efficiency.

#### Outcomes

- 3.4 We have developed and designed our Strategic Plan to deliver the nine national health and wellbeing outcomes for integration. These are high-level statements of what health and social care partners are attempting to achieve through integration; through the pursuit of quality improvement across health and social care; and through focussing on the experiences and quality of services for service users, carers and their families.



### Nine National Health and Wellbeing Outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
3. People who use health and social care services have positive experiences of those services, and have their dignity respected
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5. Health and social care services contribute to reducing health inequalities
6. People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing
7. People who use health and social care services are safe from harm
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9. Resources are used effectively and efficiently in the provision of health and social care services

3.5 Our outcomes are also informed by the Single Outcome Agreement and in particular:

- Older people are able to live independently in the community with an improved quality of life
- We live longer healthier lives and have reduced health inequalities
- People most at risk are protected and supported to achieve improved life chances.

Our priority outcomes are outlined in figure 7 along with our approach and the enablers which will support achievement of our objectives.



Figure 7 Priority Outcomes for IJB and Approach

## Approach

- 3.6 Key elements to reduce the health inequalities gap and improve wellbeing include a focus on early intervention and prevention and ensuring care pathways are person centred. Through adopting a personal outcomes based approach in delivery of our services we will ensure our services put service users and their carers at the heart of our support and through conversation with them we will seek to understand the extent to which they are achieving the outcomes important to them in their lives. We will further develop integrated teams and systems to support delivery of seamless frontline services.

## Corporate Plans

- 3.7 Sitting alongside the IJB's Strategic Plan are *Delivering Better Outcomes*, West Lothian Council's Corporate Plan 2013-17: and NHS Lothian's Strategic Plan, *Our Health, Our Care, Our Future* (figure 8)



**Figure 8: Summary of Corporate Plans**

## Organisational Development

- 3.8 There are many component parts which are crucial to delivering an integrated health and social care system for the people of West Lothian. As set out in the preceding sections there are a number of challenges facing the organisation and in order to develop our capabilities and maximise the opportunities integration of health and social care brings we have identified development priorities (Figure 9)



**Figure 9: Current Challenges and Development Priorities**

- 3.9 Building on our strong foundation of successful partnership working across health and social care boundaries we will ensure:
- Services are developed and delivered more innovatively and effectively; bringing together those who provide community based health and social care.
  - Services are designed and shaped to meet local needs and priorities
  - Integration of health and social care services, both within the community and with specialist services, is underpinned by service redesign, clinical and care networks and by appropriate contractual, financial and planning mechanisms.
  - Health improvement activity is focussed in local communities, tackles inequalities and promotes policies that address poverty and deprivation by working within community planning frameworks.
  - Involvement of, and partnership with staff, trade unions and professional bodies, including

those staff who are contracted to the NHS, as well as those who are directly employed by the NHS and the Local Authority.

- ✚ We secure effective public, patient and carer involvement by building on existing and developing new, mechanisms.

## Our Workforce

- 3.10 Delivering health and social care services involves a large workforce across all sectors and presents both challenges and opportunities in terms of workforce planning and development.
- 3.11 Harnessing the experience and skills of professionals on the frontline along with that of our partners and colleagues from across the statutory, third and independent sectors will be key to achieving our ambition and it is essential we make sure that those working in health and social care are equipped to make best use of their collective skills and resources to improve outcomes for individuals.
- 3.12 We recognise that success is dependent on a combination of working arrangements operating within and across partner agencies and in terms of workforce planning and development this requires us to take into account:
- ✚ The changing philosophy and culture of care
  - ✚ Realignment of skills and staff working differently
  - ✚ The ageing profile of our workforce which may result in significant numbers reaching retirement age at the same time
  - ✚ The future workforce may require supported entry routes and seek different working patterns from those traditionally found in health and social care sectors
  - ✚ Competition from other sectors and industries as well as other local authorities and NHS areas
  - ✚ Recruitment can be to the detriment of other parts of our health and social care system – i.e. we are all competing for the same workforce.

Potential solutions to these challenges include:

- ✚ Making employment opportunities attractive to the potential workforce
  - ✚ Development of clear structures with opportunities for career progression
  - ✚ Aligning, matching, developing and coordinating our skills and workforce
  - ✚ Developing a more generic care assistant role with transferable skills to work across the partnership.
- 3.13 For health and social care integration to be successful individuals, teams and organisations will need to develop new ways of working together and this will be underpinned by strong leadership, evolving management arrangements, processes and relationships.
- 3.14 The development of the organisation and workforce will be an iterative process to reflect strategic developments and respond to local needs and availability of resources.

## Partnership Working

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

## Partnership with our workforce

- 3.16 The changing nature of adult health and social care is complex and challenging. As outlined in the previous section we will seek to ensure that our workforce is motivated, knowledgeable and skilled and able to respond to the changes we envisage. Critical to delivering this Strategic Plan and making it real is the need to explicitly involve, support and develop our workforce. We will, therefore, continue to develop our plans in partnership with our staff and their representatives to ensure they are fully engaged and able to contribute to the design and delivery of health and social care integration.

## Partnership with our service users and carers

- 3.17 The idea that people should have a stronger voice in decisions about their health and care, and that service should better reflect their needs and preferences, has been a policy goal for many years. Evidence shows that when service users are involved in planning, decisions are better, health and health outcomes improve, and resources are allocated more efficiently.
- 3.18 We recognise we need to promote and emphasise the need for greater personalisation of care and support for people closer to their own communities.
- 3.19 Personalisation means recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. Personalised approaches such as self-directed support involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives. People need access to information, advocacy and advice so they can make informed decisions.
- 3.20 Personalisation is also about making sure there is an integrated, community based approach for everyone. This involves building community capacity and local strategic planning and commissioning so that people have a good choice of support regardless of age or disability.
- 3.21 *Self-Directed Support: A National Strategy for Scotland* has been developed to help take forward and embed this person centred approach in the delivery of health and social care services. We will embed this approach in all our planning and commissioning. The growing emphasis on personalisation and personal outcomes has significance for those who work in or with health, social care and support services and for the skills they will require in undertaking new functions and tasks. The development of our workforce to recognise and support a personal outcomes approach is crucial and we will address this through our Organisational Development Plan.

### Partnership with localities and communities

- 3.22 Scottish Government's Public Service reform agenda is based upon the 'Four Pillars' of Reform – Place, Prevention, Performance and People. This agenda proposes a new relationship between citizens and public services in which communities and individuals are empowered to take a real stake in the planning and delivery of public services in a way which best meets local needs and priorities. As detailed in section 2 the health and care needs of each locality will be a major driver for shaping the way in which services and resources are planned and delivered, working with local stakeholders and communities.

### Partnership with the Third (Voluntary) Sector

- 3.23 The third sector has a crucial role to play in our health and social care system. We currently commission services from a number of third sector organisations and through a range of means, including for example: by joining up and activating diverse parts of the third sector to support health and social care outcomes; joint commissioning and supporting the exploration of the development of the their role in enhancing prevention, self-management and co-production; we can improve the sustainability of our care system.

### Partnership with the Independent Sector

- 3.24 The Independent Sector includes both Care Home and Care at Home providers and are key partners in health and social care provision. Overall the independent sector has become the largest provider of social care delivery across Scotland and the assurance of delivery of quality care through the sector and the need to support this is an important consideration. We will continue to work with the Independent Sector to build on existing relationships and to consider models of care which support the Strategic Plan, offer real choice and value for money and to deliver and develop the high quality care that communities require and deserve.

### Partnership with Independent Contractors

- 3.25 **General Practice** is patient focussed with an emphasis on positive outcomes for the individual. GPs and practice staff play an essential role in anticipatory care; preventing hospital admission; and maintaining people with complex needs at home for as long as possible. Health and social care integration offers the opportunity for a renewed focus on the central role of primary care teams and how we develop and commission services around localities.
- 3.26 Our localities are made up of a number of primary care populations and GP practices have started to come together to discuss how they might organise themselves into clusters to support the development of new models and deliver services and care plans in partnership with local statutory and non statutory providers in care and local communities. This will help to build a different relationship with local communities and a shared understanding of the local care priorities.
- 3.27 **Community Pharmacies** play an important role in our health care provision being placed in the heart of our communities and offering a wide range of contracted services including acute



prescriptions, minor ailments, public health and chronic medication as well as enhanced care to, for example, palliative care patients, those with complex medication regimes and substance misusers.

- 3.28 Under the Scottish Government's *Prescription For Excellence* pharmacists will develop their role, working across acute, primary care and community services and will provide more clinical care in communities. This will enhance the General Practice capacity with potential for post diagnostic caseloads to be allocated to pharmacists to optimise their complementary skills and support those with long term conditions.
- 3.29 There is good access to an NHS **dentist** for people living in West Lothian with 84.4% of adults registered with a dentist (March 2015). A positive improvement in oral care and oral health means more people are keeping their natural teeth. However tooth decay and gum disease are still two of the commonest diseases in the world; together with mouth cancer these diseases continue to present major public health challenges and as with other health problems these diseases are more common in those from more disadvantaged sections of the population. The key priorities for dental provision in West Lothian include:
- ✚ Improving registration and participation rates.
  - ✚ Reducing unregistered patients attending for pain to Out Of Hours care through encouraging registration and routine attendance.
  - ✚ Improving access to dental care for vulnerable groups and rolling out the 'Caring for Smiles' and other programmes developed nationally for local implementation.
  - ✚ Prevention of oral cancer through encouraging dental teams to promote stop smoking services and deliver brief interventions on alcohol.
- 3.30 Community **optometrists**, along with other independent contractors, are an important part of primary health care, providing a service which is accessible, convenient and flexible. Optometrists play a key role in the prevention of sight loss and also in the management of those with sight loss. The importance of optometrists in providing regular eye health checks and their role in early intervention, detection and prevention of sight loss is valued.

### Partnership with Community Planning

- 3.31 The broad aim of community planning is to improve outcomes for the people and communities across West Lothian by ensuring that public services work in a more integrated and effective way. The IJB has a key role within the Community Planning Partnership (CPP) to deliver specific Single Outcome Agreement results and will establish robust arrangements with the CPP and its thematic groups to ensure the delivery of shared objectives.

### Partnership with other Integration Joint Boards



- 3.32 NHS Lothian provides services across four Integration Joint Boards - West Lothian, East Lothian, Midlothian, and the City of Edinburgh. Within West Lothian we will be responsible for delivery of some health services on a pan Lothian basis on behalf of these other partnerships and therefore our local plan must take cognisance of the other Lothian plans in order to ensure maximum effectiveness and best use of resources.

### Hosted Services

- 3.33 Each IJB in Lothian hosts or manages a range of services provided on a pan Lothian basis on behalf of the other IJBs. Embedding effective two way working relationships and communication with all hosted services and host IJBs is paramount, not only to influence strategic planning and redesign but to ensure the right services are developed and delivered for people in West Lothian. We will actively work with NHS Lothian and our neighbouring IJBs to ensure optimal influence and impact.

### Partnership with NHS Acute Sector

- 3.34 St John's Hospital is one of NHS Lothian's 4 major hospital sites, and provides the majority of hospital unscheduled care services for the residents of West Lothian which are to be strategically planned by the IJB going forward. This includes;

-  Emergency department;
-  Medical emergencies, including respiratory, stroke, diabetes, and chronic heart disease.

St John's Hospital also provides services for the whole of the Lothian region and in some cases for patients from Fife and the Borders too.

- 3.35 The future emphasis is on ensuring that patients are cared for in the right place at the right time. This means an increased focus on avoiding hospital admission, and keeping people in their homes where it is safe to do so. This will require investment in services that manage chronic diseases in the community and in providing an improved pathway for patients who are frail, with multiple chronic and acute illnesses. This will also require development of strong partnership working between GPs, social care, and the hospital sector.

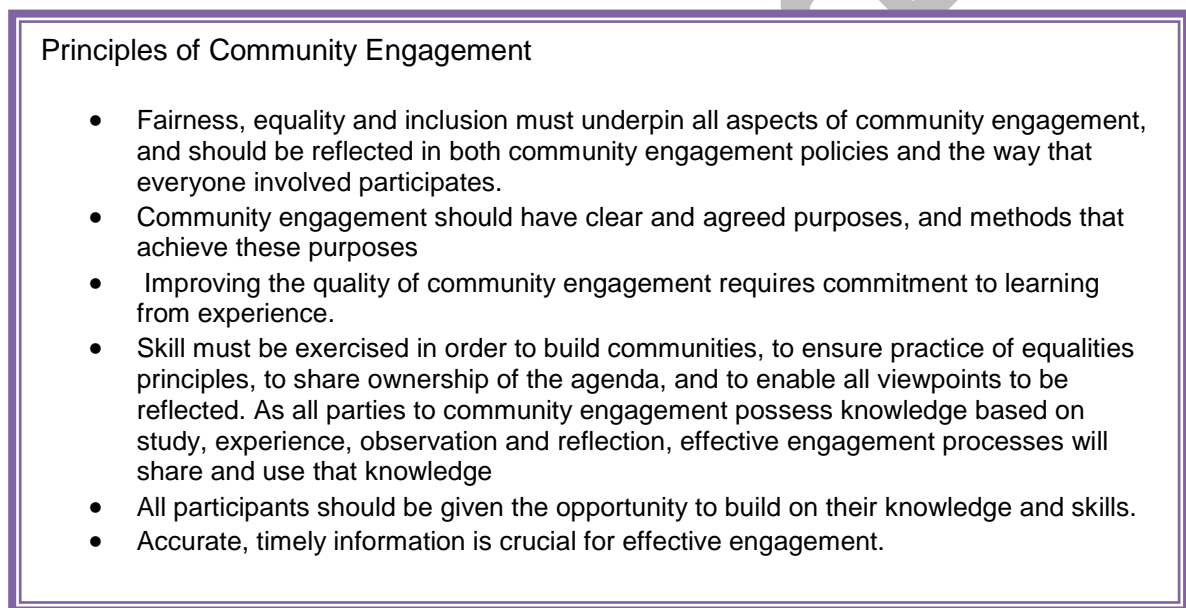
### Housing

- 3.36 Health and social care integration is not just about health and social care services and some housing functions will become part of our integration arrangements. Housing is widely recognised as an essential feature of health and wellbeing with social housing providers providing a critical link to the wider community, having a strong neighbourhood management role and delivering on a variety of projects that contribute to individual and community wellbeing.
- 3.37 Housing Support Services and Aids and Adaptations will be delegated to the IJB and other housing services will be closely aligned to health and social care, including sheltered housing, housing with care and supported housing, housing options information, advice and homelessness, services to address fuel poverty.
- 3.38 Housing can make a particular contribution to the achievement of the nine national health and wellbeing outcomes and this is more fully explained in the Housing Contribution Statement in Appendix 3.



## Participation and Engagement

- 3.39 There is general recognition at both a national and local level that communities are the engine house for delivering transformation and in order to realise our vision, the planning and delivery of services must take account of needs at a local level.
- 3.40 Our Participation and Engagement Strategy brings together NHS and Council Social Policy engagement activity within a single unified systematic approach which will improve standards of engagement and involvement across all services and staff groups, with the goal of improving outcomes for patients and service users. This is underpinned by the principles of community engagement (figure 10).<sup>14</sup>



**Figure 10 : Principles of Community Engagement**

- 3.41 Engaging the population is fundamental to building resilient individuals and communities. Effective involvement helps to ensure that services are responsive to need and are developed in a way which ensures that they are accessible and acceptable and, thereby, reduces non-attendance and subsequent costs. Involving people in decisions about them and having control can boost self-confidence and self-efficacy as well as improving decision making.
- 3.42 We recognise that to work and engage effectively and meaningfully with communities:
- ✚ Takes a significant investment of time and resources;
  - ✚ Must be maintained over the longer term to be effective; and
  - ✚ Requires a specific skill set to undertake this effectively.
- 3.43 There are many mutual benefits to be gained since engagement, inclusion and participation are key to the development of our local plans as is an ethos of openness and transparency.

<sup>14</sup> Communities Scotland (2005) National Standards for Community Engagement

- 3.44 To ensure engagement results in improvements appropriate tools such as VOiCE<sup>15</sup> (Visioning Outcomes in Community Engagement) will be used to plan, implement and review the effectiveness of the engagement, with feedback to stakeholders being a key element of the engagement process.
- 3.45 We will build on the Investors in People (IIP) standard with which both NHS Lothian and West Lothian Council are separately accredited to support staff engagement. This will enable us to
- ✚ improve our performance through the workforce,
  - ✚ develop effective strategies for learning and development,
  - ✚ promote effective leadership and management;
  - ✚ recognise and value our workforce's contribution,
  - ✚ Involve our workforce in decision-making and
  - ✚ measure the impact of workforce engagement activity.

### Quality Improvement

- 3.46 The importance of effective and efficient services has never been greater for the public sector. We will use the **Public Service Improvement Framework** (PSIF) which is based on total quality management approaches, to drive continuous improvement, maximise efficiency, and promote effective quality management.
- 3.47 The PSIF provides a framework of key questions to challenge and stimulate performance through a structured process, which is developed to suit the organisation's needs and drivers. Using a self-assessment approach we will continue to undertake comprehensive review of our activities and results which will help us to identify our strengths and the areas for improvement. The outputs will inform our development plan and identify improvement initiatives.
- 3.48 The Scottish General Practice contract is changing in 2017 which will have a key focus on quality and improvement. Transitional arrangements for **quality in primary care** are being put in place in 2016/17. This will move towards a system of values-driven governance that reflects and is sensitive to the needs of different communities and allows expertise to be shared across clusters of practices.
- 3.49 Whilst all GPs will continue to be focussed on quality outcomes we will support the development of new roles (cluster leads) with responsibility for leadership and involvement in service improvements and putting quality at the heart of practice, service activity and design as well as promoting quality care in the wider health and social care system.
- 3.50 We will continue to support a range of improvement activity to reduce Hospital Associated Infection, and promote **safe care** through the Scottish Patient Safety Programme across acute, primary care and mental health services and through active engagement with care providers.

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<sup>15</sup> <http://www.voicescotland.org.uk/>

## Equality Outcomes

- 3.51 The public sector equality duty in the Equality Act 2010 came into force in Scotland in April 2011 and requires Scottish public authorities to have 'due regard' to the need to eliminate unlawful discrimination; advance equality of opportunity; and foster good relations
- 3.52 All Scottish Public authorities must publish a report on 'mainstreaming' equality and identifying a set of equality outcomes. The IJB is classed as a public body and in compliance with the regulations will develop a set of equality outcomes and produce an Equality Mainstreaming Report by 30 April 2016.

Final Draft

## 4. Strategic Commissioning Plan

- 4.1 Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place<sup>16</sup>. This includes challenging historical spending patterns in light of what we know about our population needs and in particular managing the major trends of a growing, ageing population with increasing co morbidity.
- 4.2 The changes in our population require a different type of health and social care system, one that is modelled on supporting people to live independently in the community. Therefore the real added value of strategic commissioning will be in our ability to shift resources from the traditional models of care to new models of care which is a crucial element of public sector reform.

### Strategic Commissioning Principles

- 4.3 To achieve our vision and the best possible outcomes for people living in West Lothian who are assessed as needing a health or social care service, the following principles have been identified to ensure a longer term strategic approach to commissioning;
- ✚ To implement outcomes based approach to the commissioning of care and support services.
  - ✚ To commission health and social services which meet the needs and outcomes of individual service users which are personalised and offer more choice.
  - ✚ To commission quality services which achieve best value.
  - ✚ To work with our strategic partners and colleagues within the council and NHS to ensure a strategic approach to the commissioning of services.
  - ✚ To ensure transparency and equality when commissioning services appropriate stakeholder involvement and consultation which includes service users, their carers and providers is undertaken.
  - ✚ Positively engage, consult and communicate with the independent and voluntary sectors.
  - ✚ To ensure that approved procurement procedures are adhered to.
- 4.4 Building on the experience of the former CHCP we are committed to working with partners to
- ✚ Commission services which focus on prevention and early intervention
  - ✚ Empower people to live independently through applying the principles of personalisation in the way in which we commission services.
  - ✚ Undertake appropriate consultation and involvement with service users and their carers to achieve their agreed outcomes when commissioning services.
  - ✚ Engage positively with providers of health and social care services in the public, voluntary and private sector.

<sup>16</sup>Joint Strategic Commissioning – A Definition: Strategic Commissioning Steering Group, June 2012

- ✚ Adhere to relevant procurement legislation and guidance and ensure that services are commissioned in a way that is fair, transparent and open.
- ✚ Ensure that quality, equality and best value principles are embedded through our commissioning processes.

4.5 Commissioning is an ongoing and evolving process and our approach in developing commissioning plans is based on an annual Analyse, Plan, Do and Review cycle (Figure 8).

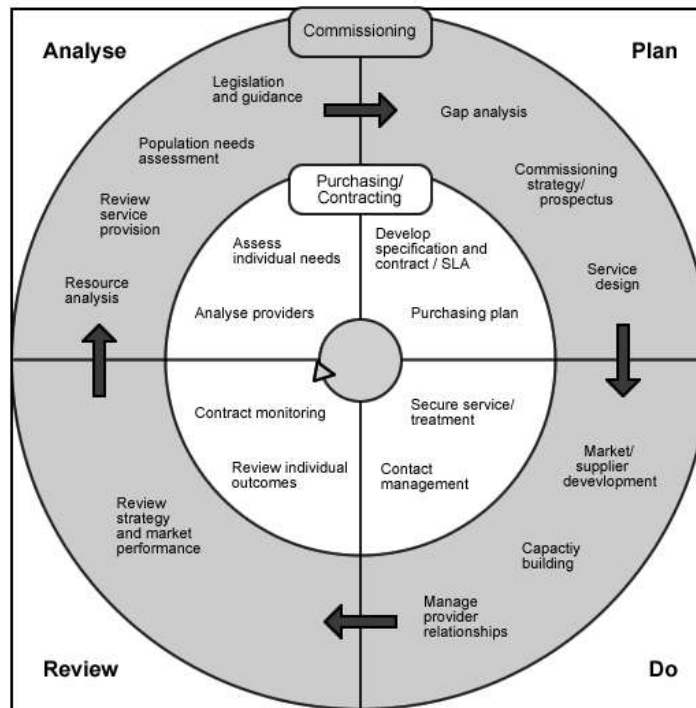


Figure 8 Strategic Commissioning Cycle<sup>17</sup>

### Commissioning Plans

- 4.6 We are required by the Scottish Government to develop strategic commissioning plans for all adult care groups. Our strategic commissioning plans will incorporate the important role of informal, community capacity building and asset based approaches, to deliver more effective preventative and anticipatory interventions, in order to optimise wellbeing and the potential to reduce unnecessary demand at the ‘front door’ of the formal health and social care system.
- 4.7 The commissioning plans will be consistent with appropriate commitments within the following related high level strategies: West Lothian IJB Strategic Plan, West Lothian Single Outcome Agreement, NHS Lothian Local Delivery Plan, NHS Lothian Clinical Strategy, West Lothian Housing Strategy, and West Lothian Council Corporate Plan.
- 4.8 Each Care Group commissioning plan will confirm the total resources available across health

<sup>17</sup> Joint Strategic Commissioning – A Definition - Joint Strategic Commissioning across adult health and social care” Scottish Government COSLA and NHS Scotland prepared by the National Steering Group for Joint Strategic Commissioning June 2012 <http://www.jitscotland.org.uk/action-areas/commissioning/>

and social care in respect of service users and carers and relate this information to the needs of Care Group population as determined by the needs assessment; such resources should be consistent with the relevant Directions issued by the IJB.

- 4.9 The Care Group commissioning plans will:
- ✚ Confirm desired outcomes and link investment to them
  - ✚ Detail how improvement will be delivered against outcomes and associated performance indicators
  - ✚ Prioritise investment and disinvestment through a coherent and transparent approach
  - ✚ Ensure that resource deployment and performance is consistent with the duty of Best Value
  - ✚ Reflect needs and plans as articulated at locality level
  - ✚ Ensure that sound clinical and care governance is embedded.
- 4.10 A working group is being established to develop a three year commissioning plan for each *Care Group* in accordance with the Scottish Government guidance on Strategic Commissioning Plans<sup>18</sup>. The plans will be informed by a detailed needs assessment which will be prepared in conjunction with the IJB Strategic Planning Group.
- 4.11 3 year Commissioning Plans will be developed for the following Care Groups:
- Substance Misuse
  - Adults with Learning Disabilities
  - Adults with Physical Disabilities
  - Mental Health
  - Older People.
- 4.12 Strategic commissioning has been used as the delivery vehicle for achieving national and local health and wellbeing outcomes within West Lothian since 2011 through the former CHCP. We will build on the valuable experience gained in commissioning and will embed the approaches in our planning and resource allocation processes.
- 4.13 The commissioning plans will be designed to deliver on the following strategic outcomes
- ✚ People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
  - ✚ Resources are used effectively and efficiently in the provision of health and social care services
  - ✚ People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
  - ✚ Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

<sup>18</sup> <http://www.gov.scot/Resource/0046/00466819.pdf>

- 4.14 The following provides a summary of progress in reviewing the commissioning plans for each of the Care Groups and identifies the priorities and commissioning intentions.

### Substance Misuse Commissioning Plan

- 4.15 The Alcohol and Drug Partnership (ADP) have the responsibility for commissioning of substance misuse services and are required to provide an annual report to the Scottish Government. The ADP will report in governance terms through the IJB to the Community Planning Partnership and it is anticipated that the requirement to report separately to the Scottish Government may change in the future and for all their activity to be absorbed within the standard governance framework of the IJB.
- 4.16 The ADP has led the way on strategic commissioning in West Lothian and have used their commissioning plan as the key partnership mechanism to oversee progress against performance and where appropriate to modify activity and resources to achieve outcomes.
- 4.17 The substance misuse needs assessment was reviewed in 2015 and the ADP Commissioning Plan was revised and approved by the Scottish Government in 2015. The ADP will monitor the performance and provide annual reports as required by the Scottish Government. The ADP priorities are set out in table 2 and the commissioning plan will be due for full revision in 2018.

**Table 2: ADP Priorities 2015-2018**

#### **Contract Monitoring & Review**

Review contract, Explore potential efficiencies.

#### **Prevention and Early Intervention**

Commission services with outcomes relating to family wellbeing.

Extend provision of alcohol brief interventions (ABIs) for people who are drinking heavily but not in need of treatment.

Develop a best practice guide to enable schools to provide consistent, evidence based prevention programs.

#### **Recovery**

Review new Through Care and After Care service, including arrangements relating to housing support and the need for specialist provision.

### Adults with Learning Disabilities

- 4.18 The current commissioning plan for Adults with Learning Disabilities 2012-2015 is due for review and work to progress the needs assessment is well underway and is expected to be concluded by end of March 2016. The current commissioning priorities are outlined in table 3 and these will be revised in the new commissioning plan to fully reflect the needs assessment.
- 4.19 In addition the commissioning plan will be informed by ongoing work of the Lothian Learning Disabilities Collaborative Strategic Planning Group. This group is responsible for the modernisation of the whole system of specialist service provision to people with learning disability encompassing



- ✚ In patient assessment and treatment services
- ✚ Development of integrated community teams with capacity to deliver national targets
- ✚ Up streaming of rehabilitative services for people with LD and complex needs.
- ✚ Delivery of local services for people with profound and multiple disabilities.

The schedule is to have a final draft of the Learning Disabilities Commissioning Plan by September 2016.

**Table 3: Adults with Learning Disabilities Commissioning Plan 2012-2015**

<b>Scottish Enhanced Services Programme</b>
Ensure screening & management of long term conditions is delivered to the same standards, quality and accessibility as the rest of the population.
<b>Complex Care</b>
Explore most effective arrangements to meet needs of individuals with LD & complex care needs within Lothian Partnership.
<b>Support for Carers</b>
Develop Information Sharing Protocol with Carers' of West Lothian to facilitate early provision of information, advice & support.
<b>Services for Autism Spectrum Disorders (ASD)</b>
Development of services for people with ASD which is systematic, evidence based and sustainable.
<b>Employability &amp; Lifelong Learning</b>
Explore development of Social Enterprise to develop employability and employment opportunities.

### Adults with Physical Disabilities

- 4.20 The current commissioning plan for Physical Disabilities 2012-2015 is due for review and work to progress the needs assessment is well underway and is expected to be concluded by end of March 2016. The current commissioning priorities are outlined in table 4 and these will be revised in the new commissioning plan to fully reflect the needs assessment. The preparation of the commissioning plan will be developed through the Physical Disabilities commissioning group in conjunction with the Strategic Planning Group. The schedule is to have a final draft of the Physical Disabilities Commissioning Plan by June 2016.

**Table 4: Physical Disabilities Commissioning Plan 2012-2015**

<b>Employability</b>
Increase delivery of 'B4 and On2 Work' employability advocacy and support.
<b>Short Breaks from Caring (respite)</b>
A five year contract (with an option to extend for a further three years) is in place for 2010-2015.
<b>Day support</b>
Provide a range of support to access education, college courses, work experience, employment and volunteering opportunities as well as support at times of transition.
<b>Information and Advice Services</b>
<ul style="list-style-type: none"> <li>• Information &amp; Advice Service</li> <li>• Peer Counselling Service</li> <li>• Independent Living</li> </ul>
<b>Commission</b>
<ul style="list-style-type: none"> <li>• Community Rehabilitation and Brain Injury Service</li> <li>• Services for the Deaf, Deafened and Hard of Hearing</li> <li>• Services for the Blind and People with Sight Loss</li> </ul>



## Mental Health

- 4.21 The current commissioning plan for Mental Health 2012-2015 is due for review. It will be important to ensure that the revised plan reflects the scope of the IJB's responsibility and we will commission a comprehensive needs assessment to support our planning. The commissioning plan will be developed through the Mental Health Commissioning Group in conjunction with the Strategic Planning Group. The current commissioning priorities are outlined in table 5 and these will be revised in the new commissioning plan to fully reflect the needs assessment. The planned schedule is to conclude the needs assessment by June 2016 and to have a final draft of the Mental Health Commissioning Plan by September 2016.

**Table 5: Mental Health Commissioning Plan 2012-2015**

<b>Advocacy</b>
Identify the advocacy needs for people with drug and/or alcohol problems and explore commissioning of resource if required (MHAP).
<b>Adult Protection</b>
Develop Care Programme Approach within West Lothian.
<b>Housing Support</b>
Ensure that Housing Support Services are integrated with other care-related services, are outcomes-focused, and compatible with new legislation such as Self-directed Support.
<b>Specialist Respite</b>
Commission a new respite service for the mental health client group that promotes equity of access, is person-centred, and maximises economies of scale.
<b>Inpatient Provision</b>
Redesign the support for the day to day clinical management and coordination of acute care.
<b>Rehabilitation</b>
Ensure a robust review system for people with severe and enduring illness that is recovery orientated and is holistic in nature including physical health care monitoring.
<b>Commissioning reviews</b>
Undertake commissioning review of Community Nursing, Psychiatry & Psychology to understand demand & inform capacity plans.

## Older People

- 4.22 The West Lothian Health and Social Care Partnership have already invested significant effort and resources to simplify and improve services, and access to services, for older people, particularly frail older people and meeting the needs of older people will remain one of our top priorities during the lifetime of this plan.
- 4.23 The first Commissioning Plan for Older People was developed in 2012 (Table 6) as a key requirement for the Older People's Change Fund. We have since established a Frail Elderly Programme with the main objective of a whole system redesign to deliver a quality, financially sustainable and cost effective service provision.
- 4.24 The frail elderly programme provides a solid foundation for revision of the Older People's Commissioning Plan, the scope of which will be widened to include the acute hospital service provision. To support our planning we will commission a comprehensive needs

assessment and the commissioning plan will be developed through the Frail Elderly Programme Board in conjunction with the Strategic Planning Group.

- 4.25 The proposed schedule for the Older People's Commission Plan would be to conclude the needs assessment by June 2016 and to have a final draft of the Older People's Commissioning Plan by September 2016.

**Table 6: Older People's Commissioning Plan 2012-2015**

<p><b>Live at Home or in a Homely Setting for Longer</b>  Review contract arrangements for care at home.  Explore future commissioning options for day care service for older people.  Explore step up and step down care provision in West Lothian and intermediate care pathways, including consideration of care homes as provider.</p>
<p><b>Joined Up Care Pathways</b>  Develop integrated assessment and rehabilitation service to support provision of specialist multidisciplinary assessment for older people and timely access to rehabilitation.</p>
<p><b>End of Life Care</b>  Review specialist service agreements.  Monitor access to palliative care services for those with non malignant conditions.</p>
<p><b>Frail Elderly Development Priorities</b></p>
<p><b>Comprehensive geriatric assessment and frailty pathway in hospital</b>  Implement a multidimensional interdisciplinary Comprehensive Geriatric Assessment on admission.  Explore and test roles of elderly care assessment nurse, specialised discharge, rehabilitation, day hospital and ambulatory care services.</p>
<p><b>Frailty capacity modelling</b>  Create analytical model of current systems to assess costs and benefits of proposed changes and prioritise investment.</p>
<p><b>Mental Health</b>  Continue to progress towards preventative, assessment and outcome focussed services.  1 year post diagnostic support for people with new dementia diagnosis.  Develop Behavioural Support service.  Redesign Mental Health Elderly Day Service.</p>
<p><b>Supporting health and care in the community</b>  Review current arrangements and performance to advise on short term Integrated Care Fund investments and sustainability after the end of the Fund.  Review contractual arrangements for provision of care at home.  Review <i>REACT</i> hospital at home and rehabilitation care pathways to prevent admission and facilitate early supported discharge.</p>

- 4.26 The Strategic Planning Group will have a key role in developing and finalising the commissioning plans and in continuing to review progress, measured against the statutory outcomes for health and wellbeing, and associated indicators. The strategic commissioning plan will be revised as necessary (and at least every three years), with the involvement of the Strategic Planning Group and this section will be updated in accordance with the schedule for the revised versions of the commissioning plans.

## 5 Strategic Priorities

### Context

- 5.1 The previous sections presented the variety of reasons why we need to change the way in which we deliver services. Despite progress towards a more joined up service approach, some inefficiency remains in terms of integrated working. By integrating services, there will be opportunities to improve personal outcomes; provide more care at home or in a homely setting; and, ultimately, enhance the experience of the people who use our services and their carers.
- 5.2 In summary, we know that:
- ✚ We need to do more to shift the balance of care and service provision towards more community based services and reduce the reliance on admissions to institutional care;
  - ✚ People should be supported to regain their health and independence as far as possible using personally-defined outcomes as the goals around which support is configured;
  - ✚ Some people, including those at the end of their lives, end up in hospital when they could be supported at home if a range of community based services were available;
  - ✚ Delays in discharge arrangements and prolonged hospital stays can result in reduced confidence and less likelihood of independent living;
  - ✚ There are significant differences in health inequalities in relation to healthy life expectancies across our localities and communities of interest;
  - ✚ To enable people to lead healthier life styles and to remain as independent as possible we need to provide information, advice and support (preventative and anticipatory);
  - ✚ Demand for services is increasing and that some services have waiting times
  - ✚ The short to medium term public funding position is challenging.

### Strategic Opportunity

- 5.3 The integration of health and social care represents a major opportunity to deliver improved outcomes for the communities we serve. Transforming the way in which we deliver services is expected to reduce reliance on hospital services; lead to improvements in achieving the nine national outcomes for integration; and empower people to manage their own conditions through the increased provision of advice, support and care in primary and community settings
- 5.4 The strategic priorities and commissioning intentions set out for the period of this plan are based on best available information, both local and national. This learning continues to emerge and it is recognised that there is often limited published evidence to support decision making at this time. All the proposed changes will be evaluated on an ongoing basis in order to assess their impact on outcomes for people and their contribution to the whole system.

### Our Key Priorities

- 5.5 The 2020 vision for Health and Social Care and the Christie Commission on Public Sector

Reform (2011) highlighted the need for change. They both emphasise the need for communities to be involved; to empower people; and that, wherever possible, services should be provided in the person's own home. They also remind us that prevention of ill health should be given a greater priority.

- 5.6 In order to achieve the priorities set out below, we are committed to :
- ✚ Using a variety of activities to involve people within local communities; to describe the assets within communities and to identify enablers and barriers to inform improvements;
  - ✚ Involving a wide range of partners within local communities, organisations, local groups and businesses to develop opportunities within communities so that these can support people to achieve personal outcomes;
  - ✚ Developing staff skills to ensure that they can use feedback from service users' experiences to improve these services.
- 5.7 Our Strategic Priorities for the period of this plan are focussed on
- ✚ Tackling Inequalities
  - ✚ Prevention and Early Intervention
  - ✚ Integrated and Coordinated Care
  - ✚ Managing Our Resources Effectively.

### **Tackling inequalities**

- 5.8 There are communities in West Lothian that have higher levels of need and it is important that the level of service provision reflects this. However, targeting solely these communities would not be sufficient to address health inequalities because not all of the people who are income deprived live in recognised 'areas of deprivation'.
- 5.9 High quality, universal health and social care, that is provided based on need rather than ability to pay, is important to mitigate and reduce health inequalities. It is also important to reduce barriers to accessing care – such as mismatch between service design and patient need, cultural differences between patients and staff, low expectations, poor experience, transport costs and lack of capacity where the need is highest.
- 5.10 To reduce the impacts of individuals' social circumstances on health, professionals need to recognise these issues, reflect them in management plans and refer people to appropriate sources of support such as welfare advice.
- 5.11 We will enhance our role to address health inequalities by:
- ✚ Ensuring services are accessible to all based on need, and barriers to care are addressed.
  - ✚ Prioritising prevention, primary and community services to maximise benefit to the most disadvantaged groups.
  - ✚ Providing workforce education and training to build awareness of health inequalities and skills to work with all communities.
  - ✚ Taking a social history in consultations and using this to tailor support to individuals' needs.
  - ✚ Supporting services and initiatives that support individuals and communities to reduce

the impacts of inequalities on their health.

- ✚ Ensuring the organisation uses its purchasing power to support the local communities and creates a culture of equality and fairness.
- ✚ Working with community planning partners on initiatives to address underlying social inequalities that result in health inequalities.

**Impact:-**

- ✓ Increased focus on prevention, self-management and shared decision making
- ✓ Improved general health and wellbeing in the population and reduced health inequalities
- ✓ Better quality relationships between service users and those providing them

## Prevention and Early Intervention

- 5.12 By shifting the focus of services towards the prevention of ill health, to anticipate at an early stage the need for support and to react where possible to prevent crises we will enable individuals to make better health and wellbeing decisions and achieve better outcomes.
- 5.13 We recognise the vital role played by carers and need to make sure that carers remain in good health, and that their health-related quality of life does not deteriorate as a result of their caring responsibilities.
- 5.14 We are committed to improving access to information, advice and support to enable people and their carers to lead healthier life styles and to remain as independent as possible and make active contributions to their families and communities.
- 5.15 We recognise that we need to increase our capacity to support people at home through new models that provide greater choice and control including timely provision of aids and adaptations and technology enabled care.
- 5.16 We will continue to develop our approach and focus our activities to enable people to manage their own conditions and to stay healthy and more independent for longer. This will include improving access to services and anticipatory care planning to promote early intervention and recovery, and reduce the risk of deterioration in health and wellbeing.
- 5.17 Throughout the period of the plan we will review key activities to ensure that they are aligned to the Strategic Priorities, and that they make best use of existing investment. This will include
  - ✚ Review of service provisions which support choice and control for individuals
  - ✚ Development of opportunities to provide greater choice of personalised shared care and support for cost effective respite, day care and residential care.
  - ✚ Review of services to reduce social isolation;
  - ✚ Redesigning care and clinical pathways to be more streamlined, resulting in speedier decision making and earlier service provision through proactive anticipatory care planning;

- ✚ Systematically identifying and treating frail people within community settings
- ✚ Increasing our investment in technology enabled care
- ✚ Promoting carers as equal partners in the planning and delivery of care and support and ensuring their needs are identified and appropriate support given to enable them to continue in their caring role<sup>19</sup>.

**Impact:-**

- ✓ Increased focus on prevention, self-management and shared decision making
- ✓ Increased primary and community care capacity
- ✓ Reduced reliance on hospital beds and other health and care services
- ✓ Improved support for carers

**Integrated and Co-ordinated Care**

- 5.18 Providing integrated care that crosses the boundaries between primary, hospital and social care is a goal of health systems worldwide. Through working with people in their own communities and using our collective resources wisely we can transform how we deliver services to ensure they are high quality, safe, effective, based on achieving personal outcomes and delivered in a way which enhances the health and wellbeing of the people of West Lothian.
- 5.19 Our focus will be on ensuring:
- ✚ Provision of more integrated and coordinated care at home to enhance the experiences of service users and their carers;
  - ✚ We support those who are at risk of harm, to receive the necessary care and support they need to keep them safe;
  - ✚ Health and social care is provided with the right level of support at the right time to meet individual needs and to reduce avoidable emergency admissions
  - ✚ Health and social care services are better coordinated for those requiring care at the end of their lives, and for their families and carers;
  - ✚ A structured, coordinated and strategic approach to community support is created for people with frailty including dementia and their carers to ensure that they remain in the community for as long as possible.
- 5.20 Our approach centres on ensuring we deliver the right care, in the right place at the right time for each individual, so that people are:
- ✚ Assessed, treated and supported at home and within the community wherever possible and are admitted to hospital only when clinically necessary
  - ✚ Discharged from hospital as soon as possible with support to recover and regain their independence at home and experience a smooth transition between services
  - ✚ Safe and protected and have their care and support reviewed regularly to ensure these remain appropriate.

<sup>19</sup> The Carers (Scotland) Bill 2016



- 5.21 By integrating services further, there will be significant opportunities to improve outcomes and to provide more care in people's own homes. The main activities will include:
- ✚ Enhancing the capacity and capability of teams to provide more responsive services including extending provision into the traditional out of hours period, over seven days, and providing more acute care and treatment at home
  - ✚ Reviewing the design of care and support services to work with communities and care providers to provide more coordinated care particularly to support those at risk of harm, deterioration or hospital admission.
  - ✚ Improving information and technology applications to support integrated working;
  - ✚ All sectors working more closely together to provide an enabling approach to support recovery in line with personal outcomes
  - ✚ Placing 'good conversations' at the centre of our engagement with people so that they are actively involved in decisions about how their health and social care needs should be addressed.
- 5.22 Providing a higher proportion of care in the community including early clinical and care assessments will reduce the number of avoidable admissions as well as delays in discharge. It is anticipated that with greater integration and coordination it may be possible to realign resources to community based services and build sustainability for the future. The predicted demographic changes will present challenges and it is intended that community models of care will be enhanced to meet any increasing demand.
- 5.23 Day of care audits have highlighted that community hospital beds are often occupied by people whose care needs can be met either at home or in another community setting. Therefore as community alternatives are established we will review our community hospital and care provisions to ensure that our care models are sustainable and focussed on achieving the best outcomes.

**Impact:-**

- ✓ Delivery of high quality, safe and effective services focussed on achievement of personal outcomes
- ✓ Effective and appropriate use of acute resources
- ✓ Effective and appropriate use of community hospitals
- ✓ Increased primary and community care capacity
- ✓ Improved health and social care coordination across the whole system

**Managing our resources effectively**

- 5.24 This plan is intended to be viewed as a continuum of work with further development to make the vision a reality. As outlined in section 7 there is a requirement to identify and develop an aligned resources framework to support delivery of the plan. There is a clear recognition that the Strategic Plan and its associated programmes of work will have to be delivered within the finite resources available to the partner organisations and detailed implementation plans will be developed to support the strategic intentions. These will include fully costed models to ensure that all plans are sustainable within the resources

available to the IJB.

- 5.25 It is essential therefore that we make the best use of our shared resources (people, buildings, technology, information, procurement approaches) and the capacity available by working collaboratively across the statutory, third and independent sectors, housing organisations, communities and with individual citizens, including unpaid carers, to deliver timely, high quality, integrated and personalised services whilst managing the financial challenge and appropriate care and support to people with health and social care needs.
- 5.26 This will require new and innovative ways of working. As functions, strategies and services are reviewed and integrated the pattern of spend will alter as we continue to shift the balance of care from institutional to community settings.

### Transformational Change

- 5.27 As described above and in the previous sections our plan is focussed on achieving a sustainable health and care system for West Lothian. This will require transformational change over time in order to improve health and wellbeing outcomes and support the transition to the future model of care. Throughout this process we will ensure our change programmes are well connected and we will establish planning and accountability structures to ensure consistency in delivery of integrated health and social care outcomes.
- 5.28 The transformation map (Figure 9) runs over three phases which are designed as a journey from where we are now to where we want to be.
- ✚ Phase 1: Current Position– where understanding the context and what needs to be done is important, and where action needs to begin
  - ✚ Phase 2: Transformation Phase – where change and sustainability is becoming the norm and we are on the way to a more effective and sustainable health and care system; and
  - ✚ Phase 3: The Future State – where better, more effective care, improved outcomes and integrated ways of working and sustainability have become routine.



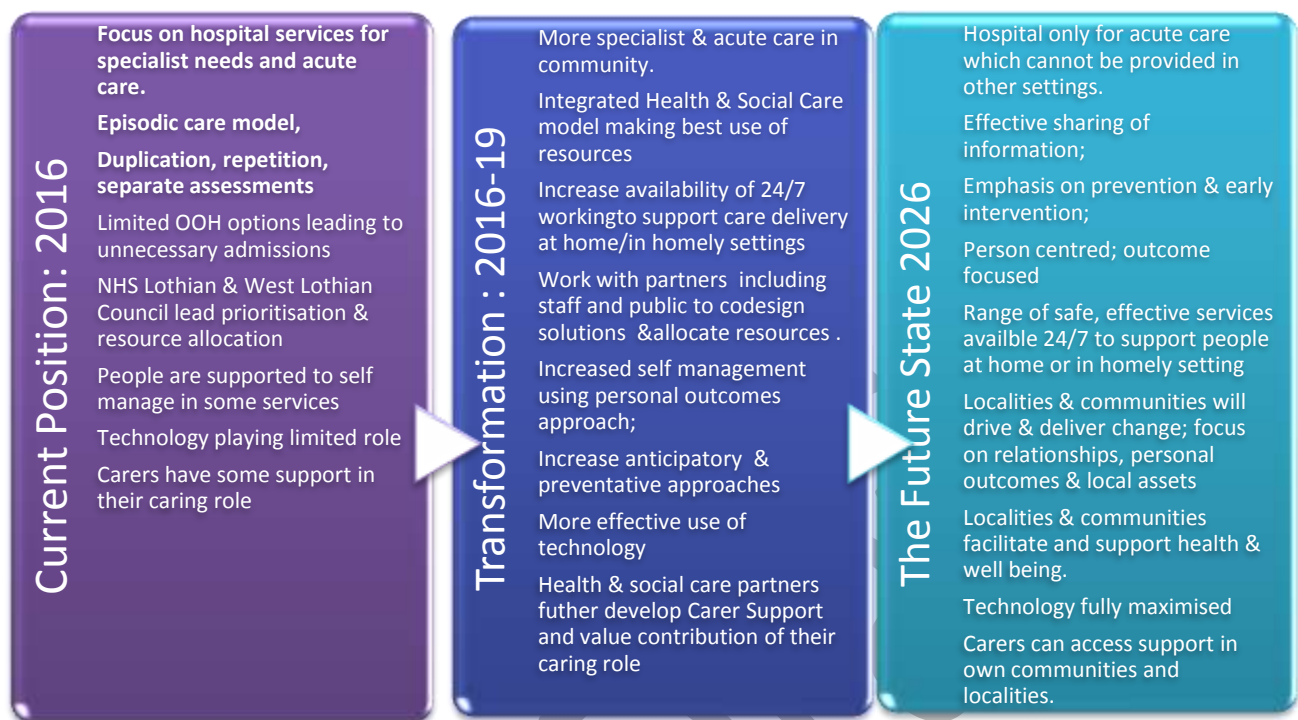


Figure 9: Transformation Map

## 6 Monitoring Performance

### National Reporting

- 6.1 The integration of health and social care has two key objectives which are mutually reinforcing - securing better outcomes and experiences for individuals and communities and obtaining better use of resources across health, care and support systems at national and local levels.
- 6.2 The IJB will be responsible for monitoring and reporting in relation to the operational delivery of the integrated services on behalf of NHS Lothian and West Lothian Council and for the continuous review of progress of the implementation of the strategic plan measured against the national outcomes for health and wellbeing and associated indicators. We will publish an annual performance report setting out how well are achieving these outcomes. This will include information in relation to a core suite of indicators supported by local measures that are appropriate for the whole system under integration.

### Baseline Performance: National Health and Wellbeing Outcomes



- 6.3 23 core indicators have been developed from national data sources so that the measurement approach for the agreed integration health and wellbeing outcomes is consistent across all areas.
- 6.4 The core indicators which are shown below are grouped into two types of complementary measures:
-  Personal outcomes and quality measures (indicators 1-10; table 7) and
  -  Indicators derived from organisational / system data (indicators 11-23; table 8)

Table 7: Personal outcomes and quality measures (2014)		West Lothian Performance	National Performance	Local Improvement target
1	Percentage of adults able to look after their health very well or quite well.	94%	94%	95%
2	Percentage of adults supported at home who agree that they are supported to live as independently as possible.	85%	84%	85%
3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	80%	84%	84%
4	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.	79%	80%	80%
5	Percentage of adults receiving any care or support who rate it as excellent or good	80%	84%	84%
6	Percentage of people with positive experience of care at their GP practice.	80%	87%	87%
7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	82%	86%	86%
8	Percentage of carers who feel supported to continue in their caring role.	48%	44%	50%
9	Percentage of adults supported at home who agree they felt safe.	83%	86%	86%
10	Percentage of staff who say they would recommend their workplace as a good place to work	Not currently available	Not currently available	70%

- 6.5 Whilst much of the personal outcomes and quality data indicate West Lothian is on a par with Scotland there are areas for improvement which will be addressed through personal outcomes based approaches and better engagement with service users and their carers. We have set local improvement targets for each of the indicators and will review these on an annual basis.

Table 8: Indicators derived from organisational / system data (2014-15)		West Lothian Performance	National Performance	Local Improvement target
11	Premature mortality rate. (European Age Standardised Rate per 100,000 population <75)	411.2	423.2	411
12	Rate of emergency admissions for adults (Crude rate per 100,000 population)	10878	10436	10436
13	Rate of emergency bed days for adults (Crude Rate per 100,000 population)	56647	75597	56647
14	Readmissions to hospital within 28 days of discharge (European Age Sex Standardised Rate per 1,000 population)	9.39	8.48	8.48
15	Proportion of last 6 months of life spent at home or in a community setting	91.1%	90.8%	91%
16	Falls Rate (Crude rate per 1000 population over age 65)	20.9	20.1	20
17	Proportion of care services graded Good (4) or better in Care Inspectorate inspections	Not Yet Available	Not Yet available	
18	Percentage of adults with intensive needs receiving care at home	69.6%	61.4%	70%
19	Number of days people spend in hospital when they are ready to be discharged (Crude rate per 1000 total population)	60	117	56
20	Percentage of total health and care spend on hospital stays where the patient is admitted in an emergency	19.4%	21.9%	19%
21	Percentage of people admitted from home to hospital during the year, who are discharged to a care home	Not Yet Available	Not Yet available	
22	Percentage of people who are discharged from hospital within 72 hours of being ready	42.9%	Lothian average 25.9%	45%
23	Expenditure on end of life care	Not Yet Available	Not Yet available	

- 6.6 One of the main aims of health and social care integration is to ensure people, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community for as long as possible.
- 6.7 Our aim is to support people to live independently at home for as long as possible and to shift the balance of care from institutional care to care at home or as close to home as possible in a community setting.
- 6.8 Key points from analysis if the data indicates
- ✚ There has been an increase over time in the percentage of adults with intensive care needs receiving care at home
  - ✚ There is an Increasing trend towards last 6 months of life being spent in a community setting whilst the Scottish trend is static

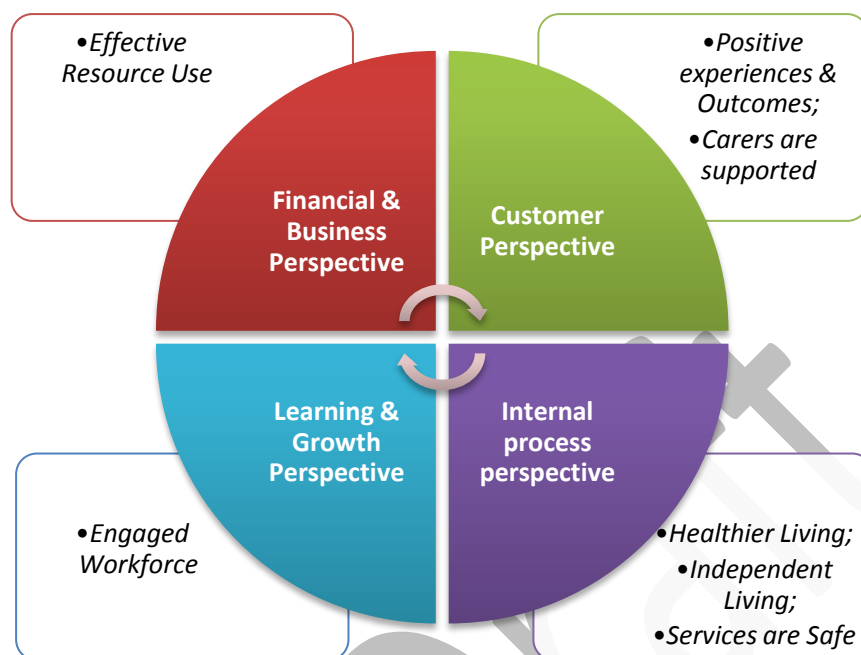
- ✚ Although West Lothian has a slightly higher emergency admission rate than Scotland, it has a much lower emergency bed day rate with majority of Bed Days in general & geriatric medicine
- ✚ 28 day readmission rates are slightly higher than Scotland rate and the length of stay at St John's Hospital is lower than average
- ✚ The falls rate is steady and similar to Scotland – falls are a significant source of complex admissions and bed days
- ✚ West Lothian has a low bed day rate for delays compared to Scotland and other 3 Lothian H&SCPs, although the rate is increasing.
- ✚ There is a lower percentage spend on emergency stays compared to Scotland and other 3 Lothian H&SCPs
- ✚ West Lothian has the highest percentage of patients being discharged within 3 days across the 4 Lothian partnerships. The main reason for longer delays was patients awaiting completion of social care arrangements which would allow them to live in their own home.

- 6.9 The data demonstrates that there has been some progress made in shifting the balance of care from institutional to community settings and indicates there are areas of good practice supporting integrated services and systems. However there is room for improvement to reduce emergency admissions and readmissions and to further improve performance around delayed discharges to consistently achieve the 72 hour standard.
- 6.10 The core indicators will continue to be developed and improved over time and it is noted that some of them still require data development. In addition to the core indicators we will continue to work with Lothian Analytical Services and the other IJBs to agree a Lothian Core dataset to support planning and monitoring of performance across health and social care. This dataset will include the measures for the Local Delivery Plan, as well as indicators for social care, primary care and community (still in development) (Appendix 2).

### Balanced Scorecard

- 6.11 We have adopted a balanced scorecard approach (figure 10) to provide the framework for our strategic measurement and management system. The scorecard will measure organisational performance across four balanced perspectives: Financial; Customer; Internal Processes; Learning and Growth.
- 6.12 We will continue to develop local measures and contextualising data to provide a broader picture of local performance and once our strategic commissioning plans have been finalised, there will be a need to review and develop our performance reports. This will ensure that we have the most appropriate means to allow progress against our commissioning plans to be measured.
- 6.13 The Performance Framework will continue to evolve and will be reviewed regularly to ensure that the contained improvement measures continue to be relevant and reflective of the National Outcomes and local indicators (once developed) to which they are aligned. Our performance framework will be also be aligned to the requirements of the Health

Improvement, Efficiency, Access and Treatment (HEAT) standards and targets as well as the Single Outcome Agreement.



**Figure 10 Balanced Scorecard**

### Benchmarking

- 6.14 West Lothian participates in the Local Government Benchmarking Network (LGBF) comparing performance on a number of performance indicators. West Lothian Adult Social Care Services are included in the benchmarking framework and are allocated a benchmarking family based on similar geography, population, deprivation levels and community needs. The benchmarking family group includes Clackmannanshire, Dumfries and Galloway, Falkirk, Fife, Renfrewshire, South Ayrshire and South Lanarkshire
- 6.15 LGBF performance is analysed to ensure that the variation and causal impact in relation to local priorities and policy choices are understood. This is to be facilitated by authorities working as part of 'family groups' to interrogate the data. These family groups will in time also serve as a forum for sharing learning and knowledge across authorities.

### Data Sharing and Information Governance

- 6.16 Better data sharing across health and social care will play a key role in the integration agenda. As an IJB we will need to be able to assess and forecast need, link investment to outcomes, consider options for alternative interventions and plan for the range, nature and quality of future services.
- 6.17 Effective information systems are necessary to ensure that good intelligence underpins our process of local strategic planning and decision making. To support this the Information and Statistics Division has been commissioned to work with NHS Boards, Local Authorities and others to develop a linked individual level dataset for partnerships. There is therefore a need to ensure information is managed and shared in a safe and effective manner through sound governance, performance and scrutiny arrangements.

## 7 Financial Framework

### Context

- 7.1 The Strategic Plan is intended to be viewed as a continuum of work with further development required to make the vision a reality. The plan provides the strategic framework for the development of health and social care services over the next few years and lays the foundation for the integration of the plan into the core work of NHS Lothian, West Lothian Council and partners with priorities and proposals reflected in each organisation's business plan.
- 7.2 Therefore, there is a requirement to identify and develop an aligned resource strategy including a clear financial framework which will support delivery of the plan. There is clear recognition 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.
- 7.3 Both partner organisations have complex financial arrangements focusing primarily on annual budget plans. Consequently, the forecast of a longer term financial plan to match the delivery programmes outlined in this document is challenging and not without risk; this section seeks to describe the financial position of both the NHS and West Lothian Council and the planned approach in relation to the delivery of this Strategic Plan.

### Partnership Budget

- 7.4 Section 39 of the Public Sector (Joint Working) (Scotland) Act 2014 requires that each Integration Authority to publish an Annual Financial Statement on the resources that it plans to spend in implementing the Strategic Plan.

The main services to be delegated and integrated are

- ✚ Adult social care services
- ✚ Primary care and community health services
- ✚ Set aside adult acute services.

### Adult Social Care Services

- 7.5 The council's approved 2016/17 contribution to the IJB is shown below along with indicative resources for 2017/18 and 2018/19. The indicative 2017/18 resources reflect the council's currently approved planning assumptions which will be updated as necessary subject to the 2017/18 budget settlement from the Scottish Government. At this stage, given uncertainty around funding for future years, the indicative 2018/19 resources are shown as being unchanged from the 2017/18 resources.

### NHS Delegated Services

- 7.6 At this stage a finalised 2016/17 NHS Lothian budget is still to be agreed. Therefore, the current 2016/17 budget resources shown are indicative and reflect the current working assumptions which may be updated upon finalisation of the 2016/17 budget.



- 7.7 For the purposes of 2017/18 and 2018/19, and given the uncertainty around future funding settlements, the budgets are indicatively shown at the same level as the current indicative 2016/17 budgets.
- 7.8 As part of ongoing public sector funding constraints, both West Lothian Council and NHS Lothian will face significant financial challenges over the period to 2018/19. In addition, health and social care demands are continuing to increase and both these factors will inevitably impact on the level of future resources available to meet the care needs of the West Lothian population.

### Annual Financial Statement

	2016/17 Approved Budget	2017/18 Indicative Budget	2018/19 Indicative Budget	Total Indicative 2016/17 to 2018/19
<b><u>Adult Social Care Services</u></b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>
Learning Disabilities	13,565	14,204	14,204	41,973
Physical Disabilities	6,255	6,456	6,456	19,167
Mental Health	2,941	2,966	2,966	8,873
Older People Assess & Care	27,903	28,177	28,177	84,257
Care Homes and HWC	7,090	7,163	7,163	21,416
Contracts & Commissioning				
Support	5,841	5,693	5,693	17,227
Other Social Care Services	3,090	2,641	2,641	8,372
<b>Total Adult Social Care Services</b>	<b>66,685</b>	<b>67,300</b>	<b>67,300</b>	<b>201,285</b>
<b><u>Core Health Services</u></b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>
Community Hospitals	3,123	3,123	3,123	9,369
Mental Health	11,304	11,304	11,304	33,912
District Nursing	2,870	2,870	2,870	8,610
Community AHPS	3,219	3,219	3,219	9,657
GMS	26,141	26,141	26,141	78,423
Prescribing	30,315	30,315	30,315	90,945
Resource Transfer	6,886	6,886	6,886	20,658
Other Core	7,816	7,816	7,816	23,448
<b>Total Core Health Services</b>	<b>91,674</b>	<b>91,674</b>	<b>91,674</b>	<b>275,022</b>



	2016/17 Indicative Budget	2017/18 Indicative Budget	2018/19 Indicative Budget	Total Indicative 2016/17 to 2018/19
<b>Hosted Health Services</b>				
Sexual Health	908	908	908	2,724
Hosted AHP Services	2,260	2,260	2,260	6,780
Hosted Rehabilitation Medicine	880	880	880	2,640
Learning Disabilities	3,284	3,284	3,284	9,852
Mental Health	610	610	610	1,830
Substance Misuse	1,017	1,017	1,017	3,051
Oral Health Services	2,096	2,096	2,096	6,288
Hosted Psychology Service	2,831	2,831	2,831	8,493
Public Health	283	283	283	849
Lothian Unscheduled Care Service	1,924	1,924	1,924	5,772
UNPAC	807	807	807	2,421
Strategic Programmes	1,679	1,679	1,679	5,037
Other Hosted Services	317	317	317	951
<b>Total Hosted Health Services</b>	<b>18,896</b>	<b>18,896</b>	<b>18,896</b>	<b>56,688</b>
<b>Acute Set Aside Services</b>				
A & E (outpatients)	4,116	4,116	4,116	12,348
Cardiology	5,797	5,797	5,797	17,391
Diabetes	513	513	513	1,539
Endocrinology	405	405	405	1,215
Gastroenterology	1,787	1,787	1,787	5,361
General Medicine	7,014	7,014	7,014	21,042
Geriatric Medicine	5,069	5,069	5,069	15,207
Infectious Disease	3,015	3,015	3,015	9,045
Rehabilitation Medicine	727	727	727	2,181
Respiratory Medicine	177	177	177	531
Therapies/Management	116	116	116	348
<b>Total Acute Set Aside Services</b>	<b>28,736</b>	<b>28,736</b>	<b>28,736</b>	<b>86,208</b>
<b>TOTAL</b>	<b>205,991</b>	<b>206,606</b>	<b>206,606</b>	<b>619,203</b>

## Directions

- 7.9 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) places a duty on the IJB to develop a strategic plan for integrated functions and budgets under their control. The IJBs require a mechanism to action their strategic commissioning plans, and this is laid out in sections 26 to 28 of the Act. This mechanism takes the form of binding Directions from the IJB to one or both of the Health Board and Local Authority. These Directions must be in writing and should set out a clear framework for operational delivery of the functions that have been delegated to the IJB.

- 7.10 A suite of Directions have been prepared for the operational delivery of the functions which clearly identify which of the integrated health and social care functions they relate to, how the named service or services are to be provided. Where appropriate, the same document has been used to give Directions to carry out multiple functions.

Final Draft

## 8 Clinical and Care Governance

- 8.1 Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality of care and support is the responsibility of everyone working in the organisation. The Health Board, the Council and the IJB are accountable for ensuring appropriate clinical and care governance arrangements for their duties under the Public Bodies (Joint Working) (Scotland) Act 2014.
- 8.2 The quality of service delivery will be measured through performance targets, improvement measures and reporting arrangements designed to address organisational and individual care risks, promote continuous improvement and ensure that all professional and clinical standards, legislation and guidance are met. Embedded from frontline staff through to the board, good governance should define, drive and provide oversight of the culture, processes and accountabilities of those delivering care.
- 8.3 Plans will be put in place, as set out in this Strategic Plan, to ensure that staff working in Integrated Services have the skills and knowledge to provide the appropriate standard of care. This will require a clear governance framework within which professionals and the wider workforce will operate. Where groups of staff require professional leadership, this will be provided by the relevant Health Lead or Chief Social Work Officer, as appropriate. The Organisational Development Plan will identify training requirements that will be put in place to support improvement in services and outcomes.
- 8.4 The members of the Integration Joint Board will actively promote an organisational culture that supports human rights and social justice; value partnership working through example; affirm the contribution of staff through the application of best practice, including learning and development; and be transparent and open to innovation, continuous learning and improvement.
- 8.5 The Director of Health and Social Care's role is to provide a single senior point of overall strategic and operational advice to the IJB and be a member of the senior management teams of the Health Board and the Council. He will manage the Health and Social Care Partnership and the Integrated Services delivered by it, and has overall responsibility for the professional standards of staff working in integrated services.
- 8.6 The IJB will put in place structures and processes to support clinical and care governance, thus providing assurance on the quality of health and social care. A Health and Care Governance Group will be established with membership from the Health Board, the Council and others, including
- Members of Senior Management Team
  - Clinical Director
  - Chief Nurse

- Allied Health Professional Lead
- Chief Social Work Officer.
- Public Health Consultant.
- Associate Medical Director Acute Services
- Associate Nurse Director Acute Services
- Service user and carer representatives.
- Third sector and independent sector representatives.

- 8.7 The role of the Health and Care Governance Group will be to consider matters relating to strategic plan development, governance, risk management, service user feedback and complaints, care standards, education, learning, continuous improvement and inspection activity. The Health and Care Governance Group provides advice to the strategic planning and locality planning groups within the Partnership.
- 8.8 The Strategic Planning Group will be able to invite appropriately qualified individuals from other sectors to join its membership. This will include NHS Board professional committees, managed care networks and public protection committees.
- 8.9 Further assurance is provided through the responsibility of the Chief Social Work Officer to report directly to the Council and the responsibility of the Health Leads to report directly to the Medical Director and Nurse Director who in turn report to the NHS Board on professional matters.
- 8.10 Arrangements for monitoring and scrutiny of progress and performance will be developed in line with the review of integration structures and processes and will be embedded within community and locality planning mechanisms.
- 8.11 As detailed in the Integration Scheme, the Integration Joint Board will provide the overall governance to the partnership.
- 8.12 There will be a series of Care Groups whose main responsibility will be to oversee the development, implementation and review of the Commissioning Plans.
- 8.13 Locality representatives and locality priorities will be fully represented in all governance and planning structures.
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## Appendix 1: Health and Social Care Services to be integrated

Services currently provided by West Lothian Council	Services currently provided by NHS Lothian
<ul style="list-style-type: none"> <li>✚ Social work services for adults and older people</li> <li>✚ Services and support for adults with physical disabilities, learning disabilities</li> <li>✚ Mental health services</li> <li>✚ Drug and alcohol services</li> <li>✚ Adult protection and domestic abuse</li> <li>✚ Carers support services</li> <li>✚ Community care assessment teams</li> <li>✚ Support services</li> <li>✚ Care home services</li> <li>✚ Adult placement services</li> <li>✚ Health improvement services</li> <li>✚ Housing support services, aids and adaptations</li> <li>✚ Day services</li> <li>✚ Local area co-ordination</li> <li>✚ Respite provision</li> <li>✚ Occupational therapy services</li> <li>✚ Re-ablement services, equipment and telecare.</li> </ul>	<ul style="list-style-type: none"> <li>✚ Accident and emergency services provided in a hospital</li> <li>✚ Inpatient hospital services relating to the following branches of medicine— <ul style="list-style-type: none"> <li>✚ General medicine</li> <li>✚ Geriatric medicine</li> <li>✚ Rehabilitation medicine</li> <li>✚ Respiratory medicine</li> <li>✚ Psychiatry of learning disability,</li> <li>✚ Palliative care services provided in a hospital</li> <li>✚ Palliative care services provided out with a hospital</li> </ul> </li> <li>✚ Inpatient hospital services provided by general medical practitioners</li> <li>✚ Services provided in a hospital in relation to an addiction or dependence on any substance</li> <li>✚ Mental health services provided in a hospital, except secure forensic mental health services</li> <li>✚ District nursing services</li> <li>✚ Services provided out with a hospital in relation to an addiction or dependence on any substance</li> <li>✚ Services provided by allied health professionals in an outpatient department, clinic, or hospital</li> <li>✚ The public dental service</li> <li>✚ Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health (Scotland) Act 1978</li> <li>✚ Defined general dental services.</li> <li>✚ Defined ophthalmic services</li> <li>✚ Defined pharmaceutical services.</li> <li>✚ Primary medical services during out-of-hours.</li> <li>✚ Services provided out with a hospital in relation to geriatric medicine</li> <li>✚ Community learning disability services</li> <li>✚ Community mental health services</li> <li>✚ Community continence services</li> <li>✚ Community kidney dialysis services</li> <li>✚ Services provided by health professionals that aim to promote public health</li> <li>✚ Edinburgh Dental Institute</li> <li>✚ Psychology and Psychological Therapies</li> </ul>

## Appendix 2: Performance Indicators

### Core Suite of National Integration Indicators

<b>Outcome Indicators based on survey feedback, to emphasise the importance of a personal outcomes approach and the key role of user feedback in improving quality</b> While national user feedback will only be available every 2 years it is expected that performance reports will be supplemented each year with related information that is collected more often	
1.	Percentage of adults able to look after their health very well or quite well.
2.	Percentage of adults supported at home who agree that they are supported to live as independently as possible.
3.	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
4.	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5.	Percentage of adults receiving any care or support who rate it as excellent or good
6.	Percentage of people with positive experience of care at their GP practice.
7.	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
8.	Percentage of carers who feel supported to continue in their caring role.
9.	Percentage of adults supported at home who agree they felt safe
10.	Percentage of staff who say they would recommend their workplace as a good place to work.*
<b>Indicators derived from organisational/system data primarily collected for other reasons.</b> These indicators will be available annually or more often.	
11.	Premature mortality rate.
12a.	Rate of emergency admissions for adults - SMR01
12b.	Rate of emergency admissions for adults - SMR04
13.	Rate of emergency bed days for adults.*
14.	Readmissions to hospital within 28 days of discharge
15.	Proportion of last 6 months of life spent at home or in community setting.
16.	Falls rate per 1,000 populations in over 65s
17.	Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
18.	Percentage of adults with intensive needs receiving care at home
19.	Number of days people spend in hospital when they are ready to be discharged
20.	Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency
21.	Percentage of people admitted from home to hospital during the year, who are discharged to a care home
22.	Percentage of people who are discharged from hospital within 72 hours of being ready
23.	Expenditure on end of life care.*

## LDP Indicators

1. People diagnosed and treated in 1st stage of breast, colorectal and lung cancer (25% increase)
2. 31 days from decision to treat (95%)
3. 62 days from urgent referral with suspicion of cancer (95%)
4. People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support
5. 12 weeks Treatment Time Guarantee (TTG 100%)
6. 18 weeks Referral to Treatment (RTT 90%)
7. 12 weeks for first outpatient appointment (95% with stretch 100%)
8. At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation
9. Eligible patients commence IVF treatment within 12 months (90%)
10. 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)
11. 18 weeks referral to treatment for Psychological Therapies (90%)
12. Clostridium difficile infections per 1,000 occupied bed days (0.32)
13. SAB infections per 1,000 acute occupied bed days (0.24)
14. Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)
15. Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings
16. Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas
17. 48 hour access or advance booking to an appropriate member of the GP team (90%)
18. Sickness absence 4%
19. 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
20. Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement

## Social Care Indicators

1. Number of domiciliary care hours provided in the snapshot week for people aged 65+
1a. Total number of people 65+ who are supported in a care home
1b. Number and % of people supported in a care home who are receiving FPNC only
2. Number of people waiting for a domiciliary care package who are waiting:
a) in hospital
b) at home in the community – with no dom care service in place
c) at home in the community – where the person is already receiving a domiciliary care service but needs additional hours
3. For people waiting for domiciliary care in the following locations, number of hours of support needed:
a) in hospital
b) at home in the community – with no dom care service in place
c) at home in the community – where the person is already receiving a domiciliary care service but needs additional hours
4. Number of people aged 65+ who are waiting in hospital for a care home place



## Appendix 3: Housing Contribution Statement

### 1 Executive Summary<sup>20</sup>

The Housing Contribution Statement sets out the role of social housing providers in West Lothian to achieving outcomes for Health and Social Care. This is an integral part of West Lothian Integration Joint Board's Strategic Plan and also links into the development of the new Local Housing Strategy (LHS) to be prepared during 2016. Whilst the council provides some of the resources to address the range of needs identified, it cannot deliver a viable approach without the input of their partners including Registered Social Landlords (RSLs), care providers and voluntary organisations. The Housing Contribution Statement has been developed in consultation with Registered Social Landlords (RSLs) operating in West Lothian.

### 2 Identifying Housing Need and Demand

The Housing Need and Demand Assessment (HNDA2), covering the South East Scotland Strategic Plan area, for the Strategic Development Plan 2 has been completed and provides a robust, shared evidence base for housing policy and land use planning.

### 3 Key Housing Points

- ✚ Between 2012 and 2037 the number of households in West Lothian is projected to increase by 17% (from 73,847 to 86,487) which will have a significant effect on housing provision.
- ✚ The projected increase in the number of older people is likely to have a significant impact on the need and demand for health and housing related services.
- ✚ According to the most recent SHCS survey (2011-2013)
  - 36% of households have one or more persons who have a long term condition or disability. Of these 28% live in the social rented sector and 62% in the owner occupied sector.
  - 10% of households in West Lothian are in receipt of care services compared to 7% in the 2009-11 survey
  - 22% of dwellings had adaptations an increase of 6% from 2009 -11 survey.
- ✚ Since 2011/12 homeless applications have decreased from 1726 in 2011/12 to 1331 in 2014/15 however there are in excess of 1000 homeless presentations each year
- ✚ Work has been undertaken to understand the accommodation requirements of specific client groups in West Lothian and this forms the basis of the Joint Accommodation Strategy between Social Policy and Housing, Construction and Building Services.
- ✚ In West Lothian more than £1million is spent each year on adaptations to homes in the private sector, RSL housing and council housing. These range from major adaptations such as wet floor showers to the provision of grab rails.
- ✚ The council administers a number of projects to address fuel poverty and coordinates work for homeowners, RSLs and council properties to enable property condition to be improved e.g. external wall insulation for area based schemes. The Advice Shop also provides assistance to households at risk of fuel poverty.

<sup>20</sup> The full Housing Contribution Statement can be obtained from West Lothian Council Committee Services

## 4 Housing Related Challenges

The challenge of balancing the aspiration for people to live independently for as long as possible with the range of complex needs that often present later in life affects both housing support provision and provision of specialist accommodation.

There is pressure on temporary accommodation for homeless households with particular difficulty in securing wheelchair accessible housing for the limited number of homeless people with this requirement.

The need for core and cluster properties has been identified for people with mental health issues and for people with learning disability.

There are particular challenges in housing people with addictions and providing the housing support that they require on a consistent basis.

There is a need to ensure that cases of delayed discharge from hospital are minimised. Whilst this may not result directly in the provision of new accommodation, in some cases, it may mean significant resources are required to adapt an existing property.

Improvement in health care and technology has resulted in children with more complex needs and disabilities surviving longer which may lead to requirement for significant adaptation to existing property as they become adults.

Young people in transition are also a group that may have particular housing needs with a potential requirement to consider shared living projects

Families at risk of domestic violence face considerable issues in relation to housing especially if they prefer to move away from the family home which can create issues in terms of schooling and family support networks.

Welfare reform continues to have a significant impact on people with additional or complex needs in West Lothian. People with particular needs often need additional space in their homes to accommodate access and equipment and this group are at risk from the *bedroom tax* should the discretionary housing payment cease.

## 5 New Housing Supply

- ✚ Since 2009, the council have built approximately 50 bungalows suitable for older people or people with disabilities with a further 137 planned.
- ✚ A development of 7 homes has been built for people with profound physical disabilities in Uphall and a further two housing developments for older people and people with disabilities in Bathgate and Broxburn.
- ✚ The Blackburn homeless unit has been refurbished and provides additional temporary accommodation for homeless families.
- ✚ Housing Associations have built 78 homes for people with particular needs between 2007 and 2015.

## 6 Integration and Delegated Functions

The housing functions that are being delegated by West Lothian Council to West Lothian Integration Joint Board are:

- ✚ Housing Support Services
- ✚ Aids and Adaptations – an adaptation is defined in housing legislation as an alteration or addition to the home to support the accommodation, welfare or employment of a disabled person or older person, and their independent living. Common examples include ramps, level access, wet floor showers and kitchen conversions

Other housing services that the council is responsible for will be closely aligned to health and social care. These include

- ✚ Sheltered housing,
- ✚ Housing with care and supported housing,
- ✚ Housing options information and advice and homelessness,
- ✚ Services to address fuel poverty.

## 7 Shared outcomes and priorities

The new LHS will seek to ensure:

- ✚ Independent living is supported in the context of an ageing population and increasing health and social care demand.
- ✚ Strategic alignment in supporting care and people in their own homes and provision of adaptations.
- ✚ Provision of services for all tenures including care and repair, telecare and telehealth.
- ✚ Specialist housing provision is planned and linked to integration of health and social care.
- ✚ The future need for care home provision is identified
- ✚ Information is provided on how adaptations and adapted properties can enable people to live in their own homes for longer.
- ✚ Local initiatives that support prevention and facilitate hospital discharge to home as early as possible are supported.

Housing can make a particular contribution to the achievement of the nine national health and wellbeing outcomes and in particular

1. Outcome 2 – *People including those with disabilities or long term conditions, or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community* \_ through the provision of good quality housing to support a range of needs.
2. Outcome 9 – Resources are used effectively in the provision of health and social care- where effective housing solutions can prevent costly health and social care responses.

## West Lothian IJB

# Strategic Plan 2016/26

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**March 2016**

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